Annex D
Operationalising Gavi 6.0 recalibration outcomes

Additional analyses for Board

December 2025

gavi.org

Content

Summary: Updates to vaccine programme reductions post Board retreat

Deep dives on next slides

Recap: Option selected at July Board retreat		Updates since Board retreat
Lever 1 - Reduce scope, pace or pause routine programmes and/or campaigns		
Routine programmes without campaigns		
Malaria	*Reduce scope*: Limit scope to 70% mod-high transmission areas	Updated costing applying 70% cap to countries introducing or scaling in Gavi 6.0; future forecast updates are expected to bring further savings due to programme phasing
Hexavalent	*New option from Board*: switch from 4 to 3 doses	Updated costing based on Board steer – keep same level of ambition of the hexavalent programme as pre-recalibration
Polio (IPV)	*Reduce scope:* Fractional dosing in 6 low risk Gavi eligible countries	Proposed updated approach to giving countries the choice to transition to fractional dosing (or not) based on local evidence and feasibility
Routine programmes with preventive campaigns at time of routine introduction		
Measles/M. Rubella	*Reduce scope and pace:* Pace new introductions and linked catch-up campaigns	Updated with proposed reduced age range for MR catch up campaigns and preserve the scope for follow up campaigns (see below)
Yellow Fever	*Reduce scope:* Fractional dosing for campaigns, lower wastage for routine	*No update post Board retreat*
Typhoid	*Reduce scope:* Limit eligibility based on stringent disease burden requirements	*No update post Board retreat*
Multivalent Meningitis	*Reduce scope and pace:* Further increase campaigns sub-national targeting to higher risk areas within high-risk countries (approx. 40-75% of eligible populations)	*No update post Board retreat*
Meningitis A	*Reduce scope:*Increase campaign sub-national targeting to high-risk areas, reduce wastage assumptions for routine	*No update post Board retreat*
Jap. Encephalitis	*Reduce scope and pace:* Pace all intros and catch-up campaigns	*No update post Board retreat*
Other preventive campaigns		
Cholera	*Reduce scope and pace:* Pace all new preventive campaigns with approved volume to be reallocated among high-risk countries	*No update post Board retreat – confirmed need for some flexibility across the programme between preventive and reactive*
Measles/M. Rubella	*Reduce scope:* Limit age eligibility and/or increase subnational targeting	Updated with proposed reduced age range for MR catch up campaigns and preserve the scope for follow up campaigns (see above)
Yellow Fever	*Reduce scope:* Fractional dosing for targeted vaccination campaigns	*No update post Board retreat*

Measles/MR and Malaria updates from ongoing CVB Task Team work will be included in the Board presentation under agenda item 05a

Hexavalent | Recommended refinement

Board steer on cost reductions from recalibration retreat

Programme	Base 6.0 cost	Board Steer	Cost Reduction	Health impact	Board ask for technical consultations
Hexavalent	US$ 425 million	Switch from 4 dose to a 3-dose schedule	US$ 90 million (placeholder)	N/A (no change in ambition)	Keeping the same level of ambition as pre-recalibration and refine estimated cost reduction

This reflects the **total cost of hexavalent (in line with the Board 2024 steer to pace the programme)**, the incremental cost of hexavalent vs. IPV and pentavalent is $220m. Costs not incurred through support for hexavalent would be partially offset by an increase in the pentavalent and IPV forecast.

An **alternative approach** is being explored to enable **acceleration of Hexa implementation** through **market shaping** interventions (within the updated cost)

Update post refinement recommended to PPC

Approach	Updated cost reduction	Health impact	Recap of risks and implications

Board Steer: confirmed approach to switch from 4 dose to a 3-dose schedule (aligning to updated SAGE recommendations)	US$ 60 million	N/A (no change in ambition)	• Continued likelihood of a single supplier market if volumes fall below the minimum viable threshold to sustain 2 suppliers*, would result in:
			  ◦ Reduced supply security, especially in case of supply disruptions
			  ◦ No competition potentially resulting in higher prices
			  ◦ Limited flexibility to accommodate unforeseen demand surges
			• Updated forecast is needed to validate country interest (e.g., Ethiopia / Pakistan) in switching to Hexa: Flexibility should be maintained to allow for polio-priority countries to switch (maintain level of ambition).

*As guided by the Board in April 2024, the 6.0 base forecast for Hexa was modeled on the minimum viable supply needed to sustain a two-supplier market, therefore any cuts risk a monopolistic market

Measles-Measles / Rubella | Recommended refinement

Note: In consultations, a general discomfort was raised with lever selected at the retreat due to the high number of lives lost vs. baseline

Board steer on cost reductions from recalibration retreat

Programme	Base 6.0 cost	Board Steer	Health impact	Cost Reduction	Board ask for technical consultations
Routine programme / catch-up campaigns	US $335 (routine) / $300 million (catch up)	Scope and Pace introductions with catch-up campaigns	~ 340,000 lives lost (estimated)	US$ 85 million	Raised concerns on level of health impact - in particular from follow up campaigns reductions - and ask to further validate cost reduction for measles
Follow up campaigns	US$ 400 million	Reduce scope (i.e., target by limiting age eligibility and/or increase subnational targeting)		US$ 110 million	

Update post refinement recommended to PPC

Approach	Updated cost reduction	Updated health impact	Recap of risks and implications
• **Target MR intros with catch-up campaigns** (for example, by age 9m to <10y) - explore reduction of age range of MR catch-up campaigns in some countries e.g., based on epidemiological criteria • **Maintain M/MR follow-up campaigns** (6/9m-59m) at full-scope	Up to US$ 91 million – under consultation	~ 72k lives lost (estimated) - preliminary new data	• **Health impact:** loss of health impact is very high relative to other vaccine programmes and for significantly lower savings • **Outbreaks risk:** due to loss of measles vaccination impact in older age children in countries with immunity gaps • **Lack of data:** new programmatic approach, insufficient available data for comprehensive technical and risk analysis

Updates from the ongoing CVB Task Team work not yet reflected – they will be included in the Board presentation under agenda item 05a

Cholera | Recommended refinement

Board steer on cost reductions from recalibration retreat

Programme	Base 6.0 cost	Board Steer	Cost Reduction	Health impact	Board ask for technical consultations
Preventive campaigns	US$ 660 million	Pace: all new preventive campaigns with approved volume (25-30 million doses per year) to be reallocated among high-risk countries	-US$ 377 million	~ 16,000 lives lost (estimated)	Explore if further reductions can be achieved
Stockpiles	US$ 495 million	N/A	+$US 112 million	N/A	
Total	**US$ 1,155 million**		**-US$ 265 million**[1]		

Update post refinement recommended to PPC

Approach	Updated cost reduction	Updated health impact	Recap of risks and implications
• Keep the US$ 265 million reduction through pace all new preventive campaigns with approved volume - 25-30 million doses per year - to be reallocated among high-endemic countries • Confirmed support to retain some fungibility between preventive and reactive campaigns	-US$ 265 million (no change)[2]	~ 16,000 lives lost estimated (no change)	• New co-financing requirements for preventive campaigns might lead countries to further rely on outbreak response. Therefore, important to monitor potential implications of co-financing requirements on country demand, especially given the risk of perverse incentives where countries will prioritise reactive campaigns (no co-financing) over preventive ones. • Identify and implement measures to improve predictability of supply for preventive campaigns for approved countries (to avoid overreliance on outbreak response).

