IMMUNIZATION AGENDA 2030

IMMUNIZATION AGENDA 2030 MID-TERM REVIEW

NOVEMBER 2025

CONTENTS

FOREWORD

by the Immunization Agenda 2030 Partnership Council[1]

The Immunization Agenda 2030 (IA2030) is the world's collective vision to ensure that everyone, everywhere, at every age fully benefits from vaccines. At its core, IA2030 reflects the values of equity, country ownership, and partnership. Developed with broad consultation and launched at the World Health Assembly in 2020, it laid the foundation for a more inclusive, resilient, and life-course approach to immunization in every region of the world during the decade to come.

This Mid-Term Review marks a pivotal moment to assess and reset the IA2030 for the second half of the decade. As we reflect on the first five years of IA2030, we do so in the context of a deeply changed global health landscape. The COVID-19 pandemic profoundly disrupted health systems and routine immunization, while also demonstrating the life-saving power of vaccines, and the critical importance of timely, coordinated response. Today, rising geopolitical instability, climate-related disruptions, weakened public confidence in the form of growing vaccine hesitancy and misinformation spread, as well as constrained financing all mount pressure on countries and the global immunization ecosystem.

This report has convened thought leaders to provide critical analysis and offers a clear-eyed assessment of where we stand. It celebrates the significant progress that has already been made, including 17 million future deaths averted between 2021 and 2024 due to immunization efforts, but also acknowledges that **major efforts will be needed to achieve most 2030 targets** and in areas such as routine vaccination coverage, reaching 'zero-dose' children, or preventing large outbreaks, the world has still not fully recovered from the disastrous effects of the pandemic on immunization. It also rightly highlights that important progress has been achieved, such as in new vaccine introductions, as well as the successes of many individual countries, often in highly challenging situations. On the **overall vision, priorities and targets** of IA2030, the report recommends a recommitment to the direction articulated in 2020. The vision of IA2030 remains as **relevant today** as it was then and can **continue to provide the guiding light** towards which our collective and committed immunization efforts are directed.

In addition to reviewing the metrics, extensive consultations and dialogue have rigorously examined the IA2030 architecture and operating model to understand what form it should take for the next five years to enable the greatest impact. These conversations have identified key challenges, including **a lack of direct country inputs, disjointed governance,** and the need for more **streamlined and targeted ways of working.**

Looking ahead, the **Review recommends a 'build from here' approach.** Founded upon a **renewed commitment to the vision and priorities** outlined in the IA2030 strategy and review of key challenges and priorities, it recommends a continued push towards greater country ownership, more rigorous prioritization, greater integration of immunization into primary healthcare, enhanced coordination – especially considering reduced global health resources, and tailoring of support according to individual country needs. Achieving IA2030's goals will depend on how well all stakeholders can mobilise behind a shared effort, prioritised towards the **most important priority areas of reaching zero-dose children, reducing outbreaks, and increasing base-level coverage in the key vaccines.**

Finally, this report recommends that while we continue to deliver for today, **we must also more proactively now look beyond 2030.** The environment in which immunization activities – nationally, regionally, globally – occur has drastically changed since 2020. The direction of travel in many areas is also taking shape – the shift in development spending, the time-limited nature of important global programmes, the increased role of countries in prioritising and integrating immunization activities. During the period 2026-30, we have a choice – either we react to each new development, or we **take proactive action, together, to shape a renewed vision for immunization programmes** within this wider direction of travel.

We wish to thank all those who contributed to the development of this Mid-Term Review – including representatives of Member States, IA2030 partners, and immunization experts at all levels and across all regions who participated in the process with thoughtfulness, urgency, and candour. Your insights have shaped this important milestone and will guide the next phase of IA2030 implementation.

We must now take this opportunity to act - with renewed focus, aligned efforts, and a steadfast belief in the power of vaccines to save lives and advance health for all.

[1] WHO, UNICEF, Gavi, CEPI, World Bank, IFRC, European Commission, Africa CDC, Wellcome, Gates Foundation, plus independent members.

ACKNOWLEDGEMENTS

Immunization Agenda 2030 (IA2030) gratefully acknowledges the many experts and agencies who contributed to the planning, development, and review of this report.

This report was developed under the overall strategic lead and technical direction of the Immunization Agenda Partnership Council that is co-chaired by Dr Jeremy Farrar (Assistant Director-General - Health Promotion, Disease Prevention, and Care, WHO) and Dr Eleanor Nwadinobi. The lead writers at WHO were Benedict Millinchip (Senior Lead, Immunization Strategy) and Dr Naor Bar-Zeev (Unit Head, Immunization Decision Making) with close support and regular input from the IA2030 Coordination Group members including the rotating chairs: Dr Kate O'Brien (Director - Immunization, Vaccines, and Biologicals, WHO), Dr Ephrem Lemango (Associate Director – Immunization, UNICEF), and Thabani Maphosa (Chief Country Delivery Officer, Gavi).

The IA2030 Partnership Council recognizes the extensive consultation process that was led by the IA2030 Secretariat and gives special thanks to more than 100 individuals that participated in the development and review of this report. This included analysis of key studies and extensive consultations across all critical IA2030 stakeholders including partners, experts, and other key groups from various regions and countries who generously provided a comprehensive and candid reflection on progress in the first five years.

MID-TERM REVIEW ON A PAGE

FINDINGS

- **The vision and strategic priorities of IA2030 remain as relevant as ever.** Though developed before the COVID-19 pandemic, IA2030's vision and strategic priorities remain highly relevant and comprehensive and should continue to guide global immunization efforts despite ongoing challenges.

- **The global landscape has shifted significantly since 2021, and will continue to evolve, adding further pressure on immunization systems.** Megatrends such as geopolitical instability, shifting demographics and population ageing, climate change, and increasing financial constraints add pressures on countries and partners, forcing all stakeholders to navigate complex trade-offs and competing priorities within a constrained set of resources.

- **While immunization has proven enormous impact over decades, progress is now stalling.** Between 1974 and 2024, immunization saved an estimated 154 million lives,[2] and the COVID-19 vaccines saved millions more. However, most IA2030 indicators are advancing too slowly to achieve the 2030 targets set by the strategy.

- **The IA2030 governance model requires significant adaptation to fit the changing context.** While IA2030 structures enabled broad engagement, ways of working must shift from top-down global models to put regions and countries at the center of strategic decision-making and enable local ownership of immunization programs.

RECOMMENDATIONS

- **Within a challenging global context, all immunization stakeholders should recommit to the vision and goals of IA2030** with a focus on priority areas that will achieve the greatest impact over the next five years and beyond.

- **Acknowledge the new global reality and enable countries to achieve greater ownership and sustainability in their immunization programmes.** IA2030 should proactively shape its response to wider global trends. As donor funding decreases and funding agencies commit to finite lifespans, IA2030 partners should support all regions and countries to take fuller ownership of their immunization programmes, within a sustainable and equitable health system.

- **Stakeholders at all levels should coordinate efforts to direct limited resources to collective priorities.** Focus should be on priority areas, particularly supporting fragile, conflict and vulnerable (FCV) settings, enabling development and use of National Immunization Strategies (NIS), strengthening the use of data to inform decision-making and drive action at all levels, and strongly integrating of immunization in PHC and linkages with other platforms and priorities (e.g., life-course, health security). Partners note that middle-income countries (MICs) face distinct challenges requiring tailored interventions, which is a priority now being advanced through the IA2030 partnership.

- **To support the delivery of the recommendations above, the IA2030 governance model must evolve and strengthen the use of data for action at all levels.**

  - The IA2030 Partnership Council should be reaffirmed as a global coordination and strategic forum to facilitate regional and country programmes. While countries and regions must be at the centre of IA2030 priorities and activities, IAPC should focus on 'global goods' and cross-cutting themes, responding to regional needs.

  - The IA2030 Coordination Group and Secretariat should be empowered to take collective decisions and sufficiently resourced to commission and coordinate activities that accelerate priority areas of work.

  - Global standing working groups should be transitioned to time-bound, output-focused task teams in most cases. Remaining groups must be resourced, have clear outputs and be the core forum for their area of work.

  - Regional working groups should be supported to better provide tailored support to countries.

  - Monitoring efforts should be streamlined and strengthened further, particularly at national and subnational levels, by supporting countries in developing data use improvement plans and embedding performance tracking in continuous quality improvement cycles under NIS.

[2] (World Health Organization 2025)

EXECUTIVE SUMMARY

The IA2030 decade runs from 2021 to 2030; 2025 therefore represents a critical mid-point to take stock of progress and identify necessary shifts for the rest of the decade. This Mid-Term Review includes a summary of progress towards IA2030 targets and the results of an extensive community consultation with immunization stakeholders at country, regional and global levels. It sets out a set of refinements to the IA2030 governance model designed to ensure more focused and coordinated support for countries in pursuit of IA2030 objectives.

FINDINGS

In 2021, member states agreed a bold vision for the decade, a set of strategic priorities and ambitious yet achievable targets to be achieved by 2030. The IA2030 vision, priorities and targets remain not only relevant but more important than ever. The vision of IA2030 continues to provide the guiding light for immunization efforts globally, aiming for a *world where everyone, everywhere, at every age fully benefits from vaccines for good health and well-being.*[3]

The world has changed dramatically since 2021. The COVID-19 pandemic impacted all countries, and its effects are still being felt in many. Mega-trends such as accelerated climate change, artificial intelligence, demographics shifts and urbanisation, are affecting all areas of health and all areas of society, including immunization.[4] Other key shifts include reductions in official development assistance (ODA), greater political instability, weakening public confidence, rising vaccine hesitancy, an increase in the number and complexity of conflicts.

Within this context, significant progress has been achieved in immunization. More than 150 million deaths have been averted since 1974[5] through vaccines targeting 14[6] common pathogens, and vaccination continues to save more than 4 million lives every year. COVID-19 vaccines saved tens of millions[7] of lives globally, boasting the largest and quickest vaccine rollout in global history.

Despite strong partnerships across the immunization ecosystem, the IA2030 governance model has not been able to mobilise the collective action it was designed to enable. The IA2030 Partnership Council plays an important convening role but would benefit from a stronger mandate and broader representation to drive accountability and action. The IA2030 Coordination Group, while composed of key partners, has limited influence across partner activities and is hindered by insufficient resources to deliver coordinated partner action. The purpose of the IA2030 working groups and regional forums requires evolution to drive greater impact and measurable outputs.

[3] (World Health Organization 2020)

[4] (Gavi, Covid-19 vaccines & AI 2025)

[5] (Nature 2024)

[6] Diphtheria, Haemophilus influenzae type B, hepatitis B, Japanese encephalitis, measles, meningitis A, pertussis, invasive pneumococcal disease, poliomyelitis, rotavirus, rubella, tetanus, tuberculosis, and yellow fever

[7] (Watson 2025)

RECOMMENDATIONS

Reaffirm the IA2030 vision and strategic priorities: The vision of IA2030 is as relevant in 2025 as it was when agreed. The priorities agreed and the targets set were the right ones. Fully achieving them all by 2030 will be a challenge, but they remain key aspirations. Collectively, working to increase coverage, reach zero-dose children and other vulnerable groups, reduce outbreaks and introduce new vaccines will save lives, improve health security and deliver greater prosperity.

Acknowledge the new global reality and enable countries to achieve greater ownership of their immunization programmes: From 2026 onwards, regions and countries must be even more fully at the heart of the immunization agenda. As the global health landscape continues to evolve, the direction of travel is becoming clearer - IA2030 should proactively shape its response to these trends. As donor funding decreases and funding agencies commit to finite lifespans,[8] IA2030 partners should support all regions and countries to take fuller ownership of their immunization programmes, within sustainable and equitable health system. IA2030 can support this shift by enabling countries to develop, update and track progress against National Immunization Strategies, and by strengthening national and subnational capacity for data-driven decision-making and implementation. IA2030 will play an important role in collectively defining a pathway towards country self-sufficiency that accounts for shifting trends, working with regions and countries to enable them to navigate and respond to local shifts.

Provide tailored support in priority areas: Fragile, conflict, and vulnerable (FCV) settings present some of the greatest risks to immunization progress. Although these countries account for 24% of the global birth cohort, they were home to more than 50% of the world's zero-dose children in 2024. IA2030 partners should prioritize coordinated action in these contexts by partnering with established Gavi Alliance working groups on fragile countries to drive cross-partner alignment on immunization policies and delivery approaches. This work should explicitly recognize the need for increased financing in FCV settings, ensure the integration of immunization plans with humanitarian and development strategies, promote nuanced and context-specific advocacy delivery and system strengthening models, and foster trust through sustained community engagement.

Many middle-income countries are struggling to maintain vaccination coverage, facing challenges to introduce additional vaccines to their portfolios in the face of restricted domestic financing and reduced external support.[9] IA2030 partners should take on a greater role to support this cohort of countries, maturing the newly commissioned cross-partner IA2030 MIC task team with the necessary resources, mandate and clear objectives to support countries to make meaningful progress. This could include (1) the development of a MIC vaccine-preventable disease outbreak response mechanism; (2) further market support to achieve collective pricing; (3) support with vaccine prioritisation in light of reduced resources; (4) ongoing support to mature domestic financing levers to enable sustainable immunization programmes.

[8] (Gavi 2025) and (Gates Foundation 2025)

[9] (World Health Organization 2025)

RECOMMENDATIONS

Evolve the IA2030 governance model: To accelerate progress towards IA2030 targets and support the delivery of the above recommendations, the IA2030 architecture and ways of working must be reviewed to place further emphasis on regional and country ownership and facilitate action at all levels.

First, the **IA2030 Partnership Council** should be reaffirmed as a global coordination and strategic forum to facilitate regional and country work. IAPC serves as a facilitating and coordinating cross-partner leadership body and will focus on global goods which include topics that cut across multiple topics or address systematic challenges. This requires closer, two-way collaboration with regions and countries as well as stronger engagement and accountability mechanisms for IAPC. To take on this role, the membership of the IA2030 Partnership Council should be reconstituted, for example to bring in direct country voices, vaccine manufacturers and industry representatives, and non-immunization representatives to challenge traditionally siloed ways of working. Further, to effectively transition towards a decentralized, regionally-led model, close collaboration and engagement with regions is needed to understand local needs and challenges and gradually empower regions to assume greater leadership roles.

Second, **the IA2030 Coordination Group,** supported by a jointly resourced Secretariat, should be empowered to take collective decision and commission pieces of work that generate evidence to support its prioritization and decision-making. Membership of the Coordination Group should be bolstered to ensure sufficient representation of the partners with the levers to make a difference, including greater representation from regions where possible. The Coordination Group should then be given a mandate to act through collective action to task work and track outputs. This could include access to a pooled fund that enables the Coordination Group to collectively commission activity that is time-limited and tasked to deliver measurable outputs. Building on the lessons learnt from the Covax Strategic Coordination Office, the IA2030 Partnership Council and Coordination Group should be supported by a Secretariat that is staffed from across partner teams, allowing staff to serve as effective links with their respective organizations and increase shared ownership. Further consideration will be needed to define the operating model for further resourcing the Coordination Group[10] and Secretariat especially considering that most partners face short-term financial pressure and downsized staff.

Third, **the IA2030 working groups** should be transitioned to time-bound task teams with a clearly defined scope and a mandate to deliver clear outputs and/or actionable recommendations to global partners and other stakeholders. These should be backed with the necessary resources and organizational support requiwred for them to carry out high-quality pieces of work with the potential to have a major impact on decision-making.

Fourth, at the regional level, **IA2030 coordination forums should be strengthened,** by clarifying mandates, ensuring inclusive membership, and establishing clear accountability mechanisms that support a regionally coordinated approach to achieving IA2030 targets.

IA2030 partners should **work in partnership with regional bodies** to strengthen their IA2030 coordination forums by clarifying mandates, driving inclusive membership, and establishing clear accountability mechanisms that support **region-led immunization planning and delivery.** Better alignment across levels will reduce fragmentation, enhance coherence, and ensure regional priorities are reflected in global planning. These platforms can also promote country ownership, facilitate peer learning, and support more agile, context-specific delivery.

Finally, shift the focus of IA2030 Monitoring & Evaluation to **strengthening of monitoring, evaluation and action cycles,** particularly at national and subnational levels: Tracking of outcomes and operational performance should be embedded as part of continuous quality improvement cycles at all levels of immunization programmes, linked to annual operational plans and within the context of National Immunization Strategies. Countries should be supported to **develop data use improvement plans** that incorporate technologies, processes and skills development to promote data use for action at all levels.

[10] (World Health Organization 2023)

01
INTRODUCTION

IMMUNIZATION CONTEXT

Vaccines are among the most impactful public health interventions. Vaccines against 14 common pathogens have collectively saved 154 million lives over the past 50 years,[11] including 146 million children under the age of five. Vaccines have reduced infant mortality by 40% globally (52% in Africa).[12] **The benefits of vaccines extend far beyond the prevention of death.** They promote health equity by improving access to care, reducing disability and long-term morbidity, and preventing the loss of caregivers and labour force participation. In this way, vaccines are foundational to a thriving and prosperous society. **With an estimated return of $54 for every $1 invested, immunization is one of the most cost-effective health interventions available.** Ensuring equitable, universal access to vaccines remains essential to sustaining current health gains and preventing future deaths from vaccine-preventable diseases.

IMMUNIZATION AGENDA 2030 BACKGROUND

The Immunization Agenda 2030 (IA2030) was created by countries and a broad set of partners in and beyond immunization as a unifying framework for immunization, building on the successes and lessons of previous global strategies, the Global Immunization Vision and Strategy (GIVS) and the Global Vaccine Action Plan (GVAP).

[11] Diphtheria, Haemophilus influenzae type B, hepatitis B, Japanese encephalitis, measles, meningitis A, pertussis, invasive pneumococcal disease, poliomyelitis, rotavirus, rubella, tetanus, tuberculosis, and yellow fever

[12] (Shattock 2024)

FIGURE 1

Overview of global vaccination strategies and frameworks from 2000 to 2030. Sourced from World Health Organization, Immunization Agenda 2030, Gavi and NIH National Library of Medicine.

	2000 — HISTORY OF IMMUNIZATION FRAMEWORKS — 2030		
	Global Immunization Vision and Strategy	**Global Vaccine Action Plan (GVAP)**	**Immunization Agenda 2030**
Dates	**2006-2015**	**2011-2020**	**2020-2030**
Vision	*Immunization is valued, widely accessible, strengthens health, and ensures fair global vaccine access.*	*"All individuals and communities enjoy ives free from vaccine preventable diseases"*	*"A world where everyone, everywhere, at every age fully benefits from vaccines for good health and well-being"*
Impact Goals	**By 2010 or earlier** ▪ Increase coverage. ▪ Reduce measles mortality **By 2015 or earlier** ▪ Sustain coverage. ▪ Reduce morbidity and mortality. ▪ Ensure access to vaccines of assured quality ▪ Introduce new vaccines ▪ Ensure capacity for surveillance and monitoring. ▪ Strengthen systems. ▪ Assure sustainability	▪ Achieve a world free of poliomyelitis; ▪ Meet vaccination coverage targets in every region, country and community: ▪ Exceed the Millennium Development Goal ▪ Exceed the Millennium Development Goal 4 target for reducing child mortality ▪ Meet global and regional elimination targets; and ▪ Develop and introduce new and improved vaccines and technologies.	▪ Reduce mortality and morbidity from vaccine-preventable diseases for everyone throughout the life course ▪ Leave no one behind, by increasing equitable access and use of new and existing vaccines ▪ Ensure good health and well-being for everyone by strengthening immunization within primary health care and contributing to universal health coverage and sustainable development.

IA2030 builds on a foundation of global partner collaboration, beginning in the early 2000s, to advance the coverage and impact of immunization globally. In 2019, a WHO-commissioned review of lessons learned from the Global Vaccine Action Plan (GVAP), alongside interviews with key stakeholders, identified a range of challenges that hindered GVAP's impact, including:

- **Limited Country Ownership and Engagement**: GVAP's perceived top-down design, unrealistic targets, and minimal country-level involvement undermined national ownership and reduced its relevance and impact.
- **Weak Governance, Coordination, and Operational Support:** The strategy lacked effective governance and operational structures, suffering from poor alignment with existing mechanisms and partners
- **Insufficient Resources, Advocacy, and Strategic Alignment:** GVAP was under-resourced, lacked strong leadership backing, and failed to align with key partner strategies or communicate effectively

IA2030 was developed in response to these shortcomings. Extensive consultations, centering country engagement, were conducted to reflect on lessons learned, assess IA2030's role within the global health architecture, and inform its governance and operational design. The result was a unifying framework to directly address past challenges through:

- **Flexible and Adaptive Strategy:** IA2030 recognized the need to tailor implementation activities to local contexts and respond to evolving needs and challenges.
- **Integrated, Systems-Based Approach:** IA2030 emphasized opportunities to strengthen health systems by embedding immunization within primary health care and adopting a life course approach
- **Focus on Equity and Supply Resilience:** IA2030 prioritized reducing inequities through targeted strategies and calls for a reliable, affordable global vaccine supply to support sustainable access for all.

The Framework for Action draws on the following principles *[extract from the 2020-2021 Framework for Action]:*

- **Instilling broad ownership to achieve the IA2030 vision** among all immunization and non-immunization stakeholders, including those involved in health system strengthening and disease-specific initiatives.
- **Country ownership is key to achieving the IA2030 vision** because the most important actions will be the responsibility of individual countries.
- **Leveraging and strengthening existing mechanisms** for coordination, accountability, planning, M&E and advocacy at country, regional and global levels.
- **Promoting continuous quality improvement cycles** using timely, reliable and fit-for-purpose data.
- **Building and strengthening** stakeholder accountability and technical alignment to address country needs.
- **Aligning and harmonizing** with existing regional and national plans and global strategies, including the Sustainable Development Goals (SDGs), particularly SDG 3: Good Health and Well-Being, Universal Health Coverage (UHC), Gavi 5.0 and other global health agendas, such as the UN Decade of Healthy Ageing.

In November 2020, the World Health Assembly endorsed the Immunization Agenda 2030: A Global Strategy to Leave No One Behind (IA2030) as an immunization vision for the decade. The year 2025 marks the midpoint of the IA2030 decade. This Mid-Term Review reflects on the evolving global landscape and progress to date. Alongside the accompanying 2025 IA2030 Global Progress Report, it outlines a series of changes designed to strengthen collaborative action across stakeholders at national, regional and global levels in pursuit of IA2030 objectives.

FIGURE 2

Evolution and key milestones of the Immunization Agenda 2030.

2019-2020

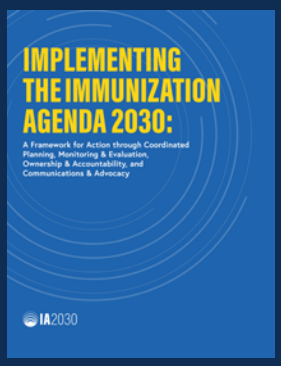
Co-development of the Strategy and Vision across partners

WHA 73 - Aug 2020

Member States endorse IA2030

2020-2021

Implementation planning, design of architecture



WHA 74 - May 2021

Member States endorse IA2030 Framework for Action

2021-2022

Activating operational levels and providing first global report

WHA 75 - May 2022

Member States receive first global report for IA2030

2022-2023

Intensification of immunization recovery: catch-up, restore and strengthen

WIW - April 2023

Launch of IA2030 **"Big Catch-up"**

2023-2024

Implementation of "Big Catch-up" and EPI@50 celebrations

WHA 77 - May 2024

Member States receive second global report for IA2030

02
GLOBAL TRENDS & IMPLICATIONS

This chapter highlights key trends to contextualize IA2030 implementation and outcomes to date, anticipate drivers shaping the next phase, and support interpretation of immunization metrics in light of broader global developments.

Global trends

In 2019-2020, as the Immunization Agenda 2030 was being developed, several global trends influenced the global health landscape. These included:

- **Increasing global forced displacement:** Globally, the number of displaced people doubled from 41.1 million in 2010 to 82.4 million by 2020, fueled by a growing number of concurrent conflicts, climate disasters triggering internal displacement and heightening vulnerability of those already displaced.[13] Accessing and serving vulnerable populations remains a significant operational challenge.

- **Stagnating global health aid:** Global health ODA, traditionally driven by G7 countries, was stagnant from 2012 to 2019 (pre-COVID-19-related funding), while its share of total ODA funding declined from over 16% in 2014 to ~13% in 2019.[14] While Global Health ODA picked up during the Covid-19 pandemic, it has since fallen as investment shifts to greater support for refugees in donor countries because of geopolitical conflicts (Figure 13). Within immunization work, Gavi's recent replenishment for the 6.0 (2026-2030) strategic period fell short of the $11.9 Billion target. Alongside other impacts, this will result in reductions to immunization-related expenditure across the core Gavi Alliance partners: Gavi Secretariat, UNICEF, and WHO, as well as for others.

- **Growing spread of misleading information and erosion of trust:** There has been an accelerated spread of inaccurate or misleading information about vaccines, particularly through social media, further eroding public trust[15] and deepening the spread of an anti-vaccination sentiment. This sentiment has potential to impact political agendas, religious or cultural perspectives, and broader public sentiment which may further affect uptake of vaccines as evidenced by the resurgence of diseases that were making progress toward their control or elimination (such as measles).

- **Demographic changes:** Between 2010 and 2019 the world's population grew by roughly 750 million, reaching an estimated 7.7 billion. Africa and the Eastern Mediterranean registered the highest gains, and the global urban population share climbed from just over half to about 55 percent by 2018.[16] Additionally, the global number of people aged 60 years and older is projected to increase by 34% from 2019 to 2030.[17] This further highlights the importance of integration with the life course approach to health.

- **Climate change and natural disasters:** A changing, less predictable climate expanded malaria, dengue, and other vector-borne diseases into new regions, worsened water-borne threats like cholera after floods, and disrupted the timing and duration of seasonal outbreaks.[18] The effects of climate change, and subsequent environmental changes, may also cause shifts in migration patterns which increase zoonotic spillover risks.

