

How to talk about typhoid

Menu of Messages

The more we talk about typhoid, the better we'll be able to prioritize it. These messages were developed for use by anyone interested in communicating the impact of typhoid on the health and development of children and families around the world and the value of an integrated package of solutions for typhoid control and prevention.

Divided by issue area, these messages are intended to provide options for communicating to a variety of audiences—including more general audiences and more technical audiences.

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MAIN MESSAGES

Typhoid is a **serious and sometimes fatal** disease with an **underestimated but significant** burden among children in Asia and sub-Saharan Africa.

The best way to take on typhoid is through an **integrated prevention and treatment** approach including vaccines; improvements in safe water, sanitation, and hygiene (WASH); availability of dependable typhoid diagnostics; and appropriate antibiotics.

While typhoid can be treated with antibiotics, the rate of cases resistant to available antibiotics is increasing globally. **It is only a matter of time until typhoid becomes untreatable**, raising the urgency for prevention through proven interventions such as vaccines and improved WASH.

The World Health Organization (WHO) **recommends typhoid conjugate vaccine (TCV)** for use in all typhoid-endemic countries and countries with a high burden of drug-resistant typhoid. TCV has several advantages compared to previously available typhoid vaccines including higher efficacy, longer-lasting protection, single dose administration, and suitability for children as young as six months old, allowing for delivery through routine childhood immunization programs.

Three large Phase 3 efficacy studies conducted in Bangladesh, Malawi, and Nepal show that TCV is safe and protective against typhoid in children 9 months and older.

A single dose of TCV prevented 79-85% of typhoid cases in children in Phase 3 studies in Bangladesh, Malawi, and Nepal. These results demonstrate that TCVs are safe and protective across diverse settings in Africa and Asia.

Data show a single dose of TCV demonstrates strong and durable protection for at least 4 years.

By **raising awareness** about integrated typhoid prevention and treatment solutions, **mobilizing resources**, and **accelerating uptake** of new solutions such as TCVs, we can take on typhoid together.



DISEASE BURDEN

Drug Resistance

Climate Change,
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Urbanization

Hidden Burdens
Of Typhoid

Typhoid is a serious and sometimes fatal disease that causes fever, fatigue, headache, abdominal pain, and diarrhea or constipation. In severe cases, typhoid can cause intestinal perforation. It places a significant and underestimated burden on children in Asia and sub-Saharan Africa, with poor communities often being most susceptible.

Although typhoid has largely been eliminated in industrialized countries, it continues to be a **substantial public health issue in many low- and middle-income countries**.

An estimated 70-80 percent of typhoid deaths occur in Asia, though data from Africa suggests the typhoid burden may be greater than previously thought.

Typhoid can be transmitted in either epidemic or endemic fashion.

The Global Burden of Disease reports that in 2023 there were more than **6 million cases** and more than **71,000 deaths** due to typhoid worldwide each year. However, the burden is likely underestimated due to difficulties in surveillance and diagnostic challenges.

Typhoid symptoms, such as fever and fatigue, are common to many illnesses and are often mistaken for other diseases such as malaria, pneumonia, dengue, or influenza.

Blood cultures are the current gold standard test for typhoid diagnosis. These tests are expensive and require equipment that is not routinely available in many low- and middle-income settings with a high burden of typhoid.

Typhoid is caused by bacteria called *Salmonella enterica* serovar Typhi.

Typhoid is an enteric fever and cannot be clinically distinguished from other enteric fever caused by *Salmonella enterica* serovar Paratyphi. Together, the *S. Typhi* and *S. Paratyphi* are “typhoidal *Salmonella*.”

Non-typhoidal *Salmonella* serovars can cause a serious bloodborne disease (known as invasive nontyphoidal *Salmonella* [iNTS]) and diarrheal disease. It may be difficult to clinically distinguish iNTS from enteric fever.



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Children and adolescents **younger than 15 years of age are disproportionately impacted** by typhoid.

