About the GAVI Alliance

The GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation) was launched in 2000 as a global public-private partnership to improve access to childhood vaccines in the poorest countries. The alliance brings together governments of industrialized and developing countries, the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF), the World Bank, the Bill and Melinda Gates Foundation, vaccine manufacturers, non-governmental organizations, and academic institutions.

As a global health financier, GAVI contributes to the achievement of Millennium Development Goal (MDG) 4, which aims to reduce the global under-five mortality rate by two-thirds between 1990 and 2015. GAVI’s 2011–2015 Strategy has four objectives:

- Increasing the use of new and underused vaccines (e.g., hepatitis B, pneumococcal, and rotavirus vaccines);
- Strengthening countries’ health and immunization delivery systems to improve vaccination coverage;
- Improving the predictability and sustainability of global and national financing for immunization; and
- Shaping vaccine markets to bring down the price of vaccines.

GAVI’s work is based on an innovative model. GAVI is not an implementing agency, relying instead on countries and partners to ensure that resources provided by GAVI are used to meet local needs. Program proposals are developed by the countries that GAVI supports, without involvement by the GAVI Secretariat. Proposals are then reviewed by an independent expert panel for their technical soundness and recommended to the GAVI Board for approval. GAVI also explicitly incentivizes countries to achieve results to make sure that funds are used efficiently and effectively.

In raising the resources to finance immunization programs, GAVI uses innovative financing mechanisms, such as the International Finance Facility for Immunisation (IFFIm), in addition to traditional donor contributions. Leveraging funding through these mechanisms has made it possible to introduce vaccines protecting against diseases that cause large numbers of deaths (e.g., hepatitis B and pneumococcal disease).

Resource Mobilization

In June 2011, GAVI held its first pledging conference in London, where donors committed US$4.3 billion for 2011–2015. Before the introduction of a formal replenishment process, all donor contributions were made on an ad hoc basis. At the London conference, donors agreed to hold a mid-term accountability review meeting in 2013. At this meeting, a plan for GAVI’s second replenishment cycle for 2015 and beyond will be established.

GAVI receives direct funding from governments and private sources and mobilizes additional financing for immunization through new and innovative financing mechanisms.

Direct contributions: As of June 2011, GAVI had attracted US$8.3 billion in direct funding from public and private donors (for the period 2000–2015). Five donors account for 83% of the total direct contributions to GAVI (see Top 5 donors to GAVI below). The Bill and Melinda Gates Foundation is the donor with the largest direct commitments to date (US$2.5 billion), followed by the governments of the United Kingdom (US$1.7 billion), Norway (US$1.2 billion), the United States (US$1.1 billion), and the Netherlands (US$391 million).
Innovative financing mechanisms: GAVI uses two innovative mechanisms to leverage additional funding for immunization, IFFIm, and Advanced Market Commitments (AMCs).

The International Finance Facility for Immunisation (IFFIm)
IFFIm was created to frontload funding for immunization: it converts long-term and legally binding donor pledges into immediately available resources for GAVI programs by issuing bonds in the capital markets. The donor pledges are used to repay the IFFIm bonds and to pay for the bond interest. Ten donors have pledged a total of US$6.1 billion to IFFIm over the next twenty years, up until 2031 (see Contributions of IFFIM donors below).

Contributions of IFFIm donors (as of June 2011)

<table>
<thead>
<tr>
<th>Country</th>
<th>Contributions in US$ millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>2,660</td>
</tr>
<tr>
<td>France</td>
<td>1,733</td>
</tr>
<tr>
<td>Italy</td>
<td>1,733</td>
</tr>
<tr>
<td>Norway</td>
<td>690</td>
</tr>
<tr>
<td>Spain</td>
<td>293</td>
</tr>
<tr>
<td>Japan</td>
<td>259</td>
</tr>
<tr>
<td>Australia</td>
<td>257</td>
</tr>
<tr>
<td>Netherlands</td>
<td>113</td>
</tr>
<tr>
<td>Sweden</td>
<td>41</td>
</tr>
<tr>
<td>South Africa</td>
<td>19</td>
</tr>
<tr>
<td>Brazil</td>
<td>19</td>
</tr>
<tr>
<td>UK</td>
<td>19</td>
</tr>
</tbody>
</table>