- **Resurgent disease outbreaks:** Resurgent measles, yellow fever, diphtheria, and emerging infections such as Ebola highlighted that strong disease-surveillance and immunization systems were essential to detect, prevent, and contain infectious threat.[19]

[13] (UNHCR 2022)
[14] (Focus 2030 2025) and (OECD 2025)
[15] (World Health Organization 2020)
[16] (World Health Organization 2020)
[17] (World Health Organization 2020)
[18] (World Health Organization 2024)
[19] (World Health Organization 2024)

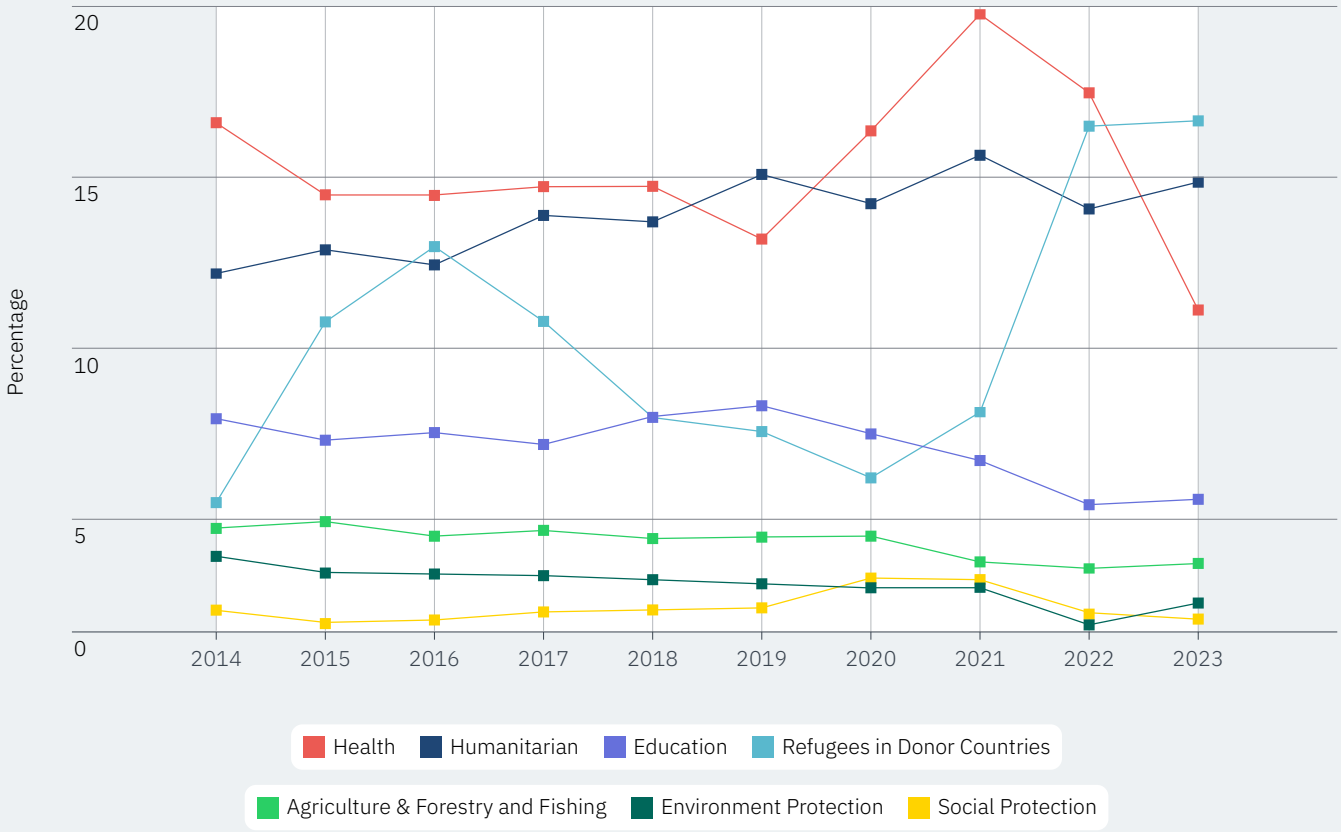
IN 2025, IMMUNIZATION CONTINUES TO ENCOUNTER SIGNIFICANT CHALLENGES, INCLUDING:

Constrained global funding landscape

From 2020 onwards, global aid patterns began to shift, with increased allocations toward refugee-related support within donor countries in response to global crises (such as Ukraine and Syria among others). During this period, most major aid sectors, including health (excluding COVID-19), education, and environmental protection, either stagnated or experienced declines.[20]

FIGURE 3

Graph showing the share of ODA aid to selected sectors from 2014-2023. Sourced from OECD Data.

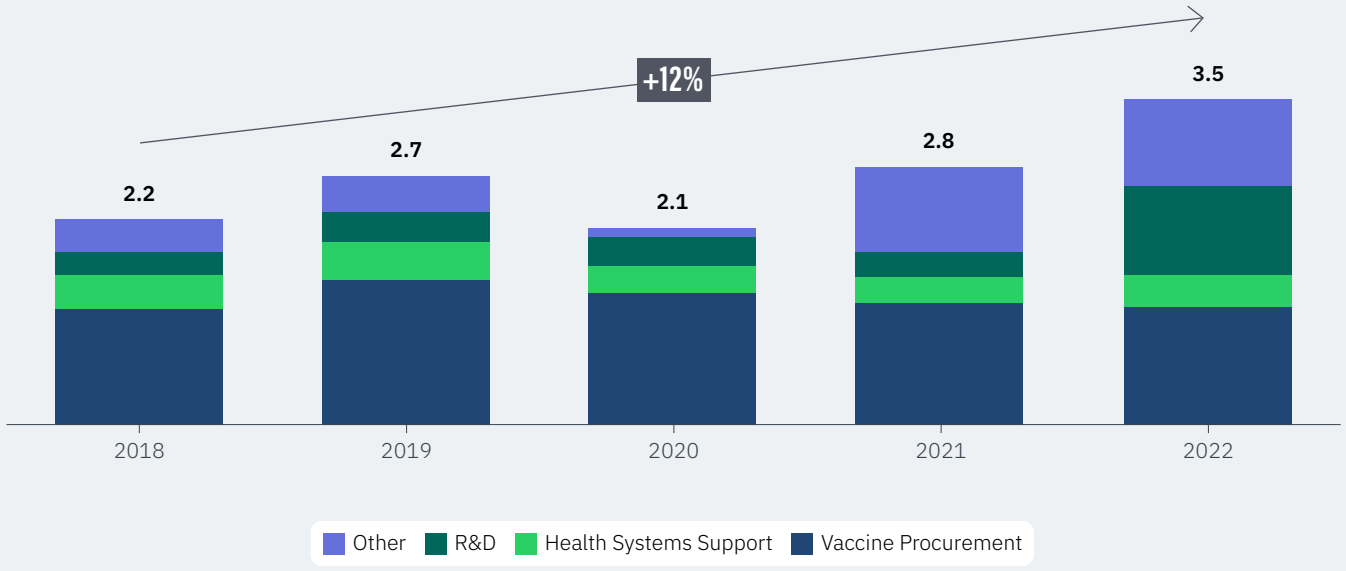


Despite flat overall health funding, ODA and Other Official Flows (OOF) for vaccines have grown at a compound annual growth rate (CAGR) of 12% since 2018.[21] excluding COVID-19-related support. However, this upward trend has not shielded immunization funding from the broader shocks affecting global health financing. Budget reductions for technical assistance and delivery of critical programmes such as measles immunization have already been implemented or signalled by major donor governments,[22] with limited prospects of recovery to previous levels.

[20] (OECD 2025)
[21] (OECD 2024)
[22] (Sunny 2025)

FIGURE 4

ODA & OOF inflows globally on vaccines (excluding Covid-19 support). Sourced from OECD CRS Database.

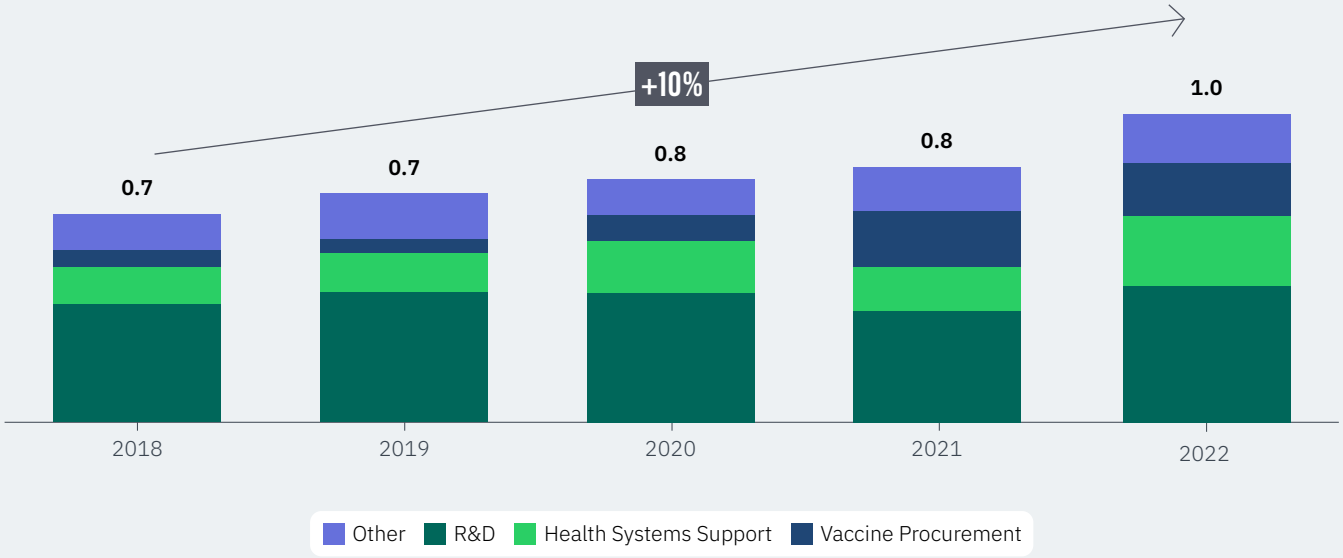


Philanthropic contributions to vaccine funding have also shown sustained growth, with a 10% Compound Annual Growth Rate (CAGR) since 2018 (excluding COVID-19).[23] While this reflects continued engagement in global health, philanthropic investments have historically concentrated on research and development, innovation, and systems strengthening, supporting long-term sustainability rather than immediate delivery.

[23] (OECD 2024)

FIGURE 5

Private philanthropy gross disbursements on vaccine funding (excluding Covid-19 support). Sourced from OECD CRS Database.



Constrained global financing may lead to gaps in immunization and broader health budgets at country level, which may require increased commitment and financing from governments to address.

Weakening public confidence

Rising vaccine hesitancy and surging anti-science sentiment are undermining global immunization progress and jeopardizing hard-won gains. In the United States, measles cases spiked to an over 30-year high in 2025 following a post pandemic dip in vaccination coverage and growing vaccine scepticism.[24] Research shows that rising vaccine hesitancy and declining trust in public health institutions are complex and multi-faceted, driven by a combination of factors such as misinformation campaigns, conspiracy theories, religious opposition, low health literacy, sociodemographic factors and in some cases the politization of vaccines that undermines science. Additionally, there are heightened concerns about vaccine side effects, particularly among parents, following the COVID-19 pandemic.[25] These trends highlight an urgent need for immunization actors to prioritize trust-building, counter misinformation, and reinforce public confidence in vaccination efforts worldwide.

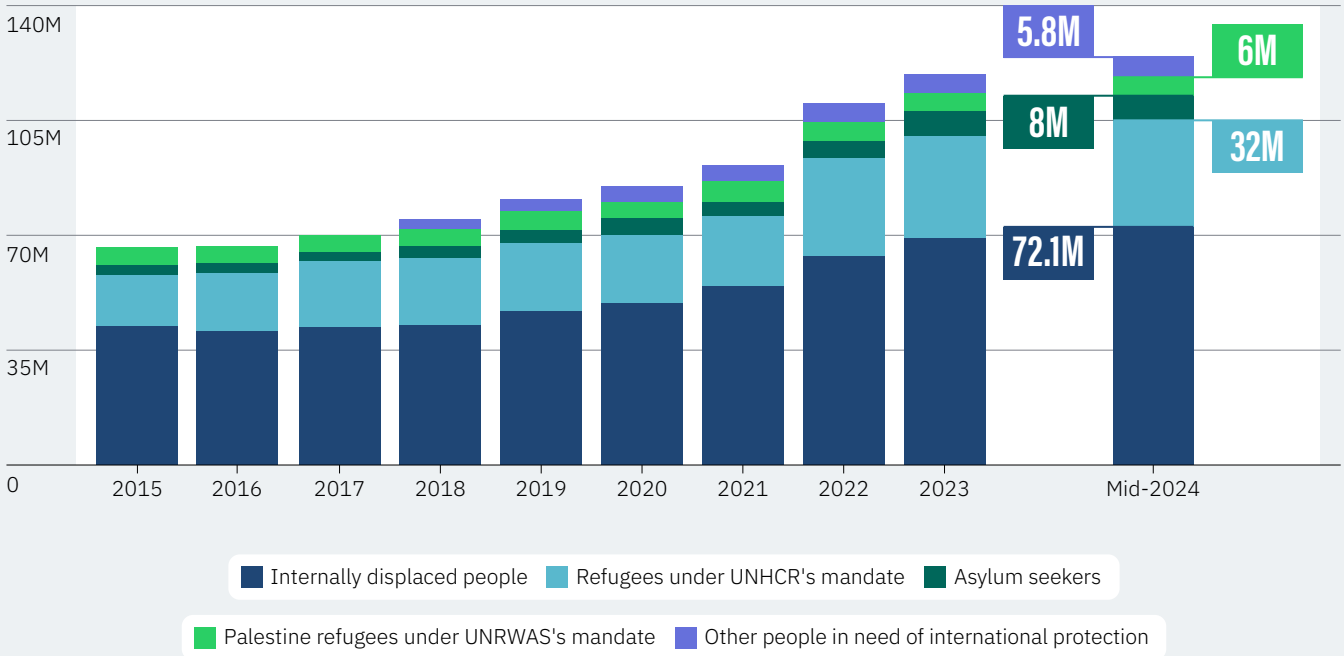
Persistent geopolitical instability

Fragile, vulnerable and conflict settings remain a priority as global conflicts persist, including protracted conflicts such as those in Sudan and Democratic Republic of Congo, and post-2020 conflicts erupting in countries such as Ukraine, Gaza and Myanmar among others, leaving over 120 million people worldwide displaced.[26] Marginalized and vulnerable groups (e.g., zero-dose children, women, and the older population) are disproportionately impacted by such conflicts, leading to inequitable health outcomes globally. *Deeper assessment of the impact of fragile, conflict and vulnerable settings is contained further in the report.*

Geopolitical megatrends, as demonstrated in the global funding landscape trend, has also contributed to the shift in priorities for major donor governments which may contribute to reorientation of public health spending and international aid to other priorities. This undermines global health security, to which immunization is a major contributor.

[24] (Garcia de Jesus 2025)
[25] (Shah 2025)
[26] (UNHCR 2024)

FIGURE 6
Graph depicting the cumulative frequency of people forcibly displaced from 2015 to mid-2024. Adapted from UNHRC Global Trends in Forced Displacement 2024 report.



Accelerated climate change impact

Climate change is accelerating the spread and severity of infectious diseases, reaching new regions;

- Existing priority diseases will spread to new regions unaccustomed to outbreaks (e.g., ~8.4b people at risk annually from malaria & dengue by end of century[27])
- Current low-incidence infectious diseases can become endemic as their transmission becomes enabled by climate change; examples already with Zika, Japanese Encephalitis (JE) & Rift Valley Fever in Asia, Latin America, North America & Europe[28]

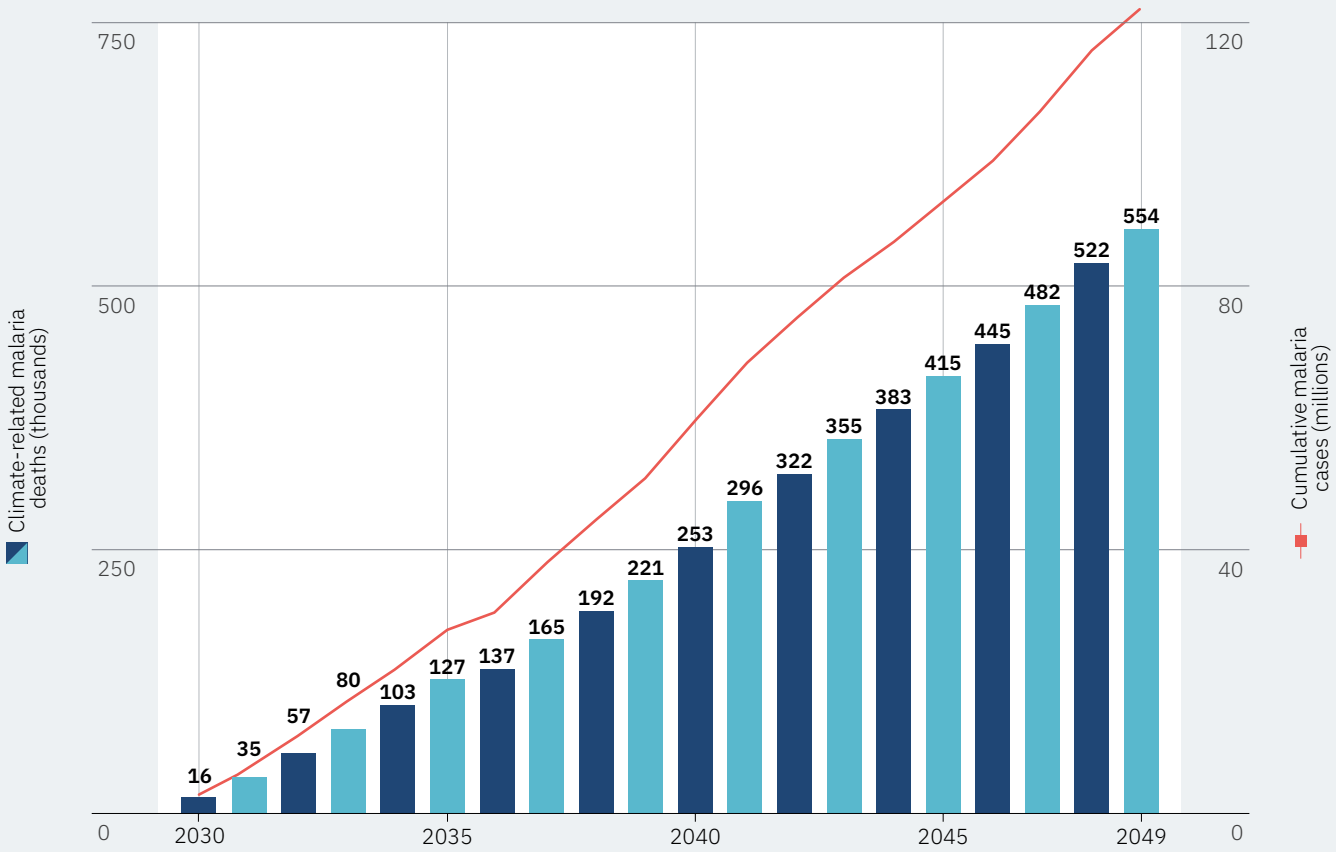
Further, extreme weather events are increasingly disrupting sanitation and healthcare access, further compounding the burden of, and mortality from, climate-sensitive infectious diseases. For example, in the case of malaria, disruptions to larval habitats, access to insecticide-treated nets, poorer housing quality and disruptions to health care services are expected to drive increased cases and deaths - with over 550,000 additional malaria deaths projected between 2030 and 2049 compared to the current climate scenario.[29]

The future of how climate change could impact long-term health security and health outcomes remains uncertain, but the risk of increasing pandemics, disease outbreaks, and changing epidemiology are material to consider in future immunization and public health strategies.

[27] (Colon-Gonzalez 2021)
[28] (Independent Panel on Climate Change 2022)
[29] (Malaria Atlas Project 2025)

FIGURE 7

Projected cumulative malaria cases and climate-related malaria deaths 2030-2049. Sourced from Malaria Atlas Project.



IN ADDITION, SEVERAL TRENDS HAVE EMERGED OR BECOME INCREASINGLY EVIDENT DURING 2020-25

Impact of COVID-19 pandemic

The COVID-19 pandemic significantly disrupted routine immunization systems worldwide, straining health services and diverting resources toward emergency response. As a result, many countries experienced interruptions in vaccine delivery and reduced access to essential immunization services. This disruption led to backsliding in coverage across multiple routine vaccines, reversing hard-won gains of the past decade. For example, global coverage of the third dose of diphtheria–tetanus–pertussis (DTP3) fell from 86% in 2019 to 81% in 2021 – the largest sustained decline in three decades.

Increasing integration across health areas

There has been an increased shift from vertical, disease-specific prevention and care initiatives toward integrated service delivery anchored in primary health care.[30] WHO's 2024 policy brief on re-orienting models of care places essential public-health functions "at the core of integrated health services," emphasising shared platforms for supply chains, data, and workforce training. Major financiers are following suit: the Global Fund's Resilient and Sustainable Systems for Health (RSSH) approach ties HIV, TB, and malaria grants to broader PHC strengthening.[31] Further, the Gavi Alliance 6.0 strategy includes a dedicated 'Health Systems Strengthening Strategy' focused on stronger integration of immunization within PHC. To remain effective and efficient, immunization must continue to break vertical programmatic silos—embedding vaccination within PHC packages across the life cycle, harmonising data and supply-chain systems with other health areas, and co-designing delivery models that leverage integrated platforms. As many new vaccines in the pipeline will be available for adults, and subsequently delivered outside the traditional EPI platforms, integration with other health areas becomes increasingly important (for example, NCD programs, care for older people, SRH programs etc.).

Evolving Global Health architecture

Major funders and agencies are recalibrating their roles, signaling a shift toward finite lifespans and deeper collaboration across the global health architecture. The Gates Foundation, for example, has pledged to double spending and close by 2045, committing its full endowment to making tangible impact rather than perpetual grant-making.[32] In parallel, Gavi's 'Leap' approach explicitly seeks "meaningful engagement with other global health agencies" to reduce overlap and improve country delivery, while also stating that global agencies should 'commit to define a date to put themselves out of business'.[33]

Heightened call for country-led and regionally-owned public health approaches

Increasing emphasis is being placed on national ownership, with countries taking greater responsibility for setting priorities and leading decision-making processes for public health. This shift was championed by the Lusaka Agenda (2023), which promotes country-led, sustainable and equitable health systems as a pathway towards Universal Health Coverage. Mirroring this trend, regional bodies such

[30] (World Health Organization 2024)
[31] (The Global Fund 2025)
[32] (Gates Foundation 2025)
[33] (Gavi 2025)

as Africa CDC and WHO's regional offices are increasing their roles relative to those of global forums and offices.

Rapid rise of Artificial Intelligence

Artificial intelligence is rapidly permeating the health sector, moving from pilot projects to large-scale applications that enhance prediction, diagnosis, and operational efficiency. In January 2024, WHO issued global guidance on the ethics and governance of large multimodal AI models for health, underscoring both the technology's transformative potential and the need for robust safeguards.[34] For example, new deep-learning tools achieved over 97 percent accuracy in malaria diagnosis from blood-smear images, promising faster, low-cost results in resource-limited settings.[35] AI presents potential for game-changing application in immunization, such as strengthening zero-dose mapping, optimising cold-chain logistics, and improving real-time surveillance. Ensuring data governance and equity considerations keep pace with technological advances will be of paramount importance.

IMPLICATIONS FOR GLOBAL HEALTH AND IMMUNIZATION

Stronger country ownership will be essential to sustain gains

In this shifting context, stronger country ownership will be crucial. Strong political awareness and commitment, as well as sustainably planned increases in domestic resource allocation, will be needed to safeguard and build upon the progress made, especially the gains achieved prior to COVID-19. It is key to recognize that immunization is also central to the broader health security agenda and closely linked to emergency preparedness and response. A key enabler of this shift will be the strengthening of national and subnational data and analytics capabilities, which are critical for making informed decisions. These must be supported by robust, data-driven prioritization processes that allow countries to allocate limited resources more effectively. Access to, and the routine use of, subnational data further promotes ownership by increasing understanding of disease burden across different population groups as well as the broader socioeconomic and health impacts of vaccine preventable diseases – highlighting the benefits of immunization as a means to address inequities in society.

New financing models will be needed

In an environment where traditional financing mechanisms are giving way to non-traditional and more fragmented sources of support, countries will require support via evolved or new financing models. These could include access to outbreak response loan or revolving fund-type facilities, new regional procurement models, or different domestic financing levers, developed with the support of international partners. For immunization specifically, developing innovative and blended financing mechanisms for immunization will be increasingly important to mobilize resources and sustain momentum in a competitive global health financing environment.

The era of large-scale, external funding for country health activities is coming to an end. Country immunization programs will need to increase sustainability, delivering more with reduced external support

The global health landscape is under strain. As external financing declines, governments and Ministries of Health will have to shoulder a larger share of essential health services using already constrained domestic budgets. Without new efficiencies and additional funding streams, momentum toward universal health coverage could stall and gains made in health outcomes could reverse. Within immunization, Gavi's 6.0 replenishment mobilized US$9 billion, falling short of the US$11.9 billion target,[36] while reductions in the budgets of WHO and UNICEF mean immunization capacities in both organisations will significantly reduce in the coming years.[37] Both in-country and regional/global levels face severe resource constraints, which will limit the scale of support they can provide to countries. These cuts signal a shift in how immunization planning and delivery will need to be approached going forward. Likely impacts include consolidation of teams across global, regional, and country levels, with associated reductions in staffing and reprioritization of programs, which may lead to an initial reduction in coverage. Maintaining balance across routine

[34] (World Health Organization 2024)
[35] (Mujahid 2024)
[36] (Gavi 2025)
[37] (Devex 2025)

immunization, outbreak preparedness and response, and the introduction of new vaccines will become increasingly challenging. Clear prioritization at both global and country levels will be essential to sustain progress and mitigate the risks of backsliding.

Immunization must adapt to the shifting global health architecture

As major funders and global health agencies shift toward time-bound mandates and deeper collaboration, countries are facing shorter funding horizons and increasing expectations for coordination and co-financing. This evolution calls for greater clarity in roles, streamlined engagement across agencies, and more sustainable, country-owned systems. For immunization, these changes create risks, such as widening funding gaps, and opportunities to reduce fragmentation, align investments, and integrate delivery models.

Progress in fragile settings will be pivotal for global goals

Fragile, conflict-affected, and vulnerable settings continue to pose one of the greatest challenges to achieving global immunization goals. These contexts are often the source of large populations of zero-dose children, as well as recurring outbreaks of vaccine-preventable diseases such as measles, diphtheria and yellow fever. Without sustained and targeted investment, these settings could undermine global efforts to eliminate and eradicate key diseases.

Investing in vaccine innovation can accelerate progress towards goals

Scaling current prevention measures will not be enough to meet long-term goals. There is an urgent need for early investment in innovative tools, such as next-generation vaccines, which will be critical for sustainable eradication and long-term control. Additionally, there is a need to scale new rapid-response platforms that can address increasing outbreak risk. This reinforces the case for not only timely, sustained investment in vaccine research, innovation, and delivery mechanisms, but also for these efforts to be coordinated and aligned with country needs and priorities.

Climate resilience must become a core feature of immunization delivery

Climate-related shocks are increasingly disrupting immunization delivery, disease surveillance, and outbreak response systems. As displacement and extreme weather events become more frequent, controlling vaccine-preventable diseases will require coordinated investments in climate adaptation and targeted outreach to displaced and hard-to-reach populations. Immunization strategies must increasingly innovate across the value chain (from vaccine research and production to last-mile delivery) to reduce the sizeable carbon footprint as a programme.

IMPLICATIONS FOR IA2030

With key immunization metrics lagging 2019 baseline levels in 2024,[38] the global immunization ecosystem now faces a shorter timeline in which to achieve the IA2030 goals and targets, within an increasingly complex and resource-constrained landscape. To continue playing its role and do so in a way that is both responsive and impactful in this post-pandemic world, IA2030 must adapt its role, priorities, and operations in response to evolving global trends, aligning IA2030 efforts not only toward 2030 but to 2040 and beyond. This includes sharpening its focus in the highly constrained environment - prioritising achievable gains and feasible impact by strengthening existing systems and leveraging proven models to support progress.

IA2030 is uniquely positioned as the global platform that orients, coordinates, and accelerates collective action in response to emerging megatrends. By applying a disciplined lens to determine where IA2030 adds greatest value, the global strategy can chart a cohesive pathway through today's volatility and lead the immunization ecosystem toward its 2030 and 2040 goals.

Potential criteria to consider in selecting focus areas for IA2030 includes:

- **Cross-regional relevance:** Priorities should address challenges that matter across multiple regions and income settings.
- **Complementarity, not duplication:** IA2030 strategic priorities can, if properly structured and resourced, focus on filling gaps no other entity is equipped or mandated to tackle, leveraging existing partner strengths whenever possible.
- **Strategic, not operational:** IA2030 strategic priorities could focus on coordination to address high-level system challenges, leaving day-to-day implementation to the appropriate agencies and country mechanisms.
- **Collective added value:** Chosen priorities must require coordinated, multi-partner engagement rather than fragmented or single-actor efforts.
- **Feasibility:** IA2030 partners should focus on output-oriented activities that can be implemented through the broader partnership to address identified challenges.

