COUNTRY VACCINE BUDGETS (INCLUDING PORTFOLIO OPTIMISATION AND PRIORITISATION)

BOARD MEETING
Marta Tufet Bayona
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gavi.org

July Board retreat provided in-principle steer on ‘Country Vaccine Budgets’ (CVB) in Gavi 6.0

CVBs are **country-specific budgets** for Gavi vaccine support in Gavi 6.0

Objectives aligned to Gavi 6.0 Strategic Goals

- **Maximise health impact and value for money**
- **Minimise risk of disruptive outbreaks**
- **Ensure equitable access to vaccines**
- **Improve financial and programmatic sustainability**
- **Protect market health**

Principles

- **Country flexibility**
- **Simplicity**
- **Continuity of support**

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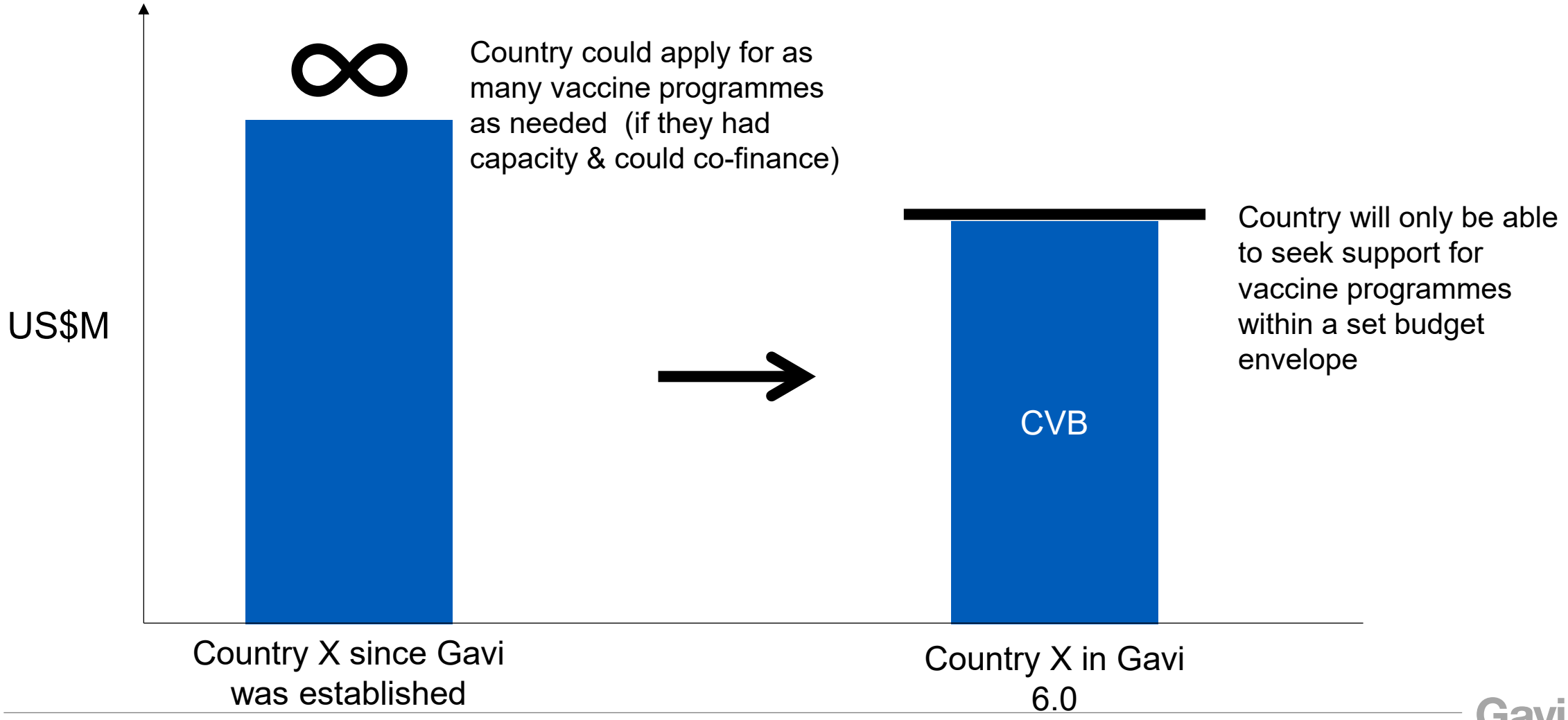
From unlimited to capped vaccine budgets



