Gavi 6.0 Funding Guidelines

Gavi
The Vaccine Alliance

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Contents

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Acronyms

Acronym	Full Term
AT	Accelerated transition phase
BeSD	Behavioural and social drivers
CCE	Cold chain equipment
CP	Catalytic phase
CSO	Civil society organisation
EPI	Expanded Programme on Immunization
FED	Fragility, Emergencies and Displaced Populations (FED) policy
GAF	Grant Accountability Framework
GMS	Grant management system
GNI	Gross national income
GRM	Gavi Resilience Mechanism
ICG	International Coordinating Group on Vaccine Provision
IDA	International Development Association
IRC	Independent Review Committee
ISF	Initial self-financing phase
IVB	Immunization, Vaccines and Biologicals Department (WHO)
MNCH	Maternal, newborn, and child health
M&RP ORF	Measles & Rubella Partnership Outbreak Response Fund
NVI	New vaccine introduction
OOC	One-off costs
PEP	Post-exposure prophylaxis
PT	Preparatory transition phase
RCM	Rapid cycle monitoring
RFP	Request for proposals
SCM	Senior Country Manager
SOP	Standard operating procedure
TA	Technical assistance
UNICEF	United Nations Children’s Fund
VCF	Vaccine catalytic financing
VPOP	Vaccine Portfolio Optimisation and Prioritisation
WHO	World Health Organization
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

At a glance

What is this guidance for?	• Explain the scope of Gavi support to countries in the 2026–2030 strategic period (Gavi 6.0), including vaccine and cash funding. • Explain how countries should plan and prioritise their immunisation programmes within the vaccine and cash support that Gavi provides. • Clarify requirements for the Gavi 6.0 country application. • Describe how to access other types of support (e.g. outbreaks, emergencies).
Who is this guidance for?	**Countries in one of Gavi's four transition phases**: initial self-financing (ISF), preparatory transition (PT), accelerated transition (AT), and catalytic phase (CP) See Gavi's Eligibility policy here: https://www.gavi.org/programmes-impact/programmatic-policies/eligibility-policy
What is new in Gavi 6.0?	**For ISF, PT, and AT countries:** • **One country application**, aligned to the Gavi 6.0 strategic period, covering both vaccines and cash to deepen country decision-making. • **One vaccine budget** for procurement of Gavi-supported vaccines for the entire strategic period (2026–2030), making planning and budgeting more predictable and helping guide countries to prioritise. • **One cash budget** for the entire strategic period (2026–2030), consolidating multiple cash grants into one budget to bolster country ownership and facilitate integration. • **New co-financing rules** including percentage-based co-financing for selected vaccines in ISF countries, caps for PT countries, new co-financing requirements for Gavi-supported campaigns, and updated requirements for malaria vaccines. **For catalytic phase countries:** • Targeted support for new vaccine introductions in former and never Gavi-supported middle-income countries. **For fragile and humanitarian (F&H) contexts, emergencies, and unforeseen needs:** • A **fragile and humanitarian approach**, providing tailored support for countries facing fragility or emergencies, backed by the new Gavi Resilience Mechanism for unforeseen needs. • **Outbreak response**: separate support for outbreak vaccination through global mechanisms, including the International Coordinating Group on Vaccine Provision (ICG)-managed stockpiles. • **First Response Fund**: pre-positioned surge financing for major public health emergencies, including outbreaks, epidemics and pandemics. **For countries in all transition phases:** • **One grant accountability framework**, offering a more holistic view of grant performance including expected contributions of individual grantees, and streamlining reporting and reviews. • **One grants management system**, a new digital platform to submit applications, and which consolidates all funding data in one place, simplifying grant management and reporting.
Duration of support	**For ISF, PT, and AT countries:** the grant covers the Gavi 6.0 strategic period (2026–2030). **For catalytic phase countries:** programmes are timebound (up to two years) and operate independently of the five-year grant cycle, allowing countries to access support at any point in the Gavi 6.0 strategic period.
How to apply	Countries submit their applications through the grants management system, in coordination with the Gavi Secretariat Country Team.
Where to get help	Countries should contact their Gavi Secretariat Senior Country Manager as the first point of contact.

1. Introduction

1.1. Purpose of these guidelines

These guidelines explain how countries can plan for and access Gavi support during the 2026–2030 strategic period (Gavi 6.0). They set out the types of support available, how this support can advance national immunisation objectives in line with Gavi's strategic goals, and the pathways through which countries can access it.

Details on application development, submission, and review are provided in Annex 2: Process Guidelines.

1.2. Who these guidelines are for

These guidelines are for countries in one of Gavi's four transition phases: initial self-financing (ISF), preparatory transition (PT), accelerated transition (AT), and catalytic phase (CP); and for the national stakeholders, Alliance partners, and other organisations involved in planning, applying for, implementing, and overseeing that support.

Refer to Gavi's Eligibility policy and the current list of eligible countries here: https://www.gavi.org/programmes-impact/programmatic-policies/eligibility-policy

In these guidelines, "countries" refers to the national authorities and institutions responsible for planning, applying for and overseeing Gavi support. "Grantees" refers, where relevant, to all entities that receive and manage Gavi funds.

1.3. How to use this document

This document is organised into five parts, Parts A to E, reflecting how different types of support are accessed.

Part A: Planned support through the country application (ISF, AT, PT countries)

Part A describes how Gavi support is structured in Gavi 6.0 and the types of support countries can request including:

- **The vaccine budget** to support vaccine procurement
- **The cash budget** for health systems and delivery support to strengthen routine immunisation, support new vaccine introductions, plan and implement preventive campaigns. This also includes support for cold chain equipment procurement and technical assistance provided by core partners (UNICEF, WHO, World Bank, CDC/F); and/or by expanded partners such as CSOs (not-for-profit), private sector (for-profit) and other UN agencies.
- **Diagnostic support**, the diseases for which it is available, and how countries can access it.

It also provides guidance on how countries should prioritise and sequence investments within available resources when preparing their Gavi 6.0 application. It sets out the approach to country-led planning and prioritisation across vaccine programmes, cash-supported interventions, campaigns,

and technical assistance, aligned with national objectives and the National Immunization Strategy (NIS).

Part B: Co-financing and country joint investment requirements (all countries)

Part B explains the co-financing and country joint investment requirements that apply to countries, including routine vaccines, preventive campaigns and cold chain equipment.

Part C: Catalytic phase support (catalytic phase countries only)

Part C explains the planned support available to countries in the catalytic phase (CP).

Part D: Emergency support, outbreak response, and unforeseen needs (all countries)

Part D explains how countries across ISF, PT, AT, and CP can access **additional support outside the application** in response to unforeseen events, including outbreaks, emergencies, and pandemics, through global mechanisms and dedicated Gavi emergency funding.

Part E: Grant monitoring (all countries)

Part E sets out expectations for grant implementation, monitoring, learning, and accountability once support has been approved.

Throughout the document, dedicated call-out boxes appear:

Guidance for fragile and humanitarian (F&H) settings
A dedicated call-out box highlights how the approach is adapted for fragile and humanitarian settings, setting out any tailored support, requirements, or considerations. Countries and partners working in F&H settings should consult both the main guidelines and the relevant F&H-specific provisions. Refer to Gavi Board paper on F&H approach (paper 10, July 2025 meeting): https://www.gavi.org/governance/gavi-board/minutes/24-25-july-2025

Key references
A dedicated call-out box to provide links to relevant Gavi policies, Board papers, and other supporting documents and resources from Alliance partners. • **Gavi Board papers:** https://www.gavi.org/about-us/governance/gavi-board • **Gavi programmatic policies:** https://www.gavi.org/partner-countries/programmatic-policies • **Alliance partner guidance and tools:** relevant technical guidance and resources will be referenced throughout these guidelines, where applicable

1.4. What has changed in Gavi 6.0

Gavi 6.0 support is designed to help countries introduce and sustain priority vaccine programmes, reach missed children – especially zero-dose and under-immunised children, whether through routine

immunisation or campaigns – and strengthen the sustainability of national immunisation programmes over time. The Gavi 6.0 strategy sets out programmatic priorities and introduces several shifts from the previous strategic period, to shape the Alliance's support to countries. Many of these shifts aim to facilitate programmatic integration and enable prioritisation of Gavi-supported investments across vaccines and cash support while strengthening the impact, efficiency and sustainability of immunisation.

Vaccines:

- Gavi 6.0 provides eligible countries with access to the widest portfolio of critical life-saving vaccines ever.

- The Alliance supports countries to introduce and scale up vaccines for prevention of endemic and outbreak-prone diseases through newly introduced, country-specific vaccine budgets that cover the entire strategic period. Within this budget, countries will need to strengthen prioritisation and optimisation of their vaccine programmes to maximise health outcomes, including through improving effectiveness of preventive vaccination campaigns. More details in Part A – Vaccine Budget.

- Gavi also continues to offer equitable and timely access to vaccines and operational funding to respond to outbreaks, epidemics, and pandemics. This includes mechanisms like expanded vaccine stockpiles and a new 'First Response Fund' for major public health emergencies. More details in Part D.

Health Systems Strategy and equity:

- Through a new Health Systems Strategy and country-specific cash budgets and technical assistance, the Alliance will support countries to strengthen the equity and sustainability of routine immunisation. Key shifts include a focus on integrated planning of Gavi support and on primary health care-oriented investments (e.g. through aligning with other funders like the Global Fund and multilateral development banks), as well as stronger monitoring of health systems investments. A new differentiation framework helps countries tailor support based on their needs and context. It includes a set of innovative 'flagship interventions' which are expected to have the greatest catalytic impact. See more details in Part A – Cash Budget.

- A new fragile and humanitarian approach introduces targeted shifts to enable better reach in difficult settings. These include support for children aged one to five years who have never been vaccinated, differentiated support for hard-to-reach areas, and new ways to channel Gavi support more effectively to communities left behind. Countries with sub-national fragile areas and catalytic phase countries facing fragility or emergencies can receive specific support. A new funding mechanism (Gavi Resilience Mechanism) helps respond to unforeseen needs arising during the Gavi 6.0 strategy period. See more details in Part D.

Sustainability:

- Gavi continues to focus on making immunisation sustainable, both financially and programmatically. In Gavi 6.0, this brings changes to how countries transition away from Gavi support. Alongside updated co-financing rules for vaccines and cold chain equipment used in routine immunisation, these include increased and more consistent co-financing of vaccines

used in preventive vaccination campaigns. A new Gavi catalytic phase provides targeted support for new vaccine introductions in former and never Gavi-supported middle-income countries.

- In rare cases of widespread, large-scale conflict or disaster profoundly hampering government functioning, a country may be considered for a co-financing waiver (up to three years) or a partial co-financing obligation.

Gavi 6.0 funding architecture:

- **One application for all Gavi support:** Countries will submit one new country application or reprogramme and consolidate existing grants into a Gavi 6.0 vaccine and cash grant. To maximise the impact, efficiency and sustainability of Gavi support, countries are encouraged to adopt an integrated, holistic approach in their funding applications that brings together vaccine procurement needs with their cash support requests.

- **One vaccine budget for ISF, PT, and AT countries:** Countries will obtain one vaccine budget to support the procurement of vaccines for the Gavi 6.0 period. It comprises two parts: (1) a guaranteed budget for specific vaccines; and (2) a discretionary budget for other Gavi-eligible vaccines. Countries will have received an indicative budget in March 2026. Final vaccine budgets will be communicated in July 2026.

- **One cash budget for ISF, PT, and AT countries:** Countries will receive one cash budget to support health systems and immunisation strengthening. Three guardrails will apply within this budget: (i) minimum 10% allocation of total cash budget for civil society organisations; (ii) minimum spend for purchase of cold chain equipment, and (iii) a minimum and maximum spend on operational costs for measles/measles-rubella (M/MR) follow-up vaccination campaigns, with each country's specific range communicated individually. This cash budget consolidates previous Gavi grants, including Health System Strengthening (HSS), Equity Accelerator Funding (EAF), TCA (Targeted Country Assistance), Cold Chain Equipment Optimisation Platform (CCEOP) and cash for new vaccine introductions, switches and campaign operations. In March 2026, each country received an indicative cash budget for the Gavi 6.0 period. Final cash budgets will be communicated in July 2026.

  Countries can plan for and access technical assistance through two routes: Country Foundations Grants, which provide long-term, predictable support for the five essential immunisation functions delivered primarily through WHO, UNICEF and, in some contexts, other partners; and through the cash budget, which now integrates most of the technical support that was previously provided through separate mechanisms. Countries are expected to plan for, prioritise and account for any additional technical assistance needs within their cash budget beyond what is provided in the Country Foundations grants.

- **Gavi Grant Accountability Framework**: Under Gavi 6.0, the Grant Accountability Framework (GAF) replaces the previous Monitoring and Learning approach with a more integrated and implementation-focused model. Monitoring now places greater emphasis on grantee-level results, such as budget use, activity implementation, and a mix of required and tailored indicators against which grantees are expected to set targets. Monitoring of the GAF should be based on a strong foundation of regular subnational monitoring and review.

Table 1: Summary of key changes from Gavi 5.0/5.1 to Gavi 6.0

Category	*From (Gavi 5.0/5.1)*	*To (Gavi 6.0)*
Vaccine support	Countries applied for eligible vaccine support on a rolling basis.	**One vaccine budget**: countries receive a defined vaccine budget for the entire 6.0 period and must prioritise within it.
Cash support	Multiple separate cash funding streams.	**One cash budget**: countries receive a set cash budget for the entire 6.0 period that consolidates previous Gavi grants.
Co-financing	ISF countries paid a flat US$ 0.20 per dose for most vaccines; no co-financing applied to preventive campaigns; no caps for PT countries; bespoke co-financing rules for malaria vaccines.	For selected vaccine programmes, ISF countries co-finance based on a percentage of vaccine price, including 4% for HPV and 7% for PCV. Co-financing applies to Gavi-supported preventive campaigns at 5%, 10%, or 20%, depending on transition phase, with an exception for ISF countries in 2026. Co-financing capped at 80% for PT countries. New co-financing rules for malaria vaccines apply: ISF: US$ 0.20 per dose (unchanged), PT: starts at US$ 0.20, increases 30% annually, AT: Standard policy, linear increase to 100% in fully self-financing phase. **Country joint investment for CCE:** reduced in Gavi 6.0, from 20% to 10% for ISF, 50% to 20% for PT and 50% to 35% for AT.
Application model	Multiple vaccine and cash grants and rolling applications throughout the strategic period across these.	**One country application** submitted within the first two years of the 6.0 period covering both vaccine and cash support. Countries that recently went through a full portfolio planning process can instead consolidate and reprogramme their existing grants within the new cash and vaccine budgets.
Technical assistance	Technical assistance was accessed through a mix of separate mechanisms, including standalone support streams.	Long-term core functions supported through Country Foundations and additional support financed through cash budget.
Fragility and emergencies	Support for fragility and emergencies was available through existing policies and mechanisms, but pathways were more fragmented.	Gavi 6.0 introduces a more explicit F&H approach, including tailored support pathways and the Gavi Resilience Mechanism for unforeseen needs, and the First Response Fund for major public health emergencies.
Monitoring	Previous grant-specific monitoring approaches.	A revised Grant Accountability Framework supports monitoring of integrated grants and the contributions of individual grantees.

1.5. Overview of Gavi 6.0 support pathways

Gavi 6.0 provides countries with an integrated package of support; from procuring vaccines to delivering them through routine immunisation and preventive campaigns, complemented by targeted diagnostics and health system and immunisation strengthening investments.

Table 2: Gavi 6.0 support and access pathways

Type/applicable countries	Support area	What Gavi supports in 6.0	How support is accessed
Planned – ISF, PT, AT	Vaccine procurement (routine programmes, new routine introductions, preventive campaigns)	Procurement of vaccines for existing routine immunisation programmes, planned new introductions and scale-up, one-off catch-up campaigns linked to introductions, periodic measles/measles-rubella follow-up campaigns, and targeted or mass preventive campaigns.	Country application or reprogramming, with financing provided through the **vaccine budget.**
Planned – ISF, PT, AT	Health system and immunisation strengthening support	Strengthening of routine immunisation, including cold chain equipment, operational support for new vaccine introductions, and planning and implementation of preventive campaigns.	Country application or reprogramming and consolidation of existing grants, with financing provided through the **cash budget.**
Planned – ISF, PT, AT	Diagnostics (linked to vaccines)	Procurement of diagnostics for selected diseases with adjunct vaccine programmes, including cholera, yellow fever, and measles, to support effective targeted vaccination.	Country application. Financing provided through separate diagnostics procurement support, **outside of vaccine budget and cash budget.**
Planned – ISF, PT, AT	Technical Assistance (TA)	Both short-term, project-based TA and longer-term TA support covering staff and operational costs for sustainable programme delivery.	Country application or reprogramming and consolidation of existing grants, with financing provided through the cash budget. Financing provided through the **cash budget** (short- and long-term TA). For long-term essential functions, through the **Country Foundation Support** application and grant.
Planned – Catalytic phase	Catalytic phase support	Time-limited, targeted support for new vaccine introductions, vaccine optimisation, product switches, and, where relevant, fragility- and emergency-related support.	Country application, financed through the differentiated support arrangements for **catalytic phase countries.**
Unplanned – ISF, PT, AT, and catalytic phase	Outbreaks and emergencies vaccine procurement and operational funding	Vaccine procurement, operational funding, and other support in response to confirmed outbreaks, epidemics, pandemics, and other eligible unforeseen needs.	Accessed **through dedicated mechanisms**, outside the country application and vaccine and cash budgets.

1.6. Eligibility

Gavi's support is designed to prioritise the world's lowest-income countries, using gross national income (GNI) per capita as the primary eligibility criterion. For 2026, the threshold for eligibility for Gavi support is US$ 2,300 GNI per capita (based on World Bank Atlas method data from 2024). Eligibility is reassessed annually and determines a country's placement within one of four transition phases, each with distinct funding and co-financing requirements.

Guidance for fragile and humanitarian settings
Gavi 6.0 recognises that fragile and humanitarian (F&H) settings require a differentiated approach to programme funding. Countries classified as fragile under the Fragility, Emergencies and Displaced Populations (FED) policy, as well as subnational fragile areas in non-fragile countries, may access tailored support pathways described throughout these guidelines. Countries with identified subnational fragile areas should work with their Senior Country Manager to determine eligibility and access pathways for differentiated support.

Key reference
Refer to **Gavi's Eligibility policy** and the current list of eligible countries here: https://www.gavi.org/programmes-impact/programmatic-policies/eligibility-policy

Part A. Planned support through the country application (ISF, PT, AT countries)

Part A sets out the planned support available to countries in the Initial Self-Financing, Preparatory Transition, and Accelerated Transition phases under Gavi 6.0. With defined vaccine and cash budgets, countries will need to plan holistically and prioritise across both within available resources. This includes making deliberate choices about which vaccine programmes to maintain, introduce, scale up, or optimise, and which delivery, systems, campaign, and technical assistance investments to prioritise alongside them. Countries are encouraged to undertake a country-led portfolio prioritisation exercise to inform these decisions, drawing on national priorities, including the National Immunization Strategy (NIS), available domestic and external resources, and long-term affordability. **Prioritisation and optimisation across both vaccine and cash support are therefore core features of Gavi 6.0**.

Key points:

- All planning for routine services, introductions and campaigns should prioritise zero-dose children and missed communities.
- Countries should identify and address gender-related barriers to ensure equitable access to vaccines for all populations.
- Gavi support is intended to be catalytic. As part of prioritisation, countries are encouraged to consider the medium- to long-term programmatic and financial implications of their choices including country co-financing, and sustained domestic financing commitments, as well as long-term strategic health system strengthening, are essential to ensure programmatic and financial sustainability.
- Gavi support is primarily aimed at supporting the timely delivery of routine vaccination as the core of the national immunisation programmes to deliver vaccines and reach immunisation targets effectively and efficiently. Considerations are explicitly provided for countries requesting campaign support.

Further guidance
See **Annex 1: Prioritisation guidance** for detailed guidance on country-led vaccine and cash prioritisation and optimisation as well as links to available tools and resources.

2. Vaccines

2.1. Vaccine Portfolio Optimisation and Prioritisation (VPOP)

The country-led planning process to assess vaccine priorities is the Vaccine Portfolio Optimisation and Prioritisation (VPOP), which for this purpose is defined as follows:

Prioritisation: Choosing which programmatic objectives to prioritise, which vaccines to invest in, and in what sequence. Particularly relevant when limited by resources, country capacity or supply scarcity, countries need to assess in a systematic, evidence-informed way which vaccines to introduce, scale up and/or maintain within available resources, reflecting their context, needs, and long-term sustainability.

Optimisation: Choosing which vaccine products, presentations or schedules are best for the country context (see Table 3 below for Gavi-supported options). This process is an opportunity for countries to review and assess their existing vaccine portfolio, inclusive of their costing implications to maximise impact, efficiency and coverage. For some countries, savings from optimisation decisions can release resources and support expanding the options of prioritisation decisions.

As countries are provided with a set vaccine budget for vaccine procurement, there will be trade-offs required and more strategic decision-making in Gavi 6.0. Countries are encouraged to review their portfolio against relevant criteria inclusive of programmatic implications, cost and operational impact, following an evidence-based approach and centred around their National Immunization Strategy (NIS).

Gavi and partners have developed guidance, tools and technical support that help National Immunization Technical Advisory Groups (NITAGs), Expanded Programme on Immunization (EPI) teams, Ministries of Health (MoHs) and Ministries of Finance (MoFs) navigate these trade-offs. All decisions to introduce vaccines, conduct campaigns, or introduce switches are expected to be informed by national technical processes, including discussion and recommendation by NITAG or equivalent body; where a NITAG does not exist, countries should outline plans to establish one as part of requests for new vaccine support.

Beyond the initial preparation to develop a holistic application, there are other moments when a country might need to assess their portfolio, such as a new technical recommendation being available (i.e. Strategic Advisory Group of Experts (SAGE)) or changes in the vaccine market. If this assessment results in a decision to switch or reprioritise new vaccine introductions (NVIs), a country can request this change as part of a grant modification process.

Table 3. Overview of optimisation options within the Gavi portfolio

Vaccine	Product formulation/presentation	Schedule
Human papillomavirus (HPV)	• 4 product options (+1 submitted for WHO Prequalification (PQ))	• Shift to single-dose schedule
Pneumococcal conjugate vaccine (PCV)	• 4 product options • Presentation switch from 4 to 5 doses/vial	• 3+0 or 2+1 schedule • 1+1 schedule for mature programmes meeting specific criteria*
Rotavirus	• 3 product options • Presentation switch from 1 to 5 doses/vial or from 5- to 10-dose vials	N/A

Pentavalent + Inactivated polio vaccine (IPV)/Hexavalent	• Presentation options for Penta and IPV	• Switch to 3-dose Hexa schedule from 4 dose Hexa or 3 Penta + 2 IPV
Yellow fever	• Presentation switch from 10 to 5 doses/vial	N/A
Meningococcal Meningitis	• Replacement of MenA with Men5CV (MenACYWX)	N/A
Measles/measles-rubella (M/MR)	• Presentation switch from 10 to 5 doses/vial	N/A
Inactivated polio vaccine (IPV)	• Schedule switch • Switch to 2nd dose IPV	N/A
Pentavalent	• Introduction/Schedule switch • DTwP or Penta for second year of life (2YL) booster	N/A

2.2. Vaccine budget and eligible vaccine programmes

The vaccine budget is the funding available to a country for vaccine procurement during the Gavi 6.0 period (2026–2030). It supports more predictable planning and requires countries to make choices within a defined budget. The vaccine budget covers routine vaccine programmes, new vaccine introductions, switches and planned preventive campaigns. It does not cover vaccines for outbreak response, epidemics and/or pandemics, which are accessed through separate mechanisms.

Further guidance
Further guidance on emergency support, outbreak response and unforeseen needs is provided in Part D.

Gavi-eligible vaccines are categorised into two vaccine budget portions: 'guaranteed' and 'discretionary'. Considerations for inclusion of vaccines in the guaranteed portion include health impact, value for money, global relevance, inter-country equity, and continuity of support. This is not based on or referring to WHO guidance or country policy.

Table 4: Components of vaccine budgets

Component	Description	Vaccine programmes
Guaranteed budget	To continue funding existing vaccine programmes or to introduce new ones/conduct preventive immunisation campaigns according to the vaccines listed on the right. Calculated based on the forecasted demand over 6.0.	• **Hepatitis B birth dose** • **Human papillomavirus (HPV)** (including initial multiage cohort) • **Measles/measles-rubella (M/MR)** (routine including five-dose presentation switch, catch-up 6/9m–<10y, and follow-up campaigns 6/9m–59m) • **Pentavalent and inactivated polio vaccine (IPV) or Hexavalent**

		• **Pneumococcal conjugate** (routine and catch-up) • **Rotavirus** • **Yellow fever** (routine only)
Discretionary budget	To fund all other Gavi-eligible vaccines according to the list on the right. These funds may not be sufficient to cover all needs. Countries must use their discretion to consider trade-offs or mobilise additional funds to self-finance these vaccines. Calculated based on an allocation formula (under-five mortality inversely scaled to GNI per capita).	All other vaccines (limited to the allocated budget) in the Gavi menu, which currently include: • **Diphtheria, tetanus, and pertussis-containing (DTP) boosters** • **Japanese encephalitis (JE)** (+ catch-up) • **Malaria** • **Meningococcal A/Multivalent meningococcal conjugate vaccine (MMCV)** (+ catch-up) • **Oral cholera vaccine (OCV) campaigns** • **Rabies post-exposure prophylaxis (PEP)** • **Respiratory syncytial virus (RSV)** • **Typhoid conjugate vaccine (TCV)** (+ catch-up) • **Yellow fever campaigns** • **Wider age range for M/MR follow-up (>5 years) or catch-up (10–14 years)** • M/MR routine doses 24–59m (e.g. for PIRI) • Future vaccines including potential dengue, Group B streptococcus (GBS) and tuberculosis will be added as they become available.

Key points:

- The terms **'**guaranteed' and 'discretionary' refer to the Gavi-funded portion of vaccine financing only. They do not describe the full cost of the vaccine programme, which may also include country co-financing where applicable.
- The guaranteed budget is based on forecast demand over the 6.0 period, informed by standard assumptions used by Gavi for budget-setting. The discretionary budget is allocated through a formula designed to balance simplicity and equity, with a greater share directed to countries with lower income and higher under-five mortality.
- Vaccine-specific scope, eligibility, and co-financing rules continue to apply, as set out in these guidelines and Annex 3: Vaccine Menu.
- Within the vaccine budget, discretionary funding may not be sufficient to cover all possible vaccine introductions or sustain all programmes under that budget. Countries may therefore need to prioritise which programmes to maintain or introduce, optimise existing programmes, or self-finance some programmes where needed.
- The guaranteed budget cannot be used to procure vaccines listed in the discretionary budget unless a country chooses to fully self-finance a programme under the guaranteed budget list. In that case it may reallocate the equivalent Gavi funds to other vaccines listed in the discretionary budget list. However, if a guaranteed programme is discontinued or not introduced within the strategic period, the associated Gavi funds are available and cannot be used.
- For ISF countries, Gavi ensures that the vaccine budgets cover the Gavi share of:
    - the forecasted cost of existing immunisation programmes categorised under the discretionary budget; and

- malaria vaccine scale-up and new malaria vaccine introductions in up to 70% of moderate- to high-transmission areas.

Further guidance
See **Annex 3: Vaccine Menu** for detailed, vaccine-specific guidance on eligibility, support modalities, and requirements. See **Part D** for support available for outbreak response vaccines and other unforeseen needs. For product information for vaccines and cold chain equipment, see https://www.gavi.org/our-work/market-shaping/product-information-vaccines-cold-chain-equipment

2.3. Uses of vaccine procurement support

Gavi's vaccine support includes procurement of WHO-prequalified vaccines through UNICEF Supply Division, according to Gavi's Detailed Product Profiles.

Vaccine support may cover routine delivery through fixed-site, outreach, mobile, and school-based services, as well as periodic intensification of routine immunisation (PIRI) and planned preventive campaigns. It may also include catch-up doses for previously missed children, including children up to five years of age within the country's vaccine budget.

Gavi vaccine procurement support in 6.0 covers three main uses:

- **Routine immunisation:** procurement of vaccines to support country-led routine immunisation programmes, including routinised catch-up, with the aim of providing vaccines for all children through routine services.

- **New introductions and scale-up:** procurement of vaccines for new introductions and expansion of coverage, including eligible catch-up campaign activities.

- **Planned preventive campaigns:** procurement of vaccines for three main key types of planned preventive campaigns:
  - **Catch-up campaigns linked with routine introductions**: designed to rapidly increase population immunity and accelerate impact when a vaccine is newly introduced (e.g. measles-rubella, human papillomavirus, typhoid, meningitis A, multivalent meningitis, Japanese encephalitis, pneumococcal).
  - **Large-scale preventive campaigns**: national or subnational campaigns to protect populations at risk, aiming to prevent large and disruptive outbreaks (e.g. cholera, preventive Ebola, yellow fever).
  - **Periodic follow-up campaigns for measles/measles-rubella (M/MR)**: to close measles immunity gaps in countries with insufficient routine immunisation coverage to prevent outbreaks. Campaigns should be used to strength the routine immunisation system and to reach measles zero-dose children and under-immunised populations.

Campaigns can be delivered in an integrated way, for example, to strengthen coverage of routine antigens, to deliver multiple preventive approaches at once, or integrated with non-vaccination interventions.

All decisions to introduce vaccines or conduct campaigns should be informed by national technical processes, including discussion and recommendation by a National Immunization Technical Advisory Group (NITAG) or equivalent body. Countries without a NITAG should outline plans to establish one as part of requests for new vaccine support.

Guidance for fragile and humanitarian settings
Many communities in F&H settings have been missed for years, leaving a growing number of zero-dose and under-immunised children in clusters that risk high mortality and fuel outbreaks. In Gavi 6.0, countries are encouraged to use catch-up vaccination to reach previously missed children, including children aged one to five where appropriate. This is especially important in F&H settings, where older unvaccinated children may face higher risks. Countries in F&H settings should include catch-up strategies in their applications and may request additional vaccine support for older age cohorts where epidemiological data supports this approach.

Further guidance
Global Routine Immunization Strategies and Practices (GRISP): https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/implementation/global-routine-immunization-strategies-and-practices-(grisp) WHO guidance on immunisation campaigns: https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/implementation/immunization-campaigns

2.4. Integration with other health programmes

For some vaccine programmes, countries should plan in close coordination with related health programmes and partners to ensure coherent prioritisation, delivery and use of available resources. The considerations below highlight areas where programme integration is particularly important in Gavi 6.0.

2.4.1. Malaria vaccine programme considerations

Malaria vaccine-related funding requests and applications should be based on prioritised and costed national malaria and immunisation programme strategies. These programme strategies should consider the optimal mix of malaria control interventions, including malaria vaccines, according to the country context, to optimise the use and impact of all available resources, including domestic funds.

Integrated malaria planning with the National Malaria Control Programme or equivalent and other partners, including the Global Fund, is strongly recommended. Gavi and the Global Fund will jointly

provide the Malaria Funders Information Package on available support for malaria programming to support holistic planning.

Further guidance
See **Annex 3: Vaccine Menu** for further details on Gavi's scope of support to the malaria vaccine.

2.4.2. Polio considerations and collaboration with GPEI

Gavi and the Global Polio Eradication Initiative (GPEI) have agreed to strengthen collaboration in countries and priority geographies where poliovirus continues to circulate, recognising that eradication remains unfinished, and resources are becoming increasingly constrained. This collaboration will focus on strategies that: (1) improve the targeting and coverage of routine polio vaccines, including IPV, hexavalent, and bOPV; and (2) advance a more systematic and comprehensive approach to integration during and outside campaigns.

In polio high-risk settings, particularly those with persistently low IPV coverage, a switch to the combination hexavalent vaccine from standalone pentavalent and IPV offers potential programmatic benefits by simplifying schedules, improving uptake through a single delivery platform, and supporting more efficient, integrated and sustainable service delivery alongside other essential antigens.

Under Gavi 6.0, this collaboration is intended to ensure that Gavi-supported investments in routine immunisation are aligned with, and reinforced by, polio assets, particularly in efforts to reach zero-dose and under-immunised children in the highest-risk settings – notably in Afghanistan, Chad, Djibouti, Democratic Republic of the Congo, Ethiopia, Niger, Nigeria, Pakistan, Somalia, Sudan and Yemen. In parallel, GPEI will prioritise the use of its remaining assets and capabilities to support Gavi-supported immunisation outcomes, including integrated outreach and service delivery in priority geographies, among other areas of alignment.

Gavi and GPEI will engage priority countries to clarify expectations, available support, and how integration will be operationalised under reduced funding envelopes. Support will be risk-based and geographically focused, with particular focus at the subnational level. Jointly agreed priorities have been set for EPI/polio country-level workplans, including scaling integrated, multi-antigen campaign and outreach approaches and routine immunisation strengthening, while systematically documenting cost savings, bottlenecks and lessons learned for replication.

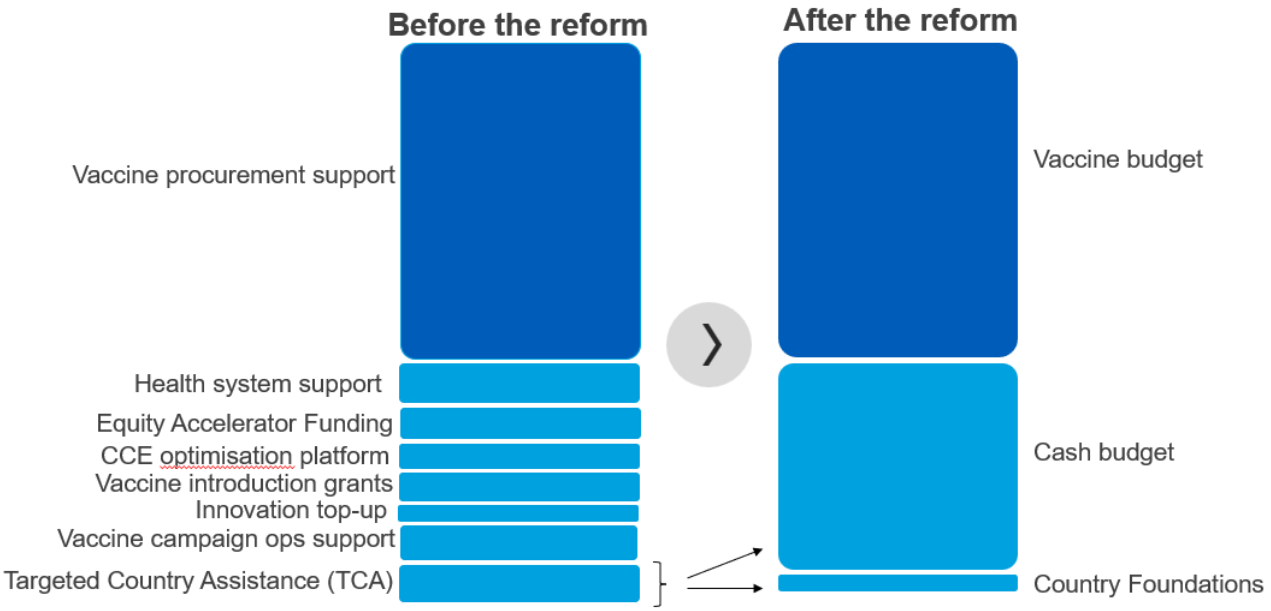
Further guidance
See **Annex 3: Vaccine Menu** for further details on Gavi's scope of support for hexavalent vaccine.

3. Cash

3.1. Cash budget

The cash budget is a set budget allocation provided to countries for health systems and delivery support activities to support immunisation programme goals. It replaces multiple previous cash funding streams under a single grant framework and is intended to support more integrated planning across immunisation priorities.

Figure 1. Consolidation of multiple cash funding streams into one cash budget under Gavi 6.0



The Gavi 6.0 Health Systems Strategy guides the planning, implementation, and monitoring of Gavi's cash investments to strengthen national immunisation programmes and outcomes. The Health Systems Strategy has **two goals** in support of the Gavi 6.0 strategy:

- **Equity** – sustaining high routine immunisation coverage, reaching un- and under-immunised children, including through integrated primary health care services, PIRIs, high-quality campaigns and reducing drop-out to ensure children are fully immunised through the second year of life. In addition, the strategy seeks to support countries to strengthen other immunisation touchpoints (e.g. for adolescents) and implement catch-up vaccination approaches.

- **Sustainability** – strengthen country capacity and financial resources to maintain high, equitable coverage through primary health care and respond to shocks, with the ultimate aim of sustaining immunisation programmes without Gavi support.

Countries can use the cash budget to strengthen the equity and sustainability of their immunisation programmes by supporting immunisation delivery and the systems that underpin it, including procurement of cold chain equipment (CCE), supporting new vaccine introductions, maintaining or improving coverage, reaching zero-dose and under-immunised children including through preventive campaigns, financing campaign operational costs, and providing technical assistance beyond the essential support financed through Country Foundations. With the exception of the three guardrails (see 3.2), countries have flexibility to allocate the cash budget across these priority areas in alignment with their goals and priorities and Gavi's guidance.

Countries should plan the use of the cash budget together with the vaccine budget. Under Gavi 6.0, countries are expected to make deliberate choices across both vaccine and cash support within available resources. This means considering not only which vaccine programmes to maintain, introduce, scale up, or optimise, but also which delivery, health systems, campaign and technical assistance investments are needed to support them and to achieve broader routine immunisation goals, including reaching missed communities and zero-dose children.

Further guidance
Further guidance on country-led prioritisation across vaccine and cash support is provided in **Annex 1: Prioritisation guidance**.

Cold chain equipment (CCE) financed through the cash budget is procured jointly through UNICEF, in line with Gavi's CCE requirements and guidance.

Under the cash budget, countries are encouraged to think across the full spectrum of service delivery strategies and how these can work together to reach different communities and programme objectives. This includes routine delivery, preventive campaigns and other supplemental strategies such as periodic intensification of routine immunisation (PIRI). Countries are encouraged to consider how different strategies can complement one another to improve equity, strengthen routine immunisation and support long-term sustainability.

The Health Systems Strategy differentiation framework in Figure 2 serves as high-level guide to support countries in considering the focus of the two goals, depending on their Gavi transition status, their immunisation performance or classification as fragile and humanitarian contexts

- **Initial self-financing country priorities**: Improvements in coverage and equity with more ability for Gavi to support recurrent and operational activities. Planning for long-term sustainable financing of these costs is critical.

- **Fragile and humanitarian settings priorities**: tailored flexible healthy systems support aligned with Gavi's Fragile and Humanitarian approach. This includes essential collaboration with humanitarian partners, flexibility in immunisation schedules and age ranges, and a higher tolerance for innovative and higher-risk programming.

- **Preparatory transition and accelerated transition country priorities**: Building sustainability and institutional capacity, with less reliance on Gavi funding for recurrent operational costs and greater use of Gavi funding for catalytic, system-strengthening activities.

Figure 2: Gavi 6.0 Health Systems Strategy differentiation framework

	Initial self-financing	Preparatory transition	Acceleration transition
Focus of Gavi support	Equity (more operational)		Sustainability (more catalytic)
Approach	Focus on broad coverage improvement across key geographies	Systems strengthening to achieve and sustain high performance and prepare for transition	Strengthen core capacities of the national immunisation programme necessary for transition
	Fragile/conflict settings: Use every opportunity to immunise children, being responsive to dynamic contexts and supporting basic functioning of the immunisation programme; high appetite to support recurrent costs in general		

The Health Systems Strategy also describes **five shifts in how Gavi will support countries**:

- A more differentiated and tailored approach to health systems investments to support each country's context and needs (as above).
- Consolidating support for health systems funding into one grant, to both simplify Gavi support and enable holistic planning across the continuum of service delivery strategies.
- A more deliberate and evidence-based approach to catalysing innovation for immunisation with a focus on addressing the persistent challenges countries face.
- Strengthened partnerships and collaboration on health systems, including a more deliberate focus on primary health care integration and alignment of support with other development partners.
- More intentional measurement, monitoring and learning of health systems programming, including for campaigns (See Part E Grant Monitoring for more detail).