With this lens in mind, IA2030 could primarily concentrate on areas such as strengthening national and subnational prioritisation so countries (especially those under fiscal pressure) can effectively prioritise and navigate trade-offs in scaling routine services, introducing new vaccines, strengthening outbreak preparedness, scaling delivery in FCV or other settings to reach zero-dose children, and navigating immunization coordination as global health initiatives evolve or sunset.

In doing so, IA2030 plays a dual role as an ally and advocate for stronger country and regional leadership (bringing specific local challenges to the global scale), while also articulating a global perspective that supports equity, whole-of-market analysis, and collaboration on innovation and diffusion that benefits the global good.

By focusing on the most critical priorities for the ecosystem, IA2030 partners can ensure coordination, marshal resources, and safeguard immunization gains while preparing for future challenges.

[38] (World Health Organization 2025)

03
PROGRESS OF IA2030 IMPACT METRICS

Context

To track progress, IA2030's Framework for Action includes a comprehensive monitoring and evaluation (M&E) framework. This includes three **Impact Goals** derived from the IA2030 vision statement, progress towards which is tracked by seven Impact Goal indicators:

TABLE 1

IA2030 Impact Goals and 2030 targets

IA2030 Impact Goals	Targets
01 **Reduce mortality and morbidity from vaccine-preventable diseases for everyone throughout the life course**	**1.1** 50 million future deaths averted globally
	1.2 All countries achieve VPD control, elimination and eradication targets
	1.3 All selected VPDs have a declining trend in the number of large or disruptive outbreaks
02 **Leave no one behind, by increasing equitable access and use of new and existing vaccines**	**2.1** 50% reduction in the number of zero-dose children
	2.2 500 vaccine introductions in low- and middle-income countries
03 **Ensure good health and well-being for everyone by strengthening immunization within primary health care and contributing to universal health coverage and sustainable development**	**3.1** 90% global coverage for DTP3, MCV2, PCV3 and HPVc
	3.2 Improve Universal Health Coverage

The IA2030 M&E framework also includes multiple indicators linked to IA2030's **seven strategic priorities.** Specific numerical targets have not been set for strategic priority indicators at the global level. Regions have developed **regional strategies and frameworks** aligned with the global IA2030 strategy. These are associated with regional M&E frameworks, providing the basis for data use to inform regional decision-making.

Immunization data reporting

The global IA2030 monitoring and evaluation framework includes a set of indicators for tracking progress towards 2030 goals. Most of the data relating to these indicators is collected annually from countries using the **electronic Joint Reporting Form (eJRF).** These data are reviewed and quality-assured within WHO and by countries before being publicly released jointly by WHO and UNICEF (WUENIC data release). Data for other indicators are collated from a wide range of other sources and verified in dialogue with technical focal points within WHO, UNICEF and other partner organizations. Data analyses and visualizations are also discussed with WHO and UNICEF Regional Offices before publication in the Global Progress Report.

In 2025, Indonesia transitioned from the WHO South-East Asia Region to the Western Pacific Region. For the regional analyses in this Global Progress Report, Indonesia has been included in the Western Pacific Region and figures for earlier years have been recalculated.

Most data in the Global Progress Report are also made available in an interactive form through the online **IA2030 Scorecard**. The Scorecard also provides the latest year's data from individual countries.

To aid analysis, criteria have been established for each Impact Goal indicator to determine whether the world is

on- or off-track to achieve 2030 targets. For simplicity, these criteria are based on assumptions such as linear progress towards 2030 targets, so should be interpreted with caution. Nevertheless, they provide a high-level indication of progress to date. A **"trend assessment"** (trend-positive or trend-negative) adds granularity by showing whether the year-on-year change has brought each indicator closer to or further away from the trajectory required to achieve 2030 targets.

Mid-term assessment

At the half-way point of the IA2030 decade, this review includes an assessment of changes both since 2023 and in comparison to baseline. For Impact Goal indicators, the remaining challenges to achieve 2030 indicators are described.

Key Trends

Global immunization coverage for DTP3 was 85% in 2024, slightly higher than in 2023. However, this average masks much regional and country-level variation, with many success stories being balanced by deterioration elsewhere. Because of inadequate coverage, vaccine-preventable disease outbreaks continue to affect multiple countries. More positively, a surge in new vaccine introductions, particularly of malaria vaccine, is ensuring wider global access to life-saving vaccines.

Of the key IA2030 Impact Goal indicators, in comparison to 2023:

- 4.3 million future deaths were averted by vaccination against 14 key pathogens, 9.1% lower than initially targeted.
- Global DTP3 coverage rose by 1pp to 85%.
- Global coverage of 'newer' vaccines, particularly pneumococcal conjugate vaccine (PCV) and human papillomavirus (HPV) vaccine, increased significantly.
- Numbers of zero-dose children fell slightly, from 14.5 million to 14.3 million.
- New vaccine introductions in low- and middle-income countries increased from 36 to 47.
- The numbers of **large or disruptive outbreaks** fell slightly (from 109 to 105) but remain at historically high levels; MCV1 coverage remains below baseline and, although MCV2 coverage has been increasing, measles vaccination coverage is insufficient to keep measles in check.

Mid-term status report

At the half-way point of the IA2030 decade, most IA2030 Impact Goal indicators are off-track to achieve 2030 targets.

- **Future deaths averted:** Although 16.7 million future deaths have been averted by immunization in 2021–2024, failure to achieve IA2030 targets will lead to 1.6 million avoidable future deaths from vaccine-preventable diseases.
- **Elimination and eradication:** The world is not on course to achieve vaccine-preventable disease elimination and eradication targets.
- **Outbreaks:** Large or disruptive outbreaks are running at far higher levels than at baseline.
- **Zero-dose children:** The annual numbers of zero-dose children are still higher than at baseline.
- **New vaccine introductions:** The world is on-track to achieve 500 new vaccine introductions in low- and middle-income countries by 2030.
- **Coverage:** Only five additional countries have achieved 90% coverage for DTP3, MCV2, PCV3 and HPV vaccine; DTP3 coverage has yet to return to its pre-pandemic baseline, but coverage of PCV3, HPV vaccine and, to a lesser extent, MCV2 has been increasing rapidly, driven mostly by new introductions.

The positives

More children than ever before (72 million) were vaccinated in 57 Gavi-eligible countries in 2024. DTP3 coverage increased by 1% to 82% and the numbers of zero-dose children in Gavi-eligible countries fell by 500,000.

With funding support from Gavi and technical support from Alliance partners, low- and middle-income countries achieved **more than 300 new vaccine introductions** during 2021–2024. Although gaps remain, this has led to a significant closing of the vaccine availability equity gap globally, which will be further reduced with planned HPV vaccine introductions in the coming years. The **breadth of protection** (average coverage across multiple vaccines) in Gavi countries is now 73%, just 4% lower than in non-Gavi countries.

Global figures hide great **country-level variation.** Several countries have achieved significant increases in DTP3, in some cases despite challenging contexts. For example, coverage increased by 7% in Syria, 7% in Mali and 6% in Haiti between 2023 and 2024.

Several countries markedly reduced numbers of **zero-dose children** in 2024, particularly India (down 700,000) and Ethiopia (down 150,000). DTP1 coverage increased by 5% or more in eight countries (including Vietnam up 19%, Libya up 16% and Syria up 9%), reducing the proportion of zero-dose children in these countries.

Room for improvement

For most IA2030 indicators, the world remains **off-track to achieve IA2030 targets.** Inadequate coverage (often compounded by poor quality follow-up campaigns) is leading to persistently high levels of **vaccine-preventable disease outbreaks,** particularly of measles and cVDPV. Although this is a global phenomenon, the WHO African, Eastern Mediterranean and European Regions are particularly affected.

Coverage data highlight that **outlier countries** are often having a disproportionate effect on summary figures. In many cases, these are countries affected by **conflict and fragility,** the numbers of which have been growing. Countries which are sufficiently affected to necessitate the development of a humanitarian response plan accounted for 24% of the annual birth cohort but 51% of zero-dose children in 2024.

Conflict is having a particularly marked impact in the WHO African and Eastern Mediterranean Regions. Countries such as Sudan and Yemen have experienced a major increase in the numbers of zero-dose children since 2019, primarily because of conflict. Conflict overspill and displacement also creates challenges for neighbouring countries.

Although **HPV vaccine** remains below 50% and is particularly low in the WHO Eastern Mediterranean Region, where coverage is below 10% with countries only recently starting the process of introductions.

DTP3 coverage in **Gavi-eligible countries** was affected during the COVID-19 pandemic, as was the case for many other countries. Overall, coverage has almost returned to pre-pandemic levels. However, there appears to be a growing **divergence between coverage in low-income and lower middle-income countries** – the latter have returned to baseline (86%) while the former, at 70% coverage, are still 8% below baseline. The DTP3 coverage gap between these two groups of countries has increased from 9% to 16% since 2019.

Future prospects

The data up to 2024 indicate that global efforts to support **country vaccine introductions** have been highly successful, addressing an important aspect of the vaccine equity gap. The Gavi 6.0 replenishment for the 2025-2030 period will ensure continued support for new vaccine introductions. The support is for introduction of existing vaccines, and for the newly developed vaccine for respiratory syncytial virus (RSV), already being widely introduced in high-income countries. Use of RSV preventative vaccines and monoclonal antibodies could help to prevent infections that kill at least 100,000 young children a year, the overwhelming majority in low- and middle-income countries. Later in the decade, urgently needed new TB vaccines may become available, depending on the outcomes of investigational trials.

Less success has been achieved in addressing **vaccine coverage inequalities**. DTP3 coverage continues to show a strong association with country income level, and this disparity has increased since 2019. The exception is the relatively good recovery of lower middle-income countries, and there are opportunities to learn from **'positive outliers'** to identify factors associated with comparatively high performance.

The data also emphasize the fundamental impact of **local contextual factors**, as significant variation in performance is seen within each income group. Conflict and fragility are clearly of critical importance, but even within this group, contexts differ markedly, requiring highly tailored approaches.

Addressing the low vaccine coverage seen in **low-income countries** will also require a supportive approach based on an understanding of individual country needs. The encouraging signs of progress in countries beginning to recover from conflict show that difficult situations can turn around, with immunization providing an important bridgehead for the rebuilding and revitalization of health systems.

Although the IA2030 strategy emphasizes the key connections between immunization and **primary health care (PHC)** and the universal health coverage (UHC) agenda, progress in this area has proven difficult to track systematically. Vaccination increasingly has a **life-course dimension**, with important vaccines for protection of health available and recommended for use at ages from birth through all life stages, including for the elderly. Yet many countries are struggling to establish vaccine programmes outside the traditional window of infancy (or, indeed, to integrate the full range of childhood vaccines that their populations could benefit from). At the same time, vaccines are just one intervention relevant to disease control and health at different ages. The fact that many countries run parallel, vertical health programmes is a challenge to the delivery of **integrated, community-oriented and patient-centred care**. Further thought needs to be given to the optimal relationship between immunization and other health programmes across the life-course, and how systems strengthening can deliver mutual benefits across different areas.

These health programme and country shifts are happening alongside a major withdrawal in **global development assistance**. Initiatives such as the Lusaka Agenda emphasize the critical importance of **national sovereignty** in strengthening health systems to address health inequalities and drive forward UHC. Global partners can support implementation of the agenda, in particular by strengthening the capacity of countries to **identify priorities** and **use evidence** to address them most effectively. **Effective local data collection and use** will be increasingly important for countries to be able to monitor their performance, develop evidence-based improvement plans, and assess the impact of their implementation.

TABLE 2

Status of IA2030 Impact Goal indicators

Impact Goal	Indicator	2030 target	2024 Progress towards 2030 target[39]
01 PREVENT DISEASE 	**1.1** Number of future deaths averted through immunization	**50 million** future deaths averted by immunization in 2021-2030[40]	**OFF-TRACK** 4.3 million future deaths averted in 2024, 9.1% below 2024 target
	1.2 Number and proportion of countries achieving regional or global VPD control, elimination, and eradication targets	**All countries** achieve targets Eradication target for polio (WPV) and elimination targets for measles, rubella, and maternal and neonatal tetanus (MNT).	**OFF-TRACK** 89 countries have achieved eradication and elimination targets, 55 fewer than the 2024 target
	1.3 Number of large or disruptive VPD outbreaks	**Declining trend** in the annual number of large or disruptive VPD outbreaks	**OFF-TRACK** 105 large or disruptive outbreaks in 2024, 40% higher than at baseline
02 PROMOTE EQUITY 	**2.1** Number of zero-dose children	**50% reduction** in number of zero-dose children	**OFF-TRACK** 14.3 million zero-dose children, 39% more than the 2024 target
	2.2 Introduction of new or under-utilized vaccines in low- and middle-income countries	**500** vaccine introductions by decade's end	**ON-TRACK** 308 introductions since 2021, exceeding the 2024 target by 108
03 BUILD STRONG IMMUNIZATION PROGRAMMES 	**3.1** Vaccination coverage across the life-course	**90% coverage** of full course for selected vaccines	**OFF-TRACK** 90% coverage achieved in 35.6% of vaccine-country combinations (2024 target: 71.4%)
	3.2 UHC Service Coverage Index (SCI)	Universal Health Coverage **increase** in all countries, regions and globally	**N/A** 71 countries reported an increase in UHC-SCI score in 2021, 52 more than 2021 target

[39] Baseline year is 2019. Annual targets are based on simplistic assumptions, such as linear progress from baseline to 2030, so should be seen as approximate milestones providing an indication of progress to date.

[40] Estimates exclude deaths averted due to COVID-19 vaccination.

Strategic priorities

The **15 global strategic priority objectives indicators** (Table 3) are designed to track performance at all levels (country, regional and global), to help identify potential root causes of success and failure in relation to IA2030 impact goals, so that actions for improvement can be recommended. No global targets are provided for these indicators, due to wide regional and country variations. Regions and countries are encouraged to assess their own baseline for each indicator, set targets for these indicators and track progress, based on guidance provided in Annex 1 to the IA2030 Framework for Action.

TABLE 3

Strategic Priority (SP) indicators, baseline and 2024 data[41]

Strategic Priority	Indicator	2024 data
01 IMMUNIZATION PROGRAMMES FOR PRIMARY HEALTH CARE AND UNIVERSAL HEALTH COVERAGE	**1.1** Number of countries with a National Immunization Technical Advisory Group (NITAG) meeting six functionality criteria	**156** countries *2019 baseline: 113*
	1.2 Density of physicians, nurses and midwives per 10,000 population	**59.0** health workers per 10,000 population[42] (Physicians: 17.5; nurses/midwives: 39.5) *2019 baseline: 56.4 (17.4 physicians and 39 nurses/midwives)*
	1.3 Surveillance sensitivity: Percentage of countries achieving the non-measles/non-rubella discard rate of ≥2/100,000 persons and the non-polio acute flaccid paralysis rate of >1/100,000 population aged less than 15 years per year[43]	**40%** (countries meeting thresholds for the two surveillance indicators) *Baseline: 31%*
	1.4 Proportion of countries with district-level stockouts	**23%** (44 out of 194 countries) *2019 baseline: 45%*
	1.6 Vaccine safety reporting: Proportion of countries with at least one documented (with reporting form and/or line-listed) individual serious adverse event following immunization (AEFI) case safety report per million total population	**41%** (80 out of 194 countries) *2019 baseline: 28% (54 out of 194)*
02 COMMITMENT & DEMAND	**2.1** Proportion of countries with legislation in place that is supportive of immunization as a public good	**65%** (127 out of 194 countries) *2021: 58%*
	2.2 Proportion of countries that have implemented behavioural or social strategies (i.e.,. demand generation strategies) to address under-vaccination	**60%** (117 out of 194 countries) *Previous years' data not comparable*
03 COVERAGE & EQUITY	**3.2** DTP3, MCV1, and MCV2 coverage in the 20% of districts with lowest coverage (mean across countries)	**68% DTP3, 69% MCV1, 61% MCV2** *2019 baseline: 69% DTP3, 67% MCV1, 59% MCV2*
04 LIFE COURSE & INTEGRATION	**4.1** Breadth of protection (mean coverage for all WHO-recommended vaccine antigens)	**73%** *2019 baseline: 71%*

[41] Table only includes SP objectives for which global indicators have been specified

[42] 2022 data, latest available

[43] Interim Indicator

TABLE 3
Strategic Priority (SP) indicators, baseline and 2024 data (Continued)

Strategic Priority	Indicator	2024 data
05 OUTBREAKS & EMERGENCIES	**5.1** Proportion of polio, measles, meningococcus, yellow fever, cholera, cVDPV and Ebola outbreaks with timely detection and response	**17%** (11 out of 63 outbreaks) *average 2018–2020 baseline: 28%*
06 SUPPLY & SUSTAINABILITY	**6.1** Health of vaccine markets, disaggregated by vaccine antigens and country typology	**5/12** vaccine markets categorized as healthy *2019 baseline: 4/12*
	6.2 Proportion of countries whose domestic government and donor expenditure on primary health care increased or remained stable	Minimal data available from countries
	6.3 Proportion of low- and middle-income countries whose share of national immunization schedule vaccine expenditure funded by domestic government resources increased or remained stable[44]	**60%** (36 out of 60 countries, 2024 vs 2023) *2018–2019 baseline: 68% (38 out of 56)*
07 RESEARCH & INNOVATION	**7.1** Proportion of countries with an immunization research agenda	Indicator discontinued.
	7.2 Progress towards global research and development targets[45]	Candidates in phase 3: **13/34** (38%, unchanged) Candidates with policy recommendation: **2/34** (6%, unchanged)

Recommendations for monitoring and evaluation activity 2026-30

IA2030 **Monitoring & Evaluation** efforts should be structured around the use of data to drive action at all levels. Monitoring frameworks should be built from the ground up, founded on indicators that enable facilities to track, understand and improve their performance and outcomes. Higher administrative levels should extend these frameworks to incorporate indicators that are relevant to their supervisory, monitoring, and wider operational activities. Up-reporting of data to national, regional and global levels should be restricted to indicators of demonstrated value to inform decision-making at these levels. Mechanisms should be established to embed data collection, analysis and use to drive continuous quality improvement at all levels.

At the national level, M&E should be more locally relevant and action oriented. As well as outcomes, tracking of implementational progress and operational performance should be embedded as part of continuous quality improvement cycles across all levels. Local and self-defined performance, output and outcome targets should be part of annual operational planning and progress reporting, and integral to daily programmatic activities, within the framework of a multiyear National Immunization Strategy. Likewise, **national M&E development should be supported by the regional level**, informed by global normative guidance on data use. **Countries should be supported to develop data use improvement plans**, aligned with National Immunization Strategies and considering technologies, processes and skills development to promote data use for action at all levels. The **global monitoring framework** should be used to track overall progress annually, to facilitate inter-region and inter-country comparisons, and to assess the impact of global-level activities (e.g. on market shaping, policy needs, technical assistance support). Monitoring frameworks **should enable regions to understand differences among countries and common factors** affecting national outcomes, to guide tailored support and co-creation of solutions to shared challenges.

[44] Estimate excludes domestic expenditure on COVID-19 vaccination

[45] For 34 priority use cases for vaccines and monoclonal antibodies; comparison is between July 2024 and July 2025

04
CHALLENGES AND BARRIERS: DEEP DIVE INTO IMMUNIZATION IMPACT DRIVERS

This chapter examines the key drivers that have shaped immunization outcomes during the first half of IA2030 implementation. At the midpoint, progress has been uneven. Equitable coverage remains furthest out of reach in fragile, conflict, and vulnerable (FCV) settings, where systemic barriers and instability continue to significantly limit access. The eradication and elimination agendas are also under strain: measles is resurgent, with large, disruptive outbreaks threatening gains, and polio eradication efforts are being increasingly constrained to outbreak response and surveillance. While the Big Catch-Up has accelerated recovery efforts, implementation challenges, competing programme demands, and inconsistent performance put the goal of reaching 25 million missed children by the end of 2025 at risk. These drivers offer important insights into what is working, where challenges persist, and what must be done to course-correct in the years ahead.

4.1. IMMUNIZATION IN FRAGILE, CONFLICT, AND VULNERABLE SETTINGS

Why Immunization Matters in FCV Settings

Fragile, Conflict, and Vulnerable (FCV)[46] contexts, while not uniform, often share layers of vulnerability such as weakened governance, repeated displacement, lack of access to health services, damaged health infrastructure, and complex security dynamics. These realities lead to routine service interruptions, difficulties retaining health workers, disrupted supply chains, and highly mobile populations. The nature of FCV settings varies with some countries facing acute conflict and shifting frontlines; others in protracted crises lasting years; and some experiencing localized recovery phases where focus on rebuilding systems and trust is possible.[47] Each stage requires distinct operational strategies and financing approaches. Programs must also account for differences in national immunization schedules across borders and develop strategies tailored to the levels of accessibility in areas outside government control, where alternative authorities or humanitarian actors provide services.

In FCV settings reducing the burden of measles and other vaccine-preventable diseases ultimately depends on the ability of health systems to identify and reach vulnerable population groups including reach zero-dose children, using context-appropriate approaches such as flexible outreach, cross-border coordination and delivery through humanitarian partners. Beyond disease prevention, integrating immunization with services like nutrition, maternal and childcare provides communities with broader essential health benefits and can help restore trust in health systems.

[46] (OCHA 2024)
[47] (UNICEF 2018)

Failing to prioritize FCV settings threatens IA2030 goals and global health security. Without tailored strategies, millions of children remain unprotected, heightening the risk of outbreaks that can spread across borders and undermine years of progress. Zero-dose children often live in communities already facing food insecurity and poor access to services, further amplifying their vulnerability. Persistently low immunization coverage in FCV contexts means these areas become reservoirs for vaccine-preventable disease outbreaks that threaten not only local but also regional and global stability. Targeted approaches, including the Gavi 6.0 approach to Fragile and Humanitarian settings are important steps to support these contexts.

Key Trends and Findings

Back in 2020, immunization leaders explicitly recognized fragile and conflict-affected settings as a central equity challenge. The IA2030 strategy emphasized "targeted ways to reduce inequity," giving priority "to the populations that are not currently being reached, particularly the most marginalized communities, those living in fragile and conflict-affected settings and mobile populations, especially those moving across borders."[48] Since then, collective efforts have enabled countries to achieve measurable progress, such as funding mechanisms like Gavi's Zero-Dose Immunization Programme (ZIP), which supported more localized delivery models. Along with funding mechanisms with a clearer focus on equity in FCV contexts, important progress has been made around improved tracking of zero-dose children that also aligns with stronger guidance on localized strategies.

These achievements remain limited in scale compared to the magnitude of the challenge. In the past five years, the global landscape of fragility has shifted dramatically. The number of state-based armed conflicts rose to a historic high: 61 active conflicts in 2024, up from 59 in 2023, marking the highest level since records began in 1946, with violence targeting civilians increasing,[49] and involving 36 countries—up from 34 in 2023.[50] Beyond the numbers, more than half of conflict-affected states now face two or more simultaneous conflicts, underscoring increasing complexity and instability in many countries.

The newly released 2024[51] data highlights a critical reality: although FCV countries account for just 24% of the world's births, they account for over half of all zero-dose children.[52] In the Eastern Mediterranean Region alone, four countries, Afghanistan, Somalia, Sudan, and Yemen, are home to ~76% of zero-dose children in this region, underscoring the disproportionate concentration of risk. This persists despite targeted efforts in areas grappling with insecurity, political complexity, and weak health infrastructure. The scale of this imbalance makes FCV settings the defining challenge for immunization equity under IA2030, and calls for renewed focus, tailored strategies, and sustained resources. Importantly, investing here is not only a moral imperative but also critical for preventing outbreaks, safeguarding regional health security, and avoiding far greater economic costs from epidemic response.

Operational Gaps and Coordination Challenges

Translating FCV-specific approaches into national strategies remains limited, partly due to coordination gaps. Counties, UN agency regional offices, country teams, and relevant partners could further enhance embedding FCV needs and considerations into National Immunization Strategy (NIS) plans, even for non-state-controlled areas. This includes designing strategies that recognize gaps uncovered by the national immunization program in contested territories and the use of humanitarian principles to negotiate access while respecting political sensitivities. In parallel, it is also key to ensure that humanitarian responses and the UN Health Cluster fully integrate routine vaccines into all response actions. Despite discussions, practical implementation lags; real-time data remains incomplete; and programs (like ZIP and REACH) may not have sufficient scale for the total need. Global IA2030 guidance increasingly calls for more localized solutions, stronger regional and country advocacy, guided by global humanitarian principles. Discussions during a recent RITAG emphasized scaling good practices and innovations, including from non-state actors, and designing FCV-approaches with humanitarian partners.

Coverage Data and Diverging Trends in FCV Settings

The 2024 data shows a complex picture with diverging trajectories across countries.[53] In settings of acute active conflict, like occupied Palestinian territory (oPt), Sudan and Yemen, immunization coverage has dropped sharply, leading to a steep rise in zero-dose prevalence, with Sudan now reported as the lowest-performing country globally. Meanwhile, countries emerging from conflict, such as Mali and Niger, show encouraging signs of recovery,

[48] (World Health Organization 2020)

[49] (Davies 2025)

[50] (Peace Research Institute Oslo 2025)

[51] Note - WUENIC data are aligned with the OCHA definition of FCV, therefore 26 countries were included in the WUENIC FCV analyses, which are countries with a Humanitarian Response Plan or active Flash Appeal

[52] (World Health Organization 2025)

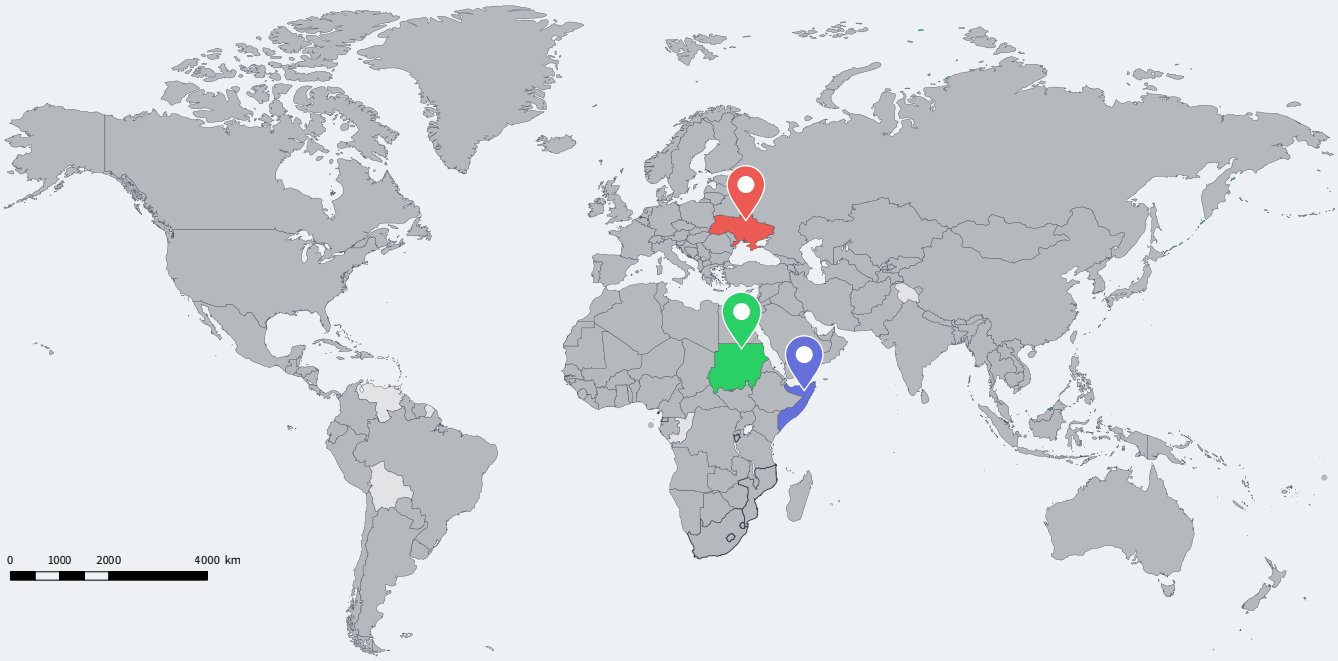
[53] (World Health Organization 2025)

with coverage levels surpassing the 2019 baseline. Notably, in November 2024, Mali became the first FCV country to introduce the HPV vaccine in the RI schedule for 10-year-old girls.[54] These trends reinforce the need for strategies to be tailored to conflict phases: rapid-response and flexible service delivery approaches during acute crises; alongside flexible service delivery, there is also a need for sustained community engagement in protracted emergencies; and system rebuilding and trust restoration in recovery contexts. Governance fragmentation across state- and non-state-controlled areas in many FCV contexts further contributes to disparities in coverage and presents significant challenges for effective planning, implementation, and accountability.