Total=US$1.6 billion

Source: GAVI data on donor contributions and pledges (accessed 7 December, 2011)

GAVI estimates that IFFIm pledges will generate a total of US$4.3 billion for GAVI programs in the 2006–2031 time frame. The difference between this amount and the donor pledges of US$6.1 billion is explained by the bond interest, the administration costs, and the “time value” of money (i.e., a dollar in hand today is worth more than a dollar promised in the future, because of the accruable interest). Between 2006 and 2010, IFFIm proceeds for GAVI programs totaled US$1.9 billion. An additional US$1.5 billion will be made available for GAVI programs between 2011 and 2015 through IFFIm, and another $1.0 billion for the 2016–2031 timeframe. This fall in IFFIm proceeds is because of the front-loaded nature of IFFIm.

Advanced Market Commitment (AMC)
In 2009, GAVI also piloted an AMC, an innovative financing mechanism to accelerate access to vaccines against pneumococcal disease.

The governments of Italy, the UK, Canada, the Russian Federation, Norway, and the Gates Foundation committed US$1.5 billion to guarantee purchases of pneumococcal vaccines (see Contributions of AMC donors below). In turn, vaccine manufacturers committed to supplying their vaccines at a price no higher than US$3.50 per dose for 10 years to be paid by GAVI and the developing countries that introduce the vaccines. For about 20% of supplied doses, manufacturers receive an additional payment of US$3.50 per dose, which is paid out of the US$1.5 billion of donor commitments.

GAVI expects that the AMC will incentivize more manufacturers to produce the pneumococcal vaccine and that the heightened competition will drive down the vaccine’s price. In addition to AMC donor funds, GAVI mobilized a corresponding amount of funding for the roll-out of pneumococcal vaccines (US$1.3 billion for the period 2010–2015).

Contributions of AMC donors (as of June 2011)

<table>
<thead>
<tr>
<th>Country</th>
<th>Contributions in US$ millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>635</td>
</tr>
<tr>
<td>UK</td>
<td>485</td>
</tr>
<tr>
<td>Canada</td>
<td>200</td>
</tr>
<tr>
<td>Russia</td>
<td>80</td>
</tr>
<tr>
<td>Gates Foundation</td>
<td>50</td>
</tr>
<tr>
<td>Norway</td>
<td>50</td>
</tr>
</tbody>
</table>

Total: US$1.5 billion

Source: GAVI data on donor contributions and pledges (accessed November 7, 2011)
GAVI also aims to increase domestic resources for immunization. Since 2008, GAVI has required countries to co-finance the costs of GAVI-supported vaccines when they (a) introduce new, GAVI-funded vaccines, or (b) apply to receive support for new vaccines beyond the initial five years of GAVI support.

By the end of 2010, 53 countries co-financed their vaccines. The co-financing levels vary according to country income, i.e., according to their ability to self-finance vaccines. At its November 2010 meeting, the GAVI Alliance Board revised the co-financing policy (the categories that determine co-financing levels have been revised). The policy will become effective in 2012. In 2010, annual co-payments totaled US$28 million, representing 10% of total GAVI vaccine support to the 53 co-financing countries. GAVI expects that annual co-financing commitments will more than triple to a total of US$100 million by 2015.

Financing Portfolio
GAVI provides different types of support to developing countries with the aim of increasing their immunization coverage (see Types of GAVI support below).