1. Includes price increases in stockpiles (+US$ 112 million) due to large volume reduction (60%) in preventive campaigns
2. US$ 3 million forecast update still to be reflected from the v23 financial forecast

Cholera | Market shaping considerations

Supplier dynamics for oral cholera vaccine

- Under Gavi 5.0, OCV demand exceeded supply. Investments were made in current (single) supplier (to build more capacity) and in pipeline suppliers (including tech transfer to African manufacturers) to meet this demand in Gavi 6.0.
- OCV also listed as a target for eventual African supplier under AVMA.

Potential trade-offs between SG4 savings and supply security and AVMA goals

- Due to the outbreak nature of cholera and the significant surge since 2021, demand is high and unpredictable, increasing the importance of supply security (including supplier diversity and buffer capacity).
- However, current SG1 reductions in Gavi 6.0 pOCV demand coupled with further country-led budget prioritisation decisions represent a level of demand and uncertainty which may become hard to sustain multiple suppliers.

OCV market risks accompanying programmatic uncertainties

- Further volume reductions to OCV may require a tolerance of higher pricing to uphold two suppliers or accepting the risk of a single–supplier situation (and increased supply security risk). Gavi is the only buyer of OCV.
- To maintain two suppliers, Gavi may need to accept a higher WAP than the lowest-possible WAP where all OCV volumes sourced from a single supplier *(any quantification of this cost differential is considered too speculative at this stage).*
- Co-financing requirements for pOCV may result in lower than forecasted demand and/or higher "spikes" in emergency demand, reducing predictability for suppliers and potentially further increasing pressure on supplier sustainability and pricing (as suppliers' factor in the increased risk).
- Reduced demand for OCV and any signaling around limitations on additional suppliers could compromise AVMA goals.

Risks to Gavi model and market shaping ability may also result in:

- Reduced level of interest in producing OCV due to reduced demand
- Loss of trust in Gavi from suppliers if previous investments in increasing supply are wasted and loss of trust from countries if Gavi is not able to secure enough supply to meet outbreak needs.

Malaria | Recommended refinement

Board steer on cost reductions from recalibration retreat

Programme	Base 6.0 cost	Board Steer	Cost Reduction	Health impact	Board ask for technical consultations
Malaria	US$ 1,115 million	Reduce scope: Prospectively limit country-level scope to 70% mod-high transmission areas	US$ 210 million	~ 32,000 lives lost (estimated)	Validate forecast assumptions and cost reduction through scoping of programme

Update post refinement recommended to PPC

Approach	Updated cost reduction	Updated health impact	Recap of risks and implications
Prospectively limit country-level scope to 70% mod-high transmission areas for countries introducing/scaling up in Gavi 6.0 **Assumptions** - 70% cap will be applied to country introductions/ scale-ups in Gavi 6.0: • 17 countries subject to prospective cap. Including 2 approved, phased scale-up allocations to be revised (COD, SDN) • 4 countries launched/launching in 2H 2025 maintain current allocation • 9 implementing countries maintain current allocation	US$ 175 million	~ 19,000 lives lost (estimated)	• Countries subject to different caps based on time of introduction

Updates from the ongoing CVB Task Team work not yet reflected – they will be included in the Board presentation under agenda item 05a

Definition and adjustments

- **Programme scope "cap" refers to vaccine support for moderate and high transmission areas and not coverage within implementing areas**
- **13 countries now identified as implementing ≥ 70% in Gavi 5.1** (9 implementing during Q3 2025 and 4 launched/launching in Q4 2025)

Malaria | Country scopes of support

Countries implementing above 70% in Gavi 5.1 & 6.0

Sierra Leone
Central African Republic
Burkina Faso
Cote d'Ivoire
Ghana
Liberia
South Sudan
Togo
Uganda
Mozambique (21 October)*
Zambia (launch 26 October)*
Guinea-Bissau (December – TBC)*
Kenya (December - TBC)*

*Preparing to introduce/scale-up (i.e., community engagement underway and doses ordered/in country)

Countries subject to the 70% cap for introduction/scale-up in Gavi 6.0

Democratic Republic of Congo
Sudan
Benin
Burundi
Cameroon
Chad
Congo Republic
Ethiopia
Gambia
Guinea
Madagascar
Malawi
Mali
Niger
Nigeria
Senegal
Tanzania

- The recommended recalibration refinement maintains this distribution for Gavi 6.0
- Countries' introduction and scale-up decisions are anticipated to be sensitive to Gavi 6.0 Grant Cycle Management and recalibration levers, resulting in additional potential savings (see next slide)

Malaria | Forecasting assumptions

- It was apparent in early discussions that there is a need to clarify the specific forecast assumptions used for the scale-up, particularly regarding coverage levels in the targeted areas in the first years following introduction.
- **Clarification:** Malaria vaccine forecast uses IRC-approved coverage levels to project volumes for scale ups and initial phase. Timing is determined from country applications or intelligence drawn from discussions with countries. For the countries that are yet to apply, benchmarks shown in below table are used.

Vaccine	Type of program	Baseline Pop.	Pop. growth	Baseline cov.	Cov. growth	Wastage
Malaria	New programs	WHO Global Dataset for high-moderate transmission settings.	UN WPP medium projection growth rate	dose 1 - DTP3. dose 2 - DTP3-5% of DTP3, dose 3 - MCV1, dose 4 - MCV- 15%of MCV1	0.66 pct/yr	7%
	On-going/ programs already applied approved	For existing approvals, 6.0 population & coverage use targets and coverage from applications. With default growth assumptions applied for population and coverage.				

- **Forecasted introductions and scale ups in v23 (Gavi 6.0):** The following slide shows the current timing of malaria vaccine introductions and scale ups in v23 and describes potential savings associated with updated timing (savings result from differences in timing between v22.1 and v23)
- **Additional analysis:** Alliance (UNICEF, WHO, and Gavi) conducting analysis of initial vaccine uptake and utilization based on administrative data. Results will be used to "pressure test" Gavi 6.0 forecasts and are anticipated by 28 November 2025.

