



Report to the GAVI Alliance Board

21-22 November 2013

Subject:	GAVI Alliance strategy 2016-2020
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Category:	For Decision
Strategic goal:	Affects all strategic goals

Section A: Overview

1 Purpose of the report

- 1.1 Adopted in 2010, the current GAVI Alliance strategy covers the period 2011-15. In April 2013, GAVI initiated a process to design its 2016-20 strategy. The timing of the process intends to ensure that a new strategy is in place for the upcoming replenishment cycle. With the replenishment meeting planned for Q4 2014 or early 2015, the GAVI Board would need to adopt its new strategy in June 2014. As with the previous strategy – and at the behest of the Board and donors – GAVI is setting ambitious goals for its next phase and will then fundraise to match that ambition.
- 1.2 The proposed strategic shifts presented in this paper were generated through a systematic process of interviews and consultations and a landscape analysis. At each phase, responses were analysed to determine where there was consensus and where there were diverging views (see myGAVI for a summary of process).
- 1.3 Of note, some of the decisions that will be taken during this Board meeting will have potential implications on the new strategy. These include in particular the decision on new vaccines presented in the Vaccine Investment strategy (see Doc 08), on polio and routine immunisation (see Doc 13), and on GAVI's engagement with graduating countries (see Doc 14).

2 Executive summary

- 2.1 **The context:** The GAVI Alliance was launched at the World Economic Forum in 2000 - the same year that the Millennium Development Goals (MDGs) were agreed. Its aim was to ensure that children in the poorest countries had equitable access to new and underused lifesaving vaccines,

preventing unnecessary mortality and ensuring children had a healthy start in life. GAVI was created as a public-private partnership, with a mission articulated at the time as “to save children’s lives and protect people’s health through the widespread use of safe vaccines, with a particular focus on the needs of developing countries

- 2.2 Since then, GAVI has gone through three strategic phases with a significant expansion of the number of vaccines supported and an acceleration in the size of its programmes and therefore its impact. GAVI is currently in its third phase which covers the period 2011-2015. Since its creation, the Alliance has contributed to reducing under 5 mortality, which is the focus of MDG 4. With the adoption of HPV and MR vaccines, it is expected that GAVI will increasingly contribute to women’s health and wellbeing.
- 2.3 The mission of GAVI as articulated under the GAVI Alliance Strategy 2011-2015 is “to save children’s lives and protect people’s health by increasing access to immunisation in poor countries”. There are four strategic goals, with associated strategic objectives, targets and a deliverables-based business plan. The goals are increasing access to and use of vaccines, strengthening health systems to deliver immunisation, increasing financial sustainability through country and donor contributions, and shaping vaccine markets (see annex A).
- 2.4 The current strategy period is characterized by an exponential scale up of vaccine introductions – in particular rotavirus and pneumococcal - as well a shift in emphasis from broad health systems strengthening to more focused investments to improve immunisation outcomes, as well as an increased focus on market shaping. In this strategy period alone, GAVI expects to have contributed to an unprecedented public health impact including the immunization of an additional 243 million children and prevention of more than 3.9 million future deaths. This has been enabled, in particular, through the participation of donors, implementing countries, and industry. Implementing countries have dramatically increased their contribution to immunisation through GAVI co-financing, prices for the three biggest cost drivers of GAVI vaccine programmes have fallen by over 34%, and donors pledged an unprecedented \$US7.4 billion to GAVI during a replenishment conference held in June 2011.
- 2.5 GAVI has also built new partnerships and synergies in global health (such as those with the Measles Rubella Initiative and the Global Polio Eradication Initiative) and has been at the forefront of tapping the private market through innovative finance mechanisms, including further fundraising through the IFFIm, the implementation of the pilot Advance Market Commitment for Pneumococcal Disease, and a new Matching Fund, focused on attracting private sector financing.
- 2.6 With the expansion in its vaccine portfolio, GAVI has moved past “new vaccines” and is now focused more holistically on all aspects of immunisation, including an integrated approach to routine immunisation and campaigns and the health systems needed to deliver them. It has

strengthened its focus on women's and girls' health through the introduction of the HPV and rubella vaccines (as MR). GAVI has also bridged the divide between infectious diseases and non-communicable diseases (NCDs) through support for two cancer preventing vaccines (Hepatitis B and HPV).

2.7 During this period, GAVI has also faced critical challenges related to strengthening routine immunisation, sustaining and improving high coverage and ensuring equitable in-country access to immunisation for everybody, no matter who they are or where they live. Currently, health systems barriers can often prevent programmes from reaching scale, and need significant strengthening and modernising. Challenges on both the supply and demand side affect vaccine availability and use. Supply chains in many places are weak and data quality can be poor, making it difficult to programme efficiently and to ensure timely and appropriate decisions. Further, political instability and civil unrest hamper progress and sustainability in fragile states and require customised approaches. At the GAVI Alliance Mid-Term Review on 30 October, participants identified all of these areas as important. They also called for even more ambition in further exploring innovative solutions and approaches to these challenges.

2.8 It is these experiences that are contributing to the design of the new GAVI "4.0" strategy.

2.9 **GAVI environment 2016-2020**

(a) The global landscape in the 2016-2020 period will be very different economically and demographically than it was in 2000 when GAVI was created but also than it was in 2010, when the current strategy was developed.

(b) There have been major shifts not only in advanced economies but also in the countries that have historically been recipients of aid, many of which now have fast growing economies. Geopolitically the donor/recipient division is blurring and there is a much stronger expectation that so-called "recipient countries" will assume increasing financial responsibility for their own essential social infrastructure. There is also an expectation that the private sector will play a stronger role not only in financial support but also in service provision.

(c) As part of this economic shift, fewer people live in extreme poverty. However, most poor people now live in countries that are classified as middle income many of which contain deep pockets of poverty.

(d) Demographically, there have also been shifts, including significant progress in reducing child mortality, partly due to increased rates of immunisation. However, the number of unimmunised children globally will only have dropped from 22 million in 2010 to an estimated 20 million by 2016.