Types of GAVI support

New and underused vaccines support (NVS) is provided as in-kind support, i.e., vaccines and other commodities, such as equipment, are provided to countries free of charge. NVS includes vaccines against the hepatitis B vaccine, Haemophilus influenzae type b (Hib) vaccine, measles vaccine (second dose), pneumococcal vaccine, rotavirus vaccine, and yellow fever vaccine.

GAVI has also funded the introduction of the meningitis A vaccine in six countries and plans to support all 25 countries that are part of the “meningitis belt” in the 2011–2015 period. It also provided funding for operational support for the introduction of this vaccine.

In November 2011, GAVI’s Board decided to open a funding window for rubella vaccines in 2012. Provided that certain conditions are met (e.g., acceptable price commitments from industry are secured), a new window for the human papillomavirus (HPV) vaccine will also be created (HPV causes cervical and other cancers). In the past, countries were eligible for NVS when their routine immunization coverage (DTP3) had reached 50% (except for meningitis A and yellow fever vaccines). For 2012 and beyond, the threshold has been raised to 70% DTP coverage.

Countries awarded support for hepatitis B, Hib, and yellow fever vaccines can request vaccine introduction grants—a one-time cash grant of US$100,000. All GAVI eligible countries can request injection safety support (INS), which covers auto-disable syringes, reconstitution syringes, and safety boxes. INS is usually provided as in-kind support.

Cash-based support for strengthening the capacity of health systems to deliver immunization: At the December 2011 Board meeting, GAVI’s Board decided to integrate its cash-based support into a single, performance-based financing window in 2012:

• Health system strengthening (HSS): GAVI’s HSS support aims to strengthen the capacity of health systems to deliver immunization. It was anticipated that GAVI’s future HSS funding would be provided as part of the Health Systems Funding Platform, which GAVI jointly developed with the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the World Health Organization. Despite the Global Fund’s suspension of its participation in the platform in November 2011 due to resource constraints, GAVI remains committed to the Platform’s policies and principles.

• Immunisation services support (ISS) has provided results-based funding for the strengthening of immunization systems to increase coverage of basic vaccines (DTP). ISS is currently being phased out (ISS applications are no longer accepted, and current ISS programs cannot be extended). Instead, a new performance-based funding approach, known as “incentives for routine immunisation strengthening” (IRIS), will be integrated into GAVI’s future funding of HSS above.

• Civil society organization (CSO) support: GAVI’s CSO support aims to involve CSOs in the planning and delivery of immunization services, and to encourage cooperation and coordination between the public sector and civil society. The CSO support is currently being evaluated and recommendations will be brought to GAVI’s Policy and Programme Committee (PPC) in May 2012.

Source: GAVI documentation on types of support
Only those countries with a gross national income (GNI) below a certain threshold are eligible for support. This threshold has recently changed:

Overall eligibility: When GAVI was launched in 2000, the threshold was initially set at an annual GNI per capita of up to US$1,000 (based on 1998 World Bank data). At this threshold, 75 countries were eligible for overall GAVI support. In 2006, GAVI updated the list of eligible countries (based on 2003 country income figures), and the number of eligible countries decreased to 72.

In 2009, GAVI’s Board decided that from 2011 the threshold should be raised to US$1,500 (annual GNI per capita), an amount that is roughly equivalent to US$1,000 in 2000, the year that the US$1,000 threshold was introduced. The Board also decided that the threshold should be adjusted for inflation. Adjusted for inflation, the current threshold for GAVI support is US$1,520 (as of December 2011). As several countries have experienced economic growth, a total of 57 countries are now eligible for GAVI support (35 are low-income and 21 are lower middle-income countries; South Sudan has not yet been classified by the World Bank).

Graduation: GAVI designed a graduation policy for those countries that are no longer eligible for support. While these countries can no longer submit new applications, GAVI will continue to finance those multi-year plans for immunization that have already been approved.