Malaria | Forecasted introductions and scale up in Gavi 6.0

- The total malaria forecast for Gavi 6.0 (net of AFC-approved adjustments) is **US$ 806 million** (v23)
- All vaccine introductions and/or scale-ups in 6.0 are capped at 70% of moderate and high transmission areas (countries shown in the table). The v23 forecasted Gavi costs for vaccine scale ups and new introductions in 6.0 is **US$ 447 million**
- The forecasted launch dates in v23 have been adjusted for the countries in blue
  - The v23 forecasted savings from the updated launch dates (in blue) is ~**US$ 40 million**
  - Additional savings associated with changes to introduction and/or scale ups (based on informal feedback from countries) may yield an additional ~ **US$ 30 million** savings
  - **The total range of savings from country-led pacing estimated as US$ 40-70 million**

Country	v23 Introduction or scale up target dates for 6.0
Democratic Republic of Congo	Jul-25 (phased)
Sudan	Dec-25 (phased)
Benin	**Apr-27**
Burundi	Jul-26
Cameroon	**Oct-27**
Chad	Jun-26
Congo Republic (introduction)	**Jan-28**
Ethiopia	Jun-26
Gambia	Apr-26
Guinea	**Oct-27**
Madagascar (introduction)	**Jan-28**
Malawi	**Oct-27**
Mali	May-26
Niger	**Oct-27**
Nigeria	Mar-26
Senegal (introduction)	**Sep-27**
United Republic of Tanzania (introduction)	**Jun-28**

Malaria | Market shaping considerations

Pricing dynamics for malaria vaccine

- The malaria vaccine programme launched with a high initial price for RTS,S/AS01, the 'first mover' vaccine, while the second malaria vaccine, R21/Matrix-M, launched at a lower price, a similar dynamic seen in many vaccine markets.
- Given recent announcements by all three suppliers at the Gavi Global Summit in June, malaria vaccine prices and the overall WAP of the malaria vaccine programe will reduce during Gavi 6.0.
- The price differential for malaria vaccines will also narrow throughout 6.0 and is consistent with other Gavi vaccine programmes. It is already not the highest price differential seen within Gavi's programmes.

Additional savings from hypothetical transition to single supplier market

- Switching the entire programme to the single lowest-price suppler could yield additional savings* in line with what we would realise in many other vaccine programmes if other programmes were intentionally moved to a monopoly market.

Malaria market risks accompanying hypothetical single supplier market

- Achieving savings would come with the trade-off of less secure malaria supply, with no alternative sources to buffer any supply disruptions
- Both malaria vaccines include a proprietary adjuvant (R21/Matrix M from Novavax, and RTSS/ASO1 from GSK)
- Risk of long-term monopolistic price increases (as seen in other single supplier markets)
- Supply contracts are in place with all suppliers and investment being made by all manufactures over several years for production capacity for Gavi (Gavi is only buyer of the malaria vaccine)

Risks to Gavi model and market shaping ability may also

- Result in loss of trust in Gavi model and lack of manufacturer incentive to invest in innovations or next-generation vaccines
- Reduces level of risk that manufacturers will take on behalf of Gavi and UNICEF**,** resulting in strong likelihood of suppliers requiring more volume guarantees

Next step: Market shaping considerations will further be assessed as part of the MSS 6.0

[12]* *To protect confidentiality and market sensitivity, more detailed analysis can only be shared at MSDC*

Gavi The Vaccine Alliance

Inactivated Polio Vaccine (IPV) | Recommended refinement

Board steer on cost reductions from recalibration retreat

Programme	Base 6.0 cost	Board Steer	Cost Reduction	Health impact	Board ask for technical consultations
Inactivated Polio Vaccine (IPV)	US$ 700 million	Reduce scope: through transition to fractional dosing in six “polio low risk” countries in 2027 - Cambodia, Lao, Kyrgyzstan, Democratic People's Republic of Korea, Solomon Islands, and Tajikistan	US$ 10 million[1]	-	No specific ask

Update post refinement recommended to PPC

Approach	Updated cost reduction	Updated health impact	Recap of risks and implications
Approach: Country-driven decision on transition to fractional dose (or not) based on evidence and feasibility, i.e. voluntary, rather than predetermined **Rationale:** Following the retreat as part of further technical engagement, technical partners raised concerns regarding the feasibility of implementing fractional dosing of IPV in certain countries	US$ 0-10 million (dependent on country decision)	-	**Policy and regulatory:** • Off-label use raises liability concerns that may affect NITAG recommendations and national decisions **Operational:** • Intradermal IPV administration in RI systems is more complex and time-consuming, requiring extra training and supervision, which may reduce vaccination coverage **Programmatic and epidemiological:** • Fractional-dose IPV may cause confusion, differing from WHO and partner guidance for three full IPV doses in hexavalent schedules • As polio remains a PHEIC, disruptions or inconsistencies in IPV implementation increase the risk of virus transmission or importation

1. Resulting cost reduction accounts for interdependency with lever 6B (IPV support to Former Gavi-eligible countries)

IPV, Hexa, Penta | Cross cutting view

	Base 6.0 cost	Description	Cost reduction*	Board decision	Feedback from consultations
IPV	US$700 million	**SG1**: fIPV in six "polio low risk" countries in 2027 - Cambodia, Lao PDR, Kyrgyzstan, DPRK, Solomon Islands, Tajikistan (starting in 2027)	**US$ 10 million**	**Board steer** Next step: work with countries to determine feasibility	• UNICEF and WHO have expressed reservations to this steer. They recommend that transitions to fIPV be country-driven, evidence-based, and voluntary – not imposed. • Marginal savings do not outweigh the policy and regulatory risks, operational challenges; and programmatic and epidemiological concerns. (See deep-dive slide 13) • Polio remains a PHEIC; high IPV coverage plays a critical role in achieving eradication.
		SG3: Removal of IPV support for former Gavi countries: UMICs (2026); LMICs (50% in 2026, no support 2027)	**US$ 25m** **US$ 65m** (IPVsubsidy for hexa)	**Board decision**	• Concern expressed about the short notice period and ability to quickly absorb this investment by the UMICs; possible miscommunication with MoH Indonesia. Donors have been asked to fund IPV for Indonesia.
		Base cost includes SG4: Market shaping approach	US$ 110 million	**Board decision**	
Penta	US$ 385 million	**Base cost includes SG4**: Market shaping approach	US$ 45 million	**Board decision**	
Hexa-valent	US$ 425 millio	**SG1**: Switch from 4 dose to a 3-dose schedule	**US$ 60m**	**Board steer** Next step: refine estimated cost reduction and keep same level of ambition	• Continued likelihood of a single supplier market if volumes fall below the minimum viable threshold to sustain 2 suppliers. • Updated forecast is needed to validate country interest (e.g., Ethiopia / Pakistan) in switching to Hexa • Flexibility should be maintained to allow for polio-priority countries to switch (maintain level of ambition). Note that an alternative Hexa approach is being explored to accelerate Hexa through market shaping (within budget)

