

**SUBJECT: GAVI 5.0: THE ALLIANCE'S 2021-2025 STRATEGY**

**Agenda item: 11**

**Category: For Guidance**

### **Section A: Introduction**

- **Gavi, the Vaccine Alliance, was founded in 2000 to accelerate access to new and underused life-saving vaccines in the world's poorest countries** suffering high rates of child mortality and morbidity. Building on the Alliance's impressive success in bridging the gap between rich and poor countries in terms of access to vaccines, the scope of Gavi's work has steadily expanded. It has been called upon to play a key role in introducing and scaling-up inactivated polio vaccine (IPV) as well as in outbreak response by funding stockpiles of vaccines for diseases with epidemic potential. The Alliance's current strategy is committed to further accelerate vaccine introductions as well as support equitable coverage of routine immunisation services, recognising that about 20% of children in Gavi-eligible countries<sup>1</sup> do not receive a full course of even basic vaccines and that immunisation coverage rates among these countries are quite uneven. As the world moves from the Millennium Development Goals (MDGs) into the Sustainable Development Goals (SDGs), the Alliance's 2021-2025 strategy ("Gavi 5.0") is an opportunity to contribute to the SDG vision of "healthy lives" and "leaving no one behind". In this context, Gavi's current mission will be more relevant than ever in the years ahead.
- **The PPC provided feedback on the questions and context related to the development of Gavi strategy 2021-2025.** It emphasised that the core focus for the Alliance will remain on its current mission of accelerating access to vaccines and increasing equitable coverage in the world's poorest countries. PPC members noted that the key question will be "how" to do so in a rapidly changing environment and with a diverse and fragile portfolio of countries. The PPC also noted that the Alliance may need to broaden its engagement in certain areas and articulate how it will contribute to global priorities such as Universal Health Coverage and Global Health Security. This might also entail engaging additional countries which are lagging behind on immunisation and help them make better use of their domestic resources for immunisation so that vulnerable children everywhere are reached with life-saving vaccines.

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<sup>1</sup> Throughout this document the term "Gavi-eligible" refers to Gavi-72 countries unless mentioned differently

- This paper reflects the PPC input, proposes a set of questions to guide the development of the strategy and puts forward a process for the Board to finalise the strategy framework in 2019.

## **Section B: Gavi 5.0: The Alliance's 2021-2025 strategy**

### **1. Building on success: The Alliance's comparative advantage**

**1.1 When it was created in 2000, Gavi offered a new model for development** – a public-private partnership bringing together key institutions and actors to finance and support country-led programmes. Over the past 18 years, the Alliance has refined this model, pioneered a number of innovative approaches such as co-financing, transition and market shaping and helped countries to achieve impact at scale. As the Alliance develops its next strategy, it can therefore build on its proven comparative advantage including:

- a) **Implementation at scale:** By the end of 2018, the Alliance will have helped countries to immunise over 700 million children through routine immunisation alone, thereby preventing more than 10 million premature deaths. The Alliance has supported over 400 introductions of new and under-used vaccines in the world's poorest countries, helping to address historic inequities in access. With Gavi support, for example, 82% of Gavi-eligible countries have introduced Pneumococcal (PCV) vaccine, while 64% have introduced Rotavirus vaccine, a level significantly higher than for never Gavi-eligible Middle Income Countries (MICs).
- b) **Country ownership and domestic resource mobilisation:** Gavi pioneered the concept of co-financing to bolster country ownership of vaccine programmes and domestic resource mobilisation. Gavi's co-financing policy requires countries to co-procure a portion of vaccine doses with countries expected to increase their domestic funding as their GNI rises. This strategic period particularly highlights the success of this model. For example, countries co-financed 16% of the cost of Gavi-supported vaccines in 2017, a level that has never been reached before. The 2018 GVAP report highlights that the African region has seen a 130% increase in government expenditure on immunisation since 2010. 16 countries have fully transitioned out of Gavi support and 20 are expected to transition by the end of this strategic period. All of them are maintaining and fully self-financing vaccines.
- c) **Market shaping:** Gavi has developed a unique market shaping model, by pooling demand from countries accounting for 60% of the global birth cohort, leveraging economies of scale and ensuring predictable demand as well as financing. This has enabled the Alliance to work with the vaccine industry to expand the number of manufacturers supplying Gavi-eligible countries from 5 in 2000 to 17 today, scale-up supply and secure significant reductions in vaccine prices. For example, the average price to fully vaccinate a child with Pentavalent,

Rotavirus and PCV vaccines has come down from US\$ 35 in 2010 to US\$ 17 in 2017.