Eligibility for new vaccines: GAVI-eligible countries are also able to access support for new vaccines. Only those countries that have reached a certain threshold in their coverage with routine immunization (three-dose diphtheria, tetanus, and pertussis vaccination [DTP3]) are eligible. When GAVI launched, the threshold was 50%, but in 2009 the GAVI Board decided that from 2011 the threshold should be raised to 70%.

Breakdown of Commitments by Type of Support
As of September 2011, GAVI had committed US$7.2 billion to over 70 countries up until 2015. Of this amount, GAVI committed US$6.1 billion (84%) to new and underused vaccines (see Commitments by type of support at the top right of this page).

Breakdown of Disbursements by Type of Support
Between 2000 and March 2011, GAVI disbursed a total of US$3.2 billion to 75 countries (see Total annual disbursements at bottom right of this page).
Of these disbursements, new and underused vaccines support (NVS) disbursements totaled US$2.4 billion, or three quarters of all GAVI disbursements:

- 71.6% of all NVS disbursements was spent on the pentavalent vaccine, combining vaccines against hepatitis B, Hib, and DTP
- 6.8% was spent on the monovalent hepatitis B vaccine
- 6.6% was spent on the DTP-hepatitis B vaccine (the “tetravalent vaccine”)
- 3.2% was spent on yellow fever vaccines
- 9.1% was spent on the pneumococcal vaccine
- the remainder (1.9%) was spent on five vaccines (rotavirus, Hib, measles, DTP-Hib, and meningitis A).

In addition to NVS, GAVI disbursed US$347.4 million for health system strengthening (HSS), US$298.2 million for immunization services support (ISS), US$107.8 million for injection safety support (INS), US$24.8 million for vaccine introduction grants, US$15.1 million for civil society organization (CSO) support, and US$5.6 million for operational support for the introduction of the meningitis A vaccine (see Disbursements by type of support below).

About 62.8% of all disbursed funding (US$2.0 billion out of US$3.2 billion) is allocated to WHO’s African Region (see Disbursements by region below).

**Disbursements by region**
(distribution of disbursements as of September 2011)

- 62.8%
- 17.2%
- 11.9%
- 4.9%
- 1.9%
- 1.3%

**Breakdown by Recipient Country**

About half (52.6%) of total disbursements (US$1.78 billion out of US$3.2 billion) was channeled to 10 out of 75 countries that received GAVI support between 2000 and September 2011 (see Top 10 recipients on the next page, top left).
Organizational Structure and Governance

GAVI relies on an innovative partnership model that brings together a range of public and private stakeholders. At the global level, the GAVI Alliance Board represents a variety of stakeholders, including governments, multilaterals, foundations, the vaccine industry, civil society, and academia. Such partnerships are also important at country level. GAVI has a lean organizational model without any country offices, and so program implementation at country level relies on effective in-country partnerships.

Global Level Structures and Governance

When GAVI was launched in 2000, it had two boards: the Board of the “Global Alliance for Vaccines and Immunisation” and the GAVI Fund Board, which served as a fiduciary agent for the alliance. Based on a merger of these two Boards, the new GAVI Alliance Board officially took up its work in October 2008. The Alliance Board is responsible for GAVI’s overall governance, including establishing strategies and policies, making funding decisions, and setting budgets. It meets twice a year, usually in June and November.

The Alliance Board is composed of representatives from donor and recipient governments, the Bill and Melinda Gates Foundation, multilateral organizations, vaccine manufacturers, civil society, and academia. Key GAVI partner institutions and stakeholders (“Representative Board members”) hold 18 seats. In addition, the Board includes nine individuals with no professional connection to GAVI’s work (“Unaffiliated Board members”), who provide independent scrutiny and who also bring to the Board their private sector and financial expertise. GAVI’s Chief Executive Officer (CEO) is an ex-officio non-voting Board Member. UNICEF, WHO, the World Bank, and the Gates Foundation hold permanent seats on the Board (see GAVI Alliance Board membership below).