Current trends of increasing drug resistance, climate change, and urbanization heighten the risk for typhoid outbreaks worldwide. Because of increased travel and transient populations, even countries that currently have little or no typhoid burden may become susceptible.



Typhoid is spread by the fecal-oral route through contaminated food and water, usually due to unsafe water, inadequate sanitation, and poor hygiene habits. This puts low-resource communities in low-income countries at the highest risk for typhoid.



If left untreated, typhoid can cause a variety of severe short- and long-term complications, including typhoid intestinal perforations.



Drug Resistance

While typhoid can be treated with antibiotics, **the rate of cases resistant to available antibiotics is increasing globally**. Resistance to even the newer antibiotics is becoming more prevalent posing a serious risk to health, particularly in low- and middle-income countries where accurate diagnosis and treatment are difficult.

Since first appearing in the 1970s, multidrug-resistant typhoid—specifically defined as resistance to chloramphenicol, ampicillin, and co-trimoxazole—has since spread globally.



During the past 30 years, a multidrug-resistant typhoid strain called H58 has emerged and spread in many parts of Asia and sub-Saharan Africa, displacing other typhoid strains and significantly changing typhoid epidemiology. In addition to multidrug resistance, this strain has also shown reduced fluoroquinolone susceptibility.



Resistance to fluoroquinolones, the preferred drug to treat multidrug-resistant typhoid since the 1990s, and to some third-generation cephalosporins is increasingly frequent, making them less suitable for use in low- and middle-income countries.



Extensively drug-resistant (XDR) typhoid emerged in Pakistan in 2016. These strains are resistant to five classes of antibiotics, leaving only one effective oral antibiotic, azithromycin, for treatment. Most typhoid cases in Sindh Province are now XDR.



Multidrug-resistant typhoid strains force the use of **more expensive, difficult to access, and harder-to-use antibiotics**, placing great pressure on public health systems in low-income countries.

It is only a matter of time until typhoid becomes untreatable, raising the urgency for prevention through proven interventions such as vaccines and improved WASH.



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Climate Change, Disasters, & Refugees

Climate change poses an increased risk for typhoid due to higher likelihood for natural disasters to occur and the additional stress placed on WASH services.

Natural disasters, such as droughts and floods, can increase the risk of typhoid outbreaks. During droughts, people are forced to search for any water they can find, and **shallow water sources are more likely to be contaminated with typhoid or other bacteria**. Flooding can overwhelm inadequate sewage systems or sanitation facilities, allowing human waste to contaminate water sources.

Emergency situations such as natural disasters or wars that result in many people living in refugee camps or shelters put people at high risk for contracting typhoid due to the close living quarters. **Camps and shelters often lack access to improved sanitation facilities** or connections to treated water systems, increasing the risks for the spread of typhoid.

Urbanization

The global trend of rapid urbanization, which is leading to overcrowded populations in cities across Asia and sub-Saharan Africa that often have **outdated, inadequate, or unsafe water and sanitation systems**, is increasing the risk of typhoid in these communities.

More than half of the world's population now lives in urban areas, which is projected to increase to nearly 70 percent by 2050. Almost half of urban residents in sub-Saharan Africa and Asia suffer from at least one disease caused by a lack of clean water and sanitation.



The disproportionate impact of typhoid on children and populations in resource-constrained areas is likely to grow with increasing urbanization, which can **exacerbate disparities in access to safe water and sanitation**.



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Hidden Burdens of Typhoid

While typhoid kills about one percent of people who contract the disease, **an estimated one-third of cases result in complications**, many of which can be serious or life threatening.

Typhoid complications include a life-threatening tear or perforation of the small intestines, hepatitis, neuropsychiatric dysfunction, and secondary infections of the lungs and heart.

