Cholera Phase I Scorecard

Modelled scenario: periodic campaigns every 3 years targeting high risk 1-<15 year olds

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~74,000 U5 future deaths averted, 2015 – 2030	
		22 U5 future deaths averted per 100K vaccinated population	
	Impact on overall mortality	~120,000 total future deaths averted, 2015 – 2030	
		37 total future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	3.3M total future cases averted, 2015 - 2030	
		1000 total future cases averted per 100K vaccinated population	
		No long term sequelae	
Additional impact conside-rations	Epidemic potential	High epidemic potential	
	Global or regional public health priority	No global or regional resolution on elimination or eradication	
	Herd immunity	Significant herd immunity effects (at 50% coverage)	
	Availability of alternative interventions	Improvements in water and sanitation for prevention; effective ORS treatment	
	Socio-economic inequity	Disproportionate impact on poor	
	Gender inequity	No disproportionate impact on one gender	
	Disease of regional importance	Burden spread across GAVI countries in all regions	
Imple-mentation feasibility	Capacity and supplier base	Capacity below potential GAVI demand; <3 manufacturers expected by 2020	
	GAVI market shaping potential	Good potential to influence market	
	Ease of supply chain integration	Packed volume greater than 12 cc / dose	
	Ease of programmatic integration	Campaigns outside routine vaccination schedule	
	Vaccine efficacy and safety	67% efficacy; no evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$1.0B total procurement cost to GAVI and countries, 2015 - 2030	
	In-country operational cost	High incremental cost due to periodic campaigns every 3 years	
	Procurement cost per event averted[2]	~$8600 procurement cost per death averted; ~$320 per case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per future death averted

GAVI ALLIANCE

Dengue Phase I Scorecard

Modelled scenario: one-time catch up campaign 2-<15 year olds followed by routine immunization at 2Y

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health Impact	Impact on child mortality	~700 U5 future deaths averted, 2015 – 2030	
		~0.4 U5 future deaths averted per 100,000 vaccinated population	
	Impact on overall mortality	~4,600 total future deaths averted, 2015 – 2030	
		~3 total future deaths averted per 100,000 vaccinated population	
	Impact on overall morbidity	~2.7M total future cases averted, 2015 – 2030	
		~1,600 total future cases averted per 100,000 vaccinated population	
		Few long term sequelae, some reports of dengue encephalitis	
Additional impact conside-rations	Epidemic potential	High epidemic potential	
	Global or regional public health priority	WHO Global Strategy for Dengue Prevention and Control with mortality and morbidity reduction goals by 2020, no elimination goals	
	Herd immunity	Insufficient data on herd immunity threshold	
	Availability of alternative interventions	Limited success of vector control measures for prevention; only supportive care	
	Socio-economic inequity	No disproportionate disease burden in the poor; all population groups are at risk	
	Gender inequity	Comparable burden in men and women	
	Disease of regional importance	Disease burden concentrated in Asia	
Imple-mentation feasibility	Capacity and supplier base	<3 manufacturers by 2020. Planned initial capacity probably below demand	
	GAVI market shaping potential	Good potential to influence market , although global demand still TBD	
	Ease of supply chain integration	Packed volume and temperature requirements unknown	Insufficient evidence
	Ease of programmatic integration	Routine immunization of 2 years old not aligned with other schedules. Catch-up campaign required	
	Vaccine efficacy and safety	Inconclusive. 30.2% preliminary finding from Phase IIb study. Efficacy might vary by serotype; safety evaluation still underway	
Cost and value for money	Vaccine procurement cost[1]	~$1.3B procurement cost to GAVI and countries, 2015 – 2030	
	In-country operational cost	Medium: 3 doses outside schedule and a medium size catch-up campaign	
	Procurement cost per event averted[2]	~$290,000 procurement cost per death averted, ~$490 per case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per future death averted

Hepatitis A Phase I Scorecard

Modelled scenario: routine immunization at 12M (intermediate endemnicity countries only[1])