GAVI Alliance Board membership

<table>
<thead>
<tr>
<th>27 voting members</th>
<th>1 non-voting member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Representative Board members</strong> (18 seats)</td>
<td><strong>Unaffiliated Board members</strong> (9 seats)</td>
</tr>
<tr>
<td>• Bill &amp; Melinda Gates Foundation*</td>
<td>• Independent individuals</td>
</tr>
<tr>
<td>• World Health Organization (WHO)*</td>
<td></td>
</tr>
<tr>
<td>• UNICEF*</td>
<td></td>
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<tr>
<td>• World Bank*</td>
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<tr>
<td>• Donor governments (5)</td>
<td></td>
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<tr>
<td>• Developing country governments (5)</td>
<td></td>
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<tr>
<td>• Vaccine industry—industrialized countries</td>
<td></td>
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<tr>
<td>• Vaccine industry—developing countries</td>
<td></td>
</tr>
<tr>
<td>• Research and technical health institutes</td>
<td></td>
</tr>
<tr>
<td>• Civil society organizations</td>
<td></td>
</tr>
</tbody>
</table>

*Permanent Board members

Source: Own calculation based on GAVI data (accessed 7 December, 2011)
The Board aims to make its decisions by consensus. If no consensus can be reached, any decision of the Board requires a two-thirds majority.

GAVI’s Alliance Board relies on six committees to support the development of policies and strategies, and to oversee specific work areas:

- Executive Committee
- Program and Policy Committee
- Governance Committee
- Investment Committee
- Audit and Finance Committee
- Evaluation and Advisory Committee.

Committee members are usually Board members, Board alternates (i.e., substitutes for Board members), or delegates with special expertise relevant to that particular committee’s work.

The GAVI Secretariat has two offices. One office is in Geneva and is staffed with 120 people; a second office, with about 30 staff members, is located in Washington, DC. The Secretariat is led by GAVI’s CEO Seth Berkley.

The Secretariat is made up of seven teams and manages GAVI’s day-to-day operations. It is tasked with:

- executing Board policies;
- providing strategic, policy, financial, legal, and administrative support;
- coordinating program approval and disbursements;
- overseeing monitoring and evaluation; and
- mobilizing financial resources.

In 2010, the secretariat had an annual operating budget of about US$55 million.

GAVI’s Independent Review Committee (IRC) reviews proposals and annual progress reports based on technical criteria and provides funding recommendations to the GAVI Alliance Board. The IRC is a system of peer review undertaken by a committee of technical experts, involving a desk-based assessment of funding applications for the different types of GAVI support and progress reports submitted by countries to GAVI. The IRC consists of three different teams that convene separately in Geneva, at different times of the year:

- one team focuses on applications for new and underused vaccines support, incentives for routine immunization strengthening, and injection safety support;
- a second team reviews applications for health system strengthening and civil society organisation support; and
- a third team, the IRC monitoring team, reviews annual progress reports.

Key GAVI partners are WHO and UNICEF. WHO’s Department of Immunisation, Vaccines and Biologicals develops technical standards to ensure the quality and safety of vaccines, and provides technical guidance to GAVI. UNICEF’s supply division in Copenhagen procures vaccines and safe injection materials for GAVI countries.

Through their country offices, both WHO and UNICEF also play a key role in supporting countries in their application for GAVI support, and subsequent implementation and monitoring of immunization programs. Both are directly funded through GAVI’s business plan (2011–2015). In 2010, WHO received US$50 million and UNICEF US$17 million for their services.

**Governance of the International Finance Facility for Immunisation**

IFFIm has its own separate governance structure. Two entities were created to make IFFIm operational: the GAVI Fund Affiliate (GFA) and the IFFIm Company. These two entities are incorporated under UK charities law, and are managed through two independent boards that receive administrative support from the GAVI Secretariat.

