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Ten years ago public and private partners came together to form the Global Alliance for Vaccines and Immunisation. They recognised that vaccines represent a uniquely cost-effective way of preventing deaths; that they were available in developed but not developing countries; and that this inequity could be addressed by pooling donors' funds and demand from countries. The partnership has evolved but these essential points remain.

This paper describes the context for discussions at the Board retreat about GAVI's strategy for 2011-2015. It describes GAVI's model, its institutions, and the environment in which it operates. It concludes by outlining some of the Alliance's achievements, the debates which have taken place since GAVI's founding, and the issues which have arisen from evaluations and during consultations on GAVI's five year strategy: the balance between country leadership and the Alliance operating globally and intervening systemically in markets; the role of civil society organisations in the Alliance; the balance between financial sustainability in countries and the desire to see the rapid introduction of new vaccines; the extent to which GAVI should support new vaccines, or increase coverage of vaccines already in use; the balance to be struck between ensuring supply security and reducing prices in the short term; the role of country co-financing; the balance between risk taking and accountability, and GAVI's role in supporting health systems. The paper addresses the funding challenge or the prioritisation mechanism currently under development.[1]

As a global public-private partnership, the GAVI Alliance builds on the diverse strengths of individual and institutional actors. Through innovation and flexibility, the Alliance brings additionality by creating a value chain – a chain brings better product to market sooner - deliberatively influencing and addressing market failure - and thus supports countries to reach more children with better public health interventions. These are delivered through a results-based model. This value chain could not have been achieved by any individual partner – rather it requires the synergies created by the GAVI Alliance.

GAVI Alliance Strategy Context

Introduction

The GAVI Alliance Board decided at its meeting in Hanoi on 17-18 November 2009 that the Alliance should develop a new strategy for 2011-2015. This document has been prepared by the GAVI Secretariat to provide the Board with context for the development of the new strategy. It should be read in conjunction with the following:

- GAVI Second Evaluation: First Update On Emerging Themes (Doc #3);
- Investing in Immunisation Through the GAVI Alliance – The Evidence Base (Doc #4).

The creation of GAVI in 2000 and the progress it has made in the last decade should be seen in the context of:

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- The launch of the Millennium Development Goals (MDGs) in 2000. GAVI has rightly been seen as having an important contribution to make to achieve the health MDGs, in particular MDG4 on reducing child mortality, but also MDGs 5 on improving maternal health, and 6 on HIV/AIDS and malaria. Because of the positive economic impact of immunisation,[1] GAVI also contributes towards MDG 1 on reducing poverty;

- A doubling of health aid since 2000,[2] in part as a result of the focus brought by the health MDGs. The Alliance has helped to stimulate this growth, and has also benefited from it;

- The Paris declaration on aid effectiveness, which stressed the importance of country ownership, alignment, harmonisation, results, and mutual accountability;

- Continuing debates over the merits of "vertical" programmes – focussed on targeted outcomes – versus "horizontal" or system-wide approaches;

- The creation of other global funds, such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), and the Global Alliance for Improved Nutrition (GAIN), both of which were founded in 2002, and mechanisms such as UNITAID, an international facility for the purchase of drugs against HIV/AIDS, Malaria and Tuberculosis which was founded in 2006;

All of these issues remain important; in the last few years, other issues have also become prominent:

- The G8 has had an important role in driving the development agenda. If the G20 takes on greater leadership on parts of the development agenda, it will have implications for GAVI, amongst other things because three countries which have benefited from GAVI support (China, India and Indonesia) will be at the table.

- An increasing focus on innovative financing; again, the Alliance has contributed to this, and benefited from it.

- The global financial crisis, its impact on economic growth, on the fiscal positions of many of GAVI's largest donors, and on the countries which receive GAVI support.

- While health remains important, climate change and food security have moved up the international agenda, as has the issue of financial transfers from developed to developing countries to address climate change.

[1] Evidence base, p.10.
[2] Global campaign for the health Millennium Development Goals. Progress report April 2008, Norwegian Agency for Development Cooperation.

- New vaccines have become available, in part stimulated by the market which the Alliance has created.

A Short History of GAVI

The global effort to extend vaccination coverage to all children began in 1974, when WHO started the Expanded Program on Immunization (EPI), working with UNICEF and the World Bank. This helped countries establish the infrastructure needed to provide a limited package of recommended vaccines, which in 1974 included 6 vaccines against tuberculosis, diphtheria, tetanus, pertussis, measles and polio.[3] The EPI steadily increased basic vaccination coverage in developing countries. By the late 1990s, however progress had stalled, with coverage falling in some countries. In 2000, the Global Alliance for Vaccines and Immunisation (GAVI) was created, recognising that vaccines and immunisation:

- represent a uniquely cost-effective way of protecting health and averting deaths;
- were under-provided in and/or were not tailored to the needs of developing countries;
- could be better provided through pooling funds and coordination between the range of international public and private actors with a commitment to strengthen immunisation.

The Alliance brought together multilateral organisations – WHO, UNICEF, the World Bank – the Bill & Melinda Gates Foundation, bilateral donors, developing country governments, research institutes, civil society and vaccine manufacturers, as well as unaffiliated individuals, with a range of expertise, including in public health and finance.

When GAVI was created, there were two boards: the Global Alliance for Vaccines and Immunisation; and the Vaccine Fund (later the GAVI Fund), which served as a financial agent and fiduciary for the Alliance. Each of the boards was supported by a separate secretariat. The Alliance had no separate legal personality, until 2009 the chairs of the Alliance Boards alternated between WHO and UNICEF, and a small secretariat was hosted by UNICEF. UNICEF provided services such as audit, human resources, and IT, but for the first five years the majority of staff were under separate independent management and legal structures based in Lyon and Washington. The Alliance heavily depended on capacities contributed by the partners and on key individuals among the partners. This was one of its strengths, as there was a strong sense of collective ownership, but this also presented a challenge, since governance was complicated. Consequently it was difficult to establish accountability with such a complex and informal structure.

[3] Brenzel L, Wolfson LJ, Fox–Rushby J, Miller M, Halsey NA. Vaccine–Preventable Diseases. In: Jamison DT, Breman JG, Measham AR, Alleyne G, Claeson M, Evans DB, et al, editors. Disease Control Priorities in Developing Countries. 2nd edition. New York: Oxford University Press; 2006. p. 389-412.

The GAVI Alliance was incorporated under a new Swiss law on international organisations, and the two boards and secretariats were brought together from 1 January 2009 as a Swiss Foundation. Although the Secretariat now comprises both organisations, it remains small (124 staff) and there is a continuing close connection and interdependence with Alliance members represented in the Board. This close connection and interdependence is found in:

- The Alliance's porous decision-making. The Secretariat acts as a convener and agenda setter, but decisions are taken by the Board based upon advice from the Secretariat and the Board's supporting structures. Partners are well represented on the supporting structures (which have clearer roles under the new governance arrangements), so institutions and individuals will have had a good opportunity for input into a decision before it is taken; and some of the partners will also be heavily involved in implementing decisions;

- An annual "workplan", currently $80m each year, which describes and funds activities by the secretariat, WHO, UNICEF, the World Bank and contracted entities, in support of the Alliance's goals. The partners report annually on the activities which have been funded.

- The fact that the secretariat relies on the multilateral partners for country presence.

GAVI is also linked through governance, shared mission and contractual agreements, to three additional organisations:

- The International Finance Facility for Immunisation Company (IFFIm), an international development financing initiative, which raises finance in the international capital markets to support and enhance GAVI programmes.

- The separate GAVI Fund Affiliate which was established to enter into pledge agreements with sovereign donors and assign these pledges to the IFFIm Company for eventual programme disbursement. The secretariat provides administrative support to both organisations as neither has employees.

- The GAVI Campaign, a US 501 (c) (3) is the former GAVI Fund, focused solely on raising funds from the private sector to support GAVI programmes.

GAVI's Business Model

The pooling of donor funds through GAVI allows it to:

- aggregate demand from many countries to create buying power and volumes worth competing for;

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- manage donor volatility from year to year and individual donor preferences for grants of differing lengths - e.g. annual versus 10 year grants – and for supporting particular countries.

This enables GAVI to make long-term commitments to countries, which in turn creates market predictability for manufacturers. As well as aggregating demand from countries, GAVI works with partners to provide robust demand forecasts, which is critical for manufacturers.

In GAVI's first phase of operations between 2000 and 2005, the primary focus was on Hepatitis B (monovalent and tetravalent vaccines), Haemophilus Influenzae type B (Hib), injection safety and Yellow Fever. There were also one-time investments in Polio, Maternal and Neonatal Tetanus, and Measles to accelerate disease control initiatives. Measles second dose, Pneumococcal and Rotavirus vaccines were added in 2006, and in 2008 the Board made a decision to support vaccines against Typhoid, Japanese Encephalitis, Meningitis, and Human Papilloma Virus (HPV). GAVI also offers cash based programmes: immunisation services which provides results based reward (since 2002), health systems strengthening (2006), and support for civil society groups (2006).

The process for disbursal to countries is as follows:

- The Secretariat prepares options for funding "windows" based on investment cases, which provide a cost-benefit analysis;

- The Board decides which windows to approve, and when they should be opened;

- The funding windows are then offered to countries, with some general and some country-specific requirements. For example, countries with DTP3 coverage above 50% were eligible to receive support to introduce new vaccines (this will rise to 70% under the new eligibility policy from January 2011, providing an incentive for countries to continue to strengthen their basic immunisation system); and countries need to fall below the income threshold, which is rising from $1000 to $1500 in 2011.[4]

- Applications for support are submitted by countries, after preparation work with countries' Health Sector (HSCC) and Inter-Agency Coordinating Committees (ICC), which includes development partners in the country: WHO and UNICEF, CSOs and bilateral donors.

- Applications are considered for technical sufficiency by the Independent Review Committee (IRC), which brings together individuals with credibility and expertise in public health, immunisation, health systems and economics, logistics and supply management, and epidemiology.

[4] The threshold is $1000 per capita as measured in 2003; in January 2011 it will rise to $1500 per capita as measured in 2010. The threshold will be adjusted annually for inflation thereafter.

- Applications recommended by the IRC are then considered by the Board for funding.

- Subject to the Board's decisions, funding is disbursed either: to purchase vaccines directly through GAVI's partner procurement agencies (mainly UNICEF[5]); or, in the case of grant programmes such as HSS, is disbursed directly to countries that comply with GAVI's Transparency and Accountability Policy (TAP).

- Funds are allocated for the duration of health plans. GAVI has no policy or process conditionality (as opposed to allocation criteria). Instead, it relies on results delivery, allowing governments to set goals and monitor progress with funding renewals extended subject to evaluations of these results.

- Since 2008, countries are required to co-finance a proportion of the costs of all new vaccines approved for introduction.

GAVI's Role in Market Shaping

New vaccines have been available to developed countries years ahead of developing ones – for example, Hepatitis B and HiB vaccines have been available in developed countries since the mid-1980's, but were not introduced into developing countries until much later because of lack of resources and political will. This is in part because developing countries lack resources to buy vaccines, but also because of particular characteristics of the vaccine market:

- High sunk fixed and semi fixed production costs;

- Long lead times for developing candidate vaccines, with a large number of potential vaccines not making it through pre-clinical tests and separate phases of trials to establish safety and efficacy, followed by licensing; and for changes to the scale of production facilities, as these need additional regulatory approval;

- Quality control processes are challenging, particularly for developing country producers.

The consequence of these barriers to market entry is that producers have considerable freedom to set prices during the early phase of vaccine production, during which time they hope to achieve a return on their investment in both successful vaccine candidates as well as those which have not made it to market.

In addition, some diseases which are prevalent in developing countries are not prevalent in developed ones – for example, Yellow Fever – or are prevalent in different strains in developing countries than developed ones – for example,

[5] UNICEF procures for most GAVI eligible countries. PAHO procures for 6 countries. Indonesia procures directly; while China was eligible for GAVI support, it also procured directly.

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Pneumococcal Disease (although some diseases are prevalent everywhere, and can be prevented by the same vaccines everywhere, for example, HPV and Hepatitis B). This meant that prior to 2000 the market for vaccines in developing countries was small and uncertain for manufacturers. In short, there was a massive failure in a market which had the potential to prevent millions of deaths.

The emergence of a new market in developing countries financially backed by GAVI, has encouraged market entry of new vaccines, including vaccines from manufacturers based in emerging economies – in 2009 GAVI bought more than half its vaccines from manufacturers based in emerging economies. This has stimulated the production of vaccines which are appropriate for developing countries. In particular the Advance Market Commitment[6] (AMC) has provided a credible and significant commitment to purchases of pneumococcal vaccine.