[54] (Gavi 2024)

FIGURE 8

Case studies of vaccination in fragile, conflict and vulnerable settings.



UKRAINE

Despite ongoing conflicts and instability, recovery-phase efforts and integration of immunization with primary healthcare in goverment-controlled areas helped **improve DTP1 coverage to 95% by 2024, above the 89% 2019 baseline level,** demonstrating the impact of recovery-focused system strengthening.

SUDAN

Coverage has fallen dramatically since conflict reignited in 2023, with **DTP1 reaching a low of 48% in 2024 from 93% just as recently as 2022,** showing a significant reversal of earlier gains from routine immunization services and coordinated campaigns. Violence, population displacement and insecurity have directly disrupted service delivery and undermined recent progress.

SOMALIA

Recent data shows **improved immunization DTP1 coverage of 78%,** while still lower than the global targets, an improvement **compared to the 65% 2019 baseline,** which was achieved during prolonged times of insecurity. UNICEF and Somalia's Ministry of Health attribute success to volunteer-led microplanning, religious leader partnerships, and flexible mobile delivery adapted to pastoral communities, highlighting effective context-specific outreach.

Disclaimer: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area nor of its authorities, or concerning the delimitation of its frontiers or boundaries.

Recommendations for the Next Five Years

The trends that challenge immunization in FCV contexts are unlikely to ease and may in fact intensify. Rising numbers of active conflicts, sustained population displacement, and mounting domestic financing constraints all suggest that reaching zero dose children in these settings will remain complex and resource intensive. Moreover, the projected contraction in official development assistance (ODA), combined with the unmet funding targets from the latest Gavi replenishment, increases the risk that FCV focused programs will be deprioritized infavour of lower cost and larger population contexts.

Yet the lessons learned between 2020–2025 clearly show that targeted, flexible, and context specific approaches can deliver results, if adequately supported. Countries like Somalia and Ukraine demonstrate that even in complex environments, adapted strategies and localized delivery can increase coverage even in times of fragility and conflict. Vaccination in these settings may also represent the greatest difference for those reached, offering life-saving protection to children and communities otherwise left behind. Moreover, linking the Fragile and Humanitarian approach with the wider humanitarian architecture and health system is crucial for embedding immunization within the full package of humanitarian health services. Building on this evidence, the second half of IA2030 must double down on equity by explicitly recognizing and financing the higher operational costs required to reach children in FCV contexts.

Given this situation and the lessons of the past five years, we recommend the following priorities to guide collective action at the global, regional, country, and local levels.

Global and Regional levels

- **Ring-fence funding for FCVs**

  Delivering vaccines in FCV settings[55] is inherently more expensive because it must go beyond standard facility-based delivery. In 2024, the average cost per child for routine immunization in stable countries[56] is approximately $73. However, reaching zero-dose children in FCV settings often exceeds that, estimated to be $115–$197 per child,[57] due to increased levels of logistical complexity. While these higher costs can attract scrutiny, this reflects the true operational reality of additional cold chain logistics and security needs, mobile outreach to displaced and remote populations, and sustained community engagement to overcome mistrust. Structural barriers mean flexible external funding is still essential. This also underscores the health security imperative to strengthen vaccination delivery in regions where governance is fragmented and where epidemiological risks transcend national boundaries.

  Additionally, the economic cost of responding to VPD outbreaks often exceeds the cost of preventive immunization. Yet recent trends heighten the risk of underinvestment. The latest Gavi replenishment, though securing over $9 billion, fell short of its original $11.9 billion target, signaling that many donors are reducing their commitments, putting FCV-focused programs at risk. Such shifts could reverse hard-won gains, especially as humanitarian and health budgets come under pressure. To safeguard progress, dedicated and ring-fenced funding for FCV immunization is essential from all partners and funders to protect these critical efforts from reallocation.

  Ongoing strategic dialogues, such as those in the context of Gavi 6.0 planning, have considered whether a context-specific standard vaccine package could help subsidize delivery costs in FCV settings. This would require clear technical guidance from SAGE, but this requires evidence-generation in FCV settings to enable such policy recommending bodies to take informed decisions.

  Expanding dedicated FCV funding, ensuring IA2030 strategies explicitly address conflict stages, and investing in innovative delivery models that are suited to complex settings and adaptable to acute, protracted, and recovery phases are essential. Updates to coordination platforms might be necessary to further bridge coordination gaps, ensuring sustained attention and accountability, with clear leadership to drive action across partners.

Country Level

- **Integrate immunization plans** with humanitarian and development strategies, adapt to local political realities, ensure flexibility in funding requirements, and formalize partnerships with diverse partners who can leverage community networks, potentially support negotiations for access, and support efforts to adapt delivery modalities, such as local NGOs, Red Cross and Red Crescent Societies, community organizations, and/or faith leaders. Countries like Mali and Burkina Faso adapted Reaching Every District/Community (RED/REC) and NIS planning for FCV contexts show adaptation is possible.

[55] (UNICEF 2024)
[56] (UNICEF 2024)
[57] (Wang 2024)

- **Increase domestic investment in immunization**, particularly in stable and accessible areas, to help external resources be more effectively targeted to conflict-affected and remote populations where delivery is more complex and costly. This approach would help optimize the use of both domestic and donor resources in advancing immunization equity.

- **Political Commitment and Complexity:** Political commitment cannot be viewed only through formal policy. In Yemen, for instance, vaccination remained a priority in government-held areas but was deprioritized in non-state-controlled areas, contributing to gaps and disparate coverage within the country.[58,59] This highlights the importance of nuanced, context-specific understanding of political realities to design effective immunization strategies.

Local Level

- **Build trust** through continuous community engagement, train community health workers, tailor social mobilization to community context and perceptions, and use qualitative and local data to guide microplanning and service delivery. There is need for better systematic use of qualitative data from sources like KAP surveys and focus group discussions (FGDs), to understand local barriers and refine microplanning, rather than relying solely on quantitative coverage data.

- Moving forward requires **deeper localization, nuanced understanding of political complexities** (e.g., areas controlled by different actors, as in Yemen), and flexible financing that accepts higher costs for delivery as the price of equity. Localization is essential across all immunization programs, but particularly in FCV settings, because it aligns delivery with community dynamics. The 2024 WUENIC data and broader evidence show local context drives outcomes, making it essential to optimize services and delivery based on local context through local actors and insights. Success depends on understanding who holds control, knowing the areas where national health authorities may have limited legitimacy or no presence, gauging community trust and hesitancy, and adapting communication and delivery through local partners. For example, Somalia's recent improvements came through local microplanning and partnerships with community and religious leaders, while Afghanistan's challenges reflect shifting political control that directly affects access. These lessons show that localization and context-driven planning are fundamental for reaching zero-dose children everywhere, not just in FCVs, as all programs benefit from tailoring strategies to local realities.

The IA2030 Mid-Term Review confirms that achieving IA2030's equity goals cannot be achieved without prioritizing FCV settings. Localized strategies, flexible delivery models, and sustained engagement have delivered results, even in complex contexts like Somalia and Ukraine, but progress remains fragile. FCV delivery is more expensive and complex, requiring adapted approaches, sometimes parallel systems, and partnerships beyond government channels. These challenges are not inefficiencies; they reflect the operational reality of reaching zero-dose children in the hardest places.

Achieving equity requires acknowledging these higher costs, resisting trade-offs that prioritize lower-cost settings, and supporting efforts through dedicated, flexible financing. Many FCV populations are beyond the reach of national systems; humanitarian actors and local partners must be part of the solution.

Ultimately, protecting children in FCV settings is not just a moral obligation, it is critical for global health security and the credibility of IA2030 itself. With context-driven strategies and sustained commitment, the next five years can still deliver on the promise to reach every child including those in the most fragile and conflict-affected places.

[58] (International Rescue Committee 2025)

[59] (InterSOS 2025)

4.2. ELIMINATION AND ERADICATION AGENDAS FOR VPD

4.2.1. MEASLES AND RUBELLA IMMUNIZATION

Context

Now is the time to push forward — not fall back

Since 2000, measles and rubella (MR) immunization efforts have dramatically reduced cases of these diseases worldwide and saved an estimated 60.3 million lives – 60% of the total lives saved through immunization in the past 50 years.[60] This marks a profound public health achievement: prior to 2000, measles ranked among the top five causes of death in children under five.[61] MR immunization efforts, currently guided by the Measles and Rubella Strategic Framework 2021-2030 (MRSF) under IA2030, have demonstrated how an effective global partnership can collaborate to support regions and countries make significant strides in closing immunity gaps and protecting vulnerable populations.

Under the MRSF and IA2030, measurable progress towards measles- and rubella-elimination has continued, with notable achievements including:

- By the end of 2024, 84 countries had verified measles elimination, and 99 countries had verified rubella elimination.'
- Between 2021 and 2025,[62] 13 additional countries[63] introduced the second dose of measles containing vaccine, and 6 additional countries[64] introduced the rubella containing vaccine (RCV) into their EPI programs. The DRC and Nigeria are planned to introduce RCV in 2025, which will significantly reduce the global disease burden given the large cohorts of unvaccinated children in these countries.
- Global coverage for the first dose measles vaccine is back up to 84% in 2024 (almost reaching the 86% coverage seen pre-pandemic). Since 2021, the second dose measles vaccine and rubella containing vaccine have steadily risen to 76% and 73% in 2024, respectively.
- The number of measles zero-dose children has started to decline, dropping to 20.6m in 2024 compared to a high of 24m in 2021.
- Over 560 million children have been vaccinated for measles and rubella (MR) through supplementary immunization activities (SIAs) between 2021-2025.[65]

Key Trends and Findings

The collective actions of the Measles & Rubella Partnership (M&RP)[66] have strengthened MR initiatives. Key achievements over the past five years (2021-2025) have opened the door to continued progress:

- Through the establishment of clear operational priorities, the partnership has strategically focused M&RP's collective efforts on high-impact activities. Examples include channelling support to accelerate the introduction of the rubella vaccine, as well as mobilizing funding for campaign preparations for large-scale campaigns in Nigeria and DRC.
- Provided critical measles outbreak response support in 19 countries, reaching more than 42 million children, often in remote or conflict-affected areas.
- Developed a centralized database for MR SIAs, which regional forums supported by the M&RP leverage to identify risks early and enable timely, coordinated responses to MR campaign challenges.
- Provided critical evidence reviews on which the Strategic Advisory Group of Experts on Immunization (SAGE) revised its policy recommendation for introduction of rubella-containing vaccines (RCV), including lifting the threshold requirement for ≥80% measles vaccine coverage. This policy change will make it possible for the

[60] (Shattock 2024)

[61] IHME, Global Burden of Disease (2024) – with minor processing by Our World in Data. "Lower respiratory infections" [dataset]. IHME, Global Burden of Disease, "Global Burden of Disease - Deaths and DALYs" [original data]

[62] Data includes all vaccine introductions between 2021 and September 2025.

[63] Benin, Chad, Comoros, Côte d'Ivoire, DRC, Guinea, Guinea-Bissau, Mali, Mauritania, Somalia, South Sudan, Uganda and Vanuatu

[64] Comoros, Mali, Pakistan, Guinea-Bissau, South Africa and Sudan

[65] Data includes children vaccinated through SIAs between 2021 and September 2025

[66] M&RP Partners include American Red Cross, U.S. Centers for Disease Control and Prevention, Gavi the Vaccine Alliance, Gates Foundation, UN Foundation, UNICEF, and WHO

remaining 13 countries[67] to introduce rubella-containing measles vaccines in their routine immunization programs more quickly than under the previous policy.

However, global progress is severely threatened. Following COVID-19-related disruptions to immunization in 2020, global measles vaccination coverage rates have stagnated over the past five years and have only now started approaching the return to 2019 levels with global coverage for the first measles vaccine (MCV1) rising back up to 84% in 2024. However, coverage remains well below the 95% threshold considered necessary to prevent outbreaks. Notably, in the decade prior, global coverage rates had begun stalling (increasing by only 2% between 2011 and 2019), underscoring that additional and different efforts will be required to break through this threshold. Furthermore, global coverage rates mask persistent inequities: high-income countries are rebounding more quickly, while low-income countries lag far behind in regaining pre-pandemic coverage levels. In 2024, 15.5m children in lower income countries had not received the first dose of measles vaccine – 75% of the 20.6m children globally.

Children in fragile, conflict-affected, and vulnerable countries are particularly at risk. While only 24% of infants live in these countries, they make up 54% of infants without any protection against measles. Further, the risk of outbreaks increases in these countries, in part because coverage rates are lower – 64% for the first dose and only 49% for both doses. In 2024, 56% of fragile, conflict-affected, and vulnerable countries experienced a large or disruptive outbreak, while only 24% of countries without these challenges did.

The high transmissibility of measles presents unique challenges to elimination. Measles rapid spread means that when immunity gaps arise or persist, outbreaks can quickly erode hard-won progress toward elimination. Each missed opportunity for vaccination has a material impact on efforts to reach and sustain the 95% coverage needed to prevent outbreaks and achieve elimination. Additionally, planning and executing MR SIAs that are both timely and of high-quality is uniquely complex given the logistics and coordination required for such large-scale activities (measles campaigns target wide age-ranges, often across broad geographies in a short window). Additionally, delays in completing campaign evaluations to assess coverage hinder countries' ability to improve the quality of SIAs, with post-campaign outbreaks often pointing to weaknesses in campaign quality.

The IA2030 identifies measles as a key tracer of the strength and equity of immunization systems. Due to its high transmissibility, measles is often the first disease to resurge when vaccination coverage drops, making it a sensitive indicator of underlying gaps in routine immunization and broader health system performance – it is known as the "canary in the coalmine". Therefore, many of the key challenges for measles immunization are faced across all vaccine-preventable diseases:

- **Delayed Detection and Outbreak Response**: The number of countries experiencing large or disruptive outbreaks continues to rise – in 2024, 59 countries experienced large or disruptive outbreaks compared to 21 in 2021. Gaps in surveillance and outbreak preparedness delay the identification of outbreaks, as well as outbreak response efforts. This allows outbreaks to expand, worsening outcomes and heightening the risk of subsequent outbreaks around the world.

- **Heightened Risk in Fragile and Conflict Settings**: as the number of children living in fragile, conflict-affected, and humanitarian settings grows, so does the risk of outbreaks. These vulnerable populations face disproportionately high risk of transmission and mortality, yet conducting high-quality campaigns in these contexts is often extremely challenging.

[67] Afghanistan, Chad, Djibouti, DRC [planned to introduce in 2025], Equatorial Guinea, Ethiopia, Gabon, Guinea, Liberia, Madagascar, Niger, Nigeria [planned to introduce in 2025], Somalia)

- **Concentration of Zero-Dose Children**: 55% of the world's measles zero-dose children are concentrated in just 10 countries: Afghanistan, Angola, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Nigeria, Pakistan, Sudan, and Yemen – reflecting deep equity gaps, heightening the risk of persistent outbreaks and underscoring the need for targeted strategies to reach marginalized populations in underserved settings.

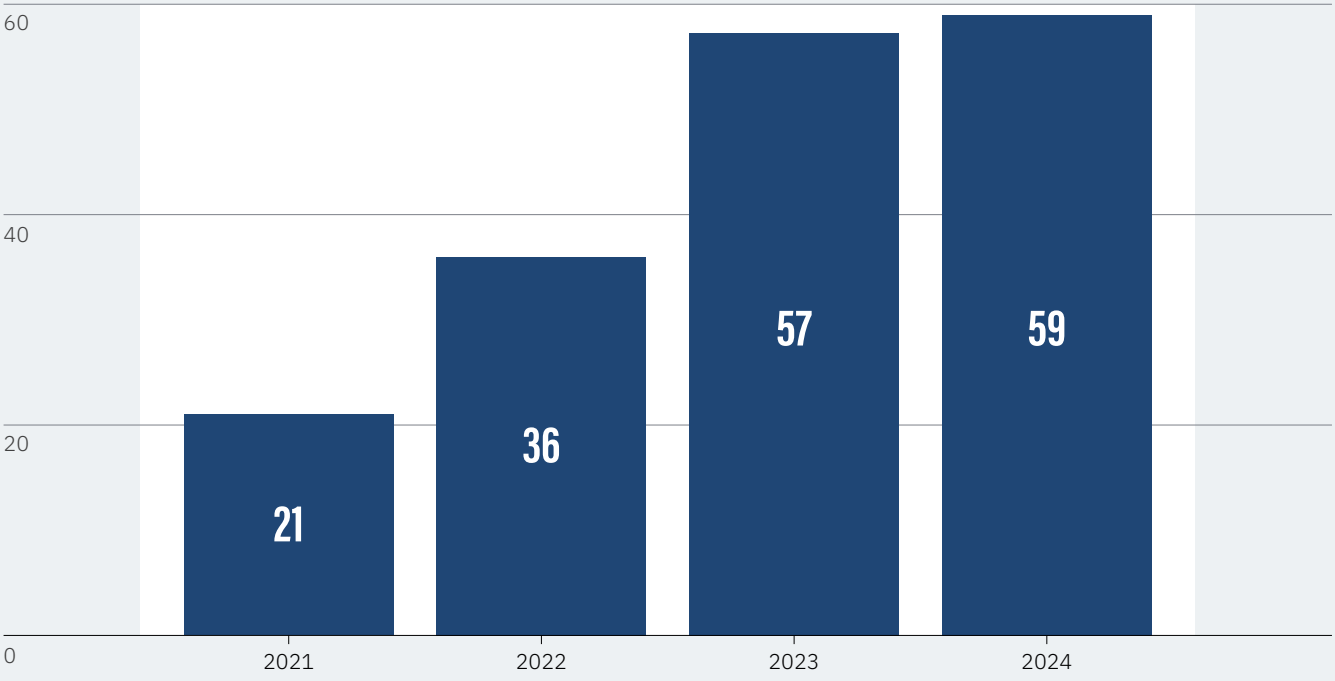
- **Challenges in Raising Routine Coverage**: workforce shortages, supply chain bottlenecks, vaccine hesitancy, monitoring and surveillance challenges and service delivery system weaknesses hinder sustained improvements in routine immunization coverage. Gaps in routine immunization have led to an over-reliance on preventive campaigns (SIAs) and outbreak response.

- **Resource Constraints and Competing Priorities**: limited resources and multiple competing health priorities can compromise the strength of routine immunization programs, as well as the ability to deliver timely and high quality SIAs, resulting in persistent immunity gaps. This challenge will likely become more pressing in the uncertain and shifting global funding context of today.

- **Now is the time to push forward, not pull back.** Progress toward IA2030 goals is at risk – since 2020, only 3 additional countries have verified measles elimination. The growing number of measles outbreaks globally signals broader weaknesses in immunization programs and health systems that must be urgently addressed to achieve all IA2030 goals, including those which are specific to measles. Measles vaccination is the most cost-effective immunization program, with an estimated $58 return for every $1 invested. It is estimated that up to 75% of the total economic benefits of vaccines and between 60[68]-80% of vaccine-preventable deaths averted are attributed to measles immunization, confirming its pivotal role in advancing IA2030 goals.[69] The global immunization ecosystem and funding landscape is shifting, bringing uncertainty and new challenges – underscoring the urgent need to accelerate, not retreat, in securing equitable, sustained protection from measles and rubella for children around the world.

[68] (Shattock 2024)
[69] (Sim 2020 August; 39(8)

FIGURE 9
Number of countries experiencing large or disruptive measles outbreaks (2021-2024).



Recommendations
Moving Toward a Measles- and Rubella-Free World

To close immunity gaps and increase coverage, we must work closely with countries and global partners to strengthen routine immunization efforts, identify and scale alternative delivery strategies to efficiently close emerging immunity gaps, and provide reliable support for high-quality and timely SIAs, employing both targeted and comprehensive approaches. Furthermore, rapid and effective outbreak response capabilities are critical. These capabilities include sensitive surveillance systems, timely laboratory confirmation, and rapid initiation of outbreak response activities.

IA2030 initiatives have successfully reached children and their communities and demonstrate that progress is possible. Achieving measles and rubella elimination will require safeguarding past gains, adapting strategies to emerging challenges, securing stable financing, and strengthening coordinated action at global, regional, and country level.

In tandem with this IA2030 MTR, the M&RP is conducting a MTR of the Measles and Rubella Strategic Framework (2021-2030). This process is focused on assessing progress to date, incorporating lessons learned, and updating the strategy to reflect the current context. The resulting framework will guide the partnership's approach for the next five years (2026-2030), ensuring it remains fit-for-purpose and accelerates progress toward measles and rubella elimination targets.

Coming soon:
A midterm evaluation report, which will include a more detailed analysis of the MRSF 2021-2030

4.2.2. POLIO

Context

The first two and a half years of the Global Polio Eradication Initiative's (GPEI's) 2022–2026 strategy have been marked by moments of inspiring success, including ending a type 2 variant polio outbreak in Ukraine amidst war, reaching millions of previously missed children in Afghanistan following the resumption of nationwide vaccination campaigns in late 2021, and quickly stopping an importation of wild poliovirus in Malawi and Mozambique.

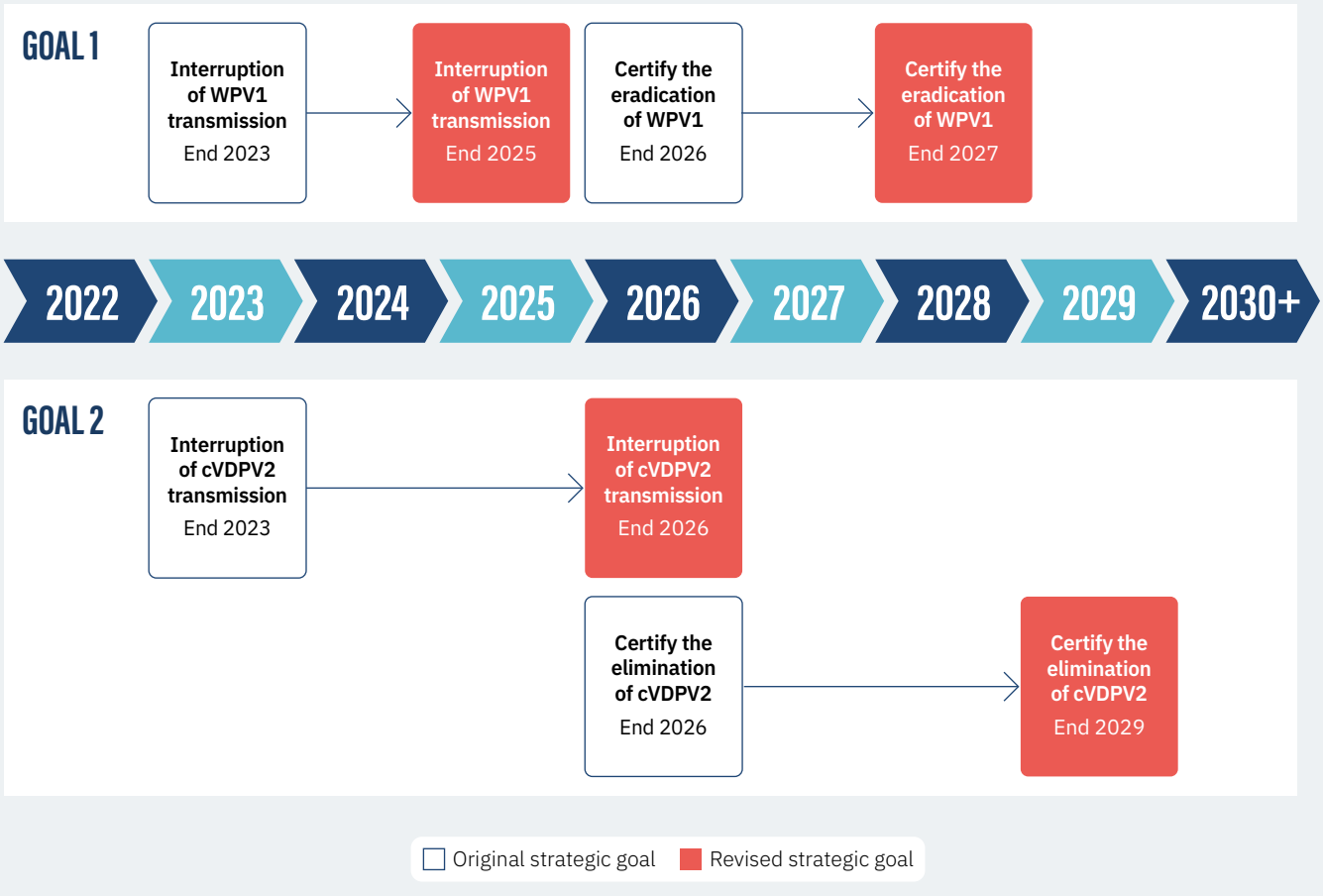
However, this progress has been made in the context of worrying global developments – such as historic backsliding in coverage of routine vaccines due to the COVID-19 pandemic and delays in regaining lost ground, rising conflict and political instability, and increasing climate-related disasters in the places at highest risk of polio. These challenges have been compounded by setbacks such as outbreaks of type 2 variant poliovirus (cVDPV2) following the global switch from the trivalent to bivalent oral polio vaccine in 2016, as well as programmatic hurdles including periodic disruptions to vaccine supply and inconsistent campaign quality.

Key Trends and Findings

The original timeline for interrupting and certifying the eradication of wild poliovirus type 1 (WPV1, Strategy Goal 1) and certifying the elimination of type 2 variant poliovirus (cVDPV2, Strategy Goal 2) will therefore not be met. Based on the current situation, and after critical analysis and expert consultations, the GPEI's Strategy Committee and Polio Oversight Board have extended the timeline for certifying the eradication of wild polio to the end of 2027 and certifying the elimination of cVDPV2 to the end of 2029 (see Figure 10).

FIGURE 10

Polio Eradication Strategy Extension 2022-2029 revised timeline.



While the 2022–2026 strategy is robust, it is only as good as its operationalization. Clear improvements to implementation and accountability will be required to interrupt and eradicate all forms of polio. The *Polio Eradication Strategy Extension 2022-2029* complements the original strategy, outlining obstacles that have hindered progress toward each goal and detailing adjustments that will be made to overcome them.