The GFA’s responsibility is to enter into pledge agreements with IFFIm donors and to assign pledges to the IFFIm Company. It also makes funding requests on behalf of the GAVI Alliance Board to the IFFIm Company Board. The IFFIm Company oversees bond issuances and other securities, and engages in donor and investor outreach activities. It also reviews and approves funding requests, submitted by the GFA. The World Bank acts as treasury manager and financial advisor for IFFIm.

**Country Level Structures and Governance**

At the country level, Interagency Coordination Committees (ICCs) bring together the expertise of in-country partners (e.g., government agencies, multilateral agencies, and civil society organizations) to make immunization programs work. Together with the government, ICC members support the design of proposals for immunization programs and oversee program implementation.

All funding requests and progress reports to GAVI, with the exception of those relating to health system strengthening (HSS), need to be signed by the country’s ICC. Proposals and progress reports for HSS must be endorsed by the country’s Health Sector Coordinating Committees (HSCCs). ICCs and HSCCs are key mechanisms for monitoring the appropriate use of GAVI funding at the country level.

Country governments—particularly their ministries of health—play a crucial role in GAVI-related processes, deciding whether a country applies for GAVI support and for what type of support. Governments also receive GAVI funds to implement immunization and HSS programs and are responsible for the deliv-
Funding Process

GAVI has two distinct funding processes—one process supports new vaccines and safe injections, the other is its cash-based support.

New Vaccines Support

Program Design and Review

Countries that want to apply for GAVI support for new and under-used vaccines have to prove that they have an adequate platform in place for the distribution of these vaccines. GAVI considers such a platform necessary to ensure the efficient and broad roll-out of new vaccines. GAVI uses the coverage level of routine vaccination (three-dose diphtheria, tetanus, and pertussis vaccination [DTP3]) as a proxy measure to determine the quality of countries’ immunization systems. From 2012 onwards, countries must reach routine vaccination coverage of 70% to be eligible for new vaccine support (up until 2011, the threshold was 50% DTP3 coverage).

Funding applications are submitted by eligible countries’ governments, usually by the health ministry, to the GAVI Secretariat. GAVI strongly encourages governments to prepare their proposals in collaboration with in-country partners who are members of the ICC. Applications must be signed by the ICC.

For NVS and INS, countries must submit a comprehensive Multi-Year Plan (cMYP) for immunization along with GAVI’s standard proposal form. Multi-year plans are a key planning and management tool for national immunization programs; they include coverage targets (e.g., for hepatitis B vaccination) that countries aim to achieve and a plan for achieving those targets.

Country proposals are reviewed and approved in funding “Rounds” – typically GAVI launches one Round per year. Each proposal is pre-assessed by a WHO expert group, which looks at the consistency and validity of the data. The IRC then assesses the technical quality of each proposal and makes a funding recommendation to the GAVI Alliance Board.

The IRC process was evaluated in 2010. The evaluation found that the IRC model should be preserved but that a number of policy, management, and operational changes are required to make it more effective (e.g., IRC reviewers are currently not allowed to consult with countries).

Once a proposal is approved by the Board, funding requests are forwarded to the GAVI Fund Executive Committee, which gives its approval for disbursement of funds or commodities. GAVI support is usually provided for the duration of the cMYP (usually 4–5 years), except for HSS funding, where the duration is determined by the national health plan. While GAVI support is usually provided on an annual basis, countries receive an estimate of the total amount of multi-year GAVI financial support when their funding proposal is approved. This multi-year amount might be adjusted depending on program performance (see below).

For countries receiving vaccines and/or safe injection supplies, the funding goes directly to UNICEF’s Supply Division to procure the needed items. UNICEF is then responsible for arranging delivery with the country.

Program Implementation and Management

Countries are required to submit annual progress reports, giving national level immunization data based on a standardized vaccination reporting questionnaire (the Joint Reporting Form [JRF], developed by WHO and UNICEF). Since countries already report much of the information requested by GAVI to WHO and UNICEF (i.e., in the JRF), GAVI’s reporting requirements are considered to be minimal and less burdensome compared with those of other donors (e.g., the Global Fund to Fight AIDS, Tuberculosis and Malaria [Global Fund]).

