About the GAVI Alliance

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

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

- The **Vaccine Goal**—Accelerating the use of new and under-used vaccines (e.g., meningitis, pneumococcal, and rotavirus vaccines)
- The **Health Systems Goal**—Strengthening the capacity of integrated health delivery systems to improve vaccination coverage
- The **Financing Goal**—Improving the predictability and sustainability of global and national financing for immunization
- The **Market-Shaping Goal**—Shaping vaccine markets to bring down and sustain the prices of appropriate and quality vaccines.

From January 2011 to September 2013, GAVI funded the roll-out of new/underused vaccines and vaccine campaigns in 47 different countries. In addition, GAVI helped to bring down the cost of vaccinating a child with three priority vaccines (pentavalent, pneumococcal, and rotavirus vaccines) from US$35 in 2010 to US$23 in 2012.

GAVI’s work is based on an innovative partnership and business model. GAVI is not an implementing agency, relying instead on countries and partners to ensure that resources provided by GAVI are used to meet local needs. Program proposals are developed by the countries that GAVI supports. These proposals are reviewed by an independent expert panel for their technical soundness and recommended to the GAVI Board for approval. GAVI also explicitly incentivizes countries to achieve results to make sure that funds are used efficiently and effectively.

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

Resource Mobilization

GAVI mobilizes resources through two main funding streams.

- It receives **direct funding** from governments and private sources, including through the GAVI Matching Fund. Under this fund, the UK Department for International Development and the Bill & Melinda Gates Foundation have pledged US$130 million combined to match contributions from companies and foundations.
- It mobilizes additional financing for immunization through two **innovative financing mechanisms**:
  - the *International Finance Facility for Immunisation*, which uses pledges from donor governments to sell bonds in the capital markets
  - the *Advance Market Commitment (AMC)*, which involves donors making advanced commitments to help speed up vaccine development and ensure affordable prices.

To further raise available funds, GAVI increasingly requires countries to co-finance vaccines.

Before the introduction of a formal replenishment process, all donor contributions were made on an ad hoc basis. In June 2011, GAVI held its first pledging conference in London, where donors committed **US$4.3 billion** for 2011–2015, bringing total pledges and contributions for 2011–2015 (including previous pledges) to US$7.4 billion. According to the 2013 Mid-Term Review report, 91% of these pledges and contributions have already been converted into signed grant agreements. The pledging conference for the second replenishment period 2016–2020 will be held in late 2014 or early 2015.

Direct Contributions

As of December 2013, GAVI had attracted **US$8.3 billion** in direct funding from public and private donors (for the period 2000–2017). Five donors account for 80% of total direct contributions to GAVI (see Top 5 donors to GAVI on p 2). The Bill & Melinda Gates Foundation is the donor with the largest direct commitments to date (US$2.5 billion), followed by the governments of the United Kingdom (US$1.7 billion), the United States (US$1.2 billion), Norway (US$1.1 billion), and the Netherlands (US$379 million).
Source: Annual donor contributions to GAVI 2000–2033 as of 31 December 2013

Matching Fund
Through the GAVI Matching Fund, GAVI partners have contributed and pledged US$205 million (as of March 2014) for the period 2011–2017 to match contributions from corporations, foundations, their customers, members, employees, and business partners. The Matching Fund aims to raise US$260 million by the end of 2015.

Contributions and pledges of IFFIm donors, 2006–2033 (as of December 2013)

As of December 2013, ten donors had contributed and pledged US$6.1 billion to IFFIm for the period 2006–2033 (See Contributions and Pledges of IFFIm Donors below). IFFIm was created in 2006 to frontload funding for immunization. It converts these long-term and legally binding donor pledges into immediately available resources for GAVI programs by issuing bonds in the capital markets. The donor pledges are used to repay the IFFIm bonds and to pay for the bond interest.

Between 2006 and December 2013, IFFIm had raised a total of US$4.3 billion in bonds for GAVI programs. As of December 2013, US$2.5 billion of IFFIm funds had been disbursed through GAVI programs.

