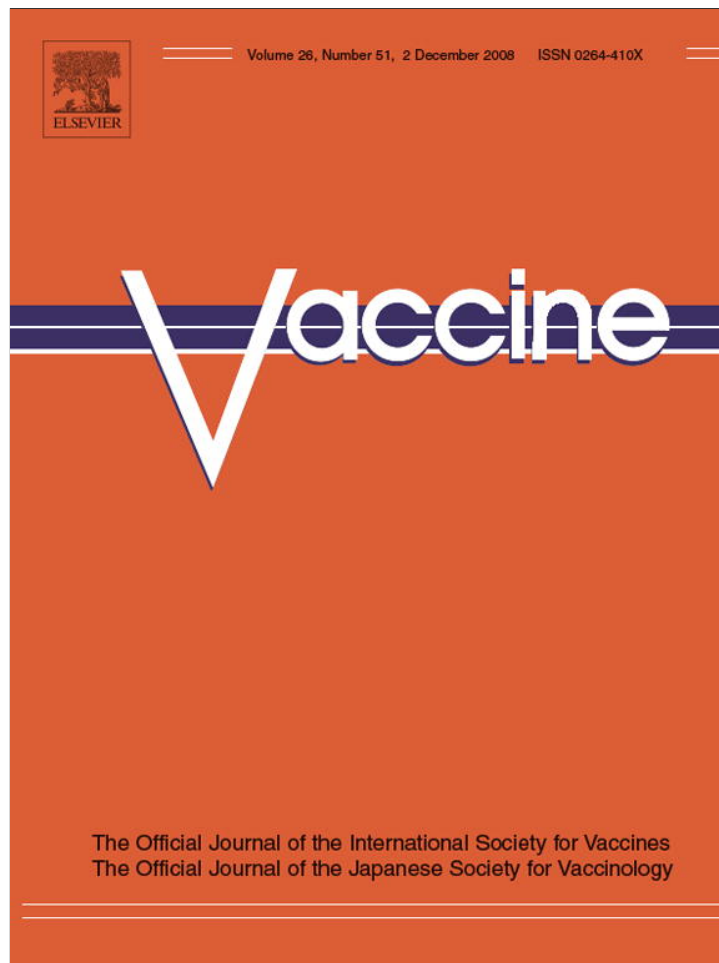


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journal homepage: www.elsevier.com/locate/vaccineThe GAVI Financing Task Force: One model of partner collaboration[☆]Julie B. Milstien^{a,*}, Lidija Kamara^{b,1}, Patrick Lydon^{b,2}, Violaine Mitchell^{c,3}, Steve Landry^{d,4}^a University of Maryland School of Medicine, 3 bis rue des Coronilles, Res Parc de Clementville, Bat C, 34070 Montpellier, France^b Immunization Vaccines and Biologicals Department, Expanded Programme on Immunization (EPI), World Health Organization, 20 Avenue Appia, CH-1211, Geneva 27, Switzerland^c Sea Bluff Farm, 530 Witty Beach Road, Metchosin BC V9C 4H8, Canada^d Global Health Program, Bill & Melinda Gates Foundation, PO Box 23350, Seattle, WA, USA

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ABSTRACT

The Global Alliance for Vaccines and Immunization, now called the GAVI Alliance, was launched in 2000 as a coalition of partners, including countries, international organizations, bilateral donors, the vaccine production industry, and nongovernmental organizations; most activities were to be implemented through these partner organizations. Four task forces were established at the outset to define issues relevant to GAVI Alliance goals and to recommend actions. This paper describes the innovations and outputs of the Financing Task Force (FTF), which worked in three areas: country support to sustainably finance vaccines and immunization programs in the context of introducing new vaccines; vaccine supply and demand issues as they impact vaccine choice, production costs and price/dose; innovative financing mechanisms for vaccines and immunization programs through, for example, capital markets. This analysis particularly focuses on the FTF's work on financial sustainability. Through its partnership, the FTF was able to leverage organizational change in its participating organizations, in the countries supported by the GAVI Alliance, and in the policies of GAVI itself. These achievements, along with areas where the desired outcome was not achieved, are summarized with lessons that may be useful to other multi-partner health alliances.