- (e) Another major contextual consideration for the GAVI Alliance in this period will be the post-2015 global development agenda and where the GAVI Alliance positions itself on that agenda. Although not yet finalised, current discussions arising from the report of the High Level Panel (HLP) of Eminent Persons on the Post 2015 Development Agenda indicate that the focus is likely to be on ending extreme poverty in the context of sustainable development. The HLP report stated that the current MDGs have not focused enough on reaching the very poorest and most excluded people, whom - it points out - are disproportionately women. Health is likely to remain an important part of the agenda, but may be less central than under the current MDGs. It might increasingly be seen as a necessary enabler for sustainable and economic development and inclusive growth, rather than as an end in itself. The HLP report has suggested as an illustrative goal “Ensuring Healthy Lives”, with four possible targets that include ending preventable infant and under-5 deaths and fully immunised people.
- (f) GAVI’s mission could be placed in the broader context of the post 2015 sustainability agenda through consolidating and accelerating the progress made in 2011-2015 and by giving a higher priority to reaching every child. To that end, a much stronger focus will be needed on economic, geographic and gender equity, especially in the most fragile countries; and on institution building through the modernisation and sustainable improvement of immunisation programmes, especially for the countries that are graduating from GAVI.
- (g) By pursuing the current programmes, the GAVI Alliance would continue to have significant impact in the next strategy phase. Although changing health demographics and lifestyle will lead to an increasing importance of NCDs, the burden of infectious diseases in developing countries will still be significant in this period and vaccines will continue to be core to and part of a broader vision of preventable child deaths. In fact, as only a small percentage of children are fully immunised, any reduction in the support to immunisation from the global community runs the significant risk of failing to increase vaccine coverage and the recurrence of epidemics.
- (h) According to impact estimates, GAVI current programmes would avert an additional 5.9 million future deaths in the period 2016-2020, which is a 50% increase from the current strategy period. This increase is primarily as a result of the impact of pentavalent programmes, as well as the uptake of the pneumococcal, rotavirus, HPV and Measles Rubella vaccines.

- (i) However, there are a number of key questions to be addressed. If the eligibility and graduation policy remains unchanged, GAVI would progressively stop supporting a number of countries that concentrate a large share of the original (and world) birth cohort. By 2020 the birth cohort represented by GAVI-eligible countries will have shrunk by 54%. In addition, the countries that will graduate in the coming years concentrate the majority of unimmunised children. Specifically, Indonesia will have graduated from support in 2016; India and Nigeria are expected to start the graduation process in the upcoming years. These three countries alone hold about 56% of the world's unimmunised children.
- (j) Another important challenge relates to coverage and equity of access to immunisation. After a rapid growth following the creation of GAVI in 2000, average coverage rates have stagnated in the past 4 years, and this will remain a major challenge in the years to come. Moreover, as more countries graduate, GAVI will increasingly be focusing its resources on more fragile countries with weaker systems, further increasing the challenges to expand coverage and equity.

2.10 Proposed strategic shifts for the period 2016-2020. Based on the context described above, the GAVI Secretariat led a consultative process with Board members, Board constituencies and implementing countries, including a public web-based consultation, to generate potential strategic shifts which the Executive Committee (EC) reviewed in September. The following emerged as the suggested directions for GAVI 4.0 (for a detailed overview of each of these strategic shifts and of the options considered by the EC, see Section B).

- (a) Play a central convening role in global immunisation: As the single largest public private partnership funding routine immunisation in the developing world, GAVI could play a critical role in convening, aligning, strengthening, coordinating or funding around immunisation in the countries where it is engaged, leading to synergies, increased coverage and more effective programmes;
- (b) Deepen GAVI's focus on improving coverage and equity of access to immunisation, including through innovative investments to modernise immunisation systems: Levels of coverage and equity, as well as the quality of data to measure them, will likely remain major challenges for GAVI countries in 2016 and beyond. In addition, many of the countries remaining eligible in the next strategy period will have relatively weaker health systems than the original set of countries in which GAVI invested. Examples of potential areas of investment raised included: modernisation of information systems (data visualisation tools, vital registration, bar coding, interoperability); modernisation of supply chain infrastructure (including but not limited to cold chain equipment); higher focus on demand-side interventions, including community-based approaches, CSO collaborations and potentially contribution of core business skills by the private sector;

- (c) Review the eligibility and graduation criteria and the forms of support offered to graduating countries, to ensure sustainable graduation from GAVI support. Most consultations highlighted the critical importance of sustainability to GAVI's model, evidenced by the graduation policy and successful co-financing to date. GAVI's approach to sustainability was identified as a core element of the model, which should remain in the next GAVI strategy. However while the current mechanism enables most GAVI countries to graduate with strong immunisation services and continuous investments in immunisation, there are notable exceptions. In fact some countries with growing economies, largely due to the export of national resources, have weak health systems and weak immunisation programmes, but will graduate from GAVI support. The Executive Committee recommended exploring criteria for eligibility and graduation beyond GNI, with a view to ensuring "performance graduation" as well as "financial graduation". The question of co-financing differentiated by vaccines was also raised.
- (d) Continue to leverage the core strength of GAVI Alliance partners and also strengthen engagement with a wider network of institutions in order to ensure successful achievement of strategic goals and targets. GAVI's strength relies on its model as an Alliance with global partners which play a key role in defining global norms and standards and country partners which provide technical assistance. Building on this model, and considering the need to strengthen efforts in the most fragile settings, GAVI has started to engage with a wider network of institutions, including civil society, to implement its business plan. The Executive Committee recommended that GAVI continue to build on this model in the next strategy period as well as assess engagement with the private sector to date, including the role it could play not only in financing but also in implementation.
- 2.11 While recognising the importance of integrating immunisation and other health interventions, the Executive Committee did not recommend market shaping or funding life-saving commodities beyond vaccines. Instead, the Executive Committee agreed that GAVI could develop criteria or incentives for implementing countries to better integrate vaccines programmes with other interventions through its grant requirements and review processes.
- 2.12 The Executive Committee also did not recommend that GAVI engages in accelerating research and development (R&D) of new vaccines. This option had been suggested by some consultations however there were strongly divergent views. That said, the Executive Committee did give guidance that GAVI continue to invest in impact and effectiveness studies as well as operational research.
- 2.13 **Strategy framework:** In addition to the areas noted above, the consultations and subsequent guidance from the Executive Committee suggested a number of adjustments to the strategy:

- (a) **Vision.** Consultations noted the opportunity for the GAVI Alliance to adopt a vision statement to complement the mission statement. The vision would describe the world to which GAVI aspires in the long term, while the mission describes the specific contribution of the GAVI Alliance to that vision. Suggestions included “A world free from vaccine preventable diseases” and “Every child fully immunised”.
- (b) **Mission.** There was strong support during consultations and at the Executive Committee to keep the current mission’s simplicity and focus on immunisation (GAVI’s mission is “*to save children’s lives and protect people’s health by increasing access to immunisation in poor countries*”). However, some suggested that specific words could be amended. Specifically, there were strongly held views at both ends of the spectrum on whether GAVI should support “poor countries” or “poor people” noting that a growing share of the world poor live in middle income countries. On balance, most consulted noted that GAVI’s fundamental model is to work with and through country systems and, as such, the “unit of support” should remain countries. That said, there were question raised on whether and how GAVI could support large and federated countries at the sub-national level, or provide non-financial support to middle income countries particularly those with low immunisation coverage, to improve access to life saving vaccines for poor people.
- (c) **Strategic goals for the period 2016-2020.** Consultations noted that the strategic goals had served GAVI well and would to a large extent remain relevant in the next period. That said, some shifts in emphasis were proposed and largely supported.
- (a) On **strategic goal 1** (currently, ‘*accelerate the uptake and use of underused and new vaccines by strengthening country decision-making and introduction*’), consultations suggested to refer to “vaccines” in general as opposed to the ‘new and underused’ because GAVI is currently supporting many WHO-recommended vaccines and because ‘new and underused vaccines’ have become the norm in GAVI countries. There was also a strong suggestion to shift from “introduction” to “uptake” or “coverage”.
- (b) On **strategic goal 2** (currently, ‘*contribute to strengthening the capacity of integrated health systems to deliver immunisation*’), consultations pointed out that immunisation coverage and equity should be at the heart of the next GAVI’s strategy, and that the new wording should reflect this.

- (c) On **strategic goal 3** (currently, *'increase the predictability of global financing and improve the sustainability of national financing for immunisation'*), consultations recognised the central importance of sustainability – both financial and programmatic – of the support provided to GAVI eligible countries, especially with the concept of graduating countries. Clarifying the interrelationship between eligibility, graduation and sustainability is critical and should be highlighted in the next strategy.
- (d) On **strategic goal 4** (currently, *'shape vaccine markets to ensure adequate supply of appropriate, quality vaccines at low and sustainable prices for developing countries'*), there was clear consensus on the need to keep this as a strategic goal and no significant or wording changes were proposed. Healthy vaccines markets including the market dynamics beyond GAVI eligible countries are key to GAVI's mission.

3 Recommendations

3.1 Board is requested to:

- (a) **Approve** the proposed set of strategic shifts for the period 2016-2020, as identified through the consultation process and as per the guidance of the Executive Committee in September 2013:
 - (a) Play a central convening role in global immunisation;
 - (b) Deepen GAVI's focus on improving coverage and equity of access to immunisation, including through innovative investments to strengthen immunisation;
 - (c) Review the eligibility and graduation criteria and the forms of support offered to graduating countries, in order to ensure sustainable graduation from GAVI support - this should include review of criteria beyond GNI;
 - (d) Continue to leverage the core strength of GAVI Alliance partners and also strengthen engagement with a wider network of institutions in order to ensure successful achievement of strategic goals and targets;
- (b) **Request** the Secretariat, working together with Alliance partners, to define:
 - (a) Priority areas for GAVI to make innovative investments to strengthen immunisation, and the process to do so;
 - (b) Potential criteria for eligibility and graduation beyond GNI and a potential menu of support options for graduating countries;

- (c) The potential role of future innovative financing products and private sector engagement;
- (d) The organisational arrangements between the Secretariat and Alliance partners in order to ensure strong programme oversight, accountability and risk management;
- (e) The strategic objectives and indicators for each strategic goal;
- (c) **Provide guidance on** GAVI's future strategic framework, including GAVI's vision, mission and strategic goals.

3.2 Processes and proposed next steps:

- (a) During phase 1 (April-June 2013), Board and constituency members shared their views on potential strategic shifts for GAVI. Interviewees were asked to comment on contextual shifts in the 2016-2020 period that could affect the strategic direction of the Alliance and to share their ideas on potential shifts to GAVI's mission, strategic goals, eligibility and model.
- (b) During the phase 2 (July-November 2013) consultations with Board members and constituencies continued, as well as a public consultation to refine and test the strategic shift emerging from phase 1. The Executive Committee at its meeting of 27 September 2013 was also asked to provide guidance on the shifts and refinements proposed in this paper. To help inform the EC discussion, the Secretariat developed a landscape analysis (See MyGAVI for landscape analysis). Further consultation followed including input from GAVI countries; a public, web-based consultation, a specific donor consultations, and consultations during the plenary and the breakout sessions of the MTR.
- (c) During the next phase (December 2013-April 2014), the Secretariat will conduct further analysis and work with technical staff from Alliance partners and Board constituencies to complete the articulation of strategy, including strategic objectives and operating principles based on the strategic shifts. This phase will culminate at a Board retreat scheduled for April 2014.

- (d) If endorsed by the Board, the shifts described above will require further analytical work. This paper proposes that the Board mandate the Secretariat, in collaboration with Alliance partners to conduct such work, including, for example (i) identifying priority areas for GAVI to make innovative investments to strengthen immunisation and the process to do so; (ii) identifying potential criteria for eligibility and graduation beyond GNI and a potential menu of support options for graduating countries; (iii) investigating the potential role of future innovative financing products and private sector engagement; (iv) ensuring that the organisational arrangements between the Secretariat and Alliance partners and with contractors is appropriate to optimise programme oversight, accountability and risk management.¹ Of note, this piece may be delivered following the adoption of the strategy given timelines and priorities.
- (e) Following the April retreat, in Phase 4 (April-June 2014), the Secretariat, working with partners, will finalize the strategy including defining programme objectives, targets and indicators for adoption in June.

4 Risk implication and mitigation

- 4.1 The Secretariat will conduct a thorough risk analysis as part of the proposed strategy development process. However, a few key risks have already been raised in the consultations in relation to the strategic shifts presented above.
- 4.2 Playing a central convening role in global immunisation entails the risk of reducing room for efforts currently led by other organisations and diluting GAVI's focus. This risk could be offset by building consensus about GAVI's convening role in an inclusive manner and by ensuring the business plan is focused and clear on "who does what."
- 4.3 Improving coverage and equity of access to immunisation, including through innovative investments to strengthen immunisation may be difficult to achieve, considering that the countries remaining as GAVI eligible will be the poorest and most fragile. However, the risk of doing nothing more or different (i.e., not recognising the need to considerably strengthen the focus on coverage and equity) or to tackle these challenges without an innovative approach outweigh risks and uncertainties.
- 4.4 Reviewing the eligibility and graduation criteria could be perceived as overriding the principle that countries above a certain income level should be responsible for financing their own immunisation services and systems. This risk could be mitigated by offering mostly non-financial support, such as technical assistance or access to tiered prices for countries beyond a certain threshold. However this would not necessarily address the very

¹ The latter workstream results from the risk management audit performed by GAVI Internal Auditor in 2013 which recommended a review of the Alliance organisational set up in light of the growing expectations vis-à-vis grant oversight and risk management.

specific issue of the more than 50% of the world's unimmunised children who live in Indonesia, India and Nigeria

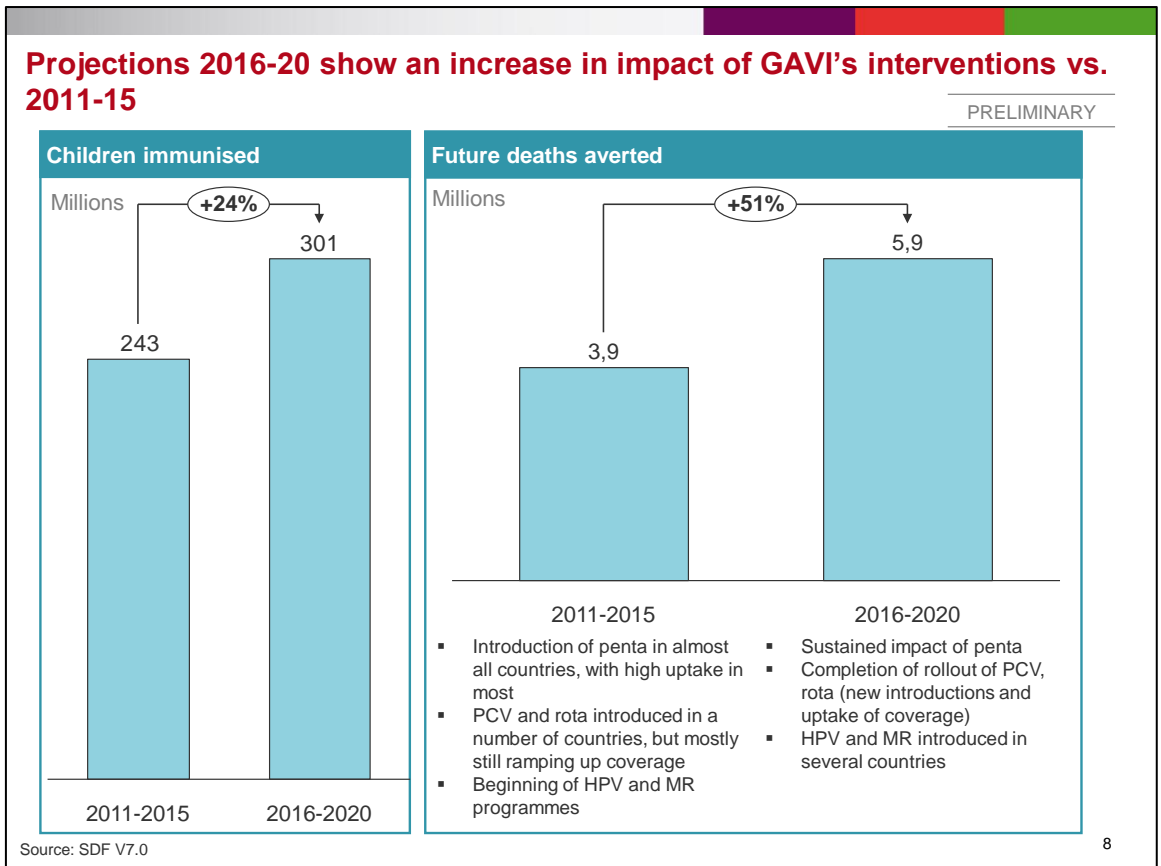
5 Financial implications: Business plan and budgets

- 5.1 The investment needed to realise the proposed strategic shifts will largely depend on the options chosen and the related implementation plan. As such, financial implications will be investigated in phase 3

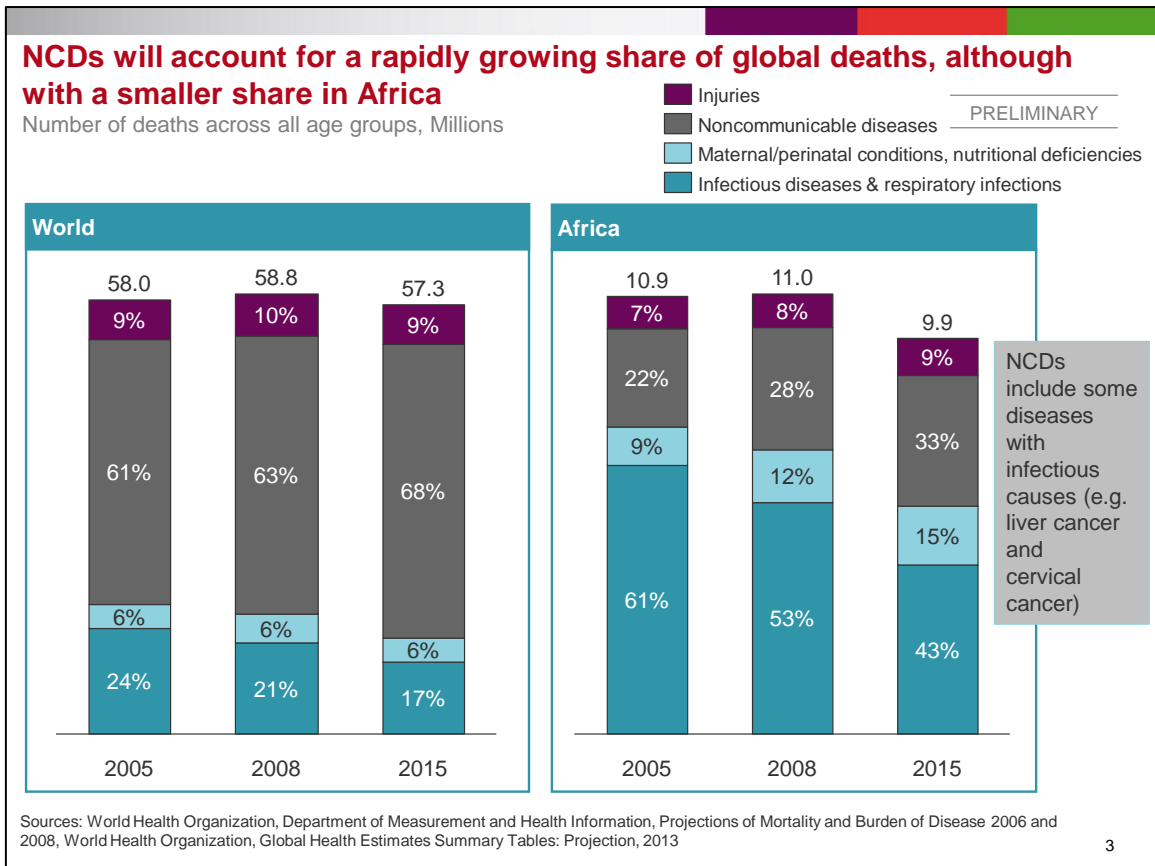
Section B: Details on proposed strategic shifts

6

- 6.1 Based on the results from the consultations and on a landscape analysis (see MyGAVI), the Executive Committee reviewed and provided guidance on a set of proposed strategic shifts, summarized below.
- 6.2 **Keep the mission focused on immunisation.** By doing so, GAVI would continue to generate significant impact and remain of primary relevance in the evolving health and development landscape.
- 6.3 Interventions in the period 2016-20 in the context of GAVI's current immunisation programmes are projected to result in approximately 5.9 million lives saved (see graph below). By 2016, all GAVI countries will have rolled out pentavalent; more than three quarters of the 56 countries currently eligible for new vaccine support from GAVI will also have introduced pneumococcal (PCV) and rotavirus vaccines, and approximately half the implementing countries will have introduced measles-rubella (MR) and human papillomavirus (HPV) or conducted HPV demonstration projects.
- 6.4 With these introductions, according to current impact estimates, GAVI is projected to reach over 300 million children in 2016-20, compared to the 243 million for the current phase. This is projected to result in approximately 5.9 million future deaths averted due to GAVI-supported interventions in 2016-20, compared to 3.9 million in the period 2011-15. This increase is due to the sustained impact of pentavalent programmes, as well as the completion of the rollout of PCV and rota (new introductions and uptake of coverage) and HPV and MR introductions. The impact of vaccine programmes in future years is one of the main drivers behind the decrease in mortality due to infectious diseases described above. In addition to the direct health impact in terms of future deaths averted, immunisation programmes sponsored by GAVI will also result in a reduction in disability due to infectious diseases, as well as in indirect economic benefits (e.g., care-givers not required to take time off work to assist children during illness).



6.5 While recognising the changing health demographics and the increasing importance of Non-Communicable Diseases (NCDs), the burden of infectious diseases in developing countries will still be significant by 2016 (see graph below) and consultations highlighted that vaccines remain core to and part of a broader vision of preventable child deaths and disability. In addition, vaccines play a critical role in the control of some NCDs (e.g., HPV and Hep B with cervical and liver cancers) and significant research is underway to better understand relationships with infectious causes of other NCDs. As such, there was therefore a strong support to keep the current mission's simplicity and focus on immunisation.

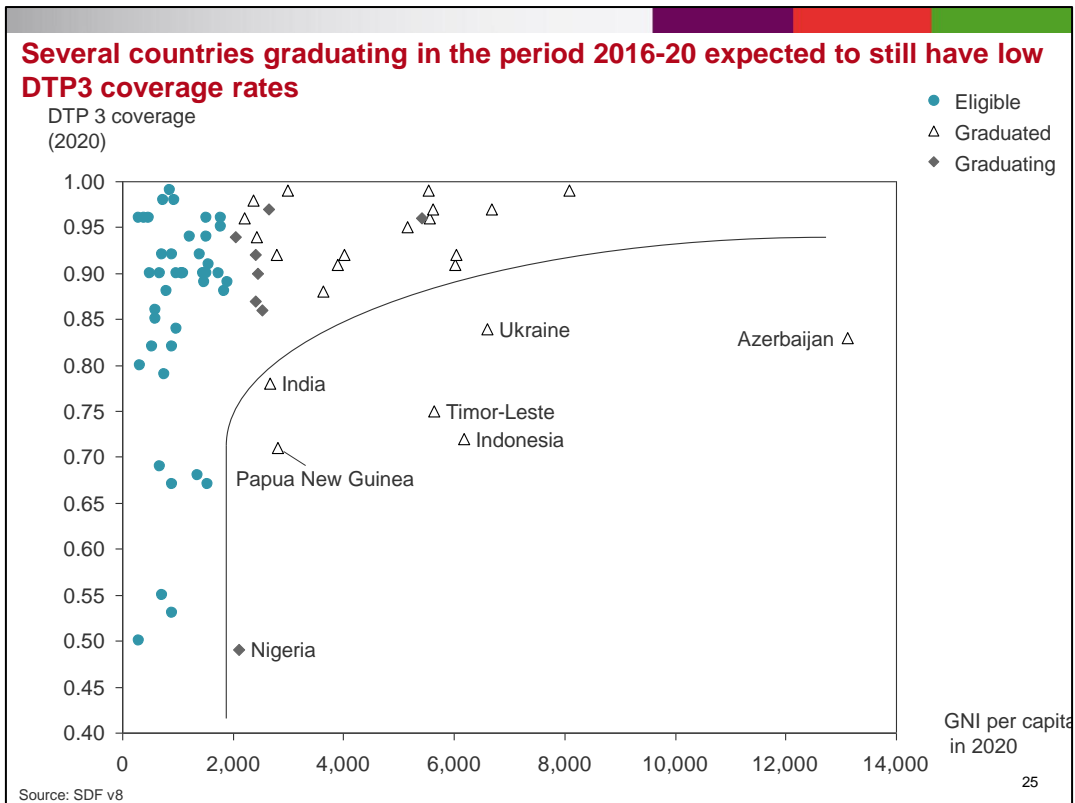


- 6.6 **Play a central convening role in global immunisation.** There are a high number of vaccine-focused public health institutions, involved either in the roll out of vaccines or in research and development. An illustrative, non-exhaustive list includes among others: Global Polio Eradication Initiative (GPEI), Malaria Vaccine Initiative (MVI), Measles & Rubella Initiative (MRI), Yellow Fever Initiative, International Aids Vaccine Initiative (IAVI), International Agency for Research on Cancer (IARC), Dengue Vaccine Initiative (DVI), Roll Back Malaria (RBM), PATH, CHAI, Diarrhoea and Pneumonia Working Group, UN Foundation, Every Woman Every Child, International Vaccine Institute (IVI), the Sabin Foundation and Aeras.
- 6.7 The Executive Committee agreed with consultations advising that, as the single largest funder of routine immunisation programmes in low income countries, GAVI could play a critical role in convening, aligning, strengthening, coordinating or funding around immunisation in developing countries.
- 6.8 **Deepen GAVI's focus on improving coverage and equity of access to immunisation, including through innovative investments to strengthen immunisation.** The Secretariat's analysis showed that the majority of introductions for the vaccines currently supported will have taken place in the period 2011-2015. That said, levels of coverage and equity, as well as the quality of data to measure them, will likely remain a challenge for GAVI countries in 2016 and beyond. After a considerable 23% improvement in DTP3 coverage between 2000 and 2009, rates have

stagnated both globally and among the 73 countries eligible for GAVI support in 2010 (on 83% and 74% levels, respectively). It is also uncertain whether the equity target set for 2015 will be met; according to recent data, in over 40% of GAVI countries, DTP3 coverage rates are 20 percentage points lower in the poorest 20% of the population than in the wealthiest 20%. Many of the countries remaining eligible in the next strategy period will also have relatively weaker health systems than the original set of countries in which GAVI invested.

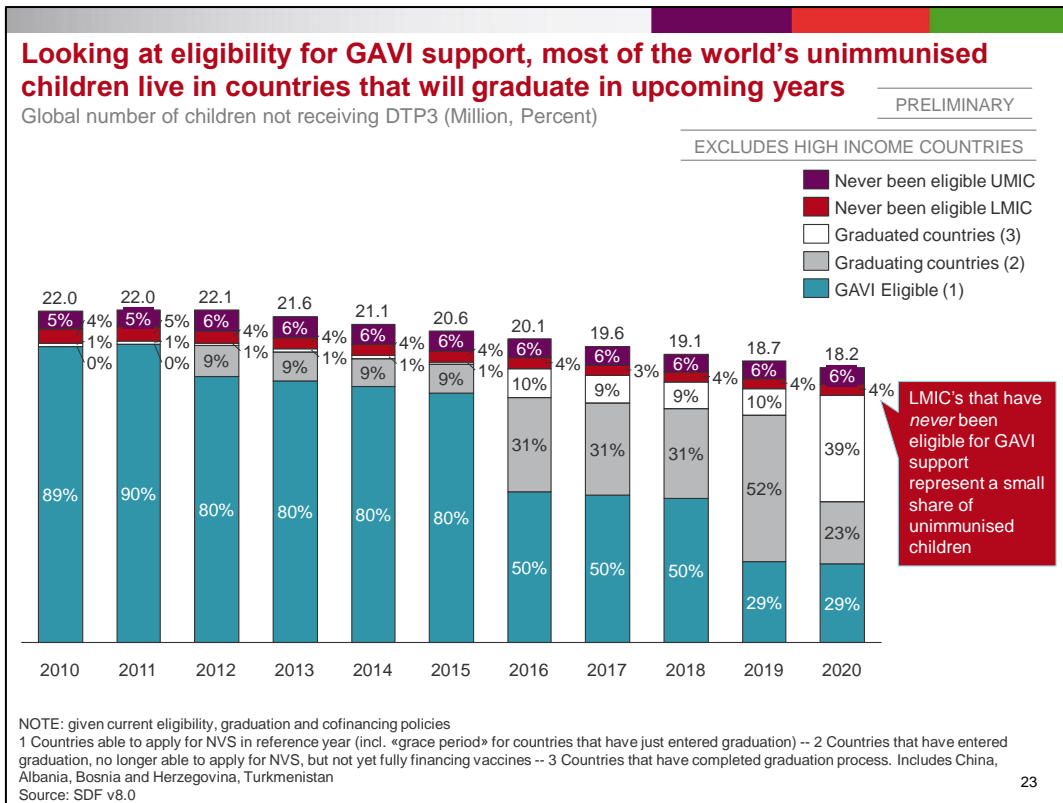
- 6.9 As such, the Executive Committee endorsed a higher focus on coverage and equity in the next strategy period for GAVI and encouraged GAVI to explore the opportunity to develop and roll out innovative approaches and technologies to resolve these issues. Examples of potential areas of investment raised during consultations included: modernisation of information systems (data visualisation tools, vital registration, bar coding, interoperability); modernisation of supply chain infrastructure (including but not limited to cold chain equipment)²; higher focus on demand-side interventions, including community-based approaches, CSO collaborations and potentially contribution of core business skills by the private sector.
- 6.10 **Review the eligibility and graduation criteria and the forms of support offered to graduating countries, in order to ensure sustainable graduation from GAVI support.** GAVI's current approach is to support poor countries, defined as having GNI per capita below a certain threshold; once its GNI surpasses the threshold, a country enters the graduation process. In other terms, GAVI's current graduation policy builds on "financial graduation". While the current mechanism enables most GAVI countries to graduate with strong immunisation services and continuous investments in immunisation, there are notable exceptions (shown on the graph below), whereby some countries with weak health systems and weak immunisation programmes may graduate from GAVI support.

² The GAVI Alliance Board has already noted the need to strengthen vaccine supply chains to make further progress in achieving its mission. A cross-Alliance process is ongoing to develop a GAVI Alliance supply chain strategy. A draft supply chain strategy framework was examined by the PPC in October 2013; a new draft will be submitted to the PPC in April 2014 and the supply chain strategy is expected to be submitted to the Board in June 2014.



6.11 The majority of the world’s unimmunised children live in GAVI eligible countries which are projected to graduate in the coming years (particularly, India, Indonesia and Nigeria). As countries graduate, the birth cohort in countries eligible for new vaccine support (NVS) will decrease by 54% between 2010 and 2020. Additionally, by 2020 the countries that will have graduated from GAVI support will hold close to three quarters of the unimmunised children living in countries that were GAVI eligible in 2010 (See graph below). Although the average GNI of these countries suggests adequate fiscal space for new vaccine support, decentralised models show poor states (often larger than many countries) that have very limited resources for health and social expenditure and large numbers of poor people and unimmunised children.

6.12 LMICs that have never been GAVI eligible represent a relatively small percentage of unimmunised children and of the birth cohort globally (approx. 4% and 5% respectively). These countries have also introduced new vaccines at a rate similar to GAVI countries. However, with regard to affordability and additional introductions, the future is uncertain.



6.13 The upcoming graduation wave will also affect GAVI's identity as a global financing facility, as geographic focus will shift more towards African countries (representing 40% of the GAVI-eligible birth cohort in 2010 and 66% in 2020). In addition, a larger percentage of countries with which GAVI is engaged would be considered "fragile" and as such have weaker health systems than the original "cohort" of countries supported by GAVI.