In many low-income countries, it can be **challenging for families to access health facilities**, which can be due to factors such as long distances to clinics or economic considerations of paying for treatment, as well as lost wages from missed work due to the time required to get to a health facility and care for an ill child. Additionally, **access to appropriate antibiotics for typhoid treatment within health facilities can be limited**, particularly if the strain is resistant to one or several classes of antibiotics. **Delays in getting access to appropriate treatment can lead to increased complications of the disease.**

Because typhoid disproportionately impacts school-age children and adolescents, **the disease can greatly disrupt a child's education**, causing rippling effects on families' and communities' economic development and potential.

Recovery from typhoid is often long, difficult, and can be costly for families.

In Bangladesh, the cost of a single case of typhoid is typically double what the average family spends on health in a year.

A analysis from Malawi found that typhoid can be economically catastrophic for families, sometimes costing more than a family's total monthly income.

A study in Kenya found that the median cost of typhoid among hospitalized children was US\$96.95, amounting to 41 days of wages for a rural general laborer.

Drug-resistant typhoid, which is spreading globally, forces the use of more expensive treatment options, further burdening families.

Recovery from typhoid can take weeks to months, many times requiring caregivers to miss work to take care of an ill child.



INTEGRATED SOLUTIONS

Water,
Sanitation & Hygiene

Typhoid Conjugate
Vaccines

Improving Diagnostics

Results

The best way to take on typhoid is through an integrated prevention and treatment approach including vaccines, improvements in safe WASH, availability of dependable typhoid diagnostics, and appropriate antibiotics.

By integrating typhoid prevention and control interventions in comprehensive policies, we can **maximize impact, reduce costs, and increase efficiency of resources and programming** to take on typhoid.

Typhoid prevention and control solutions can also be integrated into policies that tackle other important childhood diseases, such as **diarrhea, pneumonia, and neglected tropical diseases** when prevention and treatment interventions overlap.

Water, Sanitation, and Hygiene

Safe WASH precautions are key to preventing typhoid.

Because typhoid is spread via the fecal-oral route, the bacteria can pass to humans through food and water that have been contaminated with fecal matter.



By safely separating waste from water sources used for drinking, cooking, washing, or swimming and **ensuring that water is treated and free of contamination**, we can help prevent the spread of typhoid and many other diseases.

Proper food handling and hygiene practices—including handwashing with soap and water, using safe water sources, and boiling or treating food and beverages—play a large role in the prevention of typhoid, which is often spread by contaminated food or beverages.

Contaminated water and passion fruit juice sold in public markets in Uganda caused a large typhoid outbreak in 2015. Water treatment products and education about avoiding untreated beverages were an important part of outbreak control.



Given the significant burden of typhoid among hard-to-reach populations where WASH progress may be slow, the role of **preventive vaccines alongside WASH interventions** becomes even more critical in high-risk areas.

While **improved WASH infrastructure is the ideal long-term solution**, it takes capital investment and long-term implementation. TCVs can have a much more immediate health impact while progress is made with WASH.





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Typhoid Conjugate Vaccines

In 2018, **WHO recommended TCV to be prioritized in countries with the highest burden of typhoid disease or a high burden of drug-resistant *S. Typhi***. TCVs are safe and effective vaccines that overcome many of the shortfalls of the previously available typhoid vaccines. WHO has prequalified five TCVs. Currently two TCVs—Typbar TCV® and ZyVac TCV®—are eligible for introduction support from Gavi, the Vaccine Alliance.

WHO's updated policy, published in 2026, advises countries with very high typhoid incidence to consider a booster dose close to 5 years of age, particularly for children who received their first dose younger than 24 months. Countries may also consider booster doses in settings where children received a primary dose of TCV younger than 23 months, especially areas with a high case fatality ratio or very high prevalence of drug resistance.

Results from large Phase 3 efficacy studies conducted in Bangladesh, Malawi, and Nepal show that **TCV is safe and efficacious against typhoid in children 9 months and older in both African and Asian settings**. These results add additional evidence from typhoid-endemic settings that TCV provides substantial protection against typhoid.