In 2023 GPEI established a dedicated function to better integrate polio eradication efforts with other health programmes, with specific aims to increase polio vaccination coverage, reduce missed opportunities to conduct multi-antigen campaigns and reach more zero-dose children. Working through a networked model, dedicated support has been provided to seven priority countries (Afghanistan, Democratic Republic of the Congo, Madagascar, Nigeria, Pakistan, Somalia, and Yemen), with coordination support provided for the rest of the GPEI portfolio. These activities have increased visibility and intentionality of integration efforts and built a strong base that has enabled GPEI to work closer than ever with Gavi, the Vaccine Alliance, and the EPI. Collaboration on the Big Catch Up started in 2024 and in June 2025, the first ever joint meeting of the Gavi Board and the Polio Oversight Board agreed upon areas of collaboration across the programmes. At the request of the joint board, the partnerships are working together to (a) improve the targeting and coverage of routine vaccines (including bOPV and IPV/hexavalent in key geographies), and (b) implement a more systematic, comprehensive approach to integration during and outside of campaigns in select geographies of the WHO African and Eastern Mediterranean Regions.

Poliovirus surveillance has remained a central pillar of eradication efforts, with GPEI partners investing in AFP and environmental surveillance, along with sustaining global laboratory capacity. While this has enabled tracking of progress towards stopping WPV1 transmission in the two endemic countries and interrupting cVDPV2 outbreaks, challenges remain in sustaining funding, retaining technical capacity, and maintaining surveillance in hard-to-reach areas and populations. Continued high-quality poliovirus surveillance is critical for tracking progress and for certification. After GPEI's dissolution, it will be essential to preserve the surveillance technical expertise, Global Polio Laboratory Network capacity as well as information systems.

GOAL 1

Interrupt and eradicate WPV1 in the final endemic countries

Setting the stage:

- In 1988, wild poliovirus was endemic in **125 countries.**
- In 2024, wild poliovirus is endemic in **2 countries.**
- **Two out of three** types of wild poliovirus – types 2 and 3 – have been eradicated.
- **One type** of wild poliovirus – type 1 – remains in circulation.

Thanks to health workers, national authorities and global partners, between February 2021 and April 2022, the two remaining polio-endemic countries, Afghanistan and Pakistan, experienced the lowest levels of virus transmission in history. In this 15-month period, just three cases of wild poliovirus were reported, detections in wastewater were extremely low and endemic transmission was stopped in areas where the virus historically circulated in Pakistan.

The world was on the brink of ending wild polio. However, ongoing contextual challenges amidst a complex political and operational environment, both in Afghanistan and Pakistan, allowed the virus to spread in the remaining pockets.

By the end of 2022, 22 children had been paralysed by wild poliovirus across the two countries. This number declined to 12 in 2023 but rose to 99 in 2024. The virus's resurgence is an unwelcome reminder of what can happen if any trace of poliovirus is left to circulate.

Challenges:

In recent years, the GPEI has struggled to operate amid a perfect storm of conditions in Pakistan and Afghanistan. Some of these challenges are outside of the programme's control (i.e. **contextual**) but must be accounted for in activities, while others are within the programme's control (i.e. **programmatic**) and will be addressed directly to improve performance.

Key contextual challenges

- Inconsistent ability to implement all campaigns using the most effective delivery modality (house-to-house) in Afghanistan.
- Rising vaccine hesitancy due to the spread of mis- and disinformation, especially among male caregivers.
- Ongoing insecurity and conflict limiting access to certain areas, especially for female health workers.
- Climate-related disasters, including extreme heat and historic flooding.
- Economic collapse and a complex humanitarian situation in Afghanistan.
- Political instability in Pakistan leading to periods of gaps in country programme leadership and coordination.
- Weak health and essential immunization systems.
- Conservative gender norms, roles and responsibilities significantly restricting the ability of vaccination teams to reach and vaccinate all children.

Key programmatic challenges

- Inconsistent vaccination of mobile and hard-to-reach populations, leading to geographic expansion of the virus.
- Weak cross-border coordination impacting the ability to accurately identify and vaccinate all children and monitor quality of vaccination campaigns in highest risk areas.
- Community boycotts of polio campaigns due to a lack of broader services.

GOAL 2
Stop and prevent type 2 variant poliovirus outbreaks

Setting the stage:

- Campaigns target **three times** more children now than in 2020.
- Cases have declined from **688** in 2022 to **425** in 2024.[70]
- **1.4 billion** doses of novel OPV2 (nOPV2) have been administered across **42** countries by the end of 2024.

Outbreak response campaigns are based on three key pillars: **identifying** all communities to be reached by the teams, **vaccinating** children using community-specific strategies, and **verifying** that no children have been missed and that cases do not persist. Ensuring that each of these pillars holds strong throughout a campaign becomes immensely difficult in fragile settings and conflict zones (places where the virus is most prevalent). But successes in areas like these – such as the closure of Ukraine's variant polio outbreak amid war in 2022 – prove that, with commitment, resilience and adaptability, it is possible.

Today, **four "consequential geographies",** subnational areas where children are at the highest risk of encountering and spreading the virus, are the greatest engines of transmission globally. These are northern Nigeria, eastern Democratic Republic of the Congo (DRC), south-central Somalia and northern Yemen. In 2023, over 80% of cVDPV2 cases came from outbreaks that originated in Nigeria and DRC. While there has been progress, the key to achieving Goal 2 remains interruption of transmission in these countries, which will reduce the risk of repeated exportation.

The number of countries impacted by cVDPV2 has remained relatively stable, despite cross-border spread, including to new countries such as Angola, Equatorial Guinea, The Gambia, Liberia, Sierra Leone and, most recently, Gaza in the occupied Palestinian territories. The Horn of Africa also remains a concern, with persistent transmission in Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda. The small number of cases in southern Africa indicates that levels of transmission are low in this region, underscoring the opportunity to interrupt the virus there.

At the same time, improving immunization coverage rates across the board is critical. The widespread use of the novel oral polio vaccine type 2 (nOPV2) has played a role in reducing the number of cVDPV2 cases, as it is more genetically stable and therefore less likely to revert to a form that can cause paralysis in under-immunized communities. The rate that new outbreaks emerge has critically slowed over the three years of its use.

Challenges:

As in the wild poliovirus-endemic countries, variant poliovirus outbreaks occur and persist due to complex contextual and programmatic challenges that prevent the GPEI from consistently reaching every child.

Key contextual challenges

- Low and stagnating essential immunization coverage, which creates the ideal conditions for new outbreaks to emerge and spread across borders.
- Ongoing insecurity and conflict, which threaten the safety of families and health workers, particularly women, disrupt health services, and increase population movement.
- Inconsistent political commitment, leadership and accountability at all levels in countries battling outbreaks.
- Strained systems as countries face competing health priorities and emergencies, impacting the resources and attention that leaders can provide to eradication efforts.
- Fragile global vaccine supply systems impact vaccine availability, with disruptions in nOPV2 supply hampering outbreak responses in late 2023 and early 2024.
- Vaccination refusals, especially among male caregivers due to misinformation and community fatigue.

[70] (Polio Global Eradication Initiative 2025)

Key programmatic challenges

- Poor microplanning for campaigns, which limits vaccinators' abilities to reach all children.
- Delay in outbreak response due to operational constraints and difficulties quickly moving funds in countries, including vaccinator payments.
- Global funding limitations, which require difficult prioritization decisions, such as not implementing preventive campaigns with bivalent OPV.
- Challenges in coordinating the activities of multiple partners active in response to an outbreak.

Persistent gaps and operational constraints in surveillance systems impacting timely detection and notification of cases.

Recommendations

The global health and development landscape has experienced profound shifts in the last year. Escalating geopolitical tensions, regional instability, humanitarian emergencies and rising economic pressures are reshaping global health priorities and funding environments. These trends are affecting the delivery of immunization and disease surveillance in countries already destabilized by the COVID-19 pandemic and its aftermath.

This evolving context carries significant financial and operational implications for the polio eradication effort. Traditional and emerging funding sources for global health and development are all under pressure. Affected countries and implementing partners are experiencing reductions in technical, operational and financial assistance. In the context of polio eradication, coordinated planning and strategic agility is required to preserve progress and avoid a resurgence of the virus. As financial uncertainties constrain the programme's ability to sustain comprehensive support across all geographies and partners, it thus calls for targeted investments toward areas of active poliovirus transmission and those at highest risk.

To meet these challenges and maintain the programme's eradication goals, GPEI has developed a comprehensive Action Plan incorporating:

- An overview of efficiencies implemented across the programme.
- A strategic allocation of resources.
- Detailed assessment of budget and resource mobilization forecasts.
- Subnational plans for geographies where progress is essential for GPEI eradication goals.

Planning efforts are also underway to lay the groundwork for preserving the gains of the GPEI. "Sustaining a Polio-free World: A strategy for long-term success" (SPW) defines the technical standards that will be needed as functions required to sustain polio eradication become integrated into national health programmes. The SPW builds on the GPEI Eradication Strategy: it starts after certification of WPV1 eradication and certification of cVDPV2 elimination and extends for 10 years after the withdrawal of bOPV from routine immunization programmes. The SPW strategy will be presented to the 79th World Health Assembly in May 2026.

The GPEI envisions a three-year period of overlap between the two strategies. During this time, some global activities related to SPW goals and objectives will already be in progress, notably planning for bOPV cessation and establishing vaccine stockpiles. Additionally, a high-level phased planning process has been developed so national governments, relevant partners and agencies can work together to define how polio-essential functions should be transitioned and who is best positioned for long-term ownership through a well-defined governance structure.

The work of transitioning polio-essential functions to national governments has already begun in some countries and regions through the implementation of the Polio Transition Strategic Framework, Regional Action Plans and country polio transition plans. Polio transition as a process ensures that countries are well-prepared to take on financial responsibility for sustaining polio-essential functions as the GPEI focuses increasingly limited resources on the last remaining geographies with poliovirus transmission.

4.3. IMMUNIZATION EQUITY: "LEAVING NO ONE BEHIND"

Context

IA2030 aims to reach as many people as possible with life-saving vaccines, and to leave no one behind. Maximizing access to vaccines gives every person an equal opportunity to be protected. Yet complex realities mean that many children and other vulnerable groups still miss out.

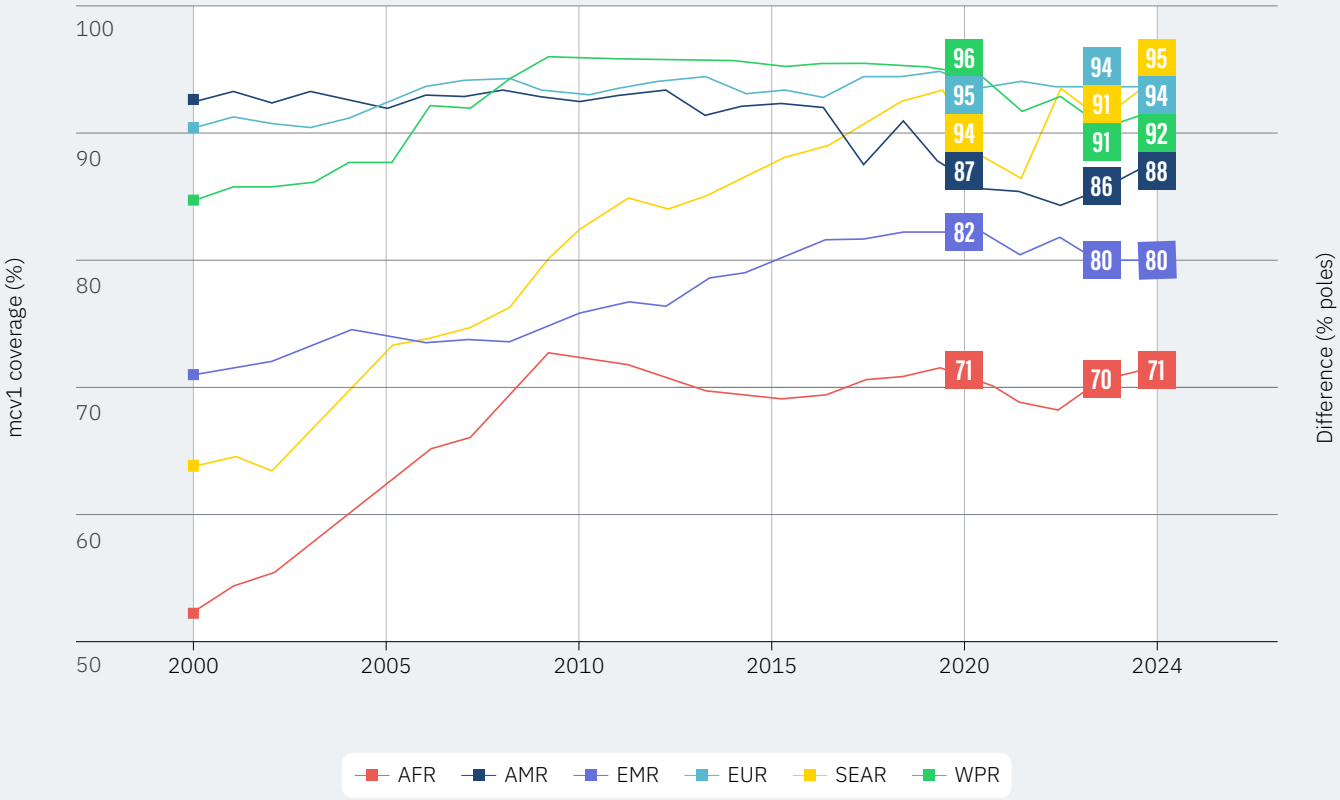
To maximize reach, each level of a global vaccine distribution system should focus not only on average performance, but specifically on those segments that are performing less well, so that all barriers for accessing vaccines at that segment can be addressed. At global level, vaccine coverage is tracked by geographic region and by World Bank Income grouping. Regions in turn track country-based performance, and countries track subnational performance. Subnational administrative units can track the performance of clinics and communities. A local vaccination clinic or outpost can track the households and children to maximize coverage and protection to their community. Other forms of distributional disparity should also be addressed at subnational level, for example examination by sex or cultural or linguistic grouping, or by socioeconomic standing. Addressing intersecting barriers to immunization (encompassing both structural factors and social dimensions) is critical to ensure principles of equity are systematically integrated across planning, delivery, and evaluation.

Key Trends and Findings

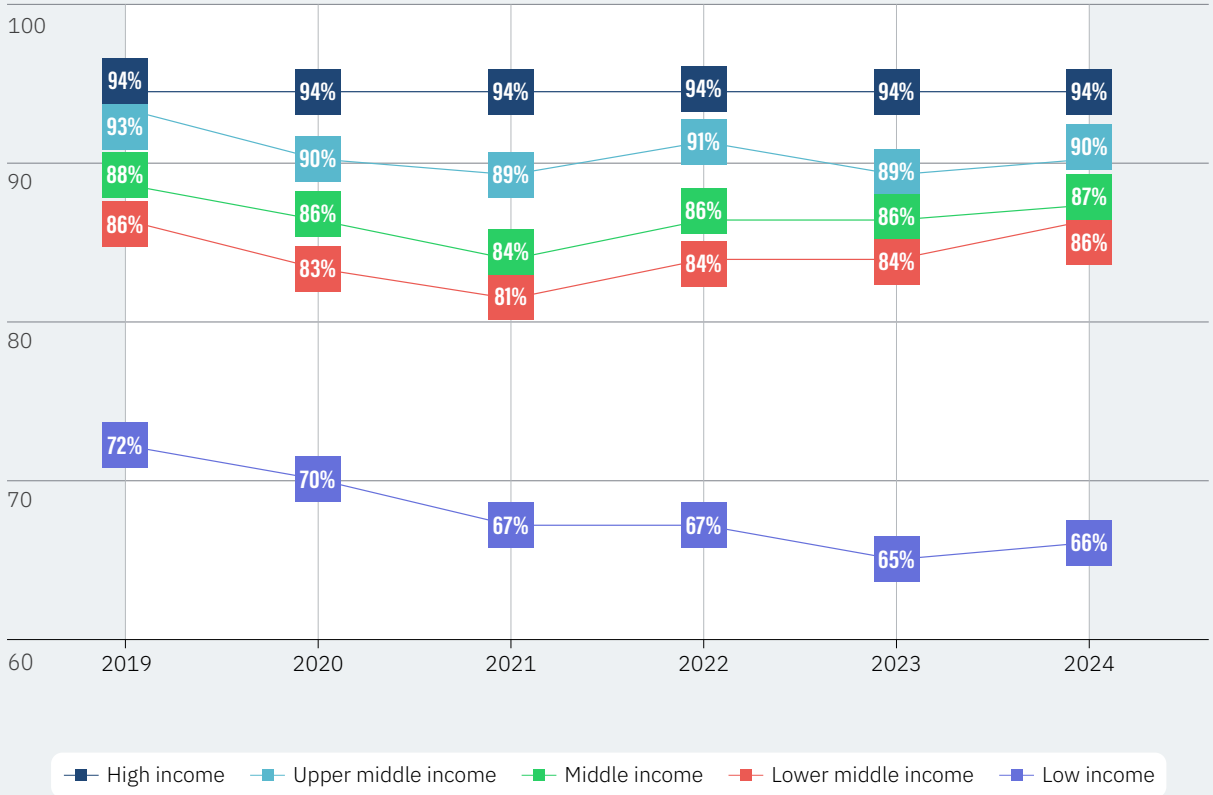
Across regions and income groups, immunization coverage rates differ markedly. Weighted mean coverage for MCV1 in the African region is 24 pp below the European region. The gap is particularly stark for LICs, MCV1 coverage is 27 percentage points lower in LICs than in HICs (Figure 12). For HPV, marked discrepancy exists across regions (data not shown), reflecting unequal opportunity to access lifesaving vaccination affecting predominantly girls.

FIGURE 11

MCV1 coverage over time, by WHO region.



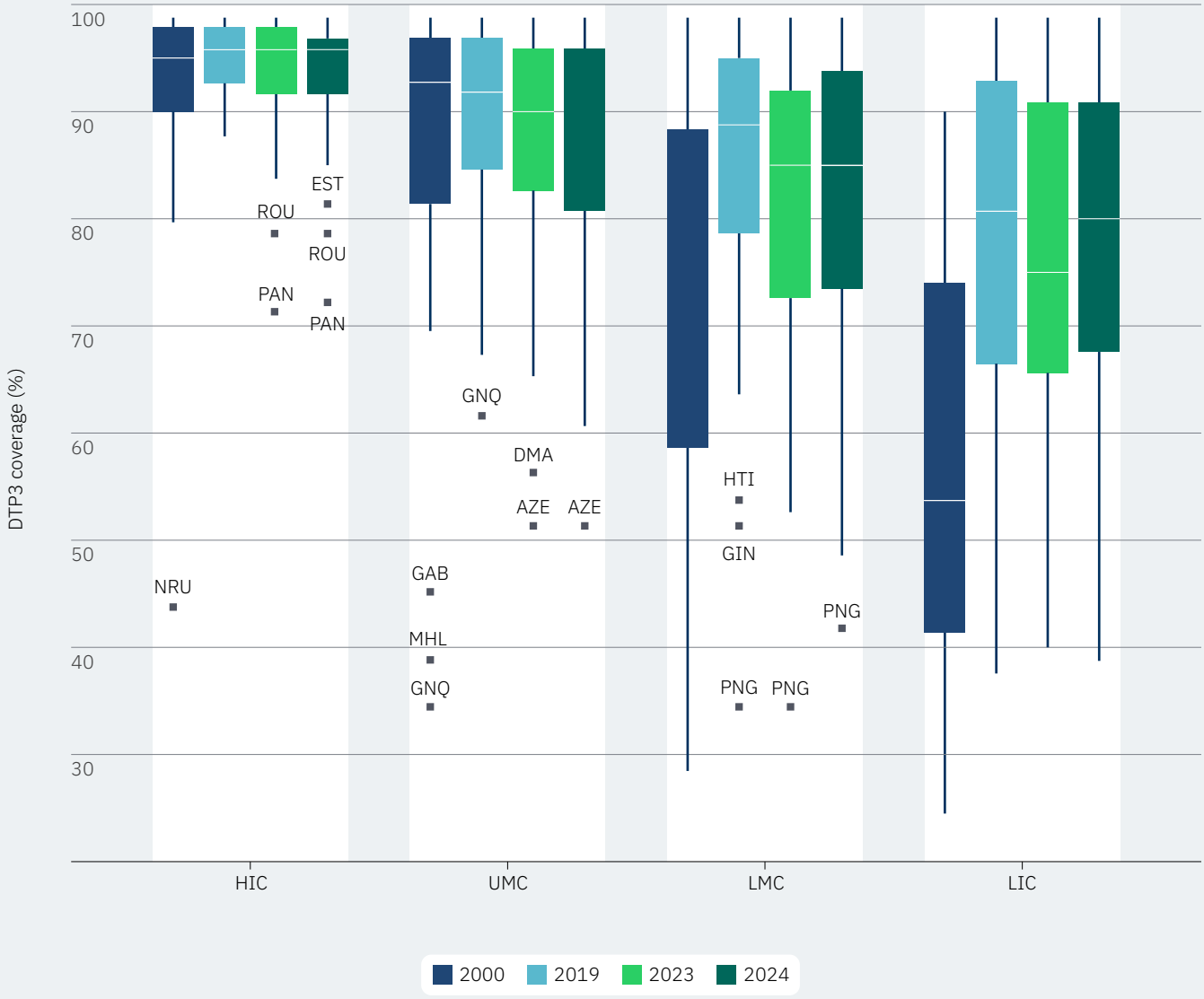
First-dose measles vaccine (MCV1) coverage rates by World Bank Income Group.



The period 2000 and 2019, saw a dramatic rise in coverage in LMICs, though in LICs the improvements stalled from 2010. Since 2019 LICs and LMICs are diverging, with LMICs showing a resilient post-pandemic recovery which is not apparent in LICs (Figure 12). Over the same periods, divergence among countries – reflected by the size of the interquartile range – narrowed somewhat initially, but persists since 2019 (Figure 13). It is also notable that there is a large overlap among WB income groups. Some LICs have coverage more akin to MICs and vice versa. Attention is needed to the specificity of country level enablers and barriers if improvements are to be achieved and sustained.

FIGURE 12

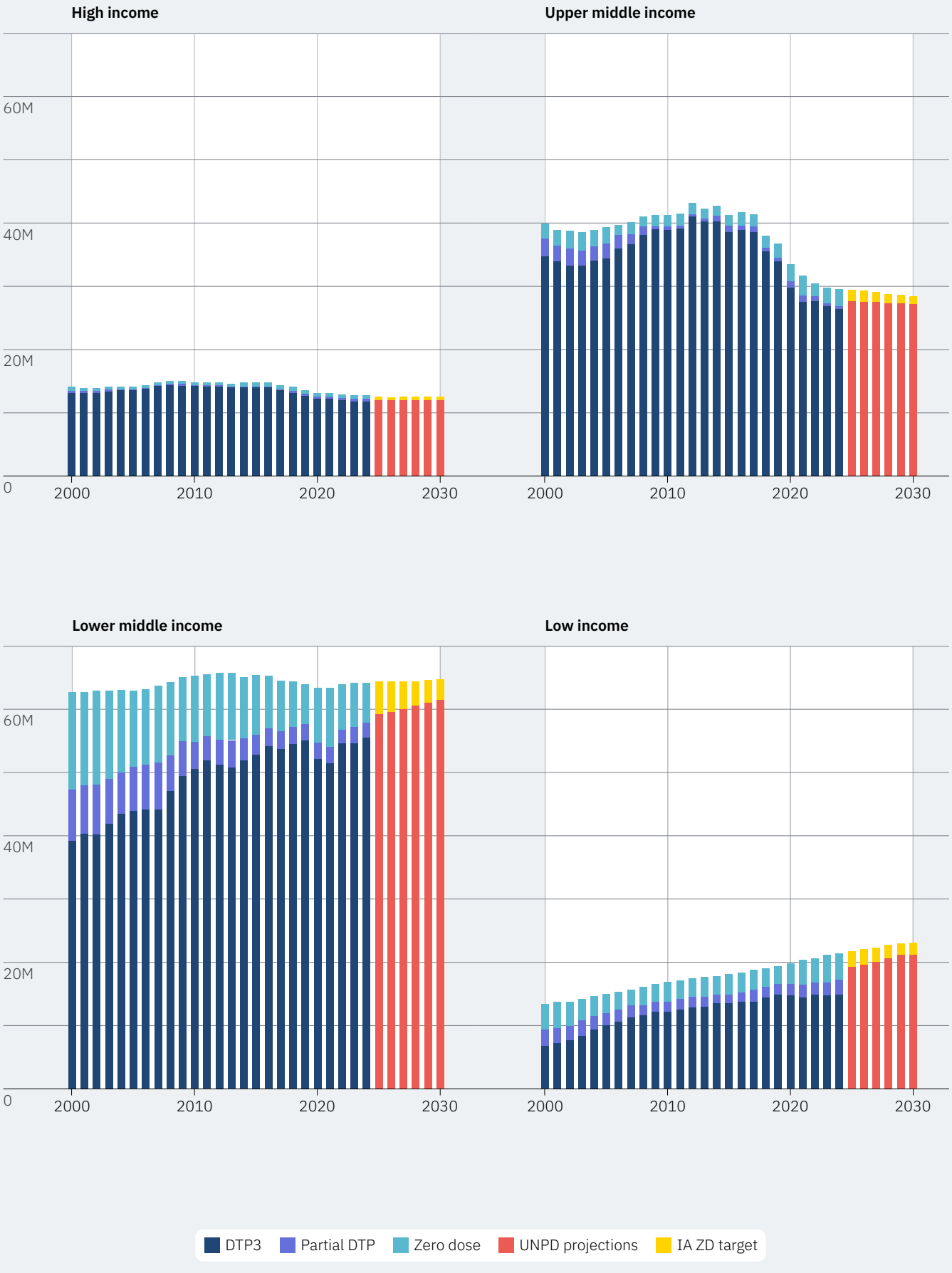
DTP3 coverage distribution over time, by World Bank income category.



Overall, in LICs immunization services are failing to reach one in 5 (DTP1) to one in 3 (MCV1) children. Moreover, annual increases in birth cohort in LICs mean that in countries with fewer resources, more children need to be reached each year just to keep coverage steady. If countries deliver the same absolute number of doses each year, inequality will rise. To close the gap in LICs, the pace of improvements has to outpace the rise in the birth cohort (Figure 12).