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~80 U5 future deaths averted, 2015 – 2030	
		~0.5 U5 future deaths averted per 100K vaccinated population	
	Impact on overall mortality	~1100 future deaths averted, 2015 – 2030	
		~7 total future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	~320,000 future cases averted, 2015 – 2030	
		~2,000 future cases averted per 100K vaccinated population	
		No long-term sequelae	
Additional impact conside-rations	Epidemic potential	Limited (disruptive) epidemic potential	
	Global or regional public health priority	No global or regional resolution on elimination or eradication	
	Herd immunity	Insufficient evidence on herd immunity	
	Availability of alternative interventions	Water and sanitation improvements viable interventions for disease control	
	Socio-economic inequity	Hepatitis A risk is associated with inadequate water supplies and poor sanitation	
	Gender inequity	Comparable burden in men and women	
	Disease of regional importance	Disease burden distributed across GAVI regions	
Imple-mentation feasibility	Capacity and supplier base	15+ vaccines already available; sufficient capacity to serve the GAVI market	
	GAVI market shaping potential	Less than 10% of global market	
	Ease of supply chain integration	Packed volume less than 3 cc / dose	
	Ease of programmatic integration	Partly aligned with other schedules (12 months); no change in health worker behavior or practices required	
	Vaccine efficacy and safety	~85%-95% efficacy; no evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[2]	~$43M total procurement cost to GAVI and countries, 2015 – 2030	
	In-country operational cost	Low cost (delivery within health system, alignment with schedule, one dose)	
	Procurement cost per event averted[3]	~$40,000 per future death averted, ~$130 per future case averted	

1. Defined as ≥50% seroprevalence by age 15 years, with <90% by age 10 years; 7 GAVI-eligible countries meet this definition
2. Procurement cost includes vaccine, syringe, safety box and freight 3. Scoring based on cost per future death averted

GAVI ALLIANCE

Hepatitis B Phase I Scorecard

Modelled scenario: birth dose in GAVI eligible countries not currently providing birth dose

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health Impact	Impact on child mortality	0 U5 future deaths averted, 2015 – 2030	
		0 U5 future deaths averted per 100,000 vaccinated population	
	Impact on overall mortality	~110,000 total future deaths averted, 2015 – 2030	
		~75 total future deaths averted per 100,000 vaccinated population	
	Impact on overall morbidity	~1.5M total future cases averted, 2015 – 2030	
		~1,000 total future cases averted per 100,000 vaccinated population	
		Chronic infection leads to liver cancer and cirrhosis	
Additional impact conside-rations	Epidemic potential	Limited epidemic potential	
	Global or regional public health priority	No global or regional elimination or eradication goals	
	Herd immunity	No demonstrated herd immunity threshold	
	Availability of alternative interventions	Treatment options available for chronic infections	
	Socio-economic inequity	No evidence that burden is concentrated within poorest socioeconomic quintile	
	Gender inequity	Burden concentrated in men	
	Disease of regional importance	Burden widespread	
Imple-mentation feasibility	Capacity and supplier base	10+ manufacturers with sufficient capacity meet incremental GAVI demand	
	GAVI market shaping potential	GAVI estimated volume share <10% of global demand	
	Ease of supply chain integration	Packed volume less than 3 cc / dose	
	Ease of programmatic integration	Aligned with BCG vaccine administration; change in health care practices required to ensure administration within 24 hours after birth	
	Vaccine efficacy and safety	High vaccine efficacy (95%); no evidence of link with serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$73M total procurement cost to GAVI and countries, 2015 – 2030	
	In-country operational cost	Low incremental burden: routine delivery within health system, single dose	
	In-country cost per event averted[2]	~$650 per death averted; ~$49 per case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per death averted

GAVI ALLIANCE

Hepatitis E Phase I Scorecard

Modelled scenario: routine immunization at 10 years

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	0 U5 future deaths averted, 2015 – 2030	
		0 U5 future deaths averted per 100K vaccinated population	
	Impact on overall mortality	~20,000 total future deaths averted, 2015 – 2030	
		~38 total future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	~1.0M total future cases averted, 2015 – 2030	
		~1,900 total future cases averted per 100K vaccinated population	
		No long-term sequelae	
Additional impact conside-rations	Epidemic potential	Limited epidemic potential	
	Global or regional public health priority	No global or regional resolution on elimination or eradication	
	Herd immunity	Insufficient evidence on herd immunity	
	Availability of alternative interventions	Water and sanitation improvements possible for disease control	
	Socio-economic inequity	HepE risk associated with inadequate water supply, poor sanitation and hygiene	
	Gender inequity	Disease burden concentrated in pregnant women (7-40% case fatality rate)	
	Disease of regional importance	Disease burden concentrated in South Asia	
Imple-mentation feasibility	Capacity and supplier base	1 manufacturer; planned expansion well below GAVI demand	
	GAVI market shaping potential	Significant potential to influence market (GAVI market is ~4x planned capacity)	
	Ease of supply chain integration	Packed volume cannot yet be determined; manufacturer could switch from prefilled syringe to single-dose vial	Insufficient evidence
	Ease of programmatic integration	Not aligned with other vaccine schedules	
	Vaccine efficacy and safety	~100% efficacy; no evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$350M from 2015-2030	
	In-country operational cost	High incremental cost: three doses delivered outside of health system	
	Procurement cost per event averted[2]	~$18,000 per future death averted, ~$350 per future case averted	

1. Procurement cost includes vaccine, syringe, safety box and freight 2. Scoring based on cost per future death averted

Influenza Seasonal Phase I Scorecard

Modelled scenario: routine immunization of pregnant women at first antenatal visit

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~170,000 U5 future deaths averted, 2015 – 2030	
		~46 U5 future deaths averted per 100,000 vaccinated pop	
	Impact on overall mortality	~200,000 total future deaths averted, 2015 – 2030	
		~56 total future deaths averted per 100,000 vaccinated pop	
	Impact on overall morbidity	~5.8 million total future cases averted, 2015 – 2030	
		~1600 total future cases averted per 100,000 vaccinated pop	
		No long term sequelae	
Additional impact conside-rations	Epidemic potential	No disruptive epidemic potential	
	Global or regional public health priority	No global or regional resolution on elimination or eradication	
	Herd immunity	Herd immunity threshold of ~80%	
	Availability of alternative interventions	No alternative to prevent; case management to alleviate symptoms	
	Socio-economic inequity	No disproportionate impact on poor	
	Gender inequity	Pregnant women are at higher risk of death and severe disease	
	Disease of regional importance	Disease burden distributed across GAVI countries	
Imple-mentation feasibility	Capacity and supplier base	Current capacity meets >100% of GAVI demand; 20+ manufacturers by 2020	
	GAVI market shaping potential	GAVI demand <10% of global demand	
	Ease of supply chain integration	Packed volume between 3 and 12 cc / dose	
	Ease of programmatic integration	Fully aligns with neonatal tetanus vaccine schedule, possible need for behavior change due to off-label vaccine use in pregnant women	
	Vaccine efficacy and safety	~70% vaccine efficacy in adults; 63% in <6 month olds through transfer of protection from mother to child; no evidence of causal link to adverse events	
Cost and value for money	Vaccine procurement cost[1]	$490 million procurement cost to GAVI and countries, 2015 - 2030	
	In-country operational cost	Low: routine delivery within health system, single dose	
	Procurement cost per event averted[2]	$2400 procurement cost per death averted, $84 procurement cost /case averted	

1. Procurement cost includes vaccine, syringe, safety box and freight
2. Scoring based on cost per death averted

GAVI ALLIANCE

Malaria Phase I Scorecard

Modelled scenario: 1 time catch-up campaign of 5 to <18 month olds and routine immunization of infants

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~440,000 U5 future deaths averted, 2015 – 2030	
		~200 U5 future deaths averted per 100K vaccinated population	
	Impact on overall mortality	~440,000 future deaths averted, 2015 – 2030	
		~200 future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	~75M future cases averted, 2015 – 2030	
		~34,000 future cases averted per 100K vaccinated population	
		No long term sequelae	
Additional impact conside-rations	Epidemic potential	High epidemic potential	
	Global or regional public health priority	No global or regional elimination or eradication goals (Millennium Development Goal 6c to 'reverse incidence' of malaria)	
	Herd immunity	Herd immunity threshold 80-99%	
	Availability of alternative interventions	Alternative disease control interventions exist (e.g., long-lasting insecticide-treated bednets, indoor residual spraying, preventative treatment and seasonal malaria chemoprevention, effective artemisinin-based combination treatment)	
	Socio-economic inequity	Highly disproportionate risk for the rural poor.; vectors prosper in rural settings	
	Gender inequity	Pregnant women are at higher risk and have more severe outcomes	
	Disease of regional importance	Burden concentrated in Africa	
Implemen tation feasibility	Capacity and supplier base	Planned capacity to meet <100% of GAVI demand; 1 manufacturer	
	GAVI market shaping potential	Good potential to influence the market	
	Ease of supply chain integration	Packed volume expected between 3 and 12 cc / dose	
	Ease of programmatic integration	Routine vaccination in EPI schedule, no change in health worker practices	
	Vaccine efficacy and safety	31.3% vaccine efficacy; no evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$2.8B total procurement cost to GAVI and countries, 2015 – 2030	
	In-country operational cost	Low operational cost: in EPI schedule; narrow age range catch-up campaign	
	Procurement cost per event averted[2]	~$6,400 procurement cost / death averted; $37 procurement cost / case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per death averted

Measles Phase I Scorecard

Modelled scenario: incremental investment to expand age cohort to <15Y in one of every three SIAs

