Gavi 6.0 Funding Guidelines

Gavi
The Vaccine Alliance

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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 existing grants into a consolidated 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.

- **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 standard 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 Gavi 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 Gavi 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 2%, 10%, or 20%. 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	Countries contributed a higher share of CCE investment costs.	Country joint investment requirements for CCE reduced in Gavi 6.0, from 20% to 10% for ISF, 50% to 20% for PT and 50% to 35% for AT with exemptions introduced in line with the Gavi FED Policy and under the specific circumstances described in the Vaccine Co-financing Policy.
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 Gavi 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 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)	• 5 product options (+1 submitted for WHO Prequalification (PQ))	• Shift to single-dose schedule
Pneumococcal conjugate vaccine (PCV)	• 5 product options	• 3+0 or 2+1 schedule • 1+1 schedule for mature programmes meeting specific criteria*

Rotavirus	• 7 presentations[1]	• 2-dose or 3-dose schedule
Hexavalent vaccine /Pentavalent vaccine + Inactivated polio vaccine (IPV)	• Presentation options for Penta and IPV	• Switch to 3-dose Hexa schedule from 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)	• 2 presentations (5-dose and 10-dose vial)	N/A
Inactivated polio vaccine (IPV)	• 3 presentations (1,5, 10-dose vials)	N/A
Pentavalent	• 2 presentations (1,10-dose vials) • 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 support during the Gavi 6.0 period (2026–2030). It is communicated to countries at the beginning of the strategic period and can be updated periodically through a Gavi annual review. 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.

Each country's Vaccine Budget compromises two components: the 'guaranteed budget' and the 'discretionary budget'. Considerations for determining which vaccine programmes fall within the guaranteed budget include health impact, value for money, global relevance, inter-country equity and continuity of support. This classification is not based on or referring to WHO guidance or individual country policy.

[1] Market impacted by supply constraints with limited availability of some presentations.

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 for the vaccines listed on the right. Initial calculation based on the forecasted demand over Gavi 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, requiring countries to prioritise across eligible programmes or mobilise additional funds to self-finance these vaccines. Calculated based on an allocation formula (under-five mortality inversely scaled to GNI per capita), after considering the ISF floor.[2]	All other vaccines (limited to the allocated budget) in the Gavi menu, which currently include: • **Diphtheria, tetanus, and whole cell 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:

[2] The ISF floor is to ensure Vaccine Budgets for ISF countries include enough support for the continuity of their existing vaccine programmes that fall under the discretionary budget and to ensure malaria vaccine scale-up and new malaria vaccine introductions in up to 70% of moderate- to high-transmission areas.

- 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:
    - Defines the funding available to each country for a set of defined vaccine programmes, whether already introduced or to be introduced (see table 4). It is based on forecast country demand over the Gavi 6.0 period. When preparing their application for Gavi support, countries can allocate their available guaranteed budget across those vaccine programmes according to: the outcomes of their VPOP process (see section 2.1); and these guidelines – considering, for example, vaccine introduction needs and timing, product selection and coverage ambitions of ongoing programmes. Countries are not permitted to reallocate 'savings' from stopping an ongoing programme to other programmes.
    - If a guaranteed programme is discontinued or not introduced within the strategic period, the associated Gavi funds cannot be used.
    - Funds in 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 on the discretionary budget list.
- The discretionary budget:
    - Defines the funding available to each country with the primary objective of providing support for vaccine programmes, whether already introduced or to be introduced, that are not catered for under the guaranteed budgets.
    - Can also be used for funding needs for vaccines within guaranteed 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. For ISF countries, it includes, at minimum, sufficient funding to 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.
- If a country's vaccine needs exceed its available Vaccine Budget when applying for Gavi support, it may need to prioritise which programmes to maintain or introduce, optimise existing programmes, place additional needs on the standby list, or self-finance some programmes where needed.
- **Countries are strongly encouraged to make use of the standby list.** It is a register of additional guaranteed and discretionary funding needs captured in the country application and considered at the time of the annual Gavi review. Needs may be fulfilled as new Gavi resourcing becomes available, following the Vaccine Budget Policy prioritisation order (see Annex 2, Vaccine Budget Simulation Tool).

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 Gavi 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 implemented in an integrated way through co-delivery or joint planning, 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.

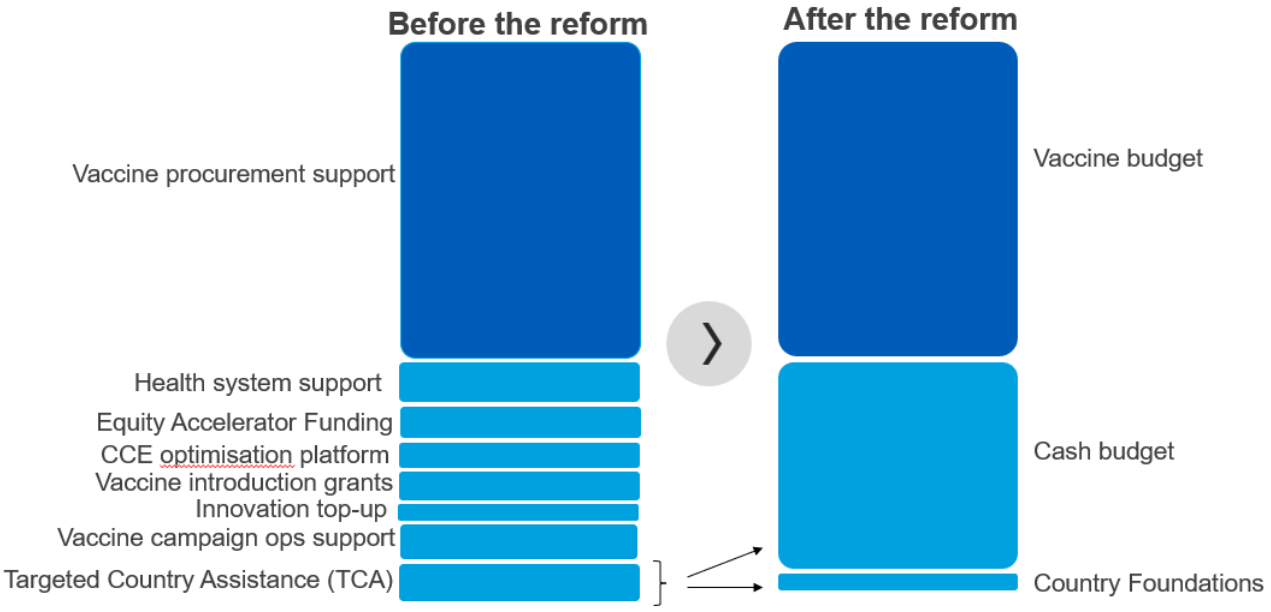
Further guidance
See **Annex 3: Vaccine Menu** for further details on Gavi's scope of support for hexavalent vaccine.

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.

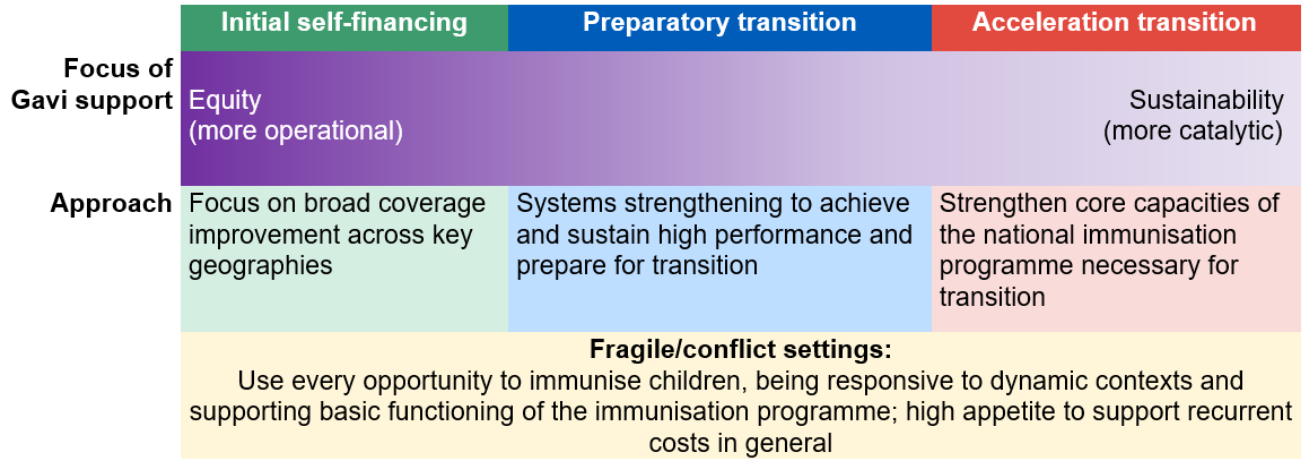
The Health Systems Strategy differentiation framework in Figure 2 serves as high-level guide to support countries in considering the focus of the two goals, depending on their Gavi transition status, their immunisation performance or classification as fragile and humanitarian contexts

- **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



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. 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

Planning for vaccine implementation support (introductions, campaigns and switches)

Within this overall approach, countries planning vaccine introductions, preventive campaigns or planned vaccine switches 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. Implementation arrangements should adequately address coordination and delivery, community engagement, data systems, safety monitoring, supply chain and cold chain planning, and financing; and confirm that the planned activities strengthen the health system.

Delivery strategies should reflect country context, and may include tailored and/or targeted delivery strategies (e.g. subnational non-selective campaign), combined where appropriate, 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 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 routine immunisation strengthening.

Vaccine implementation support associated with the Guaranteed Vaccine Budget

For vaccine introductions, preventive campaigns and planned vaccine switches in the Guaranteed Vaccine Budget, Gavi has included an associated amount of vaccine implementation support within the country's Cash Budget, based on Gavi's latest financial forecast.

Countries should include the corresponding vaccine activity in their application and clearly identify the budget for its implementation. The associated funding is conditional on the corresponding vaccine activity being included in the country's plan and ultimately taking place. If it does not proceed, the associated funding will not be disbursed.

Within these conditions, countries may programme their Cash Budget flexibly across eligible activities from the point of planning, in line with country priorities and subject to the guardrails set out in the HSIS Policy.

The amount allocated by Gavi for vaccine implementation support to support vaccines in the guaranteed budget is a planning amount and does not determine how much a country must budget or spend on the corresponding vaccine activity. Countries should budget according to what is needed for effective implementation and may programme more or less than the amount allocated by Gavi within their overall Cash Budget. Any funds remaining following implementation may be used for other eligible activities within the Cash Budget.

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 Gavi 6.0 strategy period, see Annex 5a: Engagement of Expanded Partners under Gavi 6.0. For additional information regarding the Expanded Partners' guidance on conflict of interest, see Annex 5b. 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. CSOs may also work with 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[3], administration and overheads

[3] *Programme Support Costs refer to the indirect costs incurred by an organisation to enable the implementation of programmes. Under Gavi 6.0, programme support costs will be managed within the country Cash Budget. Different arrangements may apply for approved extensions during the transition period between Gavi 5.0/5.1 and the start of new Gavi 6.0 programming.*

- 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. Further examples are available from Gavi.

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.

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 5a: Engagement of expanded partners under 6.0 - for detailed guidelines. For additional information regarding the Expanded Partners' guidance on conflict of interest, see Annex 5b: Expanded Partners' COI Guidance 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)

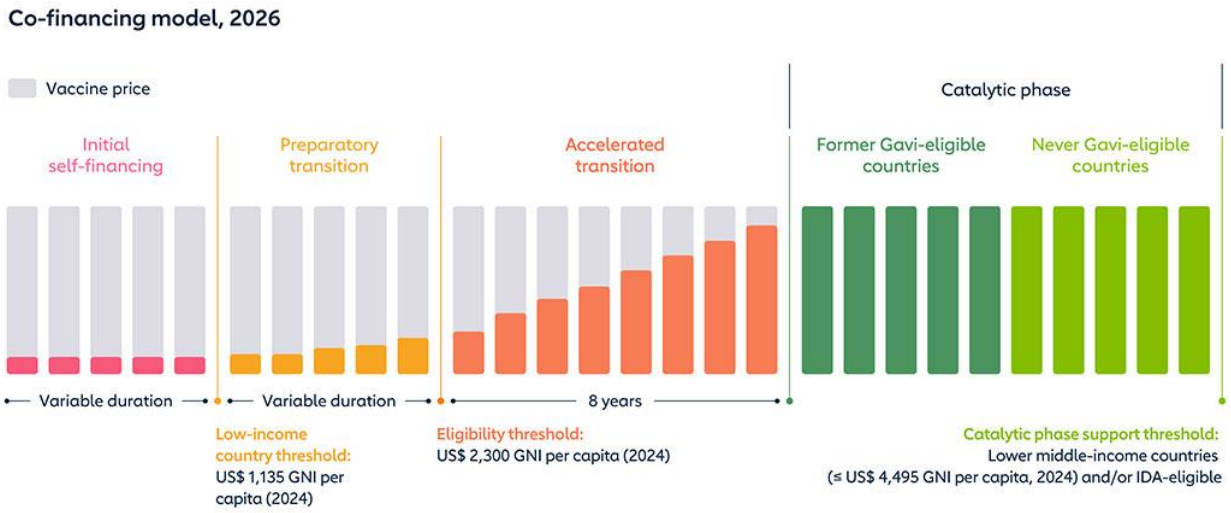
5. Co-financing and country joint investment requirements

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 and https://www.gavi.org/sites/default/files/2026-08/2026-Board-approved-Co-financing-policy.pdf 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 and co-financing 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 - HepB BD and DTP Boosters 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) - HepB BD and DTP Boosters minimum co-financing floor of US$ 0.20/dose for new introductions - 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 vaccine doses for Gavi-supported campaigns.	• 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. When two or more Gavi-supported immunisation campaigns – or one Gavi-supported campaign and one non-Gavi-supported polio campaign – are coordinated under an integrated budget and implemented within 12 months, the country's co-financing requirement will be reduced by 50%.				

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.

Table 6: Joint investment for CCE 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)**
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.

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.** Instead, support is needs-based and accessed through differentiated application and approval processes.

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 CP countries has been fully integrated into the Gavi F&H approach. The funding for this support is included in the Gavi Resilience Mechanism, an instrument of the F&H approach (see Part D). Catalytic phase countries facing fragility or emergencies are able to access time limited vaccine procurement and cash support to sustain routine immunisation or to respond to outbreaks. Pre-emptive vaccination and outbreak responses in countries will require strong rationale and depend on fund availability.

Further guidance
See **Annex 8: Catalytic phase supported areas and process guidelines** for further detailed guidance on catalytic phase-supported areas and application requirements. See **Annex 3: Vaccine Menu** for detailed vaccine guidance. See **Part D**: Emergency support, outbreak response, and unforeseen needs (all countries)

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)

Vaccine optimisation support is available to countries eligible under the catalytic phase and is intended to complement new vaccine introductions in line with the scope of the catalytic phase mandate. The objective is to support country-led assessment and, where appropriate, implementation of optimisation activities that contribute to the sustainability of HPV, PCV and rotavirus vaccine introductions.

As described under Part A, vaccine optimisation refers to the process of identifying the vaccine products, presentations, or schedules that are best suited to a country's context. Support is available to CP countries that have introduced one or more CP portfolio vaccines and are considering, preparing for, or undertaking an optimisation process. Within the catalytic phase, optimisation support is focused on strengthening the sustainability of existing HPV, PCV and rotavirus vaccine introductions. While optimisation may be considered as part of a broader review of the national immunisation programme or vaccine portfolio, Gavi support under the catalytic phase is designed to catalyse activities directly related to CP portfolio vaccines.

Country-level catalysers for vaccine optimisation

Technical assistance (TA):

Technical assistance support is available to support countries in assessing optimisation options, making evidence-based decisions and, where eligible, implementing optimisation activities. Support is tailored to country-specific needs and is intended to ensure that optimisation processes are timely, well coordinated, and aligned with long-term programme sustainability objectives. Technical assistance may be delivered through Gavi core partners and/or expanded partners.

Assessment and decision-making TA provides country-level support to assess optimisation options and support evidence-based decision-making by EPI programmes, NITAGs, and other relevant national advisory bodies.

Implementation TA is available to former Gavi-supported CP countries seeking to implement optimisation activities. Countries seeking implementation support should include an assessment demonstrating the rationale for the proposed change and its contribution to the financial sustainability of the immunisation programme.

TA and OOC funding may be used only for activities, or justified proportions of cost-shared activities, that are directly attributable to HPV, PCV and/or rotavirus vaccines. Vaccine procurement is not eligible for support.

One-off costs (OOC)

Eligible former Gavi CP-supported countries may request support for selected, time-limited one-off costs associated with implementing optimisation activities, including product, presentation, or schedule switches. This support is intended to cover essential implementation activities that cannot readily be financed through other sources. One-off cost funding may be channelled through the Ministry of Health, Gavi core partners, and/or expanded partners. Vaccine procurement is not eligible for support.

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 7: 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. New needs in chronically fragile settings; B. Emergencies including disease outbreak; C. Settings that require humanitarian programming; and 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[4] and measles outbreaks, ensuring countries can implement timely outbreak response vaccination responses and rapidly contain these outbreaks.

[4] Mpox stockpile to be launched in H2 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 8: 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

The Gavi Resilience Mechanism (GRM) is an agile funding mechanism designed to rapidly respond to unforeseen shocks, emergencies and deteriorating situations in fragile and humanitarian contexts that put immunisation systems at risk.

GRM Use Cases

The GRM covers four main use cases.

1. **New needs in chronically fragile settings:** Chronically fragile national or sub-national settings where emerging or worsening situations, including displacement or insecurity, place strain on routine immunisation systems, cannot be absorbed through existing country budgets or reprogramming and require time-limited support. *Example: Vaccine procurement following an unforeseen influx of cross-border refugees.*

2. **Emergencies, including outbreaks:** An acute emergency or confirmed disease outbreak, graded, declared, or validated by WHO or UNICEF, that is not supported through another Gavi mechanism. The response must focus on immunisation and require time-limited support to launch, sustain, or restore delivery. *Example: Restoring immunisation services following a cyclone or responding to a diphtheria outbreak.*

3. **Settings requiring humanitarian programming**: Settings where government immunisation services face severe access constraints due to conflict, insecurity, or political factors, resulting in persistent exclusion and accumulated immunity gaps that require targeted catch-up interventions. *Example: Delivering immunisation through humanitarian partners in border areas where government systems do not operate.*

4. **Catalytic phase countries facing fragility or emergencies:** Time-limited vaccine procurement and cash support to sustain routine immunisation and respond to outbreaks in Catalytic Phase countries facing fragility and/or emergencies. Pre-emptive vaccination and outbreak responses in other catalytic phase countries will require strong rationale and depend on fund availability. *Example: Vaccine procurement and cash support in areas under active conflict.*

GRM eligibility criteria

Requests for GRM support will be assessed against a set of eligibility criteria, taking into account available funding. The assessment will consider the setting and targeting of affected areas; the nature and actual or anticipated impact of the shock, event or deterioration on immunisation delivery in the targeted areas; the operational feasibility of the proposed response, including partner capacity and

access; the availability of alternative funding, including Gavi cash and Vaccine Budgets or other domestic, donor or partner resources that could be deployed; and whether the proposed support is time-bound, with appropriate arrangements for continuity once GRM funding ends.

Support provided through the GRM

Depending on the context, proposed response and needs identified in the request, GRM support may cover both vaccine and cash support. All support will be guided by the following principles:

- **Directly linked to the disruption:** Activities must address immunisation gaps caused or aggravated by the shock, event or deterioration underpinning the request.
- **Targeted to affected populations:** Activities must focus on populations directly affected, including displaced, inaccessible or missed communities.
- **Operational and time-bound:** All support must focus on the operational delivery of immunisation during the response period, rather than broader or longer-term health system strengthening.

Vaccine support

Requests for vaccines should identify available stocks and confirmed or anticipated supply and explain why these are insufficient or cannot be deployed within the required timeframe.

Gavi would retain exceptional, time-bound flexibility (up to 12 months) to support traditional vaccines through existing GRM use cases, where humanitarian programming is required and alternative financing options have been exhausted.

Cash support

GRM **may finance** time-bound operational activities required to maintain, restore or adapt immunisation services in response to the disruption. This may include service delivery and catch-up activities, community engagement, temporary surge capacity, coordination and microplanning, logistics and cold chain support, data and monitoring, and surveillance or diagnostics directly linked to the response.

GRM **does not finance** broader or longer-term health system strengthening, activities not directly linked to the identified disruption or affected populations, or costs that can be covered through existing Gavi, domestic or partner resources.

Technical assistance, cold chain or non-vaccine procurement **may be financed only exceptionally**, where they are critical to the immediate response and cannot be met through existing arrangements or resources.

How to access GRM support

A request may be initiated by the government, partners or the Gavi Country Team following a shock, event or deterioration that may warrant GRM support. Requests should be addressed to the Senior Country Manager, who will guide those submitting the request through the process.

For initial screening purposes, initial requests should briefly describe the shock, deterioration, emergency or outbreak triggering the request and its impact on immunisation; identify the affected geographical areas and population targeted for vaccination; provide a brief overview of the proposed response, including its key components under cash support and whether vaccine procurement is

foreseen; specify the requested amount; outline the proposed duration of support and what will happen when GRM support ends; confirm access and feasible implementation arrangements; explain why the response cannot be funded through the Gavi country allocation, reprogramming of that allocation, domestic resources or other donor funding; and, where applicable, describe how the proposed GRM support will complement the wider emergency response in the country.

Eligible requests will then be assigned to the relevant GRM use case and provided with an indicative funding ceiling.

Once eligibility and funding availability are confirmed, a full application outlining the proposed response will be requested and assessed through an expedited review and approval process.

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

8.1 Purpose and scope of the Grant Accountability Framework

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. Its purpose is to support effective grant performance management by bringing together the key information needed to understand what is on track, where challenges or risks are emerging, and what follow-up actions or support may be needed. This then serves as a basis for dialogue and action toward improved outcomes.

The GAF includes performance measures for each fund recipient within a country, i.e. government, Alliance core partners, civil society organisations, and other partners, reflecting the fact that grants are jointly – and collaboratively – managed by multiple stakeholders. It supports clear accountability for each fund recipient's contribution while providing a consolidated country-level view of overall grant performance. It also allows performance measures from across the grant to be rolled into an aggregate view within the Grant Management System (GMS).

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).

8.2 What is monitored and reported during implementation

This subsection provides an overview of what is monitored and reported through the GAF. For detailed guidance on what countries should complete as part of the application, please refer to Annex 2: Process guidelines.

The GAF reviews both progress and results, as outlined below. As part of the regular reporting process, each fund recipient should also submit a performance narrative explaining what the reported progress and results indicate about grant performance, including any challenges and corrective actions needed. Further details will be available in the forthcoming Grant Management Guidelines.

8.2.1 Progress

Progress monitoring assesses whether grant resources are being used and planned activities are being implemented as expected. It covers:

- **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 fund recipient 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.*

8.2.2 Results

Results are monitored through the programmatic indicators included in the Results Framework. These indicators help assess whether grant funding and activities are achieving their expected results. The Results Framework includes two types of indicators:

- **Routine monitoring indicators** are a core set of mandatory output-level indicators included in the GAF for all consolidated country grants. Countries are expected to regularly monitor these indicators (or their equivalents) at sub-national level (see below), but do not need to report detailed data to Gavi. Data for these indicators will also be made available in the GMS by the Gavi Secretariat using the global data sources identified in Exhibit A in Annex 9: Grant Accountability Framework.

- **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 fund recipient 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 fund recipient). They can be selected from a recommended list; or, if needed, created – for example, by selecting an indicator from an existing monitoring and evaluation (M&E) framework already in use.

When selecting indicators and setting targets, countries should consider progress towards reducing the number of zero-dose children, noting the Immunization Agenda 2030 (IA2030) ambition to halve the number of zero-dose children by 2030.

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 9: Grant Accountability Framework.

8.3 Campaign monitoring and reporting

Gavi-supported campaigns are subject to campaign-specific monitoring and reporting requirements, whether included within a country application or approved through a standalone campaign application. Countries are required to report against the applicable campaign indicators and submit a campaign technical report within four weeks of campaign completion. Where campaign measurement and

evaluation activities are planned, countries are also required to submit a campaign measurement and evaluation report upon completion of those activities. Both reports should be submitted through the Grant Management System.

Further information on indicators is provided in Annex 9: Grant Accountability Framework, while guidance on campaign monitoring, evaluation and reporting is provided in Annex 10: Campaign Optimisation.

8.4 Strengthening data for grant monitoring

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.

8.5 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 9: Grant Accountability Framework), or their subnational equivalents – and using those reviews to implement actions to improve performance. Countries should detail in the strategic narrative where such reviews will take place. They are not required to report the detailed results of each review to Gavi through the GAF but should report whether the reviews are taking place as planned. During Joint Alignment and Learning sessions and regular performance discussions with their SCM, countries and partners should be prepared to provide updates on how these subnational reviews have led 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.

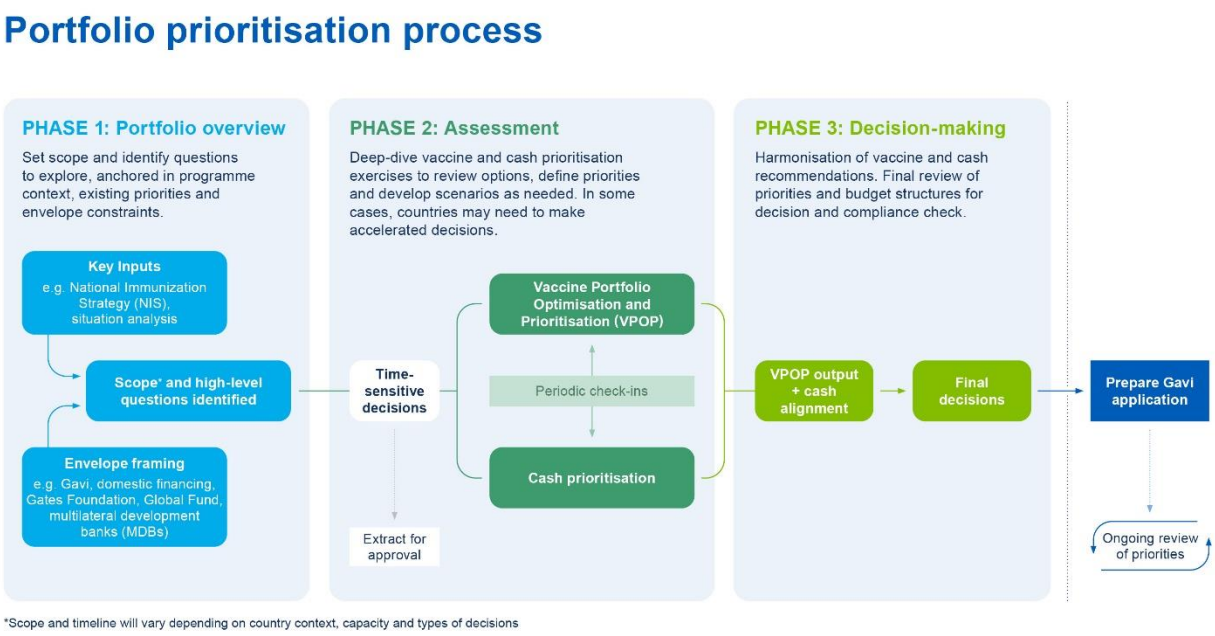
To navigate this context and support effective planning, countries are encouraged to allocate sufficient time and effort to undertake a holistic portfolio prioritisation process to inform the development of their Gavi application in line with national priorities. The term 'holistic' is used in two senses:

- **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. This includes looking at initial reach as well as retention and completion across the national immunisation schedule. Where relevant, review coverage and drop-out between antigens or doses, including for vaccination contacts beyond the infant primary series and in the second year of life, at national/sub-national levels, where data permit. 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	--
Gavi 6.0 Budget simulation tool	Gavi	Request from SCM
Gavi 6.0 HS strategy	Gavi	Gavi Guidelines Website
Gavi 6.0 Letters	Gavi	Request from SCM
Gavi 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 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 since there are activities that have an impact on both areas (e.g. campaigns are part of a VPOP plan, but any implementation costs need to be included within the cash investments); this alignment is crucial 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 (see Annex 10) 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.

- ✓ *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	--
Gavi 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	--
Gavi 6.0 HS Strategy	Gavi	Gavi Guidelines Website
Gavi 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 Vaccine Budget Simulation Tool and confirm VB figures 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.*
- ✓ *Be explicit about dependencies, particularly for domestic financing: 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.