FIGURE 13

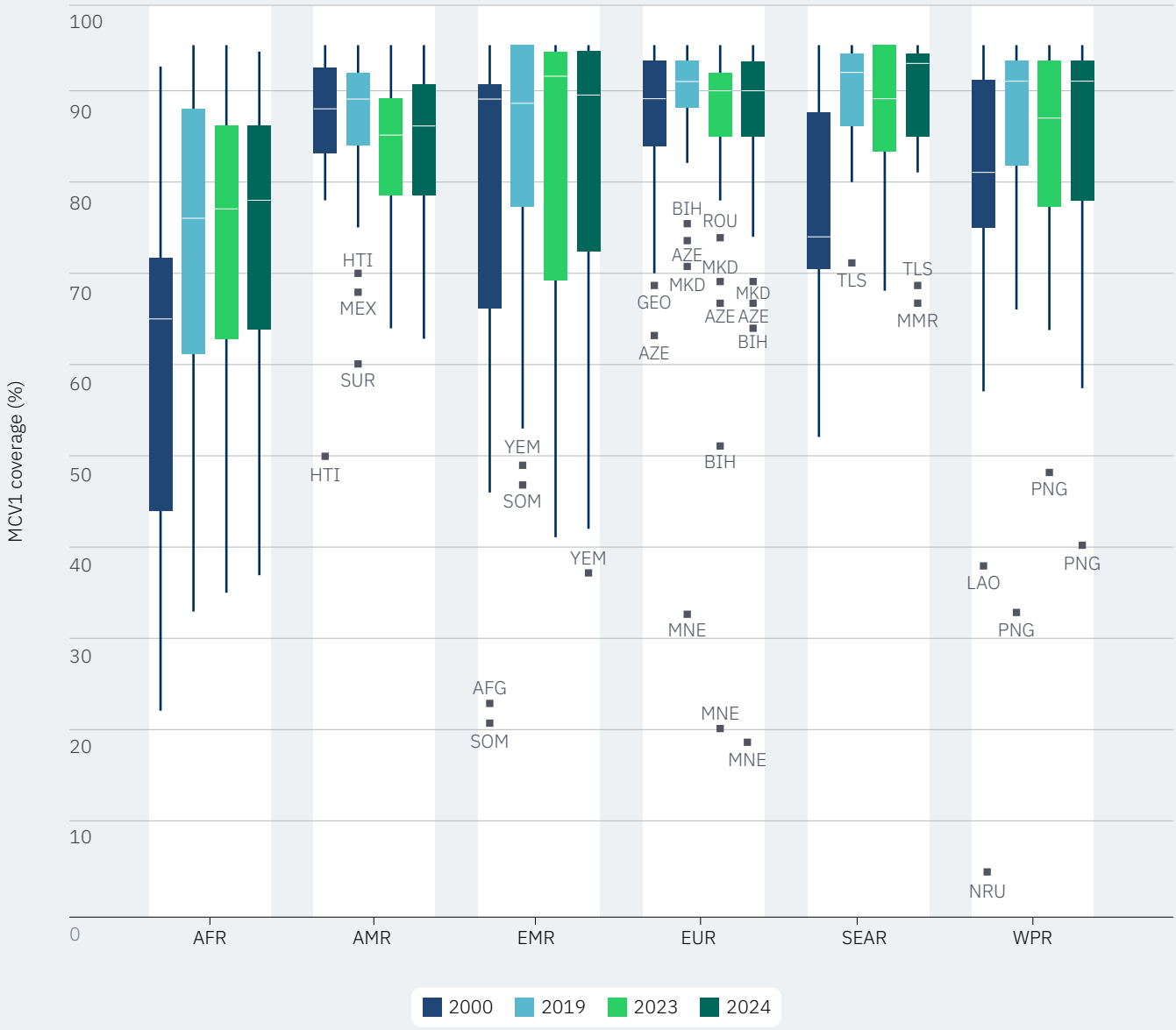
Observed (2000 - 2024) and projected (2025 - 2030) number of children fully, partially and not vaccinated with DTP, by World Bank income status.



Within regions, since 2000, the distribution of immunization coverage among countries has narrowed in the African, Southeast Asian and Western Pacific regions, as shown by the width of the interquartile range in Figure 13. Since 2019, however, countries in all regions other than the African Region have become more divergent. Across all regions there remain countries that are substantial outliers. Some of these outliers have experienced recent military conflict (e.g. Yemen, Somalia, Myanmar etc), or are managing other fragilities (e.g. Haiti, PNG), while yet others may reflect crisis in demand or trust .Closing gaps in coverage an maximizing equitable coverage requires addressing the specific contexts of and challenges facing outlying countries.

FIGURE 14

MCV1 coverage distribution over time, by region.



Within countries, the quality of data on subnational coverage may be inconsistent and less precise, making reported variation across administrative units more challenging to interpret consistently. Nonetheless, data from IA2030 Strategic Priority 3.2 suggest that across all settings, lowest performing quintiles are not benefitting from improvements in global vaccine coverage and populations in those quintiles are being left behind. Systematically collected quantitative

data on variation occurring within local communities is not available at global level, but experience suggests that at the most local level too there are population pockets that are less well reached. Reasons for low access in subgroups varies by context, but broadly follows distributional axes of other geographic, economic, and sociodemographic predictors. Systems issues can also contribute, for example stockouts at local level, driven by breakdown in procurement or delivery mechanisms. Sustained investment in strengthening subnational data systems to make them more valid and robust will allow more detailed and nuanced targeting of resources for maximizing vaccine access and implementing hyperlocal contextually impactful interventions. In such settings working toward strengthening data systems and improving data quality is important. At local level and with small populations, outcome measures fluctuate and are less meaningful. In the local setting it may be helpful to focus on measurement of process outputs, not only on coverage outcomes. At the most intimate interface between a local clinic and the community it serves, wall charts listing pregnant women and their surviving infants can ensure all individual households are approached and all children reached with immunization. This individual tracking and personal outreach which is action-oriented, is the cornerstone for all subsequent monitoring and performance evaluation, at district, higher administrative and national level. National Immunization Strategies that encourage the use of Annual Operating Plans, and that define within these plans, key performance targets, allow for iterative tracking to ensure local goals are achieved, and resources allocated to addressing specific local challenges. Variation occurs at every level, and the problems may differ depending on level (demand at local level, supply at district level, resource allocation or workforce at national level, rapidity of funding flows, markets, production and price transparency and procurement mechanisms at global level, etc). But a data system that tracks such variation at every level and evaluates its underlying causes, is a system that is then well informed and able to act and review. The solution will then be tailored to the causal problem and be context sensitive.

Bringing together findings[71] demonstrates that gender-related barriers – ranging from systemic data gaps to restrictive social norms – undermine immunization coverage and equity goals globally. Gender dynamics play a major role in shaping both the demand for and supply of immunization services, affecting outcomes for various populations including zero-dose children, adolescents eligible for HPV vaccination and communities in fragile settings. Women's limited decision-making power, restricted mobility and primary caregiving responsibilities – combined with discriminatory social norms and health systems lacking gender-responsive policies – create barriers to vaccine demand and accessibility. Gender barriers also limit the provision of health services: most healthcare workers are female, and face barriers such as safety risks during travel and inadequate working conditions that directly constrain service delivery and outreach capacity. Additionally, gender shapes how information about vaccines is shared and trusted.

Measuring and tracking inequality

Population weighted mean coverage estimates are frequently used as the main indicator of progress in immunization program performance. But the average coverage provides no information on the underlying distribution of coverage. From a measurement perspective, it is not only the average that matters, but the spread of the distribution at each level. Better average performance with narrower distribution width, suggests that all are doing better and opportunities are more available even to those who are more likely to miss out. On the other hand, improving average vaccine coverage but with wider distribution means those with easier access are doing better, but those more challenging to reach are being left behind. Decision makers at every level should consider both a coverage indicator and a distribution indicator (formally, any distribution is defined by both position (e.g. mean) and shape (e.g. variance)). A focus on distribution width in addition to population mean coverage, can help focus investigations into specific bottlenecks to be addressed with appropriately tailored context-specific interventions.

Robust granular data can help manage prioritization trade-offs

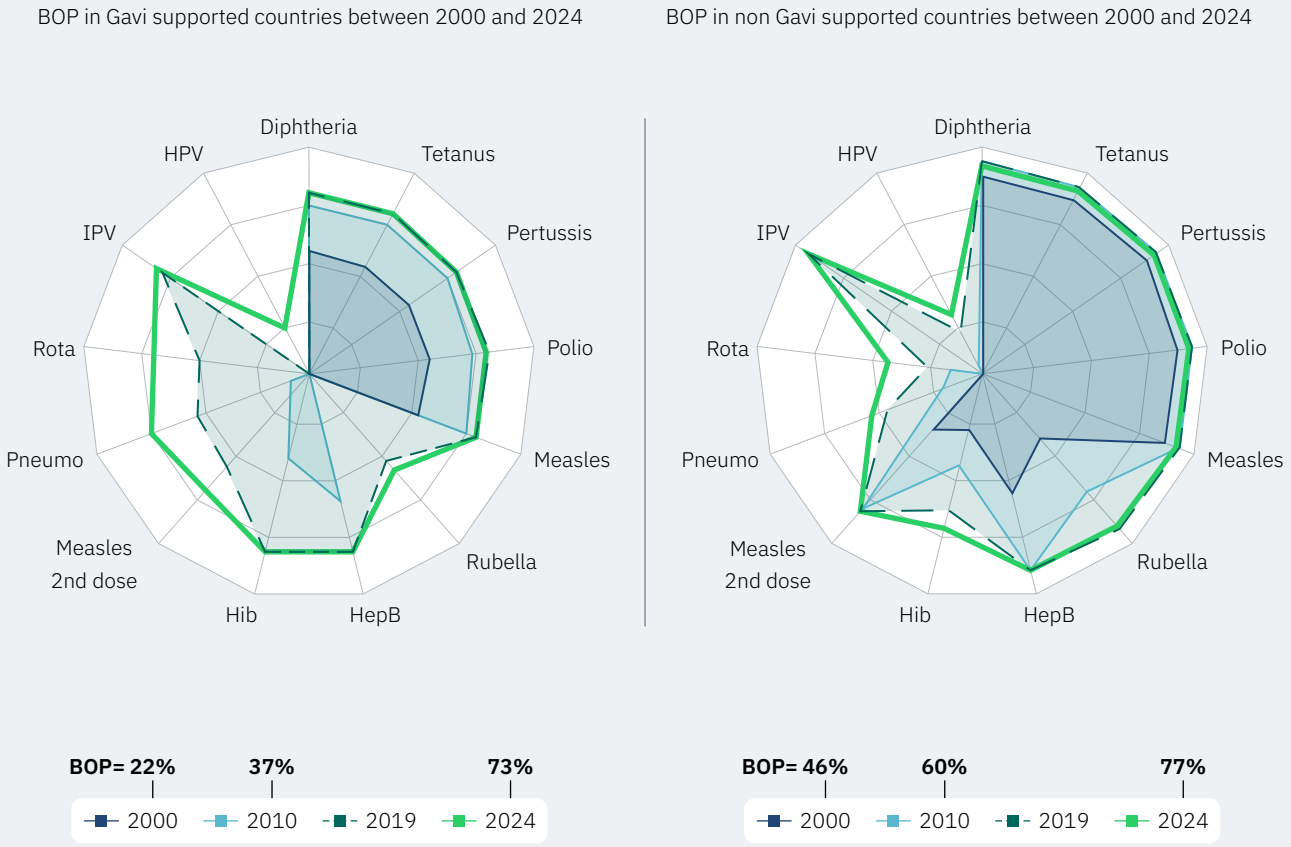
The IA2030 aims of reaching as many children and other vulnerable groups as possible with life-saving vaccines and that of leaving no one behind, seem ostensibly similar, but in some contexts may reflect a trade-off of priorities. The total number reached can be maximized by focusing efforts on concentrated centres of easy to reach sites with large numbers of zero-dose children. While leaving no one behind would require more costly outreach to remote dwelling or otherwise marginalized children, who are more challenging to reach, either because as a group level factors increase their marginalization, or because individual risk factors lead to unvaccinated children in the midst of a community with high coverage. In both cases attention to predictors of group level and individual level variance can assist in successfully targeting interventions. Leaving no one behind implies using more resources to reach fewer children. Policy makers will be better informed to make these difficult choices if data systems are robust at granular level and are designed to measure the causal predictors relevant to each level of analysis. It also required ascertainment of the marginalized, with specifically designed epidemiological survey methods.

Considering this trade-off in terms of the breadth of protection (BoP) is instructive. BoP measures the average coverage for all antigens in a national immunization program (Figure 14). It is increased by new vaccine introduction, and also by improvements in program performance of longstanding vaccines. At the initiation of the Gavi Alliance in 2000, the gap in BoP for supported and unsupported countries was 24 percentage points, now it is 4 percentage points, a resounding success of the Gavi model to improve access and achieve equity. That success was achieved largely through introduction of new vaccines, Hib, PCV, rotavirus, MCV2, hepatitis B birth dose, HPV, and rubella. To a lesser extent the increased BoP was achieved through improvements in programme performance for recently introduced vaccines. However, progress in programme performance for longstanding vaccines (BCG, DTPcV, polio, MCV1) has flatlined, and stubbornly resists increasing. Currently coverage is plateauing at about low to mid 90's in non-supported countries and at about the low 80's for supported countries. Investment in new introductions do not automatically achieve system strengthening. Further improvements now will require a focus on programme performance of existing vaccines. Future RSV or improved tuberculosis vaccines will save many lives, but increasingly countries will be facing difficult trade-offs in human resource allocation between new introductions and system strengthening. A global focus on sustainable system strengthening and robust local data that examines distributional variance and addresses local causal mechanism allows such choices to be informed, rational and explicit.

[71] (UNICEF 2025)

FIGURE 15

Breadth of Protection in Gavi and non Gavi supported countries in 2000, 2010, 2024.



Recommendations

Achieving equity in IA2030

Improving global equity in coverage can be achieved through regional focus on countries with low coverage and challenged programs and on those with large number of unvaccinated children despite strong programs. Improved national equity can be achieved by a similar focus on subnational regions, demographic groups (e.g., women) and so on. At every level, strengthening systems to correctly identify context-specific local causes is the only way to ensure such causes can be addressed. Even high performing countries should seek to identify internally pockets of the population that are less well reached or communities with whom engagement and trust can be improved. In order to achieve optimal targeting and specifically addressing locally contextual relevant factors, improvements in local monitoring and data use are needed. This requires the establishment and regular update of microplans that define performance indicators, and cycles of performance review and iterative quality improvement. Practically, at each level of immunization governance, program managers should ask where the deficiencies are, what are their direct local causes and structural determinants, and together with local communities decide how those causes can be addressed. At each level four factors need to be robustly tracked: coverage, distribution width, numbers unvaccinated, relevant local causes. A nested system that seeks to strengthen intervention at each governance level, and performance tracking and improvement can help drive resources to locations and inform and empower communities to undertake actions that are precise and targeted, and most likely effectively to achieve change.

4.4. THE BIG CATCH UP

Context

Progress has been made on the Big Catch-Up (BCU) - over 11 million children aged 1 to 5 years who likely missed vaccination previously have been reached with one or more catch-up dose, by mid-2025. Without the BCU initiative, these children might not have had access to any vaccination because of their older age. The BCU has contributed to increased focus on restoring immunization programmes and has also strengthened immunization systems by fostering the development of catch-up policies, revised immunization schedules and adaptation of reporting and monitoring tools for catch-up.

As a result of BCU efforts, we expect to close immunity gaps and hope to observe fewer outbreaks. While progress on the Big Catch-Up is encouraging, delayed implementation and lagging performance pose a high risk to not reaching the approximately 25 million missed children that countries had planned to reach by the end of 2025.

Key Trends and Findings

Big Catch-Up progress

Under the Big Catch-Up, an Alliance 'must win' originally conceived and announced by WHO and UNICEF in April 2023, 34 of 36 approved countries have started implementing catch-up immunization activities as of August 2025. As per latest reporting from end March 2025, at least 27.5 million catch-up doses of pentavalent, measles-containing vaccines (MCV), and inactivated poliovirus vaccine (IPV) have been administered, out of 149 million approved doses with over 7.1 million children aged 1 to 5 years (and up to 11 million by mid-2025) who likely missed vaccination previously estimated to have been reached with one or more catch-up dose.

Success enablers

Best practices reported by countries include increased community awareness campaigns, effective involvement of healthcare workers, community volunteers and civil society organisations to identify and reach zero-dose and under-immunised children, integration with polio and measles campaigns and vaccine introductions, and innovative approaches such as use of geographic information system (GIS) mapping. Encouragingly, as intended, the Big Catch-Up has led to systems improvements towards routinization of catch-up through approval of policies, schedules and updated data systems, as well as increased health worker and community awareness for the expansion and acceptability of offering vaccination services to children beyond the traditional age-group. This was the aim of the 'restore' and 'strengthen' aspects of the initiative.

Challenges and risks

While progress is encouraging in some countries, performance is lagging in most countries and there is high risk of not reaching the approximately 25 million missed children that countries had planned to reach by the end of 2025. Implementation timelines were delayed in many countries; 7 of the BCU countries did not begin implementation until 2025 and some of the countries that started implementation in 2024 were only partially implementing as of end of March 2025. It is estimated that countries had consumed only about 20% of the 149 million approved doses of pentavalent, MCV and IPV by the end of March 2025, which necessitates significant acceleration and or, recalibration of targets. Countries have flagged several challenges including disruptions due to global funding cuts and competing priorities such as outbreak response activities and vaccine introductions.

Recommendations

To mitigate risks and address the challenges, the Alliance is advocating for accelerated implementation across governments and national EPI programmes, revising the volumes of approved BCU doses where target adjustments are necessary, deploying technical assistance across countries, and jointly helping to resolve country-specific challenges through the cross-Alliance BCU Task Team. At countries' request, the Task Team also intends to consider certain flexibilities for continued administration of BCU doses in cases where countries have a credible plan for routinization of catch-up vaccination or substantial additional catch-up in early 2026, or in other truly exceptional circumstances.

Beyond the BCU initiative, IA2030 partners will continue to support countries to integrate catch-up policies and activities in essential immunization services, building on the catalytic momentum provided by the BCU. This would require regular planning to reach currently unreached children and vulnerable groups using routine vaccines.

05
CHALLENGES AND BARRIERS: IA2030 OPERATIONS

This chapter explores the strengths and limitations of the IA2030 governance model, grounded in its original design principles, and assesses how these have influenced delivery at country level. At the midpoint, several challenges have emerged across global mechanisms such as the Partnership Council, Coordination Group, Secretariat, and Working Groups, including unclear mandates, weak coordination between levels, and persistent resource constraints. At the country level, while progress has been made in developing National Immunization Strategies (NIS), systemic challenges in planning, prioritization, and performance tracking continue to limit effective implementation. The lessons from the first half of the decade provide a critical opportunity to refine IA2030's delivery model and strengthen its ability to support countries more effectively in the years ahead.

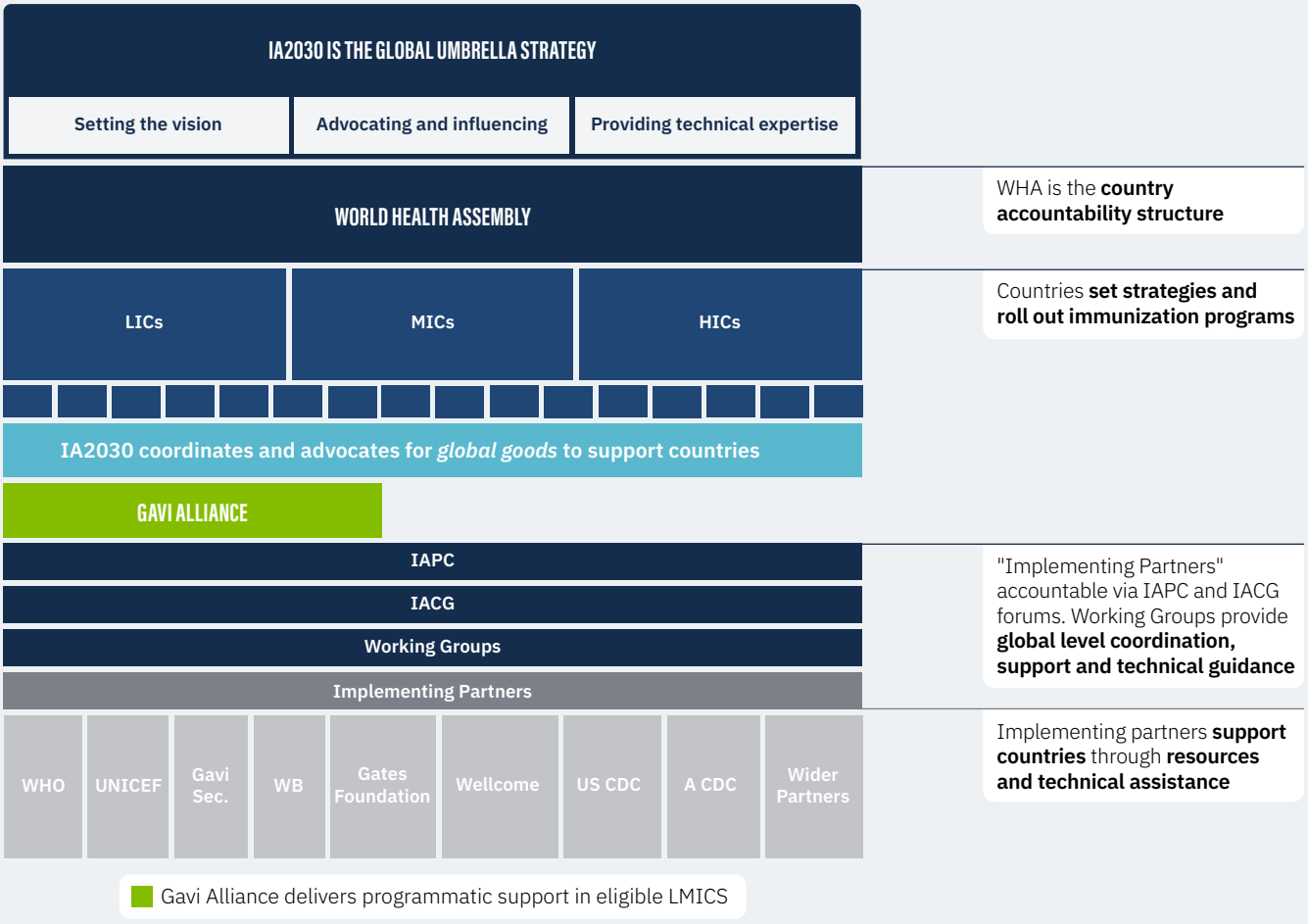
5.1. IA2030 GLOBAL AND REGIONAL OPERATIONS

Context

IA2030 was conceived as a unifying global strategy, providing an overarching framework to align and coordinate efforts across global, regional, and national stakeholders. Its purpose is to advance equitable immunization outcomes for all countries and ensure comprehensive protection against all vaccine-preventable diseases.

FIGURE 16

Depiction of IA2030 as the global immunization umbrella strategy.



The Framework for Action drew on the following guiding principles for the development of the IA2030 *[extract]:*

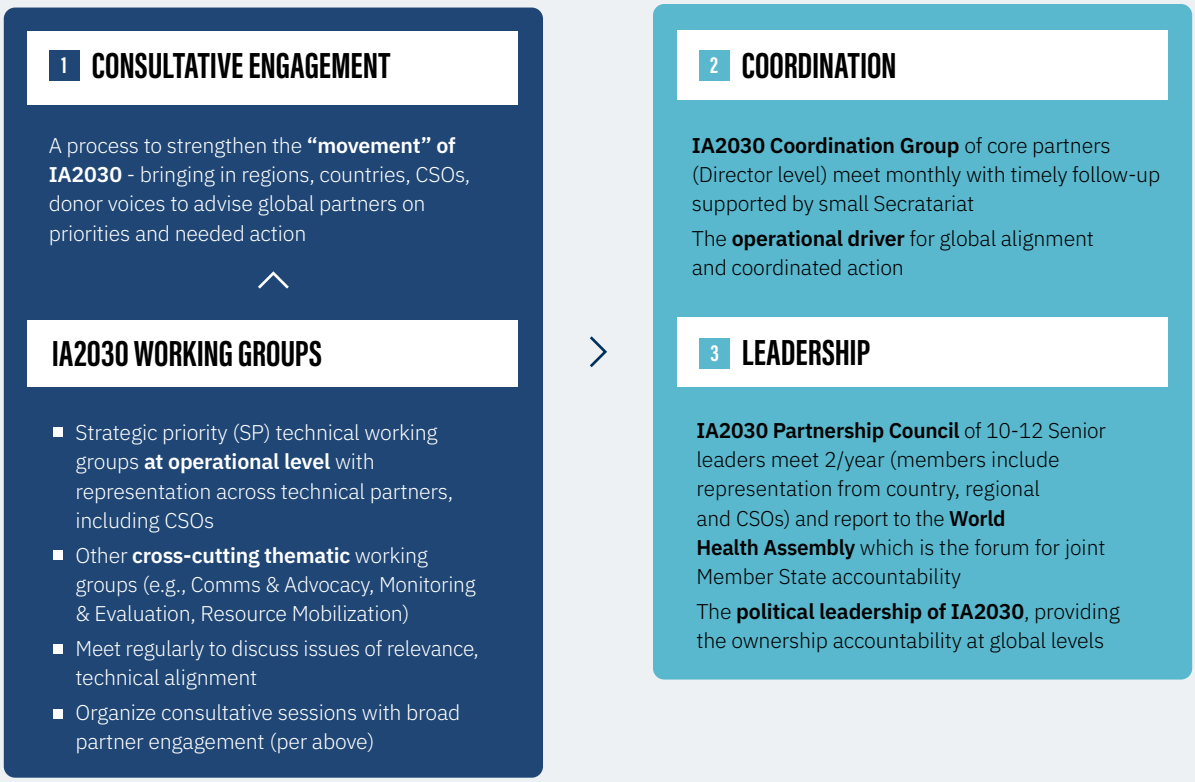
- **Instilling broad ownership to achieve the IA2030 vision** among all immunization and non-immunization stakeholders, including those involved in health system strengthening and disease-specific initiatives. Country ownership is key to achieving the IA2030 vision because the most important actions will be the responsibility of individual countries.
- **Leveraging and strengthening existing mechanisms** for coordination, accountability, planning, M&E and advocacy at country, regional and global levels.
- **Promoting continuous quality improvement cycles** using timely, reliable and fit-for-purpose data.
- **Building and strengthening** stakeholder accountability and technical alignment to address country needs.
- **Aligning and harmonizing** with existing regional and national plans and global strategies, including the Sustainable Development Goals (SDGs) - particularly SDG 3: Good Health and Well-Being, Universal Health Coverage (UHC) and Gavi 5.0.

The IA2030 governance model comprises consultation, coordination, and leadership, with each part playing an important role to form the basis of the IA2030 global partnership:

- **Consultative Engagement:** A broad consultative platform, anchored in IA2030 Working Groups, strengthens the movement's inclusivity. This enables meaningful participation from countries, regional institutions, CSOs and donors to guide global partner priorities and actions.
- **Coordination**: The **IA2030 Coordination Group** functions as the core operational engine of the agenda, facilitating alignment among global partners and driving coordinated action to implement strategic priorities.
- **Leadership:** The **World Health Assembly**, with the **IA2030 Partnership Council**, provides high-level leadership with the institutional authority and influence required to drive impactful, system-wide decisions. These bodies play a critical role in maintaining political momentum and strategic oversight.