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1. Introduction

1.1. The Children's Vaccine Initiative (CVI): the forerunner of Global Alliance for Vaccines and Immunization (GAVI)

In the 1990s, after the announcement of the achievement of the goal of universal child immunization by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) (defined as reaching 80% of the world's children with at least one dose of vaccine), the international community then turned its attention to a more visionary target: to harness new technologies to advance the immunization of children, with an ideal vaccine to be given as a single dose (preferably orally), effective when administered near birth, heat stable, containing multiple antigens, effective against diseases not currently targeted, and affordable [1]. This effort became known as the Children's Vaccine Initiative, and it was overseen by a managing body made up of high level staff members of UNICEF, WHO, the United Nations Development Programme, the Rockefeller Foundation, and the World Bank (WB). It soon became apparent that, while new vaccine presentations and formulations would be useful, the infrastructure to develop, produce, regulate, finance, and deliver these vaccines to the developing world was not yet in place. Thus, the CVI turned a major part of its focus on assessing and strengthening this infrastructure [2]. This work was agreed

[☆] This paper is an introductory document in a series of papers describing the work of the Financing Task Force in the first 5 years of the GAVI Alliance. The second and third papers in the series are focused exclusively on the FTF's work on financial sustainability in immunization programs. A larger document on which these three papers are based will be available at the WHO Immunization Financing website (http://www.who.int/immunization_financing/en/). Paper 2: Lydon P, Levine R, Makinen M, Brenzel L, Mitchell V, Milstien JB, Kamara L, Landry S. New vaccines in the poorest countries—What did we learn from the GAVI experience with Financial Sustainability? Paper 3: Kamara L, Milstien JB, Patyna M, Lydon P, Levine A, Brenzel L. Strategies for financial sustainability of immunization programs—A review of the strategies from 50 National Immunization Program Financial Sustainability Plans, both submitted to Vaccine, 2008.

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to be important, but was frustratingly slow, plagued by insufficient resources, and bedeviled by organizational conflicts. Eventually, the CVI became institutionally based in WHO, and ceased to function as a multi-partner collaboration.

1.2. The birth of GAVI

The end of the CVI era was followed by the creation of a new global alliance. With the availability of \$750 million over 5 years, from the Bill and Melinda Gates Foundation, the Global Alliance for Vaccines and Immunization, now known as the GAVI Alliance, or GAVI, was launched in 2000, after an initial board meeting in 1999 [3]. Its basic focus, a bold idea needing a larger resource base than was ever before put together globally for immunization, was to save children's lives and protect people's health through the widespread use of vaccines, especially those new and underused in the developing world that could have a large impact on developing country disease [4]. The GAVI Alliance aimed to 'make a major contribution to the two-thirds reduction in under-five mortality targeted by the international community in the Millennium Development Goals. . . by making advanced vaccine products available in the world's poorest countries and strengthening delivery systems to ensure that their children derive full benefit' [5]. The first vaccines to be supported were yellow fever vaccine in countries at high risk, and hepatitis B (HepB) and *Haemophilus influenzae* type b (Hib) vaccines, preferentially supplied as combination vaccines with diphtheria–tetanus–pertussis (DTP).

The alliance includes as members governments in both developing and industrialized countries, representatives of the vaccine industry, both the multinational companies based in industrialized countries, and the emerging suppliers, based in developing countries, nongovernmental organizations (NGOs), research and public health institutions, WHO, UNICEF, WB, and the Bill and Melinda Gates Foundation. GAVI's particular focus has been strengthening health systems and introducing specific new vaccines in 75 (now 72) of the world's poorest countries; those with Gross National Income (GNI)/capita below US \$1000.

GAVI was intended to be a public–private partnership through which each of its members would contribute to achieving the goal. The management structure developed differed from that of the CVI in several ways:

- vaccine industry had a “seat at the table;”⁵
- with a lean secretariat, GAVI's Board of Directors would be involved in management, but the bulk of “secretariat” work would be overseen by a Working Group made up of partners, and the actual work plan would be implemented by the partners;
- specific issues to be resolved were to be tackled by four time-limited task forces (research and development, implementation, advocacy, and financing), again staffed by partner organizations;
- the global level structure would be replicated at regional and national levels, working with countries to be sure that national and regional partners agreed on and implemented actions to be taken.⁶

⁵ Actually two seats, one for the multinational industry, represented by the Biologics and Vaccines Committee of the International Federation of Pharmaceutical Manufacturers Associations, and subsequently added, one for an organization made up of emerging suppliers, the Developing Country Vaccine Manufacturers Network.