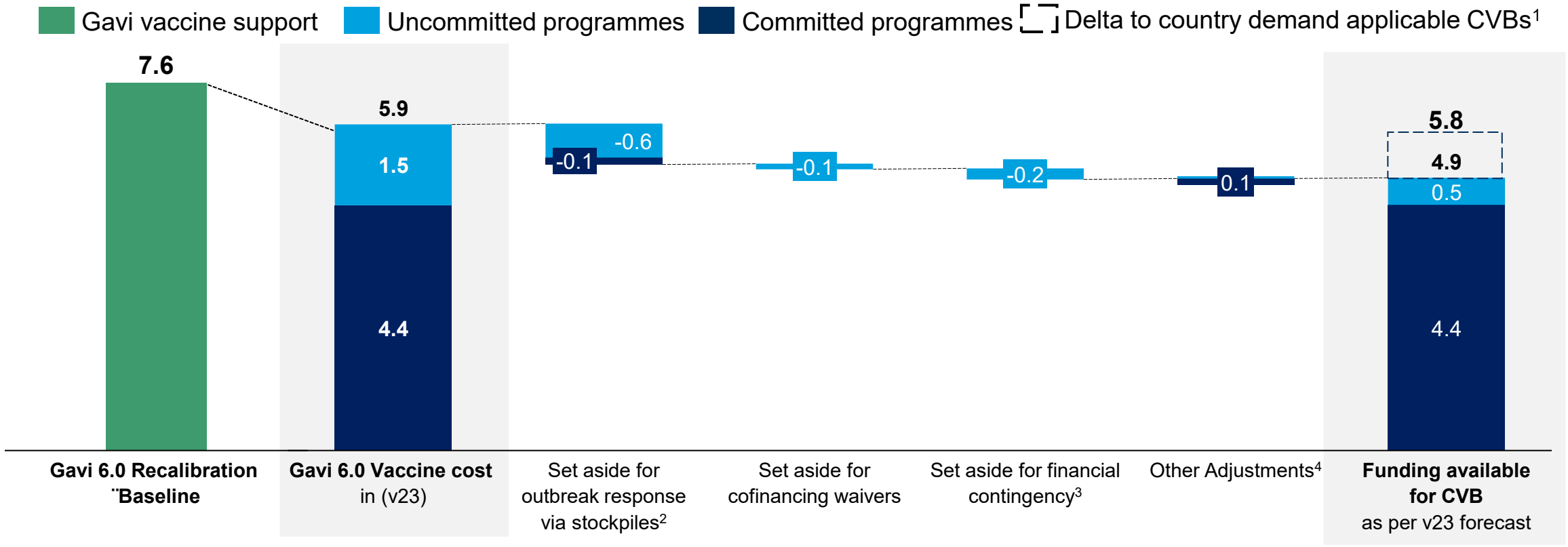
This reflects the **total cost of hexa**, the incremental cost of hexa vs. IPV and penta is US$ 220 million. Costs not incurred through support for hexa would be partially offset by an increase in the penta and IPV forecast.

Content

1. Proposed refined cost reductions to four vaccine programmes (SG1)
2. **Proposed mitigations to reduce Country Vaccine Budgets funding gap**
3. Health impact assumptions and estimates – post recalibration
4. Cash allocation by country segment – post recalibration
5. Co-financing implications – post recalibration

Country Vaccine Budgets | Funding for new vaccine launches is limited compared to demand; mitigations needed

Vaccine procurement cost – Gavi 6.0 [US$ billion]

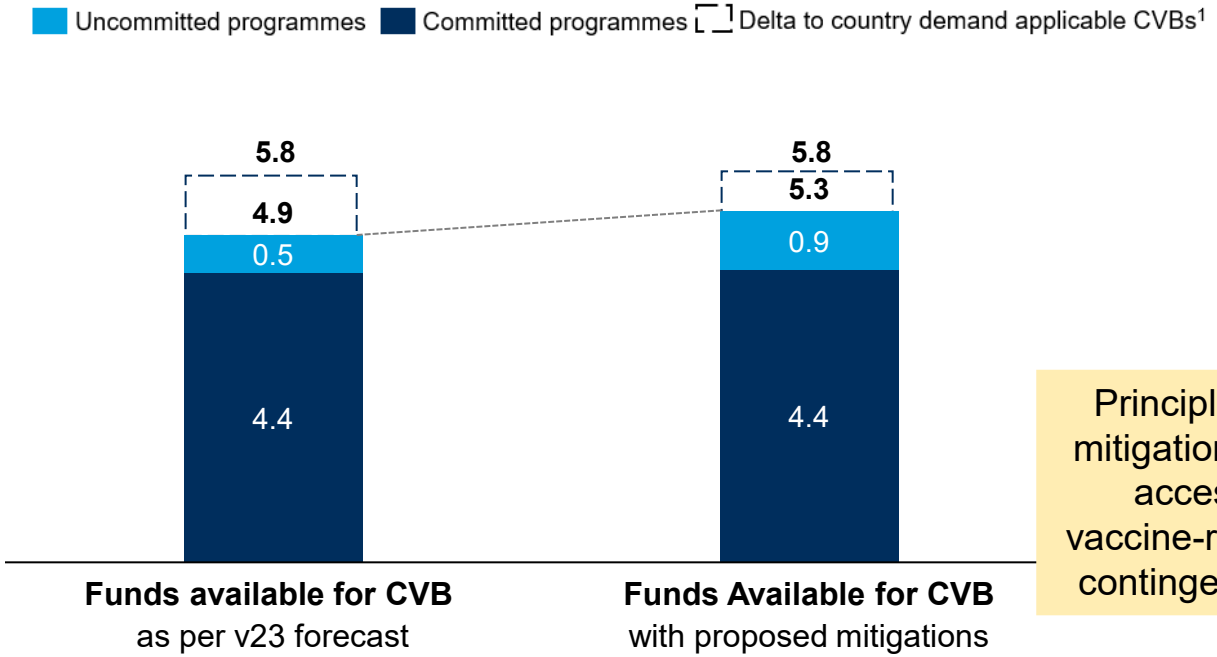


Before mitigation, available funding for new vaccines programmes under CVB would meet **~35% of country demand**
Mitigation measures are needed to reduce this gap to demand

1. Delta to country demand applicable to CVBs includes unconstrained demand for new introductions minus uncommitted resources with the total CVB budget. 2. 2026 costs considered committed. 2027-30 considered uncommitted 3. Funding set aside for central contingency include external shocks such as forex movement, price changes, approval implementation timing changes, unexpected shocks leading to countries being forced to switch products etc 4. Other adjustments includes +$43M set aside for diagnostics, +$68M for India strategy, and -$188M savings in 5.1 pre-paid doses for cholera, rota and malaria (supply financing).