Compared to the previous vaccines, TCVs provide longer-lasting protection, only require one dose, and are suitable for children younger than two years of age, allowing delivery through routine childhood immunization programs.

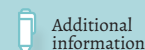
Data from Malawi show that TCVs remain highly effective and protective after a single dose in children for more than 4 years.

Pre- and post-licensure clinical trials, post-marketing surveillance, and nearly 150 million children vaccinated in introduction campaigns have reported no significant safety signals or serious adverse events related to the vaccine.

Based on studies, TCVs can be **safely co-administered** with yellow fever, measles-rubella, and meningococcal A vaccines. TCV has also been safely co-administered with polio, HPV, and multivalent meningococcal conjugate vaccines (MMCV).

Immunogenicity studies in 9 month and 15 month old children in Burkina Faso found that TCV generated a strong immune response in vaccinated children and did not interfere with the immune response generated by other routine childhood vaccines.

TCV has been safely co-administered with polio vaccines (Malawi, Pakistan, Zimbabwe), HPV vaccines (Zimbabwe), measles rubella vaccine (Kenya), and MMCV (Niger).



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TCVs are licensed for private use in several countries and is in various stages of planning for **introduction into routine immunization programs** in several countries.

Pakistan began introduction of TCV in Sindh Province in November 2019. In 2021, Punjab Province and Islamabad introduced TCV, followed by the remaining provinces in 2022. More than 44 million children were vaccinated throughout the campaigns in Pakistan. TCV is available nationally for all children at 9 months of age through the routine immunization system.



Liberia and Zimbabwe introduced TCV into their routine childhood immunization programs in 2021. Liberia vaccinated more than 1.5 million children and Zimbabwe vaccinated more than 4 million children during the introduction campaigns. Nepal introduced TCV into its routine childhood immunization program in 2022, vaccinating 7.5 million children during its introduction campaign. Malawi introduced TCV in 2023 and vaccinated more than 7 million children. In 2025, Burkina Faso, Kenya, Bangladesh, and Niger introduced TCV, vaccinating 10.5 million, 16.6 million, 42.5 million, and 15.3 million children, respectively.



In 2021 Samoa became the first country not supported by Gavi, the Vaccine Alliance, to introduce TCV into their routine immunization schedule. In 2023, Fiji, also non-Gavi eligible, conducted a campaign following increased typhoid cases in the country. In 2024, Tuvalu introduced TCV.

A study found that Typbar TCV remains stable at 45°C, demonstrating that it can be used outside of the cold chain up to 7 days prior to administration. This could facilitate great flexibility and reduce wastage when using this vaccine in vaccination campaigns.

TYPHIBEV was prequalified by WHO in 2020. Nepal, Malawi, Burkina Faso, and Bangladesh introduced TYPHIBEV into their routine immunization programs in 2022, 2023, and 2025, respectively. TYPHIBEV is currently available as an alternative product option with Gavi support.

Results from a Phase 2/3 study conducted in India demonstrated that the immune response profile of TYPHIBEV is comparable to Typbar TCV.

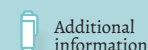


SKYTyphoid™ and ZyVac® TCV were prequalified by WHO in 2024. ZyVac TCV is eligible for support from Gavi. EuTYPH-C Inj.® Multi-dose, manufactured by EuBiologics, was prequalified by WHO in 2026.

TCV has also been used safely and effectively as part of outbreak response efforts in Pakistan and Zimbabwe. In Pakistan, TCV was used to help control an ongoing XDR typhoid outbreak.

In Hyderabad, Pakistan, TCV was found to be 95% effective against blood-culture confirmed typhoid and 97% effective against XDR typhoid.





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Two other typhoid vaccines have been recommended by WHO since 2008, but because they **do not give lasting immunity and cannot be given to children younger than two years old**, they are not widely used in routine immunization programs.

