Annex B: Human Papillomavirus (HPV) revitalisation detailed update

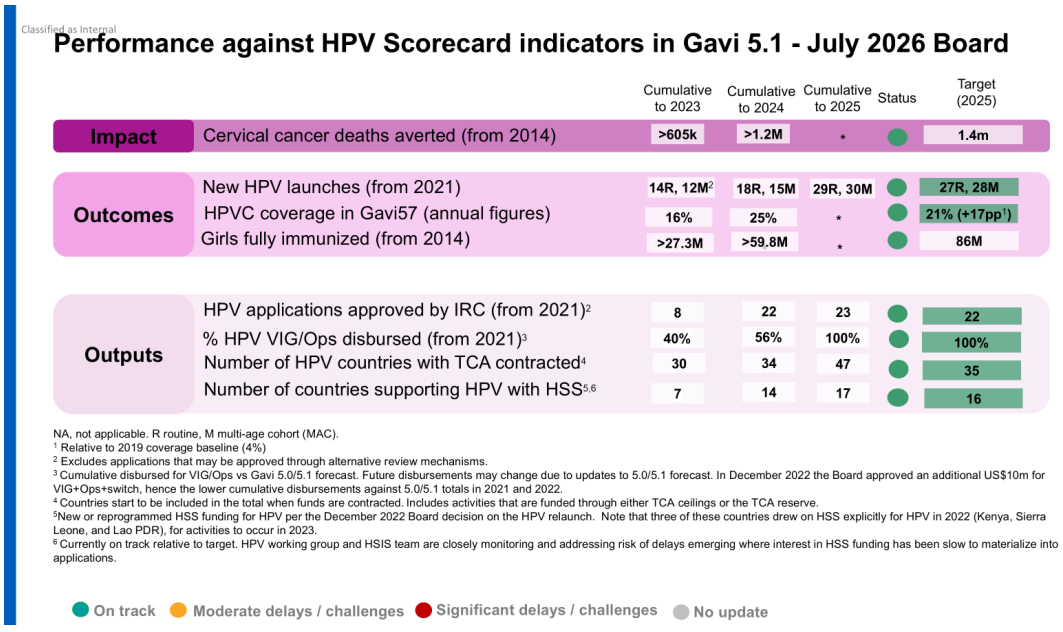
Section 1: Executive Summary

The HPV vaccine programme, a Must-Win for the Alliance in Gavi 5.0/5.1, has delivered on the revitalisation overall goal or reaching 86 million girls with the HPV vaccine and the strategic objectives to: i) accelerate quality introductions; ii) rapidly improve global and national coverage; and iii) generate long-term programmatic sustainability by integrating HPV vaccination into routine delivery mechanisms and Primary Health Care (PHC). As HPV revitalisation was a Must-Win priority for Gavi 5.0/5.1, the Board requested bi-annual updates. This annex provides updates on HPV scorecard performance and implementation of the strategic shifts supporting the revitalisation goal for the period between September and December 2025, with the final update planned for October 2026.

Section 2: Programme Status (Update to the HPV Scorecard)

Under the HPV measurement framework, the scorecard is used to track progress across the Impact, Outcome, and Output levels. All indicators with available data were achieved by the end of 2025. Performance on the remaining indicators will be confirmed in July 2026, following the release of the WHO and UNICEF HPV coverage estimates.

Figure 1: Performance against HPV Scorecard indicators in Gavi 5.0/5.1



Section 3: HPV revitalisation updates & strategic shifts

3.1 Vaccine Introductions, applications, and switches

Between the last update to the Programme and Policy Committee in October 2025 and the end of the year, Tajikistan, Cuba, Ghana, Angola, Benin, Comoros, Madagascar and Djibouti launched their national programmes, with all except Cuba delivering multi age cohort (MAC) campaigns. In addition, Malawi, Mozambique, Sierra Leone and Liberia conducted MAC campaigns reaching girls 10-18 years old. In Gavi 5.0/5.1, there were 29 routine programme introductions and 30 MAC launches. The ambitious target to support 27 routine launches and 28 MACs between 2021-2025 was reached and surpassed. Administrative data shared by countries through late 2025 were consolidated across routine introductions and MAC campaigns, with figures validated for reporting completeness and internal programme tracking to derive a cumulative estimate of girls vaccinated. This estimate indicated that the 86 million goal was achieved before the end of the year and likely exceeded during Gavi 5.0/5.1. These figures await official confirmation from WHO-UNICEF coverage estimates expected in July 2026.