Country Vaccine Budgets | With mitigations, funding for CVB could cover up to two third of country demand for new intros and campaigns, strengthening country choice

Funds available for CVB – [US$ billion]



Principle for mitigation is to access vaccine-related contingencies

Potential mitigations

An additional funding of **~US$ 400 million** could be mobilised for Country Vaccine Budgets:

- Reducing the forecast for **outbreak response (stockpiles)** **(US$ 200 million)**
- **Funding co-financing waivers through the Fragile & Humanitarian Approach** **(US$ 100 million)**

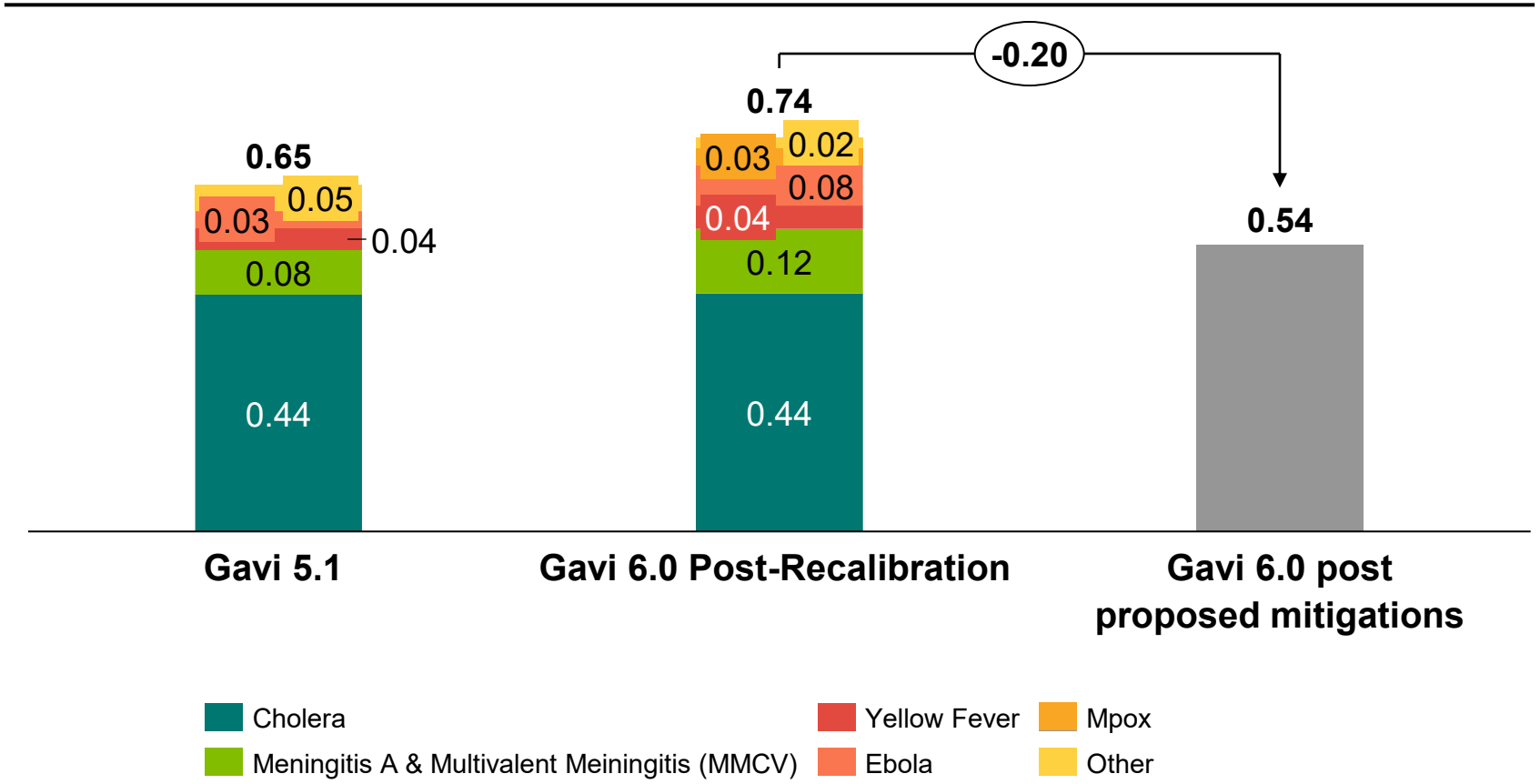
Additionally, the Secretariat will reduce the amount set aside for **vaccine procurement contingencies** **(US$ 100 million)**

With these mitigations ~US$ 900 million could be available for new programmes ~ 2/3 of country demand

1. Delta to country demand applicable to CVBs includes unconstrained demand for new introductions minus uncommitted resources with the total CVB budget.

Mitigations for CVB gap | Proposal to reduce forecast for stockpiles by US$ 200 million (1/2)

Stockpiles cost evolution with proposed mitigation, US$ billion



Forecast based on **historical demand** and **expected growth** in 6.0[1]

No cap on stockpiles, funding flexible across disease areas

Reduction would **retain this principle**

Forecast to be **monitored on an annual basis**

1. Growth in demand of stockpiles for Gavi 6.0 is driven by an increased demand for Oral Cholera Vaccines and improved supply; enhanced availability of multivalent meningitis vaccines and new WHO guidance promoting broader use to stop future outbreaks; and the operationalisation of the Mpox and Hepatitis E stockpiles

Mitigations for CVB gap | Proposal to reduce forecast for stockpiles by US$ 200 million (2/2)

Proposed changes

Reduce forecast for stockpiles for outbreak response support by ~US$ 200 million

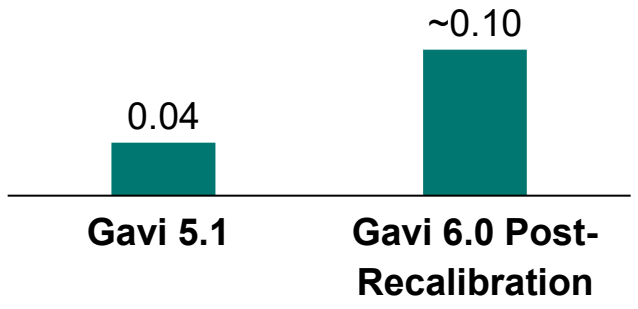
Risks and implications

- **Public health risk:** Forecasted funding likely insufficient to meet country outbreak response demands
- **Market shaping risk:** Likely price increase in certain markets if predictable supply no longer procured/assured by Gavi (e.g., Cholera)
- **Reputational risk:** Gavi might not be able to respond to outbreaks in some countries

- **Mitigation: Update forecast in the course of 6.0 if needed, enabled by reallocation from savings in other areas or mobilisation of resources**
- **Gavi Secretariat perspective is to accept the risks as strong mitigation in place**