The older WHO-recommended typhoid vaccines are an oral live attenuated vaccine, Ty21a, and an injectable Vi polysaccharide (ViPS) vaccine. Ty21a is approved for use in children six years of age and older and requires three to four doses. The ViPS vaccine is licensed for children two years of age and older with a booster dose required every two to three years. Studies show these two vaccines to be safe and to protect 50 to 80 percent of recipients.



Neither of these vaccines are routinely used in endemic areas, and uptake is low. The Ty21a vaccine requires numerous doses, and the ViPS vaccine has short-lived protection. Additionally, neither vaccine is approved for use in children younger than two years of age, which limits potential health benefits and prevents inclusion in routine childhood vaccination programs.



Gavi does not provide support for either the Ty21a or ViPS vaccines.

Several other TCVs are in various stages of development.

Expanding coverage of typhoid vaccines through routine immunization can **reduce the need for antibiotics**, slow further emergence of drug-resistant typhoid strains, and save lives.

A modeling analysis projects that TCV introduction can drastically reduce the number of drug-resistant typhoid cases, deaths, and DALYs.

TCV introduction with catch up campaigns is projected to decrease the proportion of typhoid cases that are drug resistant by 16.1% in Gavi-eligible countries over 10 years.



On average, two-thirds of cases, deaths, and DALYs due to fluoroquinolone resistant- and multidrug-resistant typhoid could be averted through TCV introduction.



TCVs are projected to be one of the most impactful vaccines for preventing drug-resistance-associated deaths. TCVs could **prevent 28,700 drug-resistance-associated deaths each year** in children younger than 15 years old.



Vaccines, by preventing bacterial and viral infections, can reduce the need for and use of antibiotics and thus reduce selective pressure for resistance. A modeling analysis found that achieving universal coverage of high-priority pediatric vaccines, through new introduction or scale-up of existing coverage, could prevent 181,500 drug-resistance-associated deaths annually in low- and middle-income countries.





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Improving Diagnostics

Currently, **diagnosing typhoid requires specialized equipment and personnel**. Because of the technical requirements and costs, typhoid diagnosis may not be feasible for many low-resource health facilities.

Blood culture is the laboratory test used to diagnose typhoid, but it has limitations.



Blood cultures correctly identify people with typhoid in only 40 to 60 percent of cases and is greatly influenced by the volume of blood collected, prior administration of antibiotics, and the timing of collection.



In low- and middle-income countries where laboratory testing may be limited, typhoid diagnosis is typically made based upon clinical symptoms. Because typhoid symptoms are common to many other illnesses such as malaria and dengue, **patients are frequently misdiagnosed**.

Difficulties with accurate typhoid diagnostics and appropriate treatment can lead to more serious complications and contribute to drug resistance.



The development of **a more cost-effective rapid diagnostic test is needed** to better characterize the typhoid disease burden and avoid over- and under-diagnosis.

While improved diagnostics and surveillance can help the global and scientific community understand the full burden of typhoid, we already know that typhoid is a significant public health issue and that proven prevention and treatment solutions are available. **By accelerating access to WASH interventions and typhoid vaccines now, we can start saving lives and improving health without having to wait for improved typhoid diagnostics.**

Results

During the past century, integrated prevention of typhoid (improved hygiene, better sanitation, clean water, and vaccines), and treatment of typhoid, (appropriate antibiotic use and supportive care) have saved millions of lives. However, the **interventions are not reaching those most at risk**, and new challenges are emerging.

We have cost-effective prevention and treatment interventions to stop this ongoing threat to children's health. **The availability of TCVs and WASH improvements offers new opportunities to take on typhoid today.**





TAKING ON TYPHOID

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to Take on Typhoid

By raising awareness about integrated typhoid prevention and treatment solutions, mobilizing resources, and accelerating uptake of new solutions such as TCVs, we can take on typhoid together.

With **renewed commitment to taking on typhoid** across the WASH, immunization, diagnostics, and treatment sectors, investments by global donors, and action by country governments, we can continue to reduce death and illness caused by typhoid.

