

# Human Papillomavirus (HPV) Data Pack

Overview of HPV and Cervical Cancer in the WHO Africa Region

Last Updated: 2026-05-04



World Health Organization

African Region



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## Data Sources

### WHO Immunization Data Portal

- <https://immunizationdata.who.int/>
- Annual WUENIC estimates for HPV vaccine coverage in countries

### 2022 burden estimates from the Global Cancer Observatory (GCO), International Agency for Research on Cancer (IARC)<sup>1</sup>

- <https://gco.iarc.who.int/en>

### WHO AFRO HPV introduction database (a combination of WHO/UNICEF Joint Reporting Form on Immunization: eJRF, Gavi and country survey)

- Internal document

### 2024 Revision of World Population Prospects (United Nations)

- <https://population.un.org/wpp/>

Note that cervical cancer estimates provided by the Global Cancer Observatory are reported with a 2-3 years delay. Historical data on cervical cancer in the AFRO region is available for only a few countries.

[1] Ferlay J, Ervik M, Lam F, Laversanne M, Colombet M, Mery L, Piñeros M, Znaor A, Soerjomataram I, Bray F (2024). Global Cancer Observatory: Cancer Today. Lyon, France: International Agency for Research on Cancer. Available from: <https://gco.iarc.who.int/today>, accessed [1 May 2026].

# HPV infection, cervical cancer and prevention form a continuum that can be interrupted at every stage

- Human Papillomaviruses (HPVs) are transmitted through close contacts, mainly via sexual contacts.
- More than 93% of cervical cancers are attributable to Human Papillomavirus (HPV) infections<sup>1</sup>.
- Cervical cancer is the 2nd most common cancer among African women<sup>2</sup>, with a median incidence in the WHO AFRO region of 32.9/100,000 population (age-standardized).
- Preventing cervical cancer with HPV vaccines costs far less than treating the disease. **With its high burden in the region and the availability of preventive measures, the opportunity to act is clear and urgent.**

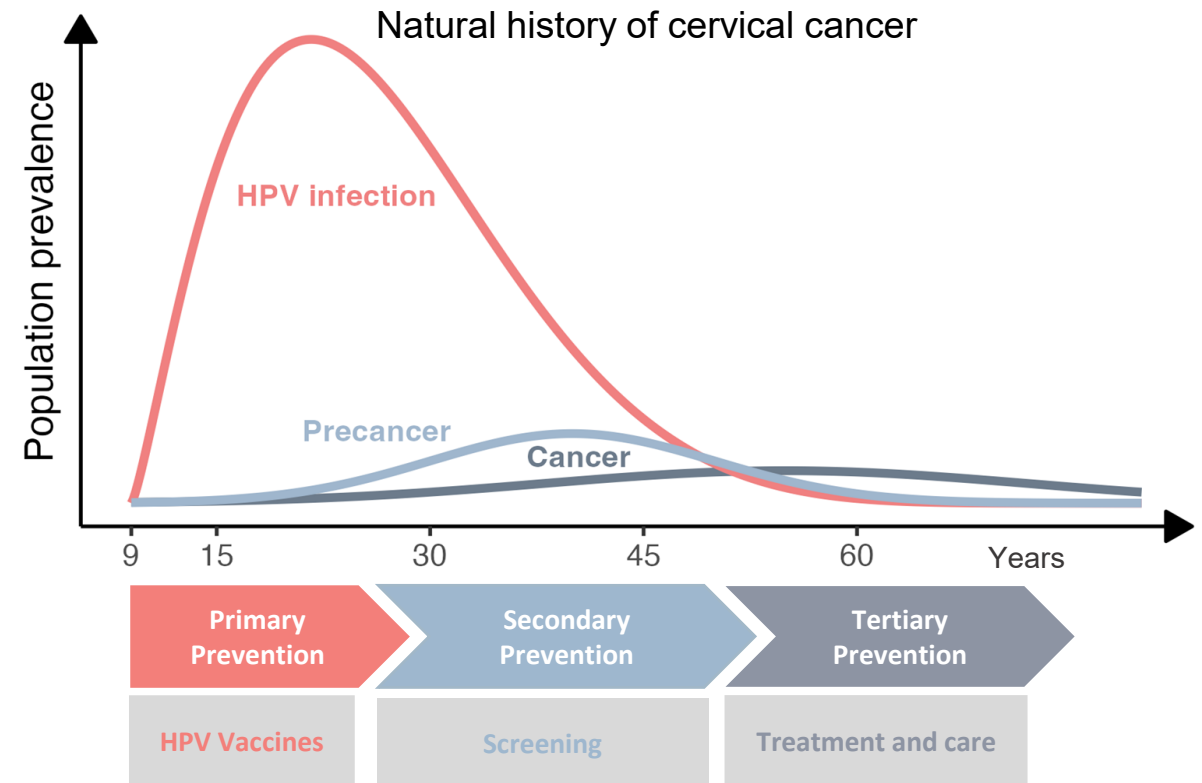


Figure adapted from WHO's global strategy for cancer elimination<sup>3</sup>.

[1] Walboomers et al. (1999). Human papillomavirus is a necessary cause of invasive cervical cancer worldwide. *J Pathol*, 189(1), 12-19.

[2] FerlayBray F, et al. Global Cancer Statistics 2022. *CA Cancer J Clin*. 2024. GLOBOCAN, IARC. <https://gco.iarc.who.int/today> (cervical cancer fact sheets, accessed May 2026).

[3] Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: WHO; 2020.

<https://www.who.int/publications/i/item/9789240014107>

# The 90-70-90 strategy: eliminating cervical cancer through vaccination, screening, and treatment

In May 2018, WHO's Director-General announced a global call for action to accelerate the elimination of cervical cancer. Member States responded during the World Health Assembly, by adopting the Global strategy to accelerate the elimination of cervical cancer as a public health problem in August 2020<sup>1</sup>

The global strategy goals for 2020–2030 to reduce current cervical cancer incidence under **4 in 100,000** (age-adjusted) can be achieved through the **90-70-90** approach:

90% of girls vaccinated by age 15, 70% of women screened with a high-performance test by ages 35 and 45, and 90% of women with pre-cancer or cancer receiving appropriate treatment.

Following review of evidence that one dose is enough to provide protection against HPV infection, WHO endorsed a single-dose HPV vaccination schedule for girls aged 9-20 years in 2022<sup>2</sup>.

[1] Global strategy to accelerate the elimination of cervical cancer as a public health problem. Geneva: World Health Organization; 2020 <https://www.who.int/initiatives/cervical-cancer-elimination-initiative#cms>, accessed July 2025.

[2] WHO position paper, December 2022 Weekly Epidemiological Record No 50. 2022; 97:645-672.

## 2030 cervical cancer elimination targets: current status, WHO African Region

### Vaccination

HPV first-dose programme coverage (proxy for age-15 indicator)

**47%** WHO 2030 target: 90%

**36 of 47 countries have introduced HPV vaccination**

Regional first-dose coverage 47%, WUENIC 2024  
10 of 47 countries reach ≥70% first-dose coverage

### Screening

Countries using HPV DNA as primary screening test

**3 / 47** WHO 2030 target: 70% of women screened

**3 of 47 countries use HPV DNA as primary test**

24 of 47 have a national screening programme  
(NCD CCS 2023: 16 opportunistic, 8 organised)  
17 countries report 10-50% coverage; none ≥70%

### Treatment

Countries offering combined-modality treatment (surgery, chemotherapy, radiotherapy)

**17 / 47** WHO 2030 target: 90% of women treated

**17 of 47 countries offer surgery, chemotherapy and radiotherapy together**

23 of 47 have national management guidelines  
Radiotherapy in 28 countries; brachytherapy in 17

### Incidence

Age-standardised cervical cancer incidence per 100,000 women

**33** WHO target: < 4 per 100,000

**Regional median 32.9 per 100,000 women**

Range across AFRO: 8.0 (Algeria) to 95.9 (Eswatini)  
Source: GLOBOCAN 2022, IARC

Sources: [WUENIC 2024](#); [WHO Cervical Cancer Country Profiles \(2021\)](#); [WHO NCD Country Capacity Survey 2023](#); DIRAC 2026; [GLOBOCAN 2022](#), IARC.

Notes: Combined-modality treatment and management guidelines figures from WHO Cervical Cancer Country Profiles 2021 (2019 country survey); other indicators from sources cited above. ASR = age-standardised rate (World standard).

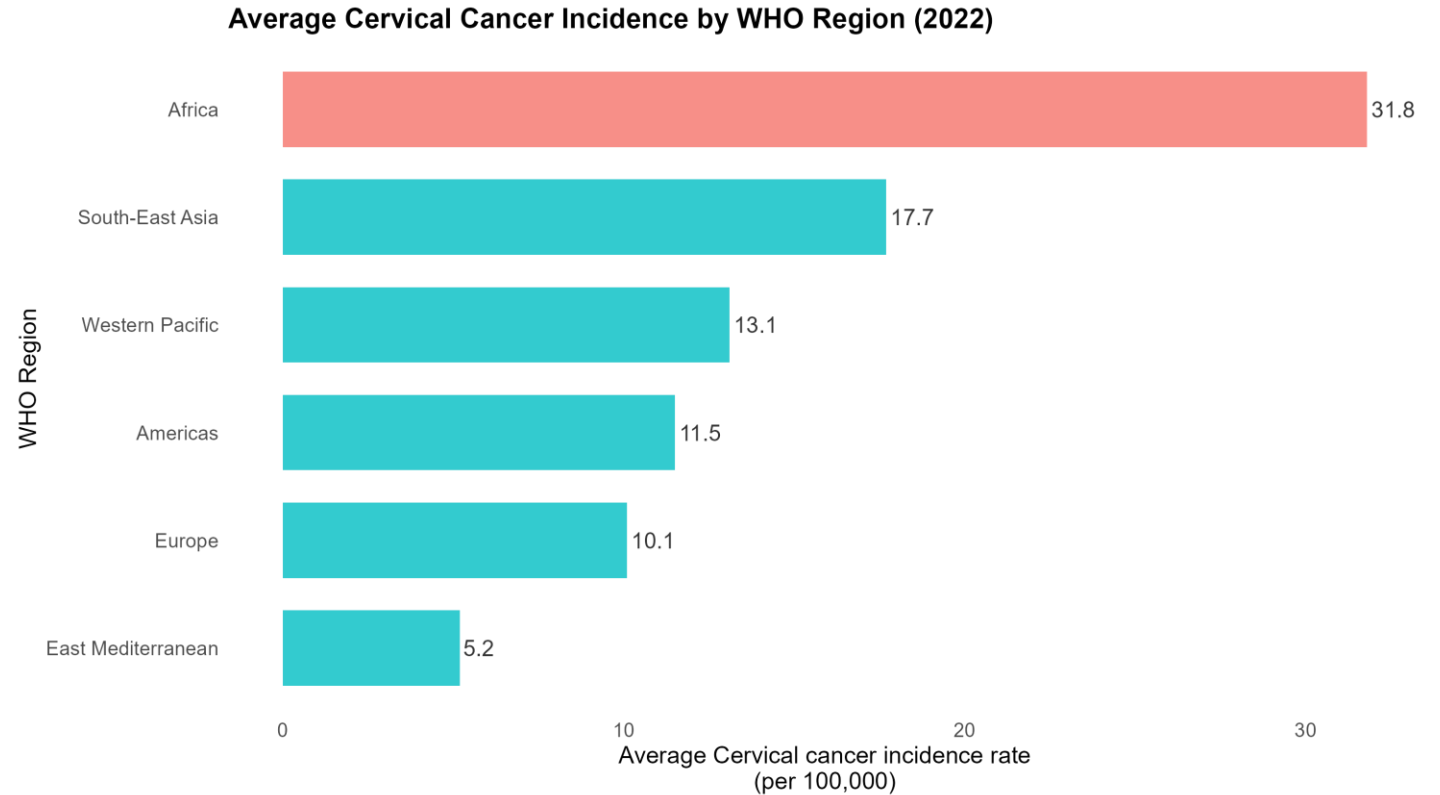
Ongoing regional efforts: WICS HPV self-sampling project (3 countries, 2 districts each); AFRO-Roche breast and cervical cancer initiative (Côte d'Ivoire, Kenya, Zimbabwe).