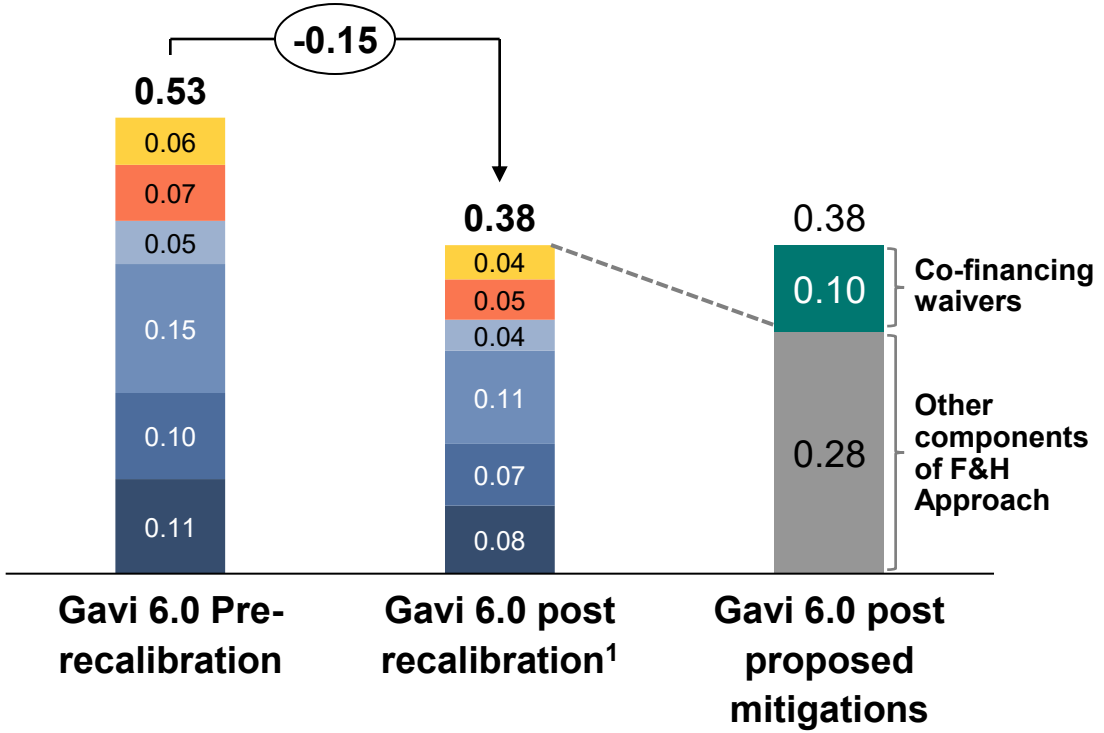
Mitigations for CVB gap | Proposal to fund ~US$ 100 million estimated co-financing waivers through the Fragile & Humanitarian (F&H) Approach

Cofinancing waivers cost evolution, US$ billion



Expected increase in Gavi 6.0 from the new **co-financing requirements for preventive campaigns** for countries facing humanitarian crises

Fragile & Humanitarian Approach cost evolution, US$ billion



- **Proposal to fund co-financing waivers** estimated at ~US$ 100 million for 6.0 **for countries facing humanitarian crises or conflict through F&H approach**
- PPC requested F&H Alliance Advisory Group to prepare a proposal on **prioritising the use cases of the F&H Approach** for consideration at May 2026 PPC

1. As per July Board Retreat, fungibility across F&H components was to be maintained. 2. Gavi Resilience Mechanism

Content

Overall | High level assumptions for health impact assessments

Strategic Goal	Activity		Est. loss of total lives saved	Assumptions
Vaccines (SG1) *Deep dive follows*	Vaccine programme: routine immunisation and preventive campaigns		~300-400k	• Used Impact Extrapolation (IE) method developed by Vaccine Impact Modelling Consortium (VIMC) • Method applies VIMC generated impact ratios (deaths averted per person fully vaccinated (FVP)) specific to country, antigen and vaccine delivery strategy, to the number of FVPs, as projected in Gavi 6.0 demand forecast • Estimates reflect a direct impact loss of approximately -200k from changes in vaccine programmes and a further ~100-200k lost from reductions obtained through vaccine envelopes (see details on next page). Does not account for potential shifts in country decisions on campaigns that may result from changes in co-financing policy.
Healthy systems & Equity (SG2)	Health system & immunisation strengthening (zero dose support)		~100-200K	• Assumption in Board retreat materials included a maximum potential loss of lives saved of 400k (option 3). This was assuming the Alliance was not delivering on the Immunisation Agenda (IA) 2030 target and hence not reaching ~6.2 million zero-dose children[2] with all vaccines in routine immunisation national schedules. VIMC IE method was used for this original assumption. • On this lever, the Board steered towards an option between 'low' and 'medium' reduction for this lever, hence the expected reduction range here between 100k and 200k.
	Fragile & Humanitarian approach[1]	Traditional vaccines	~120k	• Proportionate reduction of health impact with cost reduction chosen by the Board. Initial calculations assumed mid-point of health impact (~250-600K) based on mid-point of cost estimate ($40-90m) covering 50-100% of costs for traditional vaccines[3] in countries receiving co-fin waivers in 2024-2025 + those receiving or at risk of needing external donor financing. • Used VIMC IE method and IA2030 generated health impact ratios
		Catch-up immunisation	~20k	• Proportionate reduction of health impact with cost reduction chosen by the Board. Initial calculations assumed mid-point of health impact (~50-80K) based on mid-point of cost estimate ($40-70m) for catch-up of vaccination in 16 countries classified as fragile[4] • Used IE method and adjusted VIMC impact ratios for lower impact of vaccinating older children
		Humanitarian programming	~20k	• Proportionate reduction of health impact with cost reduction chosen by the Board. Initial calculations based on est. number of surviving infants in conflict-affected districts[5] with largest lag in DTP3 coverage vs. national WUENIC coverage. Of these districts, 40% considered extra-governmental i.e., requiring Humanitarian programming. Impact assumes all surviving infants reached via Humanitarian programming receive full package of essential routine immunisation. • Used VIMC IE method and IA2030 generated health impact ratios
		Catalytic phase (MICs) facing fragility	~20k	• Proportionate reduction of health impact with cost reduction chosen by the Board. Initial calculations based on estimates from similar programming in Gavi 5.1 • Assumes support for 3 emergencies in catalytic phase countries and 2 countries facing fragility • Excludes outbreak response

1. For full description of health impact and costing estimates – see July 2025 Board Paper 10 Annex A on the Fragile & Humanitarian Approach; 2) Based on WUENIC 2023 zero dose estimates 3) OPV, BCG, Maternal Td, MCV where not already Gavi-supported, number of children estimated with Gavi/UNICEF forecasts 4) Excludes Haiti and PNG 5) Geospatial data from Institute for Health Metrics and Evaluation (IHME), conflict data from Armed Conflict Location & Event Data Project (ACLED) and WorldPop.