CVB are budget allocations provided to Gavi-eligible countries for their vaccine procurement support

What are CVB?	Set budget allocations provided to Gavi-eligible countries for their vaccine procurement support in Gavi 6.0.
What do they apply to?	All existing commitments for routine programmes, new vaccine introductions (including new Vaccine Investment Strategy (VIS) vaccines), and preventive campaigns (eg M/MR follow up and catch-up campaigns).
What do they NOT apply to?	Outbreak response vaccines (e.g. ICG stockpiles) and other cross-country vaccine procurement cost. Separate funds have been set aside for this (see slide 12)

CVB determined by combining two components

Country Vaccine Budget

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1 **Allocation for guaranteed vaccine programmes**

Funding for countries to maintain or introduce specific guaranteed vaccine programmes.

If a country choses to self-finance these programmes it can keep the funds and repurpose them for other Gavi-eligible programmes at their discretion.

Funding is reserved in 6.0 for each country to introduce these programmes. If a country choses to not introduce (or maintain), the equivalent funds are made available to other countries.

Calculated through the forecast.

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2 **Allocation for discretionary vaccine programmes**

Funding for countries to use at their own discretion for any other Gavi vaccine programme they are eligible for.

Funds can be used to maintain existing or introduce ‘non-guaranteed’ vaccine programmes or preventive campaigns.

Calculated through a formula-based approach.

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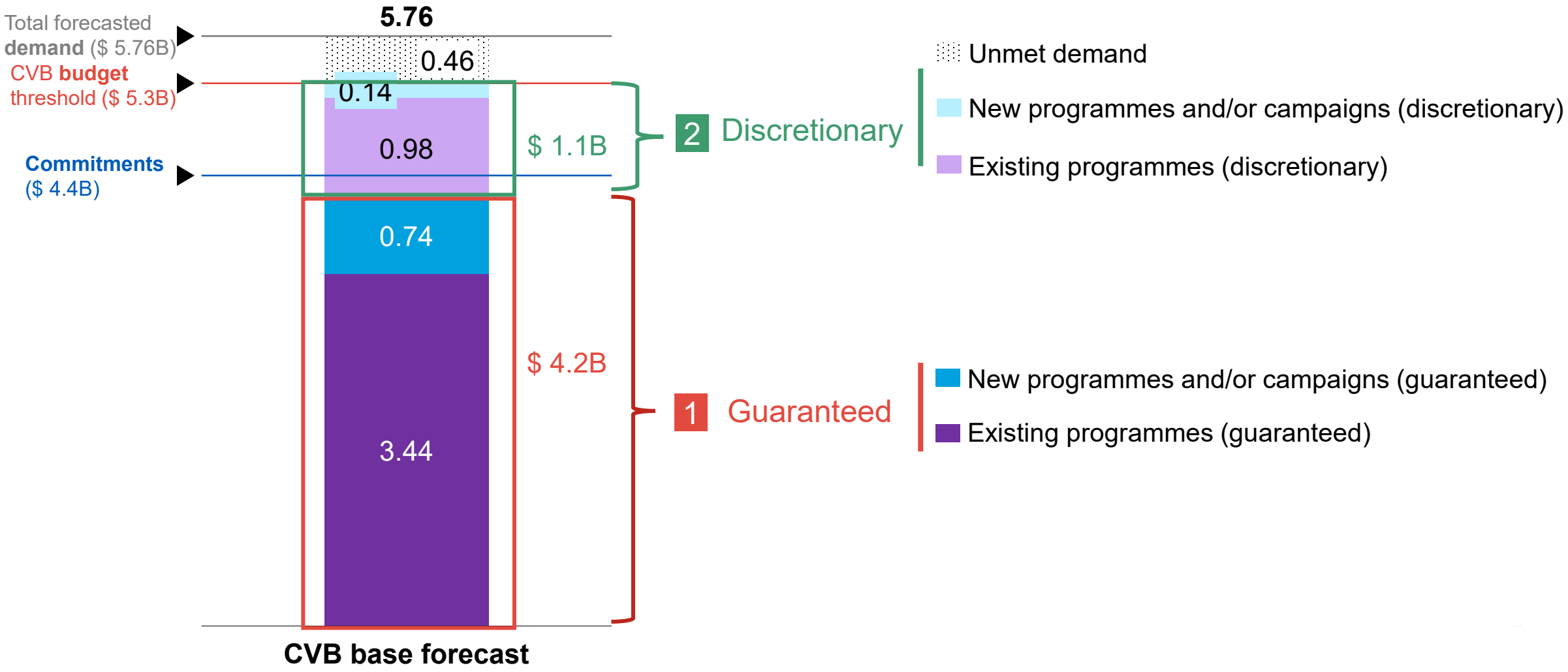
Guaranteed programmes prioritise highest value for money and global relevance

1. Guaranteed programmes	2. Discretionary programmes
Pentavalent	Malaria
Pneumococcal Conjugate (PCV) + Catch up	Yellow fever campaigns
Rotavirus	Japanese Encephalitis (JE) + catch up campaigns
Measles/ Measles Rubella (M/MR) + Catch up, follow up	Typhoid (TCV) + catch up campaigns
Human papillomavirus (HPV) + MACs	Cholera (OCV) campaigns
Inactivated Polio (IPV)	Meningococcal (Men A/MMCV) + catch up campaigns
Hexavalent	Rabies
Yellow Fever routine only	DTP-containing boosters
Hepatitis B Birth dose	Respiratory Syncytial Virus (RSV)

Rationale for guaranteed programmes: Prioritisation of programmes with the highest value for money (health impact and cost per life saved), global relevance (e.g. polio agenda), continuity of support, and inter-country equity

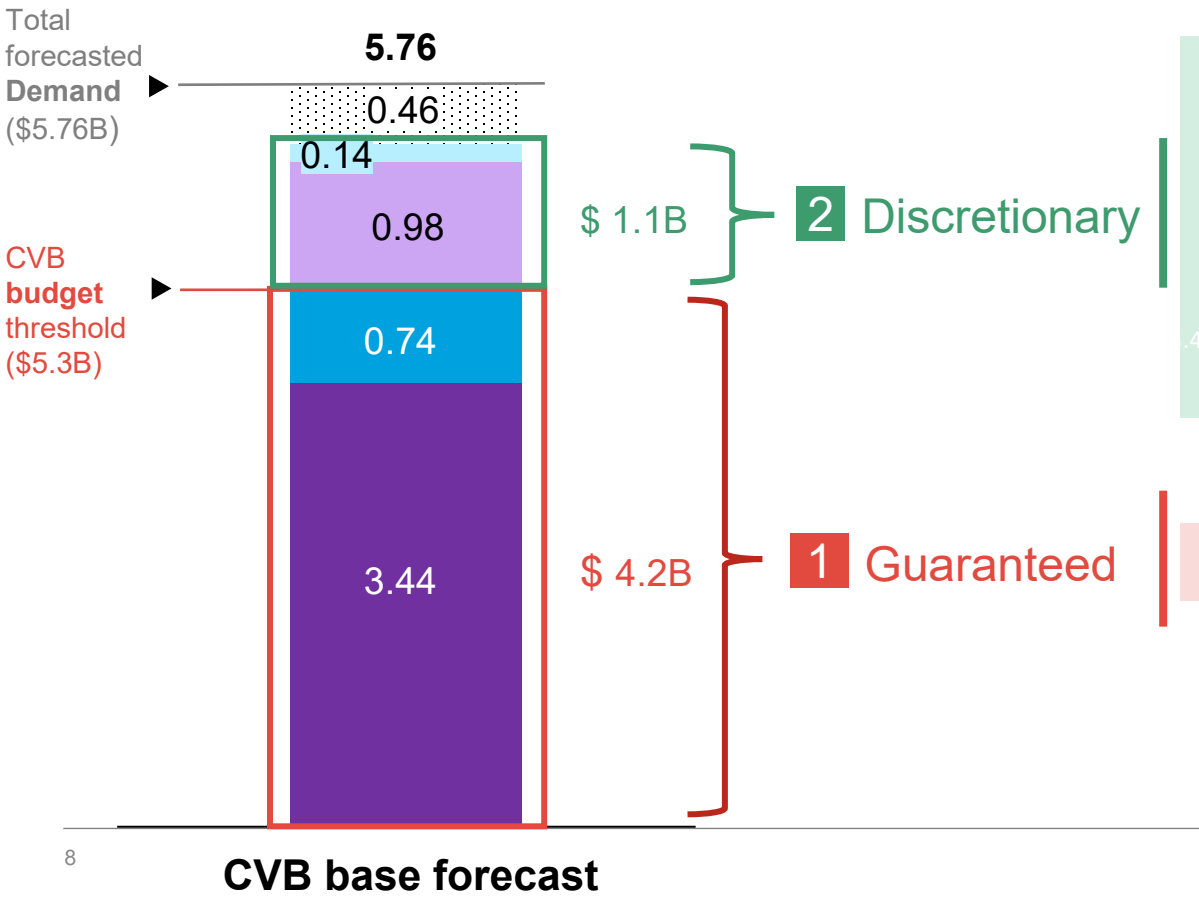
* Dengue/ TB/ GBS are VIS 2024 vaccines where vaccines are yet to be PQ'd
* Outbreaks and diagnostics are out of scope for CVB