The Alliance's Results

From the outset, the Alliance has had clear goals around accelerating the uptake of new and underused vaccines, health systems, improving sustainability, and, linked to these goals, expectations about how quickly these goals would be achieved. The Alliance was built around a set of assumptions that would improve people's access to life saving interventions. The results are set out in detail in the evidence base and evaluation papers, but in brief, the Alliance has:

- Raised additional finance for vaccination;[7]
- Helped to increase routine vaccination coverage;[8]
- Accelerated introduction of some key vaccines, Hepatitis B and Hib, helped to reduce the gap between introduction in developed and developing countries, for example through the AMC and accelerated the introduction of new injection safety standards;[9]
- Helped to encourage competition in vaccine markets and bring about price reductions, but not as far or as fast as hoped;[10]
- Contributed to strengthening immunisation systems and health systems;[11]
- Pioneered innovative financing, through the IFFIm;[12]
- Shown the value of a global health public-private partnership in bringing together interested parties to achieve more together than the partners could achieve separately.[13]

[6] Evidence base, p.31;
[7] Evidence base, p.23; second evaluation pp.10-11.
[8] Evidence base, p.27.
[9] Evidence base, pp.24-27; second evaluation pp. 7-9.
[10] Evidence base pp.28-31.
[11] Evidence base pp. 27-28; second evaluation pp.4-6.
[12] Evidence base pp.33-34; second evaluation p.12.

However, in each of these areas, challenges remain, and the strategy consultations have raised issues about the way forward. These are addressed in the following section.

Challenges for the Next Five Years

It is in the nature of alliances of independent organisations and individuals that the members of the alliance should have a range of perspectives on different issues. The purpose of consulting widely on GAVI's strategy for the next five years is to allow that range of perspectives – and expertise - to be taken into account. Throughout GAVI's existence there have been debates about areas where there are inherent trade-offs or tensions between different objectives. Some of these debates are outlined below. The Secretariat also offers a view on the challenges which these debates present.

Global Alliance and Nationally Defined Priorities

GAVI aspires to be consistent with the Paris principles, and therefore to maximise country ownership; and also to be focussed on performance and analysis of the best available evidence. As outlined above, the way in which the Alliance decides which vaccines and programmes to support involves both:

- Board analysis and consideration, advised by committees (both of which include country representatives), with Secretariat facilitation; and
- Country applications recommended by the IRC.

This leads to a balance between global judgements about the costs and benefits of particular vaccines or other forms of support, and country ownership. The Alliance attempts to intervene systemically in markets; it is inevitable therefore that country priorities will not always be fully addressed, for example, in the selection of the vaccine "menu" which is available to countries. On the other hand, the fact that countries then choose from a defined menu means that there is scope to meet national priorities.

However, evaluations have shown that, while GAVI's support is effective, GAVI needs to do more to align its own systems with those of countries so that transaction costs are lower and countries have more ownership of programmes.

A separate but related issue is the Board's appetite for risk. The Board is naturally concerned to measure the impact of the Alliance, and to fulfil its fiduciary duties – brought into sharper focus by the recent governance changes. A balance needs to be struck between a) putting in place systems to measure the impact of spending and to reduce the risk of misuse of funds, particularly in relation to cash-based programmes, and b), avoiding the creation of parallel systems which can burden the very health systems which GAVI aims to support. At present the principal

[13] Second evaluation pp.12-15.

responsibility for monitoring the effect of GAVI's programmes lies with in-country partners, primarily WHO and UNICEF.

The Challenge: how can the Alliance maintain its light touch systems, which have relatively low transaction costs for countries and which countries value, while at the same time maintaining confidence that risks are being properly managed? How can GAVI continue to be innovative and responsive while ensuring that the necessary systems and controls are in place?

The Workplan

The mandates of the Alliance's multilateral partners – WHO, UNICEF, the World Bank - encompass immunisation, and as noted above, these partners were responsible for launching the EPI in 1974. When the Alliance was created, it was clear that there would be a requirement for additional immunisation related work in the three agencies. Some donors such as DFID funded these agencies through unearmarked general budget support. Others in the early years, for example Norway and the Netherlands, funded part of this activity as earmarked contributions to those agencies. Now funding has evolved to both general budgetary contributions from donors to the multilaterals unearmarked to immunisation, and from GAVI via a workplan which also funds the work of the Secretariat. As noted in the second evaluation,[14] there are questions about how the activity funded by the workplan relates to the partners' normative mandates, and about how workplan activities are defined and monitored against the achievement of the Alliance's objectives.