Category2	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~11,000 U5 future deaths averted, 2015 – 2030	
		~2 U5 future deaths averted per 100,000 vaccinated population	
	Impact on overall mortality	~12,000 total future deaths averted, 2015 – 2030	
		~2 total future deaths averted per 100,000 vaccinated population	
	Impact on overall morbidity	~510,000 total future cases averted, 2015 – 2030	
		~110 total future cases averted per 100,000 vaccinated population	
		No significant long-term sequelae	
Additional impact conside-rations	Epidemic potential	Highly contagious; occurs in epidemics	
	Global or regional public health priority	Elimination goals in 5 of 6 WHO regions	
	Herd immunity	Herd immunity threshold above 70%	
	Availability of alternative interventions	No alternative interventions for prevention; symptom relief and vitamin administration as treatment	
	Socio-economic inequity	No higher susceptibility in poorest socioeconomic quintile	
	Gender inequity	Comparable burden in men and women	
	Disease of regional importance	Disease burden distributed across GAVI countries	
Imple-mentation feasibility	Capacity and supplier base	Capacity to supply GAVI demand, 3+ manufacturers	
	GAVI market shaping potential	GAVI demand in volume estimated to be above 25% of global demand	
	Ease of supply chain integration	Packed volume less than 3 cc / dose	
	Ease of programmatic integration	Delivered in campaigns and therefore not aligned with other schedules; no change in health worker practices/behavior required	
	Vaccine efficacy and safety	85-95% vaccine effectiveness; safe vaccine, rarely causing severe reactions	
Cost and value for money	Vaccine procurement cost[1]	~$400M from 2015-2030	
	In-country operational cost	High incremental burden: periodic campaigns, with every third campaign covering a wide age range	
	Procurement cost per event averted[2]	~$34,000 per death averted; ~$790 per case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per future death averted

Meningococcal ACWY Phase I Scorecard

Modelled scenario: routine immunization at 9 months

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~32,000 U5 future deaths averted, 2015 – 2030	
		~12 U5 future deaths averted per 100,000 vaccinated pop	
	Impact on overall mortality	~32,000 total future deaths averted, 2015 – 2030	
		~12 total future deaths averted per 100,000 vaccinated pop	
	Impact on overall morbidity	~320,000 total future cases averted, 2015 – 2030	
		~120 total future cases averted per 100,000 vaccinated pop	
		10-20% of survivors experience long term sequelae	
Additional impact conside-rations	Epidemic potential	High and disruptive epidemic potential	
	Global or regional public health priority	No global or regional resolution on elimination or eradication	
	Herd immunity	Herd immunity threshold unknown	
	Availability of alternative interventions	No alternative to prevent other than vaccination; treatment with antibiotics possible, but with limited time window	
	Socio-economic inequity	No disproportionate disease burden in the poor	
	Gender inequity	No disproportionate impact on one gender	
	Disease of regional importance	Burden concentrated in the meningitis belt of sub-Saharan Africa	
Imple-mentation feasibility	Capacity and supplier base	Capacity to meet GAVI demand TBD; 1 manufacturer from 2015-2019 with product indication that aligns with modelled strategy	TBD
	GAVI market shaping potential	GAVI share of global demand TBD	TBD
	Ease of supply chain integration	Packed volume above 12cc / dose	
	Ease of programmatic integration	Aligns with measles schedule, no significant additional training required	
	Vaccine efficacy and safety	85% vaccine efficacy; no evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$3.5 billion total procurement cost to GAVI and countries, 2015 – 2030	
	In-country operational cost	Low incremental burden: within health system and on schedule, two doses	
	Procurement cost per event averted[2]	~$110,000 procurement cost per death averted, $11,000 procurement cost per case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per death averted

Poliomyelitis Phase I Scorecard

Baseline: Single dose of IPV administered at the same visit as DTP3

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~0 U5 future deaths averted, 2015 – 2030	
		~0 U5 future deaths averted per 100K vaccinated population	
	Impact on overall mortality	~0 Total future deaths averted, 2015 – 2030	
		~0 Total future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	~0 Total future cases averted, 2015 – 2030	
		~0 Total future cases averted per 100K vaccinated population	
		Sequelae: risk of permanent disability from wild or vaccine-derived polio	
Additional impact conside-rations	Epidemic potential	High if supplementary immunization activities stop	
	Global or regional public health priority	World Health Assembly (2012) deemed completing eradication a “programmatic emergency for global public health”	
	Herd immunity	No herd immunity	
	Availability of alternative interventions	No alternative interventions (to achieve eradication)	
	Socio-economic inequity	Disproportionate impact on poor	
	Gender inequity	No unique gender inequities	
	Disease of regional importance	Polio remains endemic in only 3 countries, but no regional concentration and global relevance	
Implem-entation feasibility	Capacity and supplier base	3+ prequalified manufacturers of stand-alone IPV; planned capacity >75%	
	GAVI market shaping potential	Good potential to influence market	
	Ease of supply chain integration	Packed volume above 12cc / dose	
	Ease of programmatic integration	Administered on EPI schedule (same visit as DTP3), no special training; important to train on AEFIs and relation to OPV	
	Vaccine efficacy and safety	Greater than 90% efficacy; no evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$680M Total procurement cost to GAVI and countries, 2015 – 2030 (end ‘24)	
	In-country operational cost	Low incremental delivery cost as one dose at same visit with DTP3	
	Procurement cost per event averted[2]	High procurement cost per death averted; strategy contributes to eradication	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per future death averted

Rabies Phase I Scorecard

Modelled scenario: supplement current country provision of post-exposure prophylaxis vaccines

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~36,000 future deaths averted, 2015 – 2030	
		~600 U5 future deaths averted per 100K vaccinated population	
	Impact on overall mortality	~210,000 total future deaths averted, 2015 – 2030	
		~3500 future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	~210,000 Total future cases averted, 2015 – 2030	
		~3500 future cases averted per 100K vaccinated population	
		No long term sequelae; rabies is 100% fatal	
Additional impact conside-rations	Epidemic potential	No epidemic potential	
	Global or regional public health priority	Elimination goals in Latin America and Asia	
	Herd immunity	No herd immunity	
	Availability of alternative interventions	Cost-effective prevention can be achieved through mass dog vaccination	
	Socio-economic inequity	Worse outcomes for low income / isolated populations due to limited access to treatment	
	Gender inequity	Disproportionately impacts boys	
	Disease of regional importance	Rabies prevalent across most GAVI countries	
Imple-mentation feasibility	Capacity and supplier base	11+ manufacturers, significant supply available to meet global demand	
	GAVI market shaping potential	GAVI market would be less than 10% of global market	
	Ease of supply chain integration	Packed volume for intradermal administration between 3 and 12 cc / dose	
	Ease of programmatic integration	Not aligned with other schedules; change in health worker practices required for intradermal administration	
	Vaccine efficacy and safety	~100% efficacy; some evidence of causal link to serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$75M total procurement cost to GAVI and countries, 2015 - 2030	
	In-country operational cost	Low incremental burden: 4 visits (reactive vaccination), no campaign required	
	Procurement cost per event averted[2]	~$350 per future death averted, ~$350 per future case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per future death averted

Yellow Fever Phase I Scorecard

Modelled scenario: campaigns in endemic countries targeting high risk populations (as defined by WHO)

Category	VIS Criteria	Phase I Indicator	Phase I Evaluation
Health impact	Impact on child mortality	~730 U5 future deaths averted, 2015 – 2030	
		~1 U5 future death averted per 100K vaccinated population	
	Impact on overall mortality	~77,000 total future deaths averted, 2015 – 2030	
		~130 total future deaths averted per 100K vaccinated population	
	Impact on overall morbidity	~384,000 total future cases averted, 2015 – 2030	
		~640 total future cases averted per 100K vaccinated population	
		No long term sequelae	
Additional impact conside-rations	Epidemic potential	High epidemic potential; outbreaks in endemic countries	
	Global or regional public health priority	WHO Task Force on Immunisation in Africa goal on YF control and WHO strategic framework for YF	
	Herd immunity	Insufficient data on herd immunity threshold	
	Availability of alternative interventions	Vector control not effective as prevention; no treatment, only supportive care	
	Socio-economic inequity	Does not disproportionately impact the poor	
	Gender inequity	Comparable burden on men and women	
	Disease of regional importance	Burden concentrated In 34 endemic countries in Africa	
Imple-mentation feasibility	Capacity and supplier base	Can meet >75% of demand until 2016, after which capacity to meet full GAVI demand; 3+ manufacturers by 2020	
	GAVI market shaping potential	GAVI demand (by volume) represents a significant share of global demand	
	Ease of supply chain integration	Packed volume less than 3 cc per dose	
	Ease of programmatic integration	Delivered in campaigns and therefore not aligned with other schedules; no change in health worker practices/behavior required	
	Vaccine efficacy and safety	High efficacy (99%); very rare cases of serious adverse events	
Cost and value for money	Vaccine procurement cost[1]	~$64M total procurement cost to GAVI and countries, 2015 – 2030	
	In-country operational cost	Wide age range, but single dose and a one-time campaign	
	Procurement cost per event averted[2]	~$830 procurement cost per death averted; ~$170 per case averted	

1. Procurement cost includes vaccine, syringe, safety box, and freight 2. Scoring based on cost per future death averted