# The WHO African Region bears a disproportionate cervical cancer burden

The WHO African Region bears a disproportionately high burden of cervical cancer incidence globally.

Cervical cancer incidence remains high across the world, but the burden is especially severe in the WHO African Region.

Age-standardized incidence rate (ASR, world) values are used to make incidence rates comparable across countries with different age structures.



Source: Global Cancer Observatory (GCO)  
Cervical Cancer Incidence rates are adjusted for age, enabling comparison between countries (per 100,000).

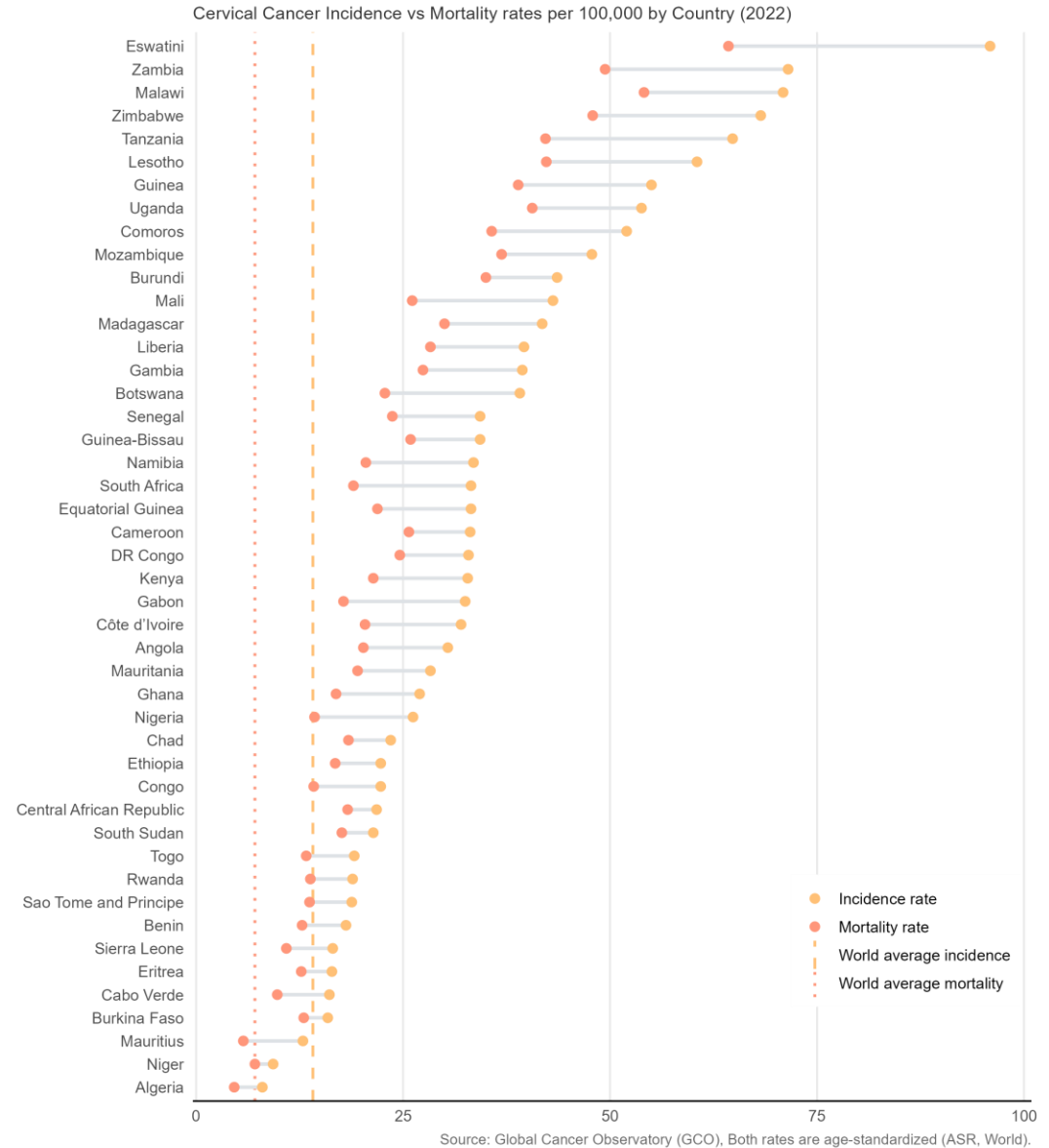
## In the WHO African Region, most cervical cancer diagnoses are a death sentence: mortality nearly equals incidence

Cervical cancer incidence and mortality rates are markedly higher in the WHO African Region than the global average, with only a few West African countries and some island nations keeping both rates below global average.

Cervical cancer is likely underdiagnosed and current incidence estimates may therefore be lower than the true burden.

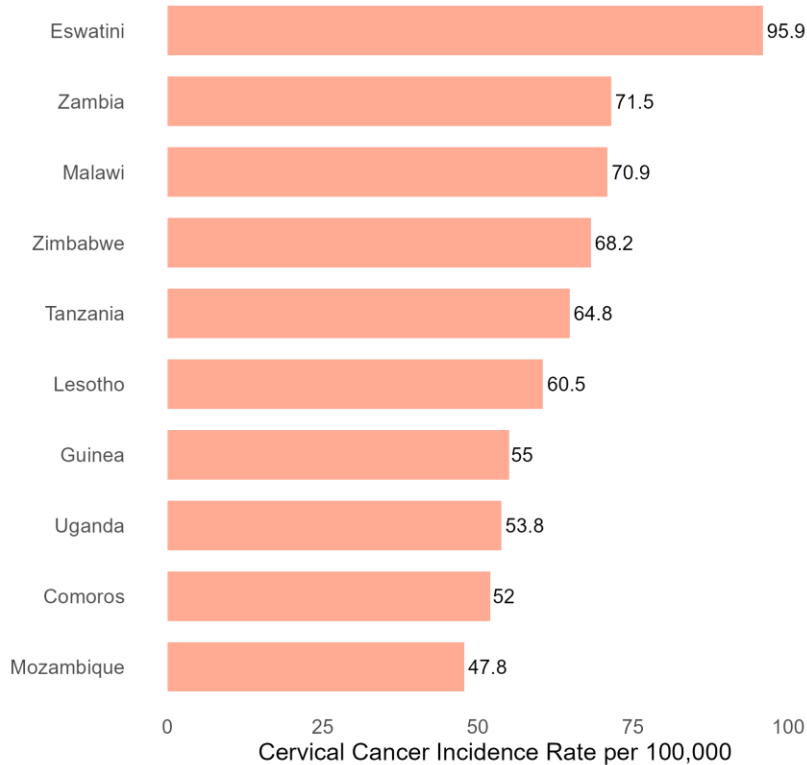
In some countries, the wide gap between incidence (low) and mortality (high) highlights that early detection and treatments are not reaching women in need.

Expanding vaccine access, screening programs and treatment & care services across the region is essential to closing this equity gap.

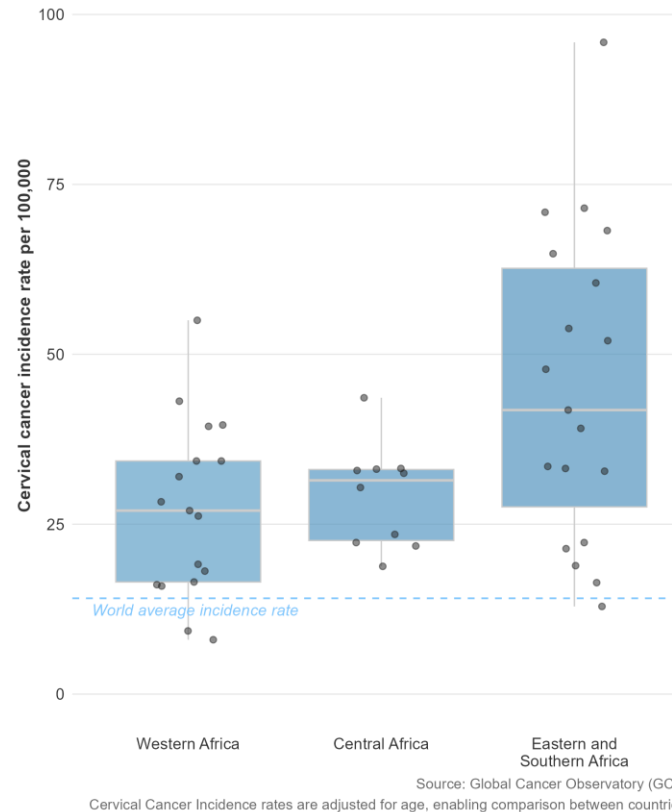


# Eastern and Southern Africa are the hotspots: several countries exceed 50 new cases per 100,000 women

**Top 10 Countries with Highest Cervical Cancer Incidence Rate**



**Cervical Cancer Incidence Rate by WHO Subregion**



The dashed line marks the global average incidence (ASR 14.1 per 100,000). Only three AFRO countries report rates below this level: Algeria (8.0), Niger (9.3) and Mauritius (12.9).