Vaccines (SG1) Deep Dive | Breakdown of health impact estimates

INDICATIVE

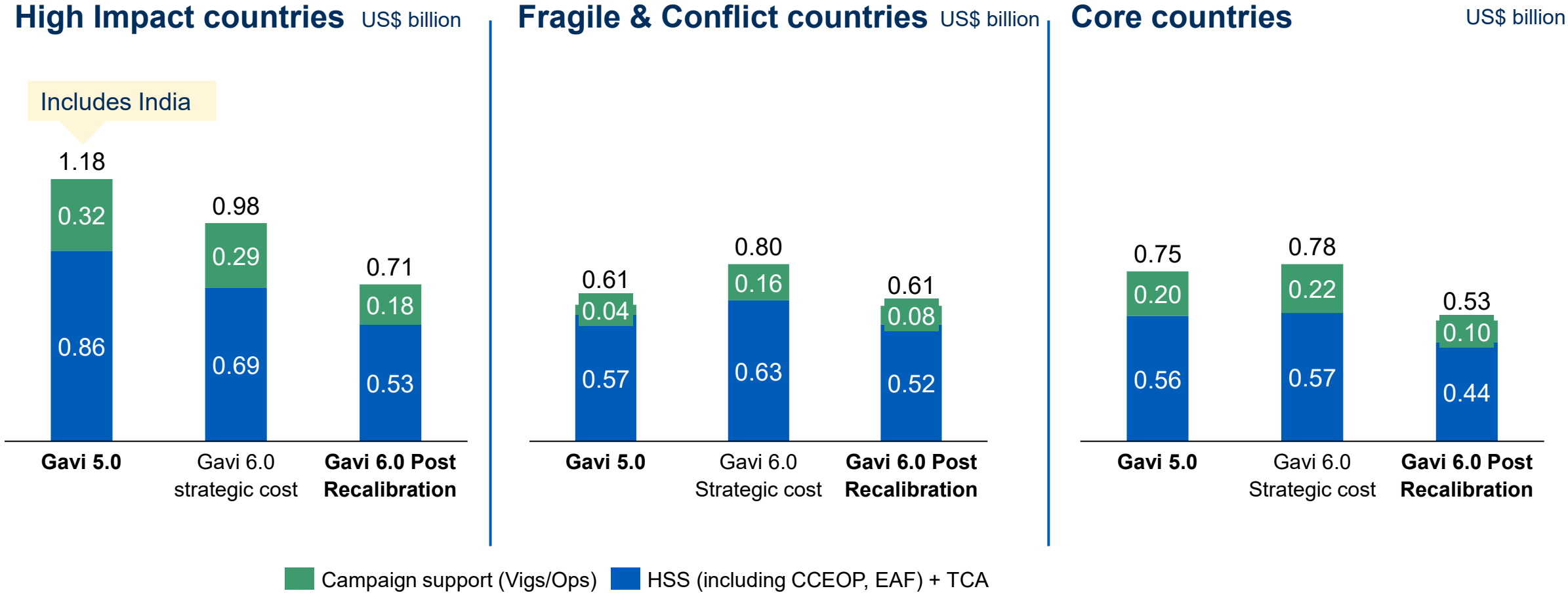
Levers	Option selected at Board retreat	Health impact (loss of lives saved)	Comments on updates to health impact estimates
Vaccine (SG1)			
Lever 1 - Reduce scope, pace or pause routine programmes and/or campaigns			
Routine programmes without campaigns			
Malaria	Limit scope to 70% mod-high transmission areas	19k	Updated post recalibration retreat
Hexavalent	New option (4 doses to 3 doses switch)	-	No update post recalibration retreat (no change in level of ambition for Hexa)
IPV	Fractional dosing on 6 low risk Gavi eligible countries	-	*No update*
Routine programmes with preventive campaigns at point of routine intro			
Measles/M.Rubella	Pace new introductions and linked catch-up campaigns	72k	MR intro/catch-up with age <10yrs, consider for all 11 countries
Typhoid	Limit eligibility based on stringent disease burden requirements	83k	*No update*
Multivalent Meningitis	Further increase campaigns sub-national targeting to higher risk areas within high-risk countries (approx. 40-75% of eligible populations)	12k	*No update*
Meningitis A	Increase campaign sub-national targeting to high-risk areas, reduce wastage assumptions for routine	2k	*No update*
Jap. Encephalitis	Pace all intros and catch-up campaigns	1k	*No update*
Yellow Fever	Fractional dosing for campaigns, lower wastage for routine	-	*No update*
Other preventive campaigns			
Cholera	Pace all new preventive campaigns with approved volume to be reallocated among high-risk countries	18k	No update post recalibration retreat
Measles/M. Rubella	Limit age eligibility and/or increase subnational targeting	-	Updated post recalibration retreat: recommendation to no longer proceed with reduction to M/MR follow up campaigns
Yellow Fever	Fractional dosing for targeted vaccination campaigns	-	*No update*
Lever 3 – Level of additional country led reductions	Introduce vaccine envelopes with additional ~US$ 800 million country led reductions	100-200k	Indicative estimate assuming similar loss of health impact per $ from country-led reductions and top-down reductions for new programmes (i.e., $1.0bln top-down reductions leading to ~200k loss of lives saved). This assumes the reductions come from new programmes given Board steer to preserve existing programmes. It does not assume disproportionate choices by countries for different programmes.

Content

1. Proposed refined cost reductions to four vaccine programmes (SG1)
2. Proposed mitigations to reduce Country Vaccine Budgets funding gap
3. Health impact assumptions and estimates – post recalibration
4. **Cash allocation by country segment – post recalibration**
5. Co-financing implications – post recalibration

Evolution of allocations across country segments between Gavi 5.0 and Gavi 6.0 post recalibration

Total cash allocated[1] to each country segment



1. Excludes Innovation Top-Up and operational support for outbreak response (global stockpiles) not allocated at country level; Allocations represent recommended caps and floors that are to be reviewed by PPC.