FIGURE 17

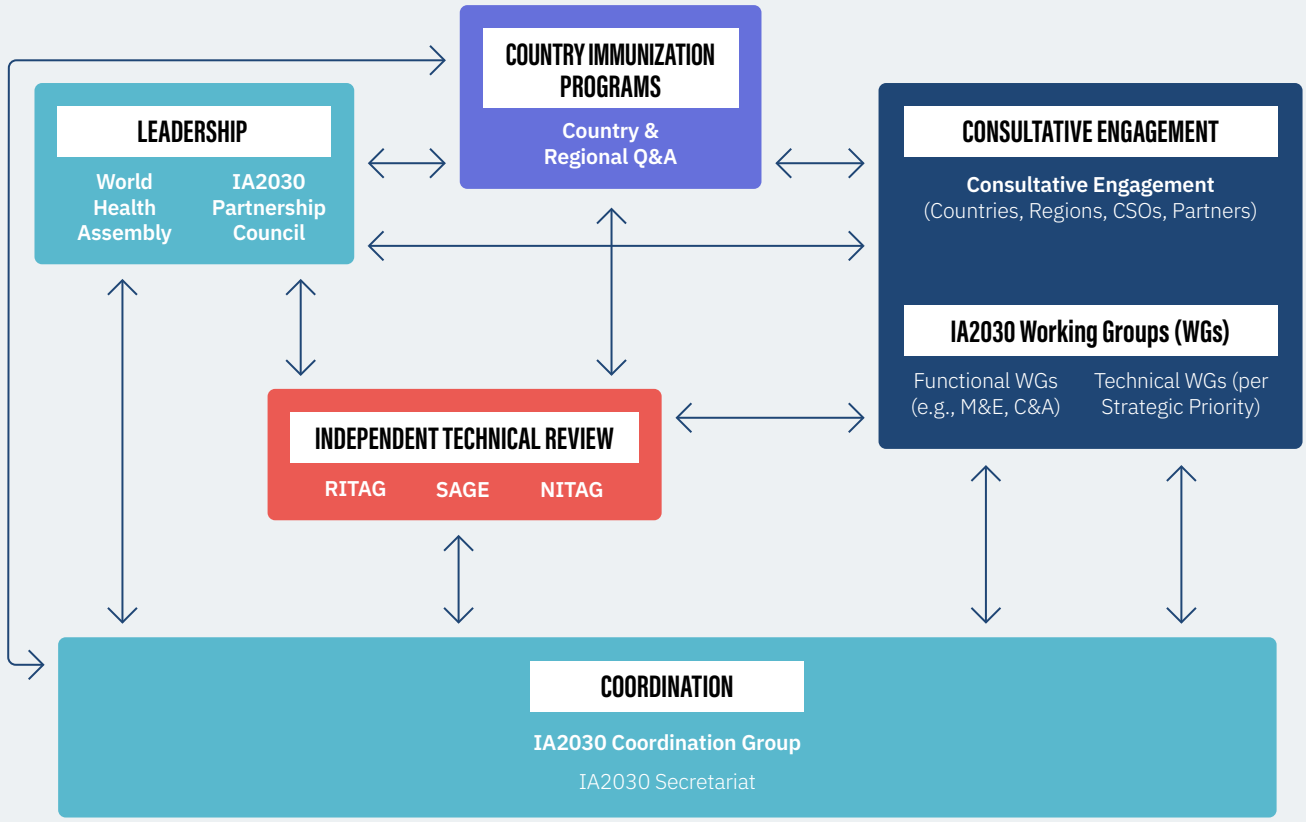
IA2030 partnership model at the global level from the IA2030 Framework for Action.



To operationalize the IA2030 framework, countries and national immunization programmes were positioned at the centre of the agenda, recognizing their essential role in driving sustainable outcomes. The global partnership model builds on existing regional and country-level structures, with an emphasis on two-way communication and information-sharing. These mechanisms are designed to ensure that global entities are guided by and accountable to regional and national stakeholders, strengthening alignment and mutual accountability across the partnership.

FIGURE 18

IA2030 information flow from the IA2030 Framework for Action Annex.



Key Trends and Findings

The IA2030 mechanism designed was deliberately inclusive and multi-level in structure with an aim to foster shared governance. However, throughout the first five years, there have been ongoing challenges, especially relating ambiguity regarding roles, responsibilities, and mutual expectations across global, regional, and country levels. Specifically, stakeholders at the regional and national levels have expressed a lack of clarity regarding decision-making and coordination processes at both the global and regional levels.

Consultations with stakeholders across the immunization ecosystem suggest that greater clarity, communication, and alignment, alongside greater outcomes orientation, could enhance IA2030's effectiveness. These insights point to tangible opportunities to strengthen coordination, reinforce mutual accountability, and ensure that all levels of the partnership are empowered to contribute meaningfully to the agenda's success.

IA2030 PARTNERSHIP COUNCIL (IAPC)

Context

The Immunization Agenda 2030 Partnership Council (IAPC) was established to provide **strategic leadership** for the IA2030 agenda. Its mandate includes **monitoring progress toward impact targets, advocating for prioritized action** to accelerate delivery, and **mobilizing political commitment and partner engagement** across the immunization ecosystem. The Council brings together senior representatives from global immunization partners, regions, and civil society, reflecting IA2030's inclusive and collaborative ethos.

Key Trends and Findings

Between 2020-2025, the IAPC convened meetings on a range of strategic topics, from the implications of WUENIC results, to alignment on collective focus of recent changes in measles activity. These engagements have **contributed meaningfully to the IA2030 agenda,** informing strategic direction and providing targeted guidance to the IA2030 Coordination Group (IACG), Working Groups, Regional activities, and the priorities of the IA2030 Secretariat.

However, inputs to this Mid-Term Review have consistently noted that the IAPC requires review and reform. This view was shared by IAPC members themselves, wider global stakeholders, as well as regional stakeholders who interact with it. Consistent feedback highlighted several key findings:

- **The role and mandate of IAPC remains unclear, in particular with reference to other immunization and wider global health forums.** As a forum with no formal decision-making or financial oversight role, the IAPC has struggled to define its purpose wider than a helpful information-sharing group – both as a forum in itself and when compared to other forums within and without immunization, such as the Gavi Board, TB Accelerator Council, PMNCH, WHO Executive Board. To remain for the next five years and beyond, this critical challenge must be addressed.

- **The membership of the Council was identified as a challenge.** The IAPC was intended to be the convening of those 'with the levers to make a difference', often in leadership positions broader than just immunization. However, these leaders have often delegated attendance to the immunization-specific representative – reducing the external, broader oversight and linkages originally intended. Those consulted for the Review also highlighted the need for more diverse representation (including country representation, industry and manufacturer associations, civil society, and other non-immunization stakeholders), as well as the need to more frequently rotate chairpersonship to keep different constituencies engaged.

- **The thematic scope of the IAPC has been too narrow.** While in theory the IAPC encompasses all immunization work, its agendas have tended to focus on a narrower scope – often around programmatic topics such as measles campaigns, vaccine-preventable disease outbreaks or global coverage data. While acknowledged as important areas, the Review responses highlighted a wish for the IAPC to more truly oversee the full value chain of vaccines – from research and development, through manufacturing and procurement, to the programmatic results.

- **The link between a global Partnership Council and regional or national activities has been too distant.** Despite a key objective of the IA2030 being to break-down distances between levels of oversight, these are identified as having broadly continued during IA2030 to date. While representation from regions is included in the IAPC, those interviewed for the Review highlighted that it has tended to be very global focus and lacks strong national or regional voices within its conversations.

Recommendations

Looking ahead, **mobilizing high-level political leadership** stands out as a critical area for strengthening if immunization efforts are going to succeed towards 2030, and beyond. **Renewed efforts to position immunization as a political priority,** particularly in light of evolving global health challenges, will be critical to unlocking the full potential of IA2030.

Through the Review, a range of **opportunities to enhance the IAPC's effectiveness were proposed.** These are summarized below:

- **Build upon the recent IA2030 Ways of Working Review to reaffirm IAPC as a global coordination and strategic leadership forum.** Without reform, the IAPC risks becoming solely an information-sharing forum for senior leaders. While this is an important role, the trends identified in Chapter 2 and the challenges highlighted in Chapters 3 and 4 indicate that the function of the IAPC needs to mature further to become more than this. The IAPC should be reaffirmed as a global coordination and strategic forum to facilitate regional and country programmes. As a global forum, IAPC's strategic leadership should focus on 'global goods' – topics that cut across multiple countries or address systematic challenges including strengthening sustainable and country-led programs, developing tailored support packages for FCVs and MICs, strengthening integration and defining the future of global health architecture.

  As countries and regions must be put at the centre of IA2030 priorities and activities, IAPC should serve as a facilitating and coordinating leadership body across partners. This implies greater regional leadership and ownership of IA2030, and additional consultation with regions will be crucial to co-define regional needs and jointly determine practical ways to empower regions and ultimately transition towards a more decentralized leadership model. IAPC should be responsive to region and country needs and ensure consistent two-way communication as the governance structure evolves.

- **Improve clarity around its role, visibility, and mandate.** Awareness of the IAPC remains limited, even within core global partner institutions, constraining opportunities for broader engagement and alignment. IAPC's value-adding role includes coordinating across partners at global level, linking with decision-makers at regional and country level, proactively setting the direction for cross-cutting health priorities, and focusing on long-term trends and the future of immunization.

  Modelled on the example of the Measles & Rubella Partnership, IAPC should further explore opportunities to consolidate governance structures of other disease-specific initiatives (for example, cholera, meningitis, yellow fever, polio, influenza, and others) to streamline engagement and ensure more effective coordination within IA2030's umbrella strategy.

- **Strengthen accountability mechanisms** and increase engagement at IAPC level. This could be achieved through governance shifts (for example, by rotating the chairperson) but IAPC should further consider other ways to strengthen accountability. This could include publishing joint-positions or communication as IAPC which are endorsed by all partners and regularly reviewing impact against targets.

  At the onset of IA2030, impact goal targets and corresponding metrics were collectively endorsed as aspirational but achievable targets. At the midpoint of IA2030, some metrics may require review to ensure that KPIs remain relevant even if overall strategic targets are not adjusted. IAPC should consider further analysis to define potential options for reconsidering existing targets and corresponding metrics which will underpin how IAPC reports against progress in future.

- **Enhance coordination with the IACG**, to ensure coherence across the IA2030 governance architecture and commitment to resource and support IACG implement its role. As IACG's role expands to include commissioning of action-oriented task-teams in lieu of standing working

groups, IAPC commits to adequately resourcing the IACG and IA2030 Secretariat. This can include allocating resources for task teams or dedicating staff time to execute Secretariat functions, for example through rotating secondments. As this model is implemented, IAPC must closely coordinate with IACG to define priorities for commissioning task teams, and holding task teams accountable for delivering against defined outputs.

IAPC should further assess the resource requirements, possible design choices, and governance models for pooled resourcing, further considering that each partner is significantly affected by current shifts in global health financing architecture which will impact their ability to commit resources and/or staff time to IA2030 operations.

Strengthen linkages with regional and country stakeholders, partners, and other decision-making entities, who expressed a need for greater clarity on the IAPC's functions and more consistent engagement. This can be achieved by bolstering representation on the IAPC – for example by including rotating country representatives from 2-3 country archetypes (such as FCVs, MICs), including vaccine manufacturing professional bodies, Civil Society Organizations, and other non-immunization actors that can ensure integration is maintained on the agenda. Ensuring two-way communication with other partners is fundamental to co-developing the future of immunization programmes that are locally relevant and integrated into PHC.

Together, these steps would help the IAPC deliver more effectively on its intended role as a driver of strategic alignment, accountability, and political momentum within the IA2030 framework.

IA2030 COORDINATION GROUP (IACG)

Context

The IACG serves as the **operational engine of the IA2030,** driving alignment, cohesion, and momentum across the partnership. Its core responsibilities include:

- **Coordinating technical and operational efforts** across IA2030 structures
- **Advancing priorities** identified by IA2030 working groups
- **Monitoring progress** and advising on formal reporting, including WUENIC and the Global Progress Report
- **Setting the agenda** for the IA2030 Partnership Council
- **Bridging IA2030 with related health and development initiatives**, and leading the implementation of the learning agenda

The IACG is composed of eight-ten core partner organizations and convenes monthly. Since its inception, IACG meetings offer regular opportunities for coordination, technical exchange, and engagement with IA2030 working groups to assess progress and recalibrate priorities.

Key Trends and Findings

Stakeholders broadly recognize the IACG's value in **tracking progress, supporting working groups,** synthesizing insights, and communicating outcomes to key fora such as SAGE and the World Health Assembly. Its contributions to the preparation of formal progress reports have been particularly valued.

However, the governance review surfaced a number of challenges:

- **Minimal visibility and understanding of the IACG's mandate and contributions** across many parts of the immunization ecosystem, even among core partner institutions.
- **Limited translation of global priorities into country-level action**. IACG deliberations are not always explicitly anchored in IA2030 strategic targets, reducing their downstream operational impact.
- **Absence of regional and country-level voices** within the IACG structure, constraining two-way communication and limiting the flow of practical insights from frontline immunization programmes into global decision-making.
- **Constrained resources that hinder the IACG's ability to fulfil its role effectively**. As an unfunded entity with no dedicated budget, it faces challenges in advancing core priorities, providing support where Gavi and other mechanisms are absent, and scaling workstreams that require dedicated personnel. Addressing these constraints will be essential to unlocking the IACG's full potential as a driver of the IA2030 strategy.
- **Unfulfilled learning agenda mandate.** The IACG's mandate to lead the IA2030 learning agenda is **conceptually strong but practically underutilized**. Use of data tools for learning, accountability, and course correction remains inconsistent and would benefit from greater investment and technical support.

Recommendations

A number of opportunities to enhance the IAPC's effectiveness were proposed during the review process. These include:

- **Bolster the composition of the IACG** to include partners with the authority and capacity to drive change, including stronger representation from regional institutions.
- **Update the Terms of Reference** to clarify roles, define shared expectations, and clearly articulate the IACG's added value both to the broader partnership and to its members.
- **Provide access to pooled funding across partners to enable the IACG to commission task teams** for time-bound initiatives with clear, measurable outcomes. Recognizing that, in the current climate committing additional funding or pooling partner resources away from other priorities will be challenging, it will be crucial to identify a limited number of areas to demonstrate effective results using the task team model. Further considerations into the design, resource needs, and operating model should be assessed.
- **Improve proactive communication** of IACG decisions, progress, and impact to increase visibility, transparency, and stakeholder engagement.

IA2030 SECRETARIAT

Context

The IA2030 Secretariat plays a **critical coordinating role** within the global immunization partnership, enabling the effective functioning of IA2030's structures through operational and logistical support. Its core responsibilities include:

- **Facilitating and following up on meetings** of the IA2030 Coordination Group (IACG) and Partnership Council (IAPC)
- **Supporting and coordinating across working group**, including providing logistical assistance
- **Maintaining the IA2030 website**
- **Contributing to the development of formal immunization progress reports**

Initially envisioned as a small, virtual team, the Secretariat is currently staffed by a dedicated WHO official, supported by external consultants to manage the demands of coordinating a multi-tiered, global mechanism.

Key Trends and Findings

Stakeholders familiar with its work have highlighted the Secretariat's valuable contributions **in convening meetings and sustaining momentum across IA2030 leadership, coordination and working groups and platforms.**

However, key challenges were raised in consultations:

Awareness of the Secretariat's mandate and contributions remains limited across much of the immunization ecosystem. To address this, there is a clear need for a **refreshed Terms of Reference,** accompanied by targeted engagement to clarify roles and expectations across all levels of the partnership.

- **Resource and capacity constraints** limit the Secretariat's ability to fully support implementation and drive delivery of the IA2030 strategy
- **The IA2030 website, managed by the Secretariat, lacks a clear vision and dynamic functionality**, limiting its effectiveness as a platform for tracking progress and engaging the broader immunization community
- **Lack of a clear outcomes-linked action plan and strong internal communication mechanism** makes it difficult to ensure consistent alignment and information flow across IA2030 stakeholders.

Recommendations

While IA2030 is and should continue to be run on a network model, with distributed coordination via partners and existing forums, much of what IA2030 partners can drive, collectively, relies on a resourced, centrally positioned Secretariat. The **IA2030 Secretariat should be flexible, sufficiently resourced, and cross-functional,** with the capacity to deploy technical and operational support across priority areas, and the authority to track delivery and report on progress across the full IA2030 ecosystem. Building on the lessons learnt from the Covax Strategic Coordination Office, it should be **staffed by individuals drawn from across the IA2030 partnership, including regional non-immunization actors where relevant,** building connections to different areas of immunization and embedding knowledge of IA2030 strategy across the network. This requires 2-3 dedicated staff across partners to operate the Secretariat, and could be achieved through a rotational or secondment program. Further consideration should be given to the design, but a well-resourced Secretariat has consistently been highlighted as a crucial enabler for implementing IA2030's strategy.

Further, the Secretariat would benefit from **developing an outcomes-focused action plan** and **reinforcing its communication channels** to ensure consistent information-sharing and alignment throughout the IA2030 structure. To reinforce and broaden its communications channels, the Secretariat should refine the IA2030 website (details on next page) and establish a social-media presence to strengthen the IA2030 identity, share updates, and engage a broader audience.

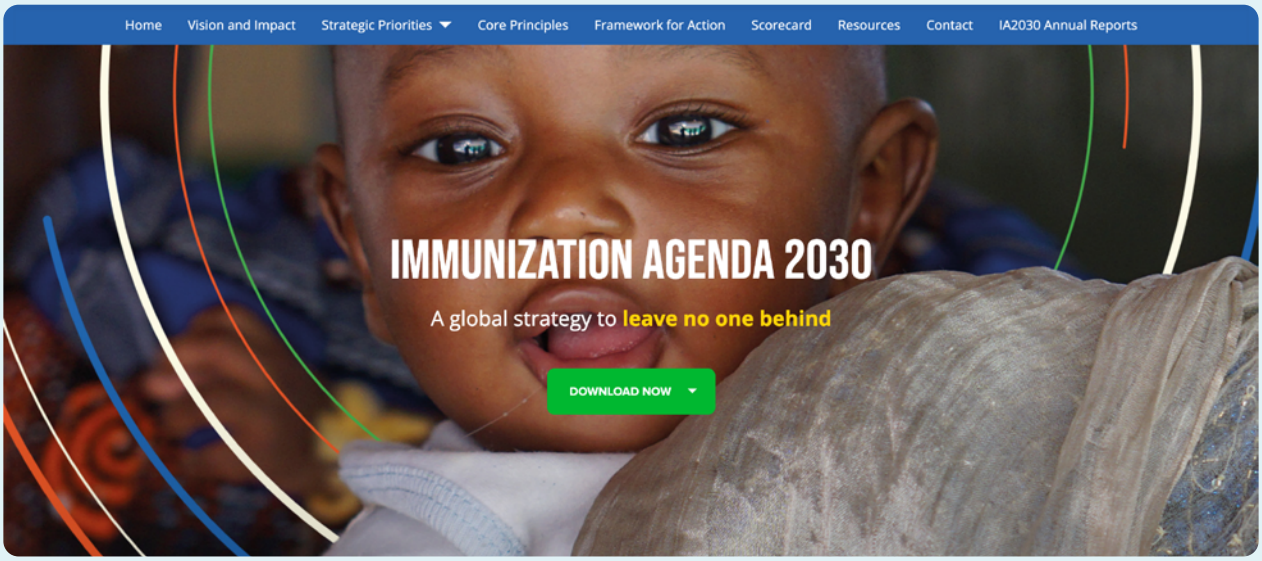
Strengthening the Secretariat's visibility, planning, and operational capacity will be foundational to the effective delivery of the IA2030 strategy in its second half.

The IA2030 website represents another opportunity for improvement.

SPOTLIGHT:

Strengthening the IA2030 Website as a Strategic Engagement Platform

The IA2030 website is a critical touchpoint for the Immunization Agenda 2030 community, serving as an important source of key information on progress and priorities.



With over **20,000 annual active users between June 2024 and July 2025,** the majority of whom are new users, the site holds significant potential to become a platform for **strategic, active engagement across the immunization ecosystem.** However, the website is currently underutilized, and several stakeholders have identified **website management as a key area for improvement** by the IA2030 Secretariat.

There are three priority areas for improving the IA2030 website:

- **Enhancing access to timely, analytical data.** The IA2030 Scorecard presents progress against baseline and 2030 targets, including country-specific views, but lacks dynamic features such as cross-regional comparisons. The indicator set, while aligned with IA2030 priorities, differs from widely used reports like WUENIC, and data updates are often delayed due to logistical challenges. **Streamlining the Global Progress Report and WUENIC processes, supported by a live dashboard** on the website, would offer users more timely, comprehensive, and interactive insights. This is already under development and launch is expected in 2026.
- **Improving relevance for country and regional users.** Website analytics show that **7 of the top 10 user countries are high-income,** with the remaining being South Africa, India and China. To better serve countries with immunization challenges, IA2030 partners should review its content strategy to ensure greater operational relevance, particularly for LICs and LMICs, such as through adequately linking the website with existing resources developed at regional level (e.g. dashboards and strategic/ operational frameworks) and other helpful platforms such as Technet.
- **Increasing engagement beyond the homepage.** Currently, **over 70% of users do not navigate past the landing page,** suggesting that key information may be hard to find or insufficiently engaging. Revisiting homepage layout, adding prominent links, and featuring more diverse content could help encourage deeper and more frequent use.

With targeted improvements, the IA2030 website can evolve from a static repository into a **dynamic, inclusive platform** that supports learning, visibility, and action. A clearer strategic vision is needed.

IA2030 WORKING GROUPS

Context

The IA2030 framework includes **11 working groups (WG)** organized into three categories, each providing technical guidance and advancing learning, programmatic support, and monitoring and evaluation (M&E) across the immunization agenda:

- **Five Strategic Priority Working Groups**, aligned to IA2030 strategic priorities (e.g., SP1/3/4 on equitable immunization through primary health care across the life course; SP2 on commitment and demand, SP5 focused on outbreaks and emergencies.).
- **Five Technical Working Groups**, focusing on areas such as disease-specific initiatives and Measles & Rubella immunization.
- **One Enabling Working Group**, which provides cross-cutting support on communications and advocacy.

Key Trends and Findings

Several areas for strengthening have emerged:

- **Inclusivity remains limited.** While working groups offer an important platform for consultative engagement, participation is often dominated by global-level actors. More systematic inclusion of voices from regions, countries, and civil society organizations (CSOs) would broaden perspectives and improve relevance to local implementation realities.
- **Engagement across members is uneven.** Many participants view working group activities as disconnected from their core responsibilities, which can reduce engagement, delay follow-up, and hinder sustained momentum. Human resource capacity constraints further exacerbate these challenges.
- **Mandates require greater clarity.** Stakeholders have called for clearer definitions of each group's purpose and scope, including an explicit **distinction between coordination and delivery roles**. This would help streamline efforts and ensure working groups are empowered and focused.
- **A shift toward outcomes-orientation is needed.** Working groups are often experienced as process heavy. A stronger focus on tangible deliverables and impact would help maximize the value of time and resources invested.
- **Stronger linkage with decision-making bodies is essential.** Currently, alignment between working group outputs and the agendas of the IACG and IAPC tends to happen only when a group is directly tasked. This limits the influence of technical recommendations on broader strategic direction.
- **Visibility remains low outside of global structures.** The roles and contributions of working groups are not well understood across the wider IA2030 ecosystem.

Recommendations

Enhancing the working groups' structure and purpose will be key to increasing their contribution to IA2030's success in the second half of the decade. To reduce fragmentation, sharpen focus, and keep coordination demands manageable amid limited resources and uneven engagement, **standing working groups at all levels should be discontinued unless they offer clear operational value to countries and partners.** Where effective forums already exist, such as within the Gavi Alliance, these should be leveraged, rather than duplicated, and adapted as needed to serve the broader immunization agenda. Sunset working groups should be transitioned into time-bound task teams that are established on a needs-basis to deliver defined, measurable outputs at both global and regional levels. Task Teams can be comprised of key focal points from current working groups, regional representatives, and other subject matter experts – these focal points will be identified and consolidated prior to sunsetting any working group.

REGIONAL-LEVEL STRUCTURES

Context

The IA2030 strategy was designed to **build upon and reinforce existing regional platforms,** drawing on the leadership of WHO Regional Advisers, Regional Immunization Technical Advisory Groups (RITAGs), and, in some regions, Regional Working Groups. As regional bodies play a key role in influencing country priorities and strategies, these mechanisms were envisioned to:

- **Translate global IA2030 strategies into regionally relevant priorities and action plans**, through the development of tailored regional IA2030 strategies and visions
- Support countries in aligning national immunization strategies with IA2030 objectives
- **Review impact data regularly** at regional and sub-regional levels
- **Coordinate regional development partner efforts**
- **Engage civil society organizations (CSOs)** to secure commitments and amplify accountability

Key Trends and Findings

By the midpoint of the IA2030 strategy, **many regions had made notable progress** in contextualizing IA2030 to reflect regional priorities through regional strategies (e.g., EIA2030 in Europe), helping to maintain relevance across a wide range of settings. However, **coordination across and with regional structures has been less systematic and more fragmented than intended.** Ambiguities in roles and responsibilities have undermined effectiveness:

- **Global stakeholders lack visibility** into regional activities, priorities, and impact
- **Regional actors are unclear** about when, how, and why to engage with global IA2030 mechanisms
- Bidirectional uncertainty has weakened alignment and diluted accountability

Other challenges surfaced include:

- **Inconsistent performance and engagement across regions.** Civil society participation, transparency in decision-making, and partner alignment vary widely, limiting consistency in implementation.
- **Weak follow-through on political commitments.** Pledges made at the regional level often remain aspirational due to limited accountability mechanisms and insufficient pathways for sustained action.
- **Structural and resource misalignment.** Some regional and national actors view global IA2030 targets as out of step with local contexts, particularly post-COVID, leading to adaptations that reduce consistency across countries.
- **Operational limitations of technical advisory groups.** RITAGs and similar bodies face high staff turnover, underfunding, and limited capacity, which hinder their ability to provide consistent and high-quality technical guidance.

Recommendations

Strengthening coordination, two-way communication, and mutual accountability between global and regional levels, while ensuring that regional platforms are adequately resourced and empowered, will be essential to unlocking the full value of the IA2030 strategy. IA2030 partners should work in partnership with regional bodies to strengthen their IA2030 coordination forums by clarifying mandates, driving inclusive membership, and establishing clear accountability mechanisms that support region-led immunization planning and delivery. Depending on the regional and contextual needs, relevant IA2030 coordination groups at the regional level could include cross-immunization forums comprised of senior leadership, taking note to ensure minimal overlap with technical for such as EPI Manager Groups that already exist. Better alignment across IA2030 levels will reduce fragmentation, enhance coherence, and ensure regional priorities are reflected in global planning. These platforms can also promote country ownership, facilitate peer learning, and support more agile, equitable and context-specific delivery. There are also opportunities for more external communications, beyond formal reporting, for example through social media which could be opportunities to raise awareness of IA2030 objectives and progress.

5.2. REVIEW OF IA2030 DELIVERY AT THE NATIONAL LEVEL

Context

In 2021, WHO published the National Immunization Strategy (NIS) guidance, building on learnings of the past decade on countries' planning processes. The NIS is a cornerstone of IA2030, enabling countries to articulate their immunization priorities, align stakeholders, and allocate resources effectively. Grounded in principles of country ownership, contextual relevance, and strategic planning, the NIS empowers governments to lead the design and implementation of tailored interventions that reflect local context, health system capacity, and community needs, including in fragile and humanitarian settings. This country-led model draws on stakeholder engagement across the health and development sectors to support integration, enhance accountability, promote sustainability through effective resource allocation and budget dialogue, and enable the prioritization of interventions that are both impactful and feasible.