The Challenge: how can the workplan partners be effectively held to account as part of an Alliance?

Civil Society Organisations

Civil society organisations (CSOs) are important to the Alliance's mission because many CSOs are involved in delivering immunisation in countries, and are involved in advocacy in support of child health and immunisation – and could potentially play a greater role. Advocacy by CSOs has been and continues to be powerful for the Global Fund to fight AIDS, Tuberculosis and Malaria. The base of support in civil society for immunisation is currently smaller and less coordinated, reflecting the different dynamic associated with diseases such as AIDS that have been prevalent in developed as well as developing countries. However, the Alliance has been working to strengthen the role of, and its relationship with, civil society. This includes working through and around the Partners' Forum in Hanoi in November 2009. The Secretariat is also working to improve the design of GAVI's civil society funding, including addressing the question of whether civil society should be directly funded, or funded through a CSO partner, rather than funded via country governments or multilateral agencies as at present. Work also needs to be done on the differential role which CSOs can play in different countries – in some they are likely to be more involved in service delivery; in others in advocacy; and a priority needs to be

[14] Second evaluation pp.14-15.

attached to working with CSOs in the countries where the most unimmunised children live.

The Challenge: how can the Alliance strengthen the role of CSOs while keeping transaction costs low?

Capacity Building and Technical Assistance

The Alliance has a strong interest in capacity building, as the success of its programmes depend upon the quality of technical assistance which supports the design, implementation and evaluation of these programmes. Many of the Alliance members also have a separate interest – in particular the multilateral partners in the Alliance – WHO, UNICEF and the World Bank – are all significant providers of technical assistance. However, there is a desire by countries to have more country ownership of technical assistance, meaning there should be more scope for country systems to procure technical assistance from a range of sources so that assistance is driven by demand rather than supply. On the other hand, donors and suppliers of assistance are acutely aware of concerns about fiduciary and other risks, and sometimes identify technical assistance that would be of benefit – such as financial management – which the countries themselves might sometimes be less enthusiastic about. Countries report that from their perspective they are disempowered when deciding on technical assistance and often have little visibility of which providers are available, or how good they might be. They therefore seek help from their partners, particularly WHO, UNICEF and the World Bank, who advise, short-list, procure, and also provide technical assistance themselves. Of course, different countries are in different positions in relation to technical assistance – some are ready to take greater control of their technical assistance, while others need more support. However, overall, systems to quality assure technical assistance are patchy, and there is particular concern about the quality of technical assistance in relation to health systems, and governance and management. This is not an issue that affects GAVI alone.

The Challenge: how can GAVI work with others to improve capacity building and the quality of technical assistance, particularly in relation to strengthening health systems?

Financial Sustainability

One of the concerns since the Alliance came together has been that GAVI's policies should be sustainable – countries should not introduce vaccines which they would have little prospect of maintaining once they had graduated from GAVI support. This concern is particularly focussed on new and more expensive vaccines. The price of pentavalent vaccine has recently fallen, but not as rapidly and as far as had been hoped. Reflecting this concern, the Secretariat has done some preliminary analysis on financial sustainability. The work shows that, even if governments do not increase the share of health spending in their national budgets, more than half of GAVI countries would spend less than 5% of their health budgets on the full vaccine

package by 2015 if GAVI support were withdrawn.[15] The Alliance is in the process of considering a revised co-financing policy, which will involve examining the evidence from the policy so far, and further analysing the fiscal space for the existing and future vaccine portfolio.

The Challenge: what relative weight should be attached to accelerating the introduction of new life saving vaccines, and maintaining financial sustainability for countries?

Market shaping and procurement

In funding the purchase of vaccines, the Alliance seeks to shape the vaccine market, with UNICEF as its primary procurement agency. There is a trade-off between a) seeking the lowest possible price and b) ensuring that there is a sufficient margin to keep more than one producer for a particular vaccine for reasons of vaccine supply security, and having multiple suppliers helps avoid giving greater long run pricing power to a monopoly manufacturer, and reduces the risk of supply interruptions for a vaccine.