⁶ The Regional Working Groups (RWGs) to be described below were designed to play this role at regional level. The structure at national level was the Interagency Coordinating Committee (ICC).

1.3. The Financing Task Force (FTF)

The FTF was established by the GAVI Board in 1999 to:

- increase the understanding of the financing of immunization services within the health sector and in the poorest countries;
- identify strategies which would improve the capacity of governments, donor partners, and development banks to finance program needs;
- identify financial strategies to stimulate research and development and production of affordable, priority vaccines [6].

The present series of papers is focused primarily on the work in countries related to financial sustainability (FS) and the development of financial sustainability plans (FSPs), which were an essential focus of the FTF. As such, it will cover the framing of the FTF work plan and collaborative model and its evolution, to be found in the current paper; the results of the FS work as determined from analyzing a global immunization financing database made up of information from FS plans of 50 countries receiving GAVI support, and a review of strategies that countries have used in achieving financial sustainability, which respectively will be the foci of the second and third papers in this series.

The FTF undertook most of its work on FS between 2001 and 2005. In June 2006, as part of the GAVI transition to Phase 2, the FTF was discontinued. As GAVI completes its first phase of work, it is useful to step back and analyze its accomplishments and failures of the FTF as a model of partner collaboration.

1.4. Study methodology

This paper was based on a thorough review of approximately 20 documents developed by the FTF during Phase 1 of the GAVI Alliance, most of which are unpublished or available only through the WHO document center or on the GAVI website [7]. The review itself is being published on the WHO immunization financing website [7]. The review of these documents was supplemented by review of published documents in the area of financing and financial sustainability commissioned by the FTF, and more than 15 face to face or telephone interviews with former FTF members, Regional Coordinators, and GAVI staff [7].

2. Results and findings

2.1. GAVI's financing model

At GAVI's inception its partners developed a specific and innovative model to transfer resources to low-income countries to strengthen immunization programs and expand health opportunities. The model was intended to be:

- *Catalytic*: based on the principle that the recipient country government and its partners will invest more in immunization;
- *Additive*: there would be non-substitution of existing immunization investments;
- *Resulting in price reduction*: 5 years' volume would drive prices down to their “mature” levels;
- *Promoting financial sustainability*: midway through the GAVI support period countries would define how they anticipated transitioning their resources away from GAVI dependence.

Originally, it was felt that this policy would stimulate manufacturer investments and eventually drive down vaccine prices so that countries with limited resources could take over funding.

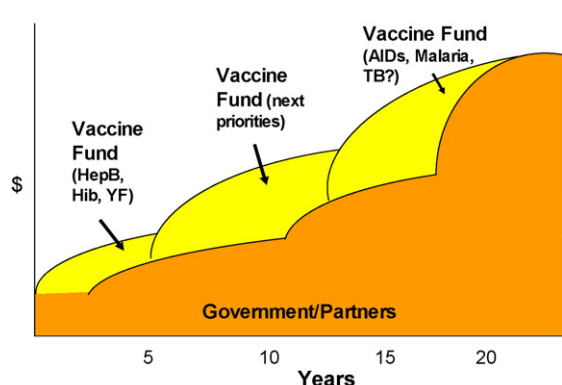


Fig. 1. Financing model for GAVI Phase 1 (adapted from [8]).

GAVI funds could then be redirected for additional new vaccines, as shown in Fig. 1. After 3 years countries were expected to demonstrate through financial plans how they intended to continue financing beyond the grant period; the FTF was charged with outlining the process for this activity. The assumptions inherent in this model were that

- national governments would be able to mobilize more funds, particularly from in-country donors;
- the price of vaccines would decline, so that even though they were more expensive than currently used vaccines, the countries would be able to take on paying for them with domestic and externally mobilized funds;
- these changes (enhanced resources from governments and partners, price decline to mature levels) were assumed to occur within 5 years following disbursement of GAVI funding to a country.

Support provided by the GAVI Alliance was in the form of multi-year grants to countries to support immunization services, new and underused vaccines (HepB, Hib, and yellow fever) and injection safety. Grants were made based on a rigorous application process in which country proposals were reviewed by a panel of independent experts drawn from a wide geographic and technical base. By the end of GAVI Phase 1, \$1.5 billion had been allocated for direct support to over 70 of the world's poorest countries.