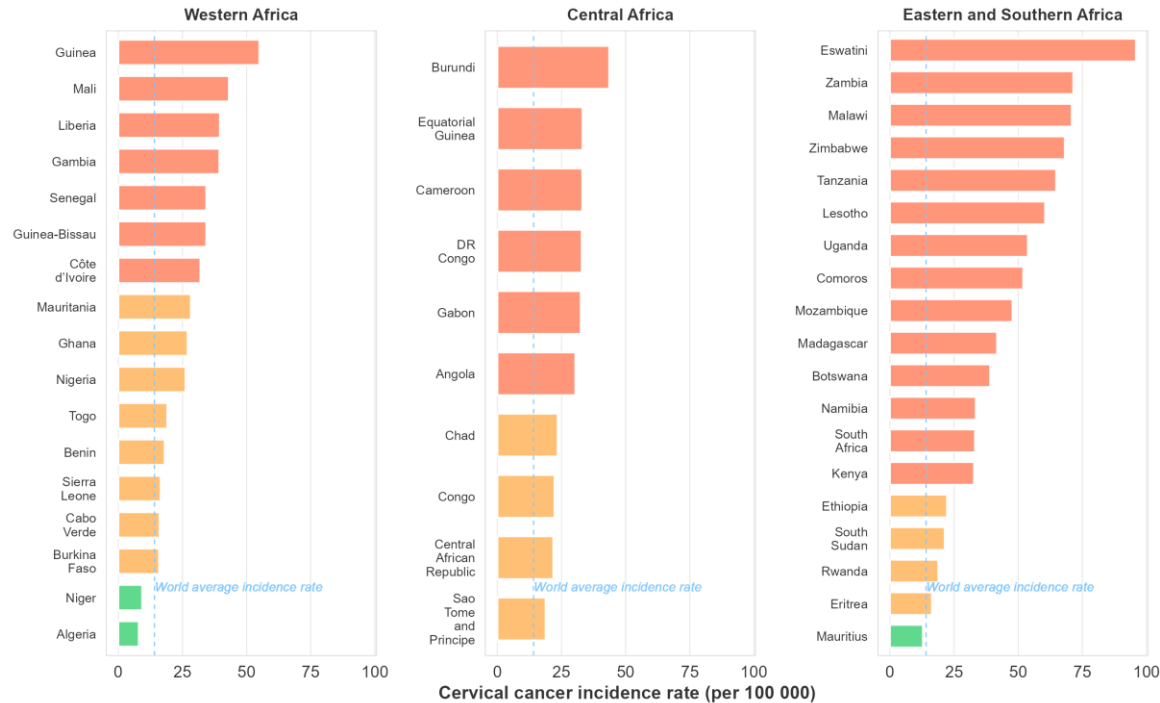
With the notable exception of Guinea, the highest incidence rates are observed in Southern and Eastern Africa, where several countries exceeding 50 new cases per 100,000 women annually. These elevated rates likely reflect existing underlying risk factors, including sexual and reproductive behaviors<sup>1</sup>.

These “hotspot” areas highlight the urgent need for prevention and control efforts.

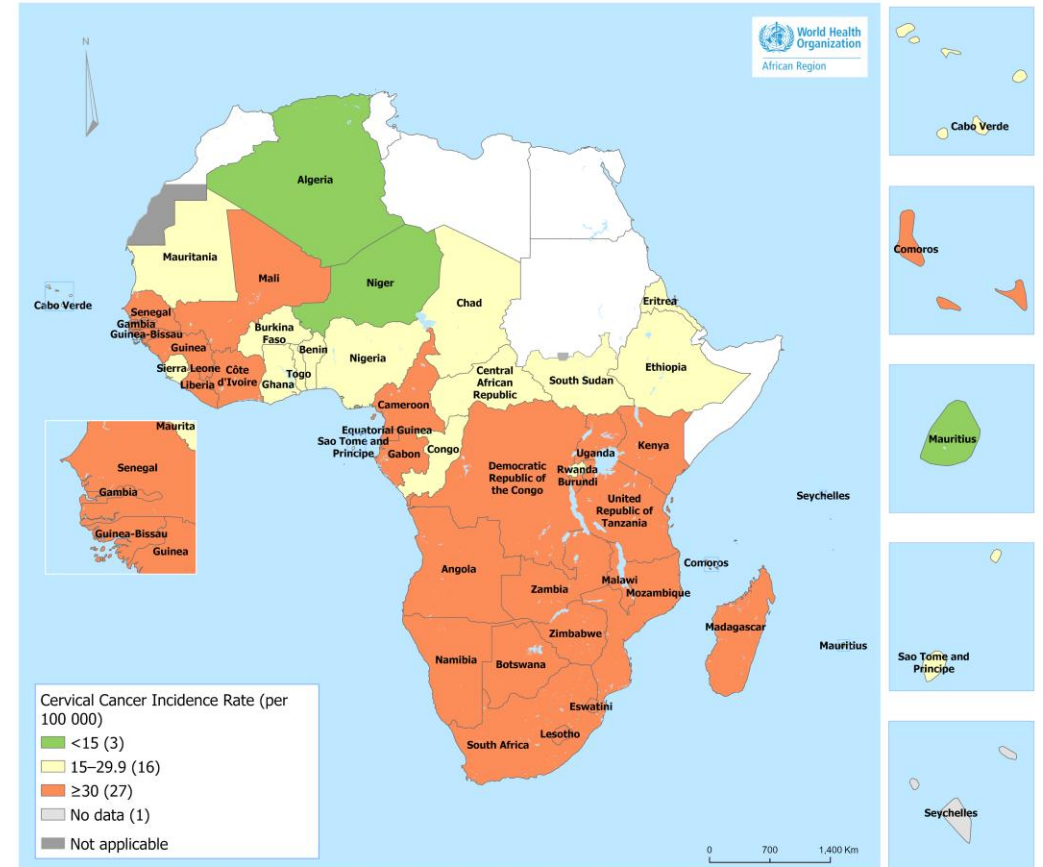
[1] Jemal, A., Center, M. M., DeSantis, C., & Ward, E. M. (2010). Global patterns of cancer incidence and mortality rates and trends. *Cancer epidemiology, biomarkers & prevention*, 19(8), 1893-1907.

# Most AFRO countries exceed the global average incidence rate, with the highest burden concentrated in Eastern and Southern Africa

Cervical Cancer Incidence Rate by WHO Subregion (2022)



Cervical Cancer Incidence rates are adjusted for age, enabling comparison between countries (per 100,000).



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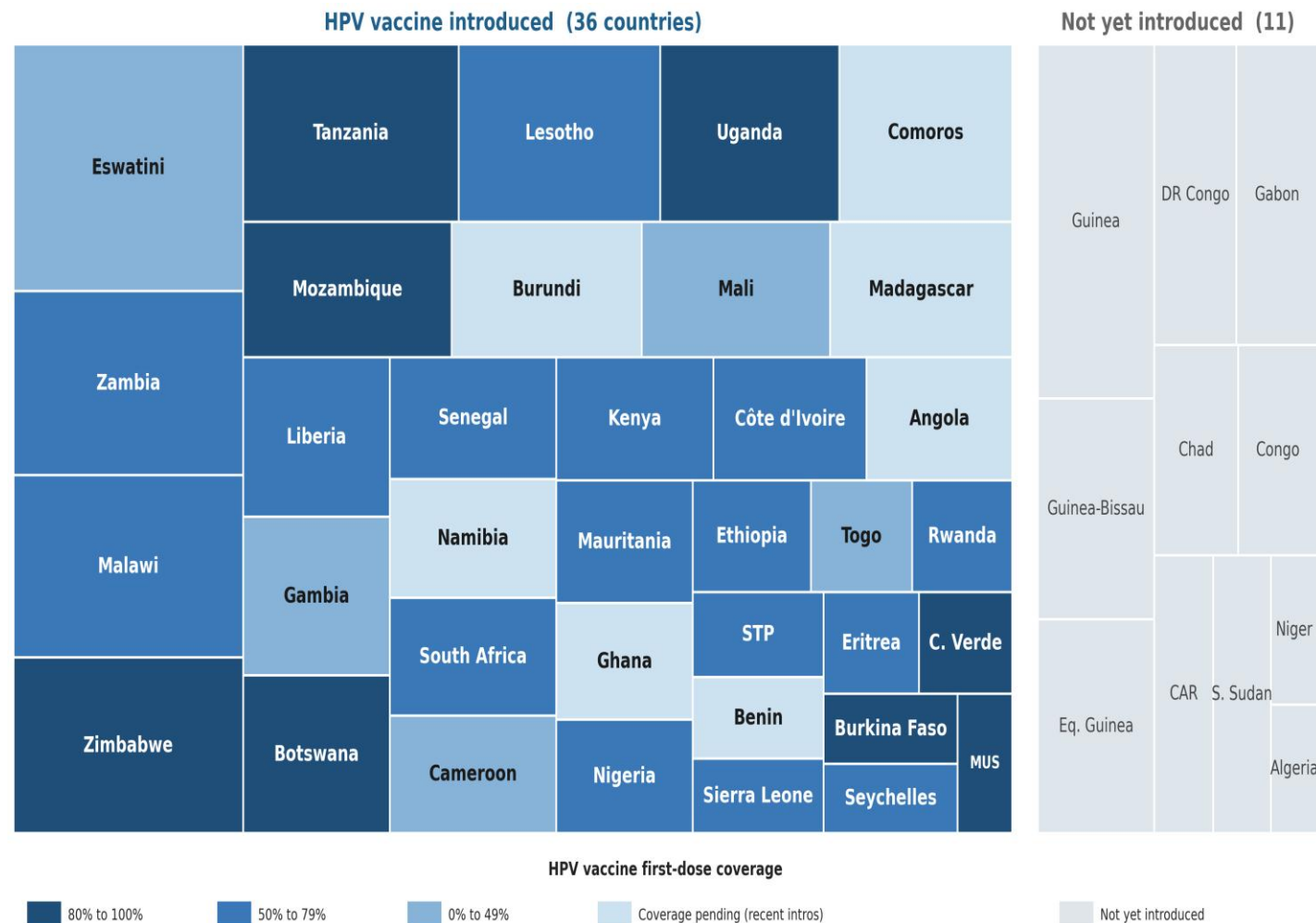
Source: Global Cancer Observatory (GCO)  
Map production date: October 10 2025, by DPC  
Regional office for Africa, World Health Organization  
© WHO 2025. All rights reserved.