Guidance for fragile and humanitarian settings

The effort to increase coverage in missed communities in F&H settings requires agile and resilient health systems. Health systems investments in these contexts must be tailored to the specific needs of each community to help overcome barriers.

Key areas of differentiated support include: community and primary care health workforce strengthening adapted to conflict and displacement contexts; community engagement approaches that account for access challenges, trust deficits, and population mobility, and the potential need to reach children up to age five; cold chain solutions appropriate for insecure or remote settings; and flexible planning processes for service delivery that can adapt to rapidly changing circumstances.

Countries in F&H settings should reference the F&H Theory of Change when designing health systems investments, ensuring alignment with the goal of reaching missed communities through agile programming.

Refer to the F&H Theory of Change here: https://www.gavi.org/sites/default/files/%20/board/minutes/2025/24-25-july10%20-%20Annex%20A%20-%20Supporting%20information.pdf

Gavi investment areas and flagship interventions:

The Health Systems Strategy also introduces 'flagship interventions' across Gavi's investment areas. The flagship interventions, and related recommended activities within each, serve as a guide to countries in prioritising the programming of Gavi health system funding to achieve national immunisation programme goals. They do not represent all activities that may be included in a request for Gavi support. Countries are not expected to implement all flagship interventions. Rather, they should identify those most relevant to their context and most likely to have the greatest impact on immunisation outcomes, including sustainably reaching zero-dose children, addressing persistent barriers to equitable coverage, and complementing existing domestic and external resources.

The priority investment areas are as follows:

1. Service delivery
2. Demand generation and community engagement
3. Human resources for health
4. Governance and management
5. Supply chain
6. Data
7. VPD surveillance, laboratory capacities, and diagnostics
8. Health financing

Within this overall approach, countries planning vaccine introductions or preventive campaigns through the vaccine budget should also plan for the associated delivery and operational costs within the cash budget. Sufficient cash resources should be allocated to support high-quality, integrated, and cost-effective implementation. Countries should demonstrate that their chosen mix of service delivery strategies – whether routine, campaign-based, or supplemental – is justified, operationally feasible, and aligned with national immunisation priorities, epidemiology, programme capacity and broader health system goals. They should also show that implementation arrangements are adequate, including coordination and delivery strategies, community engagement, data systems, safety monitoring, supply chain and cold chain planning, and financing, and that the planned activities strengthen the health system.

Countries should choose strategies accounting for country context, immunisation coverage, epidemiology and programme capacity. These may include tailored and/or targeted delivery strategies (e.g. subnational non-selective campaign) that may be combined with enhanced routine immunisation activities (e.g. PIRI and child health days or weeks, bolstered mobile and outreach, or school entry catch-up vaccination).

When planning for campaigns, countries should apply the shifts outlined by the 2025 Board-approved Gavi Health Systems Strategy for campaign effectiveness: improve campaign design, targeting and integration with routine immunisation; leverage financial provisions for campaigns (including MR guardrails); and apply enhanced MERLA (Monitoring, Evaluation, Research, Learning and Adaptation) for RI strengthening.

Further detail on eligible and ineligible activities is provided in Annex 4: Health systems strategy investment areas, including additional options relevant for F&H settings and for countries at different

transition stages. In line with Gavi's Gender policy, countries are also encouraged to identify and address gender-related barriers that affect immunisation demand, utilisation and coverage as part of their Gavi 6.0 programming.

Further guidance
Further detailed guidance on how Gavi engages expanded partners – including civil society organisations, private sector partners and other UN agency partners – under the 6.0 strategy period, see Annex 5: Engagement of Expanded Partners under 6.0 For guidance on outbreak or emergency support, see Part D Gavi Gender policy: https://www.gavi.org/partner-countries/programmatic-policies/gender-policy When planning for campaigns, countries should aim to align their plans with technical guidance and recommendations from WHO: https://www.who.int/teams/immunization-vaccines-and-biologicals/essential-programme-on-immunization/implementation/immunization-campaigns When planning for PIRIs, countries should aim to align their plans with technical guidance and recommendations from WHO: https://www.who.int/publications/m/item/periodic-intensification-of-routine-immunization

3.2. Requirements within the cash budget

3.2.1. Guardrails within the cash budget

Within the cash budget, countries are expected to plan for three guardrailed areas that safeguard critical programme functions and public health outcomes:

- **Civil society engagement:** countries must allocate a minimum of 10% of the cash budget to civil society organisations (CSOs) for immunisation delivery, community engagement, and equity-focused interventions in missed and under-served communities.
- **Cold chain equipment (CCE):** countries are expected to plan for a minimum level of investment in eligible cold chain equipment, based on country needs estimates developed at the start of the strategic period.
- **Measles/measles-rubella (M/MR) follow-up campaigns:** countries should safeguard sufficient operational funding for M/MR follow-up campaigns within the range communicated to each country by the Gavi Secretariat.

Further details on these guardrails are provided below and in the relevant annexes.

Civil society engagement

Countries must allocate a **minimum of 10% of the cash budget** to civil society organisations (CSOs) for implementation of equity-driven interventions aimed at improving immunisation coverage in historically missed and under-served communities, unless they can provide a robust rationale as to why this would not be appropriate in their context. This includes complementing and facilitating service

delivery and strengthening community engagement to generate demand and address vaccine hesitancy. Activities can involve engaging existing community health actors, such as women's groups, local champions and community leaders to address context-specific barriers to immunisation and ultimately improve uptake of immunisation services.

Gavi considers CSOs to encompass the full range of formal and informal, non-governmental and not-for-profit organisations that represent the interests, expertise and values of communities, including community-based organisations (CBOs), faith-based organisations (FBOs), international non-governmental organisations (INGOs), civil society networks, local professional associations and academia, and not-for-profit advocacy organisations.

Guidance for fragile and humanitarian settings – CSO funding allocation
In most F&H contexts, the 10% minimum Board-mandated funding allocation for CSOs will be exceeded. This reflects the critical role CSOs and humanitarian actors play in reaching missed communities where national immunisation programmes face barriers they cannot overcome. Countries in F&H settings should consider higher CSO allocations in their holistic applications, particularly for humanitarian expertise in access negotiation and service delivery; community engagement and demand generation in hard-to-reach or conflict-affected areas; service delivery through CSO and humanitarian partner networks; and surveillance and monitoring in areas with limited government presence. The specific allocation should be determined based on context analysis and in consultation with the Senior Country Manager and Alliance partners.

Cold chain equipment

Countries are expected to plan for a minimum level of investment in eligible cold chain equipment, based on CCE needs estimates developed by the Alliance at the start of the strategic period. This minimum investment acts as a planning benchmark to ensure critical cold chain gaps continue to be addressed.

The CCE minimum is not ring-fenced. Countries may plan above or below the indicated minimum investment where justified. For example, where needs are already met through domestic financing or other partner support, supported by updated inventory and gap analyses, a country may invest below the minimum level of investment. Other cold chain-related equipment such as walk-in cold rooms/freezer rooms and refrigerated vehicles can be procured under the broader cash grant.

CCE will be procured jointly through UNICEF, in line with Gavi guidance and country joint investment requirements.

Further guidance
For further guidance, see Gavi Cold Chain Equipment Programme and Technology Guide: https://www.gavi.org/news/document-library/cold-chain-equipment-programme-and-technology-guide Gavi-Eligible Cold Chain Equipment Product List: https://www.gavi.org/news/document-library/gavi-eligible-cold-chain-equipment-product-list

Measles/measles-rubella (M/MR) follow-up campaigns

Regular M/MR follow-up campaigns are an important element of maintaining population immunity and should be considered in line with relevant WHO guidance on inter-campaign intervals, targeted and selective campaigns, and campaign integration. Decisions on timing, targeting and implementation should be guided by the country's epidemiological context, including local measles epidemiology from case-based surveillance data (and modelling where available), as well as updated national measles population immunity profiles.

To support country planning and help ensure that these campaigns are financially feasible, Gavi has established planning guardrails for M/MR follow-up campaigns of US$ 0.30–0.45 per child for AT countries, US$ 0.30–0.55 per child for PT countries, and US$ 0.30–0.70 per child for ISF countries, or a minimum lump-sum allocation of US$ 100,000 – whichever is greater. Countries should ensure that sufficient resources are safeguarded within the cash budget. Exceptions to this range may be considered for F&H settings to account for higher delivery costs, or in other cases with strong justification; exceptions below the range can be considered in the event of a country demonstrating they have the necessary funding to conduct the campaign (e.g. through other sources of funding). M/MR guardrails only cover operational costs for children 6/9 months–59 months. Funding for children 5–<10years for a catch-up campaign is included in the cash budget.

Further guidance
For further detailed guidance, see Annex 3: Vaccine Menu for measles/measles-rubella vaccine

3.2.2. Cost eligibility

While Gavi provides a high degree of flexibility in budget design and implementation, it does require grantees to comply with certain rules and eligibility requirements in their budgeting. To support its approach to eligibility, Gavi provides a framework of eligible activities and costs designed to guide the investment choices and related budgeting. The budget template consists of a costed workplan of activities with the detailed cost components comprising the detailed activity included below for each activity.

Where ineligible cost or activity types are included, Gavi reserves the right to disallow these from the funding application or treat them as ineligible expenditures during implementation.

Below is a summary of the cost framework under Gavi 6.0:

- Salaries and wages (programme, administrative, technical and outreach personnel)
- Per diems, allowances and other forms of compensation
- Transport, travel and related costs
- Professional services
- Consumables associated with service delivery
- Event-related costs (trainings, meetings, workshops)

- Assets, procurement/maintenance/construction and renovations
- Cold Chain Equipment Optimisation Platform (CCEOP)-eligible equipment and associated services (Gavi Board guardrail)
- Information and communication technology activities
- Programme support costs, administration and overheads
- Results-based financing

Further guidance
Refer to Annex 7: Budget eligibility for the full definition and detailed cost eligibility framework.

3.3. Integration with primary health care and other global health initiatives

To achieve the Gavi 6.0 goals and maximise limited resources, Gavi encourages countries to seek opportunities for integrated programming within a primary health care (PHC) approach, and alignment of available domestic and external resources across programmes. Integration enables more efficient use of resources and can better meet the health needs of communities.

Integration can include:

- Aligning national and sub-national governance of health programmes to align planning, management and monitoring of health services.
- Integrating activities within the immunisation programme: Aligning routine immunisation, campaigns and new vaccine introductions through unified strategies. For example, developing one service delivery strategy to reach communities, or a single training plan that covers all immunisation activities. Every new vaccine introduction and vaccination campaign should be treated as an opportunity to strengthen systems, routine immunisation and PHC services. Countries should design introduction plans that not only ensure successful introduction of the new vaccine, but also contribute to more resilient, equitable and efficient delivery systems, and higher community acceptance of vaccination.
- Co-delivering immunisation with other PHC services, especially when reaching under-served or missed communities, with stronger roles for community health workers within community-based PHC approaches. This includes partnering with antenatal, maternal, adolescent health programmes, other health services (e.g. malaria preventive activities), and other sectors (Ministries of Finance, Education, Social Welfare, etc.) to deliver vaccines outside the EPI target age range.
- **Coordinating with other global health initiatives and funding sources**: Countries should plan Gavi cash resources alongside domestic and external funding, including those from the Global Fund, the World Bank and other partners. The Secretariats of both Gavi and the Global Fund are committed to supporting countries to better align support, especially for malaria and health system strengthening programmes. For many countries, the alignment of Gavi 6.0 and the Global Fund's GC8 cycle provides an opportunity to do this more effectively. The aim is to

make the best use of limited resources, avoid duplication and gaps in key health systems areas, and support planning and investment in cross-cutting health systems from an integrated PHC perspective. The first stage is to understand what resources are available and what they can be used for, through consultations in-country. The Gavi Secretariat can support countries in engaging Global Fund teams to better understand their investments. The second stage is a more detailed focus on collaboration for support to specific health system technical areas, such as health financing, human resources, data and supply chain. This may result in joint initiatives or complementary investments, or it can mean resources from just one source are used to support a particular area. The Secretariat can provide examples of what has worked in other countries.

- Further details are provided below on the MDB Multiplier, which enables countries to align part of their Gavi support with larger multilateral development bank investments.

Further guidance
See **Annex 4: Health systems strategy investment areas** for detailed guidance on integration under the HSS pillar

Guidance for fragile and humanitarian settings – integration with humanitarian health responses
The Alliance will enhance its collaboration with the humanitarian sector to establish immunisation as a core humanitarian health practice. This includes engagement through key mechanisms such as the Global and Country Humanitarian Health Clusters and/or the health sector response to improve coordination between EPI efforts and humanitarian responses. Where appropriate, the Alliance will advocate for the inclusion of routine immunisation in humanitarian health responses. This represents a shift from reliance on humanitarian campaigns toward more sustainable means to reach missed communities with routine immunisation. Gavi will build on its ongoing collaboration with GPEI to amplify results in humanitarian settings. Countries and partners should consider how immunisation activities can be integrated with broader humanitarian health coordination mechanisms.

The Multilateral Development Bank (MDB) Multiplier

Gavi 6.0 places emphasis on aligning with and leveraging external financing from multilateral development banks (MDBs) where there are synergies for great impact on the health and immunisation system. The MDB Multiplier is a mechanism to allow countries to deploy part of their cash grant and/or vaccine budget alongside MDB financing in health, nutrition, education, and/or sanitation projects to increase the impact on health and immunisation system investments. This enables Gavi resources to be blended with and influence larger MDB-financed health system investments in countries, with the goal to strengthen PHC and immunisation outcomes, and enhance longer-term programmatic and financial sustainability, as MDBs (e.g. World Bank, Asian Development Bank) represent a major source of health system financing in many Gavi-supported countries. This approach has already been used successfully with the World Bank and is now being expanded to other MDBs in Gavi 6.0. Of note, while Gavi cash grants cannot be used to procure vaccines, vaccine procurement is possible under an MDB operation.

Bringing together funding from Gavi and an MDB can unlock substantial synergies and increase the focus on immunisation outcomes, while avoiding duplications in the financing of immunisation and associated health system strengthening activities. This includes those aimed at strengthening surveillance and response systems for vaccine-preventable diseases, as well as information systems and cold chains. This consolidation of Gavi and MDB funding will also help to further strengthen coordination of external aid, currently a key constraint to overall progress in health outcomes given scarce resources and limited capacity to implement programmes and projects not integrated in national processes.

There is no predetermined amount that countries need to contribute from country cash grants, and it is *not* expected that countries would deploy all their Gavi cash support within an MDB-financed programme. In the projects jointly financed with the World Bank during Gavi 5.0, for example, Gavi cash support contributions ranged from US$ 2 million to US$ 52 million.

Further guidance
To learn more about how immunisation can be strengthened in a broader jointly financed MDB project, see the following examples: South Sudan: https://documents1.worldbank.org/curated/en/099121123152529349/pdf/BOSIB12886229a02a1bcdc12ee681b5fe59.pdf Pakistan: https://documents1.worldbank.org/curated/en/438401654609799746/pdf/Pakistan-National-Health-Support-Program.pdf Indonesia: https://documents1.worldbank.org/curated/en/099092923114530998/pdf/BOSIB-cf27c2f3-67ae-4b79-b328-9ff0e750abd1.pdf These links are to the World Bank's Project Appraisal Document, which is a comprehensive description of the project that includes the project rationale, objectives and implementation plan.

Opportunities will vary across country contexts, and countries are encouraged to conduct a structured assessment of joint financing opportunities. The Gavi Secretariat is available to advise if this is something countries wish to pursue, with the goal of identifying the amount of Gavi cash support the country would like to be channelled through the MDB operation.

The best opportunities to extract synergies are likely to be found when the MDB operation is at an early design stage, as the design can then ensure that immunisation objectives, activities, and/or indicators are integrated in the larger, MDB-financed health sector investment. Opportunities can also be identified during implementation of the Gavi 6.0 grant. In such cases, unallocated funds could be designated for joint financing, or previously allocated funds could be reallocated for joint financing where appropriate.

They will also demonstrate coordinated engagement across the Ministry of Health, Ministry of Finance, Gavi partners, and MDB project teams and state the kinds of activities that are expected to be funded by the Gavi cash support. It will be important to state how Gavi cash support will flow through to the Ministry of Health.

Further guidance
Further examples of the joint financing arrangements are provided in Annex 9: MDB Multiplier examples.

3.4. Technical assistance

To support countries in planning and implementing their immunisation programmes, countries can request technical assistance (TA) from partners. Under Gavi 6.0, countries can plan for and access TA support through two main routes:

Country Foundations: Country Foundations grants provide long-term, predictable technical and strategic support to ministries to strengthen and sustain essential immunisation programme functions. This support is delivered through WHO, UNICEF, and, in some contexts, other partners. This support is funded outside the cash grant and focuses on five core programme functions: (1) programme planning and coordination; (2) demand generation; (3) data systems; (4) vaccine and cold chain management; and (5) outbreak and emergency preparedness. Decisions on applications submitted by countries to access Country Foundations funding have been confirmed; and programmes will commence starting in the third quarter (Q3) of 2026 (in advance of the consolidated cash grant) to ensure core capacities are in place to support countries in planning and implementing their Gavi 6.0 immunisation programmes.

Cash budget: The majority of technical support that was previously provided through separate mechanisms (e.g. Targeted Country Assistance) is now integrated into the cash budget. While no specific guardrail exists within the cash budget for TA, countries are expected to plan for, prioritise and resource the technical assistance they need within their cash budget (provision of adequate TA to deliver will be considered by the IRC in their review of applications). The cash budget can be used to fund both short-term, project-based TA and longer-term TA (like staff costs) for all partners, including civil society and private sector partners. The award of technical assistance must follow a transparent and competitive selection process.

Importantly, funding for TA in the cash budget should be used to supplement the Country Foundations functions where amounts in the Country Foundations grants are insufficient to meet a country's needs. A strong TA plan is an important part of a strong application and will be considered in review and approval functions, if unable to be adequately resourced in the Country Foundations grants.

Partners that support countries in designing their holistic applications cannot subsequently be awarded for technical assistance or implementation activities for those same countries.

Grantee performance within the cash budget is monitored through the Grant Accountability Framework (GAF – see Part E). For partners receiving Country Foundations funding, additional reporting against the Partner Accountability Framework (PAF) is required (see below guidelines).

Further guidance
See Annex 5: Engagement of expanded partners under 6.0 - for detailed guidelines

Country Foundations guidelines: https://www.gavi.org/news/document-library/60-country-foundations-application-guidance

4. Diagnostics

Gavi supports countries to procure tests that are needed to detect and confirm cases of **cholera, yellow fever and measles**.

Surveillance-related test procurement support is designed to strengthen early detection and confirmation of cases to enable timely, targeted, evidence-based and equitable vaccination response, including for outbreaks. It ensures that vaccine programmes are optimised and aligned with relevant WHO strategies, including avoiding the conduct of unnecessary campaigns.

Countries may request diagnostics support through their holistic application. Gavi-eligible countries, including those applying for vaccine-specific support, e.g. for OCV, YF and measles, are encouraged to request adjunct diagnostic procurement support. Diagnostics procurement costs will not be charged against the country vaccine and cash budgets; it will be provided as additional top-up support.

Procurement is through UNICEF Supply Division to ensure quality assurance and country-level coordination. Broadly, supported diagnostic technologies include rapid tests, ELISA kits, PCR reagents/kits, and relevant consumable bundles, as relevant to each disease. There are currently no co-financing obligations for countries seeking diagnostic procurement support from Gavi.

Further guidance

See **Annex 3: Vaccine Menu** for detailed guidance on support for diagnostics listed:

- **Cholera**
- **Measles**
- **Yellow fever**

Part B: Co-financing and country joint investment requirements (all countries)

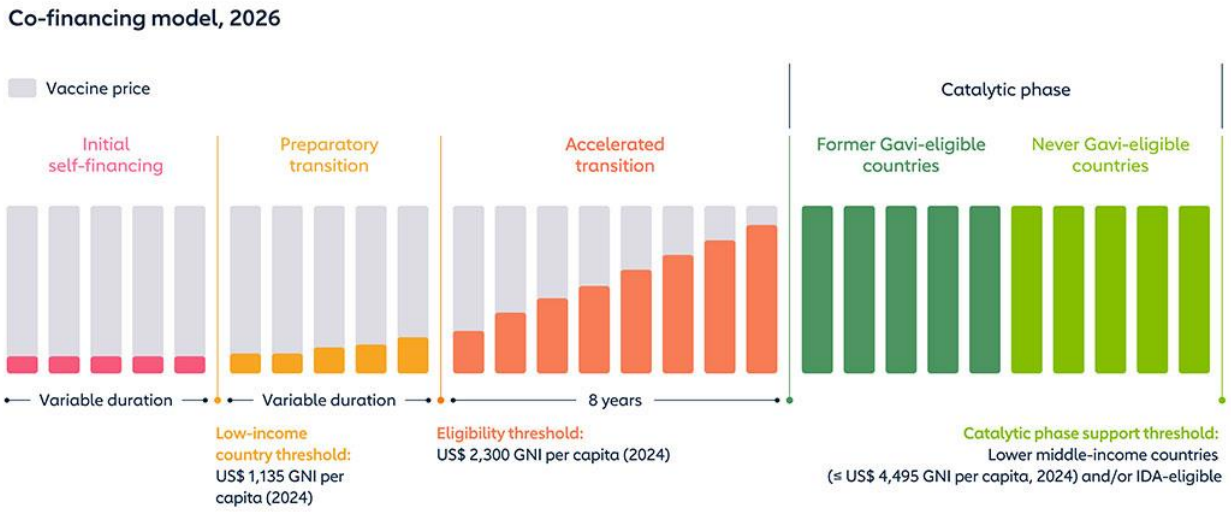
5. Co-financing and country joint investment requirements

5.1. Co-financing

Co-financing is the mechanism through which Gavi-supported countries contribute to the cost of vaccines and related supplies by financing a portion of required doses, with contribution levels increasing progressively as the country progresses through each of Gavi's four transition phases.

Further guidance
See Gavi's Eligibility and transition policy and Co-financing policy for detailed information on transition phases, eligibility thresholds and associated requirements: https://www.gavi.org/programmes-impact/programmatic-policies/eligibility-policy See Annex 3: Vaccine Menu for additional details on the co-financing requirements for specific vaccines.

Figure 3: Summary of Gavi eligibility thresholds and co-financing requirements



The table below outlines the requisites, support types, and co-financing and joint investment obligations of each of the four Gavi transition phases.

Table 5: Eligibility, co-financing and joint investment across the four Gavi transition phases

	1.Initial self-financing (ISF)	2.Preparatory transition phase (PT)	3.Accelerated transition phase (AT)	4.Catalytic phase (CP)
Definition	Countries with a GNI per capita at or below the World Bank's low-income threshold enter the initial self-financing phase. This phase marks the beginning of Gavi-supported immunisation programming with relatively low co-financing obligations.	Countries with a GNI per capita between the World Bank's low-income threshold and the Gavi eligibility threshold enter this phase which prepares countries for increased fiscal responsibility and programmatic independence.	Countries with both their latest and three-year average GNI per capita above the eligibility threshold, and co-financing ≥35%, enter this phase.	Countries not in previous phases but with GNI per capita ≤ World Bank's lower-middle income threshold or International Development Association (IDA) eligibility. This phase includes former and never-Gavi eligible countries.
Eligibility for Gavi funding support	Eligible for core programmatic support including vaccine procurement, diagnostics, cold chain infrastructure, health systems and immunisation strengthening support, and technical assistance.	Eligible for core programmatic support including vaccine procurement, diagnostics, cold chain infrastructure, health systems and immunisation strengthening support, and technical assistance. Increased emphasis on sustainability planning and domestic resource mobilisation.	Eligible for core programmatic support including vaccine procurement, diagnostics, cold chain infrastructure, health systems and immunisation strengthening support, and technical assistance. Higher sustainability planning and domestic resource mobilisation expectations.	Time-bound, targeted support for vaccine introductions and optimisation (HPV, PCV, rotavirus, and future TB and dengue). Eligible for vaccine catalytic financing, technical assistance, and one-off costs.

Co-financing requirements (routine)	• US$ 0.20 per dose with no annual increase for most vaccines • Exceptions: - No co-financing for IPV - Measles-rubella (MR): US$ 0.30/dose - Rotavirus (3-dose): US$ 0.13/dose - HPV: 4% of vaccine price - PCV: 7% of vaccine price - Rabies PEP: US$ 0.20/1ml vial • New vaccine introductions: - No separate NVI rules for ISF countries	• Year 1: Same as initial self-financing phase. • Subsequent years: Annual 15% increase in price fraction, up to 80%. • Exceptions: - No co-financing for IPV until bOPV cessation, at which point it will be US$ 0.30/dose - Final hexavalent co-financing requirement reduced to account for equivalent Gavi support of IPV - MR and measles: Per-dose co-financing increases 15% annually, capped at 80%. - Malaria: Per-dose co-financing increases 30% annually, capped at 80%. - Rabies PEP: price fraction applied to price of 1ml vial • New vaccine introductions: - Year 1: Same as initial self-financing phase. - Subsequent years: same price fraction as used for non-exceptional vaccines in country's portfolio - Minimum co-financing floor of US$ 0.20/dose for new introductions - Measles and malaria NVI at US$ 0.20/dose - MR NVI at $ 0.30/dose	• Year 1: 15% increase in price fraction. • Years 2–8: Linear increase to full Gavi price. • Exceptions: - No co-financing for IPV until bOPV cessation, at which point it will be US$ 0.30/dose - Final hexavalent co-financing requirement reduced to account for equivalent Gavi support of IPV - Rabies PEP: price fraction applied to price of 1ml vial • New vaccine introductions: - Year 1: Same as portfolio - Years 2–8: 40% to 90% price fraction (see Co-financing policy) - Minimum co-financing floor of US$ 0.20/dose - Measles NVI at US$ 0.20/dose - MR NVI at US$ 0.30/dose	Co-financing N/A as countries in CP are expected to fully finance the vaccines they introduce. Countries may apply for vaccine catalytic financing (VCF), equivalent to 50% of the vaccine cost for the first target cohort. For AT countries entering the catalytic phase, they will continue to receive IPV support in the first year of CP following current AT rules, after which they will co-financing 50% of the IPV vaccine costs in the second year of CP, and 100% of IPV costs in their third year of CP. For AT countries entering the catalytic phase, limited hexavalent vaccine support will be offered in the first and second year of CP only to account for the equivalent Gavi support of IPV.

Co-financing requirements (planned preventive campaigns)	• 2% of the total price of the vaccine doses for measles and MR follow up campaigns only in 2026. • 5% of the total price of vaccine doses for Gavi-supported campaigns from 2027 onwards.	• 10% of the total price of vaccine doses for Gavi-supported campaigns.	• 20% of the total price of vaccine doses for Gavi-supported campaigns.	Not applicable
Note: Co-financing for preventive campaigns applies to one-time catch-up campaigns and periodic follow-up campaigns. No co-financing is required for outbreak response campaigns and campaigns implemented with stockpiled vaccines such as preventive Ebola vaccination, which are fully financed by Gavi. For both routine and campaign co-financed vaccines, if a country's preferred vaccine presentation is not available in the short-term, their co-financing requirement may be adjusted based on their preferred vaccine presentation.				
Country joint investment in cold chain equipment (CCE)	• 10% of the total cost of eligible CCE and related services procured with Gavi cash support under CCE minimum floors.	• 20% of the total cost of eligible CCE and associated services procured with Gavi cash support under CCE minimum floors.	• 35% of the total cost of eligible CCE and associated services procured with Gavi cash support under CCE minimum floors.	Not applicable as CCE fully self-financed.

5.2. Country joint investment for cold chain equipment (CCE)

Countries are required to make domestic investments in eligible CCE throughout the five-year Gavi strategic cycle with the objective of facilitating the mobilisation and sustaining of domestic financing for CCE introduced with Gavi support. The joint investment requirements were lowered in Gavi 6.0 compared to Gavi 5.0. Countries will be required to provide a UNICEF procurement fee on top of their country joint investment contribution.

- The CCE country joint investment required is equivalent to the value of CCE procurement each country makes in CCE and associated services eligible under the CCE minimum floor within its cash budget, and is tiered based on the transition status at the time of submitting the application (reduced from **20% to 10%** for initial self-financing, from **50% to 20**% for preparatory transition and from **50% to 35%** for accelerated transition countries).
- Countries are restricted from using Gavi funds for their CCE joint investment. Where it is not feasible to commit domestic funds, countries may use other donor funding.
- The CCE country joint investment may be paid as a lump sum at the time of procurement. CCE procurements made by countries in Gavi-eligible CCE in Gavi 6.0 using domestic and other donor funding (excluding Gavi funds) will also count towards the country joint investment requirement.
- Countries may be exempted from the CCE joint investment requirements above in exceptional circumstances in alignment with the Gavi FED policy and under the specific circumstances described in the Vaccine Co-financing policy.

Further guidance
For further guidance, see Gavi Cold Chain Equipment Programme and Technology Guide: https://www.gavi.org/news/document-library/cold-chain-equipment-programme-and-technology-guide Gavi-Eligible Cold Chain Equipment Product List: https://www.gavi.org/news/document-library/gavi-eligible-cold-chain-equipment-product-list

Part C: Catalytic phase support (catalytic phase countries only)

6. Catalytic phase support

In Gavi 6.0 the catalytic phase (CP) provides time-limited, targeted support to eligible countries. Countries classified by the World Bank as lower-middle income or eligible to borrow from the International Development Association[1] are eligible for CP support. Unlike countries in the initial self-financing, preparatory transition, and accelerated transition phases, **CP countries do not receive a multi-year vaccine budget or cash budget.**

CP support aims primarily to drive the sustainable introduction of key missing vaccines – currently including PCV, rotavirus and HPV vaccines, with future support for dengue and TB vaccines as they become available. CP countries may also access support for vaccine optimisation, and where relevant, eligible fragility- and emergency-related support under the F&H approach (see box below).

CP countries can apply for support following a **differentiated application and approval approach.**

Guidance for fragile and humanitarian settings – support for countries in the catalytic phase
Emergency and fragility support for countries in the catalytic phase is fully integrated into the Gavi 6.0 F&H approach. Catalytic phase countries facing fragility and/or emergencies will be able to request time-limited support for: Routine immunisation vaccine procurement; critical technical assistance; and vaccine and operational costs for outbreak response. The funding for this support is included in the Gavi Resilience Mechanism, an instrument of the F&H approach (see Part D). With strong rationale, exceptional support may also be available for outbreak response support for catalytic phase countries not facing fragility or emergencies, or for pre-emptive vaccination in emergency settings (e.g. pre-emptive measles campaign upon influx of displaced populations).

Further guidance
See **Annex 2: Process guidelines** See **Annex 8: Catalytic Phase supported areas** for further detailed guidance on catalytic phase-supported areas and application requirements. See **Annex 3: Vaccine Menu** for detailed vaccine guidance.

6.1. Support available for new vaccine introductions

Gavi aims to achieve the catalytic phase's objective, to drive sustainable introduction of key missing vaccines, by working at two levels. Firstly, Gavi will work at the global/multi-country level to address systemic issues that commonly stand in the way of sustainable and equitable new vaccine introductions by addressing, for example, gaps in evidence and decision-making capacity, challenges

related to financial sustainability and affordability (See **Annex 8** for further detailed guidance on catalytic phase supported areas).

Secondly, Gavi remains flexible and responsive to country-specific needs by providing support through **country-level catalysers**, such as technical assistance, one-off costs, and vaccine financing support. CP support for new vaccines introduction is available only for national (or scaling up to nationwide) introductions.

Country-level catalysers

Technical assistance (TA):

Technical assistance support may be provided before or after a country takes a formal decision to introduce a vaccine. It can support planning, decision-making, preparation, implementation, learning, and evaluation related to new vaccine introductions. TA may be provided through Gavi core partners, including WHO and UNICEF, as well as/or expanded partners (e.g. civil society organisations, faith-based organisations, academic institutions, etc.) depending on country-specific needs and the comparative advantages of in-country partners.

One-off costs (OOC)

One-off costs provide flexible funding for eligible introduction-related activities that are critical to implementation but difficult to finance through other sources. OOC support may be requested once a country has taken a formal decision to introduce the vaccine. Applications should demonstrate national commitment to introduction and long-term sustainability. OOC support may be channelled through the Ministry of Health, Gavi's core partners, and/or expanded partners (e.g. civil society organisations, faith-based organisations, academic institutions, etc.).

Vaccine catalytic financing (VCF)

VCF helps countries to accelerate new vaccine introductions by providing vaccine procurement support for half (50%) of the first birth (or target) cohort, to facilitate early uptake and reduce initial financial barriers. VCF support is only available for vaccines eligible for funding in the catalytic phase, based on the schedule of the country's preferred product.

6.2. Support available for vaccine optimisation (including product switches)

Support for vaccine optimisation, including product switches, is a new support lever of the catalytic phase. It is intended to support informed decision-making and financial sustainability of vaccine introductions.

Country-level support aims to enable countries to **assess and implement** vaccine optimisation activities and product switches.

Optimisation assessment

Catalytic phase countries may request support to assess vaccine optimisation or product switch options, either as a standalone activity or alongside a new vaccine introduction. This support is provided through technical assistance (through core and/or expanded partners) and may include

analysis of financial sustainability, procurement implications, market access and the expected programmatic or health impact of the proposed change.

Optimisation implementation

Where a country decides to proceed with vaccine optimisation or a product switch, Gavi may provide targeted support for implementation. Applications should include an assessment demonstrating the rationale for the change and its contribution to financial sustainability for the country's immunisation programme. Vaccine procurement is not eligible for support. Implementation support is available only to catalytic phase countries that transitioned out of standard Gavi support (former Gavi country).

Technical assistance for implementation may support planning, microplanning, operational guidance, supply chain preparation, training, data system updates, communication, and coordination across national and sub-national levels. This support is tailored to country-specific needs and is designed to help ensure that implementation is timely, well-coordinated, and aligned with long-term programme sustainability and equity goals. This support may be provided through Gavi core partners and/or expanded partners.

One-off costs may be used to support eligible one-off activities needed to implement vaccine optimisation or product switches, including planning, training, materials, and other operational requirements. This support is intended for activities that are essential to implementation but difficult to finance through other sources. This support, comparable to a switch grant, may cover planning, training, and other operational needs and materials. OOC support may be channelled through the Ministry of Health, Gavi's core partners, and/or expanded partners.

Part D: Emergency support, outbreak response, and unforeseen needs (all countries)

7. Available support for emergencies, unforeseen needs and outbreak response

Gavi funds four mechanisms to respond to health emergencies and unforeseen needs, including outbreaks – all focused on providing immunisation-related support. Any funding, vaccines or technical assistance provided via these mechanisms are outside of and additional to vaccine and cash budgets.

Table 6: Gavi-funded mechanisms to response to emergencies, unforeseen needs, and outbreak response

Mechanism	Scope
Global mechanisms for outbreak response: A. **International Coordinating Group on Vaccine Provision (ICG)** B. **Measles & Rubella Partnership Outbreak Response Fund (M&RP ORF)**	A. Vaccine stockpiles and operational funds for cholera, Ebola, meningitis, mpox and yellow fever outbreaks B. Vaccines and operational funds for measles outbreaks
Gavi Resilience Mechanism	A. Newly arising needs in chronically fragile countries and subnational pockets; B. Emergencies including disease outbreak support not covered through existing mechanisms; C. Settings requiring humanitarian programming; D. Catalytic phase countries facing fragility or emergencies.
First Response Fund	May provide funding in response to significant epidemics and pandemics (with 80% of funds reserved for pandemic emergencies/public health emergencies of international concern) should this be recommended by the Secretariat and/or Gavi Board.

7.1. Outbreak response coordinated via global mechanisms

Through the ICG and M&RP ORF mechanisms, Gavi provides emergency vaccination support including vaccines and operational funds for cholera, Ebola, meningitis, yellow fever, mpox[1] and measles outbreaks, ensuring countries can implement timely outbreak response vaccination responses and rapidly contain these outbreaks.

[1] Mpox stockpile to be launched in mid-2026.

Funding through these mechanisms may be used for the following type of support:

- Vaccines and immunisation supplies rapidly delivered from global stockpiles or available global vaccine supplies;
- Operational funding to support emergency vaccination implementation (e.g. training, communication and mobilisation, cold chain and vaccine transport, monitoring and evaluation, technical assistance to rapidly bolster and strengthen countries' emergency response capacities).

Note: Countries can request to utilise a portion of their cash grants to begin rapid implementation of outbreak response vaccination activities once an outbreak response request and budget have been approved. The funds will be replenished thereafter according to the approved outbreak response budget.

To access support:

Ebola, cholera, meningitis and yellow fever outbreak response vaccination is coordinated through the International Coordinating Group on Vaccine Provision (ICG) mechanism. Mpox outbreak vaccination will also be coordinated via the ICG as of the latter half of 2026.

Measles outbreak response vaccination is coordinated via the Measles & Rubella Partnership (M&RP) Outbreak Response Fund (ORF).

The respective websites detailing the application instructions and e-mail to which applications should be submitted are provided in the table below:

Table 7: Further resources for outbreak response

Mechanism	Secretariat	Application instructions	Application email	Link to guidelines (outbreak response vaccination)
Ebola	WHO-WHE (ICG)	https://www.who.int/groups/icg/ebola-virus-disease	ICGsecretariat@who.int	Extraordinary meeting of the Strategic Advisory Group of Experts on Immunization on Ebola vaccination, May 2024
Cholera	WHO-WHE (ICG)	https://www.who.int/groups/icg/cholera	ICGsecretariat@who.int	https://www.who.int/news-room/fact-sheets/detail/cholera
Meningitis	WHO-WHE (ICG)	https://www.who.int/groups/icg/meningitis	ICGsecretariat@who.int	https://www.who.int/publications/i/item/WHO-HSE-PED-CED-14.5
Yellow fever	WHO-WHE (ICG)	https://www.who.int/groups/icg/yellow-fever	ICGsecretariat@who.int	https://www.who.int/initiatives/eye-strategy
Measles	WHO-IVB (M&RP)	https://measlesrubellapartnership.org/resources/outbreaks/	MRP-ORF@who.int	https://www.who.int/publications/i/item/9789240052079
Mpox	WHO-WHE (ICG)	Forthcoming in 2026	ICGsecretariat@who.int	Forthcoming in 2026

Note: Countries are strongly encouraged to maximise their cash budgets to build resilience across their systems and workforce capacities, and to invest in strengthening epidemic prevention, preparedness, and response efforts. Collaboration and co-investment with other funders such as the

Global Fund and the World Bank are also encouraged. Recommended activities linked to resilience and emergency preparedness and response have been integrated across investment areas and flagship interventions; examples of such are included in the annexes on health systems investment areas, and various disease-specific guidance documents including a suite of activities linked to outbreak detection, preparedness and response under the surveillance, laboratory and diagnostics section. Countries are also encouraged to identify and prioritise technical assistance to support these efforts as part of their country application process and cash budgets. Strengthening digital surveillance, early warning systems, and rapid data-sharing platforms is a core component of emergency preparedness and can be supported through the cash budget.

7.2. Gavi Resilience Mechanism

[This section reflects the use cases approved by the Board in December 2025. Further updates may be required following Board consideration in July 2026.]

The Gavi Resilience Mechanism (GRM) is an agile funding mechanism designed to rapidly respond to unforeseen needs. Funding is made available to address exceptional circumstances and needs, and only once other avenues of funding have been considered (such as funding available via vaccine or cash budgets).

The GRM is designed to respond to: (i) newly arising needs in chronically fragile countries and sub-national pockets; (ii) emergencies including disease outbreak support not covered through existing mechanisms; (iii) settings requiring humanitarian programming – i.e. Gavi's Humanitarian Partnerships (ZIP)-like approaches; and (iv) catalytic phase countries facing fragility or emergencies.

The GRM builds on the Board-approved higher risk appetite under the FED policy and tolerates higher programmatic and financial risk to enable rapid responses.

Funding through this mechanism may be used for the following type of support:

- Vaccines and immunisation supplies;
- Operational funding;
- Technical assistance;
- Protection of health workers and additional needs for the continuation of routine immunisation services during emergencies or outbreaks.