The submission of a satisfactory progress report is a condition for receiving ongoing support. This progress report is pre-assessed by a WHO team and then reviewed by the IRC monitoring team. Part of this review is an assessment of financial and programmatic performance. The IRC measures progress against the country-proposed targets that countries have outlined in their cMYPs or in their national health plans. If countries miss their targets, the coverage targets for the subsequent years are downgraded and the specific vaccines that GAVI provides to countries are adjusted accordingly.

Cash Support for Strengthening Health System Capacity to Deliver Immunization

At its November 2011 meeting, the GAVI Alliance Board decided that GAVI’s cash-based support should be integrated into a single, performance-based funding window and should be delivered through the Health Systems Funding Platform (“the Platform”) to improve immunization outcomes. The Platform was jointly set up by GAVI, the Global Fund, and the World Bank, and facilitated by WHO.

To operationalize the Platform, GAVI and the Global Fund released a joint proposal form in 2011 for accessing HSS support from either GAVI or the Global Fund alone, or for a joint HSS funding request to both funders. While GAVI was already using this form in 2011, the Global Fund Board has suspended the integration of Platform procedures into its financing model until at least 2014. Countries will still be able to use the proposal
Form to access cash-based support from GAVI, and can request cash-based support as soon as their existing GAVI cash support elapses on a rolling basis.

Countries will also have the opportunity to access funding through their national health strategies and plans. A key requirement is that strategies/plans include clear linkages to improvements in immunization coverage and equity.

Operational guidelines for the implementation of GAVI’s cash-based support are not yet publicly available, but as shown by GAVI’s CEO in a Board presentation, cash-based support will be split into two different types of payments: fixed and performance. The percentage of funds provided as fixed payments depends on DTP3 coverage at baseline. Countries with lower coverage will receive a higher share of fixed funds, and countries with higher coverage will receive a lower percentage of fixed funds.

For cash-based support—as opposed to vaccine support—the maximum amount of funding that a country can receive is determined by the size of the country’s birth cohort and the country’s income per capita.

**Results**

GAVI has significantly expanded access to childhood vaccination worldwide (see GAVI’s support for vaccine introduction below).

The World Health Organization (WHO) estimates that by the end of 2010, 326 million additional children had been immunized against life-threatening diseases with GAVI support (the numbers below do not add up to 326 million because of the provision of combination vaccines that immunize one child against many diseases):

- 296 million children were immunized against hepatitis;
- 124 million children were immunized against Haemophilus influenzae type b (Hib); and
- 42 million children were immunized against yellow fever.

Immunization coverage has climbed steadily in the last decade:

- Coverage levels for the hepatitis B vaccine in the 76 countries that received support from GAVI since 2000 increased from 17% in 2000 to 65% in 2009 (see Immunization coverage in 76 GAVI-supported countries on page 10, top left.).
- In the same time frame, coverage with the Hib vaccine was scaled up from 1% to 27% in countries supported by GAVI.
- For routine immunization, GAVI countries reached an average DTP3 coverage of 78% in 2009, up from 66% in 2000. However, the growth in average DTP3 coverage has slowed in GAVI countries as countries are approaching high routine immunization coverage levels. Such growth slowed from an annual average increase of 3% between 2002 and 2005 to an average annual increase of just 1% between 2005 and 2009.
- WHO projects that from 2000–2010, GAVI-funded vaccines had averted over 5.5 million future deaths (see Projected future deaths averted through GAVI support on page 10, top right). GAVI support to routine vaccine programs had prevented 4 million future deaths caused by hepatitis B alone.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>GAVI support</th>
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<tbody>
<tr>
<td>Hepatitis B</td>
<td>Supported all 68 countries that qualify for hepatitis B vaccine to introduce it into their routine immunization programs</td>
</tr>
<tr>
<td>Hib</td>
<td>Supported 65 out of 67 currently qualifying countries to introduce Hib vaccines, usually in combination with diphtheria, tetanus, and pertussis vaccination [DTP] and hepatitis B vaccines in the ‘pentavalent’ vaccine</td>
</tr>
<tr>
<td>Yellow fever</td>
<td>Supported 17 out of 21 countries that qualify for the vaccine to introduce routine yellow fever immunization</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>37 of 71 qualifying countries have been approved for vaccine support</td>
</tr>
<tr>
<td>Meningococcal A</td>
<td>All 7 qualifying countries have been approved for vaccine support</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>21 of 71 qualifying countries have been approved for vaccine support</td>
</tr>
</tbody>
</table>