All countries must transition to a single grant no later than 1 January 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. 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. More details on diagnostics support can be found 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

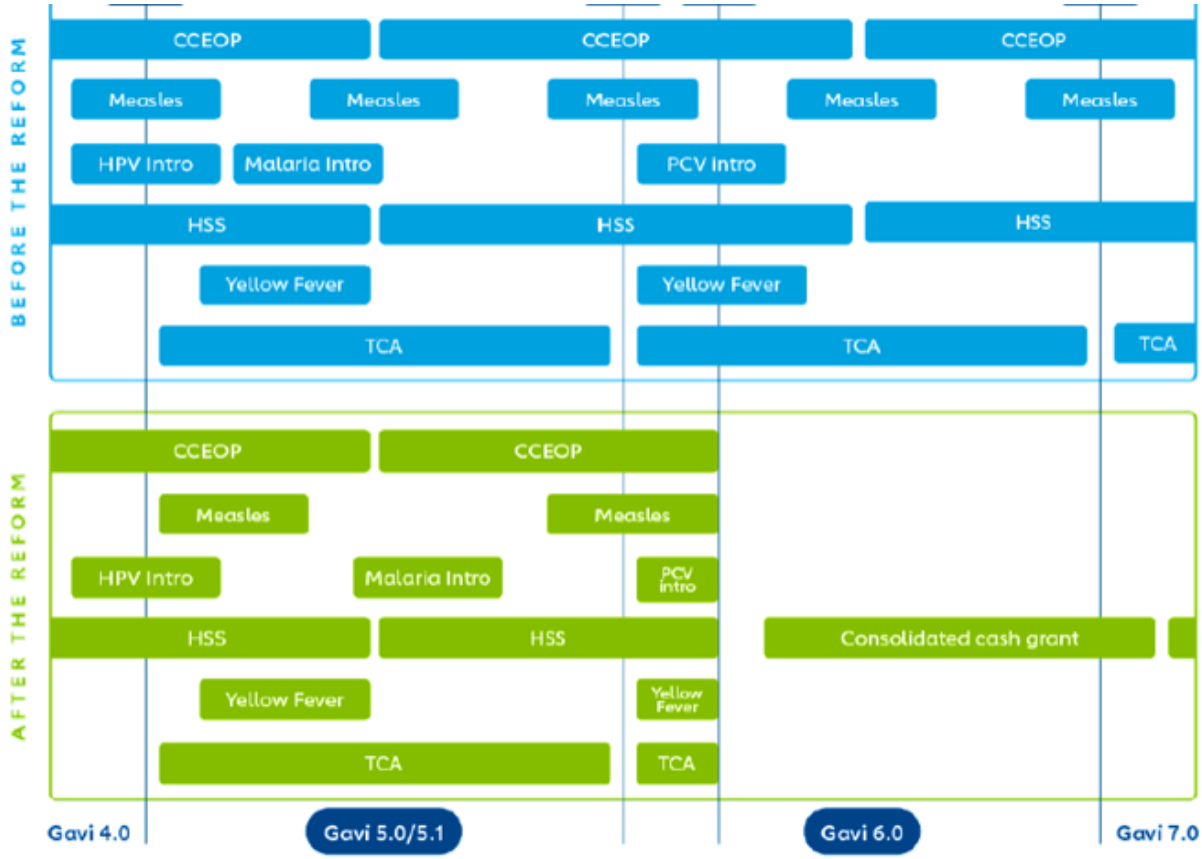
Countries should refer to the Interim Guidance for clarity on the initial process for transitioning from their 5.1 grants to Gavi's 6.0 strategy during the **interim period** between January 2026 and the start of their single Gavi 6.0 grant. This applies to paused Decision Letters and applications, time 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 Gavi 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 application that includes all support requested in alignment with Gavi 6.0 funding available.
- **Pathway 2:** Reprogramming application. Countries with existing HSS funding recently programmed through a Full Portfolio Plan 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 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, a budget, a results framework, a template to identify targeted areas and a vaccine dose plan. 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 application.

Prior to beginning application development, countries are encouraged to plan for their new country application or reprogramming 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.

Countries are highly encouraged to work with partners including Core Alliance Partners and civil society organisations in the development of their application.

Developing a Gavi funding application

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

For each of these, templates will be available on the Gavi website, through the Gavi SCM, and/or through the country portal of the Grant Management System.

The Gavi documents required at application include;

1) Strategic narrative template, including the relevant annexes
2) Budget template
3) Results framework template
4) Targeted areas template
5) Vaccine Budget Simulation Tool
6) Government signature forms (for both the Ministry of Health and Ministry of Finance)

Each template is accompanied by detailed instructions and is differentiated according to country context and application pathway. A detailed Application Checklist that outlines the documents required for a Gavi application is available on the website in both English and French.

Each of the templates will be available for offline completion before submission through the GMS.

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.

The narrative also includes a number of Annexes in which countries can provide information on specific programmes for which they are requesting support:

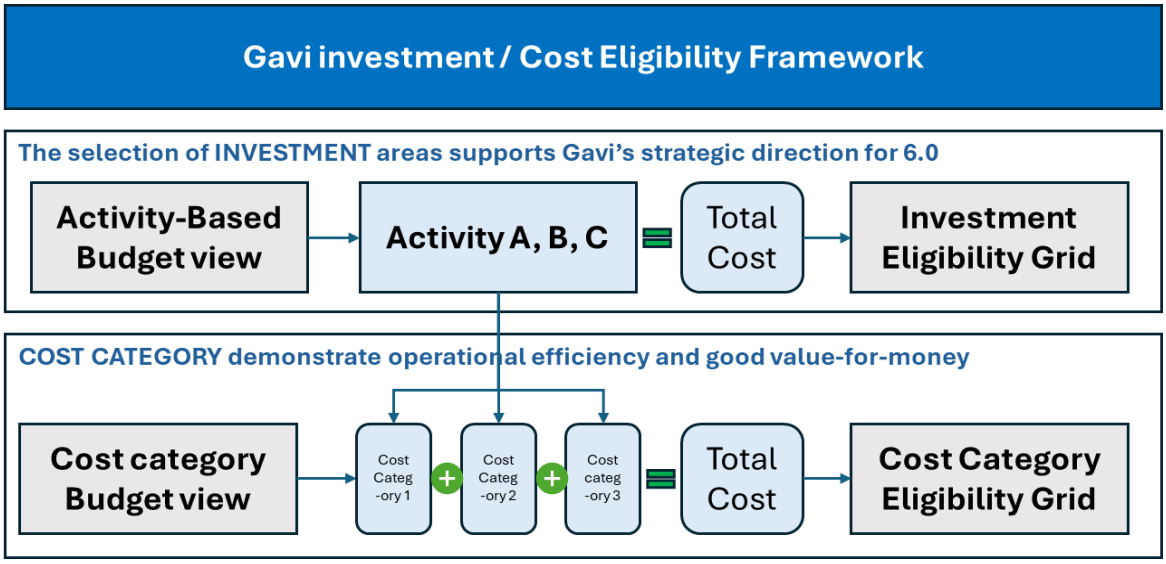
Annex A – NVS within the first 3 years of a grant
Annex B – NVS in years 4 or 5 of a grant
Annex C – Cold Chain Equipment
Annex D – Diagnostics Support
Annex E – Portfolio Optimisation (Switch Requests)
Annex F – Vaccine Budget Explanation

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 and reprogramming applications, detailed budgeting is required for the first three years of the maximum five-year grant term (ending 2030). 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.

Gavi has adopted activity-based budgeting. Under this budgeting method, budgets are prepared at activity level and costed with their different cost elements. The activities and cost categories are based on the Gavi's strategic objectives and investment areas, as well as cost eligibility. The primary budget building concept 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 is 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. Please note that the free-text field in the budget template is mandatory and should be used to provide a description of the budget assumptions for the activity.

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.

A User Guide to the Budget Template is available on the Gavi website in both English and French for more information on how to complete the budget.

Gavi Grant Accountability Framework

Gavi 6.0 grants will be monitored using a grant accountability framework (GAF). 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 by bringing together data on financial utilisation, vaccine consumption, grant activities and programmatic results.

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).

To establish the GAF, the results framework template, which includes programmatic indicators and targets, must be completed as part of the new country application or reprogramming grant request.

Results Framework template: Establishing indicators and targets

A. For all countries

As part of a grant application, countries will be required to complete the Results Framework template. Baselines and targets need to be set by the country for the required grant-linked KPIs, as detailed further in Annex 9: 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 Gavi 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.

B. For polio high-risk settings

In the 13 polio high-risk countries[5] prioritised under the Gavi-GPEI collaboration, an IPVc indicator is a required tailored indicator. This requirement applies irrespective of the country's Gavi 6.0 cash funding ceiling. Countries to which this requirement applies should select the indicator and set its baseline and targets in the Results Framework at the time of application.

C. For activities implemented by CSOs

To support proportionate and consistent indicator selection and the assessment of CSO contributions to national immunisation programmes, Gavi has identified a set of recommended tailored indicators reflecting common areas of CSO support. Countries should select indicators and set targets at the time of application, even if the implementing CSO or CSOs will only be identified after the application is approved. In such cases, the indicators and targets should capture the principal results expected from the planned CSO-supported activities as a whole.

[5] Afghanistan, Angola, Chad, Djibouti, the Democratic Republic of the Congo, Ethiopia, Madagascar, Niger, Nigeria, Pakistan, Somalia, Sudan and Yemen

Countries should normally select from the recommended indicators where these are relevant to the planned activities. Another tailored indicator may be selected where it more accurately captures the expected CSO contribution. The recommended tailored indicators are listed in Annex 9: Grant Accountability Framework. These recommended indicators are also intended to promote coherence with relevant Gavi 6.0 monitoring frameworks and to minimise duplicate reporting requirements.

Where CSO activities are financed or coordinated through a CSO Fund Manager or Alliance Partners, the tailored indicators should be assigned to the fund recipient responsible for consolidating and reporting the relevant results.

D. For technical assistance activities

Where technical assistance providers are not known at the time of application, applicants should select tailored indicators that capture the principal measurable results expected from the most material technical assistance activities included in the budget, normally prioritising the five highest-value activities.

Each indicator should be assigned to the applicable fund-recipient category in the Results Framework, based on the Partner type and, for CSOs, the anticipated funding mechanism identified in the budget template (for technical assistance the expected funding mechanism is Gavi direct contracting).

A separate tailored indicator is not required for every technical assistance activity, as one provider may ultimately deliver multiple activities. Lower-value or more transactional technical assistance activities may instead be monitored through activity implementation-status reporting.

Targeted Areas template

Countries will also be asked to complete the Targeted Areas template[6]. This template will be available through the Gavi Secretariat. Countries should identify and list which subnational areas (at both Admin 1 and Admin 2 level) will be receiving support through their Gavi 6.0 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 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 what countries report through the WHO/UNICEF electronic Joint Reporting Form (eJRF).

The areas identified should be consistent with the priorities and activities described in the strategic narrative and with the corresponding allocations in the Budget template. **Countries should provide a brief description in the Targeted Areas Template of the overall approach used to select the listed areas. A separate justification is not required for each individual area.**

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

Vaccine Budget Simulation Tool

Description and instruction for completion

The Vaccine Budget Simulation Tool (VBST) is a planning and decision-support tool designed to help countries explore vaccine programme scenarios within the context of their Vaccine Budget.

The tool supports countries in planning their Gavi 6.0 vaccine programmes by enabling them to assess alternative programme configurations and their implications for programme costs and budget alignment. Users can explore trade-offs through programme prioritisation, product optimisation, self-financing, Stand-By List activities, and other scenario adjustments to align programme ambitions with funding constraints and identify options to address funding needs. Detailed guidance on using the tool is provided in the user guide and video demonstrations available on the Gavi website.

As part of the application process, countries should use the tool to identify their preferred scenario, which should serve as the basis for the vaccine dose plan and should be submitted and further articulated with the application annexes. If a country identifies additional programme ambitions that exceed the Vaccine Budget (e.g. additional new guaranteed or discretionary introductions, coverage expansion, catch-up activities), these should be documented as Stand-By List activities both in the tool and in Annex F of their application. Such activities may be considered for funding should additional Gavi resources become available during the strategic period.

The tool's functionality is expected to be integrated into Gavi's Grants Management System (GMS), creating a more streamlined experience for planning, scenario analysis, and applications.

Government signature forms

As part of their application, countries are required to sign and submit separate signature forms (provided by Gavi) from both the Ministry of Health and Ministry of Finance. These forms commit the country to its Gavi Co-financing obligations throughout the Gavi 6.0 strategic period.

For countries applying for HPV support, the signature form for the Ministry of Health must also be signed by the Ministry of Education.

Other required documentation

In addition to the Gavi templates listed above, countries are also required to submit the following documentation as part of their applications:

- A current National Immunisation Strategy (or equivalent, if available)
- ICC meeting minutes (or other evidence of ICC or equivalent engagement or endorsement)
- NITAG endorsement (e.g. through meeting minutes) of all NVI requests (including product, presentation and schedule)
- WHO's CCE Inventory and Gap Analysis Tool
- CCE Deployment Toolkit (for country-led deployments)

It is also recommended, but not required, that countries submit any other supporting documentation that may provide further context for their request for support. These include, but are not limited to:

- A recent EPI review
- NITAG endorsement of the overall application portfolio (in addition to the required NITAG endorsements for individual antigens)
- Existing Plans of Action, relevant Assessments, etc.
- EVM Assessments and Comprehensive Improvement Plans (if applying for Supply Chain Support).

Additional required documentation is required for specific programmes. For example, a country requesting support for Cholera Diagnostics would also be required to submit a Government-endorsed control, response and elimination plan for cholera; its existing surveillance reporting template; an Implementation Readiness Checklist; and evidence of its Import/Customs procedures for the diagnostic equipment. Countries should review the relevant Annexes in detail to ensure they understand what is required for their applications.

A detailed list of application requirements is included in the Application Checklist in both English and French on Gavi's website.

Recommended technical pre-review by Gavi Secretariat and Alliance Partners prior to application submission:

At least three weeks prior to application submission, countries are encouraged to share their application materials with their Senior Country Manager and WHO and UNICEF Country teams for a technical pre-review. The technical pre-review is a recommended collaborative step intended to help countries submit high-quality applications that are complete, coherent, technically sound, and well positioned for Independent Review Committee review, and consolidate practical feedback before the official submission.

Application submission

All applications in Gavi 6.0 will be accepted through the country portal on the GMS or by email submission to proposals@gavi.org. To ensure applications are complete, a submission checklist is available on the website and through Gavi SCMs, listing key items across both core and supporting documents.

Before applications proceed to review by the Independent Review Committee, 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 through the new or reprogramming pathway 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 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 review each support request holistically following the IRC review criteria published on Gavi's website. The IRC will consider linkages across programmes to ensure 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:
A) Rationale, prioritisation, and equity;
B) programme design, integration, and systems strengthening;
C) Feasibility, implementation capacity, and risk;
D) Governance, accountability, monitoring, and learning; and
E) Financing, value for money, and sustainability.

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 the IRC review, a set of recommendations will be issued for the country, partners and for Gavi Secretariat that will need to be resolved before the grant can be approved by Gavi or in some cases, before the first disbursement can take place. This stage is called issue resolution and should be completed within 30 calendar days of the review sign-off. During this time, country and partners will work with the SCM to ensure that the IRC recommendations have been addressed before the application is submitted to the Gavi Grant Operationalisation Group (GO Group) for review (please see below).

The GO Group is a forum of Gavi Secretariat senior leaders who provide approval for applications to ensure approved grants are of high-quality and implementation-ready, and risks are sufficiently mitigated. The GO Group approval is the final stage of the application review process and triggers internal system approvals, after which contracting can commence as per Gavi rules and regulations.

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 (and at which seniority level), the GO Group, or the IRC.

Other types of 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.

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)

The GRM is an agile funding mechanism that provides time-bound vaccine and cash support in response to unforeseen shocks, emergencies and deteriorating situations that put immunisation delivery at risk. It covers four use cases: new needs in chronically fragile settings; emergencies, including outbreaks; settings requiring humanitarian programming; and Catalytic Phase countries facing fragility or emergencies. Requests may be initiated by governments, partners or Gavi Country Teams and will first undergo eligibility screening. Eligible requests will be assigned to the relevant use case and provided with an indicative funding ceiling, after which a full application will be assessed through an expedited review and approval process. Countries and partners may contact their Senior Country Manager for further guidance on the application process and to access the relevant templates.

Annex 3: Vaccine menu

- Oral cholera vaccine (OCV)
    - Cholera diagnostics
- Diphtheria, tetanus and pertussis-containing boosters (DTPcV boosters)
- Ebola vaccine (preventive vaccination)
- Hepatitis B birth dose vaccine (HepB-BD)
- Hexavalent Vaccine (DTwP-Hep-Hib-IPV)
- 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
- Pentavalent vaccine (Diphtheria, tetanus and pertussis, hepatitis B, *Haemophilus influenzae* type b) combination vaccine
- 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 Gavi 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 new 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 for preventive OCV campaigns are those with documented endemic cholera burden (i.e. high historical incidence and persistence) based on national surveillance data disaggregated by year and administrative level. For pOCV applications, countries are

required to identify Priority Areas for Multisectoral Interventions (PAMIs) for cholera control using the GTFCC methodology and use available GTFCC tools, including the PAMI identification tool and preventive vaccination targeting tool, to justify the selection and prioritisation of areas targeted for vaccination.

- 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)[7] 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.

[7] 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.

Scope of Gavi support
Support for diagnostics is **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 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 essential for sustaining protection against diphtheria, tetanus, and pertussis beyond early childhood, as immunity from the primary series declines over time. Given in the second year of life, at school age and during adolescence, they help maintain population immunity and reduce the risk of outbreaks.

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

- DTwP cv 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.
- Countries may choose from different DTP-containing booster vaccines. Gavi vaccine support is limited to DTwP or pentavalent vaccines for the first booster dose.
- Td vaccines for the second and third booster doses are not supported;
- Operational funding through cash grants is available to establish the three booster platforms where they are not already in place.

- Countries should consult the Gavi DPPs for available vaccine options

Hexavalent Vaccine (DTwP-Hep-Hib-IPV)

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 vaccine.
- Countries should allow 6–12 months between decision and planned launch.

Special co-financing considerations

- Initial Self-Financing (ISF) countries will have to co-finance US$ 0.20 per dose of hexavalent, which is equivalent to the current co-financed share of pentavalent

- Preparatory and Accelerated Transition (PT and AT) countries will have to co-finance hexavalent based on their co-finance share. The co-finance calculations for countries eligible for two doses of IPV will include a subsidy to purchase hexavalent vaccines equivalent to two doses of IPV, in line with the projected annual overall weighted average price of IPV;
- Fully self-financing lower-middle income countries (LMICs[8]) are eligible for a temporary subsidy in 2026 to purchase hexavalent vaccines equivalent to their IPV eligibility (one or two doses), and aligned with the projected annual weighted average price of the IPV presentation used by the country. This subsidy will be reduced by 50% in 2027, and by 2028 LMICs will be required to fully finance their hexavalent vaccination programmes.

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

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

the correct quantifications of the target population, track individuals vaccinated against this 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.
    - 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 are encouraged to develop 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.[9] 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.[10].

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

[9] 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.

[10] 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.

- 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
- Rubella vaccines: WHO position paper – July 2020: https://www.who.int/publications/i/item/WHO-WER9527
- 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 https://iris.who.int/items/12c29b34-aef3-4cb6-a765-85eb9110fca7 (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 impact assessment decision-making tool: https://www.technet-21.org/en/resources/tool/mcv-5-dose-vial-assessment-support-tool may be used to assess the operational implications of the switch, particularly on cold chain capacity. For costing estimates and financial planning, countries should use the CVB tool as the primary source of costing outputs.

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 immunisation 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 follow-up 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 follow-up 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 un- and under-vaccinated children. See Campaign Optimisation annex.

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.
- Countries must provide a clear epidemiological and programmatic justification for the selected target age range for the MR catch-up campaign. The proposed age range should be informed by the country's susceptibility profile, including available immunity gap analyses by birth cohort, surveillance data, outbreak epidemiology, vaccination coverage trends and operational considerations. Countries should submit supporting evidence demonstrating why the proposed age range is expected to achieve and sustain population immunity and reduce the risk of measles and rubella transmission.

- Where the proposed target age range differs from the age range for MR introductory catch-up campaign under the guaranteed budget covering 6/9 months to under 10 years old, countries should provide a specific rationale and supporting evidence for the selected approach. Within the holistic application, explain the rationale, timing and process including implementation plan 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 PCCS is not a requirement under Gavi 6.0. For further details see Annex 10A: Campaign Optimisation.

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 interim guidance on the introduction and use of measles IgM rapid tests for public health surveillance. 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 IgM Rapid Diagnostic Test Introduction – Interim Guidance for Use in Public Health Surveillance: https://www.technet-21.org/en/resources/guidance/measles-igm-rapid-diagnostic-test-introduction-interim-guidance-for-use-in-public-health-surveillance
- 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 campaign or postponed introduction/campaign due to Vaccine Budget constraints. While the optimal strategy for disease prevention would be a campaign at time of the switch, in the context of limited fiscal resources, countries may choose to do RI-only or campaign only, and they remain eligible for the additional support in the future, should resources (Gavi and country) be available. 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.

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

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 immunisation – 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 DTPcv 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.
    - 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[11]):** Beginning 2026, these countries will be eligible for support for IPV eligibility (one or two doses). Support for IPV will

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

be reduced by 50% in 2027; by 2028, LMICs will be required to fully finance their IPV vaccination programmes.

- **Upper-middle income countries (UMICs[12])** 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

- 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.

[12] Armenia, Azerbaijan, Cuba, Georgia, Guyana, Indonesia, Moldova, Mongolia, Ukraine

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

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. Whilst the optimal strategy for disease prevention would be a campaign at time of the YF introduction into RI, in the context of limited fiscal resources, countries may choose to do RI-only, and they remain eligible for the additional support in the future, should resources (Gavi and country) be available.
- 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 testing

- 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 (total and by test method – IgM rapid test, IgM ELISA, RT-qPCR), number of cases with at least one positive test result (total and by method), number of lab confirmed YF cases (per GYfLAN confirmatory algorithm), number of probable IgM+ YF cases where recent YF infection was excluded confirmatory and differential testing (per GYfLAN algorithm, 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

Gavi's **Health Systems Strategy (2026–2030)** has two goals: to make immunisation programmes more equitable and more sustainable. It aims to help countries reach and fully immunise zero-dose and under-immunised children, sustain coverage gains, and build the institutional, operational, and financial capacity needed to maintain strong and resilient immunisation programmes over time. Guided by a primary health care approach, the strategy focuses on eight investment areas detailed in this annex, while promoting innovation, stronger partnerships, country-tailored support, and improved learning and accountability to maximise the impact of Gavi's investments.

The two goals of the Health Systems Strategy:

- **Sustainability:** Sustainability and differentiation are core principles of Gavi's Health Systems Strategy. The strategy promotes **programmatic sustainability** by strengthening the systems, capacities and financing needed for countries to maintain equitable immunisation services after they transition from Gavi support. At the same time, it embraces **differentiation** by tailoring the focus of Gavi support to the countries' specific contexts, challenges, and needs, recognising that the pathways to stronger and more sustainable immunisation programmes will vary across settings.

- **Equity**: Equity is a core goal of Gavi's Health Systems Strategy and is especially important in Gavi 6.0, where countries will need to make sharper choices with more constrained resources. Equitable programming helps ensure that limited funding is directed to the children, communities and service bottlenecks where it can have the greatest immunisation impact. This means using evidence on zero-dose and under-immunised children, missed communities, performance gaps, gender and other access barriers to decide where and how to invest. Countries should use this annex together with the Gavi Equity Playbook to identify who is being missed and why, select differentiated and, where useful, integrated approaches, monitor whether priority populations are reached, and adapt investments through programme reviews so equity gains are sustained over time.

To support this differentiation, the annex provides illustrative examples of activities for countries to consider across the Gavi transition continuum, with a greater emphasis on catalytic and sustainability-focused activities as countries near transition. The transition summaries and activity examples across all eight investment areas should be read as a flexible menu for consideration, rather than as activities assigned exclusively to countries in each phase**. They are not prescriptive and should not be interpreted as fixed categories or a standard sequence that every country must follow.** Countries should select and adapt investments based on their specific context, including the maturity and performance of relevant health system sub-systems, identified bottlenecks, implementation capacity, national priorities, and available domestic and external resources. A country may therefore draw on examples associated with different transition phases where these are relevant to its needs. Transition status may be particularly important for some sustainability and financing considerations, including in accelerated transition countries, but it is only one factor informing investment choices.

This annex is a practical reference for using the eight health systems strategy investment areas during application design, review, and prioritisation. It explains the main priorities, gives examples of eligible activities across the transition pathway, highlights what may need to be adapted in fragile and humanitarian settings, and clarifies activities that will not be funded by Gavi. Summaries at the beginning of each investment area give the main ideas for transition success, that is, ways to sustain progress once they transition from Gavi support. Activities that are considered particularly relevant to transition success and are often missed are highlighted below, like this.

Unless otherwise stated, ineligible activities listed under “All contexts” apply to all countries, including fragile and humanitarian contexts. Additional context-specific ineligibilities are listed separately where relevant.

1. Service delivery

Sustainable, context-specific service delivery strategies help countries reach zero-dose children, under-immunised populations, and missed communities. Gavi support should strengthen equitable, evidence-based, prioritised, integrated, and resilient delivery through routine immunisation, campaigns, and catch-up activities, with stronger links to PHC systems, continuity of care, and government-led delivery models.

Transition summary

ISF	PT	AT
Establish and test reliable delivery approaches that reach zero-dose children, under-immunised populations, and missed communities while identifying which models are feasible and most effective in different settings.	**Make proven delivery approaches part of routine systems, integrated** within PHC, microplanning, supervision, referral, outreach/catch-up, and accountability processes.	**Sustain equitable delivery** through government-led systems, routine financing, programme reviews, and adaptation to changing needs.

Flagship structure

The three flagships strengthen different parts of service delivery and should be applied based on country and sub-national bottlenecks. Together, they help countries reach zero-dose children, under-immunised populations, and missed communities through sustainable immunisation and PHC delivery models.

- **Flagship 1.1** integrates immunisation with PHC and other last-mile service platforms, with a focus on zero-dose and missed communities.
- **Flagship 1.2** improves service quality and caregiver experience at vaccination touchpoints to reduce drop-out and support return visits.
- **Flagship 1.3** strengthens microplanning, catch-up, and flexible delivery to reach un- and under-immunised children, including older age groups.

Flagship 1.1: Accelerate integration of immunisation and other PHC services at the last mile, prioritising zero-dose and missed communities

Flagship 1.1 asks and answers the question *"how do children enter the system?"*

This flagship integrates immunisation with PHC and other relevant services. It aims to improve access, reduce missed opportunities, and strengthen continuity of care for zero-dose children, under-immunised populations, and missed communities. Integrated delivery approaches should be selected based on local evidence of why children are missed, including access barriers, service availability, caregiver constraints, trust, gender-related barriers, quality of care, or weak referral and follow-up systems.

ISF	PT	AT
Service Integration: Deliver immunisation with PHC services where appropriate and feasible, such as nutrition, Vitamin A, deworming, growth monitoring, ANC/PNC, child health, and school health.	Include agreed integrated service packages in PHC delivery plans, district microplans, with clear referral and follow-up pathways using existing, supervision, budgets, performance reviews, and accountability processes to manage implementation (see flagship 2.4).	Sustain government-led management, performance review, and improvement of integrated PHC and immunisation services including periodic assessment of whether integrated delivery remains equitable, efficient and feasible.
Community & Outreach Delivery: Map and use PHC, child health, community, education, nutrition, and humanitarian platforms and establish outreach & task-sharing CHW-supported delivery to identify and reach missed children.	Integrate effective outreach and CHW-supported approaches and set up coordination and referral pathways between immunisation and PHC programmes, including maternal, newborn, child health, nutrition, school health, and community platforms.	Strengthen delivery approaches that sustain access for underserved, mobile, peri-urban and hard-to-reach populations and use periodic reviews to improve integrated delivery approaches, equity, efficiency, and continuity of care.
Continuity of Care/Service Delivery Pathway: Use campaigns, periodic intensification of routine immunisation, and child-health contacts to identify and vaccinate missed children.	Include catch-up, referral, and follow-up pathways in routine service delivery and district planning systems.	Sustain and improve catch-up, referral, and continuity-of-care mechanisms to maintain gains and prevent backsliding.
Equity & Gender Responsive Delivery: Use integrated & co-delivery platforms and where possible introduce practical service changes that address gender-related barriers, such as timing, privacy, safety, accessibility, and caregiver convenience to improve access for priority child/adolescent services.	Align integrated outreach approaches with service quality objectives and integrate gender-responsive delivery approaches into routine standards, district plans, delivery models, supervision, and quality-improvement processes.	Periodically review & strengthen integrated delivery packages and routinely assess and address gender-, equity-, and inclusion-related barriers through service-delivery improvement processes.