As a result of downgraded credit ratings of some of IFFIm’s key donors, the facility was downgraded by one notch by Moody’s in March, then subsequently by Fitch in April and Standard & Poor’s in November 2013. However IFFIm reported that the adjustment was not expected to impair its ability to provide funding for GAVI.

Contributions and pledges from GAVI Matching Fund and private sector partners, 2011–2017 (as of March 2014)

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

The governments of Italy, the United Kingdom, Canada, the Russian Federation, and Norway, together with the Bill & Melinda Gates Foundation, committed US$1.5 billion to guarantee purchases of pneumococcal vaccines (see Contributions and Pledges of AMC Donors on page 3). In turn, vaccine manufacturers
committed to supplying their vaccines at a price no higher than US$3.50 per dose for 10 years to be paid by GAVI and the developing countries that introduce the vaccines. For about 20% of supplied doses, manufacturers receive an additional payment of US$3.50 per dose, which is paid out of the US$1.5 billion of donor commitments.

GAVI expects that the AMC will incentivize more manufacturers to produce the pneumococcal vaccine and that the heightened competition will drive down the vaccine’s price. In addition to AMC donor funds, GAVI mobilized a corresponding amount of funding for the roll-out of pneumococcal vaccines (US$1.6 billion for the period 2010–15). The number of pneumococcal vaccine doses introduced and procured per year through the AMC has increased from 7 million doses in 3 countries (Gambia, Rwanda, and Nicaragua) in 2010 to 58 million doses in 24 countries in 2012. According to GAVI estimates, more than 10 million children have been vaccinated through the AMC between 2010 and 2012. As of March 2013, 51 of GAVI’s 73 countries had applied, and been approved, for support for pneumococcal vaccines.

Since GAVI introduced the concept of co-financing in 2006, countries applying for new vaccine support have been required to contribute part of the cost of requested vaccines (except for measles 2nd dose, meningitis A, yellow fever preventive campaigns, and measles-rubella catch-up campaigns).

GAVI’s revised co-financing policy became effective in 2012. The policy bases co-financing levels on a country’s ability to pay, as determined by gross national income (GNI) per capita, broken into low-income, intermediate, and graduating groups. The number of countries required to co-finance vaccines increased from 27 in 2008 to 67 in 2012. Between January 2011 and August 2013, co-financing payments amounted to US$125 million, accounting for 8% of GAVI’s total funding to the co-financing countries. The policy encourages recipient commitment, with several countries contributing more than required. Co-financing is expected to further increase to around US$1 billion for the period 2016–2020. The policy is set to undergo a review process in 2014 and will be revised if needed.

Financing Portfolio

GAVI provides different types of support to developing countries with the aim of increasing their immunization coverage (Box 1). Only those countries with a GNI below a certain threshold are eligible for support. This threshold has recently changed:

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

In 2011, a revised eligibility policy came into effect. Under the updated policy, eligibility thresholds are updated annually for inflation adjustments. For 2014, the threshold for GAVI support was set at US$1,570. As several countries have experienced economic growth, the number of eligible countries is now 53. However, further conditions are set depending on the type of support, which means that not all 53 GAVI-eligible countries qualify for every type of support.

**Graduation:** GAVI designed a graduation policy for countries whose GNI per capita crosses the GAVI eligibility threshold and who start a phasing out of GAVI support. During this phase, GAVI will help graduating countries be in the best position to financially sustain their routine programs. The policy aims to ensure that immunization performance can be maintained or improved after graduation, and that new vaccines for graduated countries remain affordable.
Support for a previously eligible country does not end abruptly, because existing multi-year commitments for vaccines and/or cash-based programs from GAVI will continue to be honored. In addition, countries have several options to request GAVI support while embarking on the graduation track:

- Countries entering the graduation process after December 2013 can apply for new vaccine support in the calendar year after the date that they have been informed of their expected graduation.
- Countries currently in the graduation track with DTP3 (three-dose diphtheria, tetanus, and pertussis vaccination) coverage below 90% can access health system strengthening (HSS) support.
- Countries receiving GAVI vaccine support can receive a time-limited small catalytic investment during graduation.