2.2. Description of the FTF

The FTF was composed of representatives of organizations mirroring the GAVI structure, the vaccine industry representation, several developing countries, the major international agency partners, the primary bilateral donors, research and development and public health organizations, and a number of consultants with expertise in the areas to be considered. Two co-chairs, both of whom had significant experience in immunization and immunization financing, and an FTF coordinator assured leadership. "The engagement in FTF work of a wide range of able and committed contributors at country, regional and global levels is regarded as a particular strength, as are the leadership and dynamism of the two co-Chairs and the FTF Coordinator, working in concert with a dedicated and resourceful Core Group [9]."

The membership consisted of an "extraordinarily committed high energy group"⁷ of around 20 "talented individuals" represent-

ing different partners, "who were willing to go beyond institutional self-interest." They were willing to take risks, to be innovative, to challenge existing systems, and to "use information to move forward." Work was done through FTF meetings, through weekly conference calls with the FTF core group, which numbered about 12, plus additional conference calls among those working on specific aspects of the FTF focus, and through major meetings of a larger consultative group, up to 200 people, which the FTF considered to be its stakeholders.

2.3. Major outputs of FTF in financial sustainability

2.3.1. Defining a process to achieve financial sustainability

In its first phase of support GAVI sought to address the question of financial sustainability in a systematic way, by requiring that all countries receiving GAVI support for new vaccines indicate in their application in general terms how they planned to finance the added recurrent cost burden, and to commit to prepare a detailed FSP. Because GAVI support had an initial term of 5 years, countries needed to plan midway through the funding period how they would manage the transition and finance the costs of immunization services with new vaccines after the end of the initial GAVI commitments. The FTF was to implement that work. Yet before the financial sustainability strategy was begun, initial discussions in 2000 with a wide group of partners revealed wide and profound philosophical differences and a lack of consensus on what financial sustainability was, is, or should be within the context of immunization in the world's poorest countries. Much of the initial thinking was based on previous work on immunization financial sustainability in the 1990s [10], which included in-depth immunization costing studies, and proposed the application of tiered pricing to vaccine procurement.

For some, financial sustainability was synonymous with "self-sufficiency" often applied to situations where external donors sought to induce developing country governments to mobilize domestic resources for activities that had previously been externally funded. For others, interpreting financial sustainability as self-sufficiency was completely unattainable in poor country settings and inconsistent with – and for many countries in direct opposition to – established GAVI milestones of increasing coverage and introducing new vaccines.

Following several heated meetings, it became apparent that the FTF could not move forward with the development of FSP guidelines to countries without a common understanding and definition of what financial sustainability meant within the GAVI context. In response to this, the FTF commissioned a paper entitled *Financial Sustainability of Childhood Immunizations: Issues and Options* (April 2001) [7], which became the centerpiece for an FTF workshop that included delegations representing ministries of health and finance from four countries, Zimbabwe, Benin, Ukraine, and Bangladesh. The workshop developed a consensus definition of financial sustainability and provided an outline for guidelines to countries on financial sustainability planning. Thus, in late June 2001 the GAVI Board accepted the following definition of financial sustainability:

Although self-sufficiency is the ultimate goal, in the nearer term sustainable financing is the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance in terms of access, utilization, quality, safety and equity.

This definition moved toward the idea that financial sustainability: (a) is a shared concern and a shared responsibility of both governments and their development partners; (b) requires matching financing to evolving program objectives; (c) includes the

⁷ Unless otherwise noted, all quotes come from interviews with former FTF members, September 2007.

concepts of *adequate* and *reliable* financial resources, focusing not only on the quantity of funds but on how well they reach the levels where they are needed; (d) is related to both *mobilization* and *efficient use* of financial resources. With the board-approved definition of financial sustainability and the recommendations of the June 2001 workshop in hand, the FTF began the process of supporting countries to achieve financial sustainability, first by the development of guidelines on how to develop a financial sustainability plan for their immunization program.

2.3.2. Institutionalizing the process and developing an evidence base

The FTF developed a model to provide support to countries in the development of the FSPs. Once tools and guidelines were developed at global level, with inputs from regional staff and countries, the FTF, through a series of capacity building exercises, including workshops, regional meetings and direct technical assistance to countries, implemented a comprehensive process. Additionally the FTF heavily promoted and earmarked resources for building longer term regional and country level capacities in immunization costing and financing through the FSP process and by using existing regional and country networks and institutions. The tools and guidelines have been widely disseminated and used by regions and countries in developing and implementing FSPs.