This result is particularly noteworthy, as it was achieved without India having introduced HPV vaccines during the Gavi 5.0/5.1 strategy period, as originally forecasted. India has since introduced the vaccine into its National Immunisation Programme in February 2026.

All but two[1] countries with HPV vaccine programmes or those approved to introduce the vaccine, have already implemented or selected a one-dose schedule. These final two are anticipated to switch in 2026. In Q1 2026, two countries launched their HPV programmes, India, and Ukraine through the Middle-Income Countries (MICS) Technical Assistance (TA) approach.

3.2 Enhanced Technical Assistance and Foundational Support

Enhanced TA under the HPV revitalisation during Gavi 5.0/5.1 included Targeted Country Assistance (TCA) provided at country level and Foundational Support (FS) provided to WHO and UNICEF Headquarters and regional offices. Forty-seven countries had their TCA plans approved for funding either through the HPV TCA Reserve or from within TCA country ceilings. Forty-two of these countries were approved from the TCA HPV Reserve, with a total budget of US$ 27.8 million committed and US$ 25.3 million disbursed. Six countries programmed HPV TA support from their own TCA country ceilings with a total budget of US$ 4.49 million. Countries accessing technical assistance through TCA were able to leverage support for three main areas: generating and using evidence for prioritisation, decision-making and applications; planning and implementation of routine HPV vaccine introductions and MAC implementation; and coverage improvement. Activities included stakeholder

[1] Eritrea, Senegal.

engagement, data collection and review, microplanning, training, demand generation, and development of monitoring tools.

Foundational support (FS) for HPV amounts to US$ 3.6 million to WHO and US$ 2.29 million to UNICEF to support work in headquarters and regional offices (ROs). FS has enabled coordination among Alliance partners at HQ and RO levels to effectively support country HPV vaccine activities, including sharing lessons and leveraging unique partner strengths.

WHO Foundational Support

WHO support included targeted support for the introductions in Tajikistan, Benin, Cuba, Ghana, Angola, Comoros, Madagascar, and Djibouti, as well as for the preparations of the launch in India and Ukraine. In several countries, delayed MACs were supported, including Mozambique, Malawi, Sierra Leone, and Liberia. WHO has supported evaluations of country programs to assess introductions through PIE/EPI reviews (in this period Nepal, Bangladesh) and develop coverage improvement plans in the context of HPV revitalisation (Lesotho) or support following the launch (Tunisia). Several other MICs (including Iran and Philippines) received support for NITAGs on the evidence for 1-dose schedule for decision-making.

WHO initiated a special learning exchange between countries to ensure optimal protection among girls and women living with HIV. Through a workshop in South Africa, co-organised with UNICEF and Gavi, 5 high HIV epidemic countries were supported to develop action plans to ensure second dose delivery through ART services as well as assessing options to provide protection for WLWHIV beyond 14 years of age. Through Gavi, the workshop also brought in partners who had implemented HPV vaccine integration in HIV programs, funded by the HPV learning agenda.

UNICEF Foundational Support

UNICEF HQ and Regional teams continued to work with respective country offices and partners to support programme planning and coordination – including readiness preparation for HPV vaccine introductions and MAC implementation; deploying social and community listening tools to avert vaccine related misinformation and improve vaccine uptake; leveraging UNICEF's multi-sectoral programmes and platforms to mobilise key stakeholders – especially from Education and Gender to facilitate HPV vaccination; and providing technical leadership for vaccine logistics planning and management – from shipment to last mile delivery.

In Pakistan, UNICEF monitored and analysed online and community (majorly social media) engagements about HPV vaccine that threatened vaccination efforts with misinformation and provided real-time insights and trends that informed appropriate response from key leaders. Similarly, UNICEF led mobilisation for various stakeholders including Education & Schools, Champions and girls through proven human-centered design approaches to create awareness and acceptability for HPV vaccine.

At the end of 2025, UNICEF concluded its HPV-Plus initiative in 21 countries that aimed at leveraging multi-sectoral platforms and integrated delivery for HPV vaccine with appropriate adolescent health services. HPV-Plus has facilitated HPV vaccination access for over 1.5 million girls, and enabled access to integrated adolescent health services to nearly 2 million girls and boys. The initiative has documented key lessons that will be critical for enhancing HPV programme sustainability and equity.