**Commitments by Support Type**

As of November 2013, GAVI had committed US$8.3 billion to 77 countries up until 2017 (see Commitments to country programs by type of support on right). An additional US$790 million has been committed to fund disease-specific multi-country “investment cases.”

**Box 1. Types of GAVI support**

| New and underused vaccines support (NVS) | Provided as in-kind support available to countries with routine immunization coverage (three-dose diphtheria-tetanus-pertussis vaccine: DTP3) of 70% or higher. NVS includes vaccines for: hepatitis B, *Haemophilus influenzae* type b (Hib), Japanese encephalitis, meningitis A, measles-rubella, pneumococcal vaccine, rotavirus vaccine, and yellow fever vaccine. Other newly funded vaccines include: |
| Health System Strengthening (HSS) | Aims to strengthen capacity of health systems to deliver immunization through a performance-based HSS funding model (since 2012). Two former funding mechanisms are currently being phased out and integrated into the HSS platform: |

- Immunization services support (ISS): provided funding for strengthening of immunization systems to increase coverage of basic vaccines (DTP)
- Civil society organization (CSO) support: to involve CSOs in the planning/delivery of immunization services, and encourage cooperation between public sector and civil society

- Injection safety support (INS) to ensure safe injection practices
- Operational support to deliver large-scale campaigns
- Vaccine introduction grants to implement critical pre-vaccine introduction activities (e.g. health worker training, social mobilization)

**Commitments to country programs by type of support, 2001–2017 (as of November 2013)**

Total=US$8.3 billion

Source: GAVI—commitments, approvals & disbursements, as of 30 November 2013
Disbursements by Year and Support Type

Total annual disbursements, 2000–2013, by year paid (as of November 2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total (US$ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>2</td>
</tr>
<tr>
<td>2001</td>
<td>114</td>
</tr>
<tr>
<td>2002</td>
<td>94</td>
</tr>
<tr>
<td>2003</td>
<td>165</td>
</tr>
<tr>
<td>2004</td>
<td>142</td>
</tr>
<tr>
<td>2005</td>
<td>222</td>
</tr>
<tr>
<td>2006</td>
<td>213</td>
</tr>
<tr>
<td>2007</td>
<td>822</td>
</tr>
<tr>
<td>2008</td>
<td>612</td>
</tr>
<tr>
<td>2009</td>
<td>374</td>
</tr>
<tr>
<td>2010</td>
<td>651</td>
</tr>
<tr>
<td>2011</td>
<td>690</td>
</tr>
<tr>
<td>2012</td>
<td>970</td>
</tr>
<tr>
<td>2013</td>
<td>1,035</td>
</tr>
</tbody>
</table>

Total=US$6.1 billion

Source: GAVI—commitments, approvals & disbursements, as of 30 November 2013

Of this amount, US$5.5 billion was disbursed through GAVI country programs, and US$640 million was used to fund disease-specific “investment cases.”

Over three quarters of GAVI disbursements to country programs (77% or US$4.2 billion) was allocated to new and underused vaccines support (NVS). Of these NVS disbursements, GAVI spent:

- 56.4% on the pentavalent vaccine, combining vaccines against hepatitis B, Hib, and DTP
- 25.1% on the pneumococcal vaccine
- 3.9% on the monovalent hepatitis B vaccine
- 3.8% on the DTP-hepatitis B vaccine (the “tetravalent vaccine”)
- The remainder (10.9%) on rotavirus, yellow fever, meningitis A, measles, DTP-Hib, Hib, and HPV.

In addition to NVS, GAVI disbursed 9.3% (US$508 million) of total country program funding for HSS, 6.2% (US$340 million) for immunization services support (ISS), 3.7% (US$200 million) for operational support, 2.0% (US$108 million) for injection safety support (INS), 1.3% (US$71 million) for vaccine introduction grants, and 0.5% (US$26 million) for civil society organization (CSO) support (see Disbursements to country programs by type of support below).

Disbursements to country programs by type of support (as of November 2013)

- New and underused vaccines: 77.1%
- Health system strengthening: 6.2%
- Immunisation services support: 9.3%
- Operational support: 2.0%
- Injection safety support: 1.3%
- Vaccine introduction grant: 0.5%
- Civil society organization support: 0.0%

Total=US$5.5 billion

Source: GAVI—commitments, approvals & disbursements, as of 30 November 2013
Breakdown by Region
About 62% (US$3.4 billion) of all disbursed funding to country programs (US$5.5 billion) has been allocated to WHO’s African Region (see Disbursements to country programs by region, below).

Disbursements to country programs by region (as of November 2013)

<table>
<thead>
<tr>
<th>Region</th>
<th>Disbursement Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Region</td>
<td>61.6%</td>
</tr>
<tr>
<td>Eastern Mediterranean Region</td>
<td>19.0%</td>
</tr>
<tr>
<td>South East Asian Region</td>
<td>19.0%</td>
</tr>
<tr>
<td>Western Pacific Region</td>
<td>12.0%</td>
</tr>
<tr>
<td>European Region</td>
<td>4.5%</td>
</tr>
<tr>
<td>American Region</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Total=US$5.5 billion

Source: GAVI—commitments, approvals & disbursements, as of 30 November 2013

Breakdown by Recipient Country
About 55% (US$2.9 billion) of the total disbursements to country programs was channeled to 10 out of 77 countries that received GAVI support between 2000 and November 2013 (see Top 10 recipients of disbursements to country programs, below).

Top 10 recipients of disbursements to country programs (as of November 2013)

<table>
<thead>
<tr>
<th>Recipient Country</th>
<th>Disbursement Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>10.7%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>9.3%</td>
</tr>
<tr>
<td>DR Congo</td>
<td>6.2%</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>5.6%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>5.3%</td>
</tr>
<tr>
<td>Kenya</td>
<td>3.3%</td>
</tr>
<tr>
<td>Ghana</td>
<td>3.2%</td>
</tr>
<tr>
<td>Uganda</td>
<td>3.2%</td>
</tr>
<tr>
<td>Republic of Sudan</td>
<td>3.0%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2.2%</td>
</tr>
<tr>
<td>Other</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Total=US$5.5 billion

Source: GAVI—commitments, approvals & disbursements, as of 30 November 2013
Organizational Structure and Governance

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

Global Level Structures and Governance

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

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

GAVI's Independent Review Committee (IRC), composed of technical experts, reviews new proposals based on technical criteria and provides funding recommendations to the GAVI Alliance Board (see section below, called Funding Process). The IRC meets three times a year.

To strengthen grant monitoring, the GAVI Board approved a new grant application, monitoring, and review (GAMR) process in 2013, which establishes a High Level Review Panel. The Panel, which is composed of senior GAVI staff and IRC members, meets about 3–6 times a year to review annual renewal requests that countries submit to secure funding for the coming year (see Funding Process).

Key GAVI partners are WHO and UNICEF. WHO's Department of Immunisation, Vaccines and Biologicals develops technical standards to ensure the quality and safety of vaccines, and provides technical guidance to GAVI. UNICEF's supply division in Copenhagen procures vaccines and safe infection materials for GAVI countries.
Through their country offices, both WHO and UNICEF also play a key role in supporting countries in their application for GAVI support, and subsequent implementation and monitoring of immunization programs. Funding for both organizations is outlined in GAVI’s 2013–2014 business plan. For 2013, WHO was set to receive US$51 million and UNICEF US$30 million to provide their services.

The International Finance Facility for Immunisation (IFFIm) has its own governance structure. In July 2013, IFFIm reported a simplification of its operational system by removing its intermediary to GAVI, the GAVI Fund Affiliate (GFA), and is currently engaged in a restructuring process. The IFFIm Company oversees bond issuances and other securities, and engages in donor and investor outreach activities. It also reviews and approves funding requests that are submitted by the GFA. The World Bank acts as treasury manager and financial advisor for IFFIm.

**Country Level Structures and Governance**

At country level, Interagency Coordination Committees (ICCs) bring together the expertise of in-country partners (e.g., government agencies, multilateral agencies, and CSOs) to conduct immunization programs. ICC members support governments in the design of proposals for immunization programs and oversee program implementation.

Proposals and progress reports for HSS must be endorsed by the country’s Health Sector Coordinating Committee (HSCC). ICCs and HSCCs are key mechanisms for monitoring the appropriate use of GAVI funding at the country level. All funding requests and progress reports to GAVI need to be signed by either the ICC or HSCC (see Funding Process).

Country governments—particularly their ministries of health—play a crucial role in GAVI-related processes, as it is their responsibility to apply for GAVI support and decide on the type of support. Governments can receive direct cash funds to implement immunization and HSS programs and are then responsible for the delivery of services. In addition, governments convene the ICCs and lead the preparation of health sector plans and comprehensive Multi-Year Plans (cMYPs). The development of both cMYPs for immunization and national health sector plans is crucial because they (a) form the basis of the country’s application to GAVI, and (b) assure that GAVI support is integrated with country plans and budgeting processes.

### Funding Process

Under the new application process, GAVI seeks to strengthen linkages between support for HSS and NVS, by aligning application and review timelines for both types of support. As of 2014, applications for both new NVS and HSS are accepted through the same application and review timelines.

**Program Design and Review**

The application process has six main steps:

1. To apply for new GAVI support, eligible countries’ governments, usually the health ministry, first submit an Expression of Interest (EOI), which may be sent to the GAVI Secretariat at any time, but at least four months prior to application submission. For the first application round of 2014, which has a deadline of May 1, 2014, the EOI is not mandatory, but submitting an EOI will become mandatory starting with the September 15, 2014 cut-off date for applications. Countries need to submit only one EOI for all types of GAVI support that they intend to seek. The EOI was introduced to improve coordination between the GAVI Secretariat, development partners, and country governments in the application process, and to better align country plans and vaccine supply availability.

2. Countries prepare and submit their application (separately for NVS and/or HSS) on a rolling basis following consultations with the country’s ICC, HSCC (for HSS applications) or equivalent, which need to endorse the applications. In addition, applications need to be signed by the Minister of Health, and usually also the Minister of Finance. Moreover, countries need to ensure that applications are aligned with their national health strategy or plan, cMYP for immunization, and other relevant plans.

3. Upon submission, the GAVI Secretariat conducts a completeness screening and an application pre-review, which looks at the consistency and validity of the presented data (e.g. on the projected date of vaccine introduction, the number of doses requested, methods for monitoring and reporting vaccine coverage, and national/regional disease burden).

4. Following the screening, the IRC reviews applications for all types of support (NVS and HSS), to ensure that the entire portfolio of GAVI support for a country is reviewed at the same time. This differs from the former approach, in which the IRC reviewed different types of support separately. The IRC assesses the technical quality of each proposal and either:
   - makes a funding recommendation to the Executive Committee or CEO, and provides feedback and comments on any key issues to applicants, or
   - requests applicants to revise and re-submit the application at a subsequent funding round if the application is incomplete or does not meet all criteria.

5. Following the recommendation for approval by the IRC, the application is approved by the Executive Committee or CEO, and countries are informed of the decision through
a decision letter or updated Partnership Framework Agreement (PFA). The PFA is an overarching legal agreement recently introduced to replace the decision letter. Going forward, all GAVI vaccine and cash funding to a country will be managed under the PFA. In addition, GAVI informs WHO and UNICEF to facilitate logistical and financial preparations (e.g. for vaccine shipments and cash disbursements).

6. Countries receive the first delivery of vaccines and commodities about six months after the application is approved. Lead times for HSS support (cash disbursement) are shorter.

Program Implementation and Monitoring
For support approved before 2014, countries need to submit an Annual Progress Report (APR) to report on progress and results achieved by the program in 2013. From 2015 onwards, the APR will be replaced by a Performance Framework that will be used for all grants as the central reference document for monitoring a program’s progress and results throughout a year. Performance Frameworks are based on a country’s existing monitoring and evaluation (M&E) systems, the details of which countries need to describe in the application. The details include indicators, baselines, targets, an analysis plan, and review mechanisms. When applying for HSS support, countries are expected to use an HSS-specific M&E framework developed by GAVI.