Once the basic framework for country support was established, it then had to be implemented. For development of FSPs in all 75 countries, for example, the FTF was faced with a decision: should it try to carry out the work itself, or institutionalize it to one or more of the partner organizations? The approach that was taken was multi-partner implementation under the oversight of the FTF, with a GAVI-funded staff member based at WHO to coordinate the FSP development process. Because estimating the costs and financing of a national immunization program is a key step in the development of a financial sustainability plan, this process was dependent on the development of an immunization financing database, using standard data capture elements from the tables and costing tools developed as part of the FSP process, managed by a health economist based in WHO, and overseen by a database development team.⁸

Although developing a definition of FS and the tools to move towards it were important outputs, the definitive outputs are, first, the number of countries that actually developed FSPs, and, even more important, the number of countries introducing new vaccines that have actually moved toward taking on the added expense through mobilizing internal funds in a sustainable manner. Table 1 is a list of countries that developed FSPs, of which there were 55.⁹ Of these, 50 plans were analyzed for trends (paper 2 of this series). India, Indonesia, and China adapted the concept to their needs.

A more telling deliverable is the number of countries that actually transitioned to take on the financial burden of new vaccines; that is countries that were considered to be “success stories.” This is further detailed in paper 3 of this series, however, of the 70 countries, of which 55 developed some form of FSP, some countries began during Phase 1 to take over government financing of vaccines that were previously GAVI-financed. These include Cambodia, Ghana, Guyana, Malawi, Rwanda, United Republic of Tanzania, and Zambia.

Table 1

FSP development during GAVI Phase 1 (2000–2005)

Region ^a	Countries with FSPs ^b
Africa (East & Southern)	Burundi, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Rwanda, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
Africa (West & Central)	Benin, Burkina Faso, Cameroon, Congo DR, Côte d'Ivoire, Gambia, Ghana, Guinea, Mali, Mauritania, Niger, Senegal, Sierra Leone
Americas	Guyana, Haiti
Eastern Mediterranean	Afghanistan, Pakistan, Sudan, Yemen
Europe	Albania, Armenia, Azerbaijan, Bosnia & Herzegovina, Georgia, Kyrgyzstan, Moldova, Tajikistan, Ukraine, Uzbekistan
South-East Asia ^c	Bangladesh, Bhutan, India, Indonesia, Korea DPR, Myanmar, Nepal, Sri Lanka
Western Pacific	Cambodia, China, Lao PDR, Vietnam

^a Unless otherwise indicated, WHO regional groupings are used throughout the paper.

^b Angola, Congo, CAR, Chad, Guinea Bissau, Liberia, Nigeria, Sao Tome, Togo, Bolivia, Honduras, Djibouti, Somalia, Turkmenistan, and Mongolia did not develop FSPs.

^c FSPs and MYPs were drafted mostly with help from regional institutions, the Chulalongkorn University and the Indian Institute of Economic Growth.

2.3.3. Developing a collaborative working method

Showing the power of the alliance, partners provided the following support for the FSP development and capacity building activities:

- **AMP:** FSP workshops support; direct country support to Togo, Benin, Côte d'Ivoire, indirect support to other African countries through the EPIVAC training initiative;
- **DFID/HLSP:** FSP workshops support; FSP lessons learned evaluations; bridge financing country consultations;
- **NORAD:** FSP lessons learned evaluations, bridge financing country consultations;
- **PATH/CVP:** FSP workshop support; training materials development; direct country support to Cambodia, Mongolia, Eritrea, Vietnam, India, Indonesia, and China;
- **The World Bank:** FSP workshops support, bridge financing country consultations; training materials development; direct country support to Albania, Tajikistan, Uzbekistan, Bosnia & Herzegovina, Ethiopia, Georgia, Ukraine, Moldova, Uganda, Ethiopia, Congo DR, Congo, Sudan, India, and China;
- **USAID/BASICS:** FSP workshops support, training materials development; pilot testing of the FSP guidelines; bridge financing country consultations; direct country support to Ghana, Cambodia, Rwanda, Uganda, and Indonesia.
- **World Health Organization:** FSP workshops support; bridge financing country consultations; training materials development; direct country support to Kenya, Mozambique, Madagascar, Eritrea, