Annex D: Big Catch-Up (BCU)

Context and objectives of the Big Catch-Up

The Big Catch-Up was a global immunisation recovery initiative launched in April 2023 by the Gavi Secretariat, WHO, UNICEF and partners in response to the significant backsliding in routine immunisation coverage caused by the COVID-19 pandemic. It was estimated that over 60 million children missed out on routine immunisation in Gavi-supported countries during the pandemic[1]. Its core **purpose has been to close immunity gaps created by the disrupted services, restore global immunisation levels and strengthen immunisation systems** so that catch-up activities become an integral part of routine immunisation programmes. At the time, catch-up of older children who missed vaccination was not systematically done or enabled under existing immunisation policies in many Gavi-eligible countries. The BCU had three interlinked goals. First, it aimed **to reach and vaccinate un- and under-immunised children** up to 5 years of age, particularly those who missed vaccines between 2019 and 2022. Second, it sought to **restore national immunisation coverage** to at least pre-pandemic (2019) levels. Third, it focused on **strengthening immunisation systems within primary health care**, so that countries are better equipped to routinely identify, reach and vaccinate missed children in the future. These goals reflect a deliberate balance between short-term recovery and longer-term system resilience by embedding catch-up vaccination as an essential function of national immunisation programmes, aligned with the Immunisation Agenda 2030 and Gavi's strategic ambitions.

In December 2023, the Gavi Board approved US$ 290 million in funding to provide additional vaccines for the BCU and agreed that these should be provided without any co-financing obligation. The Secretariat provided flexibilities to countries to use existing cash support, including COVID-19 delivery support, to support delivery of these vaccines. At the time of approval, the Board acknowledged the risks of the BCU, and that these could not be fully mitigated. It encouraged the Alliance to treat the **BCU as an emergency and do its best to manage risks** through operational processes. Agreed risk mitigation measures included assessment of in-country stock, phasing of supply, and an assessment of outstanding co-financing liabilities. WHO and UNICEF also committed to develop a robust monitoring and learning agenda to track implementation and impact of the BCU and identify lessons to strengthen routinised catch-up immunisation going forward.

BCU implementation approach

The BCU has been implemented as a **"One Alliance" effort**, with clearly defined roles across partners at global, regional, and country levels. Countries led implementation through their existing immunisation programmes, deciding whether to launch

[1] Estimated that ~20% of children that missed routine immunisation in 2020-2022 were missed due to pandemic related disruptions; the remainder likely would have been missed even without a pandemic.

integrating catch-up activities into routine services, campaigns, or targeted intensifications based on local context. The Alliance supported this through time-limited financing for vaccines and funding the deployment of ~170 dedicated technical assistance staff embedded in WHO and UNICEF regional and country teams to support implementation. WHO led on normative guidance, monitoring and learning, and UNICEF led on supply and risk management. Countries had flexibility to apply for BCU based on their ambitions and specific contexts. A streamlined, risk-based review and approval process (with higher-risk, high-volume requests subject to additional review and a two-step approval/shipment approach) was put in place to enable an accelerated launch with the first counties approved within weeks of application and first doses arriving in countries within months. Additionally, a standardised quarterly monitoring tool was used to track readiness, implementation and results supporting ongoing operational monitoring and course correction.

The BCU featured a critical role for regions with Regional Working Groups (RWGs) supporting countries in BCU planning, forecasting, delivery and peer-to-peer learning, regularly activating Country Offices. At the HQ level, a shared Project Management Office consisting of Secretariat, WHO and UNICEF colleagues proactively addressed risks, bottlenecks and processes. Throughout, the approach aimed for flexibility, equity-focused targeting of missed communities, and deliberate planning for the institutionalization of catch-up vaccination within routine immunisation systems after the BCU close-out period.

The BCU transitioned rapidly from design to large-scale delivery, with **36 countries submitting applications and receiving approvals** in approximately six months. In total, **over 190 million Gavi-funded doses were approved** to support catch-up activities, complemented by an additional 48.7 million bOPV doses funded by the Global Polio Eradication Initiative that were integrated into the BCU process in selected contexts. Vaccine shipments were phased across 2024-2025 to balance speed with risk management leveraging insights from the BCU quarterly progress reporting. In some cases, countries had started their catch-up recovery efforts with their own routine stocks and the BCU doses were used to replenish RI stocks, while others waited for BCU doses to arrive before initiating activities.

Implementation progress and results

Early implementation progress varied across countries with only 26 of 36 countries having started BCU implementation by the end of 2024, reaching an estimated 6.4 million children. An early learning was that despite the emergency nature of the BCU, readiness activities such as revising catch-up policies, training health workers, revising data recording and reporting tools and systems, and mobilising communities required time to implement alongside competing priorities. Supply lead-times for certain antigens also delayed launch in some countries. Persistent factors contributing to un- and under-immunised children which pre-date the BCU were also observed including demand-, supply- and health system-level barriers. Workforce shortages, variability in training quality, intermittent operational funding, vaccine hesitancy, and inaccessibility in conflict-affected areas among other challenges undermined the consistency and reliability of immunisation services.

In response to these challenges the Alliance encouraged further integration of catch-up functions into routine service delivery models and multi-antigen campaigns where programmatically feasible, the sharing of lessons across countries and regions, enhanced support from BCU TA to resolve specific challenges and the development of acceleration plans in a set of priority countries. As an additional risk mitigation measure to avoid overstocking and co-financing erosion where performance was behind BCU targets, certain pending BCU shipments were cancelled in mid-2025 to align shipments with performance in specific countries at risk.