6.14 Responding to the feedback from consultations, the Executive Committee noted that both the concept of eligibility and that of graduation are central to GAVI's model. Successful graduation and sustained domestic investments in immunisation, in particular, are critically important to GAVI's model of sustainability and core concepts which should remain in the next GAVI strategy. They become even more important to the extent that one considers GAVI as a development organisation, promoting sustainability as a primary objective alongside health impact, rather than purely as a global health organisation. The Executive Committee agreed that "financial graduation" (i.e., when a country surpasses the GNI threshold) and "performance graduation" (i.e., when a country's immunisation services reach a level of robustness enabling sustainable impact) are not the same thing and do not necessarily happen at the same time. To achieve each, implementing countries may require different forms of support, in different phases. Further, GAVI should reconsider if there are better measures than GNI to define eligibility.

6.15 The Executive Committee examined four options, arising from consultations:

- (a) **Option 1: Keep the GNI criteria and provide additional technical support to graduating countries:** GAVI could provide additional technical support and/or limited grants to countries on the graduation track but prior to GAVI support terminating, in order to support them in their five-year graduation process and to ensure programmatic and financial sustainability when GAVI support ceases. These could include additional investments in supply chain or improving equity and coverage, for example. Following discussion by the PPC, the Board will review a proposal on GAVI's engagement with graduating countries during its meeting (see Doc 14).
- (b) **Option 2: Keep the GNI criterion but raise the threshold** (e.g., to \$2,000): This would postpone the graduation of countries that have not yet entered the graduation process and would make some countries that are already on the graduation track eligible for support again.
- (c) **Option 3: Review eligibility and graduation criteria and expand beyond GNI:** to determine which country is eligible, GAVI would use other criteria beyond GNI per capita (e.g., immunisation coverage, size of the unimmunised population, burden of disease, the GINI coefficient, etc.). Composite measures were explored when the eligibility policy was adopted by the Board in 2009, but at that time the Board decided to use GNI as the only indicator of eligibility, because it correlated to some extent with the performance of the immunisation services and other health measures, and because it posed the least challenges in terms of data quality issues, frequency of reporting, etc. That said, expansion could stay focused on GNI while adding other categories (e.g., percentage of unimmunised children, low coverage, large birth cohort).
- (d) **Option 4: Offer a menu of support options to a wider set of countries:** GAVI would support a larger set of countries than what it currently does. The selection criteria could include, but would not necessarily be limited to GNI (e.g., coverage, number of vaccines introduced, etc.). Based on its characteristics, each implementing country (whether it is one of the 73 countries originally eligible for GAVI support or one of the countries that qualify based on the new criteria) would be offered a specific type of support from a 'menu of support' that GAVI could offer. This 'menu of support' would include vaccine support (from full financial support to catalytic support or concessional loans), HSS support (either grants or loans), access to prices (accessing GAVI prices or an adequate tiered price, support in pool procurement), and technical assistance (from day-to-day support across all immunisation-related topics to ad-hoc support on specific issues). Access to these types of support would be granted based on a set of criteria, including but not limited to GNI per capita and other development indicators, which might also trigger some support at the subnational level. GAVI could also consider working with LMICs through its market shaping efforts.

- 6.16 After examining these options, the Executive Committee recommended that GAVI consider reviewing GNI as the single defining criterion for eligibility and also expanding the criteria for graduation beyond GNI, referencing “performance graduation” as well as “financial graduation”. The Executive Committee further recommended that GAVI review the forms of support offered to graduating countries, with a view to ensuring “performance graduation”.
- 6.17 **Continue to leverage the core strengths of GAVI Alliance partners and also strengthen engagement with a wider network of institutions in order to ensure successful achievement of strategic goals and targets.** In terms of GAVI’s operating model for the period 2016-2020, the Executive Committee examined three options arising from the consultations.
- (a) **Option 1: Retain the current operating model**, in which the current partners play the lead role in supporting countries in implementation. These partners would design targeted interventions better tailored to country needs.
 - (b) **Option 2: Engage with a broader set of implementing partners in addition to current partners**, based on a deeper understanding of the needs, challenges and risks in each implementing country. This would allow the Alliance to engage with a broader set of disciplines, including more CSO and private sector participation. In this model, current partners would retain their central role in design and implementation, according to their areas of core expertise.
 - (c) **Option 3: Competitive selection of implementing partners.** In this model, the business plan would be divided into multiple areas of work and most activities would be contracted through a competitive process.
- 6.18 GAVI’s operating model had traditionally relied on a limited number of implementing partners taking the lead in broad areas of the business plan. However, in recent years GAVI has begun to expand the partnership and engage new implementing partners, including research institutions and technical bodies, civil society organisations and private sector companies. In the current operating model, Ministries of Health in GAVI countries have primary responsibility for delivering on GAVI-supported programmes. Support to country MOHs is planned, steered and reviewed through the Business Plan process, which clarifies the roles, responsibilities and accountabilities of GAVI Alliance implementing partners. The main implementing partners are the WHO and UNICEF; however, the 2013-14 Business Plan opened the possibility to engage on implementation activities (including in-country support to vaccine introductions, coverage improvement, and targeted HSS technical assistance) with additional partners selected and allocated funds in accordance with GAVI’s procurement procedures.

- 6.19 The Executive Committee agreed with most consultations that, as GAVI increases efforts to improve coverage and equity to fully immunise children, particularly in the most fragile settings, GAVI should continue to leverage the core strengths of traditional Alliance partners, but at the same time further expand and diversify its network of implementing partners. As part of this, the Secretariat is planning to assess its experience of private sector engagement so far and decide how to engage further.
- 6.20 **Leveraging the GAVI model to scale up other key life savings commodities or technologies.** A number of consultations raised the idea of using GAVI's infrastructure to deliver other types of commodities, particularly those which have synergies with immunisation, such as:
- (a) Amoxicillin, an antibiotic indicated in the treatment of pneumonia and therefore complementing GAVI's PCV programme.
 - (b) Oral rehydration salts, zinc nutritional supplements, both indicated in the treatment of diarrhoea, would complement GAVI's rotavirus programme.
 - (c) Injectable antibiotics against neonatal sepsis, complementing GAVI's impact by adding a new-born health component to it.
- 6.21 Various options were proposed, including:
- (a) **Option 1: Providing incentives or specify approval criteria to enhance integration:** Through its grant review processes, GAVI could develop criteria or incentives for implementing countries to better integrate vaccines programmes with other interventions.
 - (b) **Option 2: Engaging in market shaping:** GAVI could leverage its processes to help with market shaping related to these commodities.
 - (c) **Option 3: Funding vaccine related health commodities:** GAVI could expand its funding from funding solely vaccines to funding related commodities (e.g. ORS with Rota, Amoxicillin with pneumo) and or other commodities to leverage GAVI's systems and processes (oxytocin³).
- 6.22 While recognising the importance of integrating immunisation and other health interventions, the Executive Committee guided against market shaping or funding life-saving commodities beyond vaccines. Instead, the Executive Committee agreed that GAVI could develop criteria or incentives for implementing countries to better integrate vaccines programmes with other interventions through its grant criteria and review processes.
- 6.23 Concerning **research and development**, most of the consultations suggested that funding product development should not be in scope. However, some potential options were raised for further exploration:

³ A hormone indicated in the prevention and treatment of post-partum haemorrhage.