3.3 Health Systems Strengthening Update

Health Systems Strengthening (HSS) support continues to underpin Gavi's HPV revitalisation efforts by reinforcing delivery systems and helping to strengthen routine delivery of HPV vaccine within existing immunisation and PHC systems. Countries have continued advancing activities funded through previously allocated resources, totalling US$ 14.25 million, with a focus on strengthening adolescent-friendly delivery channels, particularly school-based strategies, and improving operational capacity for consistent HPV vaccine delivery. These investments remain critical for sustaining demand generation, improving data quality and microplanning, and embedding HPV vaccination within primary healthcare systems. As part of the US$ 14.25 million allocation, US$ 11.63 million in HSS top-ups was provided to 13 countries to reinforce HPV delivery systems. Additionally, US$ 2.67 million was reallocated from country HSS funds to support HPV delivery strengthening in 5 countries. The transition to 6.0 consolidated cash budgets will further enable countries to sustain and scale HPV vaccine delivery within their holistic plan.

3.4 HPV Learning agenda

Gavi's HPV Learning Agenda is fully committed against the US$ 16.24 million SFA earmark, with delivery focused on 3 themes and a portfolio spanning adolescent service integration, coverage measurement, and screening–vaccination integration. As of 31 March 2026, 94.4% (US$ 15.3 million) has been disbursed. The Portfolio comprises:

- **Ten adolescent service integration projects across 11 countries** tested integrated service delivery models to improve HPV coverage and adolescent health outcomes. To safeguard quality and complete dissemination, the integration portfolio's end dates were adjusted. Five received Gavi no cost extensions through March 2026. Five projects received short extensions funded by the Gates Foundation through March 2026. The cross-portfolio knowledge translation project is funded through September 2026 by the Gates Foundation. An in-person synthesis meeting for the adolescent integration portfolio was held in Arusha from 24 to 27 March. The workshop's goals were to validate draft project syntheses, consolidate cross project lessons on feasibility, acceptability, cost and equity, agree on the 2026 knowledge translation products and dissemination plan, and align final deliverables and close out requirements for projects ending in March 2026. Outputs will inform 2026 knowledge translation products, including cross country evidence summaries, targeted dissemination activities, and thematic briefs on feasibility, cost, and equity.

- **The HPV coverage measurement project**, co-funded with the Gates Foundation and led by the African Population and Health Research Center, is on track in Liberia, Rwanda, and Senegal. As of Q1 2026, household surveys and administrative data collection have been completed in all three countries, and the feasibility assessment of alternative HPV coverage estimation methods is underway. While Gavi funding ended in December 2025, activities will run through September 2026 through Gates co-funding, to complete validation of light touch approaches for sustainable coverage tracking. A results synthesis meeting is planned for June.

- **A cervical cancer screening integration project**, jointly launched with Unitaid and led by Expertise France and the Clinton Health Access Initiative (CHAI), was implemented in Côte d'Ivoire and Nigeria, concluding in November 2025. Early cross-cutting insights show that uptake is shaped by how screening is positioned within existing service contacts, such as campaigns or routine facility visits, reinforcing the importance of trusted providers, clear communication, and context-specific mobilisation and delivery strategies.

3.5 Advocacy to Accelerate HPV Introductions

Gavi participated in the 37th Annual Conference of the International Papillomavirus Society (IPVS 2025) convened in Bangkok, Thailand. Gavi led a dedicated session titled "Integration for sustainability of HPV vaccination for cervical cancer elimination: progress, challenges, and innovations in Gavi-supported countries." The panel included representatives from Tanzania, Kenya, Lao PDR and partners such as Jhpiego. Gavi also showcased progress on HPV revitalisation. Gavi's participation enabled substantive dialogue regarding scaling up, sustaining, integrating, and advocating for HPV vaccination delivery. These discussions reinforced the importance of HPV vaccination as a critical pillar in the global strategy for cervical cancer elimination. UNICEF and several learning agenda partners participated in the conference, contributing insights through poster, oral and special presentations to strengthen joint HPV advocacy.

3.6 Middle-Income Countries Approach

Nationwide HPV vaccine introductions in Cuba (Oct) and Angola (Nov), brought the total number of Middle-Income Countries (MICs) HPV introductions to 7 for the Gavi 5.0/5.1 strategic period, reducing the inter-country vaccine gap. As of Q1, there are rising concerns about the program's sustainability given Cuba's worsening economic and energy situation, particularly in the context of the country no longer being eligible for Gavi support. In Q4 2025, Ukraine and Viet Nam received MICs technical TA funding to support preparatory work for the introduction of HPV vaccines in 2026.