Fragile and humanitarian context-specific indicative activities

- Integrate vaccination into emergency health packages, humanitarian response plans with gender-responsive protection services and referral pathways, including support for survivors of gender-based violence.

- Adapt service delivery approaches to improve privacy, acceptability, safety, and access for women and adolescent girls, displaced populations, migrants, nomadic groups, mobile communities, and other crisis-affected or excluded populations.
- Engage women-led organisations, girls' networks, CSOs, CBOs, FBOs, and humanitarian actors in planning, implementation, and accountability especially where government services have limited access or trust.
- Use humanitarian coordination structures, including health clusters, to support continuity of service delivery during emergencies, displacement, insecurity and recovery periods.
- Coordinate service delivery for displaced, migrant, nomadic, and other mobile populations and other mobile populations, including referral, tracking, follow-up, and continuity-of-care mechanisms where feasible.

Ineligible activities

All contexts

- Procurement of non-immunisation commodities.
- Integration initiatives that compromise service quality.
- Procurement of vehicles without proper justification and documentation. Any country requesting support to procure vehicles must demonstrate that the procurement addresses a clear bottleneck in reaching zero-dose and under-immunised children and include a deployment plan. For vehicle procurement above 5% or US $ 500,000 of the consolidated Cash Budget (whichever is greater), countries must also submit evidence of a funded plan to manage and maintain the vehicles.

Additional PT & AT restrictions

- Service-delivery models that create recurrent costs, staffing arrangements, or operational requirements without a feasible pathway for government ownership, financing, or sustainability

Flagship 1.2: Improve service quality to drive better experience at vaccination touchpoints and thereby reduce zero-dose and drop-out rates and reinforce return visits

Flagship 1.2 asks and answers *"once children enter the system, how do they stay in it?"*

This flagship improves service quality, caregiver experience, respectful care, and follow-up systems. It aims to reduce drop-out and support return visits.

ISF	PT	AT
Service quality assessment & adaptation: Assess service quality, caregiver experience, and access barriers, then use findings to improve services and follow-up by adapting schedules, locations, packages and delivery approaches to better meet community needs.	Include service quality and client experience measures in routine supervision, review, and management systems by making quality standards part of routine systems for client-centred service delivery.	Strengthen routine quality-improvement systems that use service-experience data and client feedback to improve performance via periodic reviews.
Continuity of care/client management: Introduce missed-opportunity screening, home-based records, caregiver reminders, and follow-up mechanisms.	Integrate client management, reminders, appointments, and follow-up into routine service delivery.	Sustain and improve systems that reduce drop-out and support completion of vaccination schedules.

ISF	PT	AT
Service delivery innovation: Test human-centred design and local service-delivery innovations to improve client experience and reduce barriers including use of digital client-support. tools (SMS/IVR, digital certificates) where appropriate & sustainable.	Embed human-centred design approaches within routine service-improvement processes including use of proven digital tools for improving service experience.	Embed continuous innovation and user-centred service improvement in routine programme processes and, where possible, maintain and periodically improve sustainable digital service delivery tools that demonstrably improve access & utilisation.
Service learning systems: Partner with academic, regional, or local institutions to test, evaluate, and document promising service-delivery innovations.	Scale evidence-based innovations through routine programmes and systems.	Establish mechanisms to continuously identify, evaluate, and adopt proven service-delivery innovations.
Standards and workforce quality: Introduce protocols, job aids, and communication tools that improve the predictability and quality of service delivery.	Integrate IPCI into all training platforms (pre-service, in-service, and campaign-based) for health workers. Integrate IPCI into all training platforms (pre-service, in-service, and campaign-based) for health workers.	Strengthen workforce systems that support high-quality, people-centred service delivery.
Caregiver feedback & accountability: Collect caregiver feedback and use it to improve service quality, follow-up, and client experience.	Incorporate service-experience findings into routine review meetings and improvement plans.	Make client feedback and service-experience monitoring part of accountability and quality-improvement processes.

Fragile and humanitarian context-specific indicative activities

- Adapt quality-improvement approaches for insecure, mobile, displaced, and crisis-affected populations.
- Ensure immunisation services remain accessible, acceptable, safe, and responsive during emergencies and recovery periods.
- Use flexible and context-appropriate methods to gather caregiver feedback and assess service quality.
- Apply rapid service-access assessments and corrective actions to address service disruptions during emergencies and recovery.
- Train and support local community mobilizers and structures, including but not limited to basic interpersonal communication (IPC) and do-no-harm principles.

Ineligible activities

All contexts

- Generic quality-of-care activities not clearly linked to immunisation service delivery.
- Activities that ignore or reinforce gender, equity, inclusion, or protection barriers.
- Feedback collection activities not linked to service improvement.
- Health facility construction or rehabilitation.
- Stand-alone service-quality assessments, surveys, or studies that are not linked to corrective actions, quality-improvement plans, or routine management processes.
- Digital client-support tools that are not sustainable, integrated into routine systems, or aligned with national digital-health strategies.

Flagship 1.3: Strengthen integrated microplanning and extend and expand immunisation to reach un- and under-immunised children, including older age groups

Flagship 1.3 asks and answers *"how do we know who we are missing and how do we reach them?"*

This flagship strengthens microplanning, catch-up, and flexible delivery so countries can identify, prioritise, and reach missed populations more effectively.

ISF	PT	AT
Integrated Microplanning: Develop microplans that identify zero-dose children, under-immunised populations, gender-related barriers, and missed communities.	Include microplanning in routine district planning, supervision, preparedness planning, and review systems.	Update microplanning processes routinely to support equity, preparedness, and performance improvement.
Population Identification & Prioritisation: Use coverage, equity, surveillance, and community data to identify underserved populations.	Use multiple data sources routinely to prioritise high-risk and underserved populations.	Strengthen routine use of programme and surveillance data to prevent backsliding and guide corrective action.
Targeted delivery: Increase access through outreach, mobile services, extended hours, peri-urban outreach, pop-up sites, schools, markets, transit points, and other targeted approaches.	Include outreach and catch-up activities, costs, and follow-up actions in routine district plans and PHC delivery systems.	Finance, manage, and improve outreach and catch-up activities through routine district budgets and programme reviews.
Differentiated delivery: Strengthen identification, targeting and follow-up of missed children and improve continuity within existing immunisation priorities.	Expand continuity-of-care pathways through catch-up vaccination, second-year-of-life platforms strengthening, HPV, school health, adolescent immunisation, and other integrated delivery opportunities where appropriate, including systematic screening of vaccination status, referral and follow-up to identify and vaccinate children who have missed scheduled doses.	Sustain continuity-of-care approaches that support equitable access, catch-up vaccination, and life-course immunisation where aligned with country priorities.
Geospatial targeting: Use mapping, geospatial analysis, digital planning tools, satellite imagery, and local data to identify and reach missed populations where appropriate.	Integrate proven planning and targeting tools into routine district planning, service delivery, preparedness, and review processes.	Use integrated planning and targeting tools routinely to improve service efficiency, equity, preparedness, and continuity of care.
Campaign to Routine linkages: Link campaigns, new vaccine introductions, and catch-up activities to routine immunisation systems to strengthen continuity of care and follow-up.	Make planning processes routinely connect campaigns, routine immunisation, and PHC delivery platforms.	Periodically review and strengthen links between campaigns, routine delivery, PHC services, and life-course vaccination opportunities.
Surveillance informed planning: Link microplanning with surveillance and preparedness systems to identify outbreak-prone, mobile,	Integrate surveillance-informed planning within preparedness and review mechanisms.	Strengthen surveillance-informed planning approaches that improve resilience, outbreak preparedness, and service continuity during shocks.

ISF	PT	AT
cross-border, and vulnerable populations.		

Fragile and humanitarian context-specific indicative activities

- Update and adapt microplans during emergencies and displacement events.
- Coordinate with NGOs, humanitarian actors, and emergency-response partners.
- Develop tailored approaches for mobile, displaced, migrant, nomadic, peri-urban, and hard-to-reach populations.
- Apply security-sensitive and community-led approaches in insecure settings.
- Integrate microplanning with emergency preparedness and response efforts to maintain access to under-served populations.

Ineligible activities

All contexts

- Campaigns or zero-dose activities without equity targeting, follow-up, tailored strategies, or links to routine immunisation and PHC systems.
- Activities in fragile settings that do not adequately address safety, security, or protection risks.
- Digital, AI, or geospatial investments that lack sustainability, country ownership, privacy protections, or alignment with national strategies.
- Partnerships that lack accountability, safeguarding, monitoring, or minimum service-delivery standards.
- Microplanning, targeting, or zero-dose activities that are not informed by data or evidence on under-served populations.

2. Human resources management

A qualified, supported, paid, and effective health workforce is essential for equitable and sustainable immunisation programmes. Gavi investments in HRH should focus on workforce gaps that directly affect immunisation and PHC delivery, especially for zero-dose children, under-immunised populations, and missed communities.

Across the transition continuum, HRH investments should move from filling urgent gaps to embedding workforce functions in national HRH and PHC systems. This includes planning, deployment, retention, supervision, training, and financing, aligned with national strategies and relevant government, training, professional, local government, and partner institutions.

Transition summary

ISF	PT	AT
Address urgent workforce gaps while building foundations for planning, deployment, training, supervision, and financing.	Make workforce functions part of **national HRH, PHC, training, supervision, management, and financing systems**.	**Sustain workforce performance** through government-led systems that finance, manage, support, and improve the workforce.

Flagship structure

The four flagships cover complementary parts of workforce strengthening. Together, these flagships help countries move from filling immediate workforce gaps to building workforce systems that are part of national HRH and PHC structures and sustained through government-led planning, management, and financing.

- **Flagship 2.1** focuses on workforce availability, including planning, recruitment, deployment, retention, and financing.
- **Flagship 2.2** focuses on CHW systems, including scope of practice, competencies, PHC integration, referral pathways, and professionalisation.
- **Flagship 2.3** focuses on workforce learning systems, including competencies, training delivery, learning platforms, and CPD.
- **Flagship 2.4** focuses on workforce performance systems, including supportive supervision, accountability, feedback, and continuous improvement.

Flagship 2.1: 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

This flagship strengthens workforce planning, recruitment, deployment, retention, and financing to improve workforce availability in missed communities. Support should align with national HRH and PHC strategies and include clear sustainability plans.

Flagship 2.1A. Workforce planning

ISF	PT	AT
Assess HRIS functionality and data quality improvement needed to inform workforce planning decisions, then use to map staffing needs for routine immunisation, campaigns, catch-up activities, new vaccine introductions, and missed communities.	Strengthen HRIS to capture deployment, workload, and immunisation workforce data and link these to coverage and zero-dose analyses.	Routinely use HRIS, service-delivery, and equity data (e.g., gender equity indicators) to inform workforce planning, deployment, and financing decisions.
Assess workforce shortages, distribution inequities, training gaps, and constraints, including the sex distribution of health workers and its influence on household access, then use findings to improve immunisation and PHC services.	Integrate immunisation workforce planning into routine HRH, PHC, district planning, and workforce forecasting processes.	Periodically update workforce plans to reflect evolving programme, demographic, and service-delivery needs.
Map workforce needs for campaigns, outbreak response, catch-up activities, and new vaccine introductions, then use findings to plan staffing and deployment.	Strengthen collaboration between EPI programmes, HR directorates, planning units, training institutions, and subnational authorities to support routine workforce planning and deployment decisions.	Strengthen routine coordination between MoH, MoF, local government authorities, and training institutions to sustain workforce planning and prioritisation.

Flagship 2.1B. Recruitment and distribution

ISF	PT	AT
Deploy health workers to zero-dose and under-immunised communities through integrated PHC teams, task sharing, and expanded use of CHWs where legally permitted.	Update staffing structures and job descriptions so immunisation functions are included in PHC workforce frameworks, with clear costing and accountability.	Sustain government-led workforce deployment systems that maintain equitable staffing across underserved communities.
Deploy temporary surge staff for campaigns, catch-up rounds, outbreaks, emergencies, and other immunisation priorities, while maintaining routine services.	Use HRH data, equity analysis, and service-delivery needs to guide routine deployment decisions, including the sex distribution of health workers and its influence on household access.	Routinely review workforce distribution to identify and address emerging inequities and service-delivery gaps.
Use targeted deployment approaches in areas with many zero-dose children and missed communities, taking into consideration the sex distribution of health workers and its influence on household access.	Strengthen collaboration between national and subnational authorities to coordinate workforce allocation decisions.	Sustain deployment systems that support continuity of services during outbreaks, emergencies, and demographic shifts.
Identify and recruit qualified health workers from underserved, remote, fragile, and high zero-dose communities where feasible.	Integrate local recruitment approaches into workforce planning, recruitment, and deployment systems in collaboration with subnational authorities and training institutions.	Sustain locally anchored recruitment and deployment approaches that improve workforce stability, community trust, and continuity of service delivery.

Flagship 2.1C. Retention and workforce wellbeing

ISF	PT	AT
Support nationally approved, time-bound incentive packages for hard-to-reach areas, such as hardship allowances, and transport support.	Integrate retention approaches within broader HRH, civil-service, and workforce-management systems, with defined financing mechanisms and government co-ownership	Sustain retention approaches embedded within national workforce policies and financing arrangements, ensuring adequate domestic funding.
Promote safe and supportive working conditions for staff serving remote, fragile, and underserved communities.	Integrate family-friendly workforce policies (e.g. flexible scheduling, hardship housing) into workforce management systems.	Periodically review retention policies and workforce support mechanisms to improve workforce stability, wellbeing, and performance.
Assess gender-specific barriers to recruitment, deployment, and retention of women health workers, and implement targeted measures such as gender-responsive incentive packages	Strengthen gender-responsive workforce policies that address barriers affecting retention and career progression.	Sustain workforce policies that support equitable retention, wellbeing, and advancement.

Flagship 2.1D. Transition, sustainability and workforce financing

ISF	PT	AT
Map immunisation workforce positions by role, geographic	Develop transition plans for externally supported workforce	Implement and track routinely progress on transition roadmaps that

deployment, funding source and contract arrangement, including donor-supported functions, critical for campaigns, NVI, surge support, and routine programme delivery.	functions and plan for long-term domestic budget implications, with defined milestones and government financing for expected commitments.	move Gavi-supported posts onto government payrolls and systems (including routine tracking of transfer progress)
Assess workforce financing needs for immunisation priorities and future programme growth, then use findings in budgeting and sustainability planning.	Strengthen collaboration between Ministries of Health, Finance, HR directorates, and planning authorities so workforce financing and management become part of routine government systems.	Integrate immunisation-related HRH costs into routine expenditure frameworks, budgets, and medium-term plans.
Document workforce costs associated with immunisation and PHC priorities.	Integrate workforce requirements into staffing structures, workforce-costing exercises, and HRH transition planning.	Routinely review sustainability risks affecting workforce financing, staffing, deployment, and retention and use findings to adjust government financing plans accordingly.

Fragile and humanitarian context-specific indicative activities

- Link Gavi-supported HRH investments to government-led emergency, recovery, resilience, immunisation continuity, preparedness, response, and health-cluster coordination plans.
- Support practical measures that improve safety and reduce barriers for health workers operating in insecure or hard-to-reach settings, such as temporary housing, transport support, protective equipment, and access to gender-based violence referral pathways and support services.
- Use vetted NGOs or humanitarian partners to recruit health workers where government payroll systems are not functioning, with a pathway to government oversight where feasible.

Ineligible activities

All contexts

- HRH planning that is not aligned with national strategies or coordinated with national initiatives and partners.
- Incentive schemes that create unfair differences between donor-supported and government-paid staff in comparable roles.
- Parallel compensation systems that are not aligned with national HRH frameworks or pay scales.
- Funding jobs unrelated to immunisation or PHC.
- Deployment plans that are not based on workforce data or equity priorities.

Additional PT restrictions

- Temporary recruitment that does not contribute to a sustainable staffing or fiscal-absorption plan.

Additional AT restrictions

- Open-ended donor-funded posts without a transition plan or milestones for transfer to government payrolls.

Additional F&H restrictions

- Recruitment not endorsed by the Ministry of Health or not linked to a recognised emergency, recovery, or resilience-building framework.

Flagship 2.2: 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

This flagship clarifies CHW roles in immunisation, strengthens competencies and referral pathways, and embeds CHWs in PHC, workforce, and government-led management systems.

Flagship 2.2A. CHW scope of practice, competencies and PHC integration

ISF	PT	AT
Assess the legal and regulatory framework governing CHW scope of practice and, where needed, develop a pathway to expand and formalise CHW immunisation functions, including vaccine administration.	Integrate approved CHW scopes of practice into national policies, guidelines, training, and supervision systems.	Periodically review and update CHW scope of practice to reflect evolving programme priorities and PHC reforms.
Develop or update CHW and related cadre job descriptions to include immunisation functions, including demand generation, referral, follow-up of missed children, catch-up vaccination, campaigns, outbreak response, and, where appropriate, vaccine administration.	Develop national CHW guidelines that align immunisation responsibilities with PHC and integrated service delivery.	Sustain nationally approved CHW scopes of practice across routine immunisation, campaigns, outbreak response, and integrated PHC delivery.
Establish nationally approved referral pathways that link life-course immunisation with PHC services and community-based care.	Integrate CHW functions within broader PHC, outreach, and community-health service delivery models.	Periodically review CHW scopes of practice and competency requirements to reflect evolving programme priorities and PHC reforms.
Develop competency-based training packages covering vaccine administration, cold chain basics, recording and reporting, digital literacy, interpersonal communication, and gender and social barriers.	Include CHW competency standards in national workforce-development and training systems.	Sustain integrated CHW competency-development systems through national institutions and workforce programmes.

Flagship 2.2B. CHW referral systems, data and system integration

ISF	PT	AT
Assess and strengthen referral pathways linking CHWs, facilities, outreach services, campaigns, community-based care, and other PHC platforms.	Embed referral pathways within routine service-delivery, supervision, and performance-review systems.	Sustain continuity-of-care systems that support referral completion, catch-up vaccination, and life-course immunisation.
Strengthen CHW roles in identifying, referring, and following up zero-dose, under-immunised and missed children.	Integrate CHW referral and follow-up activities into district planning, monitoring, and programme-review processes.	Periodically review referral-system performance and strengthen linkages between communities and health services.
Establish systems to collect, report, review, and use data on CHW	Integrate CHW data into national digital health information systems so	Use CHW data routinely for workforce planning, performance

ISF	PT	AT
immunisation activities, referrals, follow-up actions, and community-based service delivery to improve vaccine coverage.	deployment, referrals, follow-up, and zero-dose reach become part of routine planning and monitoring.	reviews, and service-delivery improvement.
Introduce context-appropriate digital tools that support CHW documentation, referrals, and follow-up and align with national digital health plans, accounting for differences in digital literacy and phone or device access among female and male CHWs.	Strengthen interoperability between CHW reporting systems and national PHC and immunisation information systems.	Periodically review and improve CHW data quality, utilisation and system integration.

Flagship 2.2C. CHW professionalisation, financing and sustainability

ISF	PT	AT
Map and clarify CHW institutional status to inform remuneration assessment and transition planning. Assess CHW remuneration, incentives, supervision, and support arrangements to identify and manage sustainability risks, including the risk that formalised remuneration may crowd out women CHWs, and safeguard equitable access to paid roles as compensation structures evolve.	Develop phased financing and transition plans for CHW programmes, including co-financing arrangements with government and partners.	Integrate CHWs into national workforce and budget frameworks, including funded supervision structures and routine performance reviews.
Test context-appropriate approaches to strengthen CHW motivation, retention, and support consistent with national policies.	Align CHW remuneration, incentives, and support mechanisms with national HRH and PHC frameworks, and align donor and partner support to avoid parallel systems.	Sustain government-financed CHW support systems aligned with national workforce policies.
Strengthen coordination across HR directorates, PHC programmes, local government authorities, and partner-supported CHW initiatives.	Include CHW governance arrangements in workforce-planning and management systems.	Sustain government-led oversight, financing, certification, and management of CHW programmes.
Identify opportunities to strengthen CHW career progression and professional recognition.	Integrate CHW certification and career-pathway frameworks within national workforce-development systems.	Sustain CHW certification, career-development pathways, and continuing professional development systems linked to immunisation competencies.

Fragile and humanitarian context-specific indicative activities

- Partner with CSOs, and humanitarian agencies to manage CHW networks recruited from affected communities and support safe delivery of routine immunisation, campaigns, and outbreak response.
- Provide rapid, modular upskilling for CHWs using mobile, offline, or community-based learning approaches. Topics may include vaccine administration where permitted, cold chain basics, registration, defaulter tracing, and communication.
- Deploy integrated PHC teams that provide immunisation alongside maternal, newborn, and child health and other priority services, with flexibility to shift between routine delivery, campaigns, and catch-up activities.

- Adapt CHW supervision, referral, and reporting arrangements to fragile, displaced, and crisis-affected settings.

Ineligible activities

All contexts

- Creating new CHW roles focused solely on vaccination without links to PHC services.
- Standalone disease-specific CHW training that is not part of integrated PHC capacity development.
- Paying CHW stipends through short-term donor projects without sustainability plans.
- Scaling digital tools that are not adapted to country context or aligned with national digital-health plans.
- One-off training or irregular activities not linked to long-term workforce development.
- Engaging CHWs only during emergencies without longer-term integration into health systems.

Additional F&H restrictions

- Reliance on CSOs or humanitarian actors to implement CHW functions indefinitely without coordination with government systems.

Additional ISF restrictions

- CHW interventions that are not designed for eventual integration or replication within national systems.

Additional PT restrictions

- Developing CHW roles or scopes of practice that are duplicative, inconsistent with national PHC policies, or not endorsed by the Ministry of Health.

Additional AT restrictions

- Stand-alone CHW activities that are not reflected in national workforce strategies, costed plans, or government financing frameworks.

Flagship 2.3: 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

This flagship strengthens competency-based, digital, and blended learning systems for immunisation and PHC. Training should be part of national workforce development and CPD pathways.

Flagship 2.3A. Training needs assessment and competency development

ISF	PT	AT
Assess workforce competency, training, language, and literacy needs at national and subnational levels, then use findings to address priority immunisation skill gaps and develop context-appropriate learning	Integrate training-needs assessments into routine workforce planning, HRH reviews, and workforce-development processes.	Routinely review workforce competency needs and update learning priorities based on programme performance, emerging needs, and new vaccine introductions.

packages in relevant local languages and formats, including oral and visual approaches for low-literacy settings, covering vaccine safety, cold chain, data use, communication, demand generation, gender and campaign readiness.		
Develop integrated training plans for immunisation and, where appropriate, broader PHC priorities.	Align immunisation learning plans with national HRH, PHC, and workforce-development strategies.	Periodically update integrated learning plans to reflect changing programme and workforce needs.
Develop and roll out competency-based training packages on core immunisation functions, with equitable access for relevant health worker cadres and underserved areas.	Include competency-based learning approaches in national training systems and workforce-development programmes.	Periodically update competency frameworks and learning packages to reflect evolving immunisation, PHC, and outbreak-response requirements.
Embed immunisation modules within PHC curricula in partnership with national training institutions.	Align immunisation competencies with broader PHC competency frameworks, certification requirements, and professional standards.	Sustain integrated competency-development systems through national institutions and accreditation mechanisms.

Flagship 2.3B. Learning platforms and delivery systems

ISF	PT	AT
Design or upgrade digital and blended LMS platforms that host immunisation training content, work offline where needed, and support broad workforce access.	Integrate LMS platforms within national HRH, training, and CPD systems and strengthen local ownership and management.	Sustain adaptive learning approaches, including digital and AI-enabled tools where feasible, to support continuous workforce development.
Expand access to digital, blended, and other flexible learning approaches for frontline workers, particularly in underserved areas, ensuring design accounts for women's differing time constraints, mobility, and access to devices so uptake is not skewed toward men.	Include digital and blended learning approaches in routine workforce-development programmes.	Continuously improve learning platforms and learning-delivery approaches based on user feedback, learning outcomes, and technology developments.
Strengthen collaboration with universities, national training institutions, professional associations, and regional learning partners to expand access to quality learning.	Formalise partnerships between EPI programmes, HR directorates, and training institutions to support workforce development, including development of costed sustainability plans and domestic financing mechanisms for learning platforms and training systems.	Sustain nationally owned learning ecosystems that support workforce development, innovation, and adaptation.

Flagship 2.3C. Learning governance and continuous learning

ISF	PT	AT
Create training records and link them to national HRH and CPD systems so immunisation training is logged and tracked.	Strengthen national systems that track training participation, learning outcomes, and links to service-delivery improvements, disaggregated by gender, cadre, and geography.	Routinely use workforce learning data to guide workforce development, prioritisation, and resource allocation.

Establish mechanisms to monitor completion of learning programmes across cadres and geographic areas.	Integrate workforce learning data into routine HRH, immunisation, and PHC review processes.	Sustain nationally owned systems for learning governance, monitoring, and quality assurance.
Establish peer-learning approaches that enable health workers to exchange experiences and practical solutions across facilities, districts, and programmes.	Integrate peer-learning approaches into routine workforce-development and learning programmes.	Sustain peer learning through district exchanges, mentoring networks, twinning programmes, and communities of practice.
Document and share lessons learned, implementation experiences, and promising practices.	Strengthen collaboration between EPI programmes, HR directorates, training institutions, and CPD systems to support continuous learning.	Sustain continuous-learning systems that support adaptation, problem-solving, and quality improvement.

Fragile and humanitarian context-specific indicative activities

- Provide short, modular training for health workers using phones, offline applications, radio, and other context-appropriate learning approaches to build essential immunisation competencies quickly.
- Adapt training content for fragile settings, including cold chain management in insecure areas and communication approaches for mobile, displaced, or crisis-affected populations.
- Integrate immunisation training into PHC recovery, preparedness, and emergency-response plans to ensure continuity of essential services.

Ineligible activities

All contexts

- Training programmes that are not competency-based or not linked to national systems.
- Training that is not informed by needs assessments or linked to workforce records.
- Digital learning initiatives that exclude women or ignore the digital gender divide.

Additional F&H restrictions

- Training content that is not adapted to fragile or low-resource contexts.
- Training activities that are not coordinated with humanitarian actors or Ministry of Health-led recovery and response plans.

Additional PT restrictions

- Continued reliance on donor-managed or externally hosted training platforms without plans to transfer ownership and management to national institutions.
- Training activities that are not recorded within national HRH or training databases.

Additional AT restrictions

- Training programmes that are not embedded within budgeted national HRH or PHC strategies.
- Learning-performance tracking systems that are disconnected from national monitoring and evaluation platforms.

Flagship 2.4: Enable enhanced performance and accountability, leveraging supportive supervision, digital technologies and data-driven feedback loops

This flagship strengthens supportive supervision, performance management, accountability, feedback, and routine data use so workforce performance issues are identified and addressed through routine management systems.

Flagship 2.4A. Supportive supervision and workforce support

ISF	PT	AT
Establish supportive supervision for health workers in facilities, outreach services, campaigns, and integrated PHC delivery platforms.	Embed supportive supervision in routine district, subnational, and national management processes, with clear roles, schedules, reporting, and follow-up actions.	Sustain decentralised supervision systems through routine planning, budgeting, management, and performance-review processes at subnational levels.
Bundle essential tools, such as registers, job aids, checklists, and supervision tools, with supervision visits that include feedback, problem-solving, and action planning.	Strengthen capacity of district and subnational managers to conduct supervision, analyse findings, and support corrective action.	Routinely use supervision findings within district, subnational, and national planning and programme-improvement processes.
Strengthen proven supervision platforms to support real-time feedback and performance review.	Integrate supervision indicators into routine programme reviews and management systems.	Periodically review supervision systems using workforce feedback, programme performance, and service-quality data.
Pilot digital supervision approaches, including simple tools that facilitate supervision, documentation, follow-up, and feedback.	Integrate digital supervision tools into routine workforce-management and programme-monitoring systems.	Sustain digital supervision approaches and adapt them to evolving programme priorities, service-delivery models, and technology developments.

Flagship 2.4B. Performance management and accountability

ISF	PT	AT
Pilot accountability frameworks linked to immunisation performance, service-delivery indicators, and progress in reaching zero-dose children and missed communities.	Include supervision and accountability systems in routine district, subnational, and national management processes, with clear performance indicators linked to immunisation and PHC goals.	Sustain government-led workforce-performance systems linked to planning, budgeting, and programme-improvement processes.
Define key performance indicators for priority workforce cadres involved in immunisation and PHC delivery.	Include performance reviews and accountability mechanisms in routine management and programme-review processes.	Ensure national performance frameworks link HRH metrics to service quality, immunisation coverage, equity outcomes, and community feedback.
Strengthen manager capacity to use workforce and service-delivery data to identify performance gaps and follow up on corrective actions.	Integrate workforce-performance indicators within broader health-sector performance frameworks and district review systems.	Routinely review performance trends and use findings to strengthen workforce effectiveness and programme outcomes.

Flagship 2.4C. Feedback, learning and continuous performance improvement

ISF	PT	AT
Establish peer-learning groups where health workers and managers share experiences, identify bottlenecks, and exchange practical solutions.	Integrate peer-learning and problem-solving processes into routine supervision, performance-review, and programme-management systems.	Sustain continuous-improvement approaches through routine peer learning, quality-improvement processes, and performance-review mechanisms.

Develop digital feedback systems, such as dashboards and mobile tools, that provide timely feedback to health workers, supervisors, and managers.	Integrate workforce feedback and performance information into routine management, planning, and review processes.	Mainstream performance analysis to identify causes of poor performance and link actions to national improvement plans.
Establish mechanisms that connect community feedback, CHW feedback, and workforce performance reviews, particularly for zero-dose children and missed communities, ensuring feedback channels are accessible to women and reflect their perspectives as primary caregivers and frontline workers.	Use community and workforce feedback in accountability and improvement systems.	Sustain learning and improvement systems that support adaptation, service quality, and improved client experience.

Fragile and humanitarian context-specific indicative activities

- Expand flexible supervision in insecure or remote areas using simple digital tools, such as SMS check-ins, dashboards, and mobile job aids, to monitor performance and provide timely support.
- Establish checklists, tools, and job aids that can be rapidly adapted during outbreaks, emergencies, and future epidemics or pandemics.
- Adapt supervision and accountability approaches to reflect operational realities, workforce safety concerns, and service-delivery constraints in fragile settings.
- Strengthen district and local management capacity to maintain supervision and performance oversight where routine management systems are disrupted.

Ineligible activities

All contexts

- New, parallel, or vertical performance-tracking systems that are not aligned with national HIS, HRH, or strategic planning frameworks.
- Performance-enhancement initiatives that lack structured feedback loops, accountability mechanisms, follow-up actions, or use of performance data.
- Supervision approaches that mainly function as inspections and are not linked to problem-solving, coaching, performance review, or service improvement.

Additional F&H restrictions

- Performance systems that are not coordinated with emergency-health-response actors.
- One-size-fits-all supervision models that do not reflect fragile contexts or workforce safety considerations.

Additional PT restrictions

- Performance initiatives that are not linked to national HRH, PHC, or broader health-sector performance frameworks.

Additional AT restrictions

- Supervision or accountability systems that are not included in routine national or subnational budgets, management structures, performance plans, or review processes.

3. Supply chain

Strong supply chains help ensure vaccines and immunisation supplies are available where and when they are needed, especially for zero-dose children, under-immunised populations, and missed communities. Gavi support should strengthen governance, financing, data visibility, workforce capacity, infrastructure, maintenance, distribution, procurement readiness, and accountability, with links to PHC and broader health commodity systems where appropriate.

Across the transition continuum, supply-chain investments should move from programme-specific and partner-supported systems to government-led models that improve efficiency, resilience, lifecycle planning, and last-mile performance. Investments should reflect country context, digital maturity, infrastructure constraints, emergency risks, and useful opportunities to integrate across health commodities.

Countries are encouraged to review the Gavi Immunisation Supply Chain Strategy, 2026–2030 for further detail.

Transition summary

ISF	PT	AT
Build core supply-chain capacity, infrastructure, data visibility, governance, and last-mile performance.	Make supply-chain functions part of **government systems and broader health commodity systems**, including governance, digital systems, maintenance, distribution, and planning where useful.	**Sustain supply-chain performance** through domestic ownership, lifecycle planning, maintenance, resilience, and efficient last-mile delivery.

Flagship structure

The five flagships cover complementary supply-chain functions. Together, they help countries improve vaccine availability, resilience, efficiency and last-mile delivery.

- **Flagship 3.1:** Supply-chain governance, coordination, and performance management.
- **Flagship 3.2:** Supply-chain data visibility and data-driven decision-making.
- **Flagship 3.3:** Cold chain and supply-chain infrastructure.
- **Flagship 3.4:** Maintenance systems and performance monitoring.
- **Flagship 3.5:** Supply-chain network design, distribution systems, and last-mile optimisation.

Flagship 3.1: Strengthen supply-chain governance, coordination, and performance management through functional technical working groups and coordination mechanisms

This flagship strengthens supply-chain-specific governance, logistics coordination, accountability, partner alignment, and performance review across immunisation and related health-sector supply-chain functions.

ISF	PT	AT
Strengthen national and subnational logistics working groups by updating terms of reference, governance arrangements, operating procedures, performance indicators, accountability mechanisms, and decision processes. Conduct targeted reviews and use findings to address governance gaps.	Routinely use logistics governance mechanisms to support supply-chain planning, performance reviews, prioritisation, oversight, and coordination across procurement, maintenance, digital supply-chain systems, distribution, and related logistics functions.	Use governance monitoring, performance assessment, member development, knowledge transfer, and continuous improvement to strengthen logistics governance mechanisms.
Strengthen joint planning, information sharing, and coordination across EPI, supply-chain teams, PHC programmes, Ministries of Health and Finance, subnational authorities, development partners, logistics providers, and other stakeholders.	Establish routine supply-chain coordination, planning, and review processes that align government, Gavi, bilateral partners, the World Bank, the Global Fund, private-sector actors, and other stakeholders around shared logistics priorities.	Strengthen joint prioritisation, investment planning, and performance-review processes across stakeholders to improve partner alignment, reduce duplication, and maximise the impact of available resources.
Monitor governance and supply-chain performance, including participation, action tracking, implementation progress, and follow-up of key decisions.	Routinely review supply-chain performance and coordination effectiveness and use findings to strengthen accountability, prioritisation, and follow-through.	Use governance monitoring to assess decision quality, action completion, coordination effectiveness, and overall supply-chain performance.
Implement priority improvements that align immunisation supply-chain functions with broader health commodity and PHC supply-chain systems where useful. This may include governance, planning, data systems, warehousing, distribution, maintenance, and workforce functions.	Strengthen shared approaches across immunisation and broader health commodity systems, including planning, data systems, warehousing, distribution, maintenance, and workforce capacity where appropriate.	Support transition towards more integrated and sustainable supply-chain models, including stronger government stewardship of procurement, maintenance, digital systems, distribution networks, and broader health commodity management functions.

Fragile and humanitarian context-specific indicative activities

- Develop contingency plans and strengthen coordination with humanitarian actors to maintain supply-chain operations during emergencies and crises.
- Use existing humanitarian and emergency coordination mechanisms where appropriate to support supply-chain planning, implementation, and oversight.

Ineligible activities

All contexts

- Sitting allowances for National Logistics Working Groups (NLWGs) or subnational logistics working groups.

Flagship 3.2: Strengthen supply-chain data visibility and data-driven decision-making across all levels of the supply chain

This flagship strengthens supply-chain data visibility, forecasting, supply planning, analytics, and use of information for operational and strategic decisions.

ISF	PT	AT
Improve supply-chain data visibility through TSS-compliant eLMIS upgrades, forecasting and supply-planning tools, dashboards, and context-appropriate digital platforms. Strengthen SOPs, reporting workflows, and routine use of supply-chain information.	Use eLMIS, forecasting, supply-planning, and analytics platforms in routine planning, inventory management, distribution, and performance management. Improve interoperability with broader health information and digital health systems where appropriate.	Strengthen integration of supply-chain information systems with broader health commodity, procurement, and performance-management systems to support more efficient and coordinated decision-making.
Build country capacity to use forecasting, supply planning, stock management, VPOP, cash prioritisation, and country Vaccine Budget processes. Use demand forecasts, supply plans, Vaccine Budgets, co-financing information, and supply constraints to inform programme decisions.	Strengthen country ownership and routine use of forecasting, supply planning, stock management, VPOP, cash prioritisation, and country Vaccine Budget processes. Reduce reliance on external technical support by strengthening routine use of these approaches within planning, budgeting, procurement, and distribution decision-making.	Strengthen institutional capacity to manage forecasting, supply planning, stock management, VPOP, cash prioritisation, and country Vaccine Budget processes. Use workforce development, knowledge transfer, succession planning, and continuous learning to support long-term stewardship.
Strengthen national and subnational capacity to analyse and use supply-chain data through dashboards, reports, review processes, and routine performance management, including eLMIS and Thrive360 where appropriate.	Establish routine data-review and decision-making processes that use supply-chain information to identify bottlenecks, prioritise actions, improve performance, and support accountability across levels of the health system.	Expand use of supply-chain analytics to support optimisation of distribution networks, inventory management, procurement planning, maintenance approaches, and resource-allocation decisions.
Implement priority improvements that strengthen alignment between immunisation supply-chain information systems and broader health commodity data systems where beneficial.	Strengthen shared data standards, interoperability, reporting approaches, and governance arrangements across immunisation and broader health commodity systems, including linkages between eLMIS, HMIS, procurement systems, and other digital health platforms where appropriate.	Strengthen government stewardship and technical capacity to manage, finance, maintain, and continuously improve integrated digital supply-chain systems and analytics platforms over time.

Fragile and humanitarian context-specific indicative activities

- Use interim or simplified digital supply-chain tools, such as eSMT, DHIS2 Logistics modules, web-based systems, or Excel tools, where infrastructure, connectivity, security, or system maturity do not yet support TSS-compliant eLMIS platforms.
- Develop and deploy emergency supply-chain monitoring tools and rapidly strengthen workforce capacity to support their use during emergencies.

- Establish transition pathways towards more sustainable digital supply-chain systems as infrastructure, security, and system maturity improve.

Ineligible activities

All contexts

- Non-TSS-compliant vaccine eLMIS (refer to the eLMIS decision tree) systems or standalone vaccine information systems that are not interoperable with broader digital platforms. Upgrading existing systems to become TSS-compliant is encouraged.
- Digital solutions with high subscription, support, or maintenance costs that countries cannot realistically sustain after deployment.
- Advanced digitalisation investments that lack country ownership, sustainability plans, technical capacity, financing arrangements, or supporting infrastructure required for long-term operation.
- AI-enabled analytics platforms or other advanced digital solutions that require specialised computing infrastructure (for example GPU-dependent solutions) where countries do not have realistic plans and capacity to host, maintain, finance, and sustain these systems over time.

Additional F&H restrictions

- Advanced digital supply-chain solutions, such as traceability systems or control towers, where digital maturity, connectivity, infrastructure, security, or system capacity is low.

Flagship 3.3: Expand, extend, replace, and optimise cold chain and critical supply-chain infrastructure to improve last-mile availability and reach underserved populations

This flagship supports priority cold chain and supply-chain infrastructure investments that improve vaccine availability, equity, resilience, and last-mile performance.

ISF	PT	AT
Procure, install, replace, or upgrade cold chain, storage, transport, waste-management, connectivity, and solar infrastructure to address priority gaps affecting vaccine availability and last-mile access for underserved, zero-dose, and hard-to-reach populations.	Expand infrastructure deployment through routine government planning and budgeting processes and align infrastructure investments with broader immunisation, PHC, and health-sector priorities where appropriate.	Implement infrastructure replacement and renewal plans to maintain adequate storage, transport, and last-mile service capacity as vaccine portfolios, target populations, and programme needs evolve.
Develop integrated storage, distribution, and infrastructure approaches, including local logistics service providers, outsourced delivery models, 3PL/4PL arrangements, and other context-appropriate service models. Develop country-specific guidance for safe storage of immunisation products alongside other health commodities where appropriate.	Expand integrated warehousing, storage, distribution, and infrastructure approaches across immunisation and other priority health commodities where they improve efficiency, service quality, and availability.	Scale proven integrated infrastructure and service-delivery models and strengthen government oversight of contracted logistics, warehousing, transport, and infrastructure service providers.
Implement infrastructure resilience measures that address climate,	Incorporate climate resilience, disaster preparedness, and	Implement long-term infrastructure resilience and renewal strategies

ISF	PT	AT
disaster, security, and continuity risks. Examples include solarisation where grid reliability is poor or not affordable, backup power, moving equipment from flood-prone sites, reinforcing facilities exposed to storms or cyclones, contingency storage, and alternative transport routes.	continuity planning into routine infrastructure planning, budgeting, and investment decisions.	informed by operational experience, climate risks, and evolving service delivery needs.

Fragile and humanitarian context-specific indicative activities

- Enhance critical infrastructure with security protocols such as alarm systems, access controls, and other context-appropriate protection measures.
- Deploy context-appropriate technologies, such as long-term passive devices, transportable powered vaccine storage, shock-proof storage, and temporary storage solutions, to improve access in insecure, remote, mobile, or emergency settings.
- Coordinate with humanitarian actors and logistics networks to support rapid recovery of infrastructure and continuity of supply-chain operations following disruptions, emergencies, or conflict-related events.

Ineligible activities

All contexts

- Non-PQS cold chain equipment. Exceptions should be limited to clearly justified emergency or outbreak-response requirements, such as ultra-low-temperature equipment used during COVID-19 vaccine deployment.
- Traditional cold boxes and vaccine carriers.
- Transport infrastructure without clear government commitments for operational and maintenance costs.
- Warehousing investments without operationalisation plans and financing arrangements for ongoing costs.

Flagship 3.4: Strengthen cold chain and infrastructure functionality through maintenance systems, asset management, and digitally enabled performance monitoring

This flagship strengthens maintenance, asset management, technician capacity, service contracts, warranty management, and digital monitoring so infrastructure continues to function over time.

ISF	PT	AT
Strengthen asset-management systems for equipment inventories, maintenance planning, warranty tracking, supplier accountability, replacement planning, repair histories, decommissioning, and infrastructure performance. Track	Integrate cold chain and infrastructure data into national asset-management systems, equipment-management platforms, and digital maintenance tools. Incorporate asset management, warranty management, replacement	Strengthen long-term asset stewardship through lifecycle planning, replacement financing, supplier-performance management, warranty oversight, climate-resilience planning, and sustainable asset-management approaches.

climate- and disaster-related equipment risks and failures.	planning, climate-risk considerations, and performance monitoring into routine supply-chain and budgeting processes.	
Deploy RTMDs, EMS, digital maintenance platforms, temperature-monitoring systems, and other performance-monitoring tools. Develop SOPs for maintenance, escalation, repair, and follow-up, and use temperature-monitoring findings to guide corrective action.	Routinely use asset-performance, temperature-monitoring, and maintenance data to prioritise repairs, identify bottlenecks, improve uptime, identify heat-related temperature excursions, monitor failures during power interruptions, and support maintenance and replacement decisions.	Use RTMD, EMS, asset-performance, and maintenance information to optimise equipment placement, replacement planning, climate-resilience investments, maintenance investments, and long-term infrastructure performance.
Strengthen capacity of technicians, maintenance teams, biomedical personnel, and government staff to maintain, troubleshoot, repair, and monitor cold chain and supply-chain infrastructure. Establish maintenance partnerships, service networks, and integrated service models where appropriate.	Establish certification programmes and capacity-development pathways for cold chain technicians and biomedical teams. Strengthen supervision systems, service contracts, maintenance partnerships, and outsourced support models where they improve sustainability and response capacity.	Strengthen institutional capacity to sustain maintenance systems through workforce planning, succession planning, knowledge transfer, government financing, and integration with biomedical engineering and equipment-management systems.

Fragile and humanitarian context-specific indicative activities

- Maintain critical cold chain and supply-chain infrastructure using context-appropriate approaches, including mobile maintenance teams, remote support, simplified digital tools, and peer-support approaches.
- Prioritise maintenance and repair activities that preserve service continuity and vaccine availability during emergencies.

Ineligible activities

All contexts

- Standalone in-person inventory exercises that are not linked to ongoing asset-management or maintenance systems.
- One-off maintenance activities that do not contribute to sustainable maintenance systems, asset management, or long-term equipment performance.
- RTM-enabled and EMS Level III equipment deployed to sites without adequate connectivity.
- Double remote-temperature-monitoring deployments (for example, standalone RTMDs where RTM-enabled cold chain equipment is already deployed).

Additional PT restrictions

- Data subscriptions for RTMDs and EMS Level III systems.

Additional AT restrictions

- Advanced maintenance-monitoring or digital asset-management investments that lack government ownership, financing, sustainability plans, technical capacity, or supporting infrastructure required for long-term operation.

Flagship 3.5: Optimise country supply-chain network design, distribution systems, and last-mile delivery, including through new delivery technologies and partnerships

This flagship improves supply-chain network design, distribution systems, and last-mile delivery so vaccines and supplies move efficiently, reliably, and equitably.

ISF	PT	AT
Conduct supply-chain design, mapping, and optimisation exercises, then implement priority improvements. Use SCANIT and similar tools to assess routes, delivery frequency, storage locations, transport arrangements, and last-mile delivery systems, prioritising underserved, under-reached, and zero-dose populations.	Routinely use supply-chain mapping, optimisation, and performance data to guide planning, budgeting, network management, and prioritisation decisions.	Use predictive tools (including AI where appropriate), scenario planning, optimisation approaches, and performance data to continuously improve network design, disruption management, resilience, efficiency, and equity.
Pilot and implement improved delivery approaches and partnerships, including direct delivery for under-reached and zero-dose populations, logistics partnerships, outsourced service models, and other context-appropriate arrangements that improve access, availability, or efficiency, developed and tested in consultation with frontline workers	Scale proven delivery approaches and strengthen government financing, oversight, and performance monitoring of delivery arrangements. Strengthen integration with broader health commodity and PHC distribution systems where beneficial.	Strengthen sustainable government stewardship of delivery systems and partnerships through financing, contract management, performance monitoring, and continuous improvement of last-mile service delivery.
Strengthen distribution and reverse-logistics systems supporting redistribution of vaccines and supplies, movement of equipment, maintenance activities, collection of obsolete assets, waste management, and other return flows.	Integrate reverse logistics into routine supply-chain operations and coordinate with broader health commodity systems where appropriate.	Optimise distribution and reverse-logistics systems using performance, utilisation, cost, and service-quality information to improve efficiency, sustainability, and responsiveness.

Fragile and humanitarian context-specific indicative activities

- Use available data to assess the impact of conflict or emergencies, then implement priority logistics support, including changes to storage locations, delivery frequency, transport arrangements, and distribution systems.
- 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.

Ineligible activities

All contexts

- Standalone system design, mapping, optimisation, or network-design studies that are not linked to implementation of identified improvements.

Additional PT & AT restrictions

- Direct delivery outside of under-reached communities and/or zero-dose populations.

4. Data, monitoring and learning, AEFI

Good-quality, timely, accessible, and useful data are essential for planning, monitoring, accountability, learning, and continuous improvement. Gavi support should strengthen routine information systems, data quality, targeted measurement, analysis, evidence use, learning, and digital tools that help countries identify zero-dose and under-immunised populations, monitor performance, prioritise resources, and improve decisions.

Across the transition continuum, data investments should move from fragmented, partner-supported, or programme-specific activities to integrated, interoperable, government-led systems for evidence generation, decision-making, learning, and improvement across immunisation, PHC, and broader health priorities. Investments should match country digital maturity, governance, workforce capacity, infrastructure, and sustainability needs.

Transition summary

ISF	PT	AT
Make priority data gaps visible and strengthen routine systems, data quality, validation, and evidence generation.	**Use data routinely for decisions** through integrated, interoperable, government-led systems, analysis, evidence use, and learning.	Sustain and improve **nationally owned systems that generate reliable evidence, support decisions, finance recurrent costs, and enable continuous learning**.

Flagship structure

The three flagships cover complementary parts of the data-to-learning cycle.

- **Flagship 4.1** strengthens data collection systems, routine information systems, measurement, monitoring, and data-gap filling so countries have reliable evidence for programme decisions.
- **Flagship 4.2** strengthens analytics, decision-support tools, and subnational data use so countries can turn data into action.
- **Flagship 4.3** strengthens implementation research, learning systems, and knowledge translation so countries can generate new knowledge, adapt programmes, and improve effectiveness.

Flagship 4.1: Strengthen data collection systems to improve data availability at national and subnational levels

This flagship strengthens data generation, validation, availability, and reliability so programmes have the evidence they need for management, accountability, and decisions.

Flagship 4.1A. Digitally enabled routine information systems

Strengthen nationally owned routine information systems, interoperability, and digital-health infrastructure so countries can collect, manage, and sustain better routine data.

ISF	PT	AT
Upgrade national HMIS platforms, such as DHIS2, AEFI and VPD surveillance systems, campaign monitoring systems, and vaccine logistics information systems. Use upgrades to improve data collection, quality, completeness, review, and confidence in programme data, including the routine collection and use of sex-disaggregated, gender, and equity-focused data. Include practical features such as automated data-quality checks, feedback generation, and better reporting workflows.	Connect and consolidate routine information systems across immunisation, PHC, and broader health-sector platforms, including CRVS, HR information systems, supply-chain systems, and other priority digital platforms. Use interoperability to reduce duplicate reporting, harmonise definitions, and support data exchange.	Sustain and improve integrated information systems through long-term governance, domestic financing, workforce development, system maintenance, and continuous improvement. Progressively finance recurrent costs through government systems, including hosting, licensing, connectivity, technical support, and system administration.
Establish digital foundations for interoperability, including master facility lists, shared terminology services, common standards, interoperability layers or API gateways, and enterprise architecture components. Apply these foundations across priority immunisation and health-sector systems from the start.	Expand routine data exchange and consolidation across interoperable systems and government platforms. Improve consistency, comparability, and exchange of information across immunisation, PHC, logistics, surveillance, HRH, and other health-sector datasets.	Strengthen governance, stewardship, financing, and management of interoperable information ecosystems that support integrated service delivery, PHC, and broader UHC priorities.
Strengthen system reliability and performance through trained MoH personnel, information-system audits, automated data-quality checks, feedback mechanisms, data-quality reviews, and routine system monitoring. Use findings to improve completeness, timeliness, consistency, and reliability of programme data.	Use information-system audits, data-quality reviews, automated feedback, and system-performance monitoring in routine government management and quality-improvement processes.	Sustain information-system reliability through workforce succession planning, domestic financing, technical capacity, and continuous quality improvement.
Develop or update digital-health roadmaps and implementation plans using digital readiness, maturity, and data-quality assessments. Use these plans to prioritise digital investments, interoperability needs, information-system strengthening, and future use of appropriate emerging technologies, ensuring assessments capture differences in digital access and literacy across the health workforce and served populations.	Update and implement digital-health roadmaps based on implementation experience, evolving digital ecosystems, and opportunities for consolidation across immunisation, PHC, and broader health systems.	Use digital-health roadmaps to guide long-term digital transformation, sustainability, interoperability, financing, and management of emerging technologies in ways that remain feasible for government ownership and stewardship.

Fragile and humanitarian context-specific indicative activities

- Use simplified offline-capable or mobile tools for data collection, with solar chargers or power banks where needed.

- Provide time-limited technical assistance, hardware, platform customisation, or software adaptation where a budget line or sustainability plan is in place for continued support.

Ineligible activities

All contexts

- Digital health platforms, tools, or system expansions that are not embedded in approved national digital-health strategies, roadmaps, enterprise architecture, or governance arrangements.
- Activities that promote parallel routine reporting systems.
- Tools that are not scalable, not standardised, not aligned with relevant interoperability standards, or lack long-term sustainability and use plans.
- Antigen-specific vaccination campaign planning or information systems that are not scalable or interoperable with existing information systems.
- New immunisation-specific registries (EIRs). Gavi is not recommending new EIR investments in 6.0 because of setup costs, operating costs, infrastructure needs, and sustainability risks. Where countries already have EIRs, support should focus on sustainability, governance, and coordinated long-term financing rather than expansion of standalone systems.

Flagship 4.1B. Measurement, monitoring and data-gap filling

Targeted measurement should complement routine systems. It should generate or validate data, fill priority information gaps, improve population estimates, and provide evidence for programme improvement.

ISF	PT	AT
Use targeted measurement to generate or validate evidence where routine systems do not provide enough information. Examples include rapid-cycle monitoring, light-touch facility assessments, LQAS, phone surveys, BeSD, gender analysis, and real-time campaign monitoring. Use findings to identify bottlenecks, underserved populations, service barriers, data-quality issues, and evidence gaps.	Make targeted measurement part of routine programme review, monitoring, planning, and evidence-use processes so priority information gaps are identified, addressed, and followed up through government-led systems.	Sustain targeted, cost-effective measurement approaches that complement routine systems and are used to validate data, monitor equity, inform prioritisation, and support continuous programme improvement.
Conduct targeted population-estimation and coverage-validation activities where routine information systems are not sufficient. Use survey data, targeted enumeration, micro-census methods, or other validated approaches where appropriate.	Improve target-population and coverage estimates using multiple data sources, including survey data, micro-census data, targeted enumeration, geospatial analysis, machine learning, and other validated approaches.	Embed and sustainably finance approaches that improve target-population estimation and coverage measurement within routine government systems and planning processes.
Integrate immunisation indicators and modules into planned national household surveys and other large-scale data collection efforts. Conduct targeted immunisation coverage surveys only where alternative data sources are insufficient.	Routinely compare and validate routine programme data against survey findings and complementary data sources. Where suitable opportunities exist, such as MICS, DHS, or other planned national surveys, integrated approaches should be preferred over standalone immunisation coverage surveys.	Sustain integrated measurement approaches through routine government planning, financing, and review processes while reducing duplication and survey costs over time.

ISF	PT	AT
Conduct qualitative and quantitative measurement of BeSD, gender, equity, and service-readiness indicators to better understand demand-side barriers, caregiver constraints, service acceptability, workforce composition, and other factors affecting programme performance.	Routinely review and validate behavioural, gender, equity, and service-readiness evidence alongside routine information system data.	Use behavioural, gender, equity, and implementation measurement approaches in routine evidence generation and validation.
Conduct targeted implementation monitoring and assessment activities to address priority information gaps. This may include EVM assessments and other structured measurement exercises that generate evidence for programme improvement.	Incorporate findings from assessments and monitoring exercises into routine evidence review and validation processes.	Sustain cost-effective monitoring approaches that generate actionable evidence and are embedded within government review and learning systems.

Fragile and humanitarian context-specific indicative activities

- Use mobile tools with offline functionality in hard-to-reach areas.
- Strengthen security protocols for data collection in conflict-affected settings.

Ineligible activities

All contexts

- Sporadic, unplanned surveys that are not linked to evidence needs, programme design, implementation review, or routine monitoring.
- Household coverage surveys that do not include key BeSD-related questions where input into questionnaire or survey design is available.
- Interventions that collect data in an unstandardised way, do not use recognised metadata packages, or are not aligned with the country's health-information exchange or interoperability approach.

Flagship 4.2: Strengthen data analytics through technology and capacity-building to improve decision-making and programme performance

This flagship helps programmes turn available data into insights, priorities, and actions through analytics, visualisation, modelling, forecasting, and subnational data-use approaches.

Flagship 4.2A. Technology-enabled analytics and decision support

Strengthen analytical capacity through digital tools that improve visualisation, triangulation, modelling, forecasting, automated insights, and decision support.

ISF	PT	AT
Implement or pilot proven digital tools within existing HMIS/RHIS systems to improve visualisation, triangulation, modelling, forecasting, automated insights, and routine analysis of programme data.	Scale proven analytics tools and integrate them into routine planning, prioritisation, budgeting, programme review, and PHC decision-making processes.	Sustain and optimise government-owned analytics and decision-support capabilities through domestic financing, workforce development, governance, system

		maintenance, and continuous improvement.
Adapt proven digital concepts to address local programme challenges, such as population movement, denominator issues, zero-dose identification, vulnerable populations, health worker capacity gaps, and demand-side barriers.	Routinely use analytical outputs to support microplanning, targeting, prioritisation, and programme improvement across immunisation and PHC programmes.	Strengthen long-term government capability to manage, adapt, and improve analytical approaches as programme priorities and population needs evolve.
Strengthen national and subnational capacity to interpret dashboards, analytical products, modelling outputs, forecasts, and automated insights.	Embed analytical capability within routine programme planning, review, and prioritisation processes with reduced reliance on external technical support.	Sustain analytical capability through workforce development, knowledge transfer, domestic financing, and succession planning.
Conduct AI readiness assessments and develop AI governance, policy, and risk-management approaches within broader health-sector and ICT strategies.	Apply AI-enabled and advanced analytics where readiness, governance, interoperability, data quality, privacy, security, and sustainability conditions are met.	Sustain AI-enabled and advanced analytics through government-owned governance, financing, workforce capacity, privacy and security controls, quality assurance, and bias-risk mitigation.

Fragile and humanitarian context-specific indicative activities

- Adapt digital tools to improve existing data analysis without creating dependence on advanced connectivity that may not be available.
- Use innovative digital tools for specific contexts or time-limited support to MoH decision-making where routine systems are disrupted or insufficient.

Ineligible activities

All contexts

- Interventions that do not address an identified programme gap or lack a plausible pathway to integration and scale.
- Interventions that are not appropriate for the country's digital readiness, infrastructure, workforce capacity, governance arrangements, or sustainability conditions.
- Interventions that are not aligned with national strategic plans, HMIS/RHIS workplans, digital-health roadmaps, or enterprise architecture.
- Scaling GenAI interventions that lack context-specific datasets, governance arrangements, bias mitigation, privacy and security controls, or quality assurance mechanisms.
- Scaling of digital or analytics interventions without clear capacity-strengthening, transition, or government handover plans.

Flagship 4.2B. Subnational data use and performance improvement

Strengthen subnational teams to use available and improved data for local planning, problem-solving, service improvement, and performance review.

ISF	PT	AT
Develop and use integrated dashboards and analytical views that draw on HMIS/RHIS, LMIS, surveys, surveillance, campaign monitoring,	Continue strengthening integrated dashboards, subnational analytical capacity, and data-use processes while reducing reliance on external	Use data-use practices in routine health-system operations and performance reviews, supported by government ownership, domestic

and other relevant data sources. Use them to support programme review and decision-making at provincial, district, and facility levels.	technical support. Routinely use dashboards and analytical outputs in district, provincial, and national review processes.	financing, institutional capacity, and stewardship.
Strengthen routine review and interpretation of data at facility, district, and provincial levels so local teams can identify priority populations, implementation challenges, and improvement opportunities using their own data.	Make routine data interpretation and follow-up part of district, facility, and programme-management processes, ensuring subnational teams use their own data for planning and corrective action.	Sustain local data-use and follow-up practices through government systems, routine budgets, and subnational management capacity.
Use rapid subnational analysis of immunisation data to identify and resolve data-quality issues and support local decisions. This may include line-list review, correction of missing data and outliers, denominator selection, and validation using survey data where appropriate.	Make rapid analysis and data-quality troubleshooting part of routine subnational review, planning, and performance-improvement cycles.	Sustain local analytical capacity to continuously improve data quality, denominator estimates, and programme decisions.
Use improved denominator estimates, population analyses, and triangulated evidence to inform local microplanning, service-delivery planning, targeting, and resource allocation.	Routinely apply improved population and coverage estimates within district and provincial planning, service delivery, and prioritisation processes.	Use denominator improvement and evidence-based planning approaches in routine planning, budgeting, and review processes.
Work with national and regional technical groups, universities, public health institutes, and epidemiologic agencies to strengthen subnational analysis and use evidence to reach zero-dose and under-immunised children and missed communities.	Establish capacity-building pathways and results monitoring so analytical functions are progressively owned and used by national and subnational teams.	Sustain local analytical capacity and partnerships through institutional arrangements, domestic financing, and integration into routine government planning and review systems.

Fragile and humanitarian context-specific indicative activities

- Build capacity of local civil society and humanitarian organisations to collect, triangulate, analyse, and use data in fragile and humanitarian settings.

Ineligible activities

All contexts

- Investments that sustain parallel reporting systems.
- Investments not aligned with an integrated and coordinated HMIS strengthening plan.
- One-off workshops or review meetings that are not linked to routine data-use processes, follow-up actions, or programme improvement mechanisms.
- Standalone dashboards or subnational tools that are not interoperable with existing systems or databases.
- Investments that do not align with district and national health management information plans.

Flagship 4.3: Strengthen implementation research, learning systems and knowledge translation to improve programme effectiveness

This flagship supports implementation research, operational learning, peer learning, adaptive learning, and knowledge translation that address real programme challenges and improve programme effectiveness.

Countries may use their Gavi 6.0 Cash Budget to fund reviews and evaluations that address priority evidence needs and inform programme and investment decisions. Evaluations should be integrated into the country's broader monitoring, evaluation, learning and performance-management approach, with a clear plan for how findings will be used to adapt programmes, inform policy or guide future investments.

ISF	PT	AT
Use implementation research, operational learning, peer exchange, and structured learning to address priority bottlenecks, such as zero-dose children, gender and equity gaps, service-delivery constraints, workforce challenges, demand barriers, and programme management issues. Engage universities, technical institutions, professional associations, and learning partners where needed.	Continue using implementation research, operational learning, peer learning, and knowledge translation to address emerging programme challenges while integrating learning functions into routine immunisation, PHC, quality-improvement, and health-sector review processes.	Sustain nationally owned implementation research, learning, and knowledge-translation functions through domestic financing, institutional ownership, and integration into public-health, PHC, and broader health-system learning ecosystems.
Conduct implementation research and operational learning that generate evidence to improve programme design and implementation. Assess whether programme adaptations lead to better outcomes.	Routinely use implementation research findings, operational learning, programme reviews, and peer exchange to guide adaptation of immunisation and PHC strategies, policies, and implementation approaches. Continue commissioning research to address emerging priorities and challenges.	Strengthen national capacity to independently design, commission, finance, manage, and use implementation research and learning activities as part of routine government and public-health functions.
Establish peer-learning approaches, communities of practice, and collaboration between programmes, researchers, managers, technical institutions, and partner organisations to identify, adapt, and scale successful approaches.	Integrate peer-learning, adaptive-learning, and knowledge-sharing approaches into routine programme-management, review, and capacity-strengthening processes.	Sustain nationally owned learning networks and knowledge-sharing mechanisms with reduced reliance on external facilitation and project-based funding.
Strengthen capacity for implementation research, adaptive learning, facilitation, evidence synthesis, and knowledge translation.	Establish structured learning systems that connect evidence generation, programme review, planning, PHC implementation, and programme improvement.	Include learning, knowledge-translation, and continuous-improvement functions in national programmes, universities, public-health institutes, and broader health-sector learning systems.
Strengthen country capacity for peer learning, adaptive learning, NIS MEL, and EPI reviews. Use within-country, cross-country, and global-	Integrate peer-learning, adaptive-learning, NIS MEL, and EPI review functions into routine programme-management, review, quality-	Sustain in-country peer-learning and adaptive-learning functions through institutional ownership, domestic financing, and long-term capacity

to-country learning approaches to address medium-term implementation bottlenecks, virtually or in person as appropriate.	improvement, and PHC processes. Continue using peer-learning networks and implementation learning to support programme adaptation and continuous improvement.	development. Expand country-to-country, self-learning, subnational adaptive-learning, and financing-advocacy approaches where useful.

Fragile and humanitarian context-specific indicative activities

- Use short-term, problem-focused implementation learning and peer learning to address immediate implementation bottlenecks and operational challenges.
- Facilitate exchanges with peers from similar fragile, humanitarian, or conflict-affected settings to identify and adapt practical solutions.
- Use flexible learning approaches, including virtual, asynchronous, and remote learning, where travel, security, or connectivity constraints limit conventional approaches.
- Where appropriate, provide external facilitation to help countries identify and address immediate operational bottlenecks while strengthening longer-term learning capacity.

Ineligible activities

All contexts

- One-off meetings or workshops without a broader learning, application, follow-up, or programme-improvement process.
- Didactic training activities that do not include opportunities for peer exchange, adaptation, application, or continuous learning.
- One-off presentation-driven webinars.
- Standalone curricula, e-learning packages, guidance documents, or tools that are not linked to ongoing learning systems, programme-improvement processes, or application in practice.
- Unclear or poorly defined capacity-strengthening activities that lack learning objectives, application pathways, or expected results.

5. Disease surveillance

Surveillance, laboratory, and diagnostic systems help countries detect and monitor vaccine-preventable diseases (VPDs), understand disease burden, inform vaccine policy, monitor vaccine safety, and assess programme performance. These functions provide evidence for immunisation decisions and programme improvement.

Surveillance, laboratory capacity, and diagnostics are not a major HSS flagship under Gavi 6.0. They remain important enablers for other investment areas, including data systems, service delivery, and governance.

Gavi support should complement work funded by governments and partners, including the Pandemic Fund, World Bank, Global Fund, FIND, WHO, and other public-health actors. It should not duplicate, displace, or replace existing domestic or external financing.

Gavi support should not fund surveillance designed to confirm global disease eradication. Supported systems should be fit for purpose and balance performance, cost, feasibility, and sustainability.

Transition summary

ISF	PT	AT
Provide targeted support and use evidence from VPD surveillance, laboratory, diagnostic, specimen referral, and vaccine-safety functions to **inform immunisation decisions and programme improvement**.	**Use targeted evidence routinely** in EPI reviews, immunisation planning, campaign planning, prioritisation, and vaccine-safety monitoring.	Limit support to **targeted transition needs** linked to domestic planning, partner alignment, data-quality review, and immunisation-relevant surveillance functions.

Investment structure

This section presents a focused set of activities. It reflects Gavi's limited and targeted role in surveillance, laboratory capacity, and diagnostics under HSS.

ISF	PT	AT
Strengthen VPD surveillance functions that support immunisation priorities. This may include integrated surveillance, workforce capacity, data quality, timely reporting, and use of surveillance information.	Integrate targeted VPD surveillance support into routine public-health, PHC, and national surveillance systems. Use surveillance evidence in EPI planning, reviews, and programme decisions.	Support domestic planning for integrated VPD surveillance and routine use of surveillance evidence in immunisation decisions, while keeping support focused on immunisation-relevant priorities.
Provide targeted laboratory support linked to immunisation priorities. This may include quality assurance, inventory management, workforce development, training, and support to national or regional reference laboratories. Where feasible, train staff on appropriate use of diagnostics and RDTs.	Link laboratory functions with surveillance and immunisation programmes. Support routine exchange and use of surveillance and laboratory information for immunisation decisions.	Support targeted improvements in laboratory quality assurance, monitoring, evaluation, and training on new technologies. Avoid duplicating broader laboratory investments supported by governments and partners.
Procure and deploy Gavi-supported diagnostics where justified, with implementation support linked to immunisation priorities.	Integrate diagnostic functions into routine surveillance and laboratory systems. Strengthen coordination between surveillance, laboratory, diagnostic, and immunisation teams.	Plan for diagnostic functions, including domestic financing and transition arrangements where appropriate. Keep support targeted to justified immunisation-related diagnostic needs.
Support specimen referral and sample transport only where no suitable alternative exists. Use integrated transport approaches across diseases and programmes where appropriate.	Strengthen coordination and planning for specimen referral systems, using existing public-health and disease-programme transport systems where possible.	Support transition planning for specimen referral and transport systems and link them to existing public-health and disease programmes where feasible.
Strengthen systems to detect, investigate, assess, and respond to vaccine-safety concerns. This may include AEFI monitoring, safety-signal review, crisis communication, reference laboratory coordination, staff training, and integrated information systems.	Integrate vaccine-safety monitoring and response into routine immunisation and surveillance programmes, especially for new vaccines.	Maintain vaccine-safety review mechanisms, workforce capacity, quality assurance, and links with national surveillance systems.
Use surveillance and laboratory evidence in EPI planning, EPI reviews, PIRI, vaccine introductions,	Build routine use of surveillance and laboratory evidence into EPI reviews, immunisation planning, subnational prioritisation, vaccine portfolio	Maintain routine use of surveillance and laboratory evidence in immunisation policy, planning,

and identification of immunity gaps and underserved populations.	decisions, and programme optimisation.	prioritisation, and performance improvement.
Develop adaptable surveillance, laboratory, and diagnostic guidelines, training materials, and systems that can cover additional VPDs and emerging threats over time.	Integrate VPD surveillance into broader surveillance and public-health information systems where appropriate, including IHR-related platforms where feasible.	Include surveillance and laboratory data-quality audits in routine programme DQAs and performance reviews. Use monitoring and evaluation to maintain laboratory and surveillance performance.

Campaign considerations

- Use available surveillance and laboratory evidence when planning and monitoring campaigns, outbreak responses, and zero-dose activities.

Fragile and humanitarian context-specific indicative activities

- Provide targeted, time-limited support for key VPD surveillance, diagnostic, and laboratory personnel where needed to maintain critical functions.
- Strengthen community-based surveillance alongside traditional surveillance approaches where this improves early detection and reporting.
- Rapidly deploy diagnostics and laboratory capacity in response to justified emerging needs.
- Support well-justified recurrent costs for early detection, notification, diagnostics, reagents, and specimen transport where appropriate.

Ineligible activities

All contexts

- Surveillance, laboratory, or diagnostic investments that duplicate, displace, or replace government or partner financing.
- Surveillance activities designed to confirm global disease eradication.
- Salaries for routine laboratory and surveillance personnel.
- Surveillance or laboratory personnel outside government systems.
- Construction of national or subnational laboratory infrastructure.
- Large recurrent specimen-transport costs without a clear transition or sustainability plan.
- Studies on vaccine safety questions that have already been well studied or are covered by major ongoing studies.

6. 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. For vaccination beyond infancy, including in the second year of life, demand generation and community engagement approaches should reinforce the need for caregivers to return for all age-appropriate doses and, where appropriate, use reminder, recall and community follow-up approaches aligned with service availability and capacity. 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 modalities, 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.

Transition summary

ISF	PT	AT
Build evidence on behavioural, social and gender-related barriers to vaccination and **design and implement** effective approaches to increase uptake and reduce drop-out.	**Make community engagement, behavioural evidence, and feedback part of routine systems** for planning, service delivery, and budget discussions.	**Ensure long-term sustainability** of demand generation through institutional capacity, community ownership, domestic resources and continuous learning and adaptation.

Flagship structure

The two flagships cover complementary parts of demand generation and community engagement. Together, they help countries improve uptake, build trust, and respond to community needs.

- **Flagship 6.1** strengthens community engagement and digitally enabled demand generation to reach missed communities and reduce drop-out.
- **Flagship 6.2** strengthens country capacity to collect, analyse, and use social and behavioural data to better target interventions.

These flagships are closely linked to “Flagship 1.2: Improve service quality to drive better experience at vaccination touchpoints and thereby reduce zero-dose and drop-out rates and reinforce return visits” , under the **Service Delivery** investment area.

Flagship 6.1: Scale up community engagement and digitally enabled demand generation to encourage caregivers in missed communities and reduce drop-out

This flagship strengthens community engagement, trusted communication, and demand-generation approaches. Activities should use behavioural evidence, address gender and equity barriers, and include meaningful community participation.

ISF	PT	AT
Co-design and test community engagement and demand-generation approaches using behavioural insights, human-centred design, social listening, and community feedback to identify and address barriers to immunisation uptake and completion.	Institutionalise community engagement, behavioural evidence, social listening, and feedback mechanisms within routine immunisation planning, service delivery, programme management, and resource allocation processes.	Sustain community engagement and demand generation through domestic financing, strengthened community systems, local ownership, and routine use of behavioural evidence and community feedback to continuously adapt approaches.
Engage caregivers, adolescents, women-led organisations, fathers, faith leaders, traditional leaders, community influencers, and local networks to improve vaccination uptake and equity	Establish coordinated partnerships and feedback mechanisms between immunisation programmes, communities, CSOs, PHC, education, and local government platforms to support routine engagement and service improvement.	Strengthen long-term community partnerships and accountability mechanisms that reinforce trust, ownership, responsiveness, and demand for immunisation and other priority PHC services.

ISF	PT	AT
Identify and address gender-related, social, and behavioural barriers affecting women, caregivers, adolescents, zero-dose children, and underserved populations through targeted engagement approaches.	Integrate gender-responsive engagement into routine communication, planning, outreach, and community dialogue.	Use established community engagement platforms and feedback systems to continuously identify and address emerging gender, equity, and inclusion barriers.
Engage CSOs, FBOs, community groups, and trusted local actors to reach underserved, fragile, and zero-dose populations and support community feedback and dialogue.	Set up collaboration and feedback mechanisms between immunisation programmes, community actors, and service providers, including through PHC and community-health platforms.	Strengthen community-led engagement and accountability mechanisms that support trust, responsiveness, joint problem-solving, and uptake of immunisation and other priority health services.
Pilot behavioural nudges, community dialogue, social mobilisation approaches, and digital engagement channels to improve vaccination uptake and reduce drop-out.	Scale evidence-based behavioural, social mobilisation, and digital engagement approaches through routine immunisation and PHC delivery platforms.	Use periodic reviews to strengthen behavioural approaches based on community needs and programme performance.
Pilot and evaluate digital engagement approaches, including social media, SMS, IVR, digital networks, social listening platforms, and other context-appropriate technologies, to improve vaccine demand, reach under-served populations, and address behavioural barriers.	Integrate evidence-based digital engagement, social listening, and personalised communication approaches into routine immunisation communication, outreach, and community engagement strategies.	Sustain and continuously strengthen digital engagement ecosystems that leverage behavioural data, community feedback, and emerging technologies to improve trust, responsiveness, vaccine confidence, uptake, and equity.
Provide Pilot and evaluate targeted non-cash integrated incentives (e.g., such as transport support, nutritional supplements, travel support) to caregivers or recipients other context-appropriate enablers, to address identified behavioural, access, gender and equity barriers to immunisation.	Integrate evidence-based non-cash incentive approaches within routine immunisation and integrated PHC programmes, targeting populations facing persistent barriers to vaccination uptake and completion.	Sustain targeted non-cash incentive approaches through domestic systems, community platforms, and integrated health and social-service programmes, with regular review of effectiveness, equity, and sustainability.

Fragile and humanitarian context-specific indicative activities

- Adapt community engagement, demand-generation, and communication approaches for displaced, mobile, migrant, nomadic, conflict-affected, and other hard-to-reach populations, using context-specific delivery and engagement models.
- Map, engage, and coordinate with trusted local actors, including community leaders, women-led organisations, faith-based organisations, civil society organisations, humanitarian partners, and community-based organisations, to support equitable access and uptake of immunisation services.
- Map, engage, and coordinate with trusted local actors, including community leaders, women-led organisations, faith-based organisations, civil society organisations, humanitarian partners, and community-based organisations, to support equitable access and uptake of immunisation services.

- Maintain continuous engagement with all relevant stakeholders, including community based organisations with access to all parties while emphasising the neutrality of immunisation services.
- Use simple, context-appropriate engagement, social-listening, and communication tools, including reminders, prompts, and low-tech solutions, to support demand generation and community feedback in low-resource and insecure environments.
- Continuously adapt engagement strategies and demand-generation messages based on community feedback, evolving needs, population movement, and implementation experience.
- Community radio may be appropriate where access, literacy, infrastructure, or security constraints limit other communication channels.
- Use targeted non-cash integrated incentives, where appropriate, to address access, mobility, and equity barriers faced by displaced, mobile, and hard-to-reach populations, as part of broader community engagement and service delivery efforts.
- Use targeted non-cash integrated incentives, where appropriate, to address access, mobility, and equity barriers faced by displaced, mobile, and hard-to-reach populations, as part of broader community engagement and service delivery efforts.

Ineligible activities

All contexts

- Routine mass-media campaigns, including radio, that are not based on clearly identified behavioural, social, gender, or equity barriers, except in the context of new vaccine introductions or public health emergencies.
- Production of posters, flyers, banners, branded materials, signage, communication products, or media content as stand-alone activities not linked to a broader evidence-based community engagement or behaviour-change strategy.
- Generic awareness-raising campaigns that lack a clear behavioural objective, targeted audience, or evidence-informed community engagement approach.
- Paid celebrity endorsements, influencer campaigns, media productions, or promotional activities that are not grounded in behavioural evidence and programme priorities.
- Cascade training approaches that are not linked to mentoring, supportive supervision, quality improvement, institutional capacity strengthening, or IPCI training for community health workers.
- One-off community engagement activities, public relations events, workshops, launches, or campaigns that are not part of an ongoing, systematic community engagement strategy.
- Community engagement approaches that are not aligned with national immunisation priorities and strategies, or that are not informed by programme priorities, behavioural barriers, social data, or community needs.
- Physical money (e.g. bank notes).
- Cash transfers, unconditional material incentives, or broad population-wide incentives that are not linked to identified behavioural or access barriers and are not integrated within an evidence-based immunisation strategy.

Flagship 6.2: Strengthen country capacity to collect, analyse and use social and behavioural data to better target interventions

This flagship strengthens country capacity to generate and use behavioural and social evidence to improve targeting, address barriers, and adapt programmes as community perceptions change.

ISF	PT	AT
Conduct BeSD assessments, social and behavioural studies, and community listening activities to identify behavioural, social, gender, and equity-related barriers to vaccination, particularly among zero-dose and under-immunised populations.	Integrate behavioural and social evidence into routine immunisation planning, prioritisation, programme reviews, resource allocation, and service delivery improvement processes.	Use behavioural, social, and community insights as a routine component of programme management, adaptation, policy development, and continuous improvement.
Establish systems to collect, standardise, and analyse behavioural, social, community-feedback, and social-listening data, ensuring women's, men's, adolescents', and underserved populations' perspectives are captured.	Institutionalise the routine use of behavioural and social data, community feedback, and social-listening information within programme reviews, decision-making, and performance monitoring systems.	Strengthen continuous learning systems that use behavioural, social, and community insights to improve programme effectiveness, equity, and responsiveness over time.
Strengthen national and subnational capacity to collect, analyse, interpret, and use behavioural and social evidence for programme design and implementation.	Embed behavioural and social evidence within programme management, policy development, workforce capacity-building, and decision-making processes.	Maintain sustainable national capacity to generate, interpret, and apply behavioural and social evidence independently and at scale.
Introduce and test simple digital and low-tech tools to collect behavioural and social information, such as SMS feedback, IVR, chatbots, hotlines, and other context-appropriate tools.	Expand proven behavioural-data collection, feedback, and analysis approaches within routine programme-management, communication, monitoring, and review systems.	Strengthen sustainable systems for behavioural and social data collection, integration, analysis, and use within national health information and programme-management systems.
Establish systems and approaches for social listening, rumour tracking, message testing, misinformation monitoring, and rapid feedback collection.	Integrate social listening, misinformation monitoring, and rapid feedback mechanisms into routine communication, community engagement, and programme review processes	Maintain responsive systems that routinely identify and address misinformation, emerging concerns, behavioural barriers, and changing community perceptions.
Partner with academic institutions and specialist organisations to strengthen behavioural evidence, evaluation, and learning.	Build national capacity for behavioural research, monitoring, and use of findings.	Strengthen country capacity to generate and use behavioural evidence independently over time.

Fragile and humanitarian context-specific indicative activities

- Use flexible, low-tech, and context-appropriate approaches to collect behavioural, social, and community-feedback data in fragile, insecure and crisis-affected settings, including among displaced, mobile, and hard-to-reach populations.
- Use accessible tools such as SMS, IVR, mobile data collection platforms, hotlines, community feedback mechanisms, and other feasible approaches to gather timely insights where routine systems are constrained.
- Establish rapid feedback loops that combine community feedback, social listening, and implementation data to support timely adaptation of immunisation strategies during outbreaks, emergencies, population movements, and humanitarian responses.
- Monitor emerging concerns, rumours, misinformation, and barriers to access, and use findings to adapt engagement strategies, service delivery approaches, and communication messages in real time.

- Strengthen collaboration with humanitarian actors, local partners, and community networks to gather behavioural and social insights from populations that may be difficult to reach through routine government systems.
- Use behavioural and social evidence to inform context-specific prioritisation, targeting, and adaptation of immunisation services for displaced, mobile, conflict-affected, and underserved populations.

Ineligible activities

All contexts

- Research, surveys, or behavioural studies that are not linked to programme improvement, operational decision-making, policy development, or implementation adaptation.
- Stand-alone research or data-collection activities that do not include a clear plan for dissemination, capacity strengthening, integration into national systems, or use of findings for programme improvement.
- Behavioural and social data collection activities that are not linked to planning, prioritisation, service delivery improvement, programme management, resource allocation, monitoring, or review processes.
- Data collection exercises that do not generate actionable insights or contribute to improving immunisation programme performance, equity, demand, or service quality.
- Research activities conducted primarily for academic purposes without demonstrated relevance to national immunisation programme priorities or decision-making needs.
- Large-scale or repeated surveys that duplicate existing data sources and are not justified by a clearly identified evidence gap.
- Standalone survey or research activities extending beyond 8-9 months without a clear implementation, learning, or programme-improvement objective.
- Behavioural, social-listening, or community-feedback systems that collect information without clear mechanisms for analysis, feedback, decision-making, or programme adaptation.

7. Governance, policy, strategic planning and programme management

Effective governance and management help countries sustain immunisation performance, prioritise resources, coordinate stakeholders and maintain accountability. Gavi support should strengthen the structures, staffing, coordination mechanisms, advisory bodies, and performance systems needed for government-led programmes to manage changing vaccine portfolios, decentralisation, PHC integration, transition and changing country contexts.

Transition summary

ISF	PT	AT
Establish or strengthen coordination, management, prioritisation, advisory, and accountability functions.	**Shift from programme-specific or partner-supported arrangements** to government-led planning, coordination, performance review, and accountability.	**Sustain government stewardship**, decision-making, coordination, and accountability for equity, resilience, and efficient use of resources.

Flagship structure

The four flagships cover complementary governance and management functions. Together, they help countries manage immunisation programmes through stronger structures, planning, coordination, and evidence-informed decision-making.

- **Flagship 7.1:** Immunisation management structures, competencies, and staffing.
- **Flagship 7.2:** Planning, monitoring, and performance management.
- **Flagship 7.3:** Coordination, partnerships, and governance bodies.
- **Flagship 7.4:** Data-driven prioritisation, vaccine portfolio optimisation, and NITAG strengthening.

Flagship 7.1: Support countries in envisioning and evolving immunisation management at national and subnational levels, ensuring optimal structures, competencies and staffing

This flagship helps Ministries of Health define and use immunisation management structures, staffing, competencies, and accountability arrangements that remain fit for purpose as programmes change.

ISF	PT	AT
Assess programme and management needs, then address priority gaps in governance, oversight, coordination, implementation, and programme performance.	Integrate updated governance and management functions into Ministry of Health and PHC management systems, while keeping clear accountability for immunisation performance.	Use periodic reviews to keep organisational structures, management capacity, and governance arrangements fit for evolving programme responsibilities.
Design and implement updated national and subnational management models aligned with Ministry of Health reforms. This may include staffing, roles, accountability, performance management, career pathways, funding models, and gender parity.	Include revised management structures, staffing arrangements, accountability mechanisms, and decision-making processes in routine government systems.	Sustain government-led management structures, accountability systems, and performance-management processes that support programme performance, equity, and resilience.
Strengthen programme-management capacity for planning, application development, implementation oversight, risk management, partner coordination, monitoring, and decision-making. Address critical competency and staffing gaps.	Integrate management competencies, leadership development, career pathways, and organisational support functions into broader government systems.	Sustain management capacity through workforce planning, leadership development, and continuous capability strengthening.
In specific cases, co-finance critical personnel needed to implement redesigned management structures, with a clear and time-bound government financing plan.	In specific cases, continue co-financing critical personnel needed to implement redesigned management structures, with clear milestones for government financing and ownership.	Include long-term stewardship and transition functions in government structures, including procurement, budgeting, oversight, coordination, and management.

Fragile and humanitarian context-specific indicative activities

- Conduct rapid assessments of immunisation management competency and staffing gaps, especially in high zero-dose areas, and use findings to develop targeted management-strengthening plans.
- Strengthen EPI management capacity for emergency immunisation planning, implementation, reporting, and data use, with attention to local context and the needs of female frontline workers.

Additional flexibilities

- In specific exceptional cases, financing of existing staff positions or recurrent costs only where needed to maintain critical immunisation-management functions in fragile and conflict settings.

Ineligible activities

All contexts

- Financing existing staff positions or recurrent costs that are not directly linked to a defined management reform, organisational change, or management-strengthening initiative.
- Routine training activities or management courses that are not linked to new management roles, responsibilities, structures, or reform processes.

Additional F&H restrictions

- Full immunisation-management redesign during acute crises, where rapid management-capacity strengthening would be more appropriate.

Additional AT restrictions

- Salary support for personnel needed to implement redesigned management structures.

Flagship 7.2: Strengthen government capacity for planning, monitoring and performance management of immunisation at national and subnational levels

This flagship strengthens government capacity for planning, monitoring, performance management, accountability, and corrective action at national and subnational levels.

ISF	PT	AT
Map links between immunisation processes and health-sector planning cycles.	Align plans, costing, reviews, and coordination with sector planning and accountability processes.	Manage priorities through government-led sector planning, budgeting, and review platforms.
Introduce project-management approaches for key immunisation priorities, including workplans, milestones, responsibility tracking, and bottleneck resolution.	Use workplans, milestone tracking, implementation reviews, and partner coordination to manage immunisation priorities and support integration with PHC priorities.	Use implementation reviews and project-management approaches to strengthen cross-programme coordination, reduce duplication, and improve delivery and efficiency.
Establish dashboards, scorecards, programme reviews, data-quality checks, indicators, targets, and accountability mechanisms. Use them to monitor performance, prioritise actions, and guide investments.	Conduct routine national and subnational performance reviews using programme data. Bring together EPI teams, PHC programmes, managers, partners, and other stakeholders, and track agreed actions.	Strengthen performance-review and accountability processes by linking findings on performance, equity, efficiency, and financing to planning, budgeting, policy decisions, and programme optimisation.

Strengthen leadership, coaching, peer learning, M&E, and preparedness planning at national and subnational levels. Develop and test outbreak preparedness and response plans.	Include coaching, mentoring, peer learning, M&E support, and preparedness reviews in public-health institutions, programme-management structures, and emergency preparedness mechanisms.	Expand peer learning, leadership development, performance improvement, and preparedness reviews to strengthen management, resilience, and continuous improvement.

Fragile and humanitarian context-specific indicative activities

- Conduct rapid situation analyses and service-continuity mapping, then use findings to guide planning, prioritisation, and decisions.
- Train local health authorities to use rapid assessments and service-continuity analyses for programme planning and monitoring.
- Align immunisation planning with humanitarian health services and response platforms, including WASH, nutrition, protection, shelter, emergency-health, and camp-management systems.

Ineligible activities

All contexts

- Standalone training or workshops that are not part of a broader capacity-development plan, do not include monitoring, or are not aligned with national strategies.
- Hiring external consultants without using local expertise or aligning with national capacity-development plans.

Flagship 7.3: Support and strengthen government-led bodies to oversee and coordinate across immunisation and PHC, ensuring alignment between MoH, MoF, and partners

This flagship strengthens government-led coordination and oversight for immunisation and PHC. It focuses on overall governance bodies, partner alignment, joint planning, accountability and country ownership while avoiding parallel structures.

ISF	PT	AT
Assess existing coordination mechanisms and implement priority actions to strengthen, align, link, or streamline immunisation and PHC coordination structures.	Clarify mandates, responsibilities, membership, and relationships across immunisation, PHC, and broader health-sector governance structures.	Use periodic reviews to improve coordination mechanisms, governance arrangements, representation, mandates, and performance.
Strengthen ICCs, technical working groups, and other coordination platforms through updated terms of reference, governance arrangements, operating procedures, decision-making processes, and secretariat support.	Routinely use coordination bodies to support planning, budgeting, performance reviews, oversight, prioritisation, and decision-making across immunisation, PHC, and related programmes.	Improve coordination bodies through governance monitoring, member development, knowledge transfer, performance review, and continuous improvement.
Support joint planning, information sharing, and collaboration between EPI, PHC programmes, Ministries of Health and Finance, subnational	Establish routine joint planning, review, and prioritisation across immunisation, PHC, and other health	Expand joint planning, budgeting, monitoring, and performance review to improve alignment, reduce

authorities, development partners, civil society, and other relevant sectors.	programmes through agreed coordination mechanisms.	duplication, identify synergies, and maximise available resources.
Monitor coordination performance, including participation, meeting regularity, decision follow-up, and implementation of agreed actions.	Use coordination-performance reviews to improve participation, accountability, transparency, and follow-through on decisions.	Strengthen governance monitoring to assess coordination performance, decision follow-through, stakeholder engagement, and overall effectiveness.
Strengthen participation of civil society, women-led organisations, community representatives, private-sector actors, and other relevant stakeholders in coordination and governance processes.	Ensure stakeholder participation is routinely included in planning, review, accountability, and decision-making processes at national and subnational levels.	Strengthen mechanisms that support meaningful stakeholder engagement, accountability, representation, and inclusion within governance and coordination processes.
In specific cases, support Country Liaison Officers or similar functions that improve coordination between governments, Gavi, partners, and subnational actors.	Transition coordination and convening functions into routine government structures and governance mechanisms where appropriate.	Strengthen government capacity to manage coordination mechanisms independently through knowledge transfer, coaching, mentoring and organisational development support.

Fragile and humanitarian context-specific indicative activities

- Include immunisation priorities in humanitarian coordination mechanisms and emergency-response planning.
- Strengthen coordination between government, humanitarian actors, NGOs, community organisations and implementing partners to maintain immunisation services.

Additional flexibilities

- Recurrent meeting and coordination costs may be considered only where needed to maintain critical governance and coordination functions in fragile and conflict settings.

Ineligible activities

All contexts

- Construction or renovation of office buildings unless directly linked and proportionate to improving coordination capacity.
- Establishing new coordination platforms when effective mechanisms already exist.
- Technical assistance that is not embedded in national structures or does not include a clear transition and capacity-transfer plan.
- Coordination platforms composed exclusively of non-immunisation stakeholders.
- Recurrent costs for meetings and coordination platforms, except in fragile and conflict settings.

Additional F&H restrictions

- Creating new coordination mechanisms that are unlikely to function during acute crises or that duplicate existing humanitarian coordination structures.

Additional PT restrictions

- Staff, consultants, or technical assistance without a clear pathway for government absorption, knowledge transfer, or transition.

Flagship 7.4: Support countries to make evidence-informed decisions to prioritise and optimise immunisation programmes and vaccine portfolios, including through strengthening technical advisory and prioritisation mechanisms

This flagship strengthens evidence-informed decisions on immunisation priorities, vaccine portfolios, affordability and resource allocation, including through VPOP, cash prioritisation and technical advisory mechanisms.

ISF	PT	AT
Introduce VPOP and cash prioritisation approaches. Use evidence on vaccine portfolios, programme performance, delivery constraints, financing gaps, co-financing obligations, Vaccine Budgets, and available resources to identify prioritisation and optimisation options.	Integrate VPOP and cash prioritisation into immunisation planning, budgeting, programme reviews, vaccine-introduction planning, and broader PHC prioritisation.	Use prioritisation and optimisation approaches to support sustainability planning, affordability assessment, resource allocation, trade-off analysis, and decision-making across immunisation, PHC, outbreak preparedness, and other health priorities.
Strengthen NITAGs, RITAGs, secretariats, and other technical advisory mechanisms through technical assistance, operational support, evidence review, capacity building, and partner coordination.	Link technical advisory mechanisms with ICCs, EPI programmes, PHC structures, Ministries of Health, Ministries of Finance, and other decision-making bodies so recommendations inform planning, budgeting, financing, and policy.	Sustain advisory functions through succession planning, analytical capacity development, secretariat support, and stronger links with health-sector prioritisation, financing, and health technology assessment processes.
Strengthen country capacity to assess readiness for new vaccine introductions and compare options for products, presentations, schedules, delivery approaches, and programme investments. Include affordability, sustainability, Vaccine Budgets, co-financing obligations, and long-term financing implications.	Routinely incorporate optimisation, affordability, sustainability, and financing considerations into national immunisation strategies, programme reviews, annual planning processes, and broader PHC prioritisation exercises.	Use analytical approaches to assess affordability, sustainability, value for money, implementation feasibility, health impact, and opportunity costs of immunisation and PHC investment options.

Fragile and humanitarian context-specific indicative activities

- Use simplified prioritisation approaches to maintain essential immunisation services, protect high-risk populations, and respond to outbreaks and emergencies.
- Provide targeted technical assistance and evidence-review support where national technical capacity is constrained.

Ineligible activities

All contexts

- Prioritisation or optimisation exercises that are not linked to country decision-making, technical advisory mechanisms, programme planning, or policy development.
- Technical assistance that replaces national decision-making instead of strengthening country capacity and ownership.

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'.

Transition summary

ISF	PT	AT
Build financing foundations through using prioritisation, annual costing and medium term forecasting, budgeting, resource monitoring and expenditure tracking, and engagement with financing decision-makers.	**Shift toward proactive country-led health financing** by embedding immunisation in government budget processes, considering efficiency and fiscal space in decisions, strengthening public financial management, and deepening relationships with financing decision-makers.	**Sustain and protect financing** through domestic resource mobilisation in preparation for full self-financing of the immunisation system, fully functional public financial management, using transition roadmaps to manage transition.

Flagship Structure

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

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.

<table>
<tr><th>ISF</th><th>PT</th><th>AT</th></tr>
<tr><td colspan="3">• 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, 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.</td></tr>
<tr><td>• Support National Immunisation Forums to for high-level engagement on budgeting and disbursement of immunisation financing</td><td></td><td></td></tr>
<tr><td></td><td>• Assessment of medium- to long-term vaccine procurement prices and overall budget as country prepares to transition off Gavi prices</td><td></td></tr>
<tr><td></td><td></td><td>• Needs may be broader and include gathering accurate data for forecasting and budgeting exercises as well as costing and efficiency analyses.</td></tr>
</table>

Ineligible activities

- Investments that do not directly inform or improve the 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.

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 8.2: Strengthen public financial management, and use of country systems for Gavi funding.

This flagship strengthens system-level public financial management and use of country systems so immunisation funds are budgeted, tracked, audited, reported and managed with stronger fiduciary assurance and accountability.

ISF	PT	AT
Identify and address system-level PFM bottlenecks affecting immunisation and PHC financing, such as weak budget execution, expenditure tracking, reporting, audit follow-up, or limited use of country systems. Build government capacity to sustain improvements.	Make review of PFM bottlenecks part of routine budget preparation, budget execution, financial management, programme review, and PHC financing processes.	Monitor and address PFM bottlenecks through government-led systems. Use findings to improve budget credibility, fund release, expenditure tracking, and accountability.
Strengthen expenditure tracking and financial monitoring for vaccines, campaigns, operational costs, and PHC-related expenditures at the system level. Build government capacity to analyse and use expenditure information for programme, budget, and fiduciary management.	Make expenditure tracking and financial monitoring part of government planning, budget review, programme management, and PHC financing processes.	Use expenditure, execution, and audit data to support continuous improvement of financial management, resource allocation, budget credibility, and accountability.
Strengthen grant-management capacity for Gavi funding, including planning, implementation, reporting, financial oversight, risk management, and timely follow-up on financial-management issues.	Progressively increase reliance on government systems for grant management, reporting, financial oversight and implementation functions where risks can be appropriately managed. Use targeted technical support to support government leadership rather than substitute for it.	Sustain country-owned and country-financed grant-management functions through routine government structures, staffing, systems, and budgets.
Support internal and external audit processes, financial reviews, and other fiduciary assurance mechanisms required for effective grant management. Use audit findings to strengthen controls, improve financial accountability, and address recurring financial-management issues.	Integrate audit findings, financial reviews, and fiduciary recommendations into routine programme review, financial-management, and risk-management processes. Align additional assurance requirements with government processes where feasible.	Strengthen routine government-financed audit, assurance, and accountability mechanisms that support transparency, risk management, and effective use of country systems. Reduce reliance on externally financed assurance arrangements where government systems can provide adequate fiduciary confidence.

Review pass-through funders, programme support costs, fiscal agents, and partner-managed implementation arrangements. Identify ways to strengthen country systems and ensure these arrangements build government capacity where they remain necessary.	Align pass-through, fiscal-agent, and partner-managed arrangements with government financial-management, reporting, audit, and accountability processes where feasible, while maintaining appropriate fiduciary safeguards.	Use government-financed audit and assurance mechanisms as the primary source of fiduciary assurance, complemented by additional assurance measures where warranted by risk. Sustain country-led management, oversight, and accountability functions through domestic systems and financing.

Fragile and humanitarian context-specific indicative activities

- Support simplified financial-management, reporting, and expenditure-tracking arrangements where routine government systems are disrupted, incomplete, or weak.
- Strengthen basic financial accountability and fiduciary assurance mechanisms needed to maintain immunisation financing and service continuity.
- Support rapid identification and resolution of bottlenecks affecting the release, tracking, and use of funds for immunisation service delivery.
- Where use of country systems is not immediately feasible, support arrangements that maintain fiduciary assurance while preserving a pathway toward greater government ownership when conditions allow.

Ineligible activities

All contexts

- Broad public financial-management reforms that are not directly linked to improving financing, execution, accountability, or use of funds for immunisation and PHC priorities.
- Parallel financial-management, reporting, audit, or grant-management systems that duplicate government systems without clear justification or transition intent.
- Pass-through, fiscal agent, or partner-managed arrangements that substitute for country systems without a clear role in strengthening government capacity, fiduciary assurance, or transition toward country ownership.
- One-off audits, financial reviews, or assessments that are not linked to follow-up actions, improved controls, risk mitigation, or stronger financial-management systems.
- Investments that do not improve budget execution, expenditure tracking, accountability, transparency, fiduciary assurance, confidence in country systems, or use of financing for immunisation and PHC priorities.

Flagship 8.3: Enhance flow of funds and utilisation at the frontlines, and reduce opportunities for misuse, through use of digital payments and mobile money

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.

ISF	PT	AT
• 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. • **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.		
		• Support accelerated transition countries in improving budget execution and treasury fund release processes to accelerate the availability of domestic resources for vaccine procurement and immunization programmes, reducing financing delays and the risk of vaccine stock-outs

Ineligible activities

- Technical assistance for analysis of PFM bottlenecks with no deep analysis of PHC.
- Duplicative assessment of PFM bottlenecks.
- Duplicative tracking and transparency tools.

Campaign considerations

- Timing of releases are especially important for the procurement of campaign vaccine. Mobile banking solutions are very well adapted for campaigns

Flagship 8.4: Strengthen efficiency of health financing by prioritising vaccine investments, integrating health funding and scaling proven results-based financing approaches

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.

ISF	PT	AT
• 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. • Provide **non-cash integrated incentives** (e.g. nutritional supplements, travel support) to caregivers or recipients.		

Ineligible activities

- N/A

Campaign considerations

- Multi-interventions campaigns (Vitamin A, nutrition, etc) are sources of efficiency.

Flagship 8.5: 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.

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.

ISF	PT	AT
	• 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.**	

ISF	PT	AT
	• Participation in multi-country **Peer-Learning and Transition Monitoring Secretariat** and other multi-country sustainability and transition initiatives.	

Ineligible activities

- 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: Expanded Partners

Annex 5a: 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 organisations (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% 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 the partners. 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 may be a Gavi-managed CSO Fund Manager or a Core Partner. Alternative intermediary arrangements may be considered in exceptional cases where there is a clear operational and programmatic rationale. This modality is primarily used for implementation, where partners support immunisation delivery in designated geographical areas, and is generally not used for technical assistance provided by Expanded Partners.

Indirect engagement should be used where implementation involves multiple CSO partners operating at subnational level; in-country coordination and facilitation are required; partners may need operational or programmatic capacity strengthening; or direct management of multiple partners and contracts by Gavi would not be efficient or feasible.

A single intermediary should normally be engaged to contract and manage CSO partners within a country to ensure consistency, clear accountability and effective coordination with the government. The intermediary manages the full grant management cycle on behalf of Gavi, including partner selection, due diligence and pre-award assessments, contracting, disbursement, oversight and reporting, and grant/contract closure in close consultation with the government and Gavi. .

The procedures applied by any intermediary for each step across the grant management cycle must be agreed with Gavi to ensure adherence to Gavi's procurement principles, risk appetite, fiduciary standards and reporting requirements. Details of the proposed indirect engagement should be provided at the application stage.

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 (i.e. the CSO Fund Manager or Core Partner) 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 CSOs supporting immunisation delivery in designated geographical areas, a set of recommended tailored indicators reflecting common areas of CSO work has been developed to ensure consistent indicator selection and assessment of CSO contributions. For indirect engagement, intermediaries consolidate and report on the performance of sub-contracted partners.

Annex 5b: Expanded Partners' COI Guidance

1. Purpose

This note clarifies how Expanded Partners can be engaged at country level during the country application development, where the line sits between advisory input and hands-on writing, what this means for partners' eligibility to compete for implementation contracts afterward and the process to implement this approach and consider exceptions where merited.

2. The Rule

Expanded Partners are encouraged to participate in country-level dialogue and multi-stakeholder consultations to inform a country's application. However, a partner that helps draft the application itself cannot later be contracted to deliver activities under that same application.

This protects the fairness and integrity of the competitive procurement process that follows. A partner that defines the design, scope, or budget of an activity during the application phase would have an unfair advantage if it later competed to implement that same activity. This is standard practice across multilateral and bilateral development partners, not a Gavi-specific restriction.

Given that this is new guidance for Gavi 6.0, it will not be applied retroactively where partners have been performing restricted activities (defined below) in support of applications before 1 April 2026, when the requirement was published in the programme funding guidelines. For cases where partners were already engaged in the application development process, an exception can be considered using the process described under enforcement below.

3. Advisory input vs. hands-on drafting

The distinction below determines what types of activities affect a partner's future eligibility to compete for implementation contracts.

Always encouraged (no impact on eligibility)	Restricted (affects eligibility to implement)
• Joining country dialogue meetings, workshops, and multi-stakeholder consultations, and technical working group meetings for immunisation • Sharing technical insights, evidence, and global and regional best practices • Contributing to strategic discussions and prioritisation exercises • Giving verbal advice or high-level feedback on emerging priorities or programmatic approaches • Advising on most effective programmatic approaches and interventions given the context.	• Drafting, writing, editing, or structuring any part of the application • Leading definition of specific activities, interventions, or programme components • Developing detailed budgets, costings, or resource allocations • Preparing workplans, deliverables, timelines, or implementation plans • Developing technical specifications that could later be procured

Always encouraged (no impact on eligibility)	Restricted (affects eligibility to implement)
• Sharing tools, data, and lessons learned • Providing feedback on country-led proposals without drafting the final content • Providing high level costing data (lumpsum budget estimate), as general indication of activity cost • Participate and vote in ICC meetings	

Unsure where something falls? Reach out to the Gavi Secretariat Senior Country Managers and/or the Gavi Procurement Team for an ad-hoc review before proceeding.

4. How this will be enforced

Expanded Partners will be required to declare, as part of the Intent to Participate (ITP) documentation, whether they actively supported the writing of the relevant country application using the exclusion criteria defined above before participating in any related competitive process (whether a Secondary Bidding Process under the Global RFP or a Standalone Competitive Process). Where there are questions on what constitutes active support, these should be raised to the Secretariat procurement team before a partner initiates support for application development. The Secretariat will also consider exceptions to this rule where this would have a major adverse impact on an ongoing application development process. Any exception must be approved by the Secretariat's Procurement Committee before the partner initiates support for application development.

Failure to disclose prior involvement, or a conflict of interest identified later, may result in disqualification, in line with Gavi's standard conflict-of-interest policies.

5. Key reference

Read this guidance alongside Funding Guidelines, Annex 5: Engagement of expanded partners under 6.0

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.[13]

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.**

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.

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- 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

Gavi requires grantees to comply with specific budget eligibility requirements when preparing and managing Gavi-supported investments. These requirements define the types of activities and costs that may be included in Gavi budgets and are intended to support consistent, transparent and appropriate use of Gavi funding.

This annex sets out the detailed budget eligibility framework, including eligible activities and costs, as well as applicable cost category thresholds.

Cost category	Description and principles
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).
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.
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. The country must demonstrate that vehicle procurement addresses a clear bottleneck in reaching zero-dose and under-immunised children and include a deployment plan. **For vehicle procurement above 5% or US$ 500,000 of the consolidated Cash Budget (whichever is greater):** countries must also submit evidence of a funded plan to manage and maintain the vehicles. • Vehicle purchases will be dependent on a fleet analysis report of available vehicles.

Cost category	Description and principles
	• 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.
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.
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.
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 strategies, and not only use traditional face to face training modality.

Cost category	Description and principles
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.
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. • 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.

Cost category	Description and principles
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. ○ **CSO Fund Manager:** Specific requirements may apply, but indirect costs for CSOs contracted and managed by the CSO Fund Manager must not exceed 10%. • 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).

Annex 8: Catalytic Phase supported areas and process guidelines

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 **Results Framework template**. In the Results Framework template, CP countries are required to set a target for, and report against, one grant-linked KPI. Tailored indicators are optional, and implementation-status reporting is required for all activities included in the budget. Detailed reporting frequencies are provided in Annex 11: Grant Accountability Framework. The **Targeted Areas** template is optional, except for dengue support, once available.

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

	Catalyser	
NVI requirements	***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[14]

Optimisation requirements	Catalyser	
	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.

New vaccine introduction

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

[14] 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.

- 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 for new vaccine introduction

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.

Vaccine optimisation

1. Technical Assistance (TA)

Technical assistance for assessment and decision-making should help countries clarify the optimisation question, compare feasible options and prepare the evidence needed for EPI, NITAG, ICC or an equivalent advisory body to make or endorse a recommendation. This support may be used for a broader vaccine portfolio optimisation and prioritisation (VPOP), vaccine portfolio, full-schedule or routine immunisation review provided HPV, PCV and/or rotavirus form part of the decision question and the analysis can potentially contribute to the financial sustainability of those vaccine programmes. Assessment and decision-making support should be tailored to country priorities, context and decision-making needs.

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

- Identifying optimisation questions; assessing product, presentation, schedule, target-group and delivery options; and defining the decision under consideration.
- Compiling country data; reviewing vaccine evidence; analysing efficacy, safety, strain/serogroup protection, supply, VVM type and WHO recommendations.
- Using budget simulation tools; conducting affordability, fiscal-space, budget-impact and cost-effectiveness analyses; assessing procurement and delivery costs; and comparing ROI and scenario trade-offs.
- Assessing injection requirements, administration complexity, wastage, cold chain volume, product demand, schedule changes, delivery implications and ease of use.

- Convening government stakeholders; facilitating VPOP workshops; supporting EPI to translate analysis into options; and providing expert briefings on optimisation priorities, antigens and related topics.
- Preparing technical recommendations on products, schedules, strategies and policy questions; and supporting evidence-based policy and strategy adjustments.
- Documenting decisions and rationale; updating strategic plans; and developing switch or implementation plans, as relevant.

Technical assistance for implementation support may be considered for endorsed optimisation changes that have a clear entry point in HPV, PCV and/or rotavirus and are expected to contribute to the financial sustainability of the relevant vaccine introduction. This may support planning, microplanning, operational guidance, supply chain preparation, training, data system updates, communication, and coordination across national and sub-national levels.

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

- Developing or updating the switch plan, implementation timeline, coordination arrangements, risk mitigation plan and partner roles.
- Preparing or adapting job aids; updating operational guidance; and orienting national and sub-national teams on the approved optimisation change.
- Updating forecasting assumptions, stock-management guidance, cold chain planning, recording and reporting tools, HMIS fields and monitoring dashboards.
- Developing communication approaches; briefing stakeholders; monitoring early implementation; documenting lessons learned; and supporting corrective actions during roll-out.

2. One-off costs (OOC) for optimisation implementation

One-off costs may be provided to support eligible, time-limited activities required to implement vaccine optimisation activities, including product, presentation or schedule switches or other approved optimisation changes. Comparable to a switch grant, this support may cover planning, training, materials and other operational requirements that are essential to implementation but cannot readily be financed through other sources. Where implementation is embedded in a broader portfolio optimisation or programme change, support may be used only for activities, or justified proportions of cost-shared activities, that are directly attributable to HPV, PCV and/or rotavirus. Implementation support should reflect country-specific priorities and implementation requirements.

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

- Supporting time-limited coordination costs directly required for the approved switch or optimisation change, where these are not covered through existing mechanisms.

- Funding time-limited training, printing or dissemination costs that are directly required to implement the approved change and attributable to HPV, PCV or rotavirus vaccines.
- Supporting one-off updates to tools, forms (i.e. child wellness/vaccination cards), registers, dashboards or other materials needed for the approved change, limited to the eligible vaccine components.
- Funding time-limited production, dissemination, meeting or monitoring and supportive supervision costs directly linked to the approved optimisation change and where not otherwise financed.

Note on costs eligibility
The following costs are ineligible for support: • Recurring or ongoing expenditures associated with routine programme functions, including salaries, incentives, and regular operating costs. • Costs that are not directly attributable to approved optimisation activities. • Activities or expenditures that overlap with existing or planned country-level support or partner-funded initiatives. • Vaccine procurement costs.

Annex 9: Grant Accountability Framework

A) Results 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
Grant-linked key performance indicators	Percentage reduction in the number of zero-dose children	WUENIC/UNPD WPP	Gavi Secretariat
	Number of children immunised with DTP1 [1]	Country HMIS	Country
	Number of children immunised with DTP3 [1]	Country HMIS	Country
	Number of children immunised with MCV1 [1]	Country HMIS	Country
	Number of children immunised with MCV2 (if introduced) [1]	Country HMIS	Country
	Number of children immunised with HPV (if introduced) [2]	Country HMIS	Country
	Percentage of co-financing fulfilled	Secretariat Financial Records	Gavi Secretariat
	Number of children immunised with newly introduced vaccines [3]	Country HMIS	Country
	Preventive campaign coverage [4]	Survey or administrative data	Country
	Percentage of routine immunisation performance reviews, as per schedule	Country programme review records	Country
	Timely detection and response to outbreaks	ICG, MR&P, WHO	Gavi Secretariat
	Tailored Indicators [5], [6] *Tailored indicators are required for countries with 6.0*	Variable	Each grant recipient will enter the details, and

	funding ceilings >US$ 10 million. They are optional for those under that ceiling, except where a specific tailored indicator is required under these guidelines. (The available list of tailored indicators can be accessed through the GMS at the time of application, or through the offline template on Gavi's website. Applicants can also create their own indicator if needed.)		report against, their tailored indicators

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).

[1] These indicators refer to doses administered through routine immunisation, in accordance with the target population and dose schedule specified in the country's national immunisation schedule. Vaccination delivered through dedicated catch-up activities or campaigns should be reported separately against the applicable indicator.

[2] This indicator includes individuals vaccinated through both the annual routine HPV programme cohort and any Gavi-supported multi-age cohort (MAC) activity, where applicable, in accordance with the nationally recommended HPV vaccination schedule. Countries are required to report against this indicator only once HPV vaccination has been introduced.

[3] Catalytic Phase countries are required to set targets, and report, against only this Grant-Linked KPI. They should also report implementation status for all activities in the budget templates.

[4] The GAF requirements for campaigns apply whether a campaign is included in a Gavi 6.0 country application or approved through a standalone campaign application. Countries should set targets and report against the applicable campaign grant-linked KPI, for example, preventive campaign coverage for preventive campaigns or the number of children immunised with newly introduced vaccines for introduction campaigns.

Where tailored indicators are required based on the country's Gavi 6.0 cash funding ceiling, each fund recipient should select one to three tailored indicators reflecting its principal expected contribution to the campaign. This includes a core Partner or Expanded Partner providing technical assistance for a campaign.

[5] In the 13 polio high-risk countries prioritised under the Gavi-GPEI collaboration, IPVc is a required tailored indicator. This requirement applies irrespective of the country's Gavi 6.0 cash

funding ceiling. The countries to which this requirement applies are Afghanistan, Angola, Chad, Djibouti, the Democratic Republic of the Congo, Ethiopia, Madagascar, Niger, Nigeria, Pakistan, Somalia, Sudan and Yemen.

[6] For CSOs supporting immunisation or service delivery, applicants should consider prioritising the recommended CSO indicators in the table below. These indicators are intended to capture the principal contribution of CSO-supported activities to reaching target populations and delivering immunisation services. However, fund recipients may in specific circumstances select a different indicator from the full tailored-indicator catalogue, or propose another country-defined indicator where this better reflects the expected CSO contribution.

Recommended tailored indicators for CSOs

Indicator name
Number of children < 1 year of age identified and referred to receive DTP1 in [targeted area]
Number of children < 1 year of age identified and referred to receive DTP3 in [targeted area]
Number of children between 1 and <5 years of age identified and referred to receive DTP1 in [targeted area]
Number of children between 1 and <5 years of age identified and referred to receive DTP3 in [targeted area]
Number of children <1 year of age vaccinated with DTP1 in [targeted area]
Number of children <1 year of age vaccinated with DTP3 in [targeted area]
Number of children <1 year of age vaccinated with MCV1 in [targeted area]
Number of children between 1 and <5 years of age vaccinated with DTP1 in [targeted area]
Number of children between 1 and <5 years of age vaccinated with DTP3 in [targeted area]
Number of children between 1 and <5 years of age vaccinated with MCV1 in [targeted area]
Number of immunisation sessions supported in [targeted area], disaggregated by fixed/mobile/outreach sessions
Number of community health actors participating in CSO-supported immunisation activities in [targeted areas]

B) Results Framework Indicator Reference Sheet

Full definitions, numerators, denominators, data sources, and other technical specifications for the grant-linked KPIs are available on the Gavi website: **Results Framework Indicator Reference Sheet**.

C) 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

Annex 10: Campaign Optimisation

Introduction

Following a July 2026 Board decision, the Gavi 6.0 Campaign Optimisation Strategic Approach aims to improve the impact and efficiency of preventive campaigns in resource-constrained settings. In addition to the strategic shifts described in this Annex, it updates the Gavi Co-financing Policy to set **campaign co-financing rates for initial self-financing, preparatory and accelerated transition countries at 2% (as of January 2027), 10% and 20% respectively**.

This Annex should be read alongside relevant WHO normative and technical guidance (see Annex 3 for antigen-specific guidance) and would be relevant when conducting cash and vaccine portfolio optimisation and prioritisation. It does not apply to outbreak response immunisation campaigns.

Planning an optimised campaign

Preventive campaigns remain an essential strategy for closing immunity gaps and reaching missed and under-immunised populations. However, nationwide, non-selective, or standalone campaigns (i.e., a campaign implementing a single vaccine) may not always be the most appropriate approach. In many settings, different delivery approaches (described in Table 1), or a combination of these approaches, may achieve programme objectives more effectively and efficiently, strengthen routine immunisation and improve health in communities.

Selecting an appropriate campaign delivery approach

Attaining and maintaining **strong routine immunisation** as the principal and sustainable platform for vaccination delivery **should remain the overarching objective of a vaccination plan**. Where immunity gaps are identified early, countries should thus consider whether these can be addressed through routine immunisation or catch-up vaccination approaches before defaulting to a mass campaign approach.

Countries may consider one or a combination of these different campaign delivery approaches where they are better suited to closing identified immunity gaps, reaching missed populations, or improving efficiency. Countries that implemented the Big Catch-Up may leverage relevant immunisation data and analytics to inform their assessment of the feasibility of these approaches. Countries may also combine categories (e.g. subnational campaign combined with PIRI in non-campaign areas). Each campaign delivery approach may have different implications for impact, efficiency, equity, data requirements, payment modalities, operational complexity, health worker resources, vaccine supply/forecast/lead times, service delivery quality, community acceptance and cost:

Table 1: Overview of Campaign Delivery Approaches

Category	Definition	Illustrative examples
Periodic intensification of routine immunisation (PIRI)	A planned, time-limited intensification of routine immunisation, conducted periodically or intermittently to close identified coverage or immunity gaps and reach missed populations or those underserved by routine services. It supplements rather than replaces continuous routine immunisation. Doses should be captured in the health facility registers and home-based records and should count toward routine immunisation coverage data. (Source)	Study assessing Big Catch-Up in central and west Africa. Uganda and Zambia have integrated child health weeks which are designated to deliver integrated services via routine platform.
Targeted campaign	A vaccination campaign conducted in a selected geographical area (based on geographical variation in risk or immunity), based on age, or to eligible groups (based on characteristics such as occupation or risk of infection). (Source)	Mali's Yellow Fever preventive mass vaccination campaign used geographic risk assessment to target only subnational areas at risk. Ebola preventive campaigns are designated for healthcare and frontline workers in at-risk countries.
Selective campaign	Vaccination campaigns that are customised to vaccinate eligible persons based on their individual previous vaccination status. Screening of home-based records is required to determine vaccination status and eligibility. (Source)	Eritrea implemented a differentiated measles-rubella follow-up campaign using both selective and non-selective vaccination strategies based on district-specific immunisation performance and immunity gaps.
Integrated campaigns	Campaigns in which two or more programmes or interventions coordinate selected campaign functions and/or service delivery. Integration may be partial or full. (*see section 2.2 for further details)*	Nigeria integrated measles-rubella and polio vaccination, alongside malaria and Neglected Tropical Disease (NTD) interventions.

When a campaign is determined to be the appropriate delivery strategy, **countries should refer to disease-specific guidance from the WHO and consult with technical partners to determine an optimised campaign delivery approach.** As an illustration of a decision-making tool, WHO's *Targeted and selective strategies in measles and rubella vaccination campaigns: Interim guidance* provides a framework for considering targeted and selective vaccination strategies:

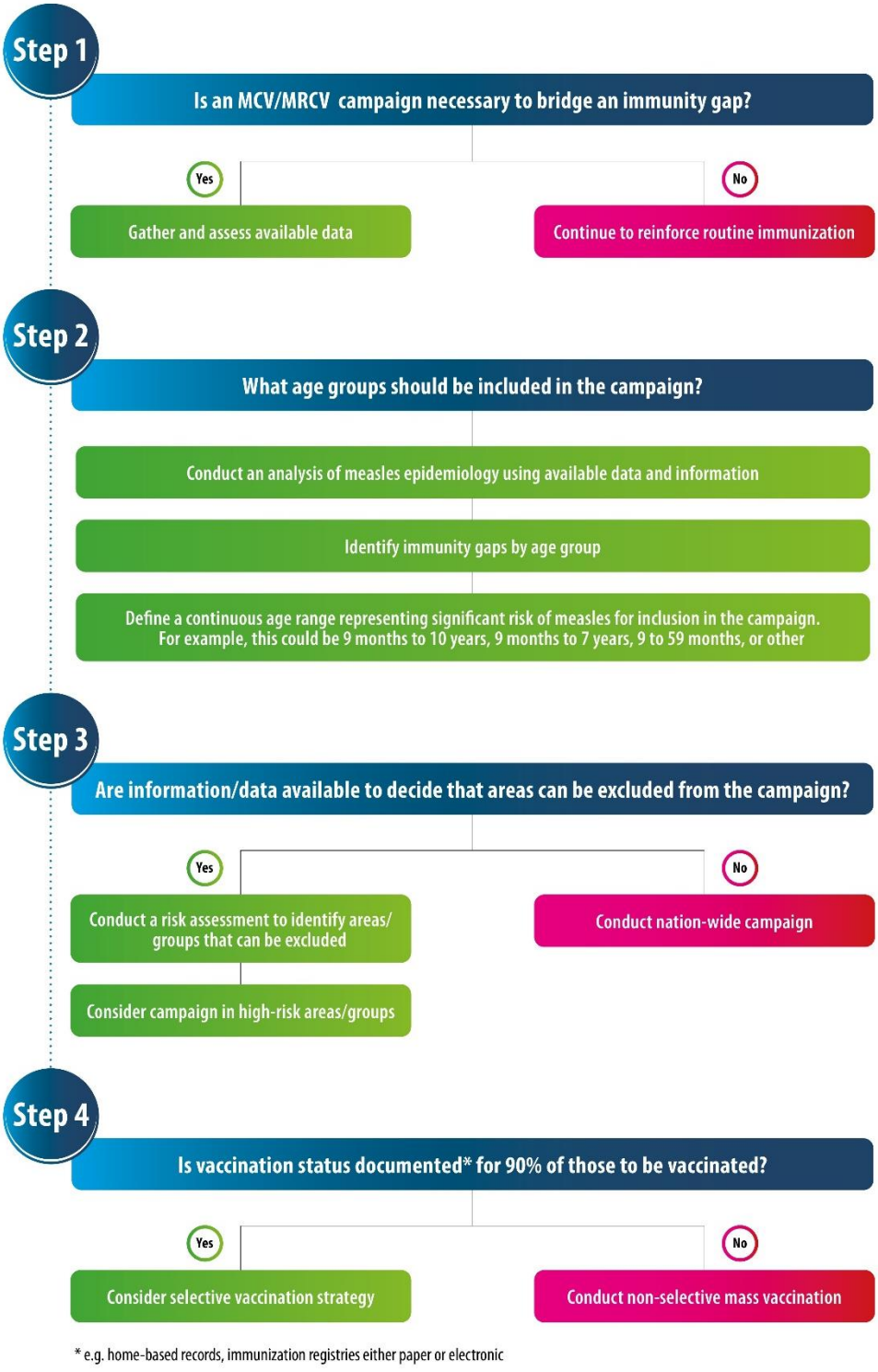


Fig 1: WHO decision framework for planning targeted or selective vaccination for M/MR follow up campaigns (Source)

There is no one-size-fits-all approach to selecting a campaign delivery approach. More targeted approaches by geography (e.g., prioritising hard-to-reach areas) or age group, or greater selectivity by individual vaccination status, may improve efficiency by focusing resources on populations with the greatest immunity gaps and may enable more tailored delivery or demand-generation. However, these benefits depend on sufficiently robust and

timely data to identify and reach the intended populations (such as vaccination records), which may require additional resources to generate and analyse.

As routine immunisation capacity and coverage improve, countries should periodically reassess the balance of the delivery approaches that have been used and progressively adapt to reinforce sustainable routine delivery through primary health care (PHC).

Key Resources

- WHO. *Periodic Intensification of Routine Immunization: Lessons Learned and Implications for Action* (2009).
- HCE Coalition. *Collaborative Action Strategy for Health Campaign Effectiveness* (2023). Presents 12 recommendations across campaign planning and implementation; monitoring, evaluation, research, learning and adaptation; and campaign financing to improve cross-programme coordination and collaboration
- Studies on supplemental immunisation approaches to reach zero-dose children: a *scoping review* and *costing study from hard-to-reach areas in Ethiopia*

Campaign integration and reduction in co-financing

Integration in campaigns involves coordinated planning and implementation across programmes, stakeholders, and health system actors. They may be fully integrated, with co-delivery of interventions and a high degree of coordination, or partially integrated, where selected campaign functions or components are integrated to strengthen coordination and efficiency when full integration is not feasible.

Countries may consider integration of functions such as joint campaign calendars, microplanning, training, logistics, social mobilisation and community engagement, workforce deployment monitoring, and data systems; or as co-delivery of interventions to the same target population. Gavi funding guidance also encourages countries to accelerate integration with immunisation and other essential PHC interventions (see section 3.3.).

Successful and effective integration of health campaigns at country level requires early planning, strong coordination across programmes (within and beyond EPI), and alignment of operational readiness. WHO and the Health Campaign Effectiveness (HCE) Coalition guidance recommends a structured approach that includes: (1) establishing a cross-campaign coordination mechanism, (2) mapping planned campaigns over a multi-year period and consolidating them into a shared campaign calendar, (3) assessing integration opportunities, (4) developing an integrated workplan and budget, and (5) regularly reviewing and adapting plans based on implementation experience and changing country priorities.

Co-financing reduction for eligible integrated immunisation campaigns

In Gavi 6.0, eligible integrated immunisation campaigns can benefit from a 50% reduction in campaign co-financing requirements where countries integrate either two or more Gavi-supported campaigns, or a Gavi-supported campaign with a non-Gavi supported polio campaign. If approved, the reduction will apply to the total Gavi co-financing amount,

e.g., to both vaccines if two Gavi-supported campaigns are being integrated and to the Gavi-supported vaccine(s) if integrated with a non-Gavi supported vaccine.

Gavi's definition of integration for the purpose of the Co-financing Policy is narrower than the broader concept of health campaign integration described above. The Board-approved approach specifies that to be eligible, campaigns being integrated should:

A. Either **co-deliver or integrate two or more core campaign functions** such as microplanning, social mobilisation, vaccination administration, supervision, monitoring or evaluation
B. Include an **integrated budget**
C. Be **implemented within a 12-month period**

To demonstrate eligibility for the co-financing reduction, applications should include the following:

BOX: Key Application Components for Co-financing Reduction

Key Components

- In **6.0 holistic/reprogramming narrative template or grant modification request**: In *section A.5*, a list of core functions to be integrated and brief description of how the assessment to integrate was done.
- In the **6.0 holistic/reprogramming budget template** or **grant modification request**, an integrated budget with activity grouping between the campaigns to be integrated.

For proposed integration with GPEI-supported polio campaigns, and for integrated campaigns in the outer years of the strategic period (i.e. 2029-2030):

The key components should be included in the holistic application to the extent possible. An integrated budget should be submitted **at least 8–12 months prior to implementation to support planning and coordination** of the integrated campaigns. Where the timing of the polio campaign confirmation does not allow for this lead time, the integrated budget should be submitted **as soon as the polio campaign is confirmed**.

Highly recommended

- A **multi-year health campaign calendar** to complement information provided in *section 3.4* of the 6.0 Narrative template. For a sample template, see page 14 of WHO Implementing Integrated Health Campaigns: Decision-Making and Planning Guide
- A high-level **chronogram** setting out integrated activities within a 12-month period.
- In *section A.12* of the **6.0 holistic/reprogramming narrative template**, the objectives of integration, the indicators that will be used to assess them, and how intervention-specific results and any operational or equity gaps will be identified and addressed.

Post Implementation Requirement:
A **campaign technical report** should be submitted within **four weeks after the end of campaign implementation** (see additional information below). This report should include a description of integration, the level of integration attained relative to what was proposed in the application for Gavi support, achievement of integration objectives and coverage achieved.

Key Resources

- WHO and HCE Coalition. *Implementing integrated health campaigns: Decision-making and planning guide*. Provides a framework for deciding whether and how to integrate campaigns and for developing multi-year cross-campaign workplans, calendars and implementation arrangements.
- GPEI and Measles & Rubella Partnership, *Operational Best Practices for Integrated Measles–Rubella and Polio Vaccination Campaigns* (2026)
- HCE Coalition. *CAS tools*. Provides adaptable tools and country examples to support cross-programme campaign planning, implementation, evaluation and financing.
- HCE Coalition. *Possibility of Campaign Integration Checklist*. Practical tool for assessing the feasibility of integrating different campaign interventions.
- GPEI Factsheet, *Integration: Polio Resources Responding to Community Needs and Strengthening Health Systems* (2026) and other *GPEI resources*

Monitoring, Evaluation and Continuous Learning

In Gavi 6.0, countries are encouraged to adopt a campaign monitoring, evaluation and learning (MEL) approach that generates implementation-relevant, country-centred, and action-oriented information to support effective and optimised campaigns, while balancing MEL design against available resources.

This section outlines MEL requirements and recommended approaches for measuring campaign performance. This annex is focused on campaign coverage measurement, reflecting the central role of coverage data in assessing campaign performance and informing programme improvement. Countries are encouraged to work closely with their focal points from the Gavi Secretariat and Alliance technical partners to identify MEL approaches that best support timely decision-making, continuous improvement across campaigns, stronger integration with routine systems, and efficient use of available resources.

As new evidence, country experiences and promising practices emerge, the technical content will be reviewed and updated by WHO and technical partners to incorporate the latest learning and support countries in selecting approaches that best fit their objectives, context and operational realities.

Grant Accountability Framework (GAF) indicators

Campaign coverage remains a standard indicator, while grantees may select additional tailored indicators that reflect their specific objectives and context. Refer to Annex 9: Grant Accountability Framework for further information.

Campaign technical report

As mentioned above, for monitoring performance and learning purposes, a campaign technical report should be submitted to Gavi through the GMS within 4 weeks of campaign completion. The report should document campaign performance, achievements, lessons learned, implementation challenges and future steps. A report template can be provided.

Intra- and post-campaign monitoring and evaluation

Countries are strongly encouraged to implement MEL activities across the campaign lifecycle to generate information that can be used both to improve campaign delivery in real time and to evaluate campaign performance after implementation.

Post-campaign coverage surveys (PCCS) are a central approach to evaluating campaign performance; however, experience to date indicates they have largely been considered by countries to be an accountability measure, with findings often not used to meaningfully inform practice. While PCCS remain an important and recommended approach for assessing campaign performance, in Gavi 6.0 they are no longer a funding requirement. This change provides greater flexibility in selecting MEL approaches that are most useful for programmatic decision-making and should not be interpreted as a reduced emphasis on campaign measurement. Rather, countries are encouraged to choose MEL approaches that best fit their context while generating robust evidence on campaign performance.

The Gavi Alliance also encourages investment in intra-campaign monitoring approaches that provide timely information during implementation and enable corrective action where needed to improve campaign quality and coverage.

A range of established campaign measurement methods is available to support both real-time monitoring and post-campaign evaluation. These methods are summarised in Annex 10A, "Detailed information on monitoring, evaluation and learning methods for campaign coverage". Aligned with the updated information in section 2 on different campaign delivery approaches, these recommended measurement approaches can be adapted to a range of delivery models, including nationwide, targeted, integrated, PIRI, or a combination of these approaches.

In line with the Gavi Alliance's commitment to learning and innovation, countries are also encouraged, where appropriate and feasible within existing budget envelopes, to test and document new approaches to campaign monitoring and evaluation. Such experiences can contribute to the global evidence base and generate practical lessons for future campaigns. Several promising or emerging methods are highlighted below, although the evidence base for these approaches continues to develop and are not yet part of WHO technical guidance.

Countries should also seek to strengthen linkages between campaign and routine measurement systems. This can reduce duplication, improve efficiency, and strengthen existing health information systems. In practice, this may include integrating campaign data into routine administrative and health information systems, leveraging or adapting existing routine immunisation data systems, and using survey-based approaches to measure both campaign and routine immunisation coverage, provided this does not compromise survey quality or feasibility.

Technical information on each method and additional resources can also be found in Annex 10A. As evidence and country experience continue to evolve, WHO technical guidance and this Annex will be updated.

Key Resources

HCE Coalition. *Framework for Measuring Health Campaign Effectiveness* (2026). Supports countries in assessing campaign effectiveness across acceptance, access, coverage, efficiency and equity and selecting context-appropriate measures for monitoring, evaluation and learning.

Digital solutions and electronic payments

Digital solutions are an important enabler of campaign optimisation and can support more effective planning, implementation, monitoring and financial accountability. Under the Gavi 6.0 Campaign Optimisation Strategic Approach, countries are encouraged to expand the appropriate use of digital tools and are expected to transition towards electronic payments for campaign workers. Gavi's implementation approach specifically promotes tools such as integrated digital microplanning, digital readiness and preparedness assessments and real-time monitoring.

Digital planning and tools

Countries are encouraged to consider digital tools across the campaign lifecycle, including for microplanning, campaign-worker registration, logistics and supply management, vaccination records, supervision, real-time monitoring and post-campaign analysis. These tools should build on and interoperate with existing national systems rather than create parallel Gavi-supported campaign-specific platforms, supporting use of campaign data for routine immunisation and broader programme learning.

The choice of digital tools should respond to country needs and system maturity. Digitalisation should not be pursued as an end in itself: countries should consider whether the proposed tool is fit for purpose, sustainable, interoperable with relevant national systems and capable of being supported beyond a single campaign.

Electronic payments for campaign workers

From September 2026, countries and partners applying for Gavi support will be required to use digital payments as the default mechanism for campaign-worker payments in settings where digital ecosystem maturity is sufficient. Where end-to-end digital payments cannot be implemented at the required scale, countries will be required to provide a campaign-specific electronic payment readiness assessment and transition plan (Annex 10B).

The ambition is to achieve full adoption of electronic payments across all Gavi-supported campaigns as soon as feasible, and no later than (applications coming in) 2028, recognising that exceptions at the subnational level and in a subset of countries with currently very

nascent systems may persist. The readiness assessment and transition plan should be endorsed by the relevant government authorities, including the Ministry of Health and the Ministry of Finance, and will be validated through Gavi's Independent Review Committee (IRC) process.

Key Resources

- WHO. *Digital Adaptation Kit for Immunizations: Operational requirements for implementing WHO recommendations in digital systems* (2025). Provides standards-based requirements for person-centred digital immunisation systems and supports interoperable, reusable digital approaches rather than parallel systems.
- WHO, UNICEF & CHAI. *Integrated Digitization of Health Campaigns Toolkit* (2025).
- UNICEF. *Digital Tool Selection Guidebook for Health Campaigns* (2025). Supports programmes in selecting digital tools appropriate to campaign objectives and country systems.

Annex 10A: MEL Detailed Information on monitoring, evaluation and learning methods for campaign measurement

The table below summarises each of the main methods and approaches for campaign measurement, setting out its primary purpose and identifying where it best fits within the campaign implementation timeline.

Function	Method	Main Purpose	Campaign phase(s)	Indicative cost^	Timing
Monitoring & Learning: Identifying opportunities for corrective action within the planned campaign. *"Where is corrective action needed, while there is still time to act?"*	**Administrative data**	Records doses administered and calculates coverage against an estimated target population, to track progress and flag areas falling behind. A shortfall may reflect data quality issues rather than missed children, and should be confirmed before mop-up.	Intra-campaign	Low-medium	Daily, throughout implementation
	Real-time monitoring (RTM)	Uses digital tools to monitor operational indicators in real time, so supervisors can redeploy teams and resolve bottlenecks during implementation. It can help identify where implementation broke down and if children were missed and why children are missed.	Intra-campaign	Medium	Continuous, throughout implementation
	Rapid convenience monitoring (RCM)	Uses "spot checks" to locate pockets of missed children for immediate revisit and mop-up, and can collect information on reasons for non-vaccination and behavioural and social drivers of immunisation (BeSD). It is not intended to be representative, so it may indicate where action is needed but should not be solely relied upon.	Intra-campaign or immediate post-campaign	Low	During implementation, or within 2 weeks of close

Function	Method	Main Purpose	Campaign phase(s)	Indicative cost^	Timing
	Lot Quality Assurance Sampling (LQAS)	Classifies districts or sub-districts against a coverage threshold, allowing for further action/ mop-up in failing areas. Also can collect information on reasons for non-vaccination and BeSD which can be used to inform targeted follow-up strategies	Immediate post-campaign	Medium	Within 2 weeks of close, while mop-up remains possible
Evaluation: Assessing overall campaign quality. *"What coverage did the campaign achieve, and did that meet our goals?"*	**Post-campaign coverage survey (PCCS)**	Representative household survey estimating coverage achieved, for national or regional reporting and accountability, and providing inputs for modelling at smaller geographies. Can also collect reasons for non-vaccination and BeSD and information on routine immunisation status to support RI monitoring, which is particularly relevant in settings that don't have recent surveys Retrospective, so results arrive too late to inform mop-up.	Post-campaign	Variable	2 weeks to 3 months after close
	Coverage modelling	Statistical and geospatial methods estimating coverage at district level and below to show where coverage was uneven. Feasible only in cases where empirical data are available. Complements a survey rather than replacing one, and informs routine immunisation or future campaign planning campaign rather than immediate action.	Post-campaign	Variable	Once survey results are available, typically 3 months or more after close

^refer to detailed table on each approach below for further information

Post-Campaign Learning: using campaign data to inform future campaigns, outreach and routine immunisation

Campaign learning should extend beyond assessment of campaign performance and coverage. Countries are encouraged to triangulate campaign monitoring and evaluation findings with routine immunisation, surveillance, equity, service delivery and financial data to assess the

contribution of campaigns to reducing immunity gaps, reaching missed populations, strengthening routine immunisation and improving the effectiveness and efficiency of immunisation investments. Findings should be used to inform future decisions regarding campaign targeting, integration, service delivery strategies and resource allocation.

Function	Learning Questions: Where can MEL help?	What actions can be taken	What methods can be used
Learning: Using campaign data to inform future campaigns, outreach and routine immunisation. *"What should change in the next campaign, and in routine immunisation?"*	**Informing future campaign planning.** Future campaigns can be designed to account for gaps/limitations in prior campaigns *What should change in the next campaign?*	Adjust delivery modality and or/ campaign timing Revise microplans, settlement lists, maps and target-population estimates Inform communication and community outreach activities Update readiness and campaign design criteria	All data sources can be used; triangulation ideal, including other qualitative or informal evidence sources
	Identification of chronically missed communities. Improve future campaign and routine immunisation strategies to ensure missed communities are reached *Who remains unreached, where and why?*	Revise and update microplans, settlement lists, maps, and target-population estimates Prioritise additional outreach/mobile delivery or increased fixed site sessions/hours Develop tailored strategies or dedicated resources to high risk or hard-to-reach areas	**LQAS** (Ideal for flagging areas with very poor performance) and **coverage modelling** (ideal for understanding geographic inequalities) best positioned, but all data sources can be relevant
	Improve understanding of key operational barriers measuring operational indicators beyond coverage can support improved understanding of system-side barriers *What constrained service readiness, quality and reach?*	Improve training and supervision of frontline staff Improve/replace supply chain equipment, vaccine transport schedules, waste management Improve recording, reporting, referral practices	**RTM** and **Administrative data** most comprehensive, but **RCM** can also provide insight. Household-survey options like LQAS and PCCS less relevant.
	Improving understanding of reasons for non-vaccination and BeSD drivers data can be broadly used to better design immunisation	Improve communication and community outreach activities	**LQAS, PCCS, and RCM** most relevant given information can

Function	Learning Questions: Where can MEL help?	What actions can be taken	What methods can be used
	strategies to better account for major demand-side barriers *Are there behavioural or social factors limiting reach? What are these?*	Prioritise additional outreach/mobile delivery or increased fixed site sessions/hours Tailor approaches with trusted leaders and groups facing specific barriers Strengthen rumour monitoring, feedback and response mechanisms	be collected directly from caregivers
	Improving data systems Identify data quality issues, gaps in operational and performance indicators, and reduce parallel/duplicate reporting systems *Is data credible, available, integrated, and timely?*	Improve/integrate utilisation of home based records Merge/integrate data systems across campaign and routine systems Ensure referral systems or defaulter tracing is in place and linked between campaign and routine systems Investigate discrepancies in numerator and denominator issues Revise microplans, settlement lists, maps and target-population estimates	**RTM** and **Administrative data** can be used to support a data quality review/assessment, while **household survey approaches** allow further opportunities for triangulation and validation.

Note that RCM, LQAS and PCCS can collect information on vaccination status and other qualitative aspects, including reasons for no vaccination and behavioural and social drivers of immunisation (BeSD), more information is available here.

Additional novel approaches for consideration

To date, campaign measurement approaches have primarily relied on routine administrative data and household surveys. While both approaches play an important role, they have limitations. Administrative data are essential but can be affected by data quality issues, while household surveys can provide robust coverage estimates but are often expensive, typically produce reliable estimates only at national or provincial levels, and do not generate information quickly enough to support real-time course correction.

A number of newer approaches seek to provide more country-centred, action-oriented, and timely information for decision-making. However, there remains limited evidence on how well these approaches meet information needs in practice, as well as on their reliability, cost, and other implementation considerations.

Consistent with the Gavi Alliance's commitment to learning and innovation, countries are encouraged to test and document promising approaches that are appropriate to their specific context and information needs. These experiences can help strengthen the global evidence base and generate practical insights for future campaign monitoring and evaluation efforts.

In addition to the established approaches outlined above, we highlight here several promising or emerging methods. As guidance and experience in campaign settings remain limited, countries are strongly encouraged to work with technical partners with expertise in the approach, to support design or implementation. Gavi also welcomes further collaboration and may be able to provide additional information on these approaches. Before including any of these approaches in your cash envelope, please contact your Senior Country Manager to engage further support and guidance from Gavi Alliance technical partners.

The table below summarises some approaches for consideration. This list is illustrative and not exhaustive; countries may also consider other approaches that are not included here.

Method / Approach	**Description**	**Main benefits of interest**	**Resources**
Mark and Recapture	Method to calculate campaign coverage using campaign tally sheets and routine immunisation status, which "marks" already-vaccinated children. The fraction of the campaign's "catch" that is already marked allows to back-calculate coverage.	More reliable real-time(ish) coverage estimation at low cost	A mark and recapture perspective on vaccination touchpoints
Embedded enumeration	Survey which uses embedded supervisors or existing staff (as opposed to independent enumerators) and GIS-based sampling to rapidly collect household data to identify immunisation hotspots and coldspots.	Reduced costs and implementation timelines; increase country ownership and sustainability	
Phone-based surveys	Includes set of approaches which in part or whole, use enumeration and sampling techniques through mobile phones (rather than in-person visits) to collect household level immunisation performance data.	Reduced costs and implementation timelines	Use of phone-based surveys for COVID coverage measurement

Alternative sampling strategies for household surveys	Includes novel approaches to household survey sampling with the aims of reducing cost and improving accuracy and efficiency. This includes adaptive sampling, GIS-based approaches to sample frame development, and purposive sampling.	Improved efficiency and costs	Geospatial approaches to sampling frame development for household surveys
Vaccinator Tracking	Set of approaches which use GIS and mobile phone technology to track the planning and conducting of vaccination sessions. Allows for easy identification of communities or settlements which have not been visited or missed.	Within campaign identification of missed communities	

Detailed tables on main measurement approaches

How to read the detailed method tables

Attribute	Definition	Scale
Description	What the method is, and how it produces a result. Factual, without judgement about when to use it.	N/A
Relevance	What this method offers that other methods do not, and what it adds to a country's overall measurement picture.	N/A
Best Used When	The conditions in a country's situation that make this method a good fit: the question being asked, the decision to be made, and the data, time and resources available. Describes conditions rather than rules about how the method should be used.	N/A
Not Appropriate When	The conditions under which this method cannot answer the question being asked.	N/A
Cost	Whether the method requires a dedicated field operation, which is the main determinant of what it costs.	**Low:** uses existing staff, systems and campaign structures, with little or no additional fieldwork. **Medium:** some dedicated fieldwork, training or data management, but not a standalone survey operation. **High:** a separate field operation with its own sampling, teams, training and supervision.
Level of Independence	How far the result is produced separately from the teams implementing the campaign.	**Low:** implementing teams collect and report their own data. **Medium:** collected by supervisors or other health staff. **High:** collected by a body not involved in campaign implementation.
Data resolution	The geographic level at which the method can realistically produce usable estimates, given typical resourcing. Determines how local a decision the result can support.	National, regional, district, or sub-district.

Attribute	Definition	Scale
Evidence base	What has been done with the method, in which settings, and what remains uncertain.	Narrative with citations of relevant resources and manuscripts rather than a rating.
Vaccine-specific considerations	How the method's design changes by antigen, including target age group, coverage threshold, and any implications for sample size.	Bulleted, by antigen where these differ.
Resources	Guidance, manuals, protocols and published evaluations that a country and its technical partners can use to implement the method.	Links to relevant resources.

The following tables provide more detailed information on each of the main measurement approaches.

Administrative coverage data	
Description	Routine data recorded by vaccinators and health workers during campaign delivery (e.g., tally sheets, registers, session/reporting forms, home-based records) and aggregated up through the health information system. Administrative coverage is calculated as the number of doses administered divided by an estimated target population. It is usually the most readily available and continuous source of campaign performance data.
Relevance	• Uses existing reporting systems (e.g. DHIS2) and routine data flows, requiring no separate additional infrastructure • Provides high levels of disaggregation (facility/session site, administrative unit, day/week of delivery) to track progress and identify underperforming areas
Best used when	• Monitoring campaign progress in near real time (e.g., daily or weekly doses administered against targets) • Resources are limited
Not appropriate when	• An accurate, robust coverage estimate is required; administrative coverage is prone to numerator errors (double counting, misreporting), denominator errors (inaccurate or outdated population estimates), and a mismatch between numerators and denominators where users from selected areas go elsewhere to receive vaccines, which can produce implausible figures such as coverage above 100% • Used alone as the main source of campaign monitoring and evaluation; it should be paired with other approaches to allow for further triangulation and more precise coverage estimation
Cost	• Low to Medium: As it leverages existing reporting systems, costs should remain low, however costs can rise if campaign-specific adaptations or additions are needed to reporting and recording tools, data entry, staff training and supervision, and IT/Infrastructure.
Sustainability	• High: Embedded in routine health information systems and supported by country ownership of the data.
Level of independence	• Low: Data are self-reported by the same staff delivering services, with no external verification-built in.
Vaccine-specific considerations	
Data resolution	Facility level
Resources	

Real-Time Monitoring (RTM)

Description	The use of digital technologies (e.g., mobile phones, tablets) and specialised software (e.g., RapidPro, DHIS2, ODK, KoBo Toolbox) to accelerate the collection, sharing, analysis and reporting of campaign data. The aim is to enable faster, same-day decision-making so that gaps can be identified and corrective actions taken while the campaign is still underway. It should complement administrative data systems, by either building additional tools to collect and process coverage information more rapidly, or collection additional operationally relevant data (e.g. training, stock, vaccination team tracking).
Relevance	• Provides near real-time (often same-day) feedback on progress against targets, enabling prompt corrective action such as redirecting teams to missed areas • Aims to improve data quality, timeliness and completeness through automated dashboards • Can monitor a wide number of areas related to campaign implementation beyond coverage, including data on stocks, training, vaccinator team tracking, rumours and vaccine hesitancy, and other community sensitization or demand generation activities
Best used when	• Same-day identification of gaps and corrective action during a campaign is a priority • Adequate enabling conditions exist, including sufficient planning, connectivity/infrastructure and staffing • It should be aligned with or built on existing reporting systems to ensure data system strengthening rather than duplication
Not appropriate when	• Network connectivity, hardware, or IT support are unreliable, which are among the most common implementation challenges • Planning timeframes are very short, leaving insufficient time for identification of key measurement priorities and tool development • Systems duplicate or run parallel to existing reporting systems • Used alone as main source of campaign monitoring and evaluation; it should be paired with other approaches to allow for further triangulation
Cost	• Medium: Many tools are open-source and free (e.g., ODK); however, funding may still be required for IT development and support, connectivity, and training. May be able to reduce printing and transport costs.
Sustainability	• Medium: Conditional on strong government ownership and leadership, alignment with existing digital systems and structures, and sustained funding; past experience (in polio and big catch-up) and learning from RTM can often carry into subsequent campaigns.
Level of independence	• Low to Medium: Typically government-led and embedded in campaign structures, though features such as team GPS tracking and the use of third-party monitors can add a degree of external verification.
Vaccine-specific considerations	
Data resolution	Facility or site level; depending on approach and data collected, can also include data at campaign or supervision team level.

Resources	• The Use of Digital Technologies and Approaches for Real-Time Monitoring of Supplementary Immunization Activities • Big Catch-Up Real-Time Monitoring Learning Brief

WHO Rapid Convenience Monitoring (RCM)	
Description	Convenience or "spot check" based approach to collect information on immunisation performance. Typically done on a small scale, and not intended to be representative but can provide opportunities to collect data on households and provide an opportunity for vaccination. It can be implemented by health workers in the same area or by external interviewers (external monitors, personnel from neighbouring districts) to add some independence
Relevance	• Cheap and fast way to purposely identify or understand pockets or low immunisation • Can be implemented with existing resources • Although not the main objective, it can be used to vaccinate missed children • Embedded nature promotes use
Best used when	• During a campaign to provide immediate feedback on campaign performance for course correction, i.e. rapid identification of missed children or settlements • Immediately following a campaign to understand if further mop-up or similar activities should take place • When resources and staff time are limited
Not appropriate when	• Does not provide representative coverage estimate and therefore should not be used for evaluative purposes or viewed as one-to-one replacement for PCCS or similar; additional monitoring approaches likely needed to supplement RCM • Given limited scope, should not be used as main mechanism for mop-up or other activities intended to vaccinate large amounts of missed children
Cost	• Low: Given low sample sizes and limited fieldwork, limited training, use of existing staffing resources, low or limited IT costs, RCM can be implemented at a very low cost.
Sustainability	• High: due to low costs, limited training, and direct involvement of country stakeholders, this approach generally has high country-stakeholder buy-in. Prior experience, for example from catch-up, or use in routine immunisation may also contribute to sustaining RCM efforts in between and across campaigns.
Level of Independence	• Low: Given embedded nature and use of pre-existing campaign staffing and resources. Independence can be improved if health workers from other areas, or independent monitors, conduct the RCM.
Vaccine-specific considerations	
Data resolution	Typically sub-district or site level, with data only available for the specific areas/sites visited.
Resources	• WHO RCM guidance toolkit • Use and abuse of rapid monitoring • RCM use in emergencies: post-earthquake vaccine campaigns in Haiti

	• Assessing and monitoring vaccination coverage: Lessons from the Americas • PAHO Tools for monitoring the coverage of integrated public health interventions, vaccination and deworming of soil-transmitted helminthiasis, Module 3

Lot Quality Assurance Sampling (LQAS)	
Description	LQAS (Lot Quality Assurance Sampling) uses small random samples drawn from defined population areas (called "lots," such as villages or health districts) to quickly classify whether each area has met a chosen performance target, such as a vaccination coverage threshold. By combining results across many lots, programmes can identify which specific areas are underperforming and need attention, while keeping sample sizes small and surveys fast and inexpensive. The method originated in industrial quality control and has been widely adapted for public health monitoring. It can be implemented by a variety of actors, from embedded approaches using immunisation programme or partner staffing to more independent approaches using external providers.
Relevance	• Useful for rapid, small-area checks to identify pockets of low performance • Allows for coverage estimation at higher geographic levels when lots are pooled, which can be done robustly but it requires statistical expertise for appropriate weighting • Can produce a clear pass/fail (accept/reject) classification that is easy for programme managers to act on • Captures reasons for non-vaccination and characteristics of missed children to inform future campaigns • Can be designed to also capture information on routine immunisation, including the overall percentage of campaign doses without prior vaccination.
Best used when	• The goal is to classify many small areas as meeting or not meeting a target, rather than to produce a precise coverage figure for each area • Rapid, low-cost decisions about where to direct follow-up (e.g., mop-up) are the priority
Not appropriate when	• A precise coverage estimate at the lot level is required; LQAS classifies rather than precisely estimates • If only national-level or region-level estimates are required, as Cluster-based survey approaches are likely more cost-efficient
Cost	• Moderate: Costs can vary widely by sampling strategy and approach. Costs can increase if statistical support is needed for proper aggregation of data from different lots.
Sustainability	• Moderate: Can be embedded in routine programme monitoring and repeated at relatively low cost, but sustained use depends on staff trained in the sampling and classification methodology and on resolving outstanding methodological questions.
Level of Independence	• Low to Moderate: Often implemented by or alongside programme staff, though the random sampling design can offer more structure and objectivity

Vaccine-specific considerations	• The coverage threshold and target age group used to classify lot should be defined per antigen and per campaign • Measles/rubella campaigns will usually require a large sample size to set the pass/fail threshold to close to 95% coverage. For most other vaccines, a threshold of 80% may be appropriate.
Data resolution	• The definition of a "Lot" can vary depending on approach, but typically provides pass/fail estimates at a sub-district or district level, with coverage estimates available at district or regional level.
Resources	• Using LQAS to monitor and measure vaccination programs • LQAS use in Gavi Learning Hubs in Nigeria • Extension of Malaria Indicator Survey with LQAS

Post-Campaign Coverage Survey (PCCS)	
Description	A representative household survey conducted after a campaign to produce a statistically valid estimate of vaccination coverage, typically using cluster sampling approaches. PCCS is generally regarded as the standard for evaluating whether a campaign met its coverage target. It is implemented by a third party to ensure impartiality and independence.
Relevance	• Provides a representative, statistically valid coverage estimate suitable for formal evaluation • Captures reasons for non-vaccination and characteristics of missed children to inform future campaigns • Enables triangulation against administrative coverage, which is useful where denominators are uncertain • Can be disaggregated by geography, age, sex, and equity dimensions, depending on the sample and questionnaire design • Can be designed to also capture information on routine immunisation, including the overall percentage of campaign doses without prior vaccination.
Best used when	• A rigorous, representative coverage estimate is needed to evaluate campaign performance • Confirming whether a campaign met its coverage target • Validating or triangulating administrative coverage where population denominators are uncertain • Understanding reasons for non-vaccination to guide corrective strategy or future planning • To provide inputs to modelling coverage at a smaller geographical level
Not appropriate when	• Rapid, real-time course correction during a campaign is needed; PCCS is retrospective and takes time to plan, field, and analyse • Resources, time, or trained survey staff are very limited • Used as a substitute for continuous monitoring during roll-out rather than as an end-of-campaign evaluation
Cost	• Variable, but likely higher than other approaches listed: Requires representative sampling, trained field teams, and dedicated data management and analysis. The sample size, and thus costs, will largely depend on desired level of precision. District-level representativeness is usually discouraged.

Sustainability	• Low to Moderate: Given the complexity, and frequent reliance on external technical support, PCCS is typically viewed as less sustainable than most other measurement options. Linking a PCCS to a routine immunisation survey may be a useful approach for resource optimisation.
Level of independence	• Moderate to High: Typically conducted or overseen by external or third-party teams using standardised methodology, giving it greater independence than embedded approaches such as RCM or administrative data.
Vaccine-specific considerations	Sample size can be calculated to allow sub-national level classification and regional/national level estimation. The sample size needed to classify survey strata will be higher for measles/rubella campaigns to set the pass/fail threshold to close to 95% coverage. For most other vaccines, a threshold of 80% may be appropriate.
Data resolution	Statistically robust estimates at national level; depending on survey and sampling design regional also available.
Resources	• World Health Organization Vaccination Coverage Cluster Surveys: Reference Manual

Coverage modelling	
Description	Coverage modelling uses statistical and geospatial models to estimate vaccination coverage, often at finer geographic resolution than surveys can directly support, by combining survey data with auxiliary information. Approaches include model-based geostatistics (MBG) and small area estimation (SAE).
Relevance	• Produces coverage estimates, with uncertainty bounds, at finer geographic resolution than surveys can directly measure, filling gaps where survey or administrative data are sparse or unreliable • Reveals within-country and within-district geographic inequality in coverage that national or subnational averages hide, helping identify under-immunised areas • Integrates multiple data sources (survey, administrative, geospatial covariates) into a single, coherent estimate
Best used when	• Suitable covariate data and geolocated survey data (e.g., PCCS or similar survey clusters) are available to fit and validate models • Direct survey or administrative data are too sparse, imprecise, or unreliable to give estimates at the geographic level needed • Understanding geographic inequality of coverage and identifying under-immunised areas is a priority • Fine-scale (grid or district) estimates are needed to guide targeting or equity analysis
Not appropriate when	• Input data are not available, of poor quality or unrepresentative, since models can propagate or amplify bias • Covariates, or geolocated survey inputs needed to fit and validate models are lacking, or when used as a substitute for improving primary data collection
Cost	• Variable: No new fieldwork is required if suitable inputs already exist, but modelling typically demands robust household survey data and specialised statistical and geospatial expertise, and computational resources

Sustainability	• Low: Once established, models can be re-run as new data arrive, but sustained use depends on specialised analytic capacity, continued availability of quality input data and covariates, and computational infrastructure, and is often reliant on external technical partners.
Level of independence	• High: Typically produced by external technical or academic groups using independent survey data, making outputs independent of programme self-report; however, they remain dependent on the quality and independence of the underlying input data.
Vaccine-specific considerations	The level of possible precision may affect usability for measles/rubella campaigns aiming at homogenous coverage of 95%.
Data resolution	District or sub-district. Modelled estimates often come in a “grid” format, where coverage is estimated at 5x5km or 10x10km grid squares. These grid squares cover the entire country and therefore can be aggregated up to district/region levels.
Resources	• Assessing Geographic Inequalities in Childhood Immunisation Coverage: A Critical Scoping Review of Spatial Analysis Methods • Geospatial approaches for mapping zero-dose prevalence and routine childhood immunisation coverage in low- and lower-middle-income countries: A scoping review

Annex 10B: Country Digital Payments Campaign Readiness Assessment and Transition Checklist[15]

Context[16]:

From September 2026, countries and partners applying for Gavi support will be required to use digital payments as the default mechanism for campaign worker payments in settings where digital ecosystem maturity is sufficient. Where end-to-end digital payments cannot yet be implemented at the required scale, countries will be required to provide a campaign-specific electronic payment readiness assessment and transition plan. The ambition is to achieve full adoption of electronic payments across all Gavi-supported campaigns as soon as feasible, and no later than 2028, recognising that exceptions at the subnational level and in a subset of countries with currently very nascent systems may persist. The readiness assessment and transition plan should be endorsed by the relevant government authorities, including the Ministry of Health and the Ministry of Finance, and will be validated through Gavi's Independent Review Committee (IRC) process.

Scope:

CAMPAIGN: [to fill out]
DATES: [to fill out]
GEOGRAPHIC SCOPE: [to fill out]
EXPECTED WORKER VOLUME: [to fill out]
PAYMENT VALUE: [to fill out]
PAYMENT MECHANISM: [to fill out]

Use:

This checklist provides a light-touch assessment to assist the country determine whether it can proceed with using end-to-end digital payments[17] to pay campaign workers in upcoming Gavi-supported campaigns or provide a strategic transition plan before large scale roll-out of digital campaign payments. For each checklist add the campaign name, dates, geographic scope, expected worker volume, payment value and proposed mechanism/provider. The

[15] This is a campaign readiness tool and not a full national assessment
[16] Digital payments are the default where it can be implemented responsibly, securely, inclusively, and without material payment delay or exclusion risk.
[17] The checklist should not only assess payment channel availability, but also the foundations required for payment, including health worker registries, role and eligibility confirmation, digital and financial literacy, health worker onboarding, and grievance redress

assessment should be completed by EPI teams, in collaboration with other programme areas to foster greater collaboration and integration opportunities. It should then be supported and signed off by Digital Health experts, programme, finance and legal teams at the country, regional and HQ level, and endorsed by the relevant MoH and MoF teams, using existing country knowledge, and should focus on whether campaign workers can be reliably identified, paid, tracked, and supported through digital payment mechanisms.

The checklist is not intended to replace or duplicate existing government or partner assessments, including those facilitated by WHO/GPEI, UNICEF, the Global Fund, Better Than Cash Alliance, or the World Bank, which provide detailed technical, fiduciary, or regulatory insights. Where such assessments or systems exist, countries should use & attach them as an evidence base to complete this rapid readiness checklist, highlighting current gaps, mitigations, and transition actions with timelines. This checklist is not normative guidance[18].

Use of existing systems:

Countries should priorities adapting, integrating, or expanding existing government, partner-supported, and private-sector payment provider platforms wherever feasible, rather than creating standalone solutions solely for Gavi-supported campaigns. However, these existing systems should be appropriately governed, scalable, interoperable, secure and suitable for repeated use across the health sector[19]. In deciding this, the country should consider whether the existing system fits a short-burst, high-volume, geography, payment window, worker profile and campaign conditions and clarify what flexibility countries have to adopt a better-fit platform rather than defaulting to what's already in place. This supports country ownership, sustainability, and alignment with broader national digital health architecture, digital public infrastructure, public financial management, and digital transformation priorities.

Resources:

Countries are encouraged to review existing campaign digitization guidance and tools, where relevant to their context.

- The **UN Principles for Responsible Digital Payments** as a guiding document that was developed by the Better Than Cash Alliance and also guided by its member governments, companies and international organizations https://responsiblepayments.org/

[18] Countries are encouraged to use existing guidance and tools where relevant to their context.

- Resources developed through the HCE Coalition Campaign Digitization Working Group which brings together organizations with practical experience in campaign digitization across countries and may be able to identify additional tools, lessons and technical expertise relevant to refining the checklist
- WHO Normative Guidance. *SMART Guidelines* and Reference Architecture Guidance for Digital Public Infrastructure for Health (DPI-H) provides the overarching WHO approach for standards-based, interoperable and software-neutral digital health systems; a dedicated SMART Guideline for campaign payments is currently in development
- UNICEF. *Digital Tool Selection Guidebook for Health Campaigns* (2025). Supports programmes in selecting digital tools appropriate to campaign objectives and country systems.
- Any shared policy, legislation, digitization tools, platforms, and frameworks deployed to harmonize technology, and governance in the health sector, countries and regional economic communities (RECs)

Instructions:

Review each question of the checklist before concluding whether a country is "ready" to proceed in using digital payments for their next Gavi-funded campaign. Where gaps are identified, briefly describe the constraints and summarize the support needed, and responsible party for each gap in the transition plan at the end of the checklist. **EPI teams may complete the initial self-assessment using best available programme knowledge and should validate finance, legal, regulator, systems, and payment provider-related responses with the relevant stakeholders, where needed.**

PART A: Readiness Conditions

The eight readiness conditions below constitute the minimum readiness basis for determining whether a country can proceed with digital payments, subject to documented mitigation of any minor residual gaps within the campaign timeline.

#	Condition	Response	Key risks requiring mitigation
1	**Proven digital mechanism** Has this payment mechanism already been used successfully for comparable high-volume payments? ***Consider:*** *recent digital payment, DFS, digital health, social protection, humanitarian cash transfer, or DPI assessments; existing government, partner, or provider systems that could be adapted. Evidence: previous payment run report, number/value of transactions, success rate, failed payments, reconciliation status, and lessons learned.*	☐ Yes ☐ No	**Electronic Payments:** System performance failure at scale; delays; loss of funds; loss of trust from frontline workers. **Cash Payments:** Reliance on cash-based mechanisms may perpetuate fiduciary, security, reconciliation, audit trail, leakage, and worker-protection risks that require documented mitigation.
2	**Government engagement** Do the responsible government institutions have confirmed roles, approvals, ownerships, focal points & escalation arrangements, and appropriately engaged in, the proposed use of this mechanism? ***Consider:*** *MoH, MoF, regulator, lead institution, stakeholder support, implementation responsibilities, and ownership of the transition.*	☐ Yes ☐ No	**Electronic Payments**: Political pushback; lack of long-term sustainability; misaligned policies; sudden project shutdown. **Cash Payments**: Weak government ownership; continued off-system cash handling; policy misalignment; limited accountability; and delayed transition to sustainable digital payments.
3	**Legal and regulatory clearance** Is the mechanism free of critical legal, regulatory, privacy, security or data-sharing barriers to immediate implementation? ***Consider:*** *approved payment channels, KYC, national ID, SIM registration, data-sharing, privacy, taxation, sanctions, audit requirements, consumer protection, fee transparency, user consent/data notice, fraud protection, and grievance/recourse requirements.*	☐ Yes ☐ No	**Electronic Payments:** Legal penalties; data privacy breaches; project freeze by financial regulatory bodies. **Cash Payments:** Breach of cash-handling, public finance, tax, or audit requirements; weak documentation and liquidation controls; increased risk of fraud, diversion, penalties, or questioned costs.
4	**Worker identification, eligibility and attendance** Can campaign workers be uniquely identified on an MoH-governed roster that is updated for each campaign?	☐ Yes ☐ No	**Electronic Payments:** Ghost workers; duplicated payments; legitimate workers excluded; unsustainable cost of fragmented registries.

#	Condition	Response	Key risks requiring mitigation
	Consider: *roster owner, last update, validation and approval process, de-duplication, worker role, location, assignment, supervisor, and payment details.*		**Cash Payments:** Weak verification of worker identity, creating risks of ghost workers, duplicate payments, inflated lists, exclusion of legitimate workers, and poor auditability of cash recipients.
5	**Payment instruction** Can each verified worker be linked to an approved payment amount and a payment destination? ***Consider****: approved compensation rules, payment amount, payment destination, authorization workflow, verification of completed duties, controls over payment file changes: authorization workflow, segregation of duties, version control, exception approval, and fee/deduction treatment.*	☐ Yes ☐ No	**Electronic Payments:** Funds routed to the wrong accounts; disputes over compensation tiers; administrative gridlock. **Cash Payments:** Weak controls over payment lists and approved amounts, creating risks of incorrect or duplicate cash payments, unauthorized list changes, entitlement disputes, and poor traceability of approvals and recipients.
6	**Provider capability** Do the payment providers have adequate coverage, processing capacity, liquidity, and operational support? ***Consider****: provider coverage, bulk-processing capacity, liquidity, operational support, service levels, and ability to meet the campaign payment window.* ***Require*** *written provider confirmation of bulk capacity, liquidity/cash-out arrangements, reporting format, failed-payment handling, fees, and escalation contacts.*	☐ Yes ☐ No	**Electronic Payments:** Provider liquidity constraints, system outages during bulk payouts, inadequate coverage, weak operational support, and workers unable to access funds on time. **Cash Payments:** Cash shortages; insecure transport or storage; weak distribution capacity; payment delays; theft, diversion, and limited audit assurance.
7	**Worker access** Can workers receive or cash out payments without disproportionate cost, delay, exclusion or safety risk ***Consider****: wallet, bank account, agent, cash-out point, travel time, transport cost, safety, fees, onboarding, complaint channels, and access for female, rural, remote, or vulnerable workers.*	☐ Yes ☐ No	**Electronic Payments:** Financial exclusion, especially for female or rural workers; excessive travel costs; limited cash-out access; and physical security risks. **Cash Payments:** Physical cash collection can expose workers,

#	Condition	Response	Key risks requiring mitigation
	check by *geography and worker group, including women, remote workers, workers without IDs/SIMs, and workers with low digital literacy.*		particularly female workers, to travel costs, payment delays, safety risks, coercion, diversion, PSEAH risks at collection points, exclusion of remote or vulnerable workers, and weak proof that the intended worker received the payment.
8	**Execution and reconciliation:** Can payments be made directly, tracked and reconciled, with failed, duplicate, reversed or disputed payments resolved? ***Consider:*** *payment status tracking, confirmation of receipt, failed transactions, duplicate payments, reversals, disputes, reconciliation reports (payment status report, failed-payment tracker, grievance log, refunds/reversals, and final liquidation file),liquidation timelines, audit evidence, grievance resolution, and follow-up responsibilities.*	☐ Yes ☐ No	**Electronic Payments:** Failed, duplicate, reversed, or disputed transactions; weak payment status tracking; delayed reconciliation; unresolved grievances; and limited audit assurance. **Cash Payments:** Manual cash execution and reconciliation create risks of leakage, delayed liquidation, weak proof of receipt, unresolved payment disputes, and limited assurance that donor funds reached the intended workers.

PART B: Readiness Decision pathway

The decision pathway below translates the readiness responses into a practical implementation decision, distinguishing between countries ready to proceed with digital payments and those requiring targeted mitigation or a time-bound transition plan.

Decision pathway	Interpretation
Ready to proceed with digital payments immediately	All eight conditions are met and no material gaps require action before implementation.
Exceptionally, not yet ready to proceed	Critical gaps remain, and transition plan has been prepared, to enable implementation within the stated 2028 deadline.

Note: Retaining cash payments is **not** a low-risk default. Where cash is used to avoid campaign delays, related fiduciary, security, reconciliation, worker-protection, and accountability risks a cash exemption justification on why cash is needed should be documented, mitigated, and addressed through a time-bound transition plan. In addition, confirmation of which digital option was considered, the approver and end date should be indicated.

Part C: Transition plan

For countries not yet ready to implement end-to-end digital payments for campaign worker payments, please provide a brief Digital Payments Transition Planning Statement.

This statement should outline:

- The main barriers currently preventing implementation of digital payments.
- Any existing national, partner, or sector assessments, strategies, or tools that will inform the country's transition approach.
- The government entities and partners expected to lead or support the development and implementation of the transition plan.
- The key workstreams anticipated to achieve readiness by 2028 (for example, worker identification and registration, payment infrastructure, provider engagement, reconciliation processes, policy or regulatory actions, training, or grievance management).
- An indicative timeline describing when a detailed transition plan is expected to be completed and implemented.

Countries are encouraged to build on existing guidance, assessments, and planning tools developed by WHO, UNICEF, the World Bank, and other partners, rather than creating new frameworks specifically for Gavi-supported campaigns. The statement is expected to be a summary only and <500 words.

The illustrative actions in the annex may be adapted to help countries complete the transition plan; they are not required actions and should be tailored to the country context while maintaining progress toward digital payment implementation.

PART D: Sign off

	INSTITUTION	SIGNATURE	OFFICIAL	DATE
Completed	**EPI**			
Endorsed	Ministry of Health			
Endorsed	Ministry of Finance			

Illustrative Actions to Support the Transition Plan[20]

Component	Near-term actions to enable campaign implementation[21]	Medium-term actions to sustain scale-up[22]
Proven mechanism	Confirm whether the proposed mechanism can support the upcoming campaign at scale; identify targeted adjustments, fallback controls, or support needs to enable implementation.	Strengthen or adapt existing government, partner, or provider-supported payment systems so they can be reused across campaigns and aligned with the 2028 digital payments deadline.
Government engagement	Brief Ministry of Health, Ministry of Finance, regulator, and other relevant stakeholders to confirm roles, approvals, and support needed for campaign implementation.	Develop a government-owned digital payment roadmap for health campaigns, aligned with national digital health, PFM, and digital transformation priorities.
Legal and regulatory clearance	Confirm applicable legal, regulatory, data-sharing, privacy, tax, audit, KYC, and SIM registration requirements before payments are initiated.	Address recurring legal or regulatory barriers through approved data-sharing arrangements, standard operating procedures, and alignment with national payment and data-protection frameworks.
Worker identification	Validate the campaign worker roster, confirm unique identifiers, remove duplicates, and document the approval process before payment instructions are issued.	Strengthen or integrate campaign worker rosters with existing HRIS, CHW, immunisation, or personnel systems to support repeated use across campaigns.
Payment instruction	Confirm approved compensation rules, payment amounts, worker payment destinations, fees, and authorization workflow before payout.	Establish a reusable payment-instruction process linking validated worker rosters to approved amounts, payment destinations, authorization controls, and audit evidence.
Provider capability	Confirm provider coverage, bulk-processing capacity, liquidity arrangements, operational support,	Strengthen provider agreements, service levels, liquidity planning, escalation procedures, and coverage

[20] In their analysis, countries should use acceptable evidence to support each component.
[21] Distinguish pre-campaign no-regret fixes from medium-term system strengthening. Avoid planning foundational reforms as if they are quick fixes
[22] medium-term actions should be linked to a country-owned roadmap aligned with digital health architecture, such as e.g, PFM, DPI, and the 2028 target.

	and escalation contacts for the campaign payment window.	arrangements for repeated campaign use.
Worker access	Identify worker access constraints, mitigate fees or travel burdens, provide onboarding, and ensure complaint channels are available during the campaign.	Expand inclusive access measures, including worker onboarding, financial literacy, agent or cash-out coverage, and accessibility for female, rural, remote, or vulnerable workers.
Execution and reconciliation	Set up payment status tracking, rapid grievance resolution, failed-payment follow-up, reconciliation, and documentation of refunds or reversals.	Institutionalize end-to-end payment tracking, reconciliation reporting, audit evidence, grievance management, and integration with provider or government payment systems.