# High-burden countries without HPV vaccines remain the priority gap for action

Box size reflects cervical cancer incidence; darker shades of blue correspond to higher HPV vaccine coverage. Grey boxes on the right side of the plot show countries that have not yet introduced HPV vaccines.

Countries with a high cervical cancer burden and no HPV vaccine introduction (grey boxes, top right) are high priority for vaccine rollout to reduce cervical cancer incidence and mortality.

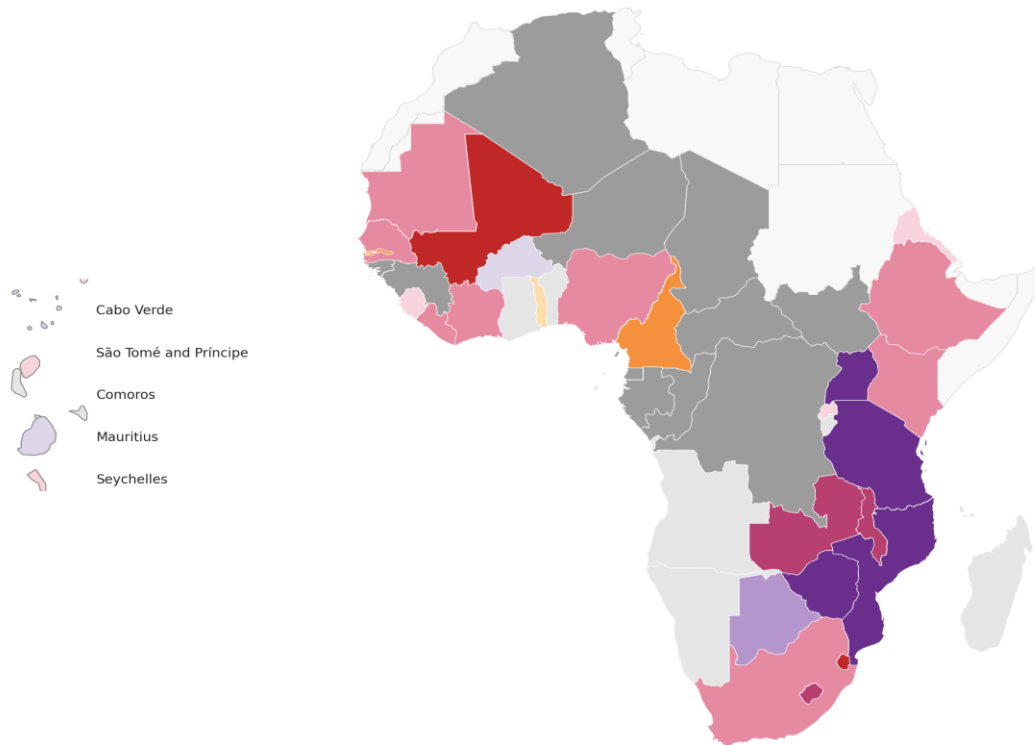
In high burden countries where the vaccine has already been introduced, coverage levels need to be strengthened.



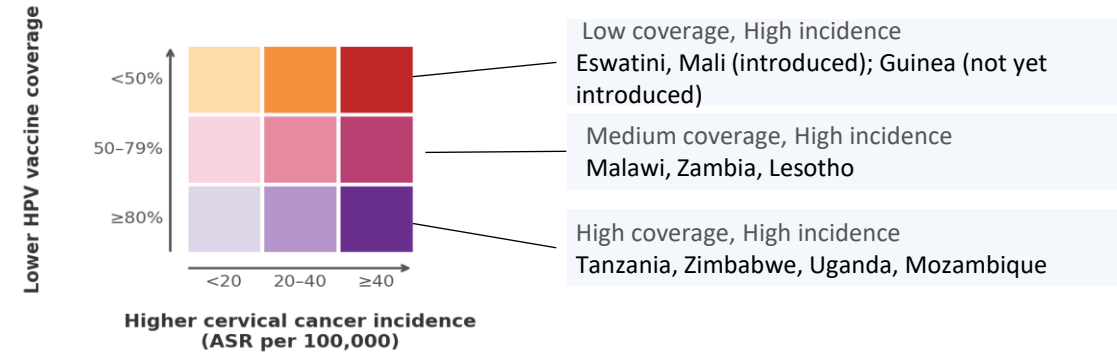
Sources: WUENIC 2024 revision (July 2025); GLOBOCAN 2022 age-standardised incidence (IARC); WHO HPV Clearing House, end of April 2026

# Countries with the highest cervical cancer incidence have the lowest HPV vaccine coverage: a gap that demands urgent action

Cervical cancer incidence rate (per 100,000), GLOBOCAN 2022, and HPV vaccine programme coverage in 2024



- Cabo Verde
- São Tomé and Príncipe
- Comoros
- Mauritius
- Seychelles

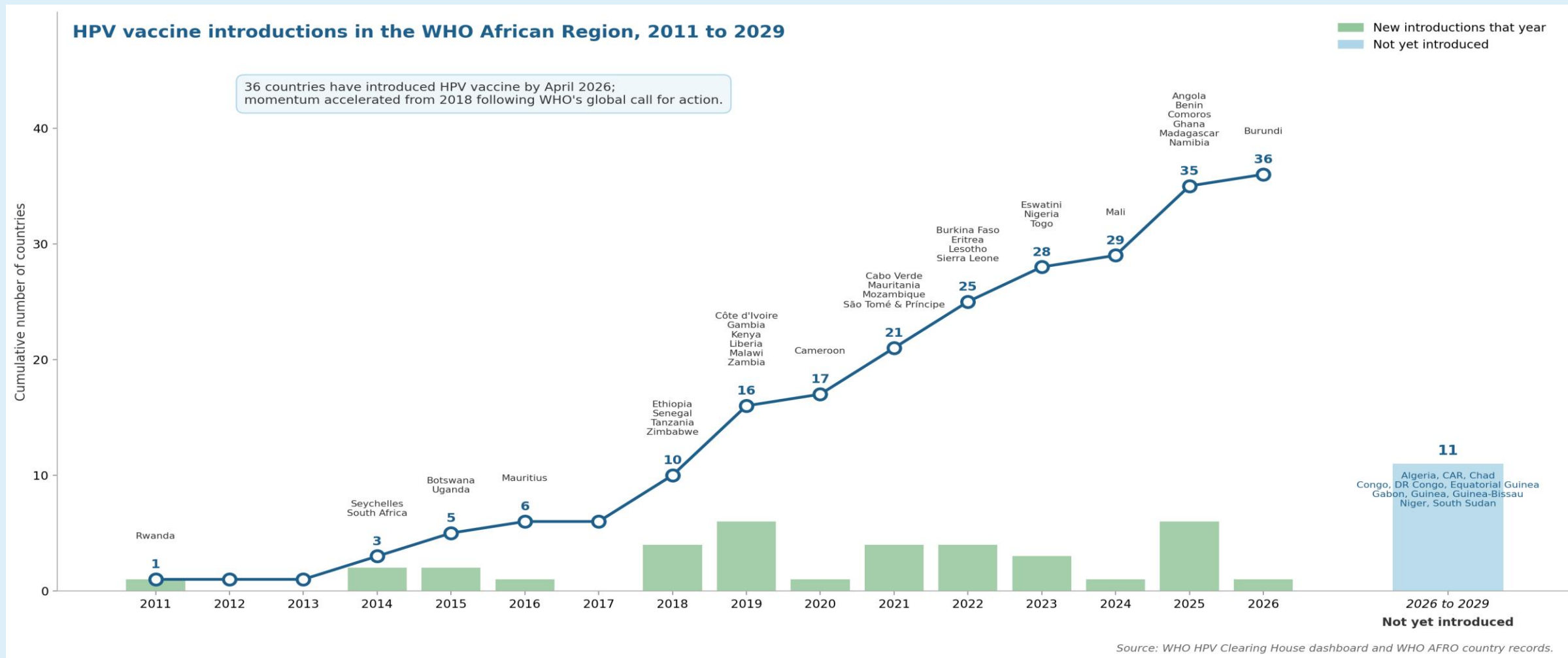


- Not yet introduced (11)
- Introduced 2025/2026, coverage pending (7)

Note: Current cervical cancer incidence reflects disease burden up to 2022. Impact of HPV vaccination on cervical cancer incidence is a lagging indicator, typically measurable 15 to 20 years after introduction given the long latency between HPV infection and cancer (Falcaro et al., Lancet 2021).

Sources: GLOBOCAN 2022 age-standardised cervical cancer incidence (IARC); WUENIC 2024 revision (HPV first-dose coverage, July 2025); WHO HPV Clearing House, end of April 2026. Thresholds: incidence <20 / 20-40 / ≥40 per 100,000 women; coverage <50% / 50-79% / ≥80%.

# HPV vaccine introduction accelerated after 2018: 36 countries have introduced, 11 more planned by 2029

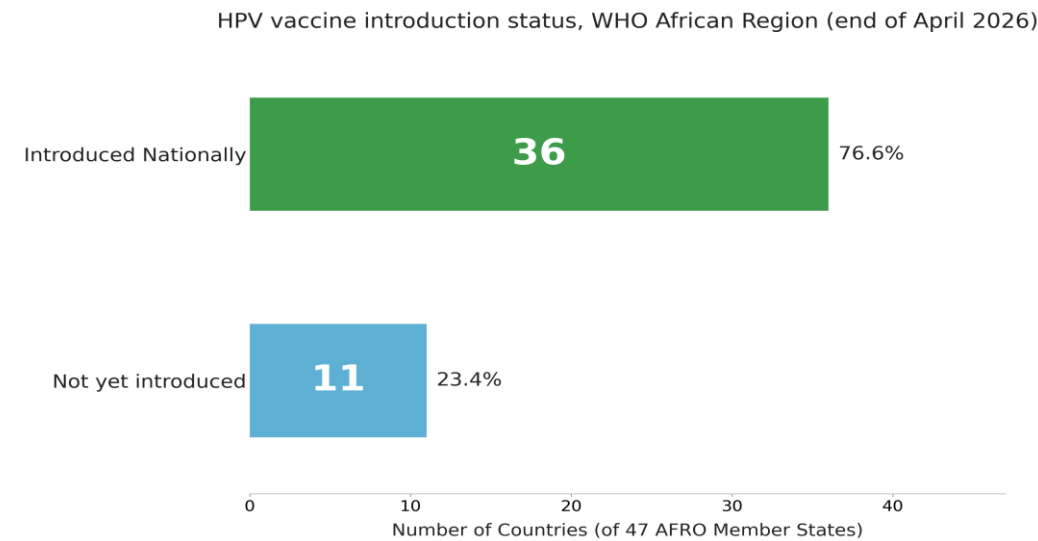


# 36 countries have introduced HPV vaccine; 11 more planned by 2029

## HPV vaccine introduction year by country, WHO African Region

Source: WHO HPV vaccine introduction dashboard, end of April 2026

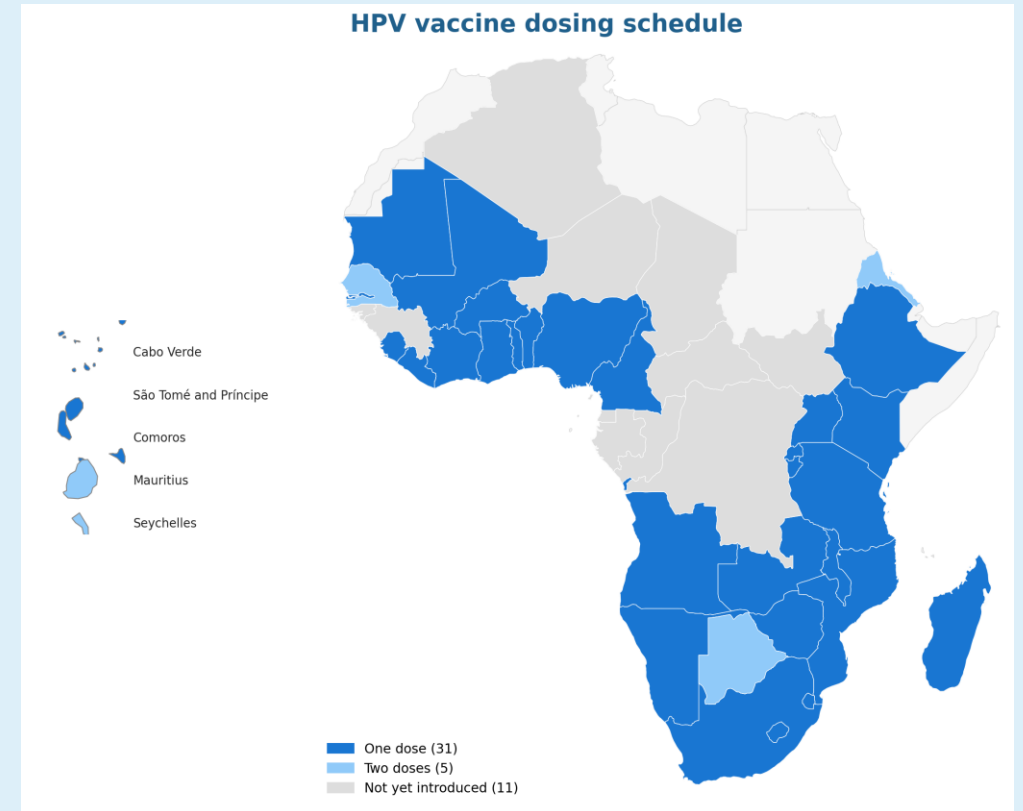
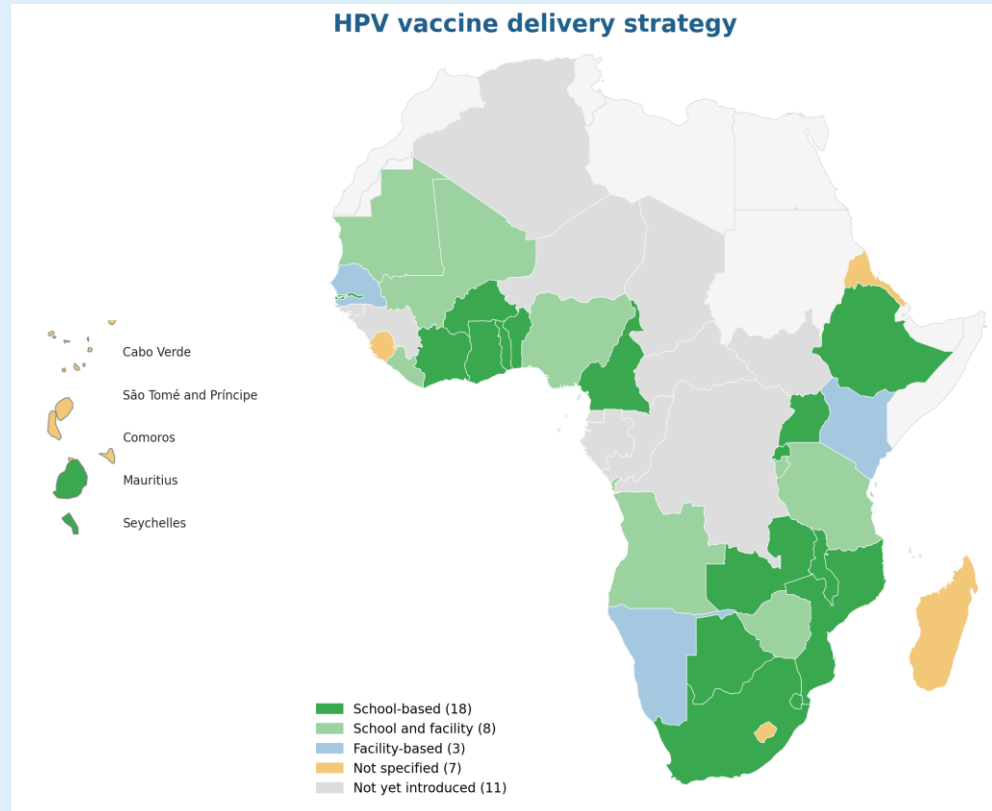
2011 to 2014 (3)	2015 to 2019 (13)	2020 to 2026 (20)	Not yet introduced (11)			
Rwanda Seychelles South Africa	2011 2014 2014	Botswana Uganda Mauritius Ethiopia Senegal Tanzania Zimbabwe Côte d'Ivoire Gambia Kenya Liberia Malawi Zambia	2015 2015 2016 2018 2018 2018 2019 2019 2019 2019 2019 2019 2019	Cameroon Cabo Verde Mauritania Mozambique São Tomé & Príncipe Burkina Faso Eritrea Lesotho Sierra Leone Eswatini Nigeria Togo Mali Angola Benin Comoros Ghana Madagascar Namibia Burundi	2020 2021 2021 2021 2021 2022 2022 2022 2022 2023 2023 2023 2024 2025 2025 2025 2025 2025 2025 2025 2026	Algeria CAR Chad Congo DR Congo Equatorial Guinea Gabon Guinea Guinea-Bissau Niger South Sudan



**36 of 47 countries have introduced HPV vaccine by April 2026; 11 remain to introduce.**

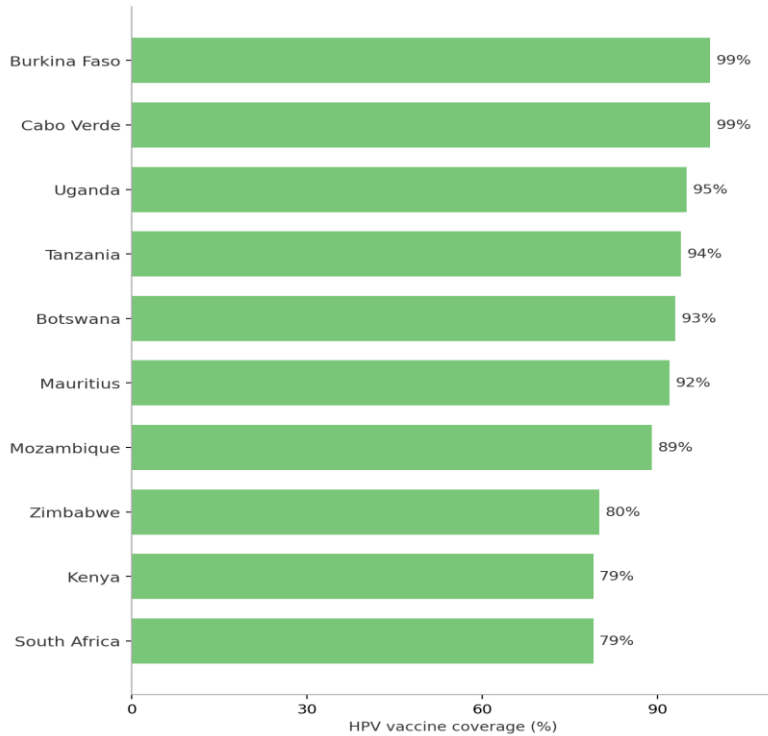
Source: WHO HPV Clearing House dashboard and WHO AFRO country records, end of April 2026.

# Most countries use a single-dose schedule; school-based delivery predominates



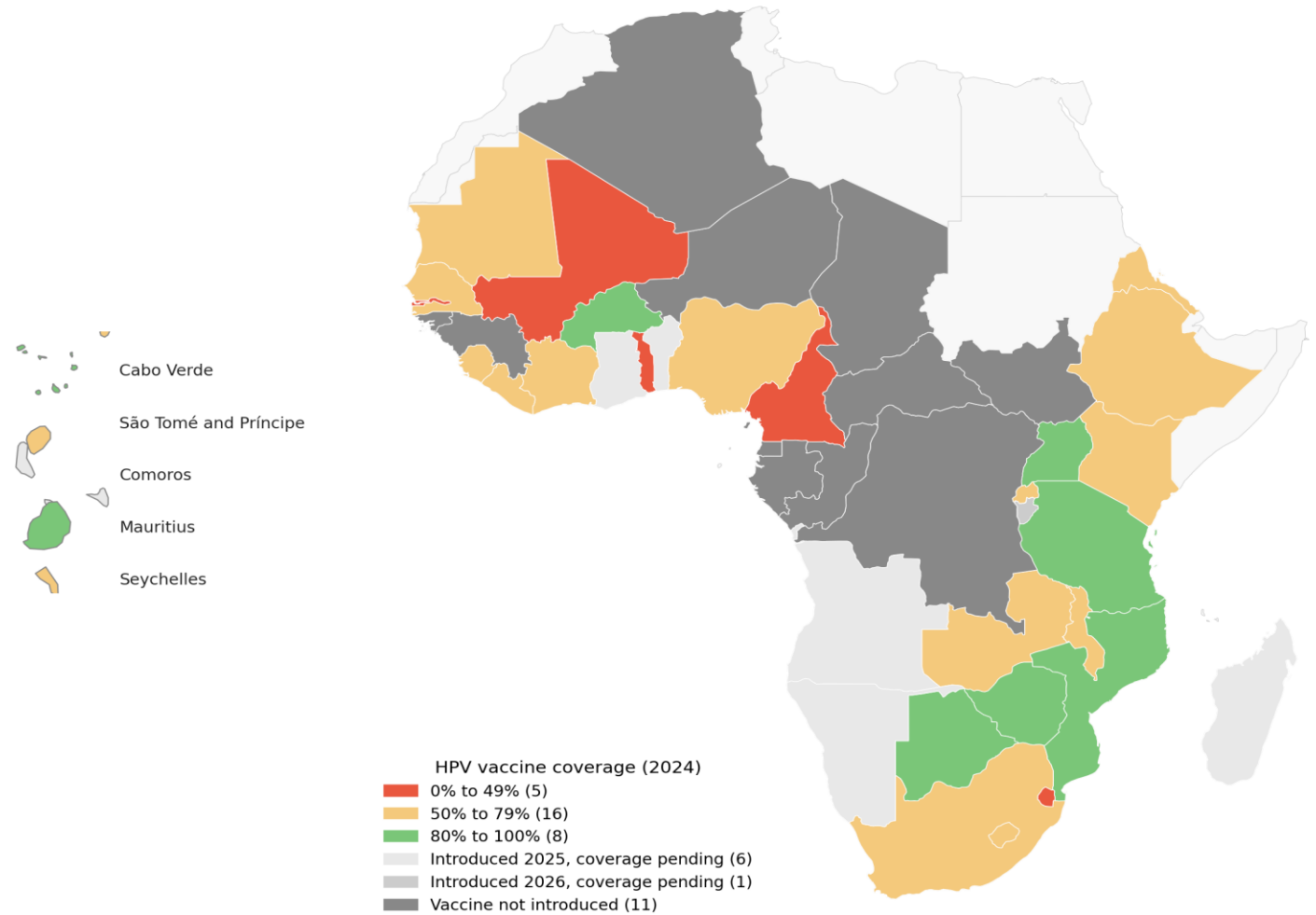
# HPV vaccine coverage remains uneven: Cabo Verde and Burkina Faso lead at 99%, but many high-burden countries lag behind

Top 10 countries with highest HPV vaccine coverage (WUENIC 2024)



HPV vaccine programme coverage by country

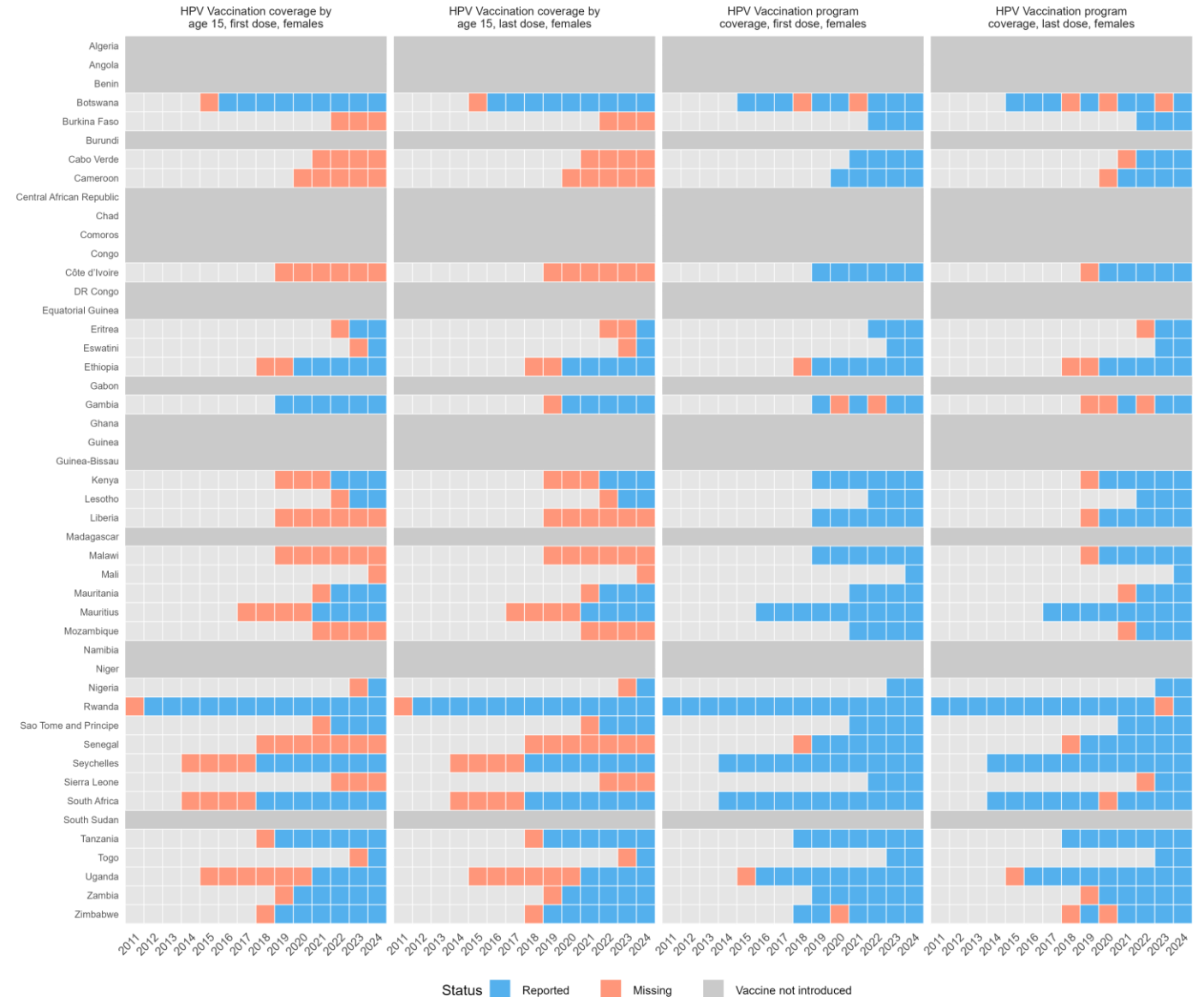
HPV vaccine programme coverage by country, WHO African Region



## Programme coverage serves as the primary indicator while age-15 data remain sparse

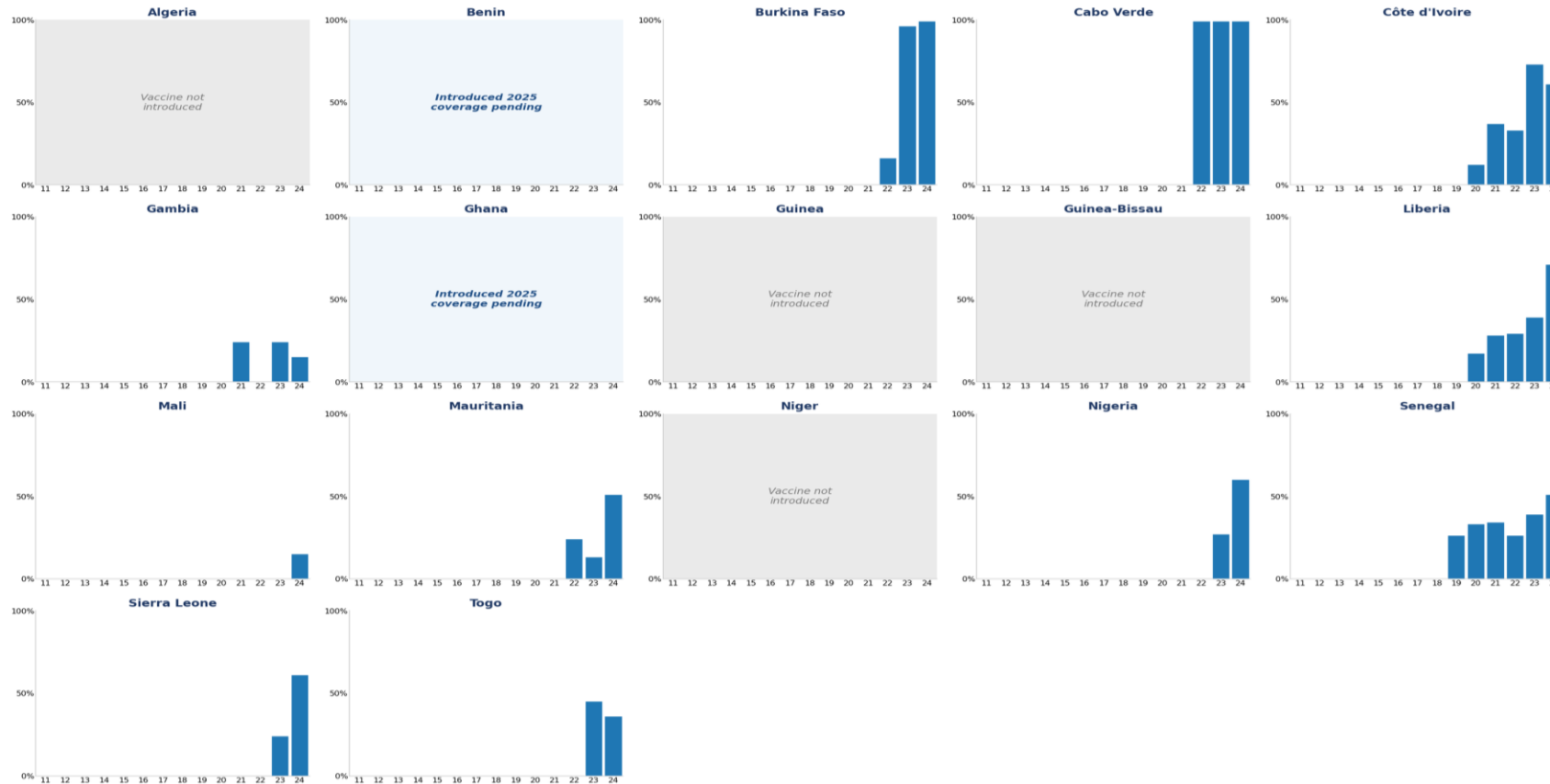
- We use program coverage of the first HPV vaccine dose in females (3<sup>rd</sup> column) as our main indicator, as it represents the most complete data reported across countries.
- To monitor progress toward cervical cancer elimination, HPV vaccination coverage among females by age 15 is the primary indicator (first column). However, data completeness is currently very low, limiting its use for tracking HPV vaccination coverage.

HPV Coverage Reporting by Country and Year (2011–2024)



# HPV vaccine coverage in West Africa remains uneven: gains in some countries, declines in others

HPV vaccine coverage by year and country — West Africa



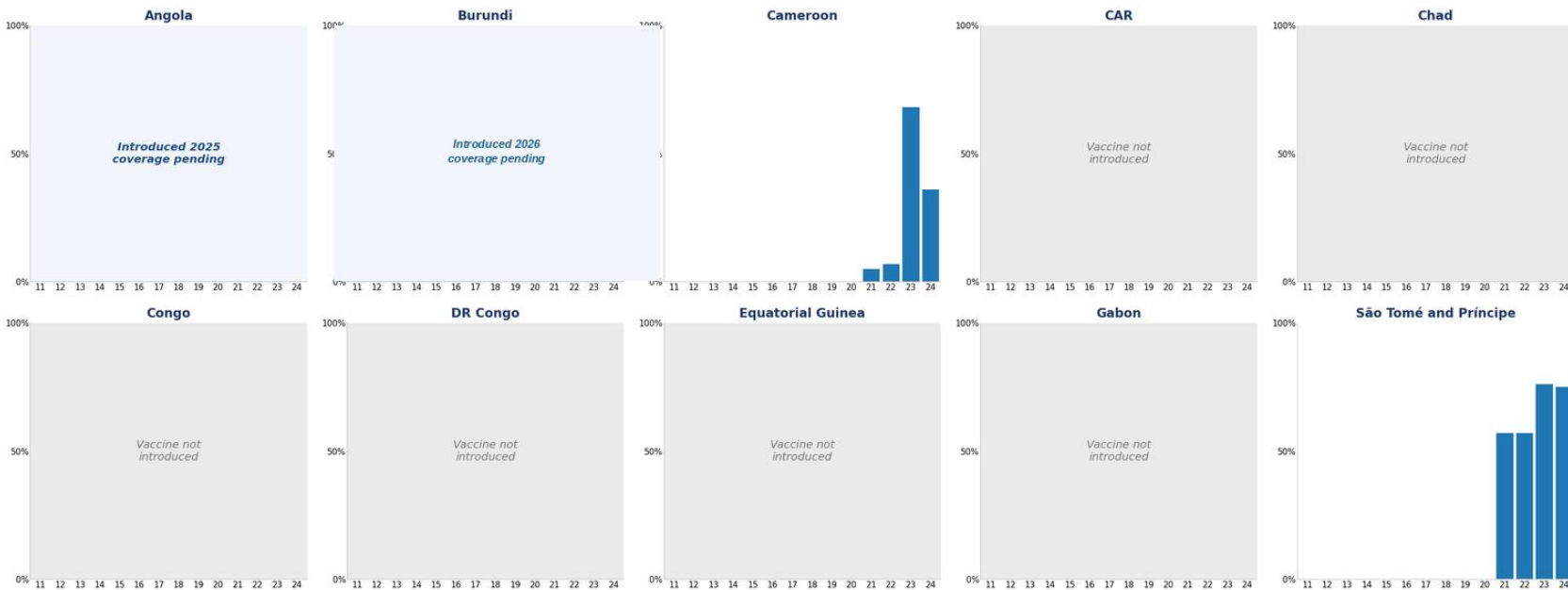
Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), 2024 revision. Each panel shows coverage 2011-2024.

HPV vaccine coverage in West Africa remains uneven, with gains (e.g., Côte d'Ivoire, Liberia) and declines to note (e.g., The Gambia, Mauritania).

With several recent and upcoming introductions programmed, applying lessons learned and a strong integration of HPV into routine immunization is essential.

# Central Africa has the lowest HPV vaccine introduction rate; coverage is stable where established

HPV vaccine coverage by year and country — Central Africa



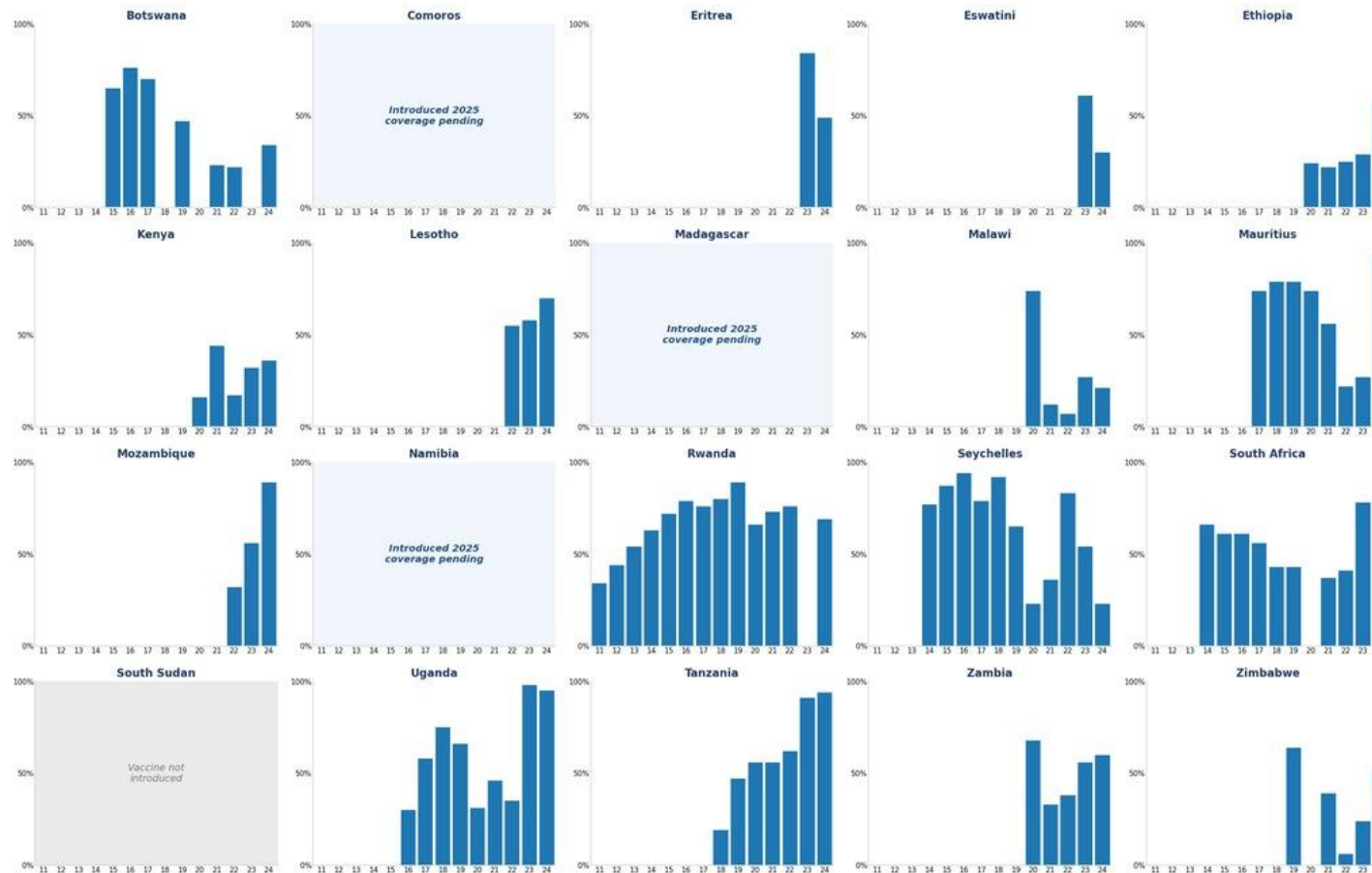
Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), 2024 revision. Each panel shows coverage 2011-2024.

Only a few countries in Central Africa have introduced the HPV vaccine; among those that have, coverages remain stable or show gradual improvement. Burundi launched in April 2026, with coverage data not yet available.

Continued efforts are needed to expand introduction across the subregion.

## Eastern and Southern Africa: high introduction but coverage fluctuations threaten progress towards the 90% target

HPV vaccine coverage by year and country — Eastern and Southern Africa



Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), 2024 revision. Each panel shows coverage 2011-2024.

HPV vaccine has now been introduced across the entire Eastern and Southern Africa subregion (except South Sudan). Comoros, Madagascar and Namibia introduced in 2025, with coverage data not yet available.

However, several countries show considerable year-to-year fluctuations (e.g., South Africa, Zimbabwe) and sustained downward trends in coverage (e.g., Botswana, Seychelles, Malawi), falling short of the WHO target of 90% vaccination coverage of girls by age 15 by 2030.

## Secondary prevention: actions for Member States and partners to strengthen cervical cancer screening

### Track performance

- Establish national screening registries or digital systems to monitor coverage, follow-up, and outcomes toward the goal of 70% of women screened starting at age 30 with regular screening every 5 to 10 years [Member States, WHO Country Offices]<sup>1</sup>.

### Adopt HPV testing

- Transition from cytology or visual inspection with acetic acid (VIA) to HPV testing [Member States, with WHO technical support]<sup>1</sup>: higher sensitivity, specificity, and longer screening intervals.

### Expand access

- Use self-sampling and existing HIV/TB lab networks to increase participation and scale testing capacity [Member States, implementing partners].

### Ensure affordability

- Support market-shaping efforts to secure affordable, high-quality diagnostics and supplies [WHO, Gavi, donors, market-shaping partners].