A country’s M&E plans need to include plans for monitoring the impact of vaccination (including, for example, information on the collection and use of pre- and post-vaccine introduction data, vaccine impact studies, and baseline information on the epidemiology of the disease). In addition, countries need to provide details on existing mechanisms for data quality assessment and are required to regularly conduct household surveys to assess immunization coverage and equity issues (GAVI considers two surveys in five years appropriate for most countries). If these data quality mechanisms and surveys do not yet exist, countries must provide details on plans to implement these, and—from the second funding year onward—need to document the progress made in order to continue receiving GAVI support.

GAVI directly extracts much of the data required for the Performance Framework through existing sources (such as the Joint Reporting Form [JRF], a standardized vaccination reporting questionnaire developed by WHO and UNICEF). Countries report the remaining indicators and data items directly to GAVI. Since countries already report much of the information requested by GAVI to the WHO and UNICEF (i.e., in the JRF), GAVI’s reporting requirements are considered to be less burdensome than those of other donors.

To supplement the Performance Framework, GAVI requires countries to report progress through a “lighter mechanism,” but details on this mechanism are currently still unclear.

Program Management
GAVI support is usually provided for the duration of the cMYP, usually 4–5 years, except for HSS funding, where the duration is determined by the national health plan. While GAVI support is usually provided on an annual basis, countries receive an estimate of the total amount of multi-year GAVI financial support when their funding proposal is approved. This multi-year amount might be adjusted depending on program performance (see below). For countries receiving vaccines and/or safe injection supplies, the funding usually goes directly to UNICEF’s Supply Division to procure the needed items. UNICEF is then responsible for arranging delivery with the country.

To secure funding for the coming year, countries submit annual renewal requests in which they provide information on national level immunization data and progress against program targets. The renewal requests are reviewed by the High Level Review Panel, which meets about 3–6 times a year and is composed of senior GAVI staff and IRC members. Requests are reviewed following a recommendation made by the Secretariat which is based on routine monitoring of grant progress (and, if necessary, in-country review missions). The High Level Review Panel replaces the former Monitoring IRC, which met once a year and made renewal recommendations only based on a desk review of countries’ annual progress reports.

At the end of a country’s strategy and planning cycle, requests for renewed GAVI support are reviewed by the IRC.

Criteria for NVS Support
In order to prove that they have an adequate national platform for distributing vaccines, countries need to fulfill certain criteria before applying for NVS support. GAVI considers such a platform necessary to ensure the efficient and broad roll-out of new vaccines. The proxy measure to determine the quality of health systems is the coverage level of DTP3 routine vaccination. In order to be eligible for NVS, countries must reach DTP3 coverage of at least 70% (according to WHO or UNICEF analysis). Prior to 2012, the coverage threshold was 50%.

Cash Support to Strengthen Health System Capacity to Deliver Immunization
At its November 2011 meeting, the GAVI Alliance Board requested that the Alliance roll out performance based health systems funding, starting in 2012.

Countries now apply for HSS grants that use a performance based funding (PBF) approach, which is designed to incentivize improved immunization outcomes by strengthening health
Based on country population and GNI per capita, GAVI determines the maximum funding amount for a country’s HSS grant (the funding ceiling). While countries receive 100% of their annual funding ceiling in the first year, in year two and onward, countries receive 80% of the ceiling if they make satisfactory progress in program implementation and in meeting intermediate results (programmed payment). Additional performance payment is disbursed if countries improve DTP3 and measles first dose coverage (if their DTP3 coverage is below 90% at baseline). For countries with DTP3 coverage at or above 90% at baseline, additional performance payment is disbursed for sustaining high DTP3 coverage and increasing equity in DTP3 coverage. If countries meet performance payment criteria, they may receive up to a maximum of 150% of their annual funding ceiling.

**Results**

GAVI has helped to significantly increase the number of children worldwide who have access to immunization. Since 2000, GAVI has supported 77 countries in its different programs; in 2013 alone, 41 new campaigns and introductions were supported. There has been particular progress in rolling out a number of new and underused vaccines across targeted countries. Key results include:

- By the end of 2013, GAVI is estimated to have contributed to preventing about 6 million future deaths and to have supported the immunization of an additional 440 million children.
- By 31 December 2013, 72 out of 73 GAVI-supported countries have introduced pentavalent vaccine, and 38 countries have introduced pneumococcal vaccine. Both of these programs have thus exceeded vaccine program targets of 69 and 35 countries, respectively. Eighteen GAVI-supported countries had introduced rotavirus vaccine by the end of 2013, below the target of 23, although a greater uptake is expected in 2014.