79% of US$ 5.3 billion CVB funds guaranteed for specific existing and new programmes in Gavi 6.0



Simple allocation formula proposed for discretionary funding that favours poorest countries with highest number of under 5 deaths

A number of different formula were considered. The task team requested for simplicity and the least number of indicators. The proposed formula favours poorest countries with the highest number of under 5-year old deaths.



Allocation Formula-based calculation:

Inverse GNI p.c. scaled to Under-5 mortality

- Countries with high under-5 deaths and low GNI per capita get more funding.
- Optimises for health impact, equitable access, financial capacity

Forecast-based quantification

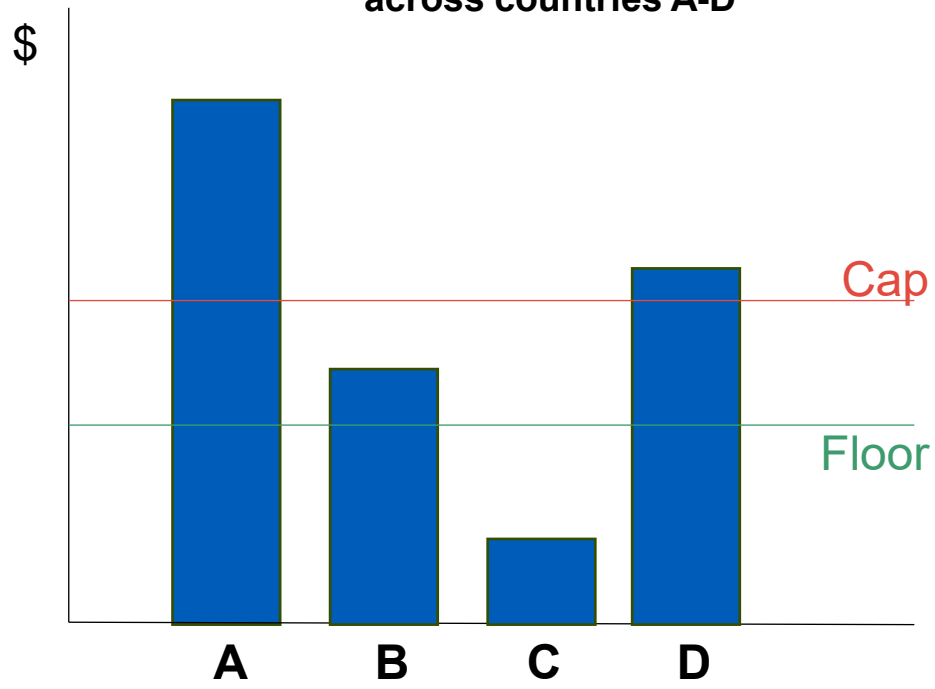
Allocation formula + caps and floors: balancing inter-country equity and continuity of support

- Allocation formula alone can create some imbalances:
- Some countries get less than needed for existing discretionary programmes.
- Others get more than needed, diverting funds.
- **Task team recommendation to set floors and caps:**

- **Floor:** Minimum allocation for **initial self-financing (ISF) countries** to cover **ongoing discretionary programmes.**
- *Rationale: Strengthen continuity of support by preventing harmful disruptions in countries with lowest fiscal capacity.*

- **Cap:** Maximum allocation at the level of **introducing all vaccines the country is eligible for**. Secretariat can lower cap if a country has limited absorptive capacity and redistribute any freed-up funds to other countries according to the CVB principles.
  Rationale: avoid overshoot considering absorptive capacity, while strengthening continuity of support by redistributing excess to other countries.