Content

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ELTRACO | Impact analysis on country co-financing obligations from Gavi 6.0 recalibration

	Lever 6A – Remove relief measures for new vaccine introductions[1]	Lever 6B – Amend exceptional co-financing for malaria[2]	Lever 6C – Increase or introduce campaign co-financing
Recalibration outcomes			
Option selected	Remove 35% cofinancing cap for new vaccine introductions for countries in Preparatory and Accelerated Transition	Degree of exceptional co-financing reduced for malaria[3]	Introduce co-financing at 5% for initial self-financing countries, 10% for Preparatory Transition countries, 20% for Accelerated Transition countries for all preventive campaigns
Cost reductions for Gavi (additional co-financing for countries)	**US$ 15 million**	**US$ 35 million**	**US$ 65 million**
Cofinancing implications for countries			
Number of countries impacted	12 countries	11 countries	54 countries
Average increase of total country co-financing over 6.0 period	+2% (affected countries)	+4% for countries with R21 +7% for countries with RTS,S	+3%
Additional information	Accelerated and Preparatory Transition **countries with new vaccine introductions impacted**; greatest impact on Guinea (+13%), Cameroon (+5%), Bangladesh (+3%), Kenya (+1%)	-	• **+9% increase in co-financing burden over Gavi 6.0** (+33% increase in campaign years) **for top 20 most impacted countries** • **+7%** increase in **Initial self-financing countries** • **+2%** increase Accelerated Transition and Preparatory Transition countries

1. Costs and countries impacted will change with v23.1 forecast and latest eligibility projections - Countries expected to be particularly impacted: (BGD) Bangladesh, (BEN) Benin, (CMR) Cameroon, (DJI) Djibouti, (GIN) Guinea, (KEN) Kenya, (KGZ) Kyrgyzstan, (MRT) Mauritania, (PAK) Pakistan, (PNG) Papua New Guinea, and (COG) Republic of the Congo. 2. Option 2 for IPV/Hexa only affect MICs countries no longer eligible to Gavi support (who do not have co-financing) and hence not shown here. 3. 30% ramp-up on co-financing per dose in Preparatory Transition countries and no extended support for Accelerated Transition countries

Deep dive | Campaign co-financing: ten 'watch list' countries with highest co-financing increase to be closely monitored

Countries	Eligibility Status	Number of campaigns	Type of campaigns	Increase in cofinancing over 6.0 period	Evolution in 6.0		Max increase in year with campaign	Health impact of campaigns (loss of lives saved)
					From	To		
Ethiopia	Initial Self Financing	2	MR catch up campaign, Yellow Fever preventive campaign	+17%	$44m	$53m	+40%	155k
Madagascar	Initial Self Financing	4	HPV MAC, Measles follow up, MR catch up, Typhoid catch up	+16%	$8.4m	$10m	+55%	71k
Chad	Initial Self Financing	3	HPV MAC, Measles follow up, Multivalent Meningitis catch up	+12%	$11m	$12.6m	+40%	22k
Guinea	Preparatory Transition	5	HPV MAC, MR catch up, Measles follow up, Pneumococcal catch up, Yellow Fever targeted campaign	+12%	$10.3m	$15.3m	+37%	85k
DR Congo	Initial Self Financing	5	HPV MAC, MR catch up, MR follow up, Cholera preventive, Typhoid catch up	+11%	$14.5m	$17.3m	+20%	255k
Benin	Preparatory Transition	4	HPV MAC, Multivalent Meningitis catch up, MR follow up, Typhoid Catch up	+9%	$20m	$24m	+33%	45k
Togo	Initial Self Financing	2	Multivalent Meningitis catch up, MR follow up	+9%	$4.3m	$4.7m	+46%	7k
Mali	Initial Self Financing	3	HPV MAC, MR follow up, Multivalent Meningitis catch up	+9%	$11m	$12.6m	+41%	63k
Somalia	Initial Self Financing	2	MR catch up, MR follow up	+8%	$6.6m	$7.2m	+35%	82k
Niger	Initial Self Financing	5	HPV MAC, Multivalent Meningitis catch up, MR catch up, Yellow Fever preventive campaign, Typhoid catch up campaign	+8%	$17.7m	$19.3m	+25%	25k

Note:
The *increase in co-financing over the 6.0 period* refers to the percentage rise in a country's co-financing obligations during the 6.0 period, compared to the baseline scenario where campaign co-financing is not included.
The *maximum increase in a year with a campaign* refers to the highest annual percentage increase in co-financing obligations for a country in any single year of the 6.0 period, specifically due to campaign-related costs.

Deep dive | Campaign co-financing: preliminary thinking on approach to risk monitoring and potential mitigations

Key risks	Potential mitigations (not exhaustive)
Unclarity from countries on new co-financing requirement as part of transition to Gavi 6.0	• Communication ongoing, additional engagement with Ministries of Health (MoH)/ Ministries of Finance (MoF), seeking confirmation of MoH/MoF endorsement of applications when submitted prior to changes in co-financing rules
Potential change in country plans, delays in campaigns or countries no longer running the campaigns leading to: • Increased loss of health impact • Increased reliance on outbreak response	• Strengthen engagement with Ministries of Finance on budgeting of additional co-financing requirements in campaign years. • Explore spreading the increase over several years through ad hoc pre-financing (e.g. costs spread over 2 years) or concessional lending (longer term)
Higher defaults due to significant increase in a given year (campaign year)	

Monitoring across these risks to focus engagement on campaigns at risk due to increased co-financing and/or limited space under countries vaccines budgets

Deep dive | Breakdown of 2026 campaign co-financing impact by country, segment, and vaccine group

New campaign cofinancing at 5% for ISF countries to be paused in 2026
(Except for Measles/MR follow-up campaigns which continue with 2% cofinancing as per current policy)

	Countries	Antigen	New cofinancing to be paused in 2026, US$ million	Existing cofinancing to apply in 2026 (i.e., for M/MR f/u campaigns), US$ million
Initial Self-Financing	Ethiopia	Yellow Fever	$2.26	-
	Mali	Multivalent Meningitis	$1.22	-
	Mozambique	Cholera	$1.04	-
	Niger	Yellow Fever	$0.63	-
	DR. Congo	Cholera	$0.56	-
	Togo	Multivalent Meningitis	$0.42	-
	Malawi	Cholera	$0.40	-
	Sierra Leone	Typhoid	$0.26	-
	Uganda	Measles-Rubella	$0.21	$0.13
	Yemen	Measles-Rubella	$0.15	$0.09
	Madagascar	Measles	$0.07	$0.04
	Malawi	Measles-Rubella	$0.07	$0.04
	Burundi	Measles-Rubella	$0.06	$0.04
	Syria	Measles-Rubella	$0.06	$0.04
	Chad[1]	Measles	$0.00	$0.00
	Total for ISF countries		**$7.41**	**$0.39**

New campaign cofinancing to apply starting 2026, at 10% for PT countries and 20% for AT countries

	Countries	Antigen	New cofinancing to apply in 2026, US$ million
Preparatory Transition	Myanmar	HPV	$1.46
	Cameroon	HPV	$1.20
	Pakistan	HPV	$0.78
	Kenya	Cholera	$0.70
	Nepal	Cholera	$0.70
	Cambodia	HPV	$0.60
	Cameroon	Measles-Rubella	$0.17
	Myanmar	Measles-Rubella	$0.13
	Guinea	Measles	$0.06
	Haiti	Measles-Rubella	$0.05
	Total for PT countries		**$5.85**
Accelerated Transition	Bangladesh	Jap. Encephalitis	$2.88
	Bangladesh	Cholera	$2.79
	Djibouti	Measles	$0.01
	Total for AT countries		**$5.68**

1. Numbers are rounded to the nearest million, rounds to zero due to small magnitude