Note: **Following formal approval from Gavi,** countries can request to utilise a portion of their cash grants to begin rapid implementation of outbreak or emergency response vaccination activities, once a request and budget have been approved via the Gavi Resilience Mechanism. The funds will be replenished thereafter.

Funding may be provided from Gavi either to governments/ministries or alternatively directly to expanded partners, including humanitarian actors.

To access support, countries, partners, and humanitarian actors should contact their Senior Country Manager as the first point of contact, who can provide appropriate guidance on what/if Gavi support may be available and how to access it.

Further guidance

The GRM is part of Gavi's broader Fragile and Humanitarian approach. Further information is available in the Gavi Board paper on the Fragile and Humanitarian approach (paper 10, July 2025 meeting): https://www.gavi.org/governance/gavi-board/minutes/24-25-july-2025

Fragility, Emergencies and Displaced Populations policy: https://www.gavi.org/news/document-library/05a-annex-c-update-gavi-s-fragility-emergencies-and-displaced-fed-populations

7.3. Gavi First Response Fund

The Gavi First Response Fund is part of Gavi's broader Day Zero Financing Facility and provides pre-positioned surge financing capacity early in a major public health emergency. The First Response Fund may provide dedicated funding and support in response to significant outbreaks, epidemics, and pandemics (with 80% of funds reserved for pandemic emergencies/public health emergencies of international concern), should this be recommended by the Secretariat and/or Gavi Board.

Funding through this mechanism may be used for the following type of support:

- Vaccines and immunisation supplies
- Operational funding to support reactive vaccination roll-out and delivery
- Technical assistance
- Protection of health workers
- Protection of routine immunisation services

To access support:

To qualify for the First Response Fund, an outbreak, epidemic, or pandemic must meet the following key criteria:

- Be a WHO graded emergency of **Grade 2 or above**;
- The outbreak, epidemic or pandemic is recommended for consideration following a technical assessment conducted by the Secretariat and informed by key partners;
- The outbreak, epidemic or pandemic is linked to a disease/pathogen for which Gavi does not have an existing programme already in place.

In the event that the First Response Fund is engaged to support response to a major public health emergency, the Secretariat will disseminate dedicated guidance and communications to affected countries on how to access support.

Part E: Grant monitoring (all countries)

8. Grant monitoring

Gavi's Grant Accountability Framework (GAF) represents an explicit agreement between a country, partners and Gavi on the key metrics used to monitor and report on the performance of Gavi grants during their implementation. This then serves as a basis for dialogue and action toward improved outcomes.

The GAF includes performance measures for each grantee within a country, i.e. government, Alliance core partners, civil society organisations, and other partners. This enables an understanding of each grantee's performance within a country application, and reflects the fact that grants are jointly – and collaboratively – managed by multiple stakeholders, including countries, partners, and the Secretariat. It also allows performance measures from across the grant to be rolled into an aggregate view within the Grant Management System.

The GAF is designed to enable monitoring of a grant's results chain, tracing the use of Gavi resources (e.g. cash and vaccines) through implementation and the resultant outcomes. This allows for both a clearer understanding of where, and why a grant may be under- or over-performing, and for responsive adjustments in pursuit of improved outcomes. In the simplest terms, the GAF allows stakeholders to understand a grant's **performance** by assessing both its **progress** (through implementation) and its **results** (through regularly reported indicators).

The following areas are reviewed as part of the GAF. A performance narrative that helps explain how the progress and results from the sources outlined below are contributing to overall grant performance should be submitted as part of the regular reporting process.

Progress

- Financial utilisation: Each grantee will report on budget utilisation – at activity level – of disbursed funding to support the management of future disbursements.

- Vaccine consumption: Countries will report on vaccine dose consumption, which will be compared to approvals and shipments to inform the management of future approval decisions in terms of timing and quantity.

- Grant activities: Each grantee will report on the implementation status of its three highest value activities under each Programme Area within the grant budget. This will allow an assessment of whether the planned work needed to achieve programmatic objectives is on track, and support decisions about future disbursements.

  Example: *A budget has 14 activities under the Programme Area "Service Delivery". Seven of these activities are managed by the country government; four are managed by UNICEF; two are managed by CSO A and one is managed by CSO B. The country government must report on the status of the three highest-value activities of the seven for which it is receiving funds. UNICEF must report on the status of the three highest-value activities of the four for which it is receiving funds. CSO A and CSO B must report on the status of each activity for which they are receiving funds, as they do not have more than three under this Programme Area.*

Results

- Programmatic indicators support understanding of whether a grant's funding and activities are achieving their expected results. There are two types of programmatic indicators in the GAF:
    - **Routine monitoring indicators** are a core set of mandatory output-level indicators included in the GAF for all consolidated country grants. Most of these indicators rely on global data sources, and so will not require active reporting by countries or partners. However, they provide insights into the strength of a country's immunisation system and reflect EPI management and progress at sub-national levels (see below).
    - **Grant-linked key performance indicators** are indicators against which targets need to be set, and against which they will be monitored. They include a set of standard indicators used across all countries, as well as tailored indicators that each grantee is expected to select to monitor its most important activities. Tailored indicators should be limited in number (e.g. no more than one to three per grantee). They can be selected from a recommended list; or, if needed, created – for example, by selecting an indicator from an existing monitoring & evaluation (M&E) framework already in use.

      Other data will be used to triangulate and support interpretation of the GAF indicators and targets, such as WUENIC estimates of coverage and drop-out rates. These will not require reporting or target setting.

Reporting frequency and tailored indicator requirements are differentiated by country segment and will form the backbone of regular assessments of grant performance by the Secretariat, country governments, partners, and other Alliance stakeholders. More details on the indicators and required reporting frequencies can be found in Annex 10: Grant Accountability Framework.

When selecting tailored indicators, it is understood that current data systems may have gaps that make it challenging to report against them (i.e. in regularly collected indicators or data quality issues). Gavi recommends investments into rapid cycle monitoring (RCM) approaches to help support subnational monitoring and review systems, as well as ensure robust measurement of key activities through tailored indicators. RCM approaches ensure that robust, near real-time data is available to use at all levels of the health system. RCM covers a broad range of activities, including rapid and frequent health facility assessments; light touch household surveys, including those with BeSD indicators; rapid quality-adjustment of HMIS data; and utilisation of data and evidence for performance.

Further guidance
See **Annex 4: Health systems strategy investment areas** for further guidance on RCM options under the "Data" section.

Importance of subnational monitoring and review

While the GAF is focused on national-level grant results, progress is often driven by improvements at subnational level. Experience from Gavi's 2021–2025 strategic period (Gavi 5.0/5.1) has shown that dramatic improvements in immunisation outcomes are possible when local health and political authorities – whether at district or state/provincial level – adopt a data-driven approach to management by frequently reviewing a small set of critical output indicators to identify and address under-performance.

In support of this approach, Gavi expects that countries and partners will be regularly reviewing subnational data – specifically, the routine monitoring indicators from the GAF (listed in Annex 10: Grant Accountability Framework), or their subnational equivalents – and using those reviews to implement actions to improve performance. Grant submissions should detail where such reviews will occur in the strategic narrative template. While the results of these subnational reviews do not need to be reported to Gavi through the GAF, there is a need to report on their regular occurrence. Countries and partner should also be prepared to provide updates on these subnational reviews during Joint Alignment and Learning sessions and regular performance discussions with their SCM of how those meetings are leading to actions to correct under-performance.

This approach should allow for both a national-level assessment of EPI performance and progress against a grant's objectives while also allowing countries and partners to understand both what is working well and what is leading to under-performance in specific, localised areas. It also means that the GAF can be viewed as an extension of a country's existing monitoring and management frameworks, where country-owned and managed information that is reviewed subnationally is then reflected in higher-level performance metrics and results captured through the GAF.

Annex 1: Prioritisation guidance

Overview of portfolio prioritisation

Gavi 6.0 introduces several changes to the structure of Gavi support to countries, in an increasingly resource-constrained environment. These changes are designed to enable greater flexibility in decision-making, notably through the introduction of vaccine and consolidated cash budget.

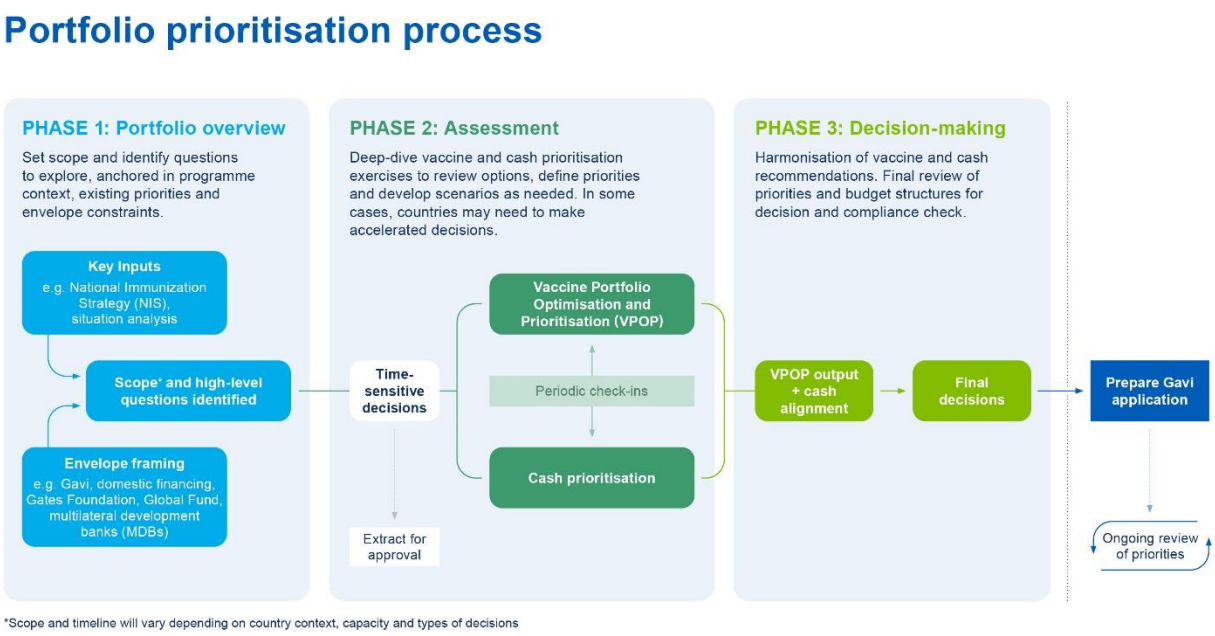
To navigate this context and support effective planning, countries are encouraged to allocate sufficient time and effort to undertake a holistic portfolio prioritisation process to inform the development of their Gavi application in line with national priorities. The term 'holistic' is used in two senses:

- **Joint vaccine and cash prioritisation:** Countries are encouraged to consider together both vaccine and cash support to determine how resources can be optimally leveraged to deliver the greatest impact and strengthen immunisation systems.
- **Beyond Gavi, beyond immunisation:** The process should consider the full-financing landscape beyond Gavi and immunisation funding to reflect priorities of National Immunization Strategy (NIS), primary health care (PHC), and broader health sector strategy.

Process overview

The following diagram summarises the three major phases recommended for a prioritisation process.

Figure 1.1 Overview of recommended portfolio prioritisation process



Best practices for stakeholder engagement

While each country will structure their process according to its own governance arrangements and planning cycles, experience across countries suggests that certain good practices can help ensure the process leads to clear priorities and well-informed decisions. Below are some considerations on engaging key stakeholders:

- ✓ **Government leadership engagement:** Particularly when collaborating across departments or funding agencies, leadership sponsorship from the Ministries of Health, Planning and Finance can help to ensure alignment. This could include an early meeting to confirm top priorities (ideally a subset of NIS priorities, if up to date) and likely trade-offs for Gavi support.
- ✓ **Clear governance:** Led by Ministry of Health, agree at the outset: who will chair the process; how trade-offs will be resolved; which bodies will engage in developing content and recommendations – i.e. National Immunization Technical Advisory Groups (NITAG), civil society organisations (CSOs) and development partners; and what body – e.g. Interagency Coordination Committee (ICC), Health Sector Working Group – will endorse the final decisions and plan.
- ✓ **Inclusive engagement:** Include MoH, Alliance partners, disease programme (malaria, polio, cholera, yellow fever, meningitis, etc.), other global health institutions (GHIs) and health system strengthening leads, NITAG Secretariat, subnational representatives, CSOs and development partners. Decisions that implicate their programmes are more durable if they are part of the process.
- ✓ **Leverage guidance on technical discussions:** Some topics will require specialised technical inputs, such as health economics or vaccinology. Guidance materials (like the VPOP Toolkit) will have more targeted advice on what is needed.
- ✓ **Transparency on constraints:** Be transparent about funding constraints early. Stakeholders who understand the envelope are more likely to engage constructively in trade-off discussions than those who encounter reductions late.

Phase 1 – portfolio overview

This phase provides a structured overview of the country's immunisation portfolio to inform prioritisation for the Gavi application. Countries should base this exercise on the National Immunization Strategy (NIS), the national health sector plan, and other recent situation analyses to ensure alignment with national objectives.

In parallel, countries should assess the full resource envelope, including domestic financing and support from Gavi and other partners, to ensure priorities are feasible within available funding.

Recommended steps

1. Setting goals, principles and process

Using the NIS or other national planning documents as the primary reference points, clearly define the prioritisation goals and principles (e.g. equity, sustainability, impact on under-immunised populations, outbreak prevention, integration across programmes and financing). If the NIS is outdated, conduct a rapid review to confirm relevance. Agree upfront on the planning process, stakeholders and decision points, in coordination with the Gavi Senior Country Manager to align with application timelines.

- ✓ Identify and engage relevant stakeholders: For some countries, there may be opportunities to find impact or cost efficiencies by coordinating with other programmes such as polio, malaria, cholera or PHC-centric efforts. Once any additional areas have been identified, ensure those stakeholders have an appropriate place to participate in the process.

2. Programme performance and evidence review

Assess performance during the Gavi 5.0 period to identify successes, constraints and persistent bottlenecks. Use the most recent diagnostics and situational analyses to validate priority gaps and inform forward-looking decisions (e.g. NIS situation analysis).

3. Defining the financial envelope

Identify available resources across Gavi vaccine and cash budgets, domestic financing and other partner funding. Compare resources against identified priorities to determine gaps and trade-offs. This supports integrated planning and coordination with other health financing partners under country leadership.

- ✓ *Consider Multilateral Development Bank (MDB) Multiplier: During grant preparation, Gavi can support countries in identifying existing or pipeline MDB operations – or potential new financing – that could contribute to Gavi objectives. Where relevant, Gavi will facilitate engagement with Ministries of Health, MDB counterparts, Alliance partners and Secretariat teams to scope joint financing or technical assistance under the Multiplier.*

- ✓ *Assess implications of the Gavi vaccine budgets: Ensure familiarity with Gavi vaccine budget policies and country specific allocations. Key considerations include:*
  - *Status of existing, planned and forecasted programmes (including NITAG recommendations)*
  - *Product and presentation cost assumptions versus current procurement costs*
  - *Current and projected vaccine co-financing obligations*
  - *Flexibility within guaranteed and discretionary budgets and conditions requiring self-financing*

- ✓ *Align vaccine and cash planning: Ensure vaccine introductions, campaigns and switches are planned alongside required cash support. Establish a clear process to maintain alignment between vaccine and cash budgets throughout prioritisation and application development.*

- ✓ *Review Gavi cash budget parameters and health system linkages: Review cash support policies and country-specific allocations under Gavi 6.0, including:*
  - *Total funding available and changes from previous cycles*
  - *Cash budget guardrails*
  - *Alignment with Gavi's health system strategy (differentiation, sustainability, flagship interventions)*
  - *Other programmes requiring coordination and/or integration (e.g. maternal, newborn, and child health (MNCH), malaria, polio, PHC)*

- ✓ *Assess realistic domestic financing contributions: Review historic and projected domestic financing, including funding levels, timing, and execution. Compare NIS projections with actual mobilisation and spending to set realistic assumptions for the strategic period.*

4. Confirmation of goals and assessment criteria

Before concluding this phase, agree on topline goals for the next five years (e.g. coverage, equity, sustainability, access to new vaccines, outbreak prevention and response). Where possible, define high-level assessment criteria (e.g. cost, feasibility, expected impact) to guide development of prioritisation options.

Resources

Material	Source	How to access
Gavi 5.0 performance data	Country	--
National plans (NIS, NHSP, etc.)	Country	--
6.0 Budget simulation tool	Gavi	Request from SCM
6.0 HS strategy	Gavi	Gavi Guidelines Website
6.0 Letters	Gavi	Request from SCM
6.0 Programme funding guidelines	Gavi	Gavi Guidelines Website
Co-financing forecast	Gavi	Request from SCM
Interim HS reprioritisation guidance	Gavi	Gavi Guidelines Website
UNICEF SD vaccine prices	**UNICEF**	**Request from UNICEF CO for latest**
NIS guidance (2026 update)	WHO	WHO NIS Website
VPOP Toolkit	WHO	NITAG Resource Center Website

Phase 2 – assessment

After comparing the national priorities against the available funding sources, key trade-off decisions will be identified that either can be discussed as part of the vaccine prioritisation and optimisation (VPOP) process or the prioritisation of cash investments.

Cash and vaccines are addressed through distinct processes due to differences in stakeholders, scope, and decision frameworks. Vaccine portfolio decisions rely heavily on NITAGs and considerations of country co-financing, while cash decisions involve stakeholders closer to delivery systems, health system functions, and operational planning. However, it is essential that these processes are brought together, coordinated and reinforce each other to allow a coherent decision in Phase 3.

Vaccine Portfolio Optimisation and Prioritisation (VPOP)

VPOP is a country-led process designed to both (1) optimise the portfolio with the vaccine products that best align to the country context, and (2) choose which routine introductions and campaigns[2] to implement and in what sequence.

In the context of Gavi 6.0, this process enables countries to make evidence-based decisions about their vaccine portfolio within the limited vaccine budget (VB) while considering available funding from domestic financing and other sources.

The VB includes guaranteed and discretionary funding; this implies that countries will need to consider vaccine procurement costs beyond co-financing considerations. For vaccines that are meant to be covered by discretionary funding, prioritisation is crucial, since this likely implies more constraints on new campaigns and routine introductions or even insufficient funding to support the full cost of ongoing programmes, so it is important to assess what is feasible against all available funding sources and explore different delivery strategies.

The goal is to identify the vaccine portfolio configuration that best contributes to the country priorities while remaining within the available funding, whether those emphasise coverage maximisation, equity, disease burden reduction, financial sustainability, or a combination.

Recommended steps

1. Framework adaptation

Use the VPOP Toolkit (including the NVI Prioritisation Sequencing Tool and Optimisation Tool) to structure the analysis. Adapt the framework to the country context aligned with the priorities and key decisions identified in Phase 1.

Define the criteria to assess the different options for optimisation and prioritisation, including measurable indicators. This will include impact on disease burden in the country, programmatic considerations and budget impact.

[2] Gavi is developing a strategic initiative on campaign optimisation for presentation to the Gavi Board in June 2026, aimed at maximising health impact by defining the optimal mix of campaigns and routine immunisation strengthening activities, improving the effectiveness of campaigns, and reviewing the campaign co-financing model. The approach builds on the three shifts of the Board-approved 2025 Gavi Health Systems Strategy – enhanced campaign design, targeting and RI integration; targeted financial provisions including MMR guardrails and updated operational thresholds; and strengthened MERLA – while also assessing where alternative or complementary approaches to preventive campaigns are suitable and how to incentivise their adoption, consistent with existing guidance on targeted and tailored delivery strategies and integration.

- ✓ *Identify implications of the vaccine budget (VB): Does the VB (guaranteed and discretionary funding) cover the cost of maintaining the current portfolio? If not, what changes could address the gap?*

- ✓ *Ensure early and constant dialogue between vaccine and cash assessments: To support a coordinated approach, it's important to use shared assumptions for both vaccine and cash assessments (e.g. target population, assumed timelines, subnational priorities, etc.), flag interdependencies early in the process (e.g. new vaccine introduction or campaign that requires operational funds or consideration of cost-savings switch), plan for regular touchpoints between both assessments and if possible, have cross-representation in both areas.*

2. Evidence collection and assessment

Collect data on disease burden, cost-effectiveness, delivery requirements, and co-financing implications for each portfolio option. Use the WHO Vaccine Compendium and the optimisation factsheets as a reference.

Compare the different optimisation and prioritisation options using the selected criteria, inclusive of budget impact, and discuss to achieve consensus.

Consider creating scenarios that represent different approaches to the portfolio (e.g. maintain current portfolio with optimisations; introduce new vaccine with a switch; maximise new introductions and campaigns within VB). These scenarios can be costed using the budget simulation tool.

- ✓ *Explore cost-saving optimisation opportunities: One of the criteria to assess optimisation choices is its financial implications. It is important to identify if there are desirable cost-saving options available (e.g. product switches, presentation changes, dose reductions) that could facilitate prioritisation decisions across the portfolio.*

- ✓ *Use evidence-based decision-making: What new introductions or campaigns are under consideration, and what is the evidence base for each (disease burden, cost-effectiveness, delivery feasibility)?*

- ✓ *Leverage disease-specific technical experts: Engage relevant experts when discussing optimisation and prioritisation options (individual subject matter experts and disease-specific working groups) particularly to brief stakeholders on trade-offs and leveraging the data available to assess different options.*

- ✓ *Consider alternative delivery strategies: If discretionary budget or country co-financing is insufficient to cover desired introduction(s) and/or campaign(s), are there ways to adjust scope (e.g. phased introduction, subnational or age-based targeting of campaigns) that would allow a programme to operate within budget constraints? What are the trade-offs of doing so? What is the optimal mix of delivery strategies (such as subnational non-selective campaigns in higher-risk areas, PIRIs in lower-risk areas, and catch-up vaccination), based on intra-country factors including immunisation coverage, disease burden and programme capacity?*

3. Financial validation

Calculate the (co-)financing trajectory and assess whether domestic financing is sufficient for long-term sustainability. This process includes conducting high-level budget dialogues ensuring Ministry of Finance awareness and alignment. Identify the operational and delivery costs that will need to be met from the cash budget (CB) and communicate these to the team assessing cash prioritisation.

4. Recommendation

Present final scenario(s) to the NITAG for recommendation on which vaccines to prioritise and optimise to what products. Ensure sufficient time for NITAG deliberation in the process timeline.

Resources

Material	Source	How to access
Campaign Effectiveness Toolkit	HCE	CAS Website, WHO Website
NITAG guidelines and procedures	Country	--
6.0 Budget simulation tool	Gavi	Request from SCM
UNICEF SD vaccine prices	UNICEF	Request from UNICEF CO for latest
Vaccine Evidence Compendium	WHO	NITAG Resource Center Website (direct)
VPOP Toolkit	WHO	NITAG Resource Center Website (direct)

Cash prioritisation

This portion of the process focuses on the programming of available cash resources against immunisation and related health system goals (e.g. PHC, MNCAH, polio, malaria). The funding available and relative distribution of resources to goals considered should have been established during Phase 1 and ideally considering other sources of funding in addition to Gavi.

The goal is to identify the set (or sets) of uses for available resources that can achieve the greatest contribution towards the goals identified in Phase 1 (i.e. furthering the reach of the programme, enhancing sustainability, ensuring introduction of new vaccines, etc). In a resource-constrained environment, this will require trade-offs, as there is unlikely to be one arrangement that meets all goals. The programme should develop different options on resource distribution to be considered by decision-makers.

For exercises incorporating Gavi 6.0 resources, the following success factors apply:

- ✓ Vaccine prioritisation and optimisation exercise will have implications for your cash budget. Consider if you need to allocate additional funds to implement switches, introductions and campaigns.
- ✓ The minimum investment requirements for Gavi cash guardrails (CSO, M/R campaigns, CCE) are observed.
- ✓ Opportunities for greater efficiency and impact made possible by the consolidated cash envelope (e.g. prioritisation between Periodic Intensifications of Routine immunisation (PIRIs) and operational costs for campaigns, programme integration including funding for intra-campaign monitoring, AEFI kits, data management of campaign data into RI tools, etc.) are identified.
- ✓ Evidence from the Gavi 5.0 period and the Health System Strategy is leveraged to identify the optimal mix of spend types – including health system investments, operational costs, CCE, TCA, and others.

- ✓ Gavi recommended health systems 'flagships' or investment areas are considered.

Depending on the country's context, additional factors may apply:

- ✓ Countries may need significant subnational engagement to prioritise needs, inform investment areas, and structure scenarios.
- ✓ For countries seeking to align funding across GHIs (e.g. Global Fund, GPEI), sufficient time to identify 'comparative advantage' of different funders is needed.
- ✓ For countries in accelerated transition (AT) or preparatory transition (PT) status, prioritise options sustainable by domestic resources post-Gavi transition, such as cost-reducing systems investments or efficient delivery models, over activities creating large ongoing costs.

Recommended steps

1. Discussion structure

Organise around the priority goals/principles from Phase 1, including any 'must-haves', and determine the criteria against which proposed activities will be assessed.

- ✓ *Treat equity as an organising lens: Anchor discussions on which equity gaps (zero-dose, under-immunised, specific vulnerable populations) can realistically be addressed within the envelope and prioritise delivery strategies accordingly.*

2. Identifying fixed budget

Identify any fixed budget elements that should be pre-committed – these include committed funding and minimum spend requirements (e.g. CCE guardrail, CSO minimum, M/R campaign minimum).

- ✓ *Make vaccine and cash interdependences explicit: Flag dependencies early (e.g. "This malaria vaccine campaign scenario requires X for outreach and Y for CCE rehabilitation") so that decision-makers see the full package rather than fragmented requests. If any switches are planned, verify that resources are sufficient and timing is practical to deliver on the schedule indicated. Any delay may cause the vaccine budget to overrun.*

3. Mapping programme obstacles and Gavi HSS solutions

Review key programme bottlenecks from the initial diagnostics (e.g. data gaps, workforce shortages, supply chain issues, etc.) and map them against Gavi health system flagships.

4. Prioritising investment areas

Assess proposed activities against the agreed criteria and develop an initial prioritised list.

- ✓ *Protect core system functions before expanding: A good first step can be to identify investments needed to maintain the basic functions or elements of the immunisation system. Before allocating resources to new activities, ensure the foundations are funded – by Gavi or other source – and consider whether these core functions can be delivered more cost-effectively, for example through integrated delivery or other efficiency gains. If routine immunisation delivery is at risk, this must be addressed first.*

5. Optimisation of activities

For each priority area, compare alternative delivery and financing models to identify the most cost-effective and scalable option within the fixed envelope.

- ✓ *Design for both differentiated and integrated delivery: Consider differentiated delivery models (e.g. fixed, outreach, mobile, PIRIs) tailored to specific contexts and cost them explicitly within scenarios. Also, be proactive in identifying opportunities to integrate with other platforms (MNCH, malaria, nutrition, polio).*

6. Sequencing priorities

Determine the order in which priorities will be considered and any necessary inputs (evidence, expertise, stakeholder input).

7. Geographic prioritisation/differentiation

Identify which geographies should be prioritised based on performance gaps, zero-dose burden, contextual constraints and delivery capacity.

- ✓ *Plan geographic and temporal sequencing deliberately: When resources are insufficient for nationwide implementation, use a transparent logic to phase or target investments (e.g. highest zero-dose burden districts first, then expansion as resources permit). Make clear in each scenario what is immediate versus deferred, and what minimum investments are required now to avoid higher costs or risks later.*

8. Scenario development

Create scenarios that allocate across priority areas within the limited funds, evaluated against the agreed criteria. Each scenario should represent a different strategic emphasis, not just a different budget level. This process will include multiple iterations based on outcomes and assumptions.

9. Scenario assessment for feasibility and sustainability

Check whether the implied implementation pace is realistic given workforce, management capacity, and procurement and disbursement timelines. Be explicit about your measure of success per given scenario.

- ✓ *Stakeholder validation: Throughout the process, engage key actors and decision-makers, including senior leadership in the Ministry and other subnational levels to ensure alignment and socialisation.*
- ✓ *Leverage comparative advantage of different funders and actors: Use the key questions on other external financing to identify which activities are best supported by Gavi cash versus other partners (e.g. WB, Global Fund, bilateral donors). Avoid designing scenarios that hinge on highly uncertain funding; where such assumptions are necessary, explicitly label them and outline contingency options.*

10. Documenting trade-offs

For each scenario, develop a brief description of advantages, risks, and what is being traded off. This is essential for informed decision-making in Phase 3.

- ✓ *State trade-offs clearly to facilitate decision: Translate technical trade-offs into a small number of clear statements (e.g. "Scenario A will reduce zero-dose by X in these districts, but delays CCE replacement in others"). Align trade-off narratives with political and strategic signals captured in Phase 1, to make it easier for leadership to choose between options.*

Resources

Material	Source	How to Access
Priorities identified in Phase 1	Country	--
6.0 HS Strategy	Gavi	Gavi Guidelines Website
6.0 Letters (incl. cash guardrails)	Gavi	Request from SCM
Interim HS Reprioritisation Guidance	Gavi	Gavi Guidelines Website
C7 Reprioritization Process Note	Global Fund	Global Fund Website, Country Focal Point
Health System Integration Primer	PATH	PATH Website
NIS Guidance (2026 update)	WHO	WHO NIS Website

Phase 3 – decision-making

This final phase is meant to get to finalise an 'application-ready' set of programmatic priorities and budget allocations for both the cash and vaccine budgets. In practice, this is when the options developed by the technical team are brought back together, validated for programmatic alignment, checked for compliance with Gavi funding rules, and ultimately presented to country leadership for decision-making.

Recommended steps

1. Harmonisation of vaccine and cash recommendations

Vaccine and cash teams are brought together to compare scenarios, identify any outstanding inconsistencies, and resolve them. Ideally, this has been done throughout, and this final check is for confirming last details (e.g. the need for additional TCA for an activity or aligning the timing of joint activities), although it might still require iteration.

- ✓ *Check for subtle alignment gaps between vaccine and cash budgets: Once all options are developed, verify that the timing and geographic prioritisation of planned activities is reasonable, check if additional technical assistance is needed to deliver all proposed activities and confirm if cash activities impact underlying vaccine assumptions (e.g. if investments are made to increase coverage, ensuring that increase is reflected in the vaccine budget proposal).*

2. Compliance validation

Confirm that the final investment proposal aligns with the Gavi Vaccine and Cash budget policies.

- ✓ *Validate numbers using the latest figures and tools: It is critical to validate vaccine budget options using the latest version of the budget simulation tool and confirm CB and VB figures (including guardrails) with the SCM.*

3. Presentation to decision-makers

The technical teams should have now developed one to three options for consideration, which can be brought to senior government leadership and any other relevant body (e.g. ICC or equivalent), as applicable. The decision-makers should be provided with a clear summary of each option, including costs, expected outcomes, trade-offs and risks.

- ✓ *Describe the options in terms of the priorities and criteria established in Phase 1: Review the priorities and criteria that were defined during the first phase and make sure that each of the*

options clearly describes how it meets those priorities, where they make trade-offs – and how the outcomes will be measured.

- ✓ *<u>Be explicit about dependencies, particularly for domestic financing:</u> If options are reliant on the commitment of funding or other actions from other stakeholders – either the government or funders – ensure those are clearly called out, including vaccine co-financing. It is also important to ensure the relevant stakeholders are involved when the options are discussed, to confirm alignment.*

4. Final decision-making

Choose the preferred option and document the rationale. This becomes the basis for the Gavi application (see Annex 2: Process guidelines).

5. Advocacy and financial strategy

Where the selected option requires domestic budget increases, Global Fund coordination, or MDB engagement, agree on the advocacy actions needed and assign responsibility. Define clear mitigation plans should additional resources not materialise, and obtain validation for them.

Annex 2: Process guidelines

Grant cycle alignment

Grant cycle alignment is a key element of Gavi's grant management reform under Gavi 6.0 and the Gavi Leap Strategy. It enables countries to plan Gavi support for their vaccines and cash needs early in the strategic period and in alignment with their national strategies though a single grant. This single grant will be operationalised within a defined implementation period of a minimum of three, and maximum of five years. This is intended to improve predictability, align national plans with Gavi's priorities, reduce administrative and financial burden, and foster a stronger focus on implementation and timely course correction. Financing for diagnostics procurement is separate and not charged against the country vaccine and cash budgets. It will be provided as additional top-up support, and countries must submit this request as part of their holistic application.

All countries must transition to a single grant no later than 1January 2028.

Grant cycle alignment does not apply to Catalytic Phase countries, diagnostics programmes, or outbreak response applications. The process for Catalytic Phase countries to apply for Gavi support is further described in the "Catalytic Phase Applications" section, for diagnostics support, in the vaccines section of Annex 3: Vaccines Menu, and for outbreak support, in the "Outbreak support" section of this annex.

Transitioning into the 6.0 strategic period

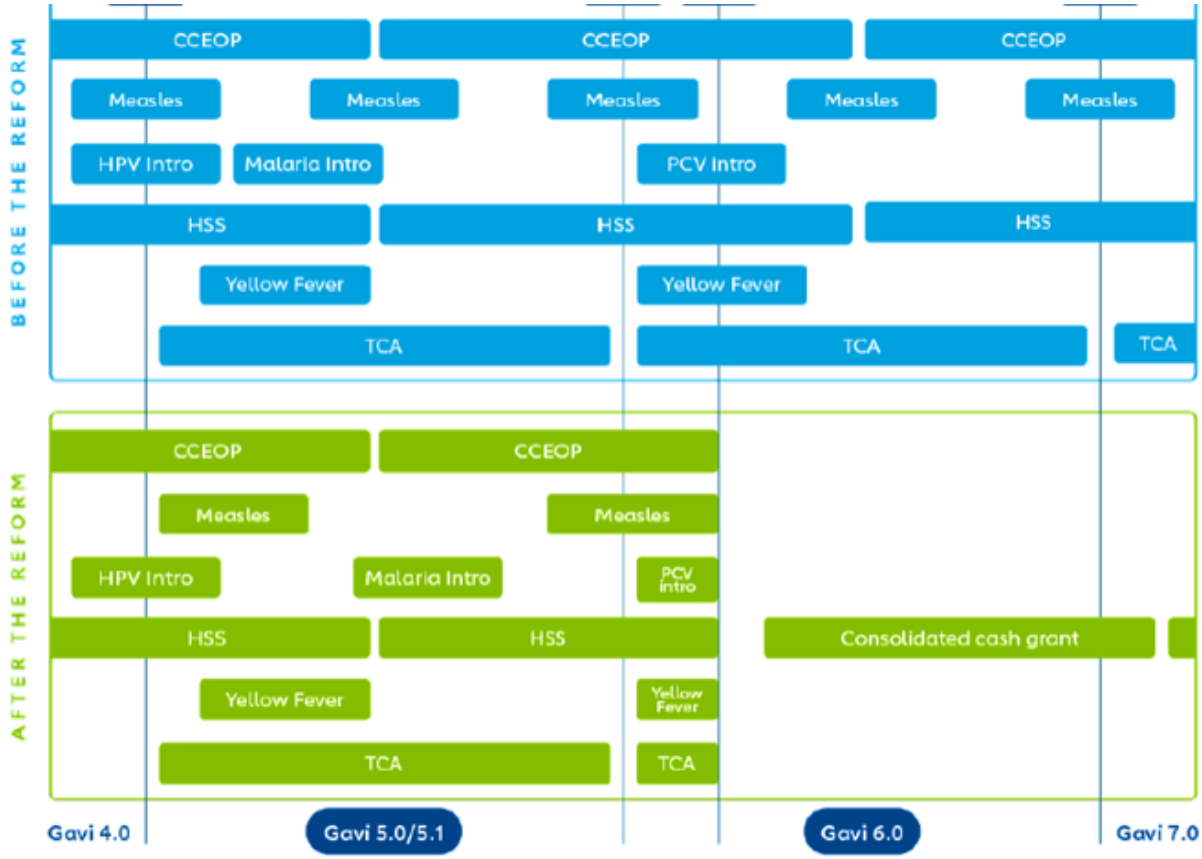
Countries should refer to the Interim Guidance for clarity on the initial process for transitioning from their 5.1 grants to Gavi's 6.0 strategy during the **interim period** between January 2026 and the start of their single Gavi 6.0 grant. This applies to paused Decision Letters and applications, time sensitive vaccine introduction and campaign requests, and switch requests. All other applications must be incorporated in the single Gavi grant via one of the two pathways described below.

Two pathways for applying for Gavi support in 6.0

Along with the updates to Gavi's strategic approach as outlined in the Funding Guidelines, the Secretariat has transformed the application process to create efficiencies, simplify steps to follow, and enable further flexibilities for countries.

In Gavi 6.0, there are two pathways for countries to apply for a single grant, and thereby achieve the principles of grant cycle alignment.

- Pathway 1: New country application: countries requesting new cash and vaccine support in Gavi 6.0 are able to submit a single holistic application that includes all support requested in alignment with Gavi 6.0 funding available.
- Pathway 2: Reprogramming and consolidated application. Countries with existing HSS funding are able to submit a single reprogramming request that consolidates and extends cash and vaccine support in alignment with Gavi 6.0 funding available.



Application roadmap

For both pathways – new country applications and reprogramming and consolidation applications – countries will follow a similar process. In order to optimise the application process, Gavi has reduced the number and complexity of application requirements in Gavi 6.0. The streamlined set of application documents includes a strategic narrative, budget and grant accountability framework. In addition, supporting documents required have been reduced to only essential materials.

In Gavi 6.0, the Grant Management System (GMS) will be used as the single digital platform for end-to-end grant management support, beginning with the submission of a new country application or reprogramming and consolidation application.

Prior to beginning application development, countries are encouraged to plan for their new country application or reprogramming and consolidation application through multi-stakeholder dialogues, followed by a structured prioritisation and optimisation process to validate national immunisation priorities. Additional information and supporting tools for these processes can be found in Annex 1: Prioritisation guidance.

Developing a Gavi funding application

Under both the new country application and reprogramming and consolidation application pathways to a single 6.0 grant, all countries will submit a simplified and streamlined set of three core documents.

For each of these, template(s) will be available on the country portal of the Grant Management System:

1) Strategic narrative: strategic narrative template
2) Budget: budget template
3) Grant accountability framework: target indicators template and targeted areas template

Each of these templates will be accompanied by detailed instructions and will be differentiated according to country context and application pathway.

Each of the templates will be downloadable, allowing countries to work offline before submission. Please note that only the budget template will be automatically saved to the GMS during offline work, while the strategic narrative and grant accountability framework templates will need to be manually re-uploaded following offline editing.

Strategic narrative

The strategic narrative template provides the opportunity for countries to describe their overall request for Gavi support, including vaccine and cash support requested during Gavi 6.0, via a set of guiding questions.

The narrative should describe the context and outline how Gavi funding in the Gavi 6.0 Strategic Period will support the country to reach immunisation objectives. Relevant sections and/or pages of national documents, such as the National Immunization Strategy (NIS) or recent programme reviews, can be used for populating the template if they contain relevant and requested information.

The strategic narrative should be used to provide an overall view of how countries will use Gavi funds including priority investments and technical assistance needs. Countries should further articulate how Gavi funding is complementary to domestic and development partner resources and should describe the country's plans for performance management and overall governance.
In addition, the strategic narrative can be used to identify any major risks that could negatively impact a grant's performance or ability to achieve its results along with the proposed mitigation measures.