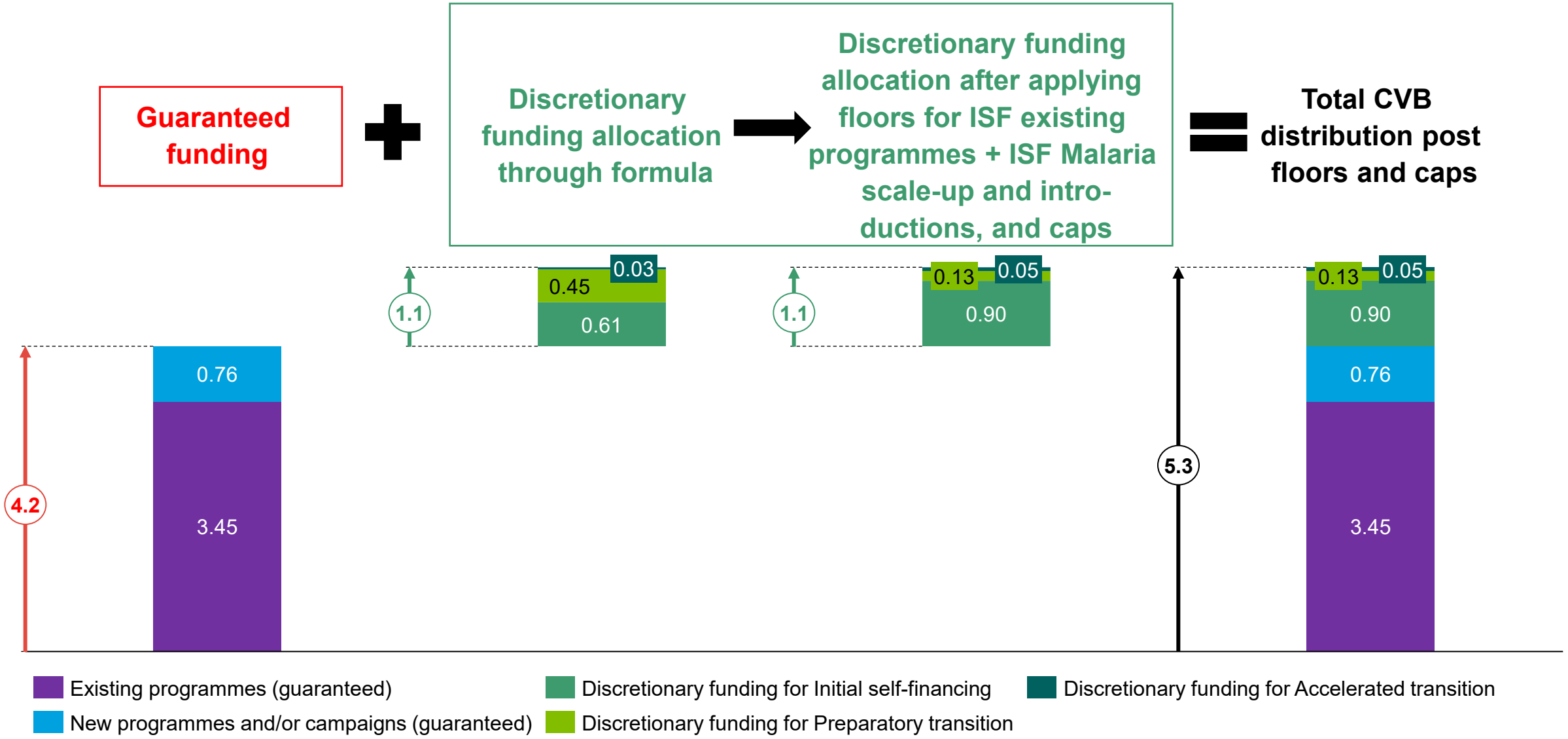
Distribution of discretionary funding across countries A-D



Countries A and D would be capped at the red line. Country C, if an ISF country, would be topped to the green line.

After 5th Task Team meeting (1 Dec.), the **ISF floor is recommended to include Malaria scale-up and new introduction costs**.

Discretionary allocation responds to higher need of ISF countries, including for malaria vaccines



Implications on malaria

Impact of CVB design choices

Total malaria programme costs (up to 70% programme scope) $848M

- 16% of total CVB budget
- Additional discretionary ISF floor assures $684M for Malaria programme costs

If all countries prioritise malaria within discretionary funds, available for malaria: $778M

- Second largest Gavi vaccine investment
- 92% of total programme cost (up to 70% cap)

8 countries would need to self-finance to reach 70% (gap of $70M, over 5 years)

- 5 PT countries: $63M (≈$12.6M per country on average)
- 3 AT countries: $7M (≈$2.3M per country on average)

Impact of 70% Malaria cap

CVB task team proposal to cap all countries at 70%, rather than 85% for those already implementing above 70%

- 13 countries already implementing above 70% (9 ISF, 2 PT, 2 AT)
- Total funding gap $75M
- Transition from >70% to 70%: 2026 as a grace period, and a proportional reduction over 2027 and 2028

Total funding gap from 70-85% and from CVB decision $145M

CVB will be reviewed periodically and include a reallocation mechanism

Overview

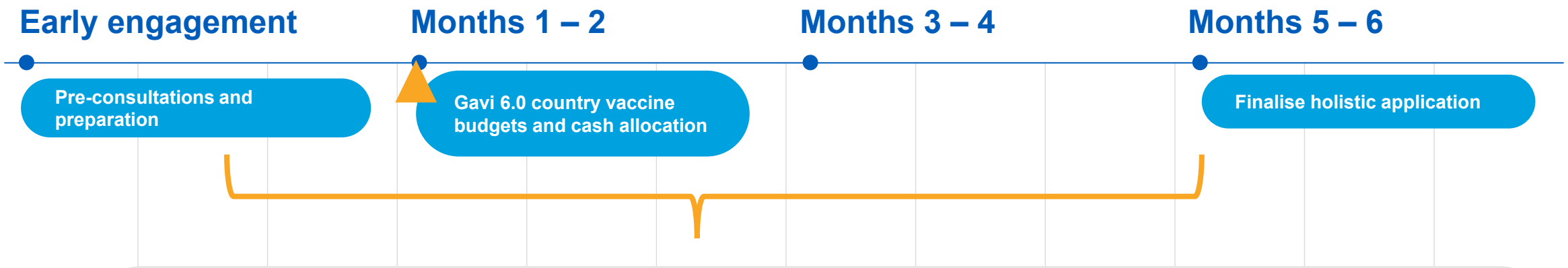
Country performance against CVB will be **reviewed periodically, with the possibility to reallocate funding,** based on **budget use and performance**

A similar review and reallocation process will apply to **prioritise CVB allocations if more or fewer Gavi resources become available**

Principles for review and reallocation

- Strengthen **budget management, financial discipline** and **predictable planning**
- Incentivise programmatic **performance** and **timely execution**
- Ensure **no funds sit idle**
- **Equitable** for all countries

VPOP is an enabler for countries to maximise the impact of their CVB in 6.0, applied mainly during their holistic application design



VPOP objectives:

- Country-led and evidence-based
- Facilitates trade-offs within limited funding envelopes

VPOP approach:

- Cross-Alliance coordination to provide tools, guidance, technical assistance, and capacity strengthening at country level

Stakeholders: Ministry of Health (inc. EPI team), National Immunisation Technical Advisory Groups (NITAGs), Ministry of Finance, Alliance partners

Country Vaccine Budgets | Recommendation (1/2)

The Gavi Board is requested to:

a) **Approve** the establishment of Country Vaccine Budgets (CVB) for the Gavi 6.0 strategic period;

b) **Approve** the approach to guaranteed programmes in CVB as set out in Doc 05b, including the inclusion of the following vaccines as guaranteed: Pentavalent, Inactivated Polio Vaccine or Hexavalent; Rotavirus; Hepatitis B birth dose; Yellow fever (routine), Measles/Measles Rubella (Routine, Catch up & follow up campaigns); Pneumococcal Conjugate (routine and catch up) and Human Papillomavirus (including Multi-Age Cohorts);

c) **Approve** the use of the under-five mortality rate inversely scaled by Gross National Income (GNI) per capita as the allocation methodology for distributing discretionary funding within the Country Vaccine Budgets;

Country Vaccine Budgets | Recommendation (2/2)

d) **Approve** the introduction of a “floor” for discretionary funding for Initial self financing (ISF) countries covering the forecasted cost of existing immunisation programmes as well as malaria scale up and new introductions;

e) **Approve** the introduction of a “cap”- a maximum allocation per country, calculated at the level of introducing all vaccines that the country is eligible for;

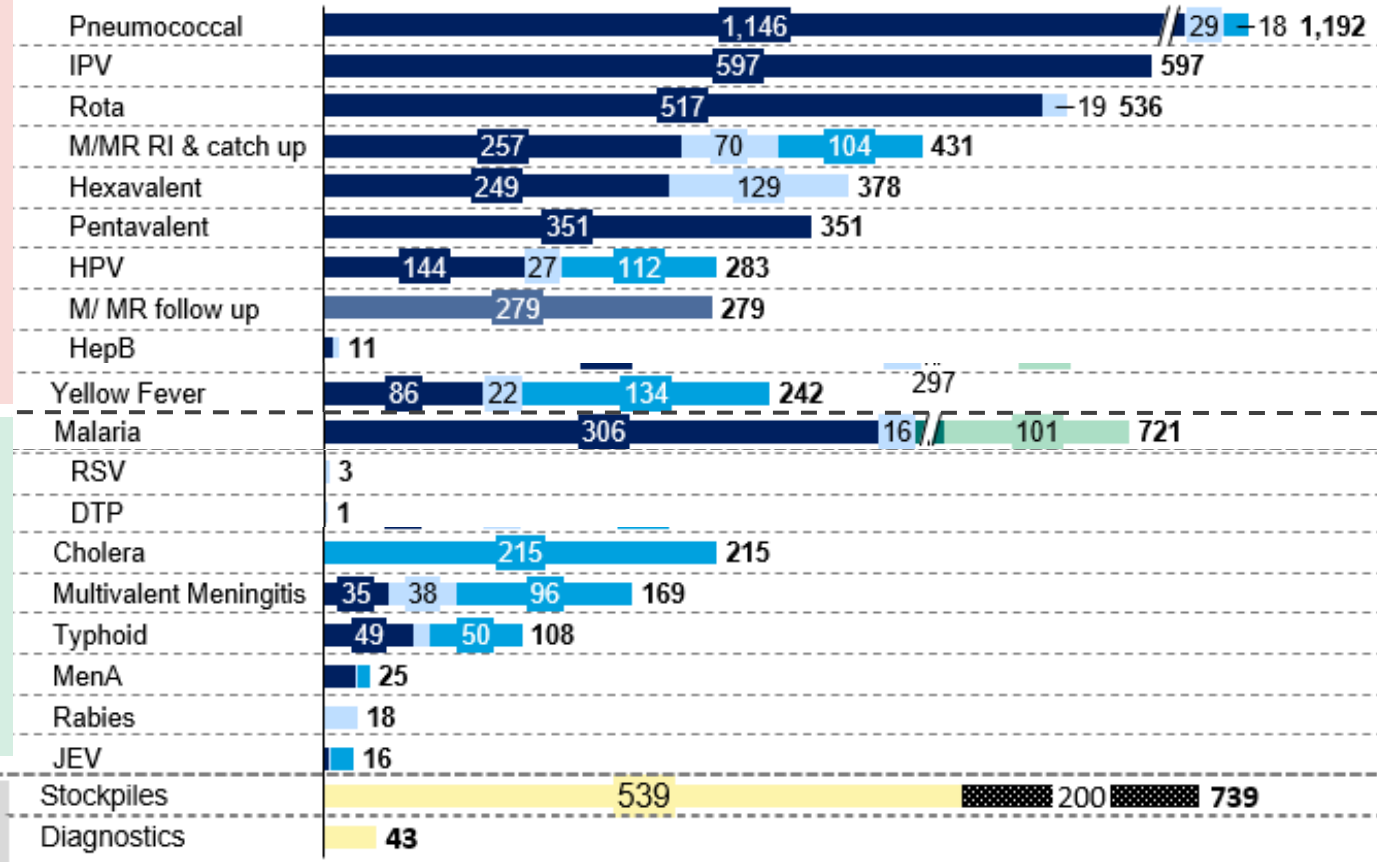
f) **Note** the ability of the Secretariat to adjust the initial discretionary allocations, including for setting a lower ceiling where absorptive capacity for new introductions is limited, and to redistribute the funding freed up to increase other countries’ discretionary allocations according to the principles of CVB;

g) **Provide guidance** on the approach for the periodic review of CVB allocations and an associated reallocation mechanism ensuring the optimal use of Gavi funding, to be brought back to the May 2026 Programme and Policy Committee and July 2026 Board meetings for decision;

h) **Provide guidance** on the approach to Vaccine Prioritisation and Optimisation (VPOP)

Gavi portfolio per vaccine programme used by Task Team to define guaranteed vs. discretionary programmes

Vaccine procurement cost per programme,v23.0 forecast, *$US million*[10]



	% of countries Introduced[4]	Future deaths adverted[5,6]	Future deaths adverted (per 100K FVP[5,7,8])	Cost per future death averted ($US[5,8,9])
Pneumococcal	93%	739,400	324	$1,550
IPV	77% (IPV2)	N/A	N/A	N/A
Rota	86%	256,400	120	$1,790
M/MR RI & catch up	80% (MR)	864,600	271	$893
Hexavalent	4%	N/A	N/A	N/A
Pentavalent	100%	2,712,600	1,200	$139
HPV	71%	1,571,800	1,294	$185
M/ MR follow up	NA	417,900	252	$615
HepB	41%	165,700	143	$140
Yellow Fever	92%	784,100	260	$498
Malaria	64%	145,000	341	$5,230
RSV	0%	4,300	88	$1,809
DTP	NA	500	27	$2,264
Cholera	NA	13,300	26	$17,189
Multivalent Meningitis	4%	30,100	71	$7,369
Typhoid	16%	100,900	100	$1,930
MenA	58%	26,500	51	$1,578
Rabies	36%	13,700	12	$2,596
JEV	0%	52,800	2,840	$306
Stockpiles	N/A	N/A	N/A	N/A
Diagnostics	N/A	N/A	N/A	N/A

1. Committed routine programmes:vaccine routine programme expenditures where decisions letters have been sent to countries, reflected in the forecast. For hexavalent MMCV commitments to countries that have not yet introduced Hexa are estimated based on the cost of continued support for Penta + IPV, assuming the switch does not occur 2.Preventive campaigns include all preventive and catch –up campaigns excluding M/MR Follow Up. 3. Includes stockpiles and outbreak response campaigns and diagnostics. 4. Launches are based on coverage data and VLD through end 2025. Eligibility based on the 56 Gavi eligible countries in 6.0, with regional values including only countries eligible to introduce those vaccines. 5. Estimates derived from the Gavi perspective, i.e., impact through Gavi-supported vaccinations and costs to Gavi. Estimates for hexavalent and MMCV are calculated incrementally to pentavalent and MenA respectively. Estimates for hexavalent and MMCV are calculated incrementally to pentavalent and MenA, respectively. Hexavalent: As pentavalent and hexavalent provide equivalent protection with a 3-dose schedule, switching to hexavalent does not result in additional deaths averted but programmatic efficiency. MMCV: The incremental impact reflects protection against MenCWXY (38%) and the booster protection for MenA achieved through catch-up campaigns during MMCV introduction (62%). 6. Estimates derived by scaling health impacts associated with the v22.1 forecast by the change in FVPs from v22.1 and v23. The health impacts associated with the v23 are in development 7. FVP= Fully vaccinated person. 8. Calculated based on the v22.1 forecast with recalibration decisions applied. 9. Costs include Gavi vaccine procurement costs and immunization cash support 10. Based on 2026 forecast numbers. Includes SG1, SG3, SG4 impacts, interdependencies, prepaid doses and other underlying forecast updates integrated at programme level. Does not reflect country-led reductions or stretched additional market shaping savings targets set by the Board at the 2025 July Retreat or any other adjustments to meet Recalibration targets. Adjustments pertaining to India 5.0 and supply cofinancing have been integrated into the antigen level forecasts. $195M adjustments not shown include delayed 5.1 launches,