The Alliance is in the process of developing a revised supply and procurement strategy, which will involve assessing the supply landscape for GAVI's existing (priority) vaccines, revising the procurement objectives, determining the potential means to achieve procurement objectives, assessing quality assurance requirements and their effects on competition, and appraising potential market-based criteria and supply chain indicators that could be used to identify when GAVI can end support for particular vaccines.

The Challenge: how can the Alliance find innovative ways to reduce vaccine prices and improve value for money including in procurement?

Health systems

One of the debates within the Alliance from the outset has been the extent to which the Alliance should focus exclusively on funding vaccines for countries, or the extent to which it should fund immunisation systems. Since the outset GAVI has sought to strengthen health systems. It first did so with ISS starting in 2002 and then began to tackle broader health system bottlenecks via the HSS programme starting in 2006. Arguments in favour of remaining focussed on supplying vaccines have been advanced:

- As countries' health system needs are so significant, and the issues they face are so systemic, GAVI is not the right vehicle for funding health systems;

- GAVI is not sufficiently funded in relation to vaccines, and therefore money spent on health systems should be reallocated to vaccines;

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[15] Based on analysis by Results for Development. World Bank country growth forecasts are used. Expenditure estimates include costs of vaccines already in use (BCG, measles, polio and yellow fever where applicable), in addition to pentavalent, pneumococcal and rotavirus vaccines (based on AVI demand forecasts).

- It is not possible to measure the effect of health systems support, including on immunisation rates.

On the other hand, arguments have been advanced in support of funding health systems that:

- Sustainability and achieving high levels of routine immunisation depend upon the effectiveness of basic health systems, particularly in rural and remote areas. As health workers and facilities have multiple functions, it is not possible to require that funding should be provided only to immunisation programmes. While not targeted at immunisation per se, most countries have used GAVI's HSS funding to target improvement in maternal and child health;

- Positioning GAVI away from being perceived as a narrow vertical programme, to one that can better respond to country demands and integrate efforts according to Paris principles, has been a powerful lever to raise funds and to work with others.

- GAVI's HSS funding has raised the profile of immunisation as part of countries' health strategies, and has improved coordination of donors in relation to health systems in countries;[16]

Funding health systems gives countries a good opportunity to set their own priorities – promoting country ownership, in accordance with the Paris principles - by deciding which areas of their health systems most need support.

The Board has decided that GAVI should participate in a joint platform which is being established with the Global Fund for AIDS, TB and Malaria, and the World Bank, with support from WHO. As these institutions are all involved in improving health systems, the aim is that transaction costs will be reduced for countries by aligning their systems around country strategies. The platform offers the opportunity to take a fresh look at what procedures are really necessary, and where possible, align them with country systems – responding to the HSS evaluation and tracking support findings that GAVI's HSS support needed to take more account of country specific contexts.

The Challenge: how can the Alliance coordinate and integrate efforts with others to help achieve MDGs 4, 5, and 6 through the joint platform, while maintaining its primary focus on vaccines?

The Alliance as the platform for vaccine delivery

The evidence base paper demonstrates the success the Alliance has had in introducing new and underused vaccines, in bringing forward new technologies such as the auto-disable syringe, and in making a significant contribution to the health

[16] Second evaluation p.5.

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Millennium Development Goals. The public-private partnership has worked by seeking to maximise the effectiveness of the capacity that each member has in its own areas of expertise and influence, and by acting as a forum and facilitator of discussions that has addressed the challenges of vaccine delivery. It has succeeded in creating a platform which reaches 79% of children in GAVI-eligible countries with three doses of DTP, holding out the prospect of achieving similar levels of coverage with new vaccines against pneumococcal disease and rotavirus.

The Challenge: how can the Alliance further strengthen its role as the default platform for delivery of new vaccines?

The debates and challenges outlined above have been reflected during the consultation on the Alliance's strategy. They will also be reflected in discussions about the policies which the Alliance is in the process of developing on co-financing and the supply strategy, and also in discussions in the approach to the June Board about the prioritisation mechanism, which will provide a mechanism to rank the vaccines and grants in GAVI's portfolio and for prioritising IRC-recommended country proposals.

Open and constructive debate about the evidence, which has characterised GAVI's first ten years, will help to create a strategy which – with sufficient funding – will capitalise on the opportunities that the Alliance has before it, and could prevent another 4.2m deaths in the next five years.