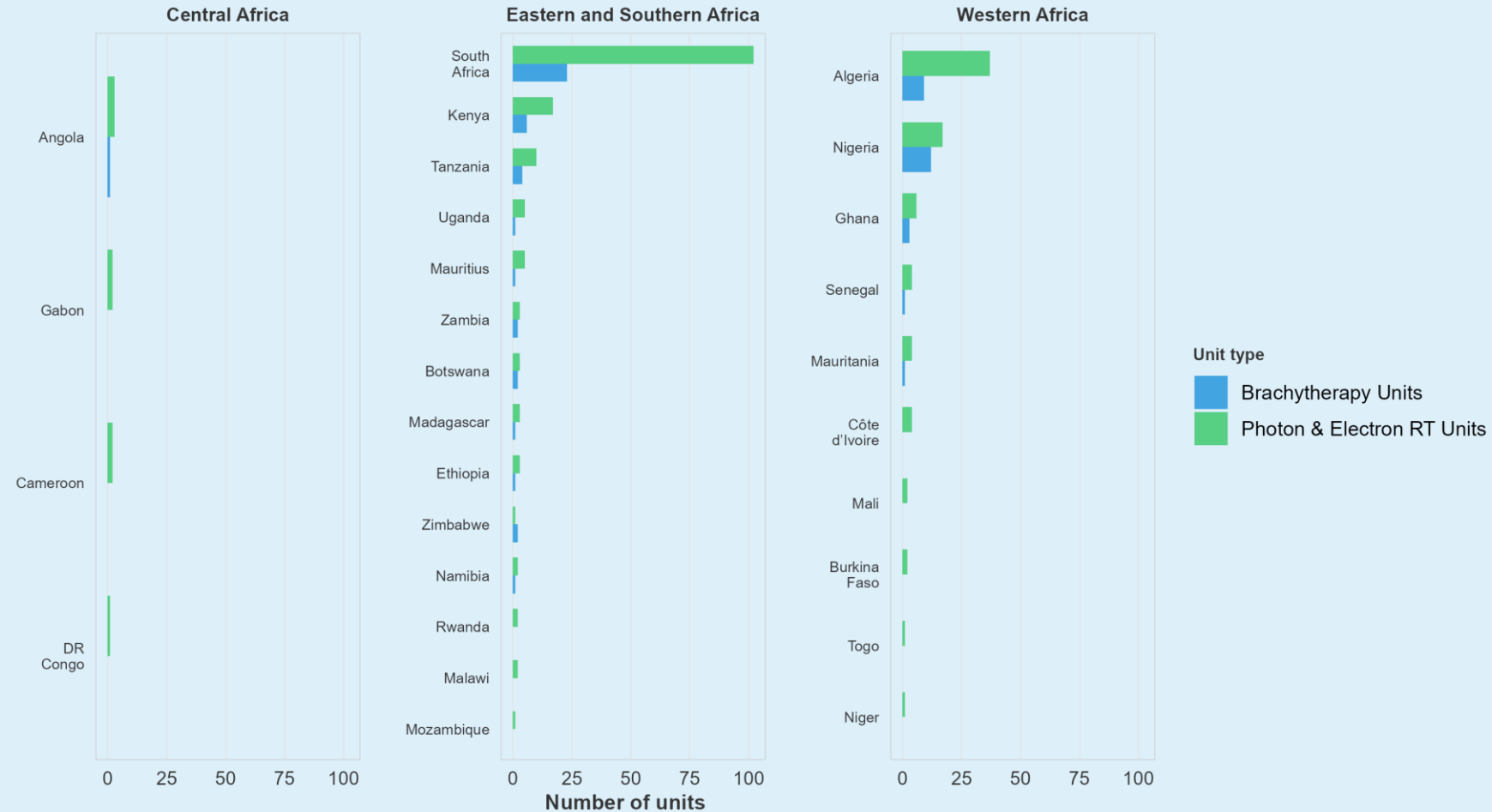
<sup>1</sup>WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, second edition. Geneva: World Health Organization; 2021. <https://www.who.int/publications/i/item/9789240030824>

# Tertiary prevention: only 17 of 47 countries have brachytherapy capacity

**Background:** Standard treatment for locally advanced cervical cancer includes chemoradiation with external beam radiotherapy, brachytherapy, and chemotherapy. Brachytherapy is essential because it delivers high-dose radiation directly to the tumour and is critical for cure and local tumour control. Without it, cure rates drop significantly.

External beam radiotherapy is available in 28 countries in the WHO African Region, but only 17 have brachytherapy units, leaving 30 countries without any brachytherapy capacity. This gap limits access to the full standard of care and weakens cervical cancer treatment outcomes.

Number of radiotherapy devices available for each country

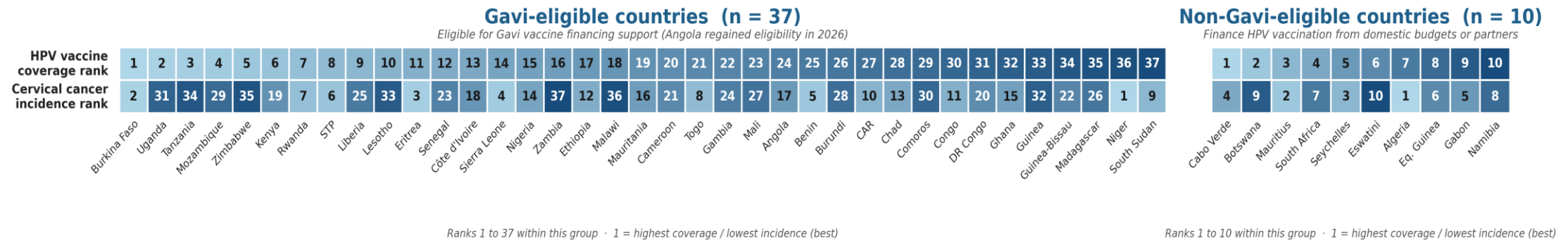


[1] Ding, L., Bi, Z., Pan, Z., Yu, X., Zhao, X., Bai, S., ... & Liu, Y. (2021). Brachytherapy-based radiotherapy is associated with improved survival for newly diagnosed metastatic cervical cancer. *Brachytherapy*, 20(2), 361-367.

Source: Directory of Radiotherapy Centres (DIRAC). These two units are crucial for cervical cancer treatment.

Radiotherapy and brachytherapy data from DIRAC 2026 (AFRO Member States only). Country updates range from 2018 to 2026.

# Country rankings by Gavi eligibility: where coverage and burden gaps persist



Sources: WUENIC 2024 revision (July 2025); GLOBOCAN 2022 (IARC); Gavi country eligibility list

- Countries are split by Gavi eligibility: 37 Gavi-eligible countries receive support for vaccine procurement, while 10 non-Gavi-eligible countries finance HPV vaccination domestically or through partners.
- Angola regained Gavi eligibility in 2026 after the Gavi Board raised the income threshold to US\$ 2,300 GNI per capita.
- Each country is ranked within its group on HPV vaccine first-dose coverage (2024) and cervical cancer incidence (GLOBOCAN 2022). Lower rank numbers indicate better performance.
- Among Gavi-eligible countries, Burkina Faso (rank 1), Uganda (2) and Tanzania (3) lead on coverage; Malawi and Zambia show the largest gaps between high burden and coverage. Among non-Gavi-eligible countries, Cabo Verde leads on coverage while Eswatini carries the highest incidence in the Region.
- Although Eswatini is not Gavi-eligible, it received an exceptional Gavi support grant in 2023 to scale up HPV vaccination.

# Recommendations and ways forward

## 1. Strengthen data quality *[Member States and WHO Country Offices]*

- Improve immunization data quality through capacity building and stronger collaboration, including collecting and sharing HPV vaccine coverage indicators.
- Triangulate data across administrative records, surveys and campaign reports for more accurate estimation of HPV coverage.

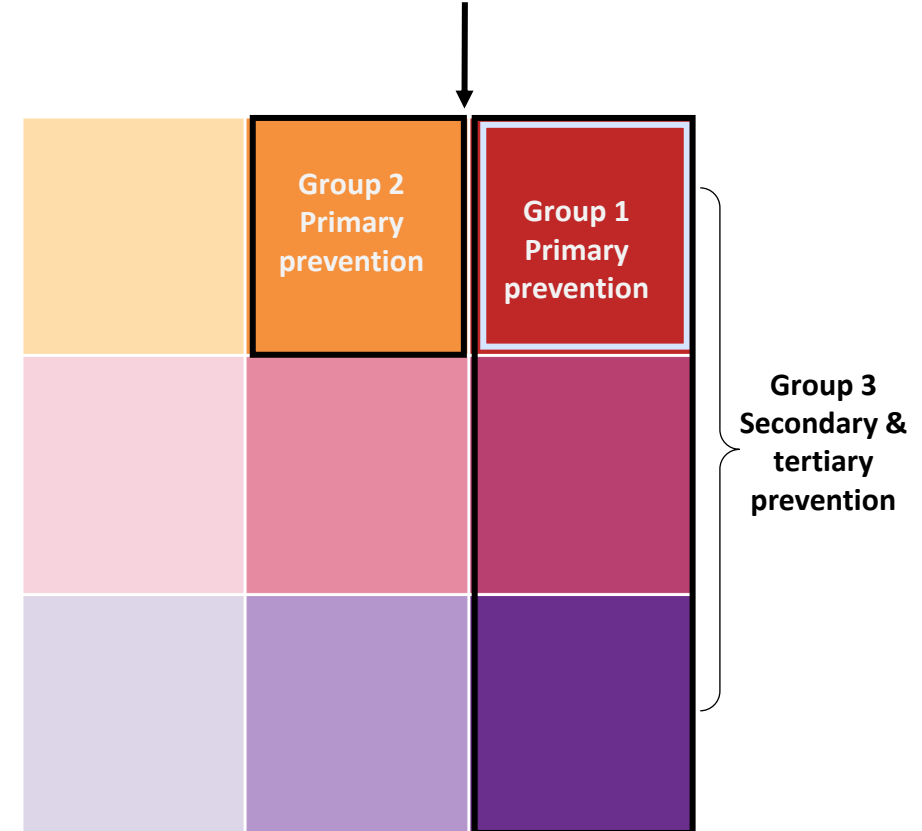
## 2. Improve data for programme planning *[WHO AFRO and technical partners]*

- Support countries in microplanning for the HPV target population.
- Collect country-level data on secondary and tertiary prevention indicators (screening and treatment).
- Conduct periodic coverage surveys to validate administrative data and correct reporting or denominator errors.

## 3. Enhance cervical cancer elimination reach and impact *[Member States, donors and implementing partners]*

- Prioritize HPV vaccine introduction in countries with high cervical cancer incidence (Group 1).
- Strengthen advocacy and communication in countries planning introduction and in those with low coverage and medium-to-high incidence (Groups 1 and 2).
- Expand screening and treatment in high cervical cancer incidence countries, regardless of vaccine coverage (Group 3).

## Priority countries to strengthen prevention efforts



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## FAQ and additional resources

- **ASR Cancer incidence indicator** : cervical cancer incidence rate is age-standardized to allow fair comparisons between countries with different age structures, ensuring differences reflect real risk, not demographics<sup>1</sup>.
- **HPV vaccination program coverage**: HPV vaccine first dose in females.
- Resources:
  - [WHO cervical cancer elimination initiative](#)
  - [Global strategy to accelerate the elimination of cervical cancer as a public health problem](#)
  - [Cervical cancer factsheet \(IARC\)](#)
  - [WHO HPV position paper \(2022\)](#)
  - [WHO HPV dashboard](#)
  - [HPV Vaccine introduction resources \(Technet-21\)](#)
  - [Vaccine Evidence Compendium on HPV vaccines](#)

[1] For more details visit this page <https://www.statcan.gc.ca/en/dai/btd/asr>

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# Contact Us

**Dr. KALU, Akpaka A.**

Vaccine Preventable Diseases (VPD) Programme  
Disease Prevention and Control (DPC) Cluster  
WHO Regional Office for Africa

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Correspondence on this publication may be directed to:  
Health Promotion, Disease Prevention and Control Cluster  
P O Box. 06 Cite de Djoué, Brazzaville, Congo  
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