The Alliance also continued efforts to support HPV uptake in specific countries. In Mongolia, through strengthening the capacity of healthcare workers and deepening community engagement to rebuild trust, coverage increased to 55% by year end. Tunisia continues to address vaccine hesitancy through tailored Risk Communication

and Community Engagement (RCCE) activities, and targeted-evidence-based advocacy. In response to a very low coverage rate as of December 2025, the country has revised its strategy by incorporating PHC based delivery, in addition to the previous school-based strategy. To improve vaccine uptake, vaccination target age has also been expanded to ages 12-18.

In November, a regional peer-learning workshop on HPV vaccine introduction in the Middle East and North Africa (MENA) region was co-organised by Gavi, the Linked Learning Platform and UNICEF MENARO. It brought together countries across the transition and income spectrum—including MICs Approach eligible countries (Algeria, Jordan, Lebanon, Tunisia, Morocco), Djibouti, and Saudi Arabia. The countries actively engaged in HPV vaccine learning exchanges, benefiting from Saudi Arabia's advanced experience in political advocacy, intersectoral coordination, school-based delivery, and communication strategies. Discussions highlighted the necessity of early preparedness, robust cross-sectoral collaboration, culturally sensitive messaging, and clear framing around cancer prevention to address hesitancy. Financial sustainability and cost-effectiveness analysis were also identified as critical drivers of policy decisions. With support from UNICEF, Morocco has since then organised a workshop to review its HPV vaccination programme, leveraging lessons and best practices from the region and globally – in efforts to revitalise HPV vaccination. These consultations set the groundwork for Gavi 6.0, as MENA is the region with the largest number of Gavi-eligible MICs yet to introduce HPV vaccination.

Section 4: HPV Vaccine Programme in 6.0

As Gavi transitions to the 6.0 strategic period, sustaining momentum from the HPV revitalisation investments and driving global equity remain central priorities. Under Gavi 6.0, HPV introduction, MACs and routine delivery are now fully embedded in countries' cash budget and guaranteed vaccine budget, requiring governments to plan for HPV vaccination alongside all other vaccines. The vaccine budget is calculated on the assumption that countries already using HPV vaccines use the lowest-price HPV products from 2028 onwards, while new-introducing countries are assumed to introduce using the lowest-price products. This underscores the need for countries to undertake an optimisation and prioritisation exercise of their EPI portfolios, including HPV.

To ensure countries had clarity on their Gavi 6.0 vaccine budget allocations, Gavi temporarily paused Decision Letters (DLs) and IRC reviews of applications submitted in September 2025 for new introductions and MACs. Countries with paused DLs are Cameroon, Guinea-Bissau, Myanmar, Chad and the Democratic Republic of Congo. Countries with paused IRC applications are Central African Republic, Republic of Congo, Haiti, Papua New Guinea and Guinea. These countries may now determine whether to unpause their DLs or application reviews, incorporate HPV into their holistic or reprogramming applications under 6.0, or take the decision not to proceed. Existing programs were not affected by the DL pause.

A major equity opportunity in 6.0 is ensuring that countries affected by fragility, conflict and displacement can move toward HPV introduction, and interest from Yemen, Niger,

Afghanistan and Syria marks important progress in extending protection to historically underserved populations. The Alliance will continue supporting all countries with paused, delayed introduction or MAC or new applications to advance HPV introduction, providing tailored guidance on product choice, co-financing and delivery planning. This combined focus will help anchor HPV within sustainable delivery systems across diverse contexts and ensure eligible girls, especially those facing the highest barriers, are reached.

Section 5: Supply Outlook

HPV supply/demand imbalances persisted over much of the Gavi5.0/5.1 strategic period but improved significantly by 2025. Despite a supply disruption in 2024, there was more supply availability in 2025 than in previous years from all three suppliers, enabling implementation of previously delayed launches and partial (first half) delivery of Gavi-funded HPV doses for India. In 6.0 it is expected that there will be sufficient supply to meet total demand. By end of 2025, 3 HPV products were available with single dose schedule recommendation by WHO. In 2025, the Gavi Board approved the inclusion of higher valency HPV vaccines (such as HPV9) on Gavi's product menu, subject to a second manufacturer's dossier being accepted for WHO Prequalification review