- d) **Innovation:** Innovation is in Gavi's DNA. The International Financing Facility for Immunisation (IFFIm) has raised US\$ 6.5 billion from capital markets through vaccine bonds, enabling the Alliance to front-load investments in countries and accelerate impact. The Advanced Market Commitment (AMC) for pneumococcal vaccines and most recent Advance Purchase Commitment (APC) for Ebola vaccines are testament to Gavi's ability to constantly innovate. Gavi has also been in the forefront of taking innovative health technologies to scale catalysing, for example, universal use of Auto Disable Syringes and Vaccine Vial Monitors (VVMs). In this strategic period, the Alliance has expanded its partnerships with private sector companies and other innovators to apply their expertise and resources to coverage and equity challenges, including through INFUSE, which is designed to identify and scale-up proven innovations.
- e) **The power of Alliance:** The Alliance represents a new development model designed to unite all institutions working in immunisation around a common strategy, backed with a significant increase in financing. The Alliance has helped to coordinate the support of all its members to countries, leverage synergies between partners, and focus each member on the areas of greatest comparative advantage. Over time, it has added new partners to meet specific needs of countries. All Alliance members share a common accountability framework with clearly defined deliverables and performance metrics and transparent reporting at country level. The Alliance has established a model that countries trust and that enables to align independent institutions and mobilise significant donor financing behind a common agenda.

## 2. Opportunities and challenges for Gavi 5.0

2.1 **Eighteen years from Gavi's creation, the world is a very different place.** The Alliance's next strategy will need to consider a number of important contextual factors, which present both new opportunities and challenges. These include:

- a) **The global development landscape is currently re-shaping in pursuit of the Sustainable Development Goals (SDGs), developed to ultimately leave no-one behind.** However, it is unclear if the world is yet on track to reach most of the SDGs, especially the 2030 target of under-5 mortality. The Alliance's work contributes to a range of SDG targets including child survival, universal access to affordable medicines and vaccines, universal health coverage (UHC), global health security, gender equity and beyond. Immunisation is a universal intervention and already reaches more households than any other (85% global DTP3 coverage in 2017). This makes immunisation a well-placed platform to reach these populations with a basic package of primary health care (PHC) interventions. And with its focus on

equitable coverage, the Alliance is working to extend this platform further to reach the remaining 20%, often vulnerable communities who may not be receiving any routine health services today.

- b) **Many countries remaining in the Gavi portfolio post-2020 will face increasing challenges related to changing demographics (e.g., growing birth cohorts, displacement, rapid urbanisation), and the impact of climate change.** These challenges may impede progress in achieving equitable coverage of immunisation: The birth cohort of countries remaining eligible for Gavi support will grow by 4.3 million children between 2016 and 2025 – this is equivalent to the current birth cohort of Indonesia. The number of state and non-state conflicts has almost doubled over the last ten years, which has contributed to record levels of displacement. Today more than 70 million people are displaced from their homes (up from 22 million in 2000), more than half of them in Gavi-eligible countries. Amongst displaced populations, immunisation coverage levels are much lower, and they can be harder to reach. Urban population is expected to grow by over 200 million in Gavi-eligible countries<sup>2</sup> by 2025, fuelling the development of urban slums with often non-existent or limited PHC provision, and populations not always registered or recognised by governments. Climate change will continue to alter disease patterns and increase the incidence of vaccine-preventable diseases.
- c) **With these developments the remaining pockets of under-immunised will be increasingly at risk of disease outbreaks and in an increasingly interconnected world, such outbreaks can spread rapidly across borders.** In 2007, 3,100 outbreaks were recorded, up from 700 in 1980. There remain significant gaps in countries' ability to prevent, detect and respond to outbreaks, with only 14 out of 65 countries assessed through Joint External Evaluations (JEEs) rated as prepared to respond to potential outbreaks. These outbreaks are no longer just a local risk but can spread in the broader region and worldwide as was illustrated by recent outbreaks of Ebola, Yellow Fever and Zika.
- d) **The world is no longer clearly divided between rich and poor or developed and developing countries.** In 2000, over 55% of vulnerable people (those living off less than US\$ 8/day) lived in Low Income Countries (LICs). In the next strategic period this is expected to fall to 20% with most vulnerable people living in MICs. Although many of these countries invest considerably in health and immunisation, there is evidence of new inequities, even in relatively wealthier countries, that were much less pronounced in 2000.
- e) **There is also evidence of back-sliding of immunisation performance in some MICs** that were never supported by Gavi, despite significant domestic investments. For example, Brazil, Iraq and

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<sup>2</sup> Gavi-eligible countries in 2025

South Africa have all experienced declines of five to ten percentage points in routine immunisation coverage over the past decade and all three are now among the ten countries with the highest number of under-immunised children worldwide. On average, never Gavi-eligible MICs<sup>3</sup> have lower levels of immunisation coverage, weaker institutions and systems (e.g., National Immunisation Technical Advisory Groups, supply chains), and have introduced fewer new vaccines despite spending significantly more on immunisation. Some MICs have also transitioned out of Gavi support without introducing some key WHO-recommended vaccines. These include countries with large birth cohorts such as Indonesia and Vietnam. The introduction agenda in these countries remains critical when in 2017, more than 500 thousands children under-5 still die of either pneumococcal pneumonia or rotavirus.

## 2.2 **These developments raise two critical questions for Gavi's 2021-2025 strategy:**

- a) How will the Alliance ensure continued progress on equitable coverage in the countries that are yet to transition?
- b) How can the global community engage non-Gavi countries to address growing inequities and maximise the impact of their domestic investments in immunisation?

## 3. **Strategic question 1: How will the Alliance ensure continued progress on equitable coverage in the countries that are yet to transition?**

3.1 **Gavi's country portfolio will be considerably more challenging in the next strategic period** as a number of relatively well-performing countries (e.g. Sri Lanka, Uzbekistan, Vietnam) will have transitioned out of Gavi support. The 49 remaining countries in 2025 will consist, at a high level, of three main segments<sup>4</sup> with similar characteristics and challenges:

- a) **Countries with relatively strong immunisation systems and coverage & equity performance.** These countries reach on average more than 90% of children with the first dose of DTP-containing vaccine. The primary objective in these countries will be to reach the last pockets of under-immunised, potentially introduce the missing vaccines and ensure programmatic and financial sustainability.
- b) **Countries with weak immunisation systems and low coverage & equity performance,** which will need to build their systems to increase

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<sup>3</sup> Throughout this document the term "never-Gavi eligible" refers to countries that have not been part of Gavi-72

<sup>4</sup> The segmentation is based on a mapping of countries against their coverage and equity performance and against the strength of their immunisation-related system (across areas such as immunisation supply chain, data quality, health workforce, financing and institutional capacity). The methodology is described in more detail in Annex B.

programme performance and raise overall coverage. This segment includes 14 countries like Guinea and Madagascar with an average DTP3 coverage of 65% in 2017, and, for example, lower performing supply chains, inadequate human resources for health and poor data systems.

- c) **Countries facing widespread conflict**, with a DTP3 coverage of 54% (2017) and where the primary challenge will be to ensure service delivery to as many children as possible and prepare for the time when there is stability, and investments in long term sustainable growth are possible. This last segment will include 6 countries such as Somalia, Yemen or South Sudan.

3.2 **It should be noted that a growing number of children will live in large and devolved countries** (e.g. in 2025, 39% of the Gavi-eligible birth cohort will be in Nigeria, DRC, Ethiopia, and Pakistan) in Gavi 5.0. Most of these countries are part of the “weak systems” segment but have variable sub-national system strength and performance. For example, provincial DTP3 coverage in Pakistan ranges from 37% to 89%. Coverage in Ethiopian states shows a similar picture, ranging from 20% to 96%<sup>5</sup>, creating large sub-national inequities. And Nigeria has one of the highest subnational inequities of all Gavi-eligible countries and a striking North-South divide: in some Northern states such as Sokoto and Jigawa DTP3 coverage is as low as 10% whereas in Lagos in the South ~80% of children are being reached with the 3<sup>rd</sup> DTP dose<sup>6</sup>.

3.3 Leaving no child behind with vaccines in this disparate and more challenging portfolio will require the Alliance to **develop more targeted and differentiated programmatic approaches that better adapt to each individual country situation and subnational picture**. More specifically:

3.4 **Vaccine support: The Alliance would take a ‘life-course’ and integrated approach to the country portfolio of vaccines.**

- a) **This would entail for each country to take a system view and identify the portfolio of vaccines that is most adapted to the local needs and capacities to achieve maximum value.** This portfolio might differ in the various country segments defined in section 3.1, and based on individual country context. In particular, with potential new vaccines supported as part of the Vaccine Investment Strategy (VIS) (see agenda item 7), countries would be supported to identify a customised mix of vaccines from the portfolio – taking into account dimensions such as disease burden, programmatic performance, health system capacity and sustainable financing. The Alliance will need to work with countries to organise the introductions of vaccines, including their timings and supplementary immunisation activities (SIAs), in a way that strengthens routine immunisation and brings

<sup>5</sup> DHS data (2017-2018 for Pakistan and 2016 for Ethiopia)

<sup>6</sup> Data from National Immunisation Coverage Survey (NICS) 2016-2017

improved coverage and equity.