The Typhoid Vaccine Acceleration Consortium (TyVAC) and the Coalition Against Typhoid (CaT) are working with countries and other partners to take on typhoid with the best available tools. **Join us to expand our impact!**

Raising Awareness

Raising awareness about the public health burden of typhoid can help donors and decision-makers prioritize existing typhoid prevention and treatment interventions, as well as accelerate the development and uptake of new interventions.

Current trends of drug resistance, climate change, and urbanization increase the risk of typhoid transmission, raising the urgency for prevention through proven interventions such as vaccines and WASH.

By sharing data, policy information, and real-life experiences about the impact of typhoid and the potential for interventions with decision-makers and advocates, we can help **raise the profile of typhoid on policy agendas**.

Mobilizing Resources

We can save lives and improve health by mobilizing policymakers and financial support to protect children and at-risk populations from typhoid.

Mobilizing country resources to fight typhoid through **country-led policies and programs is the most sustainable way to take on typhoid**. By raising awareness of typhoid disease and proven solutions among decision-makers, we can help garner interest in, and funding for, country-led typhoid prevention and control projects.



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Accelerating Access to TCVs

TCVs protect vaccinated children for at least 4 years with a single dose. By building demand for, and awareness of, TCVs now, we can accelerate access in the countries that need them most.

In 2008, WHO recommended the use of the Ty21a and ViCPS vaccines for controlling endemic disease but highlighted the need for improved vaccines, including TCVs.



In 2017, TCVs were evaluated and recommended by WHO's Strategic Advisory Group of Experts on Immunization, approved for funding support by Gavi, and prequalified by WHO.



In 2018, WHO formally recommended the use of TCVs in the national immunization programs of typhoid-endemic countries and countries with high rates of drug-resistant typhoid.



In 2019, Pakistan began introduction of TCV into its routine childhood immunization program. Liberia and Zimbabwe introduced TCV in 2021, followed by Nepal in 2022, Malawi in 2023, and Burkina Faso, Kenya, Bangladesh, and Niger in 2025. Nearly 150 million children have been vaccinated so far in campaigns. Several additional countries are considering TCV introduction given the prevalence and increasing risk of typhoid in their countries.



In 2020, WHO prequalified a second TCV, TYPHIBEV. In 2024, SKYTyphoid™ and ZyVac® TCV became the third and fourth WHO prequalified TCVs.



In 2026, WHO updated its policy to advise countries to consider introducing a booster dose close to 5 years of age in settings with very high typhoid incidence for children who received a primary dose of TCV between 9-24 months of age. Countries may also consider booster doses in settings where children received a primary dose of TCV younger than 23 months, especially areas with a high case fatality ratio or very high prevalence of drug resistance. WHO also prequalified a fifth TCV, EuTYPH-C Inj.® Multi-dose, in 2026.



By **working across sectors to raise awareness** of the potential of TCVs, to improve WASH, and to closely monitor the use of, and resistance to, antibiotics, advocates and champions can build the case for an integrated approach for typhoid control.

By **continuing to generate and share evidence of the vaccines' safety, efficacy, and cost-effectiveness** in the countries that need them most, the research community can help decision-makers determine the best strategies for introduction and build country demand for TCVs.



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TyVAC Support to Take on Typhoid

TyVAC works closely with local and global stakeholders to **prioritize TCV introduction** in Gavi-eligible countries.

TyVAC employs a **multidisciplinary strategy** to take on typhoid.

At the global level, TyVAC generates, assembles, and disseminates data with researchers and partners across the typhoid field to help guide vaccine policy and sustainable programs.



Locally, TyVAC works closely with policymakers to make evidence-based decisions about TCV prioritization in their country. TyVAC ensures decision-makers have the latest information about typhoid and TCV to consider TCV as part of their routine immunization portfolio.



TyVAC works to maintain the momentum and attention on typhoid by raising awareness about the disease to motivate the global community and endemic countries to invest in typhoid prevention and control measures.



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