- (a) **Option 1: Convene and call for action:** Taking advantage of its current voice with regards to immunisation in the developing world, GAVI could play a key advocacy role for the development of vaccines adapted to the epidemiology and setting of developing countries. This could include more active engagement of product development partnerships in the GAVI Alliance model (e.g., vaccine R&D working group or forum convened by GAVI, constituency and a Board seat for PDPs).
- (b) **Option 2: Provide market incentives to develop new products:** Similar to its work with the Advanced Market Commitment, GAVI could provide market incentives to develop these new vaccines.
- (c) **Option 3: Provide seed funding for R&D:** GAVI would provide catalytic funding to key R&D projects in the area of vaccine development.

6.24 The Executive Committee advised against increasing GAVI's engagement in accelerating research and development (R&D) of new vaccines (including new presentations) and new technologies (e.g. supply chain, immunisation delivery devices), beyond what it is already doing in terms of investment in impact and effectiveness studies as well as operational research

Section C: Implications

7 Impact on countries, GAVI stakeholders and Secretariat

7.1 The shifts described above were generated a result of consultations with GAVI countries, Board members and their constituencies, the general public and GAVI Secretariat staff. The impact on these same groups will be determined by the decisions and advice provided at the November Board and will thus be assessed prior to the April Board retreat.

8 Legal and governance implications

8.1 The Governance model will be reviewed following adoption of the new strategy to ensure the structure is "fit for purpose." This effort will be led by the Governance committee.

9 Consultation

9.1 See documents on myGAVI which describes the consultation process and results.

10 Gender implications

10.1 A revised Gender Policy will be reviewed by the Board at the same time as this paper. As part of the strategy development process, GAVI will review if it wishes to retain a stand-alone Gender Policy or combine a Gender Policy with an equity or diversity policy. In any case, gender barriers



Report to the GAVI Alliance Board

remain a critical barrier to access and will be an important area to address in the new strategy.

Section D: Annexes

Annex A: Current GAVI Strategy 2011-2015

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GAVI Alliance Strategy 2011-2015		Notes: All targets achievable with full funding (Baseline values indicated in brackets refer to 2010)		
Mission	To save children's lives and protect people's health by increasing access to immunisation in poor countries	Mission indicators: <ul style="list-style-type: none"> ■ Under-five mortality rate in GAVI-supported countries: TARGET 2015: 68 per 1000 live births (78) ■ Number of additional future deaths averted: TARGET 2011-15: 3.9 million (0) ■ Number of children fully immunised with GAVI support: TARGET 2011-15: 243 million (0) 		
Operating principles	As a public-private partnership including civil society, the GAVI Alliance plays a catalytic role providing funding to countries and demonstrates "added-value" by:	<ol style="list-style-type: none"> 1. Advocating for immunisation in the context of a broader set of cost-effective public health interventions 2. Contributing to achieving the Millennium Development Goals (MDGs) 3. Supporting national priorities, integrated delivery, budget processes and decision-making 4. Focusing on innovation, efficiency, equity, performance and results 5. Maximising cooperation and accountability among partners through the Secretariat 6. Ensuring gender equity in all areas of engagement 		
Strategic goals	1 Accelerate the uptake and use of underused and new vaccines	2 Contribute to strengthening the capacity of integrated health systems to deliver immunisation	3 Increase the predictability of global financing and improve the sustainability of national financing for immunisation	4 Shape vaccine markets
Goal-level indicators	<ul style="list-style-type: none"> ■ Country introductions of underused and new vaccines: number of GAVI-supported countries introducing underused and new vaccines TARGET 2015: Pentavalent: 69 (62) Pneumo3: 45 (3) Rota: 33 (4) ■ Coverage of underused and new vaccines: coverage of underused and new vaccines in GAVI-supported countries (% of target population) TARGET 2015: Pentavalent: 77% (39%) Pneumo3: 40% (1%) Rota last dose: 31% (1%) 	<ul style="list-style-type: none"> ■ Drop-out rate: percentage point drop out between DTP1 and DTP3 coverage TARGET 2015: 10 (12) ■ DTP3 coverage: % of surviving infants receiving 3 doses of DTP-containing vaccine TARGET 2015: 81% (75%) ■ Measles First Dose (MCV1) coverage: TARGET 2015: increased coverage (76%) ■ Equity in immunisation coverage: % of GAVI-supported countries where DTP3 coverage in the lowest wealth quintile is +/- 20% points of the coverage in the highest wealth quintile TARGET 2015: 62% (51%) 	<ul style="list-style-type: none"> ■ Resource mobilisation: resources mobilised as a % of resources needed to finance forecasted country demand for vaccine support TARGET 2015: 100% (n/a) ■ Country investments in vaccines per child: average government expenditure on vaccines per surviving infant TARGET 2015: increased investment (US\$ 3.8) ■ Fulfilment of co-financing commitments: % of countries that meet their co-financing commitments in a timely manner TARGET 2015: 100% (86%) 	<ul style="list-style-type: none"> ■ Reduction in vaccine price: change in weighted average price per child to fully immunise with pentavalent, pneumococcal and rotavirus vaccines TARGET 2015: n/a* (US\$ 35) ■ Number of products offered as a % of five-year target TARGET 2015: 100% (54%) <p>* future targets are not publicised to avoid setting a floor to a minimum price</p>
Strategic objectives	<ol style="list-style-type: none"> 1. Increase evidence-based decision-making by countries 2. Strengthen country introduction to help meet demand 	<ol style="list-style-type: none"> 1. Contribute to the resolving of the major constraints to delivering immunisation 2. Increase equity in access to services 3. Strengthen civil society engagement in the health sector 	<ol style="list-style-type: none"> 1. Increase and sustain allocation of national resources to immunisation 2. Increase donor commitments and private contributions to GAVI 3. Mobilise resources via innovative financing mechanisms 	<ol style="list-style-type: none"> 1. Ensure adequate supply to meet demand 2. Minimise costs of vaccines to GAVI and countries
Cross-cutting	<ul style="list-style-type: none"> ■ Monitoring and Evaluation ■ Advocacy, Communication and Public Policy ■ Policy Development 			Information current as of October 2013