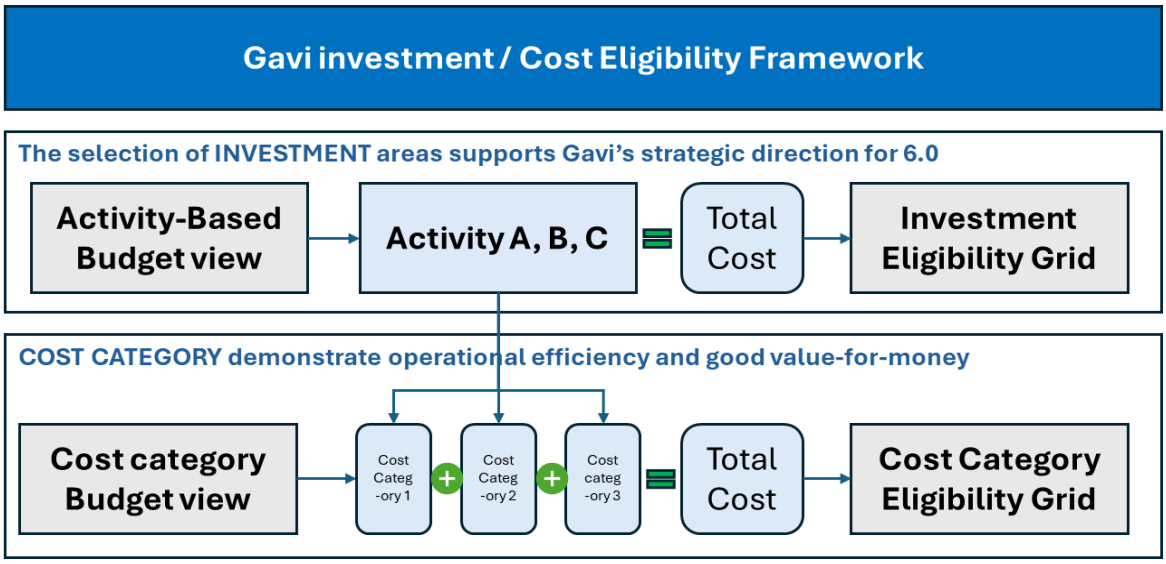
Countries are encouraged to keep the strategic narrative focused and succinct. Providing a clear overarching application narrative will also improve the understanding of other required documents, particularly the budget assumptions as described below, and may reduce the level of deliberation or follow-up needed.

Budget

While Gavi provides a high degree of flexibility in budget design and implementation, it does require grantees to comply with certain principles. For both new holistic and reprogramming applications, detailed budgeting is required for the first three years of the maximum five-year grant term. For the latter period, covering two years at maximum, countries may provide indicative budgets with a comparatively lower required level of detail.

Gavi requires grantees to comply with certain budget eligibility requirements, and provides a framework of eligible activities and costs designed to guide the budgeting of investment choices. Where ineligible cost or activity types are included, Gavi reserves the right to disregard these in the

funding application. The primary budget building concept, using the same logic as in Gavi 5.0, is illustrated as follows:



This matrix approach to the budget structure aims to promote country choice of activities within Gavi's eligibility criteria, as well as demonstrating value for money for Gavi's investments. The cost and activity framework has been re-developed for Gavi 6.0 to simplify cost categories including minor changes in cost classifications and re-alignment of activities with the Gavi 6.0 strategy. A summary of the framework under 6.0 is included below, while the full details of budget eligibility and cost category thresholds are provided in Annex 7: Budget eligibility.

Investment areas	Cost categories
1. Service delivery 2. Human resources management 3. Supply chain 4. Data, monitoring and learning, AEFI 5. Disease surveillance 6. Demand generation and community engagement 7. Governance, policy, strategic planning and programme management 8. Health financing	1. Salaries and wages (programme, administrative, technical and outreach personnel) 2. Per diems, allowances and other forms of compensation 3. Transport, travel and related costs 4. Professional services 5. Consumables associated with service delivery 6. Event related costs (trainings, meetings, workshops…) 7. Assets – procurement/maintenance/construction and renovation 8. CCEOP-eligible equipment and associated services (Gavi Board Guardrail) 9. Information and communication technology activities. 10. Programme support costs, administration and overheads 11. Results-based financing

The **budget template** follows the above standard format of Gavi's budgeting principles. It is designed for countries to list a complete set of eligible and costed activities. Inclusion of assumptions showing the detailed cost breakdown are an integral part of the Gavi budget preparation process. Gavi offers flexibility in how these assumptions are presented, with the option of using standard costs for similar

activities and allowing the insertion of country working sheets in the template. As a rule, the budget should avoid lump sums. However, where this is unavoidable due to lack of detailed breakdowns, they should still be supported with clear logic detailed in the accompanying narrative.

The application budget can be prepared either through information derived from the NIS or NHSP, or as a standalone exercise. When developing their budget, countries are also expected to demonstrate a robust connection to the country's programmatic implementation plans, and the performance monitoring of activities as described in the strategic narrative and grant accountability framework documents respectively.

Gavi grant accountability framework

Gavi 6.0 grants will be monitored using a grant accountability framework (GAF). The framework must be completed as part of the new country application or reprogramming and consolidated grant request.

The GAF is designed to enable monitoring of a grant's results chain, tracing the use of Gavi resources through implementation and the resultant outcomes. This allows for both a clearer understanding of where and why a grant may be under- or over-performing, and for responsive adjustments in pursuit of improved outcomes. In the simplest terms, the GAF allows stakeholders to understand a grant's **performance** by assessing both its **progress** (through the use of cash and vaccine resources and the implementation status of budgeted activities) and its **results** (through regularly reported indicators).

Establishing indicators and targets

As part of a grant application, countries will be required to complete the **GAF Indicators template**. Baselines and targets need to be set by the country for the required grant-linked KPIs, as detailed further in Annex 10: Grant Accountability Framework. Each grant recipient (including governments or ministries) will also need to select, and set baselines and targets for one to three tailored indicators (noting that for countries with 6.0 funding ceilings under US$ 10 million, tailored indicators are optional). Each tailored indicator should be tied to an activity from the budget template with an identified grant recipient who receives the funds for that activity. Targets should be set against the end of the grant period, though it is also possible to set annual targets over the duration of the grant.

If a grant recipient wishes to use a new indicator not available from the list of tailored indicators, they can do so, ideally drawing from indicators in existing national M&E plans, given that the creation of new indicators can be a time-consuming process during both application and reporting. If no mechanism exists to generate the data required for reporting against a tailored indicator, there must be a plan in place to ensure that data will be available, which could include using grant funding to support data activities.

Countries will also be asked to complete the **Targeted Areas template**[3]. This template will be available for download from the GMS. Countries should identify and list which subnational areas (at both Admin 1 and Admin 2 level) will be receiving support through their 6.0 consolidated cash grant. Targeting is important to ensure resources and activities are directed towards the specific areas and populations prioritised by the grant. This list should consist of the areas where the core activities of the consolidated grant take place, noting there is likely more precise targeting for select activities. Countries should also make sure the district list provided is aligned to their reporting (i.e. district lists should be the same as the eJRF).

Application submission

All applications in Gavi 6.0 will be accepted through the country portal on the GMS. To ensure applications are complete, a submission checklist is available on the portal, listing key items across both core and supporting documents. In addition to the three core application materials, necessary supporting documents include approval of relevant governance bodies and signatures from the Minister of Health and the Minister of Finance.

An application for Gavi support should be developed (ideally) or endorsed (at a minimum) by a country-level coordination forum of the country's choosing. Use of an existing forum such as an HSCC or similar that includes all relevant stakeholders (MoH, other government departments, technical partners, donor representatives and civil society) is encouraged. The forum should ensure that the requested support is fully aligned with the country's PHC strategy, timelines and plans, and is aligned with existing or planned support from domestic or other donor support. Ideally, joint planning approaches across PHC support should be adopted.

To this end, Gavi also requires countries to provide evidence of engagement from both the ICC (or equivalent forum) and the NITAG, for example in the form of meeting minutes, confirming the endorsement of all NVIs included in the application.

Before applications proceed to technical review, Gavi will conduct a compliance check to confirm that all required documents, endorsements and signatures have been submitted in full. Applications that do not meet these minimum compliance requirements will be returned to the country for completion before they can enter the formal review process.

Review by the Independent Review Committee

A country's request for new support, either a consolidated application or standalone funding request, will be reviewed by Gavi's Independent Review Committee (IRC).

The IRC comprises experts in public health, epidemiology, supply chain, development finance, economics and other relevant fields. The IRC will review countries' requests for support in accordance

[3] For Catalytic Phase countries this template is optional, unless applying for dengue.

with policies adopted by the Gavi Board and advise on whether to fund country plans and programmes. The aim of the IRC review is to make an independent recommendation as to whether a country's plan is likely to achieve the proposed results and thereby contribute to Gavi achieving its mission and strategy. The recommendation takes into account the justification provided by the country in line with Gavi's mission, including soundness of approach, readiness and feasibility of plans, system strengthening and sustainability, economic and financial considerations, and public health benefit of the investment.

The IRC will consider country support requests holistically, especially assessing linkages and continuity between programmes. It also takes into consideration reports on country performance and past country reviews, in making its recommendations.

The IRC will review each support request holistically, considering linkages across programmes and ensuring continuity with previous and ongoing investments. Applications will be assessed in a differentiated manner that accounts for country context, including situations of fragility, conflict, and vulnerability. The review will consider performance across several dimensions: equity; strategy and planning; implementation capacity; alignment, integration and sustainability; budget and financial management; governance and leadership; monitoring, evaluation and data use; and supply chain and cold chain readiness.

In making its recommendations, the IRC also draws upon country performance reports and any relevant country-specific assessments to inform its understanding of progress, risks and opportunities. Possible outcomes of the review include recommendation for **full approval**, **approval with conditions**, or a **request for re-review**. Well-prepared and complete applications are more likely to advance smoothly through the process and receive timely recommendations for approval.

Issue resolution and GO Group review

Following their review, the IRC will issue a set of recommendations for the country, partners and for Gavi Secretariat that will need to be resolved before the grant can be approved by Gavi or the first disbursement can take place. This stage is called issue resolution and should be completed within 30 days of the IRC review. During this time, country and partners will work with the SCM to ensure that the IRC recommendations have been addressed.

The application will then be reviewed by the Gavi Grant Operationalisation Group (GO Group). The GO Group is a forum of Gavi Secretariat senior leaders who provide approval for applications to ensure approved grants are high-quality, implementation-ready, and risks are sufficiently mitigated. The GO Group is the final step of the application review and the outcome of the GO Group review will be an approved Gavi grant.

Grant modification

During implementation of a single Gavi 6.0 grant, countries may need to adjust their programmes to respond to evolving national priorities, shifts in operational realities, or new evidence. Under Gavi 6.0, grant modification replaces and integrates several processes used in the 5.1 period – including minor adjustments, reallocations (moderate), reprogramming (major), new standalone vaccine requests, dose changes, and implementer changes – to ensure that all adjustments follow a single unified approach.

Grant modifications may range from minor adjustments, such as small shifts across sub-activity budget lines, to significant revisions that reflect a shift in strategic objectives or require IRC review. Countries may initiate modifications **proactively** in response to planned changes (such as changes to national immunisation strategies, WHO recommendations or Gavi policies) or **reactively** in response to emerging needs such as programmatic underperformance, financial implementation challenges, or required vaccine switches. Secretariat-initiated modification may also occur where risks, compliance concerns, or performance issues are identified. Grant modification may also be used to advance funds to initiate urgent outbreak response vaccination activities following a request's approval from the ICG, M&RP ORF, or other Gavi-funded mechanism while funds are being transferred.

The review and approval pathway for each modification will be differentiated based on the scale and nature of the change, with thresholds guiding whether approval rests with the Secretariat, SCM, GO Group, or the IRC.

Other types of support

Catalytic Phase country applications

Countries in the Catalytic Phase (CP) are invited to submit, at any time within the Gavi 6.0 strategic period, an application for support for new vaccine introduction and optimisation needs through one or more of the country-level catalysers. The application pathway process for Catalytic Phase will follow similar steps to other countries with elements of differentiation in each step to respond adequately to CP scope of support as follows:

The CP funding application

To receive support, Catalytic Phase countries follow a distinct, time-limited, and needs-based support model. CP support can be granted for up to two years of implementation, in case of a phased introduction. To access support, CP country applications will meet the core requirements for applications, namely submit 1) a **CP strategic narrative;** 2) a budget template; and 3) a grant accountability framework. On the latter, monitoring requirements for CP countries are differentiated, with selected grant-linked KPIs applicable, differentiated reporting requirements, and additional optional indicators available for tracking in the GMS. The **Targeted Areas** template is optional, except for dengue support, once available. For further guidance refer to the GAF section of this annex and to Annex 10: Grant Accountability Framework.

In addition to the above-mentioned core requirements, requests for **vaccine catalytic financing** support will include a **dose request** for 50% of the first birth (or target) cohort, to be submitted in the GMS.

Additional application documentation for CP countries

Depending on the specific need for support – whether for new vaccine introduction or optimisation support – additional documentation will be needed alongside the catalyser requested. This is necessary to show the country's commitment to equitable and sustainable vaccine introduction, as outlined below:

Table 2.1 Additional requirements – new vaccine introduction support

NVI requirements	Catalyser	
	OOC	VCF
A formal decision by the Minister of Health to introduce the vaccine	X	X
Any required legislative changes, or that these are in process and will be completed in the next six months.	X	X
NITAG, or equivalent body, recommendation.	X	X
National registration of the vaccine (if required by law).	X	X
A multi-year procurement and financing plan, or equivalent.	X	X
Signature Minister of Education (for HPV introduction support only)	X	X
A finalised **new vaccine introduction plan**	X	X

Table 2.2 Additional requirements – Optimisation support[4]

Optimisation requirements	Catalyzer	
	TA	*OOC*
Formal endorsement by the Minister of Health.	X	X
NITAG, ICC, or equivalent body, recommendation or endorsement.		X
A finalised **optimisation implementation plan (for optimisation implementation support only)**	X	X

CP application review

All CP applications for new support will be reviewed by Gavi's Independent Review Committee (IRC) following review criteria specific to CP scope of support. For more information on the IRC process see section on IRC review above. Once reviewed by the IRC, CP applications will follow similar steps as other grants, moving towards grant modification, as applicable; GO Group approval, contracting; disbursement and implementation.

Outbreak response support

Cholera, Ebola, meningitis, mpox, and yellow fever outbreak response vaccination

Countries may access the Gavi-funded global vaccine stockpiles of cholera, Ebola, meningitis, mpox, and yellow fever vaccines by applying directly to the International Coordinating Group on Vaccine Provision (ICG), that manages allocation of vaccines from the stockpiles. Operational funding from Gavi is available to support implementation ICG-approved requests. To access operational funding for ICG-approved requests, Gavi-eligible countries should submit a budget to WHO for approval, and funds will be disbursed directly by WHO.

For application forms, budget template, and guidance on processes, please refer to the ICG's website: https://www.who.int/groups/icg.

[4] Support for optimisation implementation is only available to countries that transitioned out of the standard Gavi support (former-Gavi country) and are eligible for the Catalytic Phase.

All applications should be submitted to the ICG Secretariat at: ICGsecretariat@who.int.

Measles outbreak response vaccination

Gavi-eligible countries where local resources are not enough to control the spread of a measles outbreak may access Gavi-funded vaccines, injection equipment and operational costs for outbreak response by applying directly to the Measles and Rubella Partnership Outbreak Response Fund (M&RP ORF).

For application forms, budget template, and guidance on processes, please refer to the M&RP's website: https://measlesrubellapartnership.org/resources/outbreaks/.

All applications should be submitted to the M&RP at: MRP-ORF@who.int

Catalytic phase countries facing fragility and/or emergencies may also be able to request time-limited measles outbreak response support through the Gavi Resilience Mechanism (see below).

The Gavi Resilience Mechanism (GRM) for unforeseen needs

The final parameters of the GRM are subject to Board approval in July 2026. As such, further information on process and application/review pathways will be shared later this year. In the interim, should countries, partners or humanitarian actors wish to discuss accessing the Gavi Resilience Mechanism to respond to unforeseen needs, they should contact their Gavi Senior Country Manager in the first instance, who can provide appropriate guidance on what/if Gavi support may be available and how to access it

Annex 3: Vaccine menu

- Oral cholera vaccine (OCV)
    - Cholera diagnostics
- Diphtheria, tetanus and pertussis-containing boosters (DTPcV boosters)
- Diphtheria, tetanus and pertussis-containing hexavalent vaccine
- Ebola vaccine (preventive vaccination)
- Hepatitis B birth dose vaccine (HepB-BD)
- Human papillomavirus (HPV) vaccine
- Human rabies post-exposure prophylaxis vaccine (Rabies-PEP)
- Japanese encephalitis vaccine (JEV)
- Malaria vaccine
- Measles/measles-rubella (MR) vaccine
    - Measles diagnostics
- Meningococcal meningitis vaccines
- Diphtheria, tetanus and pertussis, hepatitis B, *Haemophilus influenzae* type b combination vaccine (pentavalent)
- Pneumococcal conjugate vaccine (PCV)
- Inactivated polio vaccine (IPV)
- Respiratory syncytial virus (RSV) maternal vaccine to protect infants
- Rotavirus vaccine
- Typhoid conjugate vaccine (TCV)
- Yellow fever vaccine (YFV)
    - Yellow fever diagnostics

Vaccine programmes supported by Gavi

This section describes the scope of Gavi support and vaccine-specific application requirements for vaccine programmes supported during 6.0, as a supplement to the detailed information on application requirements. Vaccines available for outbreak response only, such as mpox are described in Part D of the Funding Guidelines. Each vaccine description includes the following sections:

- **WHO guidance:** a brief summary of key WHO recommendations with links for further information
- **Scope of Gavi support:** A description of how Gavi provides support to this vaccine program
- **Specific requirements for funding request:** If needed, any specific items that IRC would need to see in a holistic application or reprogramming request
- **Special co-financing considerations**: If needed, any unique co-financing aspects. General co-financing information is in Part B – Cofinancing and CJI requirements, only programme-specific exceptions are noted.
- **Relevant links:** Additional technical resources, if any.

For more technical information on the vaccines including delivery strategies, epidemiological targeting, and prioritisation considerations, please refer to the specific WHO and other technical documents provided as links in each section. Further information on key prioritisation and optimisation considerations are found in the NITAG Evidence Compendium: https://nitag-resource.org/compendium and in the WHO recommended vaccine tables: WHO Recommendations for routine immunization.

All Gavi procurement support for vaccines and diagnostics is provided through UNICEF SD. Detailed information on available product presentations for all vaccines is found in Gavi's Detailed Product Profiles: https://www.gavi.org/our-work/market-shaping/product-information-vaccines-cold-chain-equipment and up to date vaccines market information is found in the Immunisation Market Dashboard: https://www.unicef.org/supply/immunization-market-dashboard.

Except where noted otherwise, all programmatic requirements below are supported via the country's cash and vaccine budget.

Oral cholera vaccine (OCV)

The oral cholera vaccine helps prevent cholera, an acute diarrhoeal disease that can cause rapid dehydration and death if untreated. The vaccine is an essential tool for outbreak response and for prevention (in endemic settings) as one part of national cholera control plans. By reducing the risk and impact of large-scale epidemics, OCV strengthens health security and protects vulnerable populations. The guidance below pertains only to preventive OCV campaigns.

WHO guidance

- WHO recommends that OCV be used in areas with endemic cholera for preventive vaccination. Preventive OCV should be used as part of a multi-sectoral cholera control strategy.
- All persons at least one year of age in the targeted areas are eligible to be included.

Further information:

Cholera vaccines: WHO position paper – August 2017:
https://www.who.int/publications/i/item/cholera-vaccines-who-position-paper-august-2017

Scope of Gavi support

- OCV is supported by the **discretionary** vaccine budget.
- Gavi provides support for phased **targeted preventive OCV campaigns** in endemic-cholera areas.
- The priority areas for vaccination should be selected within the initial list of Priority Areas for Multisectoral Interventions targeted by the national cholera control plans. As part of this process, countries are also required to leverage available cholera tests and surveillance data to refine targeting and prioritise areas with demonstrated cholera burden
- For areas that that are not endemic to the levels of the prioritisation criteria for preventive vaccination other cholera control interventions might be still relevant (WASH, surveillance strengthening, enhanced case management). For these areas it is still possible to access OCV via ICG if an outbreak response.
- In endemic areas where preventive vaccination is indicated, synergies with reactive campaigns roll-out are encouraged.

Specific requirements for funding request

- Eligible targeted areas by the preventive OCV campaign are those that have documented endemic cholera burden (i.e. high historical incidence and persistence) based on national surveillance data disaggregated by year and administrative level (using available Global

Taskforce on Cholera Control (GTFCC) recommended pOCV thresholds and/or prioritisation tool[5]).

- Countries experiencing outbreaks and conducting reactive vaccination in areas originally targeted for preventive vaccination are expected to factor in these outbreak response activities and adjust their preventive vaccination plans accordingly (e.g. by removing from the preventive plan any areas that have already received two doses during reactive campaigns).
- As part of the programmatic reporting, countries are expected to describe the level of implementation of WASH activities in the areas implementing preventive OCV (i.e. included in annual monitoring).

Relevant links

- GTFCC – oral cholera vaccine: https://www.choleraoutbreak.org/book-page/section-9-oral-cholera-vaccine
- GTFCC – Identification of Priority Areas for Multisectoral Interventions (PAMIs) for cholera control: https://www.gtfcc.org/resources/identification-of-priority-areas-for-multisectoral-interventions-pamis-for-cholera-control/
- GTFCC: Guidance and tool for countries to identify priority areas for intervention https://www.gtfcc.org/resources/identification-of-priority-areas-for-multisectoral-interventions-pamis-for-cholera-control/
- GTFCC: National Cholera Plan Development <https://www.gtfcc.org/resources/template-for-national-cholera-plans/

Cholera diagnostics

Gavi support for cholera diagnostics aims to improve timely case identification, confirmation and efficient and effective response (vaccination). Rapid diagnostic testing and confirmatory laboratory methods (for example, PCR)[6] data should inform Ministries of Health requests for oral cholera vaccines (OCV) and campaign implementation per WHO/GTFCC recommendations. Cholera testing also provides evidence for hotspot mapping (PAMI), surveillance strengthening and WASH interventions.

WHO guidance

- WHO and the Global Task Force on Cholera Control (GTFCC) recommend the use of Rapid tests at health facility and district levels to screen suspected cases and culture or PCR/qPCR testing at reference laboratories for confirmation.

Scope of Gavi support

Support for diagnostics are **outside** of the cash and vaccine budgets. Procurement support currently focuses on cholera rapid tests (as listed in the UNICEF SD catalogue, refer to link below). Countries

[5] (PAMI identification tool and preventive vaccination targeting tool) in applications to Gavi for pOCV

[6] Other confirmatory methods, such as enriched RDT, have also been used in certain contexts. Efforts are ongoing to assess how RDTs may be effectively used for confirmatory testing.

eligible for Gavi vaccine support may apply. Future support may also include molecular (PCR) test kits, as required in specific contexts.

Specific requirements for funding request
To guide planning and implementation, Gavi has developed a country implementation checklist for cholera diagnostic support (refer to link below).

- *Context and rationale:* Applications must provide a rationale for testing, based on previous deployment (if applicable), historical epidemiological and testing data (reporting on country's cholera situation for the last five years), surveillance systems details (including details of what data systems are linked electronically and how cholera surveillance reports and analysis inform decision-making) documentation of recurrent outbreaks.
- *Target population*
    - Countries should define the geographic areas or high-risk populations where testing tools will be deployed, consistent with hotspot mapping (previous epidemiology), previous testing experience (if applicable), national cholera control strategies and targeted pOCV campaign prioritisation exercise conducted.
    - Countries are expected to provide an estimate on the final quantity of tests needed and a test quantification tool is provided as guidance (https://www.gavi.org/news/document-library/cholera-quantification).).
- *Delivery strategies, implementation and equity:* Countries should describe how cholera tests will be deployed and used across their health system, with a focus on reaching high-risk populations equitably and strengthening routine surveillance.
- *Data management and programmatic reporting:* Countries should ensure that cholera testing results are systematically captured, validated and integrated into existing national surveillance platforms (e.g. IDSR, EWARS, DHIS2). Reporting should follow GTFCC guidance (2024)

Special co-financing considerations
There are currently no Gavi co-financing obligations on cholera diagnostics support.

Relevant links
- GTFCC's public health surveillance for cholera – 2024 Guidance document: https://www.gtfcc.org/resources/public-health-surveillance-for-cholera/
- Gavi developed country implementation checklist for cholera diagnostic support: https://www.gavi.org/news/document-library/cholera-dx-implementation-readiness-checklist
- Gavi RDT quantification tool: https://www.gavi.org/news/document-library/cholera-quantification
- UNICEF Supply Catalogue Cholera Kits: https://supply.unicef.org/all-materials/in-vitro-diagnostic-tests/cholera-kits.html
- Target product profile for a rapid diagnostic test for surveillance of cholera outbreaks: https://www.finddx.org/wp-content/uploads/2024/04/20240403_tpp_surveillance_cholera_FV_EN.pdf

DTP-containing vaccine boosters (DTPcv boosters)

DTPcv boosters are necessary to provide continued protection against diphtheria, tetanus, and pertussis beyond early childhood, as protective immunity from the primary series wanes over time. Administered in the second year of life, at school age, and in adolescence, they sustain immunity and reduce outbreak risk.

WHO guidance

- The WHO recommends three boosters against diphtheria and tetanus and at least one booster against pertussis, beyond the primary vaccination series. As these vaccines are given in combination, schedule recommendations have been harmonised across the three antigens.
    - There is flexibility in timing, but ideally, DTPcv booster doses should be given at 12–23 months, 4–7 years and 9–15 years.
- To ensure complete protection, all three boosters are recommended, however, countries can introduce one, two, or all three boosters, in any order. Provision of any booster is beneficial, and a country may choose to build their booster programme gradually over time, based on local epidemiology and evidence-based country prioritisation.
- DTPcv booster contacts are also opportunities to provide missed doses to ensure every child is fully immunised through co-administration with other vaccines given at the same age; for example, second dose of measles-containing vaccine (MCV2), fourth dose of malaria vaccine (where applicable) and HPV vaccine.

Further information:

- Tetanus vaccines: WHO position paper – February 2017: https://www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers/tetanus
- Diphtheria vaccine: WHO position paper – August 2017: https://iris.who.int/server/api/core/bitstreams/8f8a7f94-c9cd-44c7-91c1-c8f7cf16551f/content
- Pertussis vaccines: WHO position paper – August 2015: https://iris.who.int/server/api/core/bitstreams/d4d7eeab-432e-4a08-ac13-0d2adb4a84ff/content
- WHO guideline on school health services: https://www.who.int/publications/i/item/9789240029392
- Protecting all against tetanus: guide to sustaining maternal and neonatal tetanus elimination (MNTE) and broadening tetanus protection for all populations: https://iris.who.int/items/09f6c202-64f2-4f91-bbc7-862f4fc28f47https://iris.who.int/items/09f6c202-64f2-4f91-bbc7-862f4fc28f47
- Strategic action for NITAGs

Scope of Gavi support

- DTPcv Boosters are supported by the **discretionary** vaccine budget.
- Gavi-eligible countries can apply for support to introduce any of the three WHO-recommended DTPcv boosters in the national immunisation schedule.
- As combination vaccines, there are different products that countries can choose from to use as DTPcv Boosters. Gavi vaccine support is limited to combinations with whole-cell pertussis for the first booster only with DTwP and Pentavalent) and Td for second and third booster doses. Countries should consult the Gavi DPP for available vaccine options.

- Vaccine financing support will not be provided for the second and third boosters with tetanus-diphtheria (Td) vaccine as long as the price remains equal to or below US$ 0.20 per dose.

DTP-containing hexavalent vaccine

The hexavalent vaccine combines protection against diphtheria, tetanus, pertussis, polio, Haemophilus influenzae *type b (Hib), and hepatitis B in a single injection. It simplifies immunisation schedules and reduces the number of injections (from five to three) by replacing current schedules of pentavalent and IPV, and can improve programme efficiency by increasing coverage of the second dose of IPV and timeliness of vaccination.*

WHO guidance

- All children worldwide should be fully vaccinated against polio, and every country should seek to achieve and maintain high levels of coverage with polio vaccines in support of the global commitment to eradicate polio.
- Starting from six weeks of age (minimum), WHO recommends a hexavalent vaccine schedule of three doses with a minimum interval of four weeks between doses. The vaccine could be administered using the schedules currently in place for the pentavalent vaccine (e.g. 6, 10 and 14 weeks; 8, 12 and 16 weeks)

Hexavalent contains IPV but not bOPV, and both are needed; therefore, countries will need to continue using bivalent oral polio vaccine (bOPV) in their routine immunisation until global cessation or they demonstrate readiness for bOPV cessation per WHO recommendations.

Further information:

- Polio vaccines: WHO position paper – June 2022: https://www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers/polio
- Meeting of the Strategic Advisory Group of Experts on Immunization, March 2025: conclusions and recommendations: https://iris.who.int/server/api/core/bitstreams/8dc2e79a-343e-460e-addc-eb0c0983fb94/content
- Frequently asked questions and considerations for the introduction of hexavalent vaccine (DTwP-HepB-Hib-IPV) in national immunization programmes -Update June 2025
- Hexavalent Program Information

Scope of Gavi support

- Hexavalent is supported by the **guaranteed** vaccine budget.
- All Gavi-eligible countries that have not yet introduced hexavalent into their national vaccination schedule are eligible for support for the three-dose whole-cell pertussis (wP) hexavalent vaccine.
- Adoption of hexavalent vaccine is implemented as a replacement for the existing pentavalent and IPV schedules. Gavi does **not** support procurement of routine bOPV.

Specific requirements for funding request:

- Within the holistic application, explain the timing and process of switching from pentavalent and IPV to hexavalent.
- Countries should allow 6–12 months between decision and planned launch.

Special co-financing considerations

- Co-financing calculations will include a subsidy equivalent to the country's IPV eligibility (one or two doses), based on the annual weighted average price of IPV.
- Fully self-financing lower-middle income countries (LMICs[7]) are eligible for a temporary subsidy in 2026 to purchase hexavalent vaccines equivalent to their IPV eligibility (one or two doses), aligned with the annual weighted average IPV price. This subsidy will be reduced by 50% in 2027, and by 2028 LMICs will be required to fully finance their hexavalent vaccination programmes.
- For ISF countries using ten-dose pentavalent vials, switching to hexavalent is cost-neutral, as both vaccines are co-financed at US$ 0.20 per dose.

Ebola vaccine (Preventative Vaccination)

The Ebola vaccine protects against Ebola virus disease (EVD), caused by Orthoebolavirus zairense*, a severe and often fatal illness that can cause devastating outbreaks. The vaccine is a critical tool for both outbreak prevention and control, particularly for health workers and communities in high-risk areas. By reducing the risk of transmission and supporting rapid containment, preventive vaccination with Ebola vaccine strengthens epidemic preparedness, reinforces health security and helps protect vulnerable populations during public health emergencies.*

WHO guidance

- Countries at risk of Ebola virus disease (EVD) outbreaks, caused by *Orthoebolavirus zairense*, should preventively vaccinate healthcare workers, frontline workers, national response teams and those who may be involved in EVD outbreak response or treat EVD patients with an Ebola vaccine using a cohort vaccination approach.
- Co-administration: In the absence of an outbreak, Ebola vaccines should be administered alone as a precaution given limited available data on co-administration, with other vaccinations sequenced two weeks before or after the Ebola vaccine dose.
- Use in special populations: Both licensed Ebola vaccines are well tolerated in children and adults and can be administered to individuals aged one year and above. SAGE recommends off-label use of both Ebola vaccines among pregnant and lactating women if they belong to a target group for which preventive vaccination is recommended.
- Revaccination and boosters: Revaccination in the absence of an outbreak is not currently recommended. However, SAGE recommends a booster dose after six months in the context of an outbreak.
- Vaccination records: Tracking vaccinated individuals through an individual electronic record system or national immunisation database is highly recommended to be able to ascertain vaccination status of personnel who may be involved in the response effort in the event of an EVD outbreak. Gavi support can be used to establish and utilise such a system. A post-campaign coverage survey is not recommended. Countries are instead highly encouraged to conduct an enumeration of the targeted populations prior to the vaccination activity to ensure the correct quantifications of the target population, track individuals vaccinated against this

[7] Bhutan, Bolivia, Honduras, India, Kiribati, Nicaragua, Sri Lanka, Uzbekistan, Vietnam

enumeration, and use these data to calculate the proportion of the target population reached (vaccination coverage).

Further information:

- Extraordinary meeting of the Strategic Advisory Group of Experts on Immunization on Ebola vaccination, May 2024: conclusions and recommendations: https://www.who.int/publications/i/item/WER-9927-355-362
- Ebola Vaccination Toolkit by the Global Ebola Vaccination Coordination Team (EVCT): https://www.technet-21.org/en/topics/programme-management/ebola-vaccination-toolkit
- Ebola and Marburg virus disease epidemics: preparedness, alert, control, and evaluation: https://www.who.int/publications/i/item/WHO-HSE-PED-CED-2014.05
- WHO Q&A – Ebola Virus Disease Vaccines: https://www.who.int/news-room/questions-and-answers/item/ebola-vaccines

Scope of Gavi support

- Support for preventive Ebola vaccination programmes is **outside** of the country's cash and vaccine budgets.
- Gavi-eligible countries at risk of an EVD outbreak are eligible to apply for preventive Ebola vaccination support from Gavi. At risk countries are defined as:
  - Risk Tier 1: Countries that have previously reported confirmed cases of EVD caused by *Orthoebolavirus zairense* (including imported cases). If vaccine supplies are limited, priority will be given to countries in Risk Tier 1 given these countries that are at a higher risk of an EVD outbreak.
  - Risk Tier 2: Countries that share a border with a country that has experienced an EVD outbreak resulting from a suspected animal-to-human spillover event (i.e. not as a result of an imported case).
  - Preventive Ebola vaccination should target areas at risk of an EVD outbreak. Countries might consider subnational geographic targeting. Areas that should be prioritised for subnational geographic targeting are districts with documented prior *Orthoebolavirus zairense* transmission.
- Preventive vaccination is designated for **healthcare and frontline workers** in at-risk countries, consistent with WHO recommendations. Priority target groups include:
  - National rapid response teams that would be involved in an EVD outbreak response, including mortuary staff and burial teams;
  - Medical personnel and non-medical personnel working in health care facilities and/or Ebola treatment units, or who provide community outreach services;
  - Laboratory personnel who may be exposed to Ebola virus;
  - Community health workers;
  - Traditional healers;
  - Immigration, customs and border screening officials who may be exposed to EVD cases at health posts at ports of entry during an outbreak;
  - Military and police personnel who may be exposed to EVD cases during an EVD outbreak response.

Special co-financing considerations

- Co-financing is **not** required for Ebola vaccines.

Hepatitis B birth dose vaccine

The hepatitis B birth dose vaccine prevents mother-to-child transmission of hepatitis B virus at birth, a major cause of chronic liver disease and liver cancer worldwide. Administered within 24 hours of birth, it is highly effective in blocking perinatal transmission of the virus. It complements routine infant hepatitis B vaccination.

WHO guidance

- WHO recommends that all infants (including low-birthweight and premature infants) should receive their first dose of the hepatitis B vaccine (HepB-BD) as soon as possible after birth, ideally within 24 hours, since perinatal transmission is the most important source of chronic hepatitis B virus infection globally.
- If administration within 24 hours is not feasible, a late birth dose between one to three days (i.e. within 72 hours) after birth can still be effective in preventing perinatal transmission, but effectiveness declines progressively with each passing day.

Further information:

- Hepatitis B vaccines: WHO position paper – July 2017: https://iris.who.int/server/api/core/bitstreams/c55eb2dd-3b78-452d-b93c-a4471b2bdfed/content
- A Guide for Introducing and Strengthening Hepatitis B Birth Dose Vaccination: https://www.who.int/publications/i/item/9789241509831
- Guidance for Triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis B virus: https://www.who.int/initiatives/triple-elimination-initiative-of-mother-to-child-transmission-of-hiv-syphilis-and-hepatitis-b/validation

Scope of Gavi support

- HepB-BD is supported by the **guaranteed** vaccine budget.
- All Gavi-eligible countries that have not yet introduced the HepB-BD into their national vaccination schedule are eligible to apply for HepB-BD

Specific requirements for funding request

- HepB-BD vaccines should ideally be delivered within delivery wards or in postnatal wards; applications should describe plans for integration of HepB-BD with maternal and newborn care services, in both the public and private sectors, and alignment with other maternal and neonatal health initiatives.
- Countries are encouraged to make plans to enable a larger-scale roll-out of the programme to deliver the vaccines to children born out of health facilities as soon as possible after birth including making any necessary policy changes.

Additional links

- Hepatitis B Birth Dose NITAG Toolkit: https://www.globalhep.org/tools-resources/introduction-hepatitis-b-birth-dose-vaccination-africa-toolkit-national

Human papillomavirus (HPV) vaccine

The human papillomavirus (HPV) vaccine (HPV) is a key public health intervention for the prevention of cervical cancer, which is one of the leading causes of cancer-related deaths among women in low-

and middle-income countries. Almost all cervical cancer cases are linked to persistent infection with high-risk HPV, an extremely common virus transmitted through sexual contact, and preventable with vaccination.

WHO guidance

- WHO recommends all countries to introduce HPV vaccines as primary prevention to reach the goals of the WHO cervical cancer elimination initiative.
- WHO recommends that the primary target population for HPV vaccination is girls aged 9–14 years. At introduction, if feasible and affordable, countries are encouraged to catch up through at least 18 years of age.
- Both single-dose and two-dose vaccination schedules are considered effective in this group, with the single-dose schedule offering potential programmatic and financial advantages. For immunocompromised girls (including those living with HIV), at least two doses, and three doses where possible, is recommended.
- Countries using a single-dose schedule are recommended to offer multiple opportunities for girls to get vaccinated before 15 years of age.

Further information:

- Human papillomavirus vaccines: WHO position paper, December 2022: https://www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers/human-papillomavirus-(hpv)
- Considerations for human papillomavirus (HPV) vaccine product choice, Second edition: https://iris.who.int/server/api/core/bitstreams/fd0c15ff-4139-4cce-a13c-806dbe021005/content
- HPV Vaccine Introduction Clearing House: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house
- Considerations regarding consent in vaccinating children and adolescents between 6 and 17 years old: https://www.who.int/publications/i/item/considerations-regarding-consent-in-vaccinating-children-and-adolescents-between-6-and-17-years-old
- WHO Cervical Cancer Prevention and Control Costing tool: human papillomavirus vaccination module (C4P-HPV tool): https://www.who.int/publications/m/item/WHO-Cervical-Cancer-Prevention-and-Control-Costing-tool-human-papillomavirus-vaccination-module

Scope of Gavi support

- HPV vaccine is supported by the **guaranteed** vaccine budget. The calculations of the budget amount are based on adoption of lower cost products.
- All Gavi-eligible and Catalytic Phase countries that have not yet introduced HPV vaccine into their national vaccination schedule are eligible for support.
- For countries that have not yet introduced HPV vaccination into their national EPI schedule**,** Gavi supports routine HPV vaccine introduction calculated on a single-age cohort of girls aged between 9–14 years.
- Introductions can be combined with a one-time multi-age cohort (MAC) catch-up campaign for girls up to age 14 to maximise impact in the first year. Gavi also offers delayed MAC support for countries that have already introduced HPV but have not yet implemented a Gavi-supported MAC.

- For countries with existing HPV vaccination programmes, Gavi provides support for HPV optimisation, which may include switching vaccine product or schedule. The identification of two or three product choices is recommended during application.
- Co-delivery with vaccines targeting similar age groups, such as DTPcv boosters, TCV, or M/MR could be considered.
- Either a one-dose or two-dose HPV vaccination schedule can be selected, however the guaranteed vaccine budget is calculated based on a single-dose schedule.
- Countries in the Catalytic Phase are eligible for
    - vaccine support to cover 50% of the routine immunisation target cohort; these countries are not eligible for multi-age cohort (MAC) catch-up campaign funding.
    - for countries with existing HPV vaccination programmes, Gavi provides support for optimisation. The identification of at least two product choices is recommended during application.
    - See Annex 8: Catalytic Phase supported areas for more details.

Specific requirements for funding request

- Explanation of what strategies will be used to sustainably reach girls in the target age group with the HPV vaccine.
- Describe the communication strategy to encourage uptake of this vaccine among the target group, and respond to any rumours or misinformation
- For new introductions that include school-based delivery, Ministry of Education signature to the application.

Special co-financing considerations

- ISF countries cofinance routine HPV vaccines based on a percentage of vaccine price – 4% for HPV. For countries in other stages of transition, the usual co-financing policy applies.
- Campaign co-financing policy applies to doses used for the MAC.