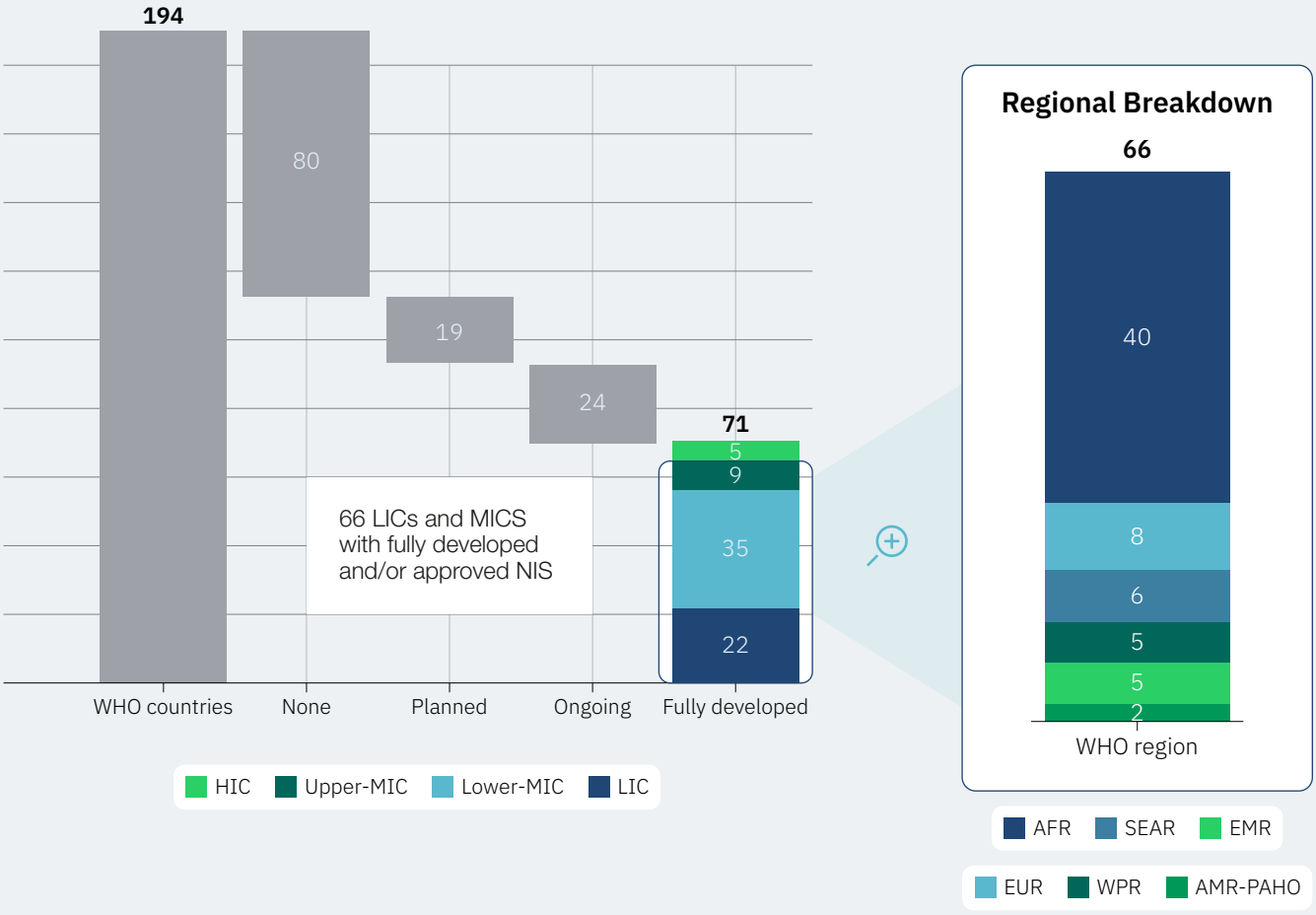
Key Trends and Findings

In October 2021, WHO's SAGE recommended that "countries develop National Immunization Strategies aligned to the IA2030 and Regional Frameworks and establish national monitoring, evaluation, and accountability processes" to support progress towards IA2030 objectives and facilitate integration with health plans.

As of 30 June 2025, 66 countries have developed their NIS, while 24 countries are currently developing theirs. An additional 19 countries have indicated plans to develop or update their NIS within the next 12 to 18 months.

FIGURE 19

Status of National Immunization Strategy development as of June 2025. Sourced from NIS Tracking Tool developed by WHO and UNICEF NIS Teams.

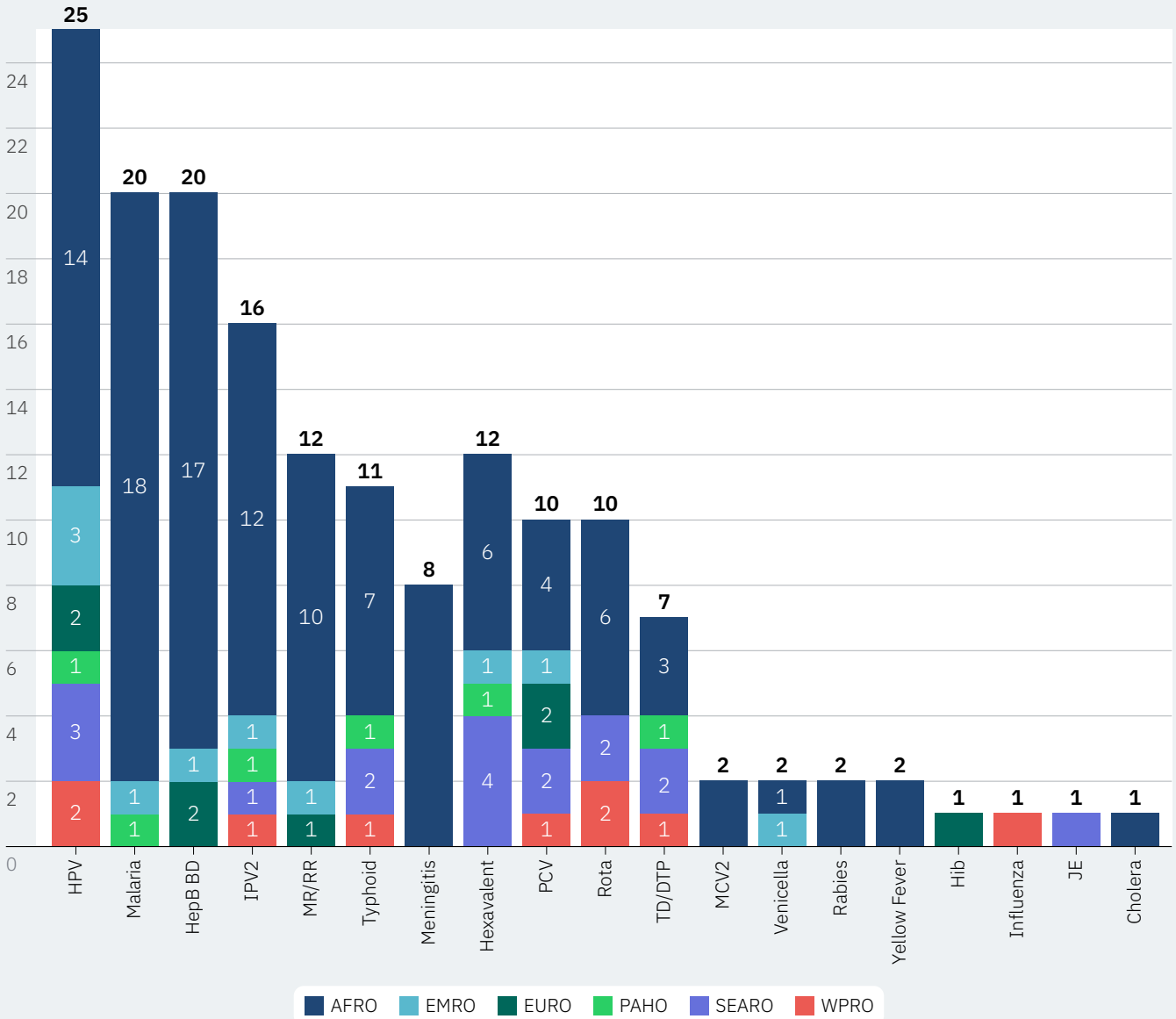


An analysis of available NIS was presented at SAGE in March 2025. This analysis highlighted that over 50% of countries across all regions and all income groups are working on their NIS. The analysis focused on low- and middle-income countries (excluding HICs) and showed that all LMIC NIS' reference both the overall IA2030 goals and specific targets. The analysis also showed that:

- There are no major differences in strategic priorities across regions, based on the review of countries' NIS
- Strategies for VPD control and gender equity are not yet well-integrated and require stronger inclusion across all regions.
- Life course vaccination activity is commonly found in MICs and UMICs at this point
- 50 countries are planning New Vaccine Introductions (NVI) with an average of 3 introductions planned for the duration of the NIS (3 to 5 years)
- The NIS development process created an opportunity for national stakeholders (beyond the immunization programme) to engage in prioritization of immunization across the health sector.

FIGURE 20

Number of countries planning new vaccine introduction in current NIS phase by vaccine. Sourced from WHO and UNICEF NIS teams.



The March 2025 SAGE session reaffirmed the emergence during the IA2030 period of the NIS as a core national process, not merely a technical document

Challenges and Barriers during the period

Despite progress in the development of National Immunization Strategies (NIS), several challenges remain. This includes:

- **Minimal information on the monitoring of implementation at country level:** Whilst the NIS is intended to be a living document, to be updated as national context evolve, global and regional levels do not have a system to systematically monitor the implementation of identified priorities in countries, challenging support provided to countries.

- **Integration with PHC is not sufficiently reflect in NIS:** While many NIS documents reference immunization as an integral part of PHC, operational alignment with national health systems and PHC priorities and execution remain inconsistent across countries due to the lack of appropriation of the guidelines at country level as well as donors' reluctancy to fund PHC activities.

- **Budget dialogue remains challenging: planning and budgeting processes are often siloed.** Budget dialogue and effective allocation of resources are therefore often insufficiently integrated into NIS processes, especially in countries supported by Gavi, resulting in aspirational plans that often reflect donor driven fragmentation and lack realistic funding pathways in light of national health priorities and available domestic funding.

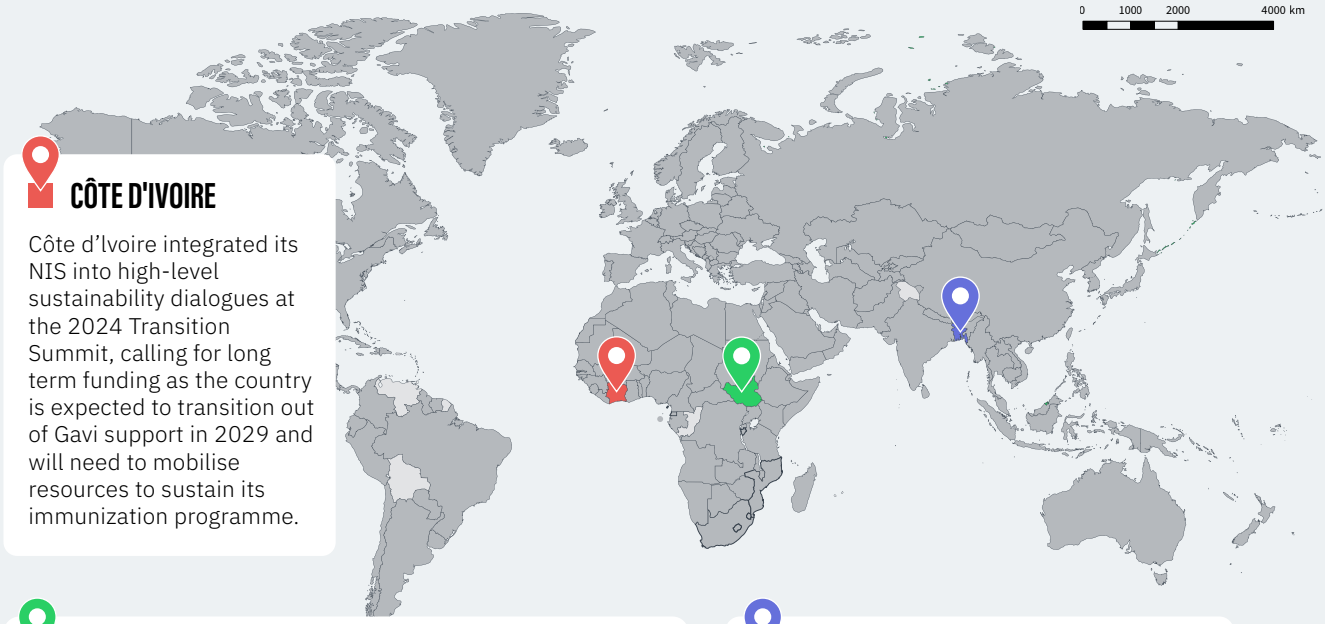
- **Insufficient link between strategy and operational planning.** NIS should systematically inform operational planning and decision-making. However, in some contexts, NIS objectives are not translated into actionable annual plans, which further highlights the challenges countries face in generating and using country-level data to inform programmatic planning, particularly in decentralized systems where data fragmentation and capacity constraints hinder evidence-based planning. To do so, countries must make implementation evidence explicit: identify data and evidence gaps; embed strategies within the NIS to close them (including better use of existing evidence); and build capacity for implementation research to generate what is missing, and monitor key indicators that are linked to overall NIS goals. NIS should become vehicles not only for planning but also for learning, adaptation, addressing inequities, and strengthening systems, which improves their usefulness and relevance as an operational tool.

Recommendations

The NIS is increasingly being leveraged as a powerful advocacy, resource mobilisation, and planning tool to raise attention on immunization priorities and align stakeholder engagement and investments (e.g., Gavi funding) with NIS targets and tackle inequities (e.g., efforts to accelerate gender barrier analysis at national level). Recent country examples highlight the opportunities a live NIS can bring, with countries using their NIS to articulate funding needs, guide donor engagement, and influence national budget allocations.

FIGURE 21

Country examples of opportunities presented by National Immunization Strategies.



CÔTE D'IVOIRE

Côte d'Ivoire integrated its NIS into high-level sustainability dialogues at the 2024 Transition Summit, calling for long term funding as the country is expected to transition out of Gavi support in 2029 and will need to mobilise resources to sustain its immunization programme.

SOUTH SUDAN

South Sudan has used the NIS as an advocacy tool for resource mobilization and to guide the programme in areas of NVI, mobilising technical assistance to support the effective introduction of new vaccines in a fragile context. The NIS was also the opportunity to set coverage targets.

BANGLADESH

Bangladesh used its NIS to inform an investment case with the Asian Development Bank for local vaccine manufacturing, a step towards more autonomy in the context of pandemic preparedness.

Disclaimer: The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area nor of its authorities, or concerning the delimitation of its frontiers or boundaries.

These examples underscore the NIS's potential not only as a planning instrument but also as a strategic platform for advocacy, resource mobilization, and investment alignment.

Additional opportunities for the second half of the IA2030 decade include:

a. Institutionalize the Use of Country-Level Data

Promote the use of subnational and disaggregated data (such as gender, age etc.) to understand barriers and inform prioritization and improvement of equitable outcomes, especially in decentralized systems. Encourage integration of NIS with national health information systems and digital platforms to enable real-time monitoring and adaptive planning. Align with the Lusaka Agenda's "One Plan, One Budget, One Report," approach by using integrated metrics (e.g., across RI and outbreak response vaccination) rooted in country PHC systems and public health functions. Support countries generate local evidence and use data as an advocacy tool to clearly demonstrate progress as well as health and socioeconomic benefits from immunization to convince policymakers and governments to sustain investments in immunization.

b. Strengthen Domestic Financing and Sustainability

In the current context of reduced ODA and limited predictability of future funding, countries face increasing pressure to assume greater financing responsibilities as external support declines. NIS should be used as a platform to advocate for increased domestic (public) financing, aligning immunization priorities with broader fiscal planning especially in Middle Income Countries. This requires building relevant capacity in countries on strategic and financial planning, including consideration of the Financial Sustainability Plan (FSP), in parallel to NIS development for countries transitioning out of Gavi support.

Looking ahead, countries must anticipate sustained resource constraints and will need to evaluate complex trade-offs across competing priorities. These trade-offs apply to both optimising immunization programs (e.g., optimizing product choice and overall vaccine portfolios, considering new vaccine introductions against scaling coverage of existing vaccines) and broader health and priorities. Partners should support countries analyse these trade-offs, make informed and evidence-based decisions and assess health outcomes overall, while considering their specific country context and challenges.

c. Strengthen linkages between planning and actual implementation

Ensure that countries NIS are effectively translated into actionable multi-year and annual operational plans, with better budget schedule integration. This requires clear implementation frameworks, with defined roles, timelines, milestones, and mechanisms to track progress at national and subnational levels.

d. Enhance Integration and Accountability

Use the NIS to place the importance of cross-and multi-sectoral coordination at the centre of national health planning, pivoting immunization as an integral part of primary health care alongside with maternal and child health and essential public health functions and linking routine immunization (RI) and outbreak response vaccination toward a broader goal of resilient health systems, anchored in PHC and essential public health functions.

NIS can enhance integration and accountability by aligning immunization goals with broader PHC and UHC agendas. By embedding immunization within national health plans, using common monitoring platforms, and linking to health financing strategies, countries can promote coordinated service delivery and reduce fragmentation. Widening stakeholder engagement, including subnational planning and defining clear roles across stakeholders fosters local governance. Moreover, incorporating equity-focused data and community input ensures that strategies are responsive, inclusive, and transparent, ultimately strengthening the health system's performance.

e. Promote country led, evidence informed decision making

Strengthen NITAG's involvement into the NIS development to ensure alignment between evidence-informed guidance and strategic planning and further promote country ownership of their decisions.

f. Continue to promote capacity building in countries, and facilitate peer Learning and Regional Collaboration

Continue to support capacity building on strategic planning through differentiated technical assistance at regional and country levels. Facilitate regional exchanges and peer reviews to share best practices and strengthen the quality of NIS documents and overall prioritisation process. Leverage regional platforms to support countries in aligning NIS with regional strategies and financing mechanisms.

06
RECOMMENDATIONS FOR THE NEXT FIVE YEARS (2026-2030)

Within a challenging global context, reaffirm and recommit to the IA2030 vision, goals and strategic priorities, but focus on priority goals to deliver greatest impact over the next five years.

The original IA2030 vision and core principles remain relevant and fit-for-purpose. Throughout the Mid-Term Review, the IA2030 partnership has reaffirmed its commitment to IA2030's founding principles.

However, all those interviewed acknowledged that the global geopolitical and financing context has shifted dramatically from the assumptions that informed IA2030's design, which further compound the challenge to achieving defined goals. COVID-19 fundamentally disrupted immunization efforts, diverting resources to outbreak response and enduring gaps in routine services. At the same time, broader global trends, including geopolitical instability, declining development assistance, and the effects of climate change, are reshaping the distribution of at-risk populations, creating an even more challenging delivery context within which to achieve the IA2030 goals.

In light of this, while there is agreement that the vision and the original priorities should remain, interviewees consistently highlighted three targets (achieving 90% coverage in core vaccines, reaching zero-dose children, preparing for and responding to outbreaks of measles, polio, and other VPDs, and epidemics) as being of higher priority than others. This prioritisation should be reflected within the work of IA2030 partners in support of countries.

Achieving IA2030's vision will require sustained advocacy and political momentum to keep immunization on the political agenda as well as a refreshed consideration for how to reach targets, remaining flexible to adapt as needed.

Acknowledge the new global reality and direction of travel for global health and immunization. Leverage IA2030 as the mechanism to support regional and country ownership and enable country-led responses to the shifting landscape.

Even as the global health landscape continues to evolve, the direction of travel is becoming clearer, both overall and for immunization programmes within it. There is now a clear direction towards enabling national sustainability, supporting regional mechanisms, increasing the drive for more integrated services, and shifting global functions to supporting and facilitating roles. Acknowledging this new reality includes recognising the importance of global and regional health security and that investments in immunization protect countries, reduce outbreak risk, and strengthen preparedness for health threats.

Those interviewed for this report consistently argued that the role of IA2030 is not only respond to global trends, but to proactively shape them. In the words of

one interviewee 'if it is not within IA2030 that we are having these conversations, where is it?' This forward look does not shift focus from IA2030's vision and targets, which remain the immediate priority, but recognises the need to prepare for 2040 and beyond. Within IA2030 and its partner organisations, immunisation leaders and technical teams can take a longer-term view by aligning separate strategies, agreeing future delivery models, and shaping investments. Looking forward, there is an opportunity to shape the agenda on emerging innovations that can accelerate progress in immunization including next-generation vaccines and platforms as well as innovative technologies.

As IA2030 partners, it is critical to streamline global and regional efforts to drive future planning. This requires reduction in duplicative efforts, redefining goals at all levels, and proactively anticipating and planning for foreseen shifts in governance, funding, and political will in the future.

Building on the positive trend of the past five years, IA2030 partners should support all countries to navigate trade-offs within immunization programmes and across broader health and development priorities, and to independently develop, maintain, update and track progress against *National Immunization Strategies* (also as part of a wider national health systems strategy).

In parallel, strengthen national and sub-national data systems, collection and reporting to enable more informed decision-making and prioritisation (including timely outbreak response) and use this data to anchor advocacy that documents progress and quantifies the health and socioeconomic returns of vaccination, thereby securing sustained investment in immunization. At the same time, use data and local evidence to bolster advocacy, community engagement and information campaigns to counter misinformation and anti-science narratives as well as sustain investments in immunization.

Through IA2030, coordinate collective efforts to provide tailored support in priority areas where dedicated efforts are needed.

IA2030 is the all-country, full-value chain forum for immunization. While the details of prioritisation will rightly happen within specific programme areas (such as targeting measles, polio and rubella elimination), IA2030 can provide an important forum – both at the global and the regional levels – for countries and their supporting partners to align on how to best deploy limited resources. Based upon the trends highlighted and those interviewed, three priority areas were especially highlighted for the next five years:

a. **Seek every opportunity to drive stronger integration of immunization into primary healthcare.** IA2030 can be an important lever to promote greater alignment between immunization and broader health system initiatives. For example, over the next five years, vaccination services can continue to be embedded within wider primary health care – including platforms for care and prevention among all adolescents, adults, and older adults; disease-specific programmes can continue their trend away from siloed campaigns to integrated, multi-antigen activities delivered across the life course. This also requires integration of non-immunization stakeholders into IA2030 forums at every level to ensure that any verticalization is challenged and partners work outside of traditional siloes.

b. **Prioritise response in fragile, conflict-affected, and vulnerable settings.** IA2030 partners should prioritize coordinated action that build on tailored approaches in these contexts by partnering with the established Gavi working groups on fragile countries as well as other partners to drive alignment on immunization policies and develop locally relevant delivery approaches. This work should explicitly recognize the need for increased financing to address higher operational costs in FCV settings, ensure the integration of immunization plans with both humanitarian and development strategies, promote nuanced and context-specific advocacy messaging and approaches, and foster trust through sustained community engagement.

c. **Strengthen IA2030 support for middle-income countries (MICs).** Support the maturation of the newly commissioned cross-partner IA2030 MIC task team with the necessary resources, mandate and clear objectives. These include (1) the development of a MIC-specific vaccine-preventable disease outbreak response mechanism; (2) further market support to achieve collective pricing; (3) support with vaccine prioritisation in light of reduced resources; (4) ongoing support to mature domestic financing levers to enable sustainable immunization programmes within strong PHC. It should be noted that MICs also require technical support which may extend beyond the focus areas for the task force.

As core partners face major funding cuts, taking a rigorous approach to defining core activities and focusing efforts will be essential. Partners must also closely coordinate on activities that will be scaled back and stopped.

To support the delivery of the recommendations above, refine the IA2030 governance model and strengthen data-driven decision making

IA2030 must clarify and strengthen its institutional role within the broader immunization architecture, and reform its delivery model to be fit-for-purpose for the next 5 years. Without a further maturing of IA2030, there is a strong risk that it becomes a 'strategy in words only'. With limited

operational coordination, IA2030 will become little more than a hope that partners' collective efforts will deliver on the targets set.

To be realised, the following steps are recommended:

a. **The Partnership Council membership and model should be reformed.** New voices should be brought in, including direct country representation, vaccine manufacturers and industry bodies, and non-immunization representatives to ensure integration is central to the agenda. Some interviewed also proposed a high-profile, non-immunization chair to rejuvenate advocacy for immunization and raise the profile of IA2030.

   Further, IAPC should be reaffirmed as a global coordination and strategic forum to facilitate regional and country work. Formal governance of specific areas of immunization will remain (e.g. GPEI, TB Accelerator, the Gavi Alliance, CEPI, WHO's Global Programme of Work), but opportunities for harmonizing disease-specific governance forums (e.g., governance bodies for Yellow Fever, Cholera, Meningitis, Hepatitis B etc) should be considered for integration into the IA2030 structure, following the example of M&RP.

   While regions and countries must be put at the center of the agenda, IAPC plays an important strategic leadership role to focus on global goods that cut across multiple countries or address systematic challenges. These include supporting development sustainable and country-led programs anchored in regional support, advocating and developing tailored support packages to FCVs and MICs, as well as integration and the future of global health architecture.

   To effectively transition towards a more decentralized regionally-led model, further consultation with regions and countries will be key to be responsive to needs and ensure IAPC effectively empowers regions to assume greater ownership.

b. **The Coordination Group should take on a greater, collective responsibility to support countries in the delivery of the IA2030 targets.** Membership of the Coordination Group should be bolstered to ensure sufficient representation of the partners with the levers to make a difference, including greater representation and engagement from regions. It should then be given a mandate to act through collective action to task work and track outputs. To implement this, IACG and the Secretariat should be adequately resourced through the partnership. This could include pooled resources for commissioning task teams and dedicating 2-3 staff to operate Secretariat functions through a rotational or secondment programme. This builds on lessons learnt from the COVAX Strategic Coordination Office.[72] Further consideration should be given to define the resourcing model and determine each partner's contributions, recognizing that partners face financial pressure and downsized staff which will affect their ability to commit additional time and resources to IA2030.

[72] (Gavi 2023)

c. **Standing working groups at all levels should be transitioned to time-bound, action-oriented task-teams unless there is a clear, operational benefit to countries and partners.** Across immunization activities – at global, regional and country levels – a renewed effort is required to reduce duplication of effort and establish a clear place for the coordination of different technical areas. In general, where functions are a global good (e.g. policy, data), they should be primarily delivered within IA2030 to maximise access, input and awareness. Where functions are context specific (e.g. FCV, low-income country programmes), these should be delivered, once, within the most sensible setting (e.g. as a Gavi Alliance working group).

   Where non-permanent coordination is required, task-and-finish teams should be constituted to deliver measurable outputs. These should be backed with the necessary resources and political support to make them a success at each stage of their activities.

d. **IA2030 partners should work in partnership with regional bodies to strengthen their IA2030 coordination forums by clarifying mandates, driving inclusive membership, and establishing clear accountability mechanisms that support region-led immunization planning and delivery.** Better alignment across levels will reduce fragmentation, enhance coherence, and ensure regional priorities are reflected in global planning. These platforms can also promote country ownership, facilitate peer learning, and support more agile, context-specific delivery.

IA2030 **Monitoring & Evaluation** should be structured around the use of data to inform decisions and drive action at all levels from the facility to the global:

a. **General principles:**

   - Monitoring frameworks should be built from the ground up, founded in indicators that enable facilities to track, understand and improve their performance and outcomes.
   - Higher administrative levels should extend these frameworks to incorporate indicators that are relevant to their supervisory and wider operational activities.
   - Mechanisms should be established to embed data collection, analysis and use to drive continuous quality improvement at all levels.

a. **National:** M&E should be more locally relevant and action oriented:

   - As well as outcomes, tracking of implementational progress and operational performance should be embedded as part of continuous quality improvement cycles across all levels.
   - Local and self-defined performance, output and outcome targets should be part of annual operational planning and progress reporting, and integral to daily programmatic activities, within the framework of a multiyear National Immunization Strategy.
   - National monitoring and evaluation frameworks should be built from the bottom up, based on outcome and performance indicators that enable ground-level staff to track performance and undertake causal analyses.
   - District, state/province and national monitoring frameworks should aggregate lower-level data and incorporate additional indicators appropriate for each level.
   - Methods for embedding monitoring and evaluation to improve the effectiveness of local action should be supported by guidance from subnational and national levels.
   - Likewise, national M&E development should be supported by the regional level, informed by global normative guidance on data use.
   - Countries should be supported to develop data use improvement plans, aligned with National Immunization Strategies and considering technologies, processes and skills development to promote data use for action at all levels.

a. **Regional:** Monitoring frameworks should enable regions to understand differences among countries and common factors affecting national outcomes, to guide tailored support and co-creation of solutions to shared challenges.

a. **Global:** The global monitoring framework should be used to track overall progress, to facilitate inter-region and inter-country comparisons, and to assess the impact of global-level activities (e.g. on market shaping).

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