Immunization coverage has climbed steadily, with coverage in 2012 reaching 43% for pentavalent vaccine (3rd dose), 9% for pneumococcal vaccine (3rd dose), and 3% for full rotavirus immunization. Despite a significant improvement in coverage of these vaccines in the 2011–2015 GAVI Strategy period, coverage levels lag behind the goals set for 2012, and GAVI is currently not on track to meet its 2015 coverage targets (77% for pentavalent vaccine [3rd dose], 40% for pneumococcal vaccine [3rd dose], and 31% for rotavirus vaccine). This lag is due to slower than expected roll-out in countries due to global supply constraints and other factors.

**Market Shaping**

One of GAVI’s strategic objectives, outlined in its 2011–2015 Strategy, is to create a competitive and sustainable vaccine market. GAVI achieves reductions in vaccine price by bringing new vaccine manufacturers to the market and thereby increasing competition.

According to the October 2013 Mid-Term Review Report, GAVI has made good progress on its goal of achieving price reductions, as the total cost for immunizing a child with pentavalent, pneumococcal, and rotavirus vaccines fell from US$35 in 2010 to US$23 in 2012. In addition, the number of manufacturers supplying vaccines to GAVI increased from 5 suppliers in 2001 to 12 suppliers by mid-2013.

The pentavalent vaccine, GAVI’s largest investment, was initially only offered by one manufacturer. From 2003 to 2013, the number of manufacturers rose from one to five and the price of the pentavalent vaccine fell from an average price of US$2.98 in 2010 to as low as US$1.19 per dose in 2013.

**Outlook**

Now in its third phase (2011–2015), GAVI has secured donor contributions and pledges of US$8.3 billion to support immunization programs in the world’s poorest countries. According to WHO estimates, GAVI is on track to reach its aim of supporting the immunization of an additional 243 million children with the last recommended dose of any GAVI-supported vaccine between 2011 and 2015.

The Alliance is continuing its broad roll-out of immunization. However, more than two million children still die each year of preventable causes and GAVI will have to continue its resource mobilization efforts in order to achieve the goals set out in the 2011–2015 strategy and beyond.

Ahead of the next Pledging Conference scheduled for late 2014/early 2015, GAVI is currently developing its new **2016–2020 strategy**, with the final draft to be approved at the Board meeting in June 2014. According to GAVI’s CEO Seth Berkley, the new strategy is likely to place a focus on (i) scaling-up vaccine coverage to every child with all recommended vaccines, and (ii) ensuring that its immunization programs are sustainable.

In November 2013, the GAVI Board decided that GAVI will begin supporting the introduction of inactivated poliovirus vaccine (IPV) as part of routine immunization programs to complement efforts by the WHO and the Global Polio Eradication Initiative (GPEI) to eradicate polio.
Over the long term, GAVI projects that in the 73 countries that it currently supports, 7 out of 10 children will be fully immunized by 2030, an increase from under 1% in 2012 (see Projected rise in proportion of fully immunized children to 2030, below).

Data were provided by the GAVI Alliance. Projections are based on current forecasting. 'GAVI 73' refers to the 73 countries currently supported by the GAVI Alliance.

---

**Funding and Authorship**

This profile was funded through a general operating support grant from the Bill & Melinda Gates Foundation to the Global Health Group at UCSF, with a subcontract to SEEK Development. The Foundation played no role in writing the profile. The profile was written by authors at SEEK Development (Raimund Zühr, and Christina Schrade), and E2Pi at the UCSF Global Health Group (Gavin Yamey). Research assistance was provided by Jessica Kraus, and Janna Jung-Irrgang (SEEK Development). For information on authors’ competing interests, see www.e2pi.org (click on Smarter Aid section).