Source: GAVI documentation on results and evidence
**Market Shaping**

One of GAVI’s strategic objectives, outlined in GAVI’s 2011–2015 Strategy, is to create a competitive and sustainable vaccine market. GAVI aims to bring down the price of vaccines by bringing new vaccine manufacturers to the market and thus increasing competition between them.

The results of GAVI’s efforts to shape markets have been mixed. For the pentavalent vaccine, GAVI’s largest investment area, there was only one manufacturer up until 2006 and the price remained relatively stable at about US$3.60 per dose. In 2007, one additional pentavalent vaccine manufacturer came to the market, and in 2008, the number of manufacturers rose to four. Between 2007 and 2010, the price of the pentavalent vaccine fell by 18%, from US$3.62 to US$2.96 per dose. In 2011, GAVI is projected to pay US$ 2.58 per dose of the combination pentavalent vaccine. However, $2.58 is still too high for developing countries to self-finance this vaccine.

The price for the DTP-HepB vaccine increased from US$1.11 in 2001 to US$1.26 in 2006, before dropping by 44% to US$0.71 in 2009.

**Outlook**

For the period 2011–2015, donors pledged US$4.3 billion at GAVI’s first pledging conference in London in June 2011. While this is a very significant amount, GAVI needs to intensify its fundraising work to ensure continued investments for immunization. Every year, 1.7 million children worldwide still die from vaccine-preventable diseases. Of the 130 million children born in 2010, an estimated 19.3 million children were not fully vaccinated (80% of these children were living in GAVI-supported countries).

With respect to effective vaccine delivery, GAVI’s Phase 2 evaluation recommended that the GAVI Secretariat’s country support and monitoring role should be strengthened. In a similar vein, the evaluation of GAVI’s health system strengthening (HSS) window suggested that GAVI lacks secretarial capacity for effectively managing and overseeing HSS grants. In a bid to improve vaccine delivery, GAVI has recently restructured the Secretariat’s Programme Delivery department (it is now called the...
Country Programmes department). GAVI is also in the process of strengthening its secretarial capacity for country programs, employing new staff members, including for HSS. Strengthening Secretariat capacity is also key for rolling out new vaccines (e.g., human papillomavirus vaccine).

Since effectively providing vaccine services requires strong health and immunization systems, it will be important for GAVI to provide its cash-based support in a manner that is more likely to take country contexts into account. While it used a “one size fits all” approach in the past, GAVI has announced that it will move towards a customized approach for fragile and underperforming countries. While especially fragile, conflict-affected countries suffer from very low immunization coverage, GAVI also needs to intensify its support for lower middle-income countries, in which the largest number of the world’s unvaccinated children lives. Of the 19.3 million children that were not fully vaccinated in 2010, almost half lived in India and Nigeria.

It will also be important for GAVI to achieve more progress towards its fourth strategic goal, the shaping of vaccine markets to bring down vaccine prices. While GAVI has helped to reduce vaccine prices, it has not yet contributed to a fall in vaccine prices that would be large enough to have major implications for country affordability and sustainability. Without more significant price reductions, most countries will remain dependent on GAVI support for many years.

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