Additional links

- HPV vaccine cost calculator for Gavi-eligible countries: https://www.path.org/our-impact/resources/hpv-vaccine-cost-calculator/
- Girl Focus Toolkit: https://girlfocustoolkit.org/
- Global HPV Communication Resource: https://globalhpv.com/
- Technet resources on HPV: https://www.technet-21.org/en/diseases/hpv

Human rabies vaccine for post-exposure prophylaxis (Rabies-PEP)

The human rabies post-exposure prophylaxis (PEP) vaccine prevents fatal rabies if given promptly after animal bite and the series of injections is completed, achieving 100% effectiveness. It complements mass dog vaccination and promotes equity by protecting high-risk and vulnerable groups, especially children.

WHO guidance

- WHO recommends a comprehensive approach to rabies PEP including immediate and thorough washing of the wound at the site of exposure to the rabies virus and, if the exposure

is severe (classified as a category 3 bite), administering rabies immunoglobulin (RIG) to neutralise the virus locally. Additionally, a full course of rabies vaccination is required for all category 2 and 3 exposures
- All age groups are eligible for rabies PEP vaccination.
- The vaccine can be given either intradermally (ID) or intramuscularly (IM) to any age group. The ID schedule includes 0.1 ml doses at two sites on days 0, 3, and 7, while the IM schedule requires 1 ml doses on days 0, 3, 7, and again between days 14 and 28.

Further information:

- Rabies vaccines: WHO position paper – April 2018: https://iris.who.int/server/api/core/bitstreams/679e1a54-9d1b-4b43-8eab-55a6f11ab267/content
- WHO Guide to introducing human rabies vaccine into national immunisation programmes: https://www.who.int/publications/i/item/9789240052499
- WHO Expert Consultation on Rabies: WHO TRS N°1012: https://www.who.int/publications/i/item/WHO-TRS-1012

Scope of Gavi support

- Rabies PEP is supported by the **discretionary** vaccine budget.
- All Gavi eligible countries including those that have introduced the vaccine with their own resources are eligible for Gavi rabies PEP vaccine support
- Introduction of the vaccine into the public health system may be nationwide or subnational/ regional as warranted by the epidemiological context.
- Gavi supports the procurement and delivery of human rabies vaccines for PEP vaccination only. Vaccines for pre-exposure prophylaxis (PrEP) and RIG are **not** supported, nor is rabies vaccine for dogs and other animals.
- However, countries could consider using excess vaccine doses (residual open vial vaccine from ID vaccination and vaccine approaching expiry date) for PrEP vaccination of high-risk groups (opportunistic PrEP vaccination).

Specific requirements for funding request

- To promote sustainability, countries are encouraged to continue their domestic investments in rabies vaccination and provide any available documentation that reflects these ongoing commitments.
- Applications should provide available data on human to dog ratio, dog bite cases, suspected, probable, confirmed rabies cases in humans and animals, adherence to and completion of PEP schedules.
- One Health rabies control relies on a coordinated human, animal, and environmental action; countries must show a national strategic plan that links mass dog vaccination, surveillance, community awareness, environmental health measures, effective dog-bite management
- and PEP delivery.
- Provide strategy for opportunistic PrEP for high-risk groups (animal handlers, veterinarians).
- Gavi strongly encourages countries to transition from IM to ID vaccination due to its public health advantages (lower cost and equally safe and effective) and applications should describe plans for this transition.

Additional links

- Rabies – TechNet-21: https://www.technet-21.org/en/diseases/rabies

Japanese encephalitis vaccine

The Japanese encephalitis vaccine prevents a mosquito-borne viral infection that can cause severe neurological disease, lifelong disability, or death. The disease primarily affects children in rural parts of Asia, where transmission is highest. A single dose of the live attenuated or recombinant vaccine or two doses of the inactivated vaccine provide long-lasting protection and play a critical role in reducing health inequities by protecting under-served rural populations most at risk.

WHO guidance

- **Routine immunisation:** JE vaccination should be integrated into RI at age >= 9 months in all areas where JE is recognised as a public health priority and where there is a suitable environment for JEV transmission.
- **One-off preventive campaign**: To accelerate population immunity, a one-time preventive campaign in the populations <15-years old should be conducted in at-risk areas (matching areas for RI) at time of introduction of JE into RI.

Further information:

- Japanese encephalitis vaccines: WHO position paper – February 2015: https://iris.who.int/server/api/core/bitstreams/2b1bf717-856b-4993-9ddf-fc2e67f0ec00/content

Scope of Gavi support:

- JEV is supported by the **discretionary** vaccine budget.
- Gavi provides support RI for at-risk countries that have not yet applied for JE vaccine support and a one-off campaign (typically at time of introduction, but exceptions may be justified) for populations <15 years old.

Specific requirements for funding request

- For both the routine immunisation and catch-up campaign scope, surveillance data should be used to inform the proposed geographic scope – such as number of Acute Encephalitis Syndrome (AES) cases per capita, and laboratory confirmation rate (% of tested AES cases that were JE IgM-positive). In the absence of data from JE/AES surveillance, data from rapid assessments and environmental and biological plausibility must be included as justification, as well as plans to establish systems or conduct studies to collect surveillance data.

Malaria vaccine

Malaria vaccines protect against mosquito-borne P. falciparum *malaria in children under five years of age, a major cause of mortality in many countries, primarily in Africa. The vaccines significantly reduce malaria illness and death in young children.*

WHO guidance

- Malaria vaccines should be provided as part of a comprehensive malaria prevention and control strategy.

- WHO recommends the use of malaria vaccines for the prevention of *P. falciparum* malaria in children living in malaria-endemic areas, prioritising areas of moderate and high transmission. (defined as annual incidence greater than 250 cases per 1,000 population; or Prevalence of *P. falciparum* infection in children (PfPR) of approximately 10% or more).
- Countries may consider providing the vaccine using an age-based, seasonal, or hybrid delivery approach.
- Malaria vaccines should be provided in a schedule of four or five doses in children beginning from around five months of age.[8] The minimum interval between doses is four weeks. The fourth dose prolongs protection and should be given 6–18 months after the third dose. To reduce additional delivery burden, countries should consider aligning the timing of the fourth dose with the timing of other vaccines and, where appropriate, other health interventions administered in the second year of life. Alternatively, the fourth dose case be given just prior to seasonal peaks in malaria transmission to align the period of highest vaccine efficacy with peak malaria risk.
- A fifth dose, given one year after the fourth dose, may be given in areas of highly seasonal transmission or where malaria risk remains high during the third year of life or beyond.
- The additional visits needed to administer the malaria vaccine are opportunities to provide other integrated malaria control and preventive health services**.**
- At the launch of vaccine introduction, expanded age eligibility can be considered in children up to five years of age to allow children who missed the initial vaccination window to receive the first dose of the malaria vaccine during routine immunisation touchpoints.[9].

Further information:

- Malaria vaccine: WHO position paper – May 2024: https://www.who.int/publications/i/item/who-wer-9919-225-248
- Subnational tailoring of malaria strategies and interventions Reference Manual: https://iris.who.int/server/api/core/bitstreams/78b4fed5-a372-4f87-8a04-edec47e092d5/content
- World Malaria Report 2025: https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2025

Scope of Gavi support

- Malaria vaccine is supported by the **discretionary** vaccine budget.
- Gavi provides support for the introduction and implementation of malaria vaccines in subnational areas where there is moderate or high *P. falciparum* malaria transmission. In 6.0, Gavi's scope of support is limited to the vaccine requirements for up to 70% of countries' areas of moderate and high *P. falciparum* malaria transmission. Requests for Gavi support for malaria vaccine in any areas of low *P. falciparum* malaria transmission may be considered

[8] Countries may consider giving the first vaccine dose earlier than five months of age on the basis of operational considerations to increase coverage or impact.

[9] Subject to local epidemiology and age of high risk, feasibility, affordability and vaccine availability. In many countries with high perennial transmission, the age of highest risk is under three years, while in areas of highly seasonal malaria, the age of highest risk may be extended.

based on a strong programmatic justification and subnational tailoring of malaria control interventions.

- Countries are responsible for defining which subnational areas they wish to target with Gavi support, based on their own data, malaria burden, mix of malaria interventions and national priorities. This targeting should align with efforts to tailor other malaria control and public health interventions. WHO and Gavi Alliance partners can provide technical assistance to countries for the prioritisation of areas of moderate and high malaria transmission.
- Countries may request Gavi support to introduce the malaria vaccine using either a four- or five-dose schedule, depending on local epidemiology.
- Countries with populations in areas with highly seasonal malaria transmission may apply for Gavi funding support to deliver the vaccine using an age-based, seasonal or hybrid delivery strategy in line with WHO recommendations.
- Countries may adopt a phased approach for vaccine roll-out by introducing in eligible administrative areas in a single phase or may phase the introduction in two or more phases.
- Gavi support for expanded age-eligibility for the first dose at launch will be constrained to the initial year 1 vaccine allocations in applicable areas and the expanded age eligibility should be aligned with routine vaccine delivery and vaccine catch-up strategies.
- Gavi supports WHO recommended and pre-qualified vaccines for the prevention of *P. falciparum* malaria in children living in malaria-endemic areas, currently RTS,S/AS01 (RTS,S) and R21/Matrix-M (R21). Countries approved to introduce malaria vaccines are matched with one of the two products based on the following principles: country preference and affordability, minimising the need for product switches, minimising introduction delays and supporting a healthy vaccine market. Switches from one product to another will be allowed on an exceptional basis with defined criteria, aligned with Gavi policy.

Specific requirements for funding request:

- *National strategic plan for malaria:* Provide the national malaria strategic plan, or an addendum to the national plan, that includes a description of how the vaccine fits within the broader mix of malaria interventions, and how it contributes to overall disease control goals. Countries that do not have a national malaria strategic plan that includes the vaccine must describe in a separate document or in an addendum if the plan is not updated to include the vaccine.

- *Malaria burden and epidemiology:* Provide local data detailing the target population and malaria transmission that includes the routine target population, by administrative area, based on data quality and malaria transmission (e.g. annual incidence or PfPR) in their context and according to WHO definitions of moderate and high transmission.

- *Subnational target populations and introduction approach:* Specify which subnational areas of moderate and high malaria transmission are/will be targeted for the malaria vaccine and which subnational areas prioritised for Gavi support. Provide a summary of the malaria vaccine approach (including one-time introduction or scale-up phases), including areas already implementing. Indicate funding sources for the phased approach including Gavi's support up to 70% of moderate and high transmission areas, and as relevant phases and areas (beyond 70%) to be supported by other funding sources or if there are identified gaps requiring resource mobilisation. For countries re-targeting the approach of their existing routine programme, additional information on how the 70% guideline will be applied would be useful.

- *Expanded age eligibility in the introduction year (if planned):* Describe the specific age of eligibility for children to receive the first dose of malaria vaccines at launch of vaccine introduction or scale-up areas, if/as applicable, to allow adequate calculation of top-up vaccine doses by Gavi.

Special co-financing considerations

Malaria co-financing requirements have changes to the following as of January 2026:

- For initial self-financing countries: Country co-financing follows the co-financing policy ($0.20 per dose);
- For preparatory transition countries: Country co-financing starts at US $0.20 per dose in the first year of introduction and the co-financing per dose increases by 30% annually; and
- For accelerated **transition countries: Country co-financing follows the co-financing policy, with linear increase** to reach 100% of vaccines costs in the first year of the fully self-financing phase.

Relevant links

- Malaria Vaccine Guidelines on Gavi and Global Fund support for complementary interventions to facilitate the deployment of malaria vaccines: https://www.gavi.org/sites/default/files/board/minutes/2024/4-5-december13%20-%20Annex%20C%20-%20Malaria%20Vaccine_JointGuidelines%20on%20Gavi%20and%20Global%20Fund%20support.pdf
- Technical resources on malaria vaccine introduction: https://www.technet-21.org/en/topics/programme-management/malaria-vaccine

Measles and measles-rubella (MR) vaccines

The measles and measles-rubella vaccines prevent two highly contagious viral diseases. Measles remains a leading cause of vaccine-preventable child mortality, while rubella infection during pregnancy can result in congenital rubella syndrome (CRS), causing lifelong disabilities for the child. Measles and rubella vaccination is essential for closing immunity gaps and protecting maternal and child health. Gavi supports countries to strengthen measles and rubella control and elimination through routine immunisation, catch-up and follow-up campaigns, and outbreak response.

WHO guidance

- WHO recommends two doses of measles-containing vaccine (MCV) in routine immunisation schedules.
- Rubella vaccine should be introduced via MR vaccine, for both males and females through a multi-age catch-up campaign followed by routine MR vaccination.
- Periodic follow-up campaigns are essential to close immunity gaps and prevent measles outbreaks, especially in settings with low routine coverage.
- In 2024, the WHO SAGE recommended to lift the requirement that countries attain 80% MCV coverage in routine or campaigns before the rubella-containing vaccine (RCV) introduction.

SAGE also recommended the universal introduction of RCV in the 13 countries that have yet to introduce the vaccine.

- The five-dose vial presentation of measles or MR reduces open vial wastage and improves coverage as compared to the ten-dose presentation in country settings in which it has been evaluated.

Further information:

- Measles vaccines: WHO position paper – April 2017:https://www.who.int/publications/i/item/who-wer9217-205-227
- WHO Rubella Position Paper
- SAGE recommendation on Rubella and congenital rubella syndrome prevention: https://www.who.int/publications/i/item/who-wer9949-719-740
- WHO SIA Planning and Implementation Guide (EN I FR)
- Targeted and selective strategies in measles and rubella vaccination campaigns: Interim guidance: https://www.who.int/publications/i/item/9789240103399
- Measles and Measles-Rubella (MR) Vaccine Five-Dose Vial Presentation – Fact Sheet 2022 UNICEF WHO – 2023: https://www.technet-21.org/en/resources/guidance/unicef-who-mcv-5-dose-fact-sheet
- 5-dose switch decision-making tool: https://www.technet-21.org/en/resources/tool/mcv-5-dose-vial-assessment-support-tool

Scope of Gavi support

- Measles and MR vaccines are supported by the **guaranteed** vaccine budget, with some differences as mentioned below.
- Gavi provides support for **routine immunisation** through the cash budget and vaccines budget for countries that are not self-financing their routine doses.
- Gavi supports the switch from the ten-dose vial presentation to the five-dose vial presentation for routine immunization if a country opts to implement the switch. Vaccine costs will be allocated as part of the vaccine budget. Countries would need to allocate funding to support operational costs of the switch implementation from their cash budget.
- Gavi supports one-time catch-up campaigns at the time of MR introduction from 6/9 months to <10 years or <15 years (depending on epidemiology and country decision on cash envelope budget and vaccine budget)
- MR catch-up campaigns targeting children 6/9 months to under 10 years old are a guaranteed programme, with doses and operational costs for this activity being included in countries' cash budgets and vaccine budgets.
- A country introducing MR can fund operational costs for children 6/9 months to 59 months from the MR guardrail.
- The operational costs and doses for children aged 5 to <10 will be allocated as part of the cash budget and vaccine budgets for campaigns and introductions taking place in 2026–2027. Vaccine and cash allocations for MR catch-up campaigns and introductions taking place in 2028–030 will be provided once the country submits its application or reprogramming request.
- Countries that want to target children aged 10 to <15 may prioritise resources from within their discretionary vaccine budget and cash budget to do so, if epidemiologically justified and a priority for the country.
- Gavi supports periodic campaigns to maintain population immunity from 6/9 months to 59 months (or older depending on epidemiology and country decision on cash budget).

- M-MR follow-up campaign operational costs for children 6/9 months to 59 months are guardrailed in countries' cash budgets, i.e. funding for them cannot be allocated to other activities.
- Countries that want to target children aged over 59 months for a preventive campaign may prioritise resources from within their discretionary vaccine budget and cash budget to do so, if epidemiologically justified and a priority for the country.
- Leveraging the board-approved operational cost flexibilities for measles/MR follow-up campaigns, Gavi strongly recommends that higher-performing countries prioritise tailored and targeted campaign delivery strategies and/or enhanced routine immunisation activities as an alternative to nationwide non-selective follow-up campaigns, with a focus on reaching measles-unvaccinated and under-vaccinated children.

Specific requirements for funding request

- In alignment with the October 2018 SAGE recommendation, countries with medium incidence and periodic outbreaks, inadequate immunity in some populations and moderate programme capacity (e.g. MCV1 coverage of 85-90% and MCV2 coverage of 80–g-90%) can conduct targeted campaigns according to the epidemiological profile of the subnational areas concerned if high quality data are available for subnational analysis. Aligned with the Gavi Board 2018 November decision, such countries may use the guardrailed amounts for national SIAs, subnational SIAs and/or enhanced routine immunisation activities targeted at reaching missed children.
- Countries must describe which enhanced routine immunisation activities will be implemented to address measles immunity gaps between follow-up campaigns and, in the long term, decrease reliance on these campaigns.
- If applying for routine enhancing activities in lieu of a follow-up campaign or as a complement to a targeted one, countries should apply the following principles to select activities:
    - improving measles-containing vaccine (MCV) coverage while strengthening routine immunisation overall;
    - strengthening routine immunisation to increase the SIA intervals and, in the long term, decrease the reliance on SIAs; and
    - aligning with existing support to ensure coherence with investments in the national expanded programme of immunisation (EPI) and those already planned and budgeted in existing Gavi support.
- Applications for campaigns should be developed in consultation between EPI, polio, nutrition, deworming, WASH, NTDs, etc to identify opportunities and scope for partial to total integration (e.g. microplanning, training, supervision, logistics, co-delivery)
- Countries requesting support should develop one plan and one budget for all integrated activities, including funding for intra-campaign monitoring, AEFI kits, data management of campaign data into RI tools.
- Within the holistic application, explain the timing and process of switching ten-dose to five-dose presentation (if part of the planned approach).

Relevant links

- PCCS Report Template Checklist: https://ars.els-cdn.com/content/image/1-s2.0-S0264410X20315036-mmc1.docx

Measles diagnostics

Gavi support for measles diagnostics aims to improve timely case identification, confirmation and efficient and effective response (vaccination). Rapid diagnostic testing for early identification of suspected cases and laboratory confirmation utilising molecular and serological methods, per WHO guidelines, should inform Ministries of Health requests for measles vaccination support for routine and preventive campaign implementation and outbreak responses.

WHO guidance

Systematic measles testing strengthens evidence on burden of disease. WHO Global Measles and Rubella Laboratory Network (GMRLN) provide comprehensive guidance on measles and rubella surveillance, including the use of rapid tests (no written guidance on deployment and use of measles IgM rapid tests is available yet and will be shared in future iterations, once available). Currently available materials can be accessed using the links shared below in this section.

Scope of Gavi support

Procurement support currently focuses on measles IgM rapid tests, as recommended by WHO/GMRLN.

Specific requirements for funding request

- Applications must provide a rationale for testing, based on historical epidemiological, testing and vaccination coverage data. The rationale should explain how access to testing will accelerate outbreak confirmation, improve timeliness of measles vaccine mobilisation, or inform decision making for reactive campaigns.
- Countries should define the geographic areas or high-risk populations where testing tools can be deployed, consistent with national and subnational measles control strategies and targeted campaigns prioritised.
- Countries are expected to provide an estimate on the final quantity of tests needed with supporting rationale for subnational deployment.
- Countries should ensure that measles testing results are systematically captured, validated, and integrated into existing national surveillance platforms (e.g. IDSR, EWARS, DHIS2). Reporting should follow relevant WHO guidelines.
- Gavi will rely primarily on WHO and partner reporting to monitor country implementation and to inform renewal of diagnostic procurement support.

Special co-financing considerations

There are currently no Gavi co-financing obligations on measles diagnostics support.

Relevant links

- Manual for the Laboratory-based Surveillance of Measles, Rubella, and Congenital Rubella Syndrome: https://www.technet-21.org/en/manual-introduction
- Measles Outbreak Guide: https://www.who.int/publications/i/item/9789240052079
- Measles Outbreak Toolkit: https://www.who.int/emergencies/outbreak-toolkit/disease-outbreak-toolboxes/measles-outbreak-toolbox

Meningococcal meningitis vaccines

Meningococcal vaccines prevent bacterial meningitis caused by Neisseria meningitidis (Nm) *a disease that can kill within hours or leave survivors with severe disabilities: The Meningococcal A conjugate vaccine (MenACV) vaccine targets serogroup A (NmA) historically responsible for devastating epidemics in Africa's meningitis belt. Multivalent meningococcal conjugate vaccines (MMCV) provide broader protection against multiple serogroups. Specifically, a pentavalent meningococcal ACWYX conjugate vaccine protects against nmACWYX (Men5CV). Building on the success of MenACV roll-out, which has dramatically reduced meningitis Nm A epidemics, and by expanded use of MMCVs, countries can further protect vulnerable populations, strengthen epidemic preparedness and advance regional health security.*

WHO guidance

- **Routine immunisation:** All countries in the meningitis belt are recommended to introduce Men5CV into their routine immunisation schedule in a single-dose schedule at 9–18 months. If Men5CV is not available, countries that have not yet introduced MenACV are recommended to do so (together with MenACV catch-up campaign) to avoid the risk of resurgence of NmA.
- **Mass preventive campaign:** In high-risk countries, and high-risk districts, a one-off mass preventive campaign with Men5CV is recommended to be conducted at the time of Men5CV introduction targeting individuals aged 1–19 or 2–19 years (depending on RI schedule). High-risk is defined as: i) initial MenACV mass preventive campaign last conducted over ten years ago; and ii) >10 districts crossing the epidemic threshold or >300 outbreak cases due to NmCWYX serogroups since 2011. Additionally, in fragile and conflict-affected settings with weaker RI systems, mass preventive Men5CV campaigns merit consideration.

Further information:

- Meningococcal vaccines: WHO position paper on the use of multivalent meningococcal conjugate vaccines in countries of the African meningitis belt, January 2024: https://www.who.int/teams/immunization-vaccines-and-biologicals/policies/position-papers/meningococcal-vaccines
- WHO position paper on meningococcal vaccination: WHO position paper on meningococcal vaccination (MenA)
- WHO position paper on the use of multivalent meningococcal conjugate vaccines in countries of the African meningitis belt

Scope of Gavi support

- Meningitis vaccines are supported by the **discretionary** vaccine budget.
- For high-risk countries, (determined by the quantitative criteria above), Gavi supports switch from MenACV to Men5CV in routine programmes with Gavi support. These countries are also eligible for a one-off mass preventive campaign, typically at time of switch from MenACV to MMCV/Men5CV but exceptions may be justified e.g. phased due to vaccine budget constraints .In exceptional circumstances, country fragile and humanitarian context may justify a highly targeted mass preventive campaign – this should be discussed with Gavi before application
- Low- and medium-risk countries in the meningitis belt can only introduce MenACV with Gavi support (until national risk profile change or financial considerations become more favourable). Low- and medium-risk countries introducing MenACV into RI are eligible to conduct a one off-MenACV mass preventive or mini catch-up campaign (if prior mass campaign, targeting cohorts born since initial preventive campaign)

Specific requirements for funding request

- **For Men5CV applications**: Countries are required to conduct a risk assessment using the MenRAT tool and methodology (with WHO support as needed) to inform the MMCV/Men5CV introduction strategy and determine high-risk areas and eligibility to Gavi support.

In the context of vaccine budgets, further campaign targeting within high- and very high-risk areas may be required. Modelling studies and research is ongoing to help inform country strategic decision-making on campaign targeting. Once available, it will be shared through Gavi and technical partners.

Diphtheria, tetanus and pertussis, hepatitis B, *Haemophilus influenzae* type b combination vaccine (pentavalent)

Protects against five major diseases in one vaccine: diphtheria, tetanus, pertussis (whooping cough), hepatitis B and *Haemophilus influenzae* type b (Hib).

WHO guidance

WHO recommends a three-dose schedule for the DTP-containing vaccine to protect children against diphtheria, pertussis, tetanus, hepatitis B, and *Haemophilus influenzae* type b (Hib). The primary doses are typically given at 6, 10, and 14 weeks of age, followed by a booster dose against diphtheria and tetanus and at least one booster against pertussis, to be given at ages 12–23 months. See section on DTP boosters in the Vaccine Menu.

Further information:

- Diphtheria vaccine: WHO position paper – August 2017: https://iris.who.int/server/api/core/bitstreams/8f8a7f94-c9cd-44c7-91c1-c8f7cf16551f/content
- Pertussis vaccines: WHO position paper – August 2015: https://iris.who.int/server/api/core/bitstreams/d4d7eeab-432e-4a08-ac13-0d2adb4a84ff/content
- Tetanus vaccines: WHO position paper – February 2017: https://iris.who.int/server/api/core/bitstreams/755f3823-3c9a-47e7-b4c5-0fa61d2400d2/content
- WHO Recommendations for interrupted or delayed routine immunization-Summary of WHO Position Papers: https://www.who.int/docs/default-source/immunization/tables/immunization-routine-table3.pdf?sfvrsn=57103ed3_2#:~:text=If%20a%20series%20cannot%20be,even%20for%20the%20primary%20series.&text=Wherever%20possible%2C%20catch%2Dup%20vaccination,higher%20risk%20for%20pneumococcal%20disease.&text=Catch%2Dup%20vaccination%20can%20be,for%20children%20%E2%89%A524%20months.&text=Unvaccinated%20children%20aged%201%E2%80%935,by%20at%20least%208%20weeks.&text=HIV%2Dpositive%20infants%20and%20pre,the%20second%20year%20of%20life

Scope of Gavi support

Pentavalent vaccine is financed through the guaranteed vaccine budget and has been supported by Gavi since 2001, with the initial objective of increasing the uptake of Hib and hepatitis B vaccines by integrating them into routine immunisation in low-income countries. Since 2012, Gavi has funded Hib

and hepatitis B vaccines exclusively through the pentavalent formulation. With this support, pentavalent vaccine is now available across the 73 lowest income countries.

Gavi-eligible countries may apply to continue using pentavalent vaccine for primary-series doses and to introduce the first DTP-containing booster into their national immunisation schedules.

Co-financing considerations
Gavi will continue to co-finance pentavalent vaccines for primary series doses in accordance with each country's transition status. Countries may use pentavalent or DTwP for the first booster dose. Vaccine co-financing applies only to the first DTP booster.

Relevant links

- DTP-HepB-Hib (pentavalent) vaccine price data: https://www.unicef.org/supply/documents/dtp-hepb-hib-pentavalent-vaccine-price-data
- Gavi Board Newsletter - Global Vaccine Alliance to deploy six-in-one vaccine to lower-income countries, establish innovative mechanisms to protect against future epidemic threats: https://www.gavi.org/news/media-room/global-vaccine-alliance-deploy-six-one-vaccine-lower-income-countries
- DTP containing Vaccine Boosters Programme Information: https://www.gavi.org/our-support/guidelines/dtp-containing-vaccine-boosters-programme-information

Pneumococcal conjugate vaccine (PCV)

The pneumococcal conjugate vaccine protects against pneumococcal disease, a leading cause of pneumonia, meningitis, and sepsis in children under five. By reducing severe illness and death, PCV has a major impact on child survival and health equity, particularly in low-resource settings where pneumonia remains the top infectious killer of children. The vaccine also reduces transmission, creating community-wide protection and supporting stronger, more resilient health systems.

WHO guidance

- WHO recommends the inclusion of PCV in all childhood immunisation programmes globally.
- Infant immunisation should begin as early as six weeks of age, with either a three-dose schedule, administered either as two primary doses plus one booster (2p+1) or three primary doses without a booster (3p+0).
- Catch-up vaccination at the time of PCV introduction, for children aged one to five years, is recommended to accelerate disease reduction, especially in settings with high disease burden and mortality.
- The WHO/UNICEF Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) highlights that pneumococcal vaccines use should be part of a comprehensive and integrated strategy alongside other related interventions such as oral rehydration therapy, exclusive breastfeeding, zinc treatment, improvements in water, sanitation and hygiene, as well as proper nutrition.
- Countries with mature PCV programmes that have achieved adequate levels of herd immunity can consider one of two cost-saving strategies: (i) the use of a reduced dose 1p+1 schedule; or (ii) the use of a 40% fractional dose of PCV13 (the only product for which evidence supported fractional dose use).

- WHO recommends the introduction of any of the PCV prequalified products, delivered with high coverage in infants to control vaccine-type invasive pneumococcal disease (VT IPD) and reduce the incidence of childhood pneumococcal pneumonia.

Further information:

- WHO pneumococcal vaccine information: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/pneumonia
- Pneumococcal conjugate vaccines in infants and children under 5 years of age: WHO position paper – September 2025: https://iris.who.int/server/api/core/bitstreams/2cce44bc-af0b-4103-9048-54353f7d7ba1/content
- Considerations for pneumococcal conjugate vaccine (PCV) product choice: https://iris.who.int/items/4d8b91ea-2c30-497b-8f38-f45daea57016

Scope of Gavi support

- PCV is supported by the **guaranteed** vaccine budget. The calculations of the budget amount are based on adoption of lower cost products.
- Gavi supports for PCV introduction into routine immunisation schedules, including a **routine cohort only**: Vaccinate children under 12 months, with an appropriate WHO-recommended schedule; and **Routine cohort + Catch-up**: vaccinate children under 12 months and conduct a catch-up vaccination campaign targeting children aged one to five years at the time of introduction.
- For countries with existing PCV vaccination programmes, Gavi provides support for PCV optimisation, which may include switching vaccine product or schedule. The identification of at least two product choices is recommended during application.
- Countries may choose a phased introduction, a phased-catch-up campaign, or a combination, depending on their specific context and capacity.

Specific requirements for funding request

- The country-level product choice should consider programmatic characteristics, vaccine supply, vaccine price, local/regional vaccine serotype prevalence and antimicrobial resistance patterns among vaccine serotypes.
- For countries that are still to introduce PCV, decisions regarding the choice of schedule should consider operational and programmatic issues, including timeliness of vaccination, the coverage expected to be achieved at the third dose, and pneumococcal disease age distribution patterns, if known.
- Once a programme has been initiated, schedule switching is only recommended if one or more factors that led to the original choice of schedule change substantially, and these should be made clear.
- Countries in the catalytic phase are eligible for:
    - support for the introduction of pneumococcal conjugate vaccine through vaccine support to cover 50% of the routine immunisation target cohort; these countries are not eligible for catch-up vaccination funding.
    - for countries with existing PCV vaccination programmes, Gavi provides support for optimisation. The identification of at least two product choices is recommended during application
    - see Annex 8: Catalytic Phase supported areas for more details.

Special co-financing considerations

- ISF countries will co-finance their routine PCV vaccines based on a percentage of vaccine price – 7% for PCV. For countries in other stages of transition, usual co-financing policy applies.
- Campaign co-financing policy applies to doses used for catch-up campaigns.

Relevant links

- Gavi-supported PCV profiles to support country decision making: https://www.gavi.org/sites/default/files/document/2020/Gavi-PCV-vaccines-profiles-july-2020.pdf
- Pneumococcal conjugate vaccine cost calculator for Gavi-eligible countries: https://www.path.org/our-impact/resources/pneumococcal-conjugate-vaccine-cost-calculator/
- Introduction of pneumococcal vaccine: A handbook for district and health facility staff: PCV13, PCV10
- SAGE recommendation on multiple injectable vaccines in a single vaccination visit: https://terrance.who.int/mediacentre/data/sage/SAGE_Docs_Ppt_Apr2015/5_session_multiple_injectable_vaccines/Apr2015_session5_multiple_inj_vaccines.pdf
- The integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD): https://www.who.int/publications/i/item/the-integrated-global-action-plan-for-prevention-and-control-of-pneumonia-and-diarrhoea-(gappd)

Inactivated polio vaccine (IPV)

The inactivated polio vaccine protects against poliomyelitis, a crippling and potentially fatal viral disease. IPV is a cornerstone of the global polio eradication strategy and ensures children are protected against paralysis while supporting the risk-based and phased withdrawal of oral polio vaccines as global eradication milestones are achieved.

WHO guidance

- WHO recommends introducing a second IPV dose (IPV2) – or hexavalent – in all countries that currently administer one IPV dose alongside bivalent oral polio vaccine (bOPV) in their routine immunisation schedules. The two doses of IPV provide immunity against paralysis from type 2 poliovirus and also boost immunity against poliovirus types 1 and 3.
- The preferred schedule is to administer the first IPV dose at 14 weeks of age (with diphtheria, tetanus toxoid and pertussis (DTP3)/ pentavalent3) and to administer the second IPV dose at least four months later (possibly along with other vaccines administered at nine months of age). This schedule provides the highest immunogenicity and may be carried out using full-dose IPV or fractional intradermal IPV (fIPV) without loss of immunogenicity.
- Regardless of the two-dose IPV schedule used, the introduction of the second IPV dose does not replace the need for bOPV where its use is recommended. Polio vaccination strategies, including the use and number of IPV and bOPV doses, should follow WHO recommendations and country-specific epidemiological risk assessments.
- As an alternative to the full dose IPV IM injection, countries may consider using fractional doses (1/5 of the full IPV dose) via the ID route, with consideration of programmatic costs and logistical implications of this option.

Further information:

- Polio Vaccines WHO Position paper – June 2022: https://www.who.int/publications/i/item/WHO-WER9725-277-300
- GPEI Guidance on IPV Vaccines: https://polioeradication.org/about-polio/the-vaccines/ipv/
- Frequently Asked Questions (FAQs) on IPV2 in RI programmes: https://www.gavi.org/sites/default/files/programmes-impact/support/WHO-FAQs-IPV2-ENG.pdf
- WHO Use of fractional dose IPV in routine immunisation programmes (April 2017): https://cdn.who.int/media/docs/default-source/immunization/tables/fipv-considerations-for-decision-making-april2017.pdf

Scope of Gavi support

- IPV is supported by the **guaranteed** vaccine budget.
- Gavi provides support for the introduction of a second dose of IPV (IPV2) into routine immunisation schedules. Support applies to IPV only and not bOPV.
- Countries introducing IPV2 should align their schedules with WHO recommendations and national polio risk assessments.

Special co-financing considerations

- **Gavi-eligible countries:** can apply for Gavi support to switch to IPV2 in RI with no co-financing requirements (until cessation bOPV).
- **Fully self-financing lower-middle income countries (LMICs[10]):** Beginning 2026, these countries will be eligible for support for IPV eligibility (one or two doses). Support for IPV will be reduced by 50% in 2027; by 2028, LMICs will be required to fully finance their IPV vaccination programmes.
- **Upper-middle income countries (UMICs[11])** are not eligible for any IPV support and must fully finance their IPV.

Respiratory syncytial virus (RSV) maternal vaccine to protect infants

Respiratory syncytial virus (RSV) is a leading cause of lower respiratory tract infections, hospitalisations and deaths in children worldwide, with the highest burden of disease in LMICs. Administered as a single dose during the third trimester of pregnancy, the maternal RSV vaccine boosts pre-existing antibodies in the mother. These antibodies are transferred to the newborn, providing passive immunity and protection against bronchiolitis and pneumonia in the first months of life, when the risk of severe disease and death is greatest.

WHO guidance

[10] Bhutan, Bolivia, Honduras, India, Kiribati, Nicaragua, Sri Lanka, Uzbekistan, Vietnam
[11] Armenia, Azerbaijan, Cuba, Georgia, Guyana, Indonesia, Moldova, Mongolia, Ukraine

- WHO recommends that all countries introduce passive immunisation, including a maternal vaccine and/or a long-acting monoclonal antibody (mAb) in infants, to prevent severe RSV disease in the first six months of life. Three safe and highly effective products have now been licensed/authorised: the maternal vaccine (RSVpreF) and current focus for Gavi support and two mAbs (nirsevimab and clesrovimab).
- Countries should choose between the maternal vaccine or the long-acting monoclonal antibody based on cost, financing, supply, anticipated coverage, and feasibility of implementation within the existing health system.
- One dose of the RSV maternal vaccine should be administered during the third trimester of pregnancy, as defined in the local context (≥28 weeks of gestation in most settings). No upper gestational age is required however, the vaccine is most effective when administered at least two weeks before delivery.
- A year-round approach to RSV immunisation is likely to be preferred in tropical and subtropical regions where RSV circulates for much of the calendar year and/or seasonality patterns are not well-described.
- The RSV maternal vaccine can potentially be given with other recommended pregnancy vaccines, including on the same day at different sites. Vaccines given earlier in pregnancy (e.g. tetanus) should not be delayed to co-administer with the maternal vaccine.
- The RSV maternal vaccine can be given during subsequent pregnancies as there is potential benefit and no expected harm from revaccination.

Further information:

- WHO position paper on immunisation to protect infants against respiratory syncytial virus disease, May 2025: https://www.who.int/publications/i/item/who-wer-10022-193-218

Scope of Gavi support

- RSV is supported by the **discretionary** vaccine budget.
- All Gavi-eligible countries that have not introduced the maternal RSV vaccine to their national vaccination schedule are eligible to introduce.
- A multi-dose vial formulation of the RSV maternal vaccine with expected WHO pre-qualification in 2026 will be available via Gavi support. Countries should consider RSV maternal vaccine to protect infants as part of holistic applications, with a first potential country introduction not earlier than 2028.

Relevant links

- Expanding the reach of RSV disease prevention: A communications toolkit: https://www.path.org/who-we-are/programs/center-for-vaccine-innovation-and-access/on-the-verge-of-rsv-disease-prevention/
- Global NITAG RSV Vaccine Evidence Compendium: https://www.nitag-resource.org/compendium/rsv
- WHO RSV Maternal Vaccine Implementation Guide (expected during 2026)
- Maternal immunisation country readiness: a checklist approach: https://pmc.ncbi.nlm.nih.gov/articles/PMC8641584/pdf/KHVI_16_1750248.pdf https://www.path.org/who-we-are/programs/center-for-vaccine-innovation-and-access/on-the-verge-of-rsv-disease-prevention/
- Adaptable Health Facility Readiness Assessment Tool for Maternal Immunization Services: https://www.alignmnh.org/resource/adaptable-health-facility-readiness-assessment-tool-for-maternal-immunization-services/

Rotavirus vaccine

The rotavirus vaccine prevents severe diarrhoea and dehydration caused by rotavirus, one of the leading causes of child mortality worldwide. Immunisation provides strong protection in early childhood, when the risk is greatest, and reduces hospitalisation and deaths due to diarrhoeal disease.

WHO guidance

- WHO recommends that rotavirus vaccines be included in all national immunisation programmes prioritising countries with high rotavirus gastroenteritis-associated mortality.
- The WHO/UNICEF Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) highlights that rotavirus vaccination use should be part of a comprehensive and integrated strategy alongside other related interventions such as oral rehydration therapy, exclusive breastfeeding, zinc treatment, improvements in water, sanitation and hygiene, as well as proper nutrition.

Further information:

- WHO rotavirus vaccine information: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/rotavirus
- Rotavirus vaccines: WHO position paper – July 2021: https://iris.who.int/server/api/core/bitstreams/5a3e09d8-363e-4f85-bfd1-dc3a5bf4c47f/content
- Meeting of the Strategic Advisory Group of Expert on Immunization, October 2020 – conclusions and recommendations: https://iris.who.int/server/api/core/bitstreams/b32b220c-b36d-477a-a412-a6899044cdbf/content

Scope of Gavi support

- Rotavirus vaccine is supported by the **guaranteed** vaccine budget.
- Gavi supports introduction of rotavirus vaccine into the routine immunisation schedule for children under 12 months of age,
- Gavi supports two oral rotavirus vaccines – monovalent (RV1) and the pentavalent (RV5).
    - RV1: WHO recommends a two-dose schedule, administered orally at the time of DTP1 and DTP2 with at least 4 weeks between doses.
    - RV5: WHO recommends a three-dose schedule, administered orally in at the time of the DTP1, DTP2, and DTP3 contacts, with at least four weeks between doses.
    - The first dose of either vaccine should be given as soon as possible after six weeks of age to ensure protection before natural rotavirus infection.
- Support is provided with either a two-dose RV1 or three-dose RV5 schedule, depending on the selected vaccine product.
- For countries with existing rotavirus vaccination programmes, Gavi provides support for rotavirus vaccine optimisation, which may include switching vaccine product. The identification of at least two product choices is recommended during application.
- In the event of a global rotavirus vaccine supply disruption, Gavi supports countries to implement mandatory product switches by covering the cost difference between vaccines and funding the associated switch and/or catch-up activities.