- b) **As part of this approach, integration of vaccines programmes with other health interventions will be critical.** This includes further integration into multi-sectoral approaches (e.g. adolescent health interventions with HPV vaccines) which will be particularly relevant for some of the VIS vaccines (e.g. water and sanitation with cholera vaccine). Gavi's immunisation investments could catalyse the development of integrated approaches for these non-immunisation interventions. The Alliance is already promoting such integration (e.g., for rotavirus, PCV, HPV and measles campaigns) but Gavi could take a more deliberate and ambitious approach in the next period, working closely with other partners and funders.
- c) **Overall, Gavi vaccine support should contribute to building a stronger immunisation platform** which will provide the opportunity for countries to leverage the immunisation touchpoints and roll out other interventions that will be part of a comprehensive primary health care (PHC) package. This can be a win-win with evidence suggesting that leveraging immunisation touchpoints to roll out other interventions can boost immunisation coverage and ensure that all those being reached with vaccines also receive a basic package of other PHC services. A stronger immunisation platform will also help counties prepare for introduction of future blockbuster vaccines such as those for TB, HIV and malaria.

### 3.5 Health systems strengthening (HSS) support:

- a) **The Alliance's HSS agenda would continue to be critical post 2020.** In the current strategic period, Gavi HSS has increasingly focused on subnational low-coverage areas with the deliberate intent to improve service delivery in the most underserved settings. This focus on reaching the most vulnerable populations with a universal intervention makes it especially relevant in the area of Universal Health Coverage as it uniquely contributes the foundations of universal primary health care in the most fragile countries.
- b) **Gavi's HSS objectives and approach might differ based on the country segment.** Gavi may prioritise direct gains in coverage over sustainability in the segment of countries facing widespread conflicts, while focusing on sustainable system improvements in the segment of countries with weak immunisation systems and on sustaining results and introducing innovative approaches in well performing countries.
- c) **Enhanced coordination with other HSS stakeholders will be critical.** There are a number of systemic issues in country that impede immunisation services and are much broader in scope and scale than what Gavi can address, including human resources for health, or primary health care delivery structures. Addressing these bottlenecks will require engagement and collaboration with other HSS funding organisations such as the Global Fund, the World Bank and its Global

Financing Facility, and bilateral donors. While Gavi's HSS support will continue to focus on immunisation-specific bottlenecks such as vaccine supply chain and demand for immunisation, the Alliance would have to ensure coordination and develop further joint approaches with other HSS actors to unlock health system bottlenecks that the Alliance cannot address alone.

- d) **Gavi's HSS agenda could also include a stronger focus on helping to prepare countries to prevent, detect and respond to future outbreaks.** Gavi is already a key contributor to the global health security agenda with US\$ 1.1 billion of investments in outbreak preparedness and response approved since 2016 (including vaccine support for outbreak-prone diseases such as measles, meningitis, cholera, yellow fever, typhoid, and polio; advanced purchase commitment for the Ebola vaccine; its stockpile engagement; and investments into vaccine-preventable disease surveillance). Historically however, the Alliance has not had a holistic approach to helping countries set up resilient systems that would prevent, detect and respond to vaccine-preventable disease outbreaks and Gavi's investments in these fields have been somewhat fragmented. In the next strategic period the Alliance may be able to enhance its contribution by taking a more strategic and deliberate approach to its existing investments and providing targeted support to address specific gaps. This might include in particular support for integrated surveillance for priority vaccine-preventable diseases as the backbone of a well-functioning immunisation program.

3.6 **Technical assistance by Alliance partners: The Alliance will continue to build on the transformations brought by the Partners' Engagement Framework (PEF).** This new approach, introduced in 2016, has brought a country-centric, bottom-up approach to working with countries, helping the Alliance to better leverage its partners' comparative strengths and to increase transparency and accountability. Technical assistance by partners in the next period will need to be even more tailored to the needs and context of countries and subnational challenges particularly those facing widespread conflict. Supporting countries in this segment might entail a new delivery and operating model, for example by working more deliberately with organisations who have the expertise to work in humanitarian and emergency contexts and adapting our policies for more rapid decision making and response.

4. **Strategic question 2: How can the global community engage non-Gavi countries to address growing inequities and maximise the impact of their domestic investments in immunisation?**

4.1 As described above, **vulnerable populations are now living in a range of countries with variable levels of income**<sup>7</sup>. In the next strategic period,

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<sup>7</sup> See detailed description of methodology in Annex A

most vulnerable people will live in MICs, often clustered in disadvantaged communities, such as displaced communities or urban slums. MICs host half of the world's refugees and internally displaced populations. The share of urban population is increasing at a faster pace in MICs than elsewhere, and more than a third of the urban population in MICs live in urban slums today.

- 4.2 **Many never-Gavi eligible MICs invest significantly in immunisation.** For example, they currently spend US\$ 90 per live birth on routine immunisation, versus US\$ 25 in Gavi-eligible countries. Despite this higher level of expenditure, **these countries are not getting adequate return on this investment and are facing significant challenges:** First, there are still many WHO-recommended vaccines to be introduced. For example, 52% of never-Gavi eligible MICs have not yet introduced PCV vaccine, and in 61% of countries Rota vaccine introductions are still pending. Second, many of these countries are experiencing issues in reaching every child. As a result, almost 70% of the world's under-immunised are expected to live in non-Gavi eligible MICs by 2030. And, as noted above, many never-Gavi eligible countries are at risk of backsliding with 45 out of 61 having seen their DTP3 coverage stagnate or drop since 2010.
- 4.3 **There are several drivers for these developments: Vaccine pricing stands out as one of the key barriers.** For example never-Gavi eligible MICs pay on average 5 (LMICs) to 6.5 (UMICs) times the Gavi price for the Pneumococcal Conjugate Vaccine (PCV). Egypt is an example of a country with strong political will for immunisation and strong health system but where access to affordable pricing has deterred the country from introducing PCV, Rotavirus and HPV vaccines. Other factors include a lack of political commitment or suboptimal know-how in running well-performing immunisation programs. South Africa, for example, faces challenges, with slipping DTP3 coverage (currently 66%) and less than half of districts reaching more than 80% of children with at least a minimum set of vaccines. Moreover, the country is faced with the challenge of providing services in urban slums – a challenge common to several Gavi countries- and repeated stock-outs of vaccines linked to poor coverage estimates and weak supply chain management. There is also a set of MICs characterised by protracted crisis, including Iraq and Libya.
- 4.4 Given the growing inequities in never-Gavi eligible countries, **the global community requires new approaches to engage these countries to maximise the impact of their domestic investments to reach their vulnerable children with life-saving vaccines.** With very limited financial investment, the Alliance could consider supporting countries through building political will for immunisation; strengthening decision making, forecasting, procurement and budgeting processes; helping to secure more affordable vaccine prices (by leveraging its market shaping expertise by working with countries to create better market dynamics, e.g. by pooling demand from countries, further leveraging economies of scale, and ensuring predictable demand perhaps by using innovative financing mechanisms to guarantee demand); catalysing new vaccine introductions;

supporting immunisation delivery system innovations and technologies; and sharing 'immunisation know-how' (e.g. by enabling south-to-south collaboration). These approaches would leverage the Alliance's comparative advantage and tools developed for eligible countries. With very limited financial investment by the Alliance (estimated <5% of the current Gavi programme envelope) the approaches would benefit non-eligible MICs faced with pressing immunisation challenges, and would move the world closer to the goal of universal immunisation and leaving no one behind.

## 5. Conclusion and next steps

### 5.1 To address the implications from the questions raised in this document, Gavi Secretariat proposes the following process:

- a) Following the Board discussion, further input on Gavi's future strategy and operating model will be gathered through individual consultations with Board members in Q1 2019.
- b) Based on these consultations, options for Gavi's strategic goals, principles of operationalisation and operating model will be presented and discussed at the Board retreat in April 2019.
- c) The Board will be asked for a decision on the potentially refined strategic goals and principles for operationalising the strategic goals at its June 2019 meeting.
- d) The Secretariat will work with the Board to further refine the approach to operationalise the strategic goals over the remainder of 2019 and 2020.

5.2 **As the strategy is being defined, the Board will also have to align on how to best allocate Gavi funding** across its country portfolio (with a likely focus on the segments most in need), portfolio of vaccines (focusing on vaccines with highest impact and best value for money), age range (likely continuing to focus on under-5 mortality while contributing to broaden the immunisation platform across the life course), global public good priorities (such as finishing polio eradication, preventing antimicrobial resistance and preventing cross border spread of infectious vaccine preventable diseases), and HSS (ensuring that health systems strengthening support remain within an appropriate range in Gavi's financial spend).

### **Section C: Actions requested of the Board**

The Gavi Alliance Board is requested to provide input on the context surrounding Gavi's strategy 2021-2025 and initial guidance on the two strategic questions laid out in this paper.

**Annexes**

**Annex A:** Methodology for income level classification

**Annex B:** Supplementary contextual analyses