By the end of Q1 2026, when the programme ended, the BCU had supported countries to **reach 20.98 million children** aged 1 to 5 years with at least one catch-up dose (based on country reported administrative data, received through the BCU quarterly Monitoring Forms and reviewed by Regional and HQ levels. Limitations include variability in recording/ reporting practices. Numbers are estimates). This meant the programme **largely achieved its target of reaching 21-22 million children.** This also means that an estimated 14.3 million previously zero-dose children aged 12-59 months received Penta1 and 17.2 million children aged 12-59 months received MCV1. The BCU also provided 25.5 million doses of IPV to un- and under-vaccinated children, an essential intervention to reach polio eradication. In addition, 18.2 million PCV, 4.3 million MenA, 4.6 million YF, 12.7 million Rota, 1.2 million TCV and over 92,000 HPV doses were delivered to countries under the BCU. Country level details can be found in Table 1.

In addition, the BCU has helped substantially strengthen systems with 97% of countries having updated their catchup policy or schedules, 88% updating their data systems and tools, and 97% having implemented capacity building activities for health workers. 32 of 36 countries plan to sustain routinised catchup beyond the programme through national policies, strategies or standard operating procedures.

Learning from the Big Catch-Up

Several key learnings emerged during the BCU programme.

- With the right political leadership and support it is possible to reach many missed children and communities.
- Establishing and routinising catch-up vaccination requires significant changes across health systems in terms of policy, data tools and systems, health worker training, and demand generation.
- Catch-up vaccination strategies are important mechanisms to close immunity gaps and there is strong country demand to sustain them. They are a particularly crucial strategy in conflict-affected and humanitarian settings when there are accessibility opportunities to vaccinate expanded age ranges.
- Investments during the BCU to strengthen identification of zero-dose and under-immunised children can support routine immunisation programmes, including updated mapping and micro-planning and remapping between BCU rounds to address data gaps.
- Strong, rapid, and structured Alliance coordination with dedicated staffing proved essential for fast design, roll-out and problem-solving of the initiative.

To consolidate these lessons, an **independent BCU evaluation** is underway and will be complemented by active dissemination of country case studies and learning products to support the institutionalisation and strengthening of routine catch-up beyond the programme period.

The evaluation assesses the design, implementation and results of the BCU across 36 countries (2023–early 2026), applying OECD-DAC criteria with equity as a cross-cutting lens. The evaluation uses a theory-based, mixed-methods approach combining document review, key informant interviews, a global online survey (that has yielded substantial completion rates) quantitative coverage analysis, and thematic case studies, with findings triangulated through hypothesis testing. It also builds on the evidence from the WHO and UNICEF 10 country case studies. Preliminary findings are scheduled for August 2026, with the final report expected in October and dissemination continuing through the end of the year.

BCU close-out and transition to Gavi 6.0

The BCU is now in a **managed close-out phase**, with an agreed Q1 2026 extension period having enabled 31 countries to complete remaining activities and utilise approved doses while maintaining delivery momentum. In parallel, the Alliance has initiated a **dose reconciliation process** in Q1-Q2 2026 to validate remaining BCU vaccine balances and ensure unused doses are repurposed for routine programmes so as not to undermine co-financing. Where material quantities of BCU doses remain unused, these may be reclassified as routine supply, with a proportional reduction to future Gavi-supported allocations.

Close-out efforts are deliberately **aligned with the transition to Gavi 6.0**. For example, catch-up institutionalisation is being discussed with countries in rounds of early country engagement regarding their vaccine budgets and the Gavi 6.0 Funding Guidelines encourage countries to consider planning for catch-up doses (including routinised catch-up) for previously missed children up to five years of age. Under the Fragility and Humanitarian approach, Gavi is providing targeted funding to incentivise and support the institutionalisation of catch-up vaccination activities in selected countries facing fragility and humanitarian challenges, through the allocation of US$ 30 million as a top-up to vaccine budgets earmarked specifically for catch-up vaccination activities. These activities respond to the learning that catch-up should be a sustainable embedded component of immunisation systems, as opposed to an emergency response, given children are missed with immunisation every year. While temporary emergency response activities can catalyse change, sustainability requires routine integration.

Table 1: Big Catch-Up Implementation Progress (15 June 2026)[2]

Country	BCU Penta utilization (%)[3]	Overall children reached
Burkina Faso	122	466,602
Niger	111	672,053
Pakistan	109	3,946,969
Kenya	108	423,178
Tajikistan	106	14,436
DPR Korea	100	289,504
Nigeria	87	2,555,046
Sudan	81	332,524
Mali	78	139,666
Ethiopia	76	3,464,109
Myanmar	73	387,243
Zambia	71	270,484
DR Congo	66	881,850
Mauritania	59	162,609
Tanzania	58	1,219,418
Mozambique	58	550,979
Cameroon	54	225,095
Cote d'Ivoire	54	564,478
Togo	53	72,349
Afghanistan	48	721,540
Somalia	48	842,074
Nepal	47	14,085
Madagascar	45	1,140,556
CAR	38	278,130
Gambia	30	47,300
Benin	30	208,521
Syria	25	542,247
South Sudan	22	40,425
Chad	21	223,582
Kyrgyzstan	20	7,027
Comoros	19	6,366
Guinea	17	140,089
Yemen	14	73,597
Guinea-Bissau	13	36,802
Burundi	5	17,296

[2] All figures based on country-reported administrative data and not independently verified. Despite Alliance-led validation and quality assurance processes, limitations including variability in recording/reporting practices and potential revaccination of individual children previously vaccinated mean reported figures may represent either an over- or under-estimate of actual children reached.
[3] % of doses shipped which have been administered + wastage.