- Countries in the catalytic phase are eligible for support for:
    - the introduction of rotavirus vaccine (see Annex 8: Catalytic Phase supported areas for more details).
    - the introduction of rotavirus vaccine through vaccine support to cover 50% of the routine immunisation target cohort.
    - for countries with existing rotavirus vaccination programmes, Gavi provides support for optimisation.

Relevant links

Rotavirus vaccine cost calculator for Gavi-eligible countries: https://www.path.org/our-impact/resources/rotavirus-vaccine-cost-calculator/

Typhoid conjugate vaccine (TCV)

The typhoid conjugate vaccine (TCV) protects against typhoid fever caused by Salmonella Typhi (S. Typhi)*, a potentially life-threatening bacterial disease that spreads through ingestion of contaminated food and water. Typhoid fever remains a major public health issue, with continuing high burden of typhoid fever throughout sub-Saharan Africa, Asia and Oceania, and a rapid increase in the emergence and spread of antimicrobial resistant strains of* S. Typhi*. TCV is highly effective and cost-effective, requires as per current WHO guidance a single dose, offering early protection in high-burden settings. The vaccine not only reduces antimicrobial resistance by preventing infection, which in turn lowers reliance on antibiotics, but also protects against potentially untreatable strain and strengthens health equity by protecting children in under-served and high-risk communities*.

WHO guidance

- SAGE recommends primary vaccination with a single dose of TCV at age 9 to 24 months in settings where typhoid is endemic. However, the first dose of TCV may be administered up to five years of age in some typhoid-endemic settings. Decisions on the age of TCV administration, target population and delivery strategy for routine and catch-up vaccination should be based on local epidemiology of typhoid fever and programmatic considerations. The vaccine has regulatory authorisation for use in people aged up to 65 years in typhoid-endemic regions.
- **Routine immunisation:** Routine introduction of TCV is to be prioritised in countries with the highest burden of typhoid disease or a high burden of antimicrobial resistant *S. Typhi* for the control of typhoid fever. Administration is recommended at 9–24 months old, or in some cases up to five years of age, as per SAGE guidance above.
- **Catch-up campaigns:** Catch-up vaccination with TCV up to 15 years of age is recommended when feasible and supported by epidemiologic data, noting that the burden of disease and programmatic feasibility are greater in this age range than in adults.
- The experiences and impact of different vaccination strategies, as well as integration with WASH or other interventions, should be monitored and documented in order to support further improvement in typhoid control

Further information:

- Typhoid vaccines: WHO position paper – March 2018: https://iris.who.int/server/api/core/bitstreams/78472e52-a4f4-483f-90da-15d5c1110dfc/content
- WHO Guidance on Co-Administration of Typhoid Vaccine with Measles-containing vaccines: https://cdn.who.int/media/docs/default-source/immunization/multiple-injections/coadministration_of_tcv_with_mcv_15aug2018.pdf?sfvrsn=ff9f92df_7#:~:text=WHO%20encourages%20routine%20programmatic%20administration,the%20second%20year%20of%20life

Gavi scope of support

- TCV is supported by the **discretionary** vaccine budget.
- Gavi supports WHO-prequalified single-dose injectable TCV products for use in both routine immunisation and one-off campaigns where there is documented typhoid burden.
- **Routine immunisation:** single dose between nine months and < five years of age, as per WHO guidance section above.
- **One-off campaign**: targeting children aged nine months to up to < 15 years old in high-burden areas, as assessed using the BRAT, and surveillance data (*S. Typhi* burden of disease, age distribution, antimicrobial patterns) with consideration given to subnational targeting. See requirements below.
- In the context of limited fiscal space, countries may choose to introduce TCV in routine immunisation in the first instance while mobilising resources for the catch-up campaign, which can be implemented at a later stage.
- Countries are encouraged to establish functioning routine surveillance for typhoid and monitoring vaccine impact.

Specific requirements for funding request

- **Requirement:** Countries are required to provide all available country-specific data on *S. Typhi* burden. This may include: (i) *S. Typhi* laboratory confirmation by blood culture and molecular testing (ii) Typhoid intestinal perforation (TIP) data, (iii) confirmed typhoid outbreaks and (iv) antimicrobial resistance patterns. Data should be disaggregated by age group if available. More information in the 'Typhoid Data Guidance for Gavi applications' link above.
- **Recommendation:** Countries may consider using the Typhoid Burden and Risk Assessment Tool (BRAT) to review and collate their data on typhoid burden.

Relevant links

- Burden and Risk Assessment of Typhoid (BRAT): technical resources: https://www.technet-21.org/fr/ressources/outil/burden-and-risk-assessment-of-typhoid-brat-a-methodology-for-countries-to-assess-available-data-on-the-burden-and-risk-of-typhoid-fever
- Typhoid data guidance for Gavi applications: https://www.gavi.org/sites/default/files/document/support/Typhoid%20data%20guidance%20for%20Gavi%20application.pdf

Yellow fever vaccine

The yellow fever (YF) vaccine is used to prevent yellow fever, a potentially fatal mosquito-borne viral disease endemic to parts of Africa and South America. A single dose of the vaccine provides lifelong protection and plays a critical role in preventing outbreaks and supporting global health security.

WHO guidance

- YF routine immunisation is recommended to be given to children at age 9–12 months, at the same time as measles-containing-vaccine, in YF-endemic countries.
- **Preventive mass vaccination campaigns (PMVCs)** – nationwide campaigns that target all at-risk populations aged >9-months are recommended for high-risk YF-endemic countries.
- Where there is low routine vaccination coverage and immunity gaps, **targeted vaccination campaigns** (TVCs) are recommended for catching up under-vaccinated cohorts or pockets, and should be targeted at age groups or geographic areas where population immunity is demonstrably low.
- Fractional dosing can be used as a dose sparing strategy during outbreak response.

Further information:

- Vaccines and vaccination against yellow fever WHO Position Paper – June 2013: https://iris.who.int/server/api/core/bitstreams/3ab5cbc3-86bd-4e69-94bf-b859f365e75b/content
- Yellow fever vaccine: WHO position on the use of fractional doses – June 2017: https://iris.who.int/server/api/core/bitstreams/7df7a244-fa68-4c3c-b702-9359e21b3d3f/content
- A Global Strategy to Eliminate Yellow Fever Epidemics (EYE) (2017-2026): https://iris.who.int/server/api/core/bitstreams/962a002f-ac2f-4ba1-bcf5-825a6d2fd36d/content

Scope of Gavi support

- YF routine immunisation is supported by the **guaranteed** vaccine budget and yellow fever campaigns by the **discretionary** vaccine budget.
- Gavi provides support to high-risk countries (as classified by EYE annually) only.
- For high-risk countries that have not yet introduced YF into routine immunisation, Gavi provides support to introduce YF into RI.
- Gavi also supports a one-time PMVCs targeting individuals aged nine months up to under 60 years in high-risk areas in high-risk countries. Campaigns may be national or subnational, dependent on epidemiology, risk, and fiscal space. Campaigns may be phased across multiple years.
- In high-risk countries that conducted a PMVC over a decade ago and that have epidemiological justification, Gavi supports one-time catch-up campaigns targeting subnational geographies and/or age groups based on conducting immunity gap analysis and root cause analyses ('Targeted Vaccination Campaigns').
- **Fractional dosing**: WHO SAGE are to review the evidence for fractional dosing for preventive campaigns in Q3 2026 (to expand the existing recommendation for use of fractional dosing as a dose sparing strategy for outbreak response). Fractional dosing reduces the dose per person from 0.5 ml to 0.1 ml and could reduce the cost per fully vaccinated person by ~75% (full cost modelling pending; based on reduction in vaccine doses). Pending recommendation, countries are advised to consider fractional dosing for PMVCs and TVCs as a route to expand campaign reach at a significantly lower cost.

Specific requirements for funding request

- **PMVCs (optional):** In the context of vaccine budgets, further campaign targeting within high and very high-risk areas may be required to fit within discretionary budgets. Risk assessment

classification of district-level risk may be used as a starting point to select subnational regions for inclusion in campaign scope.

- **Targeted vaccination campaigns**: For countries requesting targeted catch-up campaigns, provide epidemiological justification (e.g. using the immunity gap assessment tool, or other rationale based on previous coverage levels and surveillance data).

Yellow fever diagnostics

Yellow fever diagnostics strengthen national laboratory capacity for timely and reliable case confirmation, enabling early outbreak confirmation and monitoring of routine immunisation gaps in high-risk countries (per EYE annual classification). They ensure efficient and effective use of yellow fever vaccines, particularly in outbreak response and preventive campaigns under the EYE strategy.

WHO guidance

- WHO and the Eliminate Yellow Fever Epidemics (EYE) Strategy recommend a testing algorithm for routine surveillance and outbreaks (refer to links below), which should inform prevention and outbreak response strategies:
  - Molecular tests (RT-PCR) for ≤14 days of onset of febrile illness
  - YF IgM rapid tests/lateral flow assays (LFA) in a serial testing strategy and/or as supplementary tools for initial screening in field settings.
  - YF IgM ELISA-based assays to detect acute infection
- YF testing should be undertaken in national/subnational reference laboratories within members of the WHO-coordinated Global Yellow Fever Laboratory Network (GYFLaN) that meets WHO-defined performance criteria and strictly adhering to the Ministry of Health endorsed surveillance testing algorithm.

Scope of Gavi support

- Support for yellow fever diagnostics is **outside** of the Gavi vaccine and cash budgets.
- Gavi provides diagnostics procurement support to high-risk countries (as classified by EYE annually). Laboratory-based surveillance testing support is not population-based and should focus on countries where, per year, national surveillance systems identify at least 50 YF suspects that are referred for testing.
- Support is provided only to national/ subnational public health reference laboratories that are members of the WHO Global YF Laboratory Network and that adhere to recommended testing algorithms.
- Gavi supports procurement of YF molecular tests (PCR), YF IgM ELISA tests, and YF IgM rapid tests. Gavi also provides time-limited consumables (ELISA plates, pipette tips, PCR RNA extraction reagents, tubes, dried blood spots cards, etc), per WHO recommendations.

Specific requirements for funding request

Context and rationale

- Application should describe recent YF epidemiology, surveillance performance and laboratory-based surveillance testing capacity gaps.
- Rationale should link improved laboratory-based surveillance testing capacity to faster case identification and confirmation, timely outbreak confirmation, contribute to avoiding the conduct of unnecessary campaigns, and more efficient use of vaccines, in alignment with WHO/EYE targets.

Target population and dosing

- Testing should cover suspected cases detected through national surveillance, with emphasis on high- and moderate-risk areas identified by WHO under EYE.

Delivery strategies, implementation and equity

- Countries should detail logistics for import, storage, and distribution of assays to testing laboratories.
- Equity should be considered by ensuring national coverage across high-risk zones and referral systems from peripheral sites to reference labs.

Coordination and integration with other programmes

- YF diagnostic support should be integrated with national immunisation programmes, IDSR (Integrated Disease Surveillance and Response), coordinated technical assistance to support training, and performance monitoring through QA/QC, proficiency panel and laboratory assessments.

Data management and programmatic reporting

- Countries must report weekly laboratory data reporting to WHO, including number of suspected cases, number of cases tested (by test method), number of confirmed positives, number of death, following WHO-GYFLaN templates and submitted via WHO channels.

Special co-financing considerations

There are currently no Gavi co-financing obligations on yellow fever diagnostics support.

Relevant links

- A Global Strategy to Eliminate Yellow Fever Epidemics (EYE) (2017-2026): https://iris.who.int/server/api/core/bitstreams/962a002f-ac2f-4ba1-bcf5-825a6d2fd36d/content
- Yellow Fever Fact Sheet: https://www.who.int/news-room/fact-sheets/detail/yellow-fever
- Laboratory manual for yellow fever: https://www.who.int/publications/i/item/9789240084476
- Operational guidance on the use of yellow fever assays in the context of surveillance: https://www.who.int/publications/i/item/9789240082519
- Yellow Fever Outbreak Toolbox: https://www.who.int/emergencies/outbreak-toolkit/disease-outbreak-toolboxes/yellow-fever-outbreak-toolbox
- Eliminate Yellow Fever Strategy – laboratory information (EYE LABS): https://www.technet-21.org/en/eye-labs
- Yellow Fever Surveillance Assays Technical Bulletin November 2024: https://www.unicef.org/supply/media/22831/file/Technical-Bulletin-Yellow-Fever-Surveillance-Assays-Nov2024.pdf

Annex 4: Health systems strategy investment areas

The eight health systems strategy investment areas are described in detail below.

1. Service delivery

Sustainable, context-specific service delivery strategies are essential to ensure no one is left behind in a country's immunisation programme. Gavi encourages countries to implement activities under the service delivery area as part of routine immunisation and campaign activities, including catch-up vaccination efforts. Countries are encouraged to prioritise:

- differentiated strategies targeted at population groups currently systematically missed by routine immunisation and adapted to the specific barriers to reaching zero-dose, under-immunised children and missed communities. This includes working with other health programmes and non-health sectors (such as education) and ensuring immunisation is delivered with other primary health care services and, where existing, as an integral part of health benefit/Universal Health Coverage (UHC) packages within a PHC-oriented model of care;
- the safety and quality of services to increase the use demand and uptake of vaccination. This will need a focus on supporting and enabling health workers to improve their performance and overcoming gender-, inclusion-, and protection-related barriers;
- a more deliberate approach to engaging a broader set of partners, including CSOs, community-based organisations (CBOs), faith-based organisations (FBOs) and humanitarian partners to complement government service delivery where appropriate.

Flagship interventions to improve service delivery:

i) Accelerate **integration of immunisation and other PHC services** at the last mile, prioritising zero-dose and missed communities		
	Recommended activities	**Ineligible activities**
All countries	• Provide integrated delivery of immunisation (including through routine immunisation, outreaches periodic intensification of routine immunisation, and campaigns) with other services (e.g. de-worming, nutrition, WASH) • Enable screening for missed opportunities for vaccination and catch-up missed children with all antigens during other health events and service delivery points, and potential task shifting to increase cadre that can immunise (including community and/or home-based delivery, integrated community case management, malaria and other PHC service) • Optimise campaign delivery by streamlining campaign calendars and coordinating efforts with other programmes (e.g. malaria bed-net distribution and	• Procurement of non-immunisation related commodities • Integration efforts that compromise service quality • Procurement of vehicles

	chemoprevention) and using real-time data to monitor performance, reduce duplication and improve the quality of integrated service delivery • Establish structured coordination frameworks supported by Country Liaison Officers (CLOs), where relevant, to facilitate collaboration across Ministry of Health departments (e.g. EPI and MNCH) and between Ministries of Health and other sectors (e.g. humanitarian partners, education) to jointly plan and implement bundled communication and service delivery strategies • Institutionalise integrated service delivery by embedding co-delivery mandates in national and subnational PHC policies. Develop operational guidelines and implementation frameworks that define service bundles, reporting structures and accountability mechanisms, and consider task shifting such as community health workers playing greater roles in integrated services including immunisation	
Fragile/ humanitarian	• Integrate vaccination with gender-responsive protection services, in collaboration with other humanitarian actors (e.g. referral for GBV survivors). **[Gender]** • Adapt service delivery models to improve privacy, acceptability, and safety for women and adolescent girls, including confidential counselling options, respectful care practices, and measures to ensure safe and dignified access to services. [Gender] • Engage women and girl organisations in community monitoring, and accountability mechanisms to improve reach, trust and responsiveness in missed communities. [Gender] • Integrate vaccination into emergency health packages, including for extended age groups and leveraging health cluster platforms for joint planning and service delivery in hard-to-reach areas, including for access to geospatial data.	

ii) **Improve service quality** to drive better experience at vaccination touchpoints and thereby reduce zero-dose and drop-out rates and reinforce return visits		
	Recommended activities	**Ineligible activities**
All countries	• Increase the parent's understanding of benefits of immunisation, place and timing of vaccination services by increasing the use of home-based records and disseminating clear, accessible messages. [Gender] • Adapt immunisation services (e.g. location, schedule, service packages) based on community needs including using two-way engagement between	• Generic capacity building activities for improving quality of care • Efforts that are gender- and/or equity-unaware (not only ignoring the barrier but reinforcing the negative gender norm)

	communities and CHWs and human-centred design to shape locally driven innovations. [Gender; Innovation] • Leverage digital public infrastructure and tools to optimise service efficiency and, reduce client wait times, (e.g. by strengthening microplanning, appointment scheduling and follow-up, performance tracking, and alignment) and ensure interoperability with vaccine supply. • Leverage digital client management systems (e.g. appointment reminders via SMS/IVR, digital vaccination certificates) to reduce drop-out and improve client experience. [Innovation] • Implement structured protocols and job aids (digital or paper-based, as appropriate) to support predictable service schedules, efficient client flow and communication • Monitor service quality and caregiver satisfaction using real-time feedback tools (e.g. exit interviews, SMS surveys) and apply feedback and learnings to improve delivery. • Use team-based care models to link caregivers with health workers in the community, facilities, and campaigns. • Integrate Interpersonal Communication for Immunisation (IPCI) across all training platforms for health workers, including for community health workers (CHWs) [Gender] • Partner with academic/ regional centres to test, evaluate, and scale service experience innovations.	• Feedback collected without informing service improvements. • Health facility construction or rehabilitation

iii) **Strengthen integrated microplanning and extend and expand immunisation to reach un and under-immunised children**, including for older age groups (e.g. 2YL, adolescent), leveraging digital tools where appropriate

	Recommended activities	**Ineligible activities**
All countries	• Develop, implement, monitor and/or update integrated district-level micro plans for RI and campaigns which address equity gaps (e.g. Gender, zero dose) **[Gender]** • Link microplanning with surveillance systems (e.g. EWARS) so that cross-	• Campaigns or zero-dose activities without equity budgeting, follow-up, tailored strategies, or no integration with PHC/routine immunisation • Activities in conflict settings without safety protocols, use of digital tools that compromise privacy or security, or interventions that hinder access for women,

	border or high-mobility contexts, are outbreak prepared.[12,13] **[Resiliency]** • Where feasible, and given country digital maturity, leverage evidence-based digital solutions (e.g. AI-enabled or GIS mapping, satellite imagery) to optimise microplanning, identify communities, and improve efficiency of RI and campaigns **[Innovation]** • Increase the number of service delivery points for RI and campaigns for missed communities through specific, time-bound investments (e.g. use of pop-up sites in urban settings, markets and transit centres) • Extend opening hours of immunisation services to meet parents' needs **[Gender]** • Increase frequency and regularity of integrated outreach immunisation sessions • Implement periodic intensification of routine immunisation activities • Leverage new vaccine introductions and campaigns (e.g. HPV) to expand responsive service delivery. • Ensure campaign platforms use flexible outreach strategies and engage private and humanitarian actors • Ensure campaigns support continuity of care by identifying un- and under-vaccinated communities and linking them to follow-up through catch-up, mop-up, or outreach services • Implementing targeted outreach strategies for peri-urban and rural areas with high zero-dose and under-immunised populations communities including for older children where catch-up policies exist • Engage with local stakeholders across sectors to coordinate and operationalise diverse delivery approaches, ensuring accountability and equitable access to services through multiple platforms and	adolescents, or place individuals at risk • Partnerships with CSOs or other actors without clear monitoring, accountability, safeguarding, or adherence to minimal immunisation standards • Pilots (e.g. AI tools) or life-course vaccine activities outside MoH strategies, without national approval, ownership, sustainability, or co-financing • Major infrastructure or capital investments not aligned with Gavi's mandate

[12] Https://www.who.int/emergencies/surveillance/early-warning-alert-and-response-system-ewar
[13] https://www.who.int/publications/i/item/9789240012226

	modalities, including task shifting to allow a wider cadre to immunise • Fund provision of integrated or standalone routine or campaign services by CSOs, CBOs, FBOs, humanitarian actors • Promote, design, and assess delivery models that are gender-responsive, sensitive and inclusive, and support women-led organisations and girls' networks especially in hard-to-reach areas informing the design and implementation of services. **[Gender]** • Update immunisation policies, and schedules, and HW training/support to increase catch-up vaccination, including for children over 24 months old • Strengthen delivery of second year of life vaccines (e.g. MCV2 at 18 months) for timely delivery of vaccines, catch up vaccination of missed antigens, and delivery of other health interventions • Establish, implement and/or evaluate a daycare and/or school entry immunisation check and/or referral system • Establish and/or implement adolescent immunisation programmes	
Fragile/ humanitarian	• Update and adapt microplans during emergencies, aligning with preparedness and response plans and campaigns for displaced or hard-to-reach populations. • Coordinate with NGOs and humanitarian actors (e.g. in contexts where government engagement is limited or sensitive) to co-plan service delivery. • Develop tailored delivery models for mobile and displaced populations (e.g. nomadic groups, migrants, IDPs, urban/peri-urban displaced), using outreach, mobile teams, or transit-point immunisation. • Apply security-sensitive, community-led approaches to sustain immunisation in insecure areas. • Engage and equip partners (e.g. humanitarian or local actors) with cold chain and logistics support to extend services in hard-to-reach settings.	

2. Demand generation and community engagement

Demand generation and community engagement are vital to increasing immunisation uptake, addressing hesitancy, reducing drop-outs, and closing equity and gender gaps across routine services, campaigns, catch-up activities and emergency response. Grounded in gender and equity principles, and evidence from the behavioural and social sciences, the approach emphasises evidence-based, scalable, innovative solutions to reduce the prevalence of zero-dose and under-immunised children and sustain coverage gains. The flagships interventions described below provide a comprehensive and data-driven model that activates communities, improves service quality and

drives adaptive learning, encouraging countries increase vaccine confidence and uptake by embedding targeted engagement, digital demand generation, quality people-centred services, and behavioural insights into immunisation and primary health care systems.

i) **Scale-up community engagement** along with **digitally enabled demand generation** to encourage caregivers in missed communities and reduce drop-out		
	Recommended activities	**Ineligible activities**
All countries	• Co-create solutions with communities using behavioural insights and human-centred design. ***[Gender; Innovation; Health Emergency]*** • Engage targeted groups – faith leaders, adolescents, parents including fathers, caregivers – using both offline and online platforms including digital networks to strengthen understanding and demand for immunisation and other integrated PHC services. ***[Gender; Innovation; Health Emergency]*** • Strengthen institutional capacity for sustained gender-responsive community engagement and digital demand, aligned with national strategies. ***[Gender]*** • Strengthen institutional capacity for sustained gender-responsive community engagement and digital demand, aligned with national strategies. ***[Gender]*** • Strengthen institutional capacity for sustained, gender-responsive community engagement, including the use of digital channels to support demand generation, aligned with national strategies. ***[Gender; Innovation]*** • Leverage CSO funding guardrail to partner with leaders and groups – including religious and traditional CSOs/FBOs, women's groups, digital advocates, male champions, private sector and strengthen community health actors' engagement ***[Gender; Innovation; Health Emergency]*** • Use digital engagement platforms (e.g. social media, gamified approaches and other digital platforms) to build incremental reach, including private sector partnerships. ***[Gender; Innovation; Health Emergency]***	• Community engagement models not aligned with national strategy or limited to one-time events (except for new vaccine launches). • Generic production-focused activities (e.g. posters, signages, branding). • Routine mass media/radio use (except for new vaccine launches or emergencies). • Paid celebrity campaigns or media production. • Repeated cascade trainings (except IPC/I for CHWs). • One-off PR events, national launches, or workshops.

	• Pilot and scale behavioural nudges, such as through CHWs and linked to other community-based activities (e.g. community-based malaria prevention activities). ***[Gender; Innovation]*** • Strengthen systems for social listening, infodemic management, managing misinformation, and sending personalised vaccination reminders. ***[Gender; Innovation; Health Emergency]*** • Leverage emerging tech to gather and use behavioural data, and for, evidence based social media-supported public engagement on vaccines and PHC. ***[Gender; Innovation; Health Emergency]*** • *Provide non-cash integrated incentives (e.g. nutritional supplements, travel support) to caregivers or recipients* ***[Gender; Innovation; Health Emergency]***	
Fragile/ humanitarian	• A context-specific combination of recommendations in ALL COUNTRIES, with a focus on integrated community engagement: • Use simple tools like reminders and prompts to support field efforts. ***[Gender]***	Refer to all country activities, as described above, with the exception of community radio in targeted areas.
ii) Strengthen country capacity to **collect, analyse, and use social and behavioural data to better target interventions**		
	Recommended activities	**Ineligible activities**
All countries	• Standardise social and behavioural data including social and community listening data collection to ensure robust data quality, continuous implementation monitoring and strengthen data use. • Conduct regular behavioural studies (e.g. behavioural and social drivers; (BeSD)) at national and subnational levels with gender and equity-focused analysis. **[*Gender*]** • Integrate behavioural data (BeSD) into immunisation planning, monitoring, and decision-making and national systems like DHIS2 and programme reviews. • Integrate behavioural data (BeSD) into immunisation planning, monitoring, and decision-making and national systems like DHIS2 and programme reviews. • Strengthen capacity of MoH and health workers to collect and use social and behavioural data and social and	• Research that excludes national programs or does not support decision-making and capacity building. • Any standalone survey/research like activity which extends beyond eight to nine months.

	community listening data, with a focus on gender and equity. **[*Gender*]** • Use accessible digital and low-tech tools (e.g. SMS, IVR, Kobo Toolbox) for timely data collection, especially in fragile settings. **[*Gender*]** • Leverage emerging digital technologies for real-time social listening, rumour tracking, and message testing and establish rapid feedback loops (e.g. radio, WhatsApp, Facebook, and other digital platforms) to deliver and adapt messaging. **[*Gender; Innovation; Health Emergency*]** • Seek opportunities to leverage other PHC programmes to strengthen integrated immunisation and PHC messaging (e.g. antenatal care, integrated community case management, community-based malaria chemoprevention, malaria vaccination). • Support ongoing operational research, evaluation, and cost-effectiveness studies and partner with academic and/or specialist institutions to create vaccine demand knowledge hubs.	
Key references: • HCD for Health Homepage | UNICEF Human Centered Design 4 Health • GENDER AND IMMUNIZATION DEMAND (checklist) – TechNet-21 • Search | Knowledge • Demand Strategy Builder UNICEF ROSA version • VACCINE MESSAGING GUIDE: Evidence-based guidance for fostering demand for immunization through social and behavior change communications – TechNet-21 • Behavioural and social drivers of vaccination: tools and practical guidance for achieving high uptake – TechNet-21 • Embedding SBC NIS 2025.pdf – Google Drive		

3. Human resources for health

Improving the availability of qualified, skilled, motivated, remunerated and efficient health workforce is critical for both equity and sustainability of immunisation. Health workforce needs in most countries are very significant and beyond the capacity of the Alliance alone to address. The Alliance's investments in health workforce will focus primarily on addressing gaps that limit the provision of services to zero-dose children and missed communities as well as strengthening health worker capacity to deliver and manage immunisation services along with strengthening broader system components that provide productive working environment, such as advocacy to promote fair remuneration, and integration of interventions into primary health care. Gavi will work closely with other partners and donors, including the World Bank and the Global Fund, to ensure that its investments contribute to system-wide efforts to strengthen the health workforce aligned with national strategies and to partner with other stakeholders including through continued engagement in multi-partner initiatives such as the Community Health Delivery Partnership.

Key principles underpinning the HRH funding guidelines

- HRH activities must be **aligned with national systems and plans**, respect **Gavi eligibility thresholds**, and avoid parallel systems.
- National immunisation strategies (NIS) and funding applications should be **informed by recent HRH diagnostics and workforce data**, including analysis of distribution gaps, staffing needs, and training priorities.
- **Exit and sustainability strategies are always required** for investments, except for fragile and conflict contexts.
- Embed considerations to strengthen the **resilience of the health workforce**, such as supportive policies, flexible deployment, psychosocial protection, and emergency preparedness training, including their ability to prepare for, withstand, and adapt to shocks – such as pandemics, conflict, or natural disasters – while maintaining the continuity of essential immunisation.
- Use **evidence-based policies** (such as gender analysis and or sex disaggregated data) to address **workforce disparities in planning, recruitment, deployment and career development**.

Flagship intervention 1: Support targeted **recruitment, distribution and retention strategies** to fill gaps in health workforce availability in **missed communities**, guided by national policies and clear transition plans.

Design principles:

- **Align with national plans:** Activities must be part of national HRH and PHC strategies, not parallel donor schemes.
- **Sustainability:** All recruitment and incentives must have transition plans to government payrolls or financing (except in fragile/conflict contexts).
- **Equity focus:** Prioritise communities with the highest concentration of ZD children (remote, mobile, fragile, peri-urban slums).
- **Gender-sensitive:** Ensure safe working conditions and fair career opportunities for women health workers.
- **Integrated systems:** Link HRH planning with immunisation and PHC platforms, ensuring data flows across systems.

	Recommended activities	Ineligible activities
All countries	*Planning* • Utilise workforce planning tools (e.g. WISN, digital HRIS) to map staffing needs for immunisation – including campaigns, NVIs, and routine services. *Deployment* • Support deployment of health workers to clearly indicated **ZD and under-immunised areas** through **cost-effective models** (e.g. integrated PHC teams, task-sharing, CHWs vaccinating where allowed).	• HRH planning that does not align with national strategies and ignores coordination with other donors/national initiatives. • Pay or incentives that create unfair differences between donor-supported and government-paid staff (e.g. – such higher pay for Gavi-funded vaccinators or supervisors than MoH staff in the same grade/ or facility). • Creating parallel compensation systems not aligned with national HRH frameworks or pay scales.

	• Support temporary deployment of surge staff for campaigns, catch-up rounds, or emergencies **in missed communities,** while maintaining continuity of routine services. • *Retention* • Support time-bound, nationally approved incentives for postings in **hard-to-reach areas/missed communities** (e.g. hardship allowances, tuition reimbursement, career advancement). • Strengthen supportive supervision and mentorship systems that cover integrated service delivery, leadership, and equity – especially for women and CHWs.	• Funding jobs unrelated to immunisation or PHC, such as administrative roles or specialised hospital-only staff. • Deployment plans that do not match national workforce data or equity maps.
Fragile/ humanitarian	• Targeted assistance to ensure Gavi-supported HRH investments are explicitly linked to **government-led emergency or recovery frameworks** (e.g. immunisation continuity, EPRP, health cluster plans). • **Practical measures** to reduce barriers and increase safety for health workers, such as temporary housing, transport support, or protective equipment in insecure or hard-to-reach areas. • Channel support through **vetted NGOs or humanitarian partners** to recruit health workers where government payroll systems are non-functional – with clear transition plans to MoH oversight when feasible.	• Recruitment not endorsed by the Ministry of Health or not linked to a recognised emergency or resilience-building framework.
Initial self-inancing	As per all countries activities.	
Preparatory transition	As per **all countries**, plus: • Strengthen national workforce information systems (e.g. HRIS) to capture data on immunisation staff deployment and workload, and link this to **coverage and ZD mapping**. • Update staffing structures and job descriptions so immunisation roles are formally integrated into PHC frameworks, with clear costing. • [In collaboration with other GHIs] pilot/scale-up of family-friendly workforce policies (e.g. flexible	Temporary recruitment that does not feed into a sustainable staffing or fiscal absorption plan.

	scheduling, or hardship housing) to improve retention of **female health workers** in remote or high-burden immunisation areas.	
Accelerated transition	As per **all countries**, plus: • Development of **detailed transition roadmaps** for all Gavi-supported posts to move staff to government payrolls. • **Technical assistance** to Ministries of Health and Finance to integrate immunisation-related HRH costs (including surge staff for campaigns and NVIs) into expenditure frameworks/budget.	Funding **open-ended, donor-paid posts** with no plan or milestones for transition to government payroll.

Key references

- WHO (2023). Global health and care workers compact: technical guidance compilation.
- WHO (2021a). WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas ISBN 978-92-4-002422-9.
- WHO (2021b) Health labour market analysis guidebook. WHO (2021b) Health labour market analysis guidebook. ISBN 978-92-4-003554-6
- Rachel, N., Nukhba, Z., Lamisa, A., Zaina, K., Wesley, P., Abdulgafoor, B.M., (2023). Integration measurement and its applications in low- and middle-income country health systems: a scoping review. *BMC public health*, Vol.23 (1).

Flagship intervention 2: Work with countries to **define the scope of practice for community health workers in immunisation** within PHC and equip them with competencies and referral structures for integrated services.

Description: CHWs are critical frontline actors in extending immunisation and primary healthcare (PHC) services to under-served communities, especially for reaching zero-dose (ZD) children. Gavi support under this flagship aims to help countries define clear scopes of practice, equip CHWs with the necessary skills and tools, and ensure their integration into national systems for training, supervision, remuneration and data reporting.

Design principles:

- **Donor collaboration:** All CHW support should be **coordinated with other partners** to seek opportunities for integration and avoid duplication, fragmentation, or creation of parallel systems.
- **Government endorsement:** CHW roles and scopes of practice must be approved by the Ministry of Health.
- **Sustainability**: CHW remuneration, incentives, and career progression **must be aligned with national policies and frameworks** – no parallel or donor-only pay schemes.

	Recommended activities	**Ineligible activities**
All countries	• Develop or **update CHW (and related cadre) job descriptions** where required to include immunisation tasks (routine,	• Creating new CHW roles that only focus on vaccination without linking to PHC.

	catch-up, campaigns, and outbreak response), authorising CHWs to vaccinate where legally permitted. • **Support the roll-out of a nationally approved CHW scope of practice and referral pathway** that explicitly covers life-course immunisation (infants, children, adolescents, adults) and links referrals to PHC services. • Development/delivery of **competency-based CHW training packages** covering vaccine safety and administration, cold chain handling, recording/reporting, digital literacy, interpersonal communication, and approaches to address gender and social barriers.	• Funding standalone training for specific diseases that is not part of integrated PHC capacity-building. • Paying CHW stipends through short-term donor projects without sustainability plans. • Scaling up digital tools that are not adapted to the country context or not part of national digital health plans. • Carrying out one-off training or irregular activities not linked to long-term workforce development. • Engaging CHWs only during emergencies without long-term integration into health systems.
Fragile/ Conflict	• Partnerships with NGOs/CSOs/humanitarian agencies to manage CHW networks recruited from affected communities, ensuring CHWs can safely deliver routine immunisation, campaigns, and outbreak response, with strong gender-sensitive protections. • Provision of rapid, modular **upskilling for CHWs** adapted to fragile settings – using mobile, offline, or community-based learning – covering vaccine administration (where legally permitted), cold chain basics, registration/defaulter tracing, and communication. • Deploy **integrated PHC teams** that provide immunisation alongside MNCH and other priority services, with flexible plans to shift to campaigns or catch-up rounds without disrupting routine care.	• Reliance on NGOs actors to implement CHW functions indefinitely, without coordination with government.
Initial self-financing	As per all countries activities.	Funding CHW interventions that are not designed for eventual nationwide integration or replication.
Preparatory Transition	As per all countries activities, plus: • Integration of **CHW data into national digital health information** systems, so that CHW deployment, referrals, and ZD reach become core indicators for immunisation planning and monitoring. • [With other partners] Plan for **phased financial transition** for CHW programmes by co-financing salaries, incentives, and supervision costs with governments.	Developing CHW roles or scopes of practice that are duplicative, inconsistent with national PHC policies, or not endorsed by the Ministry of Health.

	• [With other partners] Develop national CHW guidelines to align scopes of practice with PHC, ensuring CHWs contribute to demand generation, referral completion, and catch-up/campaign activities.	
Accelerated Transition	• [With other partners] **Roll-out of nationally approved CHW scope of practice** nationwide, ensuring CHW roles in **routine immunisation, campaigns, and outbreak response** are fully standardised. • [With other partners] **Integration of CHWs into national workforce and budget frameworks**, including **funded supervision structures** and performance reviews with immunisation indicators. • [With other partners] Establish national CHW certification and career pathways, **linked to immunisation** competencies and CPD systems, to support retention and professionalisation.	Standalone CHW activities that are not reflected in national health workforce strategies or costed plans.
• WHO guideline on health policy and system support to optimise community health worker programmes ISBN 978-92-4-155036-9 © World Health Organization 2018. https://www.who.int/publications/i/item/9789241550369https://www.who.int/publications/i/item/9789241550369		

Flagship intervention 3: Scale-up usage of effective training using competency-based, digital and blended learning approaches and support countries to develop an integrated/one training plan for immunisation (and ideally PHC).

Description:
A skilled and motivated health workforce requires sustainable strengthening of competencies through effective training when gaps exist in HW knowledge and skills relevant to immunisation and PHC practices and delivery. This flagship supports countries to incorporate competency-based in person, digital, and/or blended learning approaches that are effective into their programmes; align training with national needs and standards; and strengthen access to training based on the needs of all health worker cadres, including CHWs, especially in under-served areas. It is important to recognise that available evidence suggests combining training with other system interventions.

Design principles:

- Training content must be **aligned with WHO standards/national curricula,** adapted to country needs and combine different topics into one integrated approach.
- Training should be **linked to performance improvement and service delivery outcomes** (not 'one-off refreshers').
- Training equity must be ensured – addressing barriers for women and CHWs in under-served areas.
- Training should be combined with supportive **supervision and mentoring**, not standalone.

• **Collaboration with national training institutions** to embed training into certification, career development, and long-term capacity-building is highly encouraged.		
	Recommended activities	**Ineligible activities**
All countries	• **Support training needs assessments (TNAs)** at national or subnational level to identify immunisation skill gaps (vaccine safety, cold chain, data, communication, demand generation, campaign readiness). • Design /upgrade **digital/blended Learning Management Systems (LMS)** that host immunisation training content, are offline-capable, and linked to national HRH/CPD systems. • Development/roll-out **of competency-based training packages** on core immunisation tasks, ensuring access for CHWs and HWs in rural and under-served areas. • **Embed immunisation modules into PHC curricula** in partnership with national training institutions. • **Create training records and link them to national HRH/CPD systems** so all immunisation-related training is logged and trackable	• Training programmes that are not competency-based or not linked to national systems. • Training not based on needs assessment and linked to training records. • Digital initiatives that exclude women or ignore the digital gender divide.
Fragile/ humanitarian	• **Delivery of short, modular training** for HWs/CHWs using **phones, offline apps, or radio** to quickly build essential immunisation skills. • **Adaptation of training content** for fragile contexts – e.g. cold chain management in insecure areas, communication strategies for mobile or displaced communities. • Integration of **immunisation training into PHC recovery and emergency response plans**, ensuring coverage for displaced and vulnerable groups.	• Training content not adapted to fragile or low-resource contexts. • Training activities not coordinated with humanitarian/emergency response actors or MoH-led recovery plans.
Initial self-financing	As per all countries activities	As per all countries activities
Preparatory transition	• **Develop/strengthen national data systems** that track **training participation**, link **learning outcomes to service delivery improvements**, and disaggregate results by gender, cadre and geography.	• Continued reliance on donor-managed or externally hosted training platforms without steps to localise ownership. • Training that is not recorded in national HRH or training databases.

Accelerated transition	• **Deploy adaptive training tools** (digital, blended, AI-enabled – where feasible) to keep HWs updated on new immunisation protocols, cold chain practices and data systems. • **Institutionalise peer learning** by funding activities such as district-level peer exchanges, mentoring networks, and twinning programmes. • Link training participation to **performance dashboards** disaggregated by cadre, gender and geography.	• Training programs not embedded within budgeted national HRH or PHC strategies. • Performance tracking systems disconnected from national M&E platforms.
References for this flagship: WHO (2022). Global Competency and Outcomes Framework for Universal Health Coverage. ISBN: 978-92-4-003466-2. WHO (2022). Global Competency and Outcomes Framework for Universal Health Coverage. ISBN: 978-92-4-003466-2.		

Flagship intervention 4: Enable enhanced **performance and accountability**, leveraging supportive supervision, digital technologies, and data-driven feedback loops.

Description: Improving how health workers perform involves using effective strategies – not just training. Countries should choose strategies and follow these guiding principles:

- Select interventions that fit the country context and address the biggest gaps.
- Combine interventions and approaches (e.g. training + supervision + community engagement) work better than standalone activities.
- Use in-person, digital, or blended methods – as long as they are practical and of good quality.
- Interventions must be part of national HRH and PHC plans, not parallel projects.
- Align with other PHC programmes and partner support to use people and resources efficiently.

	Recommended activities	**Ineligible activities**
All countries	• **Bundle support:** Provision of essential tools (registers, cold chain job aids, checklists) alongside **supportive supervision visits** that include problem-solving and feedback. • **Peer learning groups:** Support for regular facility or district-level meetings where health workers and supervisors share problems, test solutions, and learn from each other. • **Community-linked support:** Fund community and CHW engagement tied to supervision and performance reviews, especially for identifying and following up with zero-dose children. • **Digital feedback systems:** Support use of **simple digital tools** (performance dashboards, mobile apps) to track performance and provide real-time feedback to staff.	• New, parallel or vertical performance tracking systems not aligned with national HIS or strategic plan. • Performance enhancement activities lacking a feedback loop or accountability component e.g. supervision efforts without structured tools, follow-up, or data use.

Fragile/ Humanitarian	• Expand flexible supervision systems in insecure or remote areas, using simple digital tools (e.g. SMS check-ins, dashboards, mobile job aids) to monitor performance and provide timely support. • Establish checklists, tools and job-aides that can be quickly adapted to different outbreaks and future epidemics/pandemics	• Performance systems not coordinated with emergency health response actors. • One-size-fits-all supervision models that do not reflect fragile contexts or staff safety concerns.
Initial self-financing	• Strengthen proven **supervision platforms** to support real-time feedback and performance review. • Pilot **accountability frameworks** and link them to service delivery data, especially for ZD children.	
Preparatory transition	• Institutionalise **supervision and accountability systems** with clear performance indicators linked to immunisation and PHC goals.	• Performance initiatives which are not linked to national HRH or health sector performance frameworks.
Accelerated transition	• Mainstream the use of **performance analysis** to identify causes of poor performance and link interventions to national improvement plans. • Ensure national **performance frameworks** link HRH metrics to service quality, immunisation coverage, and community feedback	• Supervision or accountability systems not embedded in national budgets or performance plans.
Key references: Rowe et al. (2025). Best practices for designing interventions to improve health worker performance in low- and middle-income countries. In press.		

4. Governance and management

As health systems grow more complex, the Governance Pillar helps countries strengthen leadership, coordination, and management to ensure every child and community is reached sustainably. It supports timely, evidence-based decisions, effective stakeholder coordination, and performance management across national and subnational levels – particularly important as countries face shifting demographics, urbanisation, migration, fragility, decentralisation, digital transformation, evolving vaccine portfolios, and changing public trust dynamics.

Strong leadership and cross-sectoral collaboration are essential, with Ministries of Health taking active ownership while engaging planning, human resources, finance, and primary health care leadership, alongside ministries such as Finance, Education, Social Welfare, Gender, ICT, and Interior. Collaboration should also extend to civil society, public health institutes, statistics bodies, emergency response structures, and donors to ensure alignment, complementarity and sustainability.

Gavi support strengthens programme management and coordination mechanisms, such as Inter-agency Coordination Committees, health sector coordinating committees, and logistics working groups, while also building the capacity of National Immunisation Technical Advisory Groups (NITAGs) to make evidence-based policy and systems decisions.

Investments will be tailored to country context, focusing on: developing management and leadership capacity; fostering cross-government collaboration to reach zero-dose and under-immunised children; enhancing committee capacity to manage planning, partnerships, and resources; using data strategically for performance and accountability; and building gender-responsive programme management that eliminates discriminatory practices, ensures equitable pay and benefits, prevents harassment, and promotes gender parity in leadership.

<table>
<tr><td colspan="3">Flagship 1: Support countries in envisioning and evolving immunisation management at national and subnational levels, ensuring optimal structures, competencies and staffing</td></tr>
<tr><td colspan="3">Framing
This investment area aims to support Ministries of Health (MoH) in defining and implementing an updated vision and structure for national immunisation programme management, ensuring it is fit for purpose and aligned with the evolving role of immunisation within health systems. This flagship supports government reform and will require the assignment of a MoH focal point to marshal political engagement and shepherd a process. The cost of this flagship will depend on the scope of envisioned reform. The cost driver is likely human resource time and/or third-party engagement to support analysis, decision-making processes, plan development and provide change management supports. While this flagship is relevant for all countries (other than those experiencing acute crises), AT countries that have not undertaken a management review in preparation for transition to ensure all requisite competencies are in place, should strongly consider this flagship.</td></tr>
<tr><td></td><td>Recommended activities:</td><td>Ineligible activities:</td></tr>
<tr><td>All countries</td><td>Investments should support a continuum of activities related to:
Assess evolving programme and management needs against current immunisation governance and management structures to identify strengths and gaps including gender-related considerations and mitigation plans (e.g. for outbreak/pandemic response).
Support design and implementation at national and subnational level of updated organisational models/management structures and policies aligned with vision for reform and integrated in broader MoH ecosystem. These may include staffing structures, gender parity considerations, role definition, accountability frameworks, performance management systems, capacity building and career</td><td>Financing of existing staff positions or recurrent costs not directly linked to a defined change initiative, except for F&C.
Routine training activities or management courses (e.g. refresher trainings) not linked to new management roles or structures.</td></tr>
</table>

	pathways (including for under-represented groups in the health workforce, particularly women in mid- and senior-level roles) and funding model. • In specific cases (applicable to ISF and PT countries only), Gavi may co-finance critical personnel required to operationalise a redesigned EPI management structure, provided there is a clear, time-bound plan for progressive government financing of these functions. This could include support for country liaison officers to enable coordination between the Government, Secretariat and partners, and across sectors and levels of the health system. • Ensure change management and learning support for adoption of new structures and processes, including coaching, capacity building and iterative adaptation supports.	
Fragile/ humanitarian	• In lieu of a full redesign process, F&C countries may instead opt to conduct a rapid assessment of immunisation management capacity gaps (competencies and staffing levels) at national and subnational levels, particularly in high zero dose areas, and design and implement an immunisation management strengthening plan. • Train EPI management team on emergency-focused immunisation planning and implementation, data reporting and use, with attention to local context and needs of female frontline workers in fragile settings.	• An immunisation management redesign investment is not relevant for countries in acute crisis.
Initial self-financing	As per all countries activities	
Preparatory transition	As per all countries activities	
Accelerated transition	• Review management requirements and capacities considering upcoming transition and ensure needed capacities are present in government structures (e.g. procurement, budgeting, etc.)	• AT countries ineligible for HR salary support to operationalise a new structure

Flagship 2: Strengthen government capacity for planning, monitoring and performance management of immunisation at national and subnational levels.

Description: Strategic and operational planning are critical to define priorities and directions a country should take on immunisation over the years, using monitoring and performance assessment to help identifying challenges and obstacles, and objectives and interventions to overcome them. A costed National Immunisation Strategy (NIS) that reflects the trade-offs made between HSS, campaigns and vaccines introduction support from Gavi needs to be aligned with National Health Sector Strategy (NHSS), Immunization Agenda 2030 and regional frameworks. This provides the foundation for supporting primary health care (PHC) services and strategies. A strong costed NIS becomes an invaluable advocacy instrument at national and subnational levels for reinforced commitment and funds allocation.

	Recommended activities:	**Ineligible activities:**
All countries	• **Strengthen planning capacity:** Support national and subnational governments to develop evidence-based costed immunisation plans (such as NIS), annual operational plans (AOP) and annual budgets that feed into government's standard budgeting process) aligned with other PHC teams and strategies, where possible, and in coordination with MoF for budgeting. • Support EPI leadership and working groups to implement strong project management tools, including building work-back plans for key interventions (e.g. campaigns) with clear milestones, implementation activities, responsibilities, and deadlines, tracking progress, and removing bottlenecks. • **Improve delivery and oversight frameworks:** Support institutionalisation of real-time data collection, analysis, and use for decision-making, through dashboards, reports and scorecards, regular performance review meetings, and data quality checks, enabling the design, delivery, and iteration of evidence-based solutions, and timely follow-up on performance, at all levels. • **Enhance performance management:** Establish accountability frameworks that focus on the key drivers of immunisation coverage, set performance targets, and use review mechanisms to track progress and drive action through regular performance dialogues. • **Build sustainable leadership capacity:** Provide on-the-job coaching for national and subnational leaders, enable supervisors to provide evidence-based feedback to frontline healthcare workers, integrate training into public health	• Standalone training or workshops that do not feed into a larger capacity-building plan, have no monitoring, or are disconnected from national strategies. • Hiring expensive external consultants without engaging local expertise or aligning with national capacity development plans.

	institutions, and strengthen M&E units within MoH to embed planning, budgeting, monitoring, and performance management as core government functions. Strengthen capacities of managers involved in immunisation at central, regional and district levels on gender mainstreaming ● Ensure immunisation strategies address gender-related barriers and align with national gender equality strategies and commitments. ● Facilitate peer learning between national and subnational teams, e.g. through performance review meetings, codification and dissemination of best practices, dedicated learning calls, etc. ● Support the development of health emergency and outbreak response and preparedness plans. ● Support country liaison officers to enable coordination between governments, Gavi, and partners and strengthen performance monitoring at national and subnational levels.	
Fragile/ humanitarian	• Conduct and train local health authorities on rapid situation analysis and service continuity mapping focusing on gender and community engagement. • Support planning integration with humanitarian health services (e.g. WASH, nutrition, emergency, protection, shelter, camp management).	
Initial self-financing		
Preparatory transition	• Institutionalise routine performance reviews (quarterly/biannually) with clear accountability mechanisms at all levels. • Support decentralisation of immunisation budgeting and planning with capacity building at subnational level.	
Accelerated transition	• Integrate immunisation targets, including second year of life, into national performance frameworks. • Strengthen accountability systems by linking data with policy and financing decisions at subnational level. • Expand learning and performance review platforms to cover integration with broader PHC services and life course immunisation.	

Flagship 3: Support and strengthen government-led bodies to oversee and coordinate across immunisation and PHC, ensuring alignment between MoH, MoF, and facilitating greater collaboration amongst donors and partners.

Description: This flagship aims to reinforce national leadership and institutional capacity to oversee and align immunisation and PHC efforts, ensuring coherence across ministries and with external partners. This investment is particularly critical in contexts where multiple global health initiatives, such as Gavi, the Global Fund (TGF) the Global Polio Eradication Initiative (GPEI), operate concurrently. Without deliberate alignment, parallel coordination structures risk fragmentation, inefficiency and missed opportunities for synergy. Strengthening existing platforms (ICC, HSCC…) or strategically merging or linking them can reduce duplication, enhance accountability, and improve the effectiveness of joint planning, budgeting and performance monitoring.

	Recommended activities:	**Ineligible activities:**
All countries	• Support country-led assessments to identify the most appropriate existing coordination mechanism or platform to strengthen immunisation and link with broader PHC efforts. Where appropriate, this may involve merging, aligning, or linking existing platforms. • Ensure the chosen mechanism meets minimum requirements by reviewing terms of reference, member roles, decision-making mechanism, partner engagement, representation, operating procedures, performance indicators and financing. • Support joint planning sessions for immunisation and PHC with government in the lead focusing on data sharing. • Develop simple tools to frequently track accountability and coordination body performance (e.g. meeting frequency, participation, decision follow-up) and course-correct. • Establish provincial and district-level multi-sector coordination committees with clear terms of reference and performance indicators. • Ensure meaningful participation of CSOs including Women-led Organisations, private sector, and community representatives, with attention to gender-balanced representation (gender). • Support country liaison officers to enable coordination between governments, Gavi, and partners and strengthen performance monitoring at national and subnational levels.	• Construction or renovation of office buildings, unless directly linked and proportionate to improving coordination capacity. • Funding for new platforms when effective ones already exist (e.g. creating parallel ICC or HSCC structures). • Recurrent costs for meetings except for F&C countries. • Technical assistance not embedded in national structures and with no transition plan to the government. • Platforms formed exclusively of non-immunisation members.

Fragile/ humanitarian	• Ensure immunisation priorities are integrated into broader humanitarian and emergency response planning.	
Initial self-financing	As per all countries activities.	
Preparatory transition	As per all countries activities	Support staff, TA, or consultants without a defined pathway for government absorption or transition plan.
Accelerated transition	• Ensure institutional sustainability by building capacity (training on monitoring, partners engagement…) and/or facilitating knowledge transfer. • Develop a governance monitoring matrix to ensure the platform performs effectively.	

Flagship 4: Support countries to make data-driven decisions to prioritise and optimise vaccine portfolios and immunisation programmes including through strengthening national immunisation technical advisory groups (NITAGs).

Description: This investment area aims to support Ministries of Health (MoH) to consider how to optimise their existing vaccine portfolios (products, presentations and schedules) and assess their health system capacity to effectively introduce and deliver new vaccines. This includes potential investment trade-off decisions to determine whether introducing a prioritised new vaccine is more beneficial than optimising existing programmes or increasing system capacity to expand the reach of existing vaccines. While the need for this support is not new, the current resource-constrained environment combined with the growing number of vaccines across the life course and the introduction of vaccine budgets and consolidated cash budgets, will result in **increasingly complex trade-off decisions** of how to allocate finite resources across routine, preventive and outbreak response programmes. This further underlines the need to more urgently respond to country demand for guidance and flexible tools that is backed up by a partner-aligned, coordinated approach.

The Secretariat is currently working with Alliance and expanded partners to develop a robust vaccine portfolio optimisation and prioritisation (VPOP) approach to be rolled out in Gavi 6.0 that will be informed by lessons learned from ongoing support activities in response to country optimisation and prioritisation needs. The approach will need to be flexible to the evolving scope of Gavi's support to countries calibrated on available resources. Gavi's VPOP approach, as part of an overall strategy for country-level vaccine envelopes, will be presented to the PPC and Board later this year for guidance; strengthening of NITAGs and their secretariats will be a key area of focus.

Scope of support

Investments under this flagship area should support a range of activities that may include:

- Aligning on a cohesive vision across Alliance partners to empower evidence informed country decisions on vaccine prioritisation and optimisation in alignment with global market health goals;
- Strengthen local capacity to apply VPOP, through sharing information, trainings, coordination and partner engagement to improve decision-making processes for EPI delivery across levels of the health system

- Targeted, hands-on technical assistance and coordination mechanisms to strengthen NITAG and NITAG secretariat capacity and functioning, as well as EPI and ICC as an essential component to VPOP implementation;
- Change management and learning support to facilitate adoption of new tools and decision-making approaches through coaching, capacity building, and iterative adaptation.

Potential support mechanisms
There are several mechanisms of support that will be considered, including Gavi's consolidated funding for implementation and strengthening activities (e.g. NITAG, ICC support); foundational or catalytic funding for core and other partners at country, regional and global levels; and direct grants to regional or technical partners for capacity strengthening and TA. Additionally, the proposed support for targeted innovations, tools, and technical activities may be considered. Finally, support for strategic oversight, learning, foundational work and coordination will be required.

Implementation Considerations
VPOP approach development and implementation is complex and will require expertise, resources and time to implement given the variability of existing country capacities. Support to NITAGs and EPI technical teams to build and not fill capacity gaps will be critical for sustainable outcomes. At a global level, it will be essential to find the appropriate balance between: country prioritisation of NVI and demand for changes in products, presentations and schedules; potential trade-offs with RI strengthening activities; and global market health and vaccine supply security, and vaccine cost savings. At the country level, this workstream will need to engage with both Ministry of Health and Ministry of Finance as well as NITAGs to ensure ownership, alignment and sustainability of reforms.

5. Supply chain

Strong, efficient, resilient, and responsive supply chains are critical for ensuring potent vaccine availability where and when needed to reach zero-dose, under-immunised children and missed communities.

Gavi's guideline outlines strategic frameworks and operational recommendations to strengthen immunisation supply chains (iSC) across various country contexts. It focuses on enhancing governance, financing, data visibility, infrastructure, system optimisation, and workforce development to ensure effective vaccine delivery, especially targeting under-served and zero-dose populations. It provides a structured and phased approach to strengthening immunisation supply chains, emphasising sustainability, integration and adaptation to country contexts to improve vaccine availability and immunisation coverage.

Flagship
Support coordination, governance, and performance management of the supply chain through functional technical working groups.

Segment	**Recommended activities:**	**Ineligible activities:**

All countries	• Establish and sustain functional NLWGs and SNLWGs with defined roles, engagement, and accountability for immunisation supply chain performance. • https://www.technet-21.org/en/resources/guidance/guidance-strengthening-immunization-programmes-national-logistics-working-groups • https://www.technet-21.org/en/resources/guidance/generic-tors-templates-immunization-programmes-national-logistics-working-groups-nlwgs • Identify and pursue practical, high-impact opportunities for multisectoral collaboration and integration across health t [4,5] • Conduct full EVMAs at the recommended interval of three to five years, and targeted EVMAs to track progress in between full assessments. • Develop, update and implement cIPs, ensuring linkages to broader immunisation initiatives (e.g. polio) with tracking and reporting through the SCIP platform.	• Sitting allowances[14] for NLWGs and SLWGs.
Fragile/ humanitarian	• Undertake contingency planning, engaging humanitarian actors for operational plans, coordination and implementation of supply chain activities.	Same as all countries
Initial self-financing	Same as all countries	Same as all countries
Preparatory transition	Same as all countries	Same as all countries
Accelerated transition	• Develop or upgrade national procurement strategies and tendering processes. • Establishing multi-year procurement agreements via UNICEF/PAHO or independently using country mechanism. • Implementing digital stock management systems and real-time dashboards. • Training supply chain managers and creating career pathways for logistics staff.	Same as all countries

Flagship
Scale-up supply chain data visibility and equip users for data-driven decision-making at all levels of the supply chain including by scale-up of electronic logistics management information systems (eLMIS).

[14] Compensation for the time spent in the meeting, separate from salary or other allowances.

Segment	Recommended activities:	Ineligible activities:
All countries	• Strengthen standard operating procedures (SOPs) and workflows for effective data use across supply chain functions. • Build capacity for and routine operation of digital supply chain systems and data platforms. • Implement comprehensive forecasting and supply planning (e.g. using FSP toolbox). • Develop, customise, and link digital solutions to effectively track, analyse and triangulate all DISC indicators with programme data for decision-making. (https://thrive360.unicef.org) • Digitalise the supply chain using TSS compliant eLMIS solutions (including upgrading non-TSS to TSS compliant systems), leveraging interoperability with existing and new advanced technologies.	• Non TSS-compliant vaccine or Standalone vaccine eLMIS systems. • Solutions with high subscription fee or support costs whether open source or not, that country cannot and does not commit to sustain after deployment.
Fragile/ humanitarian	• For highly fragile context, implement interim digital solutions (e.g. eSMT, DHIS2 logistics, simplified web- or Excel-based tools) as transitional measures toward full eLMIS deployment. • Develop and deploy emergency tools (e.g. ODK) for vaccine handlers, coupled with rapid capacity building initiatives.	• Advanced solutions such as traceability, control towers etc. if digital maturity is low.
Initial self-financing	Same as all countries	Same as all countries
Preparatory transition	Same as all countries	Same as all countries
Accelerated transition	• Strengthen technical capacities and infrastructure within the government ecosystem to manage and sustain digital technologies and platforms effectively post-transition.	Same as all countries • Advanced digitalisation investments without country ownership and transition plan e.g. AI-based solutions that country wants to host but does not have infrastructure (GPUs)

Flagship
Expand, extend, and replace cold chain and critical immunisation supply chain infrastructure supporting PHC, particularly at the last mile.

Segment	Recommended activities:	Ineligible activities:
All countries	• Establish cold chain storage and transport, warehousing, waste management, and facility solarisation infrastructure based on relevant assessments and plans – supporting PHC integration where feasible.	• Non-PQS cold-chain equipment except those used in emergencies ex: ultra-low temperature equipment.

	• Develop, distribute, and operationalise country specific guidance on how to store immunisation products safely with other PHC products. • Strengthen capacity for distribution and installation of infrastructure through government or private sector partnerships including tested innovative approaches (e.g. local LSPs, 3PL/4PL models). • Conduct and improve warranty tracking, Including follow up with suppliers/contract accountability and management. • Deploy context appropriate and sustainable internet connectivity solutions. • Develop and implement CCE decommissioning plans.	• RTM -enabled and EMS level III equipment to sites without connectivity. • Double remote temperature monitoring e.g. deployment of standalone RTMDs/EMS Level 3 with RTM/EMS Level 3 enabled CCE. • Traditional cold-boxes and vaccine carriers. • Transport infrastructure without Opex and maintenance costs accounted for by government. • Warehousing investments without country operationalisation plans and opex costs.
Fragile/ humanitarian	• Enhance critical infrastructure with security protocols, i.e. alarm systems, access control. • Deploy innovative technologies (e.g. long-term passive devices, transportable powered vaccine storage devices, shock proof storage devices) and temporary storage solutions (e.g. temporary storage sites to improve access) • Coordinate with emergency actors to support rapid recovery from disruptions in conflict-affected settings (e.g. partnerships with humanitarian agencies, integration with other convoy supplies)	Same as all countries
Initial self-financing	Same as all countries	Same as all countries
Preparatory transition	Same as all countries	Same as all countries
Accelerated transition	Same as all countries • Leverage advanced technologies and innovations to strengthen critical infrastructure, (e.g. leasing of CCE, warehousing outsourcing)	Same as all countries

Related flagship
Enhance CCE functionality through strengthened maintenance systems and practices and robust digitally enabled performance/temperature monitoring.

Segment	**Recommended activities:**	**Ineligible activities:**

All countries	• Develop and/or update preventive and curative maintenance plans. • Establish and maintain an updated CCE inventory system including use of digital tools and telecommunications (e.g. phone, messaging services, email, shared Excel files). • Strengthen performance monitoring and basic maintenance systems for cold chain and infrastructure (e.g. standard KPIs, digital reporting, use of remote monitoring systems) • Develop and operationalise SOPs for infrastructure maintenance and repair. [4] • Build the capacity of local maintenance teams to respond to equipment issues and service interruptions. • Conduct temperature monitoring studies and temperature mapping exercises to assess risks across the supply chain. [link guidance]	• Standalone in-person inventory exercises. • Preventative maintenance activities.
Fragile/ humanitarian	• Maintain existing infrastructure leveraging innovative maintenance approaches (e.g. peer to peer e-learning platforms, mobile maintenance units).	Same as all countries
Initial self-financing	Same as all countries	Same as all countries
Preparatory transition	• Integrate CCE data within existing country systems using digital tools (e.g. digital CCI modules, medical equipment management systems). • Capacity building and certification programmes for cold chain technicians and biomedical teams. • Where applicable, expand use of integrated service contracts or partnerships for sustainable infrastructure support and rapid response capacity (e.g. outsourcing)	• Data subscriptions for RTMDs and EMS level III-
Accelerated transition	Same as PT	Same as PT

Flagship
Optimise country supply chain design and distribution systems, prioritising the last mile including through new delivery technologies and partnerships

Segment	**Recommended activities:**	**Ineligible activities:**
All countries	• Use existing data and mapping tools (e.g. SCANIT) to identify gaps in	• Standalone system design assessments/studies

	storage and distribution networks, evaluate optimisation scenarios and improve system efficiency. [4, 5] • Develop/update clear SOPs and operational processes for storage and distribution, including integration points with other service delivery channels. [4] • Assess, pilot, and scale alternative last-mile delivery models (e.g. direct delivery to HFs, reverse logistics, private sector outsources) integrated with PHC commodities where feasible.	
Fragile/ humanitarian	• Assess the impact of conflict or emergencies using available data and identify priority areas for logistics support and integration, including storage and distribution frequency. • Tailor logistics and distribution solutions based on emergency context and access constraints (e.g. direct delivery systems) leveraging existing supply chain assets and humanitarian actor networks.	Same as all countries
Initial self-financing	Same as all countries	Same as all countries
Preparatory transition	Same as all countries	• Direct delivery outside of under-reached communities and/or zero dose populations.
Accelerated transition	• Use of predictive tools (e.g. AI) for supply chain scenario planning and managing disruptions.	Same as PT

6. Data and digitally enabled information systems

Robust, real-time data is essential for strong planning, implementation and monitoring of programmes, and for achieving all outcomes in the theory of change. Pillar 4 of the Health Systems Strategy therefore prioritises ensuring that quality data is consistently available and used across all levels of the health system. Gavi investments will focus on systematically improving the availability, quality and use of data to plan, manage and monitor programmes. These efforts will pursue two objectives: enabling countries to collect and utilise data more effectively to strengthen programme implementation, and enabling the Alliance to better track progress and assess the impact of health systems investments at both country and portfolio levels. Priority will be given to investments that enhance visibility of process and output data in immunisation programmes, ensuring that decision-makers can act on timely information. At the same time, countries will be supported to seize the opportunities of digital transformation, with further scale-up of innovative digital technologies aligned with the Alliance's Digital Health Information Strategy for global standards and national digital health strategies:

https://www.gavi.org/sites/default/files/support/guidelines-2022/Gavi-Digital-Health-Information-Strategy-2022-2025_Eng.pdf

Flagship 1: Strengthen data collection systems to improve data availability at national and subnational levels, with follow two key areas of investment:

1.A. Strengthen and sustain digitally enabled national data systems to improve routine data collection and management.		
	Recommended activities	**Ineligible activities**

All countries	• **Improve data system reliability and efficiency:** Upgrade the national HMIS to capture life course and multiple vaccination strategy at national and subnational levels, including automation of data quality checks and feedback generation across:
	  ○ Routine systems like DHIS2
	  ○ AEFI and VPD Surveillance
	  ○ Vaccination campaign planning and monitoring
	  ○ Vaccine logistics information management systems
	• Enhance survey data using through satellite images, machine learning and geostatistical models to characterise geographic distribution of population, vaccination coverage and zero-dose children at granular level, complementing routine data system
	• **Integrate data systems and improve interoperability with broader PHC Data:** Establish data interoperability layer/API gateway and master facility lists with shared terminology services and common standards, including:
	  ○ civil registration and vital statistics
	  ○ human resources information systems
	• **Maintain information systems reliability** through adequately trained personnel within MoH, establishing information systems audits as well as data quality reviews.
	• **Roadmap development towards adopting emerging digital technologies:** Conduct readiness assessments and data quality assessments with respect to
		• Digital health platform development or scaling of interventions, tools and platforms beyond what is encouraged by Gavi or that are not embedded in National strategic roadmap.
		• Any activities promoting parallel routine reporting systems.
		• Tools that are not scalable, non-standard (e.g. not FHIR/TSS, compliant), or lack long-term sustainability and use plans.
		• Antigen-specific vaccination campaign planning or information systems not scalable or interoperable with existing information systems.
		• Immunisation-specific registries (*Gavi is not recommending investments in EIRs in 6.0 considering the set-up, routine and associated costs of enabling infrastructure critical for EIRs to function in Gavi-supported countries. In the light of available funding ceilings, there are opportunity costs to consider for such investments and how it affects other core investment areas and priorities. Where countries already have EIRs set up and running, Gavi is recommending a multi-stakeholder consultation and coordinated approach to ensure sustainability*.)

	development of digital health roadmaps and workplans.	
Fragile/ humanitarian	• Simplified offline-capable/mobile-based tools with offline data collection capabilities (bundled with alternate sources of power like solar chargers/power banks). • Time-limited TA costs, hardware and/or platform and software customisation with alternate budget line secured for sustainability.	
Initial self-financing	• See all countries	
Preparatory transition	• See all countries	
Accelerated transition	• See all countries	

1.B Support innovative measurement activities to supplement national data systems to fill data gaps and strengthen implementation monitoring.		
	Recommended activities	**Ineligible activities**

All countries	• Measurement activities to supplement routine information systems so as fill key information gaps (identified at country level) for robust monitoring of programme implementation, such as rapid cycle monitoring through:
	  ○ Light-touch and frequent health facility assessments to strengthen measurement of service-related barriers and readiness
	  ○ Innovative household survey methods and other robust measurement activities (for example LQAS and phone surveys) that reduce cost and time needed for measurement of coverage.
	• Qualitative and quantitative targeted approaches to measurement of BeSD indicators to better identify and track demand-side barriers (in particular when included in or linked with household coverage surveys).
	• Real-time monitoring of campaigns and triangulating/supporting linkages to routine immunisation.
	• Enhance survey data using through satellite images, machine learning and geostatistical models to characterise geographic distribution of
		• Sporadic unplanned data surveys which are not linked to a decision-making process (i.e. grant/programme design period, not planned for use in regular implementation review and adjustment mechanisms).
		• Where there is opportunity to have a combined immunisation coverage + MICS/DHS, that should be preferred than standalone immunisation coverage survey.
		• Household coverage surveys without key BeSD related questions included (where input on questionnaire/survey protocol is available).
		• Interventions that collect data in an unstandardised way, do not use global metadata packages, or are otherwise not aligned with a country's Health Information Exchange.

	population, vaccination coverage and zero-dose children at granular level, complementing routine data system.
	• Periodic cost-effective surveys and assessments to deepen insights in key programmatic areas, such as:
	  ○ Invest in the addition and ensure inclusion of immunisation-specific modules and indicators within planned national household surveys and other large scale data collection efforts (i.e. integrated health and demographics surveys, living standards, etc.)
	  ○ Implement targeted immunisation coverage surveys to identify children and assess reasons for non-immunisation when other data sources are insufficient.
	  ○ Effective vaccine management (EVM) assessments.
	• Integrate gender-related indicators into routine monitoring systems (e.g. service acceptability, caregiver constraints, workforce composition) and use results in district review meetings, and to inform programme decisions.	

Fragile/ humanitarian	• Support usage of mobile technology which has offline functions at the hard-to-reach areas. • Security protocols for data collection in conflict-affected areas.	
Initial self-financing	• Support activities to include the data from RCM and surveys in regular EPI review meetings.	
Preparatory transition	• Support to embed activities to improve estimates of target population and the coverage data within the existing systems.	
Accelerated transition	• Support to embed activities to improve estimates of target population and the coverage data within the existing systems.	

Flagship Intervention 2: Strengthen data analytics through technology and capacity-building to improve data use for decision-making at national and subnational levels.		
2.A. Scale proven digital tools, including testing AI-driven analytics in national HMIS to improve data visualisation, triangulation, analytical capability and data quality		
	Recommended activities	**Ineligible activities**
All countries	• Implement/pilot innovative digital tools into National HMIS platform to optimisation or perform advanced programme analytics and visualisation, including data triangulation, data quality review, modelling/forecasting and automated insight generation to facilitate ease of data use for decision making at national and subnational levels. • Support adaption of proven digital concepts to local context and scale-up of piloted interventions that addresses population movement and denominator issues, targeting of specific vulnerable population groups (e.g. ZD), health worker capacity gaps, and vaccine demand-side barriers that align to global and local standards and guidelines, are interoperable with existing national HMIS/RHIS systems and are embedded in Country strategic plans, leveraging AI and Machine Learning (ML) where applicable. • Support MoH staff capacity strengthening to utilise advanced digital system capabilities for decision-making. ○ Investments must be informed by national digital health strategies, readiness/maturity assessments, situation analyses, and be aligned with HMIS/digital health workplans or roadmaps. • Conduct AI readiness assessments and support development of AI policy/strategy within broader health sector strategies and the national ICT enterprise architecture/blueprint.	• Interventions that do not respond to a gap identified through consensus with Gavi Alliance or lack plausible pathway to integration and scale. • Interventions that are not appropriate based on the country's digital readiness and maturity levels (including digital infrastructure, etc) or not aligned with national strategic plans. • Scaling of GenAI interventions not trained on context-specific datasets, or without bias, safety, privacy and security risk assessment/mitigation, governance and content quality controls. • Scaling of interventions without clear capacity strengthening, transition or handover plans to government.
Fragile/ humanitarian	• Adaption of digital tools that support bringing improvement to existing data collection or analysis mechanisms without creating dependence on availability of advanced connectivity infrastructure which may be missing in large parts of a country.	

	• Use of such innovative digital tools and solutions may be encouraged for use in specific contexts or limited to providing ad hoc support to MoH for decision-making
Initial self-financing	• See all countries
Preparatory transition	• See all countries
Accelerated transition	• See all countries

2.B Strengthen subnational data analytics and capacity to generate timely and quality data for periodic data-driven performance reviews and decision-making		
	Recommended activities	**Ineligible activities**
All countries	• Integrate data analytics with existing routine supportive supervision or other routine data review mechanisms at the health facility level. (see examples of such integration achieved in strengthening leadership management and coordination from other countries. *Include link to examples demonstrated by ACASUS in countries.)* • Support low-cost activities to improve estimates of target population and coverage data, including use of modelling, micro-census data, or targeted enumeration activities when linked to service delivery. • Conduct rapid analysis of immunisation data at subnational levels, with focus on identification and resolution of data quality issues and use for decision-making (for example, line-list review of facility data to correct for missing data and outliers, identification of best denominators, use of survey data to validate adjustments where possible). • Collaboration with national and regional technical groups (universities, public health and epidemiologic agencies) to build capacity with defined capacity building pathways and results monitoring to strengthen denominators, triangulate data, including the use of outbreak and surveillance data, to identify and reach zero-dose, under-immunised children, missed communities and for public health emergency response.	• Investments that sustain parallel reporting systems Investment not aligned with an integrated and coordinated HMIS strengthening plan- • One-.off workshops/review meetings to discuss performance • Standalone dashboards and tools at subnational levels without interoperability with existing systems/databases. • Investments that do not align with the district and national health management information plans.
Fragile/ humanitarian	• Build capacity of local CSOs and humanitarian organisations to collect, triangulate, analyse and use data.	

Initial self-financing	• Support development of integrated dashboard for data from LMIS, HMIS/RHIS and other sources.
Preparatory transition	• Same as initial self-financing
Accelerated transition	• Embed data use practices into routine health system operations and performance reviews

Flagship intervention 3: Strengthen structured learning systems and peer-to-peer approaches through national, regional, and global collaboration, research capacity and knowledge translation		
	Recommended activities	**Ineligible activities**

All countries	• Engage local, regional and international institutions (e.g. universities, technical groups and associations) to develop comprehensive learning agenda for immunisation programme.
	• Strengthen in-country capacity in implementation research through research activities integrated with programme implementation.
	• Institutionalise knowledge translation activities to manage, disseminate, and transmit learnings, such as:
	  ○ Systematic documentation of outputs (sessions, participants, products), outcomes (knowledge, confidence, application), and impact (service delivery improvements, improved workplan monitoring). (Resources: https://zdlh.gavi.org/resources/knowledge-translation(Resources: https://zdlh.gavi.org/resources/knowledge-translation)
	  ○ Intentional involvement of women, particularly for virtual activities and that take place outside of regular working hours as women may have less access to technology and/or household responsibilities.
		One-off meetings or work shops
		• Didactic trainings
		• One-off, presentation-driven webinars
		• Standalone curricula, e-learning trainings, guidance, or tools
		• Ambiguous and vague capacity-building activities

Fragile/ Humanitarian	• Short-term or ad hoc engagements may be more appropriate and that focus on solving short-term bottlenecks and include exchanges with peers from similar contexts or from global to country. Virtual models are likely more feasible but consider limited connectivity and safety. Consider asynchronous models. External facilitation may be needed.	
Initial self-financing	• Support country capacity-strengthening activities for peer learning functions (e.g. facilitation, adaptive learning), support NIS MEL and EPI Reviews, support improving learning culture in EPI/MoH.	

	• More systematic use of peer learning approaches to solve medium term implementation bottlenecks. Within and across country approaches and global to country models may be needed. • Mix virtual and in-person depending on cost optimisation.
Preparatory transition	• Same as initial self-financing
Accelerated transition	• Directly support existing in-country peer learning functions and build capacity for sustainability of activities. • More "peer country"-to-country approaches and within country for advocacy for domestic resources . • Pilot or support self-assessment/self-learning approaches. • Subnational adaptative learning approaches.

7. VPD Surveillance, laboratory capacities and diagnostics

While surveillance, laboratory capacities and diagnostics are not a prominent flagship intervention under the Gavi 6.0 HSS strategy, they **remain a critical enabler across several other flagship interventions** (e.g Strengthen subnational data analytics and capacity to generate timely and quality data for periodic data-driven performance reviews and decision-making under **data- and digitally-enabled information systems**; strengthen community-led integrated microplanning under **service delivery**; support countries to make data-driven decisions to prioritise and optimise vaccine portfolios and immunisation programmes under **governance**). Gavi investments across surveillance, laboratory capacities and diagnostics in 6.0 should be complementary to those of other funders (e.g. the Pandemic Fund and the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, FIND) and not displace or duplicate these efforts nor domestically financed efforts. Gavi investments should not be used to support surveillance activities intended to be sensitive enough to confirm global eradication of a disease. Surveillance systems should be fit for purpose but achieve a balance between performance, costs and sustainability

Objective: Strengthen the effectiveness and efficiency of vaccination programmes – including preventive campaigns, outbreak response, and routine immunisation – by investing in robust vaccine-preventable disease surveillance systems, enhanced laboratory capacity and improved diagnostic capabilities. These investments will enable timely, data-driven decisions to support subnational targeting, vaccine prioritisation and optimisation strategies.		
	Recommended activities	**Ineligible activities**
All countries	• In alignment with Gavi-supported priorities, investments towards laboratory capacity training and strengthening, including quality assurance and inventory management, at national labs (NLs) and regional reference labs (RRLs). As	• Integrated disease surveillance that does not address the key questions for national and subnational immunisation programme decision making • Procuring diagnostics without sufficient enabling infrastructure and

	feasible, training of appropriate health personnel across levels to enable effective deployment and use of rapid tests. • Investments towards strengthening VPD surveillance – with an emphasis on comprehensive surveillance systems and interoperable digital systems to generate quality and timely information for immunisation decision making. Build capacity of data managers at national and subnational levels to ensure effective reporting and use of data across surveillance systems, diagnostic public health laboratories, and immunisation programmes. Adaptable disease surveillance, laboratory and diagnostic training materials, guidelines and systems that may be modified to incorporate additional VPDs and emerging threats • Targeted support for sample transportation to national labs and/or RRLs for timely detection and laboratory confirmation if no existing sample transportation alternatives are available in country (including integrated approaches with other programmes or diseases, such as HIV, malaria or polio), for example the use of dried blood spot, alternative specimen collection and transportation carriers, common transport logistics/route, etc. This is particularly important to	complementary training, and procuring diagnostics for use outside of the recommended routine testing algorithm • Using fragmented or vertical programme surveillance systems with no interoperability nor integration with other data/HMIS/programmes • Deploying surveillance systems without training, sustainability, or affordability plans • Piloting non-scalable or non-integrated approaches • Surveillance, laboratory or diagnostic investments that duplicate or displace existing funding • Payment of salaries of in-country laboratory and surveillance personnel (TBC: except for targeted personnel in F&C setting countries) • Infrastructure development, including building of laboratories, at national or subnational levels • Funding for surveillance and laboratory officers/personnel sat outside of national/subnational government (e.g. within partner organisations) • Large-scale sample transportation costs on a recurrent basis

	ensure adequate specimen integrity to support in-country detection capacity and protect past and current diagnostics investment. • Upskilling of community level health workers to support strengthened community and health facility surveillance/detection – towards early detection and notification • Utilisation of VPD surveillance data and generation of analytics to improve EPI programme performance and outbreak detection and response (e.g. root cause analyses of outbreaks; identification of gaps in immunisation performance; integration of surveillance reviews into EPI reviews; triangulation of disease surveillance data with coverage data to identify zero-dose, under-immunised and high-risk outbreak communities; programme targeting, including for campaigns. • Support efforts for sustainable/transition programming and planning that integrates surveillance, laboratory and diagnostics – including domestic financing in an identified timeline. • Reserve funding for procurement and deployment of diagnostic laboratory tests on an exceptional basis (e.g. for future outbreak response). • Targeted funding for sample transportation linked to Gavi supported diagnostics towards Gavi prioritised diseases – per an identified and set timeline.	

Recommended activities for other contexts	
Fragile/conflict	• Targeted and **time-limited** support of key VPD surveillance, diagnostics, laboratory personnel (salary support) to ensure foundational/critical functions continue • Investments to strengthen community based-surveillance system and capacities (in complement to traditional surveillance systems) • Additional flexibility to rapidly deploy rapid diagnostics and laboratory capacity in response to emerging needs *There may be greater willingness to fund well-justified recurrent costs in fragile and conflict settings (e.g. procurement of reagents, linked to sample transportation or broader investments to support early detection and notification)*
Initial self-financing	
Preparatory transition	• Ensuring highest level of laboratory and surveillance system performance through monitoring and evaluation mechanisms • Increased domestic investments in workforce training and digital reporting platforms
Accelerated transition	• Strengthening capacity for strategic planning and domestic planning for integrated VPD surveillance • Focus on lab quality assurance and new technology introduction trainings over basic lab capacity trainings • Digitalisation and advanced integration of VPD surveillance within IHR platforms • Systematisation of the conduct of surveillance data, including laboratory data, quality audits integrated with routine programmatic DQAs • Ensuring highest level of laboratory and surveillance system performance through WHO-coordinated global laboratory networks standardised monitoring and evaluation mechanisms (inter-laboratory re-testing, proficiency testing, laboratory assessment towards accreditation, adherence to surveillance standards, etc.)

Campaign Considerations: Campaign plan development and implementation monitoring / reporting should integrate available surveillance data. Outbreak responses should work in harmony with laboratories, diagnostics, and surveillance leads to ensure plans and implementation are effectively targeted (eg to drive identification and implementation of ring-vaccination / hot-spots models). Campaigns must also include monitoring and learning mechanisms to ensure accountability and enable timely course correction.

Key technical resources and references

- https://www.who.int/publications/m/item/global-strategy-for-comprehensive-vaccine-preventable-disease-(vpd)-surveillance
- https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/surveillance/surveillance-for-vpds
- https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/surveillance/surveillance-for-vpds/vpd-surveillance-standards
- https://www.gtfcc.org/page-resources/guidelines-technical-documents/

Objective: Strengthen country capacity to detect, evaluate and respond to serious adverse events following immunisation		
	Recommended activities	**Ineligible activities**
All countries	• Train immunisation staff and strengthen integrated information systems to detect and respond to vaccine safety concerns • Strengthen capacity to evaluate and respond to signals of new, rare, potential safety problems, especially with new vaccines • Establish and train committees to assess the relationship between the receipt of vaccine and a subsequent medical problem • Develop plans for responding to vaccine safety concerns or signals, including crisis communications plans – both for routine introductions and outbreak/epidemic/pandemic related vaccination response • Coordinate with Reference Laboratory to assess if testing is required to investigate AEFI	• Studies to assess the association between vaccines and serious adverse effects following immunisation when that association has been well studied or has major studies underway, e.g. risk of intussusception following rotavirus vaccination in Africa

8. Health financing

Scaling up domestic financing for immunisation is crucial to sustainably reduce the number of zero-dose and under-immunised children. Gavi will support investments in country health financing system strengthening during Gavi 6.0. As countries move along Gavi's transition continuum they will need to be prepared to fund a higher proportion of their vaccine procurement and operational costs for

immunisation. Investments in health financing should sustainably improve systems to ensure adequate domestic financing reaches the right recipients at the right time to spend on the best value interventions for the country. This will enable countries to smoothly transition off Gavi and other donor support.

Securing sufficient funds for immunisation requires a combination of investments along the health finance value chain. These must reflect country-specific political economies, structures and institutional arrangements, for example the level of centralisation of public administration and finance, prevalence of health insurance, size of private sector role and existence of defined 'health benefits package'.

In Gavi 6.0, health financing investments should:

1. Strengthen domestic resource mobilisation by enhancing planning, budgeting, forecasting and advocacy at national and subnational levels
2. Strengthen public financial management, and use of country systems for Gavi funding, to improve grant execution and programme implementation as well as joint Programme Management Units with the Global Fund as appropriate
3. Enhance flow of funds and utilisation at the frontlines, and reduce opportunities for misuse, through use of digital payments and mobile money
4. Strengthen efficiency of health financing by prioritising vaccine investments, integrating health funding and scaling proven results-based financing approaches
5. Support transition planning for sustained vaccine financing, ensuring immunisation funding is incorporated into national budgets, in coordination with other donors in the health sector in line with Lusaka Agenda

As financing interventions are rarely solely immunisation financing focused, and some may extend beyond the health sector, it is especially important for these to be coordinated with other donor partners to avoid duplication or competing efforts.

Flagship 1: Strengthen domestic resource mobilisation by enhancing budgeting, forecasting and advocacy at national and subnational levels.

Description: Governments need to co-finance an increasing share of Gavi-supported vaccines and contribute an increasing amount towards operational costs. The activities described below shall all contribute to an increase in domestic resources allocated to primary health care, including immunisation. To avoid verticalisation, the focus will often need to be wider than immunisation. Successful implementation will require the Ministries of Health to work with government and non-government stakeholders, especially Ministries of Finance and Treasury.

	Recommended activities	**Ineligible activities**
All countries	• Strengthening of **forecasting, planning, and budgeting capacity** at national and subnational level for vaccines, cold chain equipment and operational costs within wider PHC budget exercises, at both central and decentralised level,	• Investments that do not directly inform or improve the

	and vaccine procurement capacity at a centralised level. • Integration of immunisation requirements into the **Medium Term Expenditure Frameworks** for health/PHC or other multiyear frameworks. • Support the **development and implementation of PHC and immunisation costing, fiscal space analyses and financing strategies** to increase the fiscal space, predictability and budget for health. • **Expand advocacy efforts at national and subnational levels** through CSOs and other partners. Some capacity building on health and immunisation financing may be needed. Activities can include supporting **parliamentary briefings and budget hearings** to build political will and accountability for immunisation financing. • Support **policy dialogues and high-level health financing dialogues** to engage national leadership on immunisation financing.	planning, budgeting and execution of PHC and immunisation costs. • Health financing assessments that lack an in-depth analysis of immunisation. • Policy dialogues without focus on immunisation financing.
Initial self-financing	• Support **National Immunisation Forums** to for high-level engagement on budgeting and disbursement of immunisation financing.	
Accelerated transition	• Assessment of medium- to long-term vaccine procurement prices and overall budget as country prepares to transition off Gavi prices.	
Fragile/humanitarian	• Needs may be broader and include gathering accurate data for forecasting and budgeting exercises as well as costing and efficiency analyses.	
Campaign considerations: With the increase in co-financing for campaigns, which fluctuates over years, thorough costing, planning and advocacy will be needed for sufficient funding to be budgeted and released on time for vaccine procurement and campaign roll-out.		

Flagship 2: Strengthen public financial management, and use of country systems for Gavi funding, to improve grant execution and programme implementation as well as joint Programme Management Units with Global Fund as appropriate.

Description: Grant execution and programme implementation will be improved if specific attention is provided to national public financial management (PFM), especially with other health partners who are using similar processes. Since PFM bottlenecks are often identified as some of the sources of limited or delayed domestic funding of immunisation, strengthening PFM and using country systems for Gavi support will benefit the whole health financing system and contribute to better execution of health budgets.

	Recommended activities	Ineligible activities
All countries	• Strengthening public financial management (PFM) and use of country systems (UCS) by identifying and addressing bottlenecks (e.g. developing PFM and UCS analysis, aligning PFM manuals to donor requirements, training staff on PFM practices and its linkages to donor requirements • Build capacity of country assurances (such as internal and supreme audit institutions) to support grant activities • Align donor capacity building support to that of countries especially at the national and subnational levels for the purposes of ensuring a coordinated approach to priority areas. • Leverage on other donor PFM resources and support targeting the health sector by creating a forum for information sharing thus reducing duplication of funding	• Technical assistance for analysis of PFM bottlenecks with no deep analysis of PHC
Campaign considerations: N/A		

Flagship 3: Enhance flow of funds and utilisation at the frontlines, and reduce opportunities for misuse, through use of digital payments and mobile money

Description: Delays in immunisation funding releases can be due to inefficient public financial management processes and complex political economy contexts. Knowledge and improvement of these processes should result in facilitated flow of funds and improved transparency allowing for monitoring of releases and expenditures. Monitoring can provide more accountability. Where funding is not reaching facilities using Direct Facility Financing can be helpful and is eased with more systematic use of digital technologies.

	Recommended activities	Ineligible activities
All countries	• Support **mapping and simplification of release processes and expenditure controls** and **stock-out analysis and creation and use of release calendars** to ensure timely releases of funds, either for procurement of vaccines, or operational costs. • Implementing and strengthening mechanisms to ensure **funds flow to frontline levels**, such as Direct Facility Financing and performance based financing.	• Technical assistance for analysis of PFM bottlenecks with no deep analysis of PHC. • Duplicative assessment

	• **Capacity building in financial management** enables effective use of immunisation linked financial resources, particularly at subnational and facility levels. Capacity building should leverage economies of scale, e.g. digital training. • **Support digital technology solutions for domestic resources transfers** down to points of service delivery ensuring security, transparency, and traceability of funds, and leveraging those used for Gavi funding. • Developing and implementing methods and processes for **resource mapping, budget and expenditure tracking** at national and subnational level to support reporting and efficiency measurement. • Set up **monitoring mechanisms and accountability frameworks** to review information on immunisation and PHC expenditure at national and subnational levels, including online dashboards of funding sources and expenditure.	of PFMF bottlenecks. • Duplicative tracking and transparency tools.
Accelerated transition	• Support **stock-out analysis** and creation and use of release calendars to ensure timely releases of funds, either for procurement of vaccines, or operational costs, especially in the context of increasing co-financing shares.	
Campaign considerations: Timing of releases are especially important for the procurement of campaign vaccine. Mobile banking solutions are very well adapted for campaigns.		

Flagship 4: Strengthen efficiency of health financing by prioritising vaccine investments, integrating health funding and scaling proven results-based financing approaches

Description: In a context of scarce financing for health fiscal space can be found in gaining in efficiency of expenditure. The below activities would focus on improving public health expenditure efficiency, such as implementing result-based financing approaches as well as optimising a package of services or vaccines.

	Recommended activities	**Ineligible activities**
All countries	• Supporting **Vaccine Portfolio Optimisation and Prioritisation** exercise to identify savings and implement introductions and/or switches of vaccines to gain in efficiency in vaccine procurement. • Improve efficiency of spend through conducting **allocative efficiency and value for money analyses** and implementing recommendations.	

	• Support initiation and systemisation of **sector-wide approaches** in countries to improve coordination of donor and other financing. • Support initialisation and systemisation of **pooled financing modalities, especially with disbursement linked indicators,** to incentivise improved immunisation outcomes.	
Campaign considerations: Multi-interventions campaigns (Vitamin A, nutrition, etc) are sources of efficiency.		

Flagship 5: Support transition planning for sustained vaccine financing, ensuring immunisation funding is incorporated into national budgets, in coordination with other donors in the health sector in line with Lusaka Agenda.

Description: Countries in accelerated transition need to strategically plan for their transition off Gavi support of vaccines, operational costs and technical assistance, as well as limited time access to Gavi vaccine prices. Such planning should be integrated into national plans and strategies and rigorously monitored. Leveraging peer learning and experience is critical and recommended.

	Recommended activities	**Ineligible activities**
Preparatory and accelerated Transition	• Development and implementation of country **transition and sustainability roadmaps** and accountability frameworks. Financial and programmatic sustainability should be included, and future of processes supported by the Alliance, including forecasting, budgeting and procurement processes. • Promote **harmonisation of donor support with national transition plans** to avoid duplication and fragmentation. • Develop **transition monitoring frameworks** with indicators to track progress on domestic financing, budget execution, donor alignment and the agreed relevant metrics of the transition roadmaps. • Support regular **joint reviews of transition progress**, involving Ministries of Health, Finance, donors and civil society. • Promote transparency and accountability mechanisms, including **public reporting on immunisation financing.** • Participation in multi-country **Peer-Learning and Transition Monitoring Secretariat** and other multi-country sustainability and transition initiatives.	• Interventions that are duplicative with other partner support. • Development and implementation of non-integrated roadmaps – necessary to be aligned/integrated in other national strategies. • Fund similar initiative(s) which are not directly contributing to supporting governments to build capacity for sustainable health financing, sustainable immunisation financing, Gavi

		and/or other donors' transition.
Campaign considerations: As campaigns have relatively low co-financing compared with routine vaccines there will be a large increase in cost for financing them when countries enter the fully self-financing stage, for which they need to prepare.		

Annex 5: Engagement of expanded partners under 6.0

1. Purpose of this annex

Countries can use their Gavi 6.0 Cash Budget to access support from Expanded Partners for delivery of activities in their holistic application. Expanded Partners include civil society organisations (non-profit), private sector actors (for-profit), and UN agencies other than UNICEF and WHO.

This annex outlines Gavi's requirements and approach for identifying, selecting, assessing, and contracting Expanded Partners. A core requirement under Gavi 6.0 is that Expanded Partners are selected through transparent and competitive processes to ensure value for money, fairness and accountability.

2. Partner identification during application development

Expanded Partners comprise three categories: civil society organizations (CSOs), private sector partners, and other UN agencies. As part of preparing their holistic application, countries define activities and, in the budget template, indicate the partner category best suited to deliver each activity. This should be done at category level rather than naming specific organisations, to ensure that a fair and competitive selection process can take place after approval of the application.

Where the partner category is not yet clear, this may be indicated as "TBD", particularly for activities related to technical assistance where the required expertise may be sourced from different types of Expanded Partners.

CSOs play a critical role in reaching missed and under-served communities. In line with the Board-approved HSIS policy, countries are required to allocate at least 10 percent of their total Gavi 6.0 Cash Budget to CSO-led implementation for this purpose. This allocation should be clearly reflected in the holistic application, specifically the budget template.

The holistic application serves as the basis for partner sourcing, selection, and contracting, specifying activities, expected results, indicative budgets by partner category, and whether activities relate to implementation or technical assistance. This distinction determines the engagement and contracting approach applied.

Important Note:
Expanded Partners may be involved in early-stage consultations, including country-level multi-stakeholder dialogues, to provide input into a country's holistic application. However, to ensure fairness and avoid conflicts of interest, partners that support the development or drafting of the application itself cannot later be contracted to deliver activities under that same country application.

3. Partner sourcing, selection and engagement pathways

Gavi initiates partner sourcing and selection once the application has gone through review and approval processes. In some cases, Gavi may start sourcing and selection immediately after a country has submitted its application to save time. However, contracting can only proceed once the application has been approved. Gavi does not initiate partner sourcing and selection before application submission, except in exceptional, justified cases approved by Gavi.

Gavi engages Expanded Partners through two main pathways, based on the nature of the activities, the type of partner, and the delivery context; Direct and Indirect engagement.

In **Direct engagement**, Gavi contracts partners directly. This modality is primarily used for technical assistance but may also be used for implementation primarily where a single partner or a lead partner managing a consortium is best placed to deliver the activities.

Direct engagement is mostly done through engagement of competitively pre-selected partners through the Global Request for Proposal (RFP). Assignments are awarded through secondary bidding, or in limited, justified cases, through direct selection. Where no suitable pre-selected partner is available, standalone RFPs are launched. Single sourcing remains exceptional and subject to formal approval.

Direct engagement should be used where activities require specialised technical expertise and where contractual oversight by Gavi is required and feasible.

In **Indirect engagement**, partners, primarily local CSOs, are contracted through an intermediary, which can be a Gavi-managed CSO Fund Manager or a Core Partner. This modality is primarily used for implementation and is generally not used when Expanded Partners are providing technical assistance.

In this approach, the intermediary manages the full grant management cycle on behalf of Gavi, including partner selection, contracting, disbursement, oversight and reporting, in line with Gavi requirements and standards and in close consultation with the government.

Indirect engagement should be used where implementation involves multiple partners operating at subnational level, where in-country coordination and facilitation is required, where partners may require operational and programmatic capacity strengthening, and where managing multiple partners and contracts directly by Gavi would not be efficient or feasible.

4. Due diligence

All Expanded Partners are subject to due diligence prior to contracting to ensure they have the capacity to deliver the agreed scope of work. Due diligence covers financial, institutional, operational and programmatic aspects and is applied in a standardised manner across all partners and engagement pathways, with the level of assessment adapted to the scale and risk profile of the activities.

For partners engaged directly by Gavi, due diligence is conducted by the Secretariat or designated agents. For indirect engagement, due diligence is conducted by the intermediary using an assessment framework aligned with Gavi requirements.

5. Contracting instruments

The contracting instrument applied depends on the nature of the activity, the type of partner and the engagement pathway.

For partners engaged directly by Gavi, **Framework agreements** established through the Global RFP provide a multi-year basis for engagement, setting out scope, rates and terms for the strategic period. Specific assignments are then contracted through **Call-off contracts**, which define the detailed scope of work, deliverables, timelines, budget and performance expectations for each assignment. These are typically awarded through secondary bidding process or, where justified and approved, through direct selection.

Where Framework Agreements are not applicable, standalone **Service agreements** will be used, particularly for clearly defined, output-based assignments such as technical assistance.

Grant agreements are used more selectively under Gavi 6.0, primarily for UN agencies other than UNICEF and WHO, delivering implementation support.

For indirect engagement, contracting is managed by the intermediary using legal instruments aligned with Gavi requirements.

6. Implementation, oversight and reporting

Gavi, or the intermediary in cases of indirect engagement (i.e. the CSO Fund Manager or Core Partner), finalises contracting arrangements following completion of due diligence and may adjust scope, budget, or specific conditions based on assessment findings.

All contracts with Expanded Partners, whether call-off contracts under a framework agreement, service agreements, or grant agreements, define the scope of work, expected results, timelines, budget, and reporting requirements. Each contract aligns with the approved application and relevant Gavi performance and accountability frameworks (see Part E – Grant Monitoring), enabling the contribution of each partner to be clearly tracked, aggregated, and reflected in country-level reporting against the Cash Budget.

Gavi assigns a contract owner, who oversees implementation of the agreed scope of work, ensures engagement and collaboration with government, and maintains coordination and visibility across stakeholders.

Partners report regularly on progress and use of funds in line with Gavi 6.0 reporting requirements and cycles. For indirect engagement, intermediaries consolidate and report on the performance of sub-contracted partners.

Annex 6: Controlled Temperature Chain (CTC)

1. What is CTC?

The Controlled Temperature Chain (CTC) is a vaccine management approach that allows specific prequalified vaccines to be stored and transported at ambient temperatures of up to +40°C for at least three consecutive days just prior to administration. CTC is distinct from 'out of cold chain' (OCC), in that CTC is formally recognised and labelled on the product vial as well as has regulatory oversight and monitoring tools in place.

As of 2025, five vaccines have been qualified for CTC use under WHO pre-qualification:

Vaccine group	**Cholera**	**HPV**	**Meningitis A**	**Meningitis A, C, Y, W, X**	**Typhoid**
Product	Euvichol-S (pending PQ)	Gardasil® and Gardasil 9	MenAfriVac®	MenFive™	Typbar®
Threshold temperature	40°C	40°C	40°C	40°C	40°C
CTC duration	10 days	4 days	4 days	15 days	7 days

Hepatitis B birth dose has been used as part of OCC with successful increases in coverage, but does not yet have CTC labelling.[15]

CTC is most suitable for:

- **Preventive campaigns** (e.g. HPV, MenA, MMCV, pOCV, Typhoid)
- **Special strategies** targeting hard-to-reach or fragile populations, such as mobile populations, refugee camps, or in conflict zones.
- In settings where **cold chain infrastructure is unreliable.**

15

2. Why consider CTC?

CTC offers two major benefits for countries:

1. Reduces costs

- Eliminates the need for ice packs, freezers and daily resupply during outreach, lowering campaign logistics costs.
- Reduces closed vial wastage by avoiding freeze damage and allowing safe use of vaccines at ambient temperature.
- *Evidence:* In Chad, use of MenAfriVac® under CTC reduced logistics costs by 50% per vaccinated person. Over 5 million CTC doses have been safely delivered in 10+ countries with no increase in wastage.

2. Increases coverage and reach

- Simplifies delivery and reduces the operational burden on health workers, giving them more time to vaccinate.
- Enables longer sessions and more flexible outreach, which can reach un- and under-immunised children in hard-to-reach and fragile settings.
- *Evidence:* In Benin, nearly 100% of vaccinators preferred CTC, citing ability to vaccinate more people per day. In Uganda HPV pilots, CTC allowed staff to cover more schools per day.

CTC has been successfully used in at least 15 countries across Africa and Asia. Documented outcomes include reduced logistics costs in Chad with MenA, and health worker acceptance and satisfaction in Uganda with HPV.

Table 6.1 Overview of selected CTC studies to date

Country Area	Benin 8 villages	Uganda 4 districts	Côte d'Ivoire 2 districts	Togo 4 regions	Chad 3 regions
Year	2014	2017	2014	2014	2011
Vaccine	MenAfriVac	HPV	MenAfriVac	MenAfriVac	MenAfriVac
Study Design	NRCT	Pilot implementation	Cross-sectional study mixed methods	Cross-sectional survey	Observational campaign + Modelling
Study population	1,000 in CTC 999 non-CTC	2 intervention 2 control	~ 492 campaign staff	9,082 in CTC	1,807,158 vaccinated
Study Focus	Mass safety/coverage	Vaccine delivery using CTC	Knowledge and opinions of actors using CTC	Coverage, AEFI CTC vs. cold chain	Cost savings of CTC campaign
Findings	Safety-like cold chain; >105% coverage	Pilot demonstrated feasibility and acceptability	CTC enabled vaccination in remote settings, yet was under-utilised	Coverage 98%, 2.3% mild AEs	Cost savings; extended coverage to low-resource settings
Impact/Relevance	Demonstrated the feasibility of the CTC approach	Informed national policy and guidance for other countries	Demonstrated CTC feasibility and acceptance, yet need for coaching	Demonstrated that CTC is safe and effective	Showed cost savings and reach in weak infrastructure settings.
Reference (PMID)	Steffen, et al., 2014*	WHO 2018**	Kouassi et al, 2016	Landoh et al., 2017	Lydon et al. 2013

The benefits of CTC strategies depend on addressing key operational factors. Without proper training, planning and monitoring, the advantages of CTC can be reduced or even lost.

- **Training and supervision**
  - Health workers need simple, clear instructions to avoid confusion between CTC and non-CTC vaccines. Complex or inconsistent rules undermine efficiency and increase risk.
  - *Example:* In Uganda's HPV school-based CTC pilot, vaccinators were trained to mark the start time of CTC use on each carrier. This straightforward step ensured vials were not used beyond the approved four-day period and built staff confidence.
- **Avoiding wastage**
  - Improper handling can lead to vials being discarded if they exceed approved time or temperature limits. CTC can reduce wastage, but only with proper training and monitoring.

    Peak Temperature Threshold Indicators (PTTIs) are devices used during CTC. The PTTI remains on vaccine carriers and shows whether the carrier *has been exposed* to temperatures higher than 40°C. PTTIs should not replace VVMs.

Peak Temperature Threshold Indicators (PTTIs) are devices used during CTC. The PTTI remains on vaccine carriers and shows whether the carrier *has been exposed* to temperatures higher than 40°C. PTTIs should not replace VVMs.

    Example: In Chad's MenAfriVac® campaign, combining VVMs with Peak Temperature Threshold Indicators (PTTIs) helped staff safely use vaccines and discard only when necessary.
- **Managing co-delivery**
  - Campaigns often involve multiple vaccines, and not all are CTC-qualified. In such cases, the vaccine with the strictest cold chain sets the standard, reducing the practical benefits of CTC.
  - *Example:* In Togo, a MenA CTC campaign was run alongside other antigens. Because not all vaccines were CTC eligible, the operational advantages of CTC were limited.

3. Funding requirements for CTC inclusion in Gavi application

When considering vaccination strategies, CTC should be discussed and countries should ensure the following elements are reflected in their application if they wish to pursue CTC:

1. Vaccine eligibility

- Confirm that the vaccine is WHO-prequalified for CTC and specify the approved CTC conditions (temperature and duration).

2. Application content

- Identify the districts/areas where CTC will be used and how it fits into delivery plans.
- Provide clear rationale for utilising CTC (e.g. equity, zero-dose, fragile or hard-to-reach populations, improve access).
- Integrate CTC into the **Plan of Action** and **Ops budget**, including references in the holistic application where relevant.
- Integrate CTC into the **microplan/workplan** with operational details on training, session planning, vaccine handling, supervision, and monitoring under CTC.
- Include a **budget** that has specific CTC expenses for PTTIs (with 10% buffer stock, training materials and sessions on CTC use, supervision and monitoring activities, reporting mechanisms, and contingency provisions if temperatures exceed 40°C.

4. Feasibility and stakeholder engagement

- Summarise results of feasibility assessments (logistics, climate, training, monitoring capacity).
- Conduct consultations with national stakeholders (ICC, EPI teams, partners), including to seek discussions with NITAG.

5. Reporting commitments

- Confirm adherence to standard Gavi reporting requirements, including submission of the SIA technical report and, where applicable, a post-campaign coverage survey (PCCS).

Annex 7: Budget eligibility

Cost category	Description and principles	Indicative maximum
1. Salaries and wages	Employment costs (e.g. salaries or wages) for grantee staff directly linked to immunisation program management or implementation across all levels. • Rates and terms of employment should be aligned to national pay scales and existing structures of the implementer for similar positions funded wholly by domestic financing (or own funding for CSO/ NGO grantees).	• 20–30% of annual grant amount • F&C flexibility – 30–40% of annual grant amount
2. Per diems, allowances and other forms of compensation	Payments to non-staff, including volunteers and others taking on additional short-term duties e.g. supervision, monitoring, including training. This category also includes transport and travel allowances paid. • Performance-based supplements, incentives, top-ups are only eligible if part of an approved scheme and time-limited. • Payments to non-salaried support workers (e.g. volunteers on vaccine campaigns) at rates endorsed by the ICC or equivalent body. • DSA rates must be aligned with the official prevailing government or implementer rates.	TBD
3. Transport, travel and related costs	Procurement or rental of vehicles, and their associated fuel, service and maintenance costs. Costs of short-term hire and use of scheduled transport. • Vehicle purchases will be dependent on a fleet analysis report of available vehicles, and financing for operating costs from domestic funding. • Operating and maintenance costs – clear mechanism to link utilisation to the immunisation strategy activities. • Forms and classes of transport should reflect government policies or economical, safe and reliable transport options.	• Rental, fuel and operating costs – 20% of the annual grant • Vehicle procurement – above 10% of total grant or US$ 500,00 a distribution plan must be provided showing allocation with clear link to strengthening areas with high no. of zero-dose children

Cost category	Description and principles	Indicative maximum
4. Professional services	Short-term consultancies with defined deliverables. Where Targeted Country Assistance (TCA) has been funded to the country, this category and TCA should demonstrate alignment and non-duplication. • Fees should be consistent with local, regional and international market practice and rates, depending on the type of technical assistance (TA) or services sourced. • Generally, for international consultants, fees should not exceed the UN standard international rates; for local and/or regional consultants, fees should not exceed UN standard local rates. • TA costs should include only the incremental portion which cannot be delivered by existing resources available to the programme.	N/A
5. Vaccination consumables associated with service delivery	Costs that ensure efficient outreach and other immunisation activities. Excludes vaccines, medicines and equipment. • Non-printed items used during immunisation sessions (e.g. fluids, dressings, waste management and safety clothing or syringe boxes) • Consumables are quantified in relation to the client and dosage volumes. • PPE/ IPC is only eligible in exceptional circumstances, when a critical shortage will hinder essential immunisation activities.	N/A
6. Events-related costs	Costs related to preparation of materials, cost of trainers, venues, refreshments and accommodation (or refund of those costs on an actual receipt basis), but excludes per diem/allowances (covered in cost category 2 above) • Programmatic justification for the duration and frequency of training and the cadre and number of participants. • Choice of venue and format should reflect normal governmental (or grantee) practices. • Per diems (under cost category 2) should be reduced where event costs include accommodation, meals and transport refunds. • Implementers are encouraged to consider other modes of delivering training, including digital	N/A

Cost category	Description and principles	Indicative maximum
	strategies, and not only use traditional face to face training modality.	
7. Assets, renovation, furniture and IT equipment or maintenance	Purchase of IT and mobile communication equipment, furnishing, furniture and other assets; renovation costs. • As part of a prioritised strategy for health system strengthening, a mobile equipment investment plan would be part of the funding application – showing broad locations and purpose of usage. • Renovation costs, and related furnishing and fittings, should be justified, e.g. through a needs analysis for management or service delivery. Storage facility costs must be coordinated with CCEOP. • Procurement of IT hardware and software – justification through a needs assessment/analysis, incorporating existing IT equipment and clear linkage to service delivery. • Maintenance and repair costs of the assets are part of this category. • Operating costs of IT/data tools is a separate category. • Construction is not supported but may be considered if there is a joint financing arrangement.	N/A
8. CCEOP equipment and associated service costs	Subject to specific CCEOP eligibility constraints and prescribed menu of equipment, where grant funds are to be used for CCEOP purchase, running costs or maintenance, this category should be budgeted. • Cold storage items within the Gavi/ UNICEF catalogue where the need exists. • Specifications and suppliers are managed by UNICEF and subject to WHO standards – and must meet these to be an eligible use of funds. Small equipment, running costs, and other related costs must be requested through the CCEOP process.	
9. Printing, communication, mobile and information technology costs	The production of training, community engagement or other communication and sensitisation materials (paper, online, media or radio). Use and subscription costs for phones, data and IT services. • Printing, e.g. vaccination cards, posters and leaflets, should be integrated with PHC initiatives to avoid duplication.	N/A

Cost category	Description and principles	Indicative maximum
	• Application narrative should justify the media channel selected for communication and the message (general, targeted, time-specific, location-specific) and include effectiveness of using this media based on past experience.	
10. Programme support Costs, administration and overheads	Administrative and office costs directly related to managing the Gavi-funded activities, and agreed indirect costs recovery (ICR) levied against the value of the grant managed. ICR are acceptable as a flat rate and other shared costs should be itemised. • Grantees with dedicated office space or directly attributable rental and service charges can charge for these overhead costs. • Indirect rates must be explicitly agreed with Gavi as part of the grantee application. • Other than office related costs, other Common/programme management costs including support staff, apportioned to Gavi, should be done based on a clear rationale agreed on at the start of the funding cycle, and generally not expected to change.	• Contractually agreed rates with partners – WHO 7% and UNICEF 5% or 8% • ICR costs – maximum 10%, regardless of which level it is charged, and agreed in advance of grant signing. • Other shared costs – maximum of 10%
11. Results-based financing	Used when the grant purchases results rather than inputs. • Disbursement Linked Indicator (DLI) approach would be used to deliver a measurable output. • A programme-for-results/ services-delivered approach would define a qualitative and quantitative indicator of the result against which an agreed rate would be associated (and either disbursed or a previous release of funds be deemed as earned).	N/A

Annex 8: Catalytic Phase supported areas

1. Technical Assistance (TA) for new vaccine introduction

Given the diverse country contexts, Gavi does not specify which technical assistance activities qualify for TA support, allowing countries and partners to determine their priorities based on their needs. Activities must address a clear need and directly contribute to the success, sustainability, and equity of new PCV, rotavirus and/or HPV vaccine introductions, in line with Catalytic Phase objectives.

As a non-exclusive guide, examples of potential technical assistance could include:

- Conducting cost-effectiveness analyses
- Assessing product choice
- Developing a (costed) new vaccine introduction plan, including by conducting zero-dose and gender analysis to inform evidence-based plans that reach all children
- Forecasting national budgetary requirements for vaccines and associated supplies
- Developing a health worker training programme on new vaccine introductions
- Community engagement and communication, improving services to clients with improved health worker communication, empathy and understanding
- Developing communication and social mobilisation plans and materials for the introduction of new vaccines and reaching zero-dose children
- Designing evidence-based, context-specific behaviour change initiatives to effectively inform communities and increase vaccine demand
- Developing routinised plans for reaching traditionally missed communities
- Integrating new vaccines into national health management information systems (HMIS)
- Generating evidence on the economic benefits of sustaining new vaccines
- Conducting post-introduction evaluations
- Behavioural insights and demand generation
- Decision-making and NITAG strengthening
- Support to financial sustainability, including development of National Immunisation Strategies (NIS)

Whenever possible, activities related to multiple new vaccine introductions should be coordinated and integrated to create synergies and cost-savings

2. One-off costs for new vaccine introduction

Gavi allows CP countries to define and prioritise one-off costs relevant to their contexts and priorities. However, supported activities must be part of the country's new vaccine introduction plan, address a specific need, and directly support the success of PCV, rotavirus, or HPV vaccine roll-out in line with Catalytic Phase objectives.

As a non-exclusive guide, examples of potential support could include:

- The cost of health worker or staff training to support the new vaccine introduction

- The cost of producing communication materials and/or delivering a communication/sensitisation campaign to support the new vaccine introduction
- Vehicle rental or other modes of transportation to distribute the new vaccine to far-to-reach-areas

Whenever possible, activities related to multiple new vaccine introductions should be coordinated and integrated to create synergies and cost-savings.

Note on costs eligibility
Neither for TA nor OOC support, will funding be provided for ongoing or recurrent costs such as recurrent salaries and incentives, ongoing maintenance costs for vehicles, habitual health products and consumables, or costs that are not directly linked to the introduction of a new vaccine (e.g. costs which are associated with improving coverage of an already nationally introduced vaccine, or costs associated with strengthening wider cold chain). Gavi will also not fund non-antigen specific costs, e.g. to improve supply chain, cold chain and stock management systems (including supply chain management) for all antigens. Gavi generally does not support Cold Chain Equipment (CCE) requests. Exceptions could be considered only if the request is critical to the success of a New Vaccine Introduction – for example, if additional capacity is required for a new antigen. A 'CCE gap analysis' should be provided to justify the request and a 'sustainability plan' should clearly describe how the equipment will be maintained and funded after the initial support period. In these exceptional cases, all requests must comply with Gavi's overall framework for Supply Chain support (see Annex 4: Health systems strategy investment areas, Supply Chain). If a request is recommended for approval, Gavi will retain the right to further examine the support provided, subject to the availability of funds.

3. Vaccine catalytic financing

In addition to the cost of vaccine doses, Gavi will cover the associated cost of consumables (syringes and safety boxes), freight and costs associated with procurement through a Gavi-approved procurement partner (e.g. the handling fee). Countries choose to receive the VCF either in a single instalment or in two instalments over two years, in the case of a phased introduction.

To access VCF support, countries in the Catalytic Phase must demonstrate their commitment and capacity to ensure a sustainable and equitable introduction. Vaccine Support is only available for CP countries via one of Gavi's approved procurement partners (UNICEF and Pan American Health Organization's Revolving Fund) and at prices established through them.

Annex 9: MDB Multiplier examples

Example: Indonesia Investing in Nutrition and Early Years (INEY 2) Project

Indonesia provides a practical example of how to integrate and scale immunisation investments within a nutrition project. Under the World Bank's *Investing in Nutrition and Early Years (INEY) 2* operation, the Government of Indonesia is implementing a largescale programme to reduce stunting and strengthen primary health care, supported by a US$ 600 million results-based loan and an accompanying investment project financing (IPF) component.

To enhance the programme's focus on zero-dose and under-immunised children, Indonesia requested to channel part of its Gavi cash grant, US$ 13 million, through the INEY 2 project. Through this approach, Gavi's contribution was blended with the World Bank project to support immunisation-related activities such as strengthening routine immunisation monitoring systems, improving primary health care delivery capacity, and integrating zero-dose identification within community-level health and nutrition outreach. These immunisation priorities are reflected at scale through the World Bank project, which includes over US$ 300 million of disbursement-linked indicators (DLIs) tied to key results, including those related to immunisation within the stunting reduction strategy.

This joint financing arrangement allows Indonesia to align planning, budgeting and reporting systems across Gavi and the World Bank, while reducing transaction costs and improving efficiency. Embedding immunisation activities within a national, multi-sectoral programme also strengthens sustainability and supports more equitable coverage. Progress is monitored through the existing MDB results framework, enabling coordinated engagement between the Ministry of Health, Ministry of Finance, Gavi partners and World Bank teams.

Example: Honduras Restoring Essential Services for Health and Advancing Preparedness for Emergencies (RESHAPE) Project

In Honduras, Gavi provided **US$ 7 million in cash grant**, to complement the **US$ 60 million** World Bank's *RESHAPE* project. By channelling part of its Gavi cash support through this World Bank operation, Honduras was able to expand routine vaccination coverage and scale up health information system investments from 8 to 20 health regions. The joint financing approach supported increased childhood vaccination coverage and reductions in zero-dose children, while creating synergies with broader health system-strengthening efforts.

Through this arrangement, Gavi's contribution supports activities such as strengthening routine immunisation delivery, improving essential health service readiness, and enhancing emergency preparedness while benefiting from the World Bank's broader sectoral investments, implementation systems, and supervision mechanisms. The joint financing approach reduces fragmentation, enables more coherent planning between the Ministry of Health, Ministry of Finance, Gavi partners and the World Bank, and reinforces sustainability by aligning with the government's core health reforms.

Annex 10: Grant Accountability Framework

A) Grant Accountability Framework – overview of indicators

Type	Indicator name	Data source	Reported to GMS by:
Routine monitoring indicators	Number of immunisation sessions conducted (fixed and outreach)	eJRF	Gavi Secretariat
	Stock-out rate at district level (DTP)	Thrive 360	Gavi Secretariat
	Stock-out rate at district level (MCV)	Thrive 360	Gavi Secretariat
	Percentage of functional PQS CCE	eJRF	Gavi Secretariat
	Percentage of districts (or other admin2 unit) without data quality flags (e.g. negative drop-out, etc.)	eJRF	Gavi Secretariat
	Percentage of routine immunisation performance reviews, as per schedule	Country HMIS	Country
Grant-linked key performance indicators	Number of zero-dose children	WUENIC/UNPD WPP	Gavi Secretariat
	Number of children immunised with DTP1	Country HMIS	Country
	Number of children immunised with DTP3	Country HMIS	Country
	Number of children Immunised with MCV1	Country HMIS	Country
	Number of children Immunised with MCV2 (if introduced)	Country HMIS	Country
	Number of children immunised with HPV (if introduced)	Country HMIS	Country
	Percentage of co-financing fulfilled	Secretariat Financial Records	Gavi Secretariat
	Number of children immunised with newly introduced vaccines*	Country HMIS	Country
	Preventive campaign coverage	Survey or administrative data	Country
	Timely detection and response to outbreaks	ICG, MR&P, WHO	Gavi Secretariat
	Tailored Indicators *Tailored indicators are required for countries with 6.0 funding ceilings >US$ 10 million. They are optional for those under that ceiling.*	Variable	Each grant recipient will enter the details, and report against, their tailored indicators

	(The available list of tailored indicators can be accessed through the GMS at the time of application. Applicants can also create their own indicator if needed.)		

*Catalytic Phase countries are required to set targets, and report, against only this Grant-Linked KPI

A reminder: In addition to the indicators listed above, other data sources and indicators will be reflected in the Grant Management System to help contextualise and triangulate the results of the GAF indicators (for example: WUENIC coverage estimates and implied drop-out rates).

B) Grant Accountability Framework reporting – differentiated requirements

Differentiated reporting requirements		**High impact**	**Conflict and fragile**	**Core (incl. acc. trans.) + Catalytic Phase**
1.1 Financial performance	(a) Reported summary utilisation of cash against amounts disbursed to each grantee	Quarterly	Quarterly	6-monthly (quarterly for partners)
	(b) Reported spending against each activity at level of cost components within grant budget	Quarterly	6-monthly	6-monthly
1.2 Vaccine consumption	Reported for total grant consumption to date, by antigen	Quarterly	6-monthly	6-monthly
1.3 Activity status	(a) Reported overall implementation status by each grantee	Quarterly	Quarterly	6-monthly
	(b) Reported for each of the priority activities by each grantee* **all activities for CP grants*	Quarterly	6-monthly	6-monthly
2. Grant-linked KPIs	Reported by grantees and monitored against targets (Required indicators)	Quarterly	6-monthly	Annual
	Reported by grantees and monitored against targets (Tailored indicators)	Quarterly	6-monthly	Annual
3. Risks	Updated by all grant stakeholders when relevant ('light touch')	Quarterly	Quarterly for Severe Risks, else 6-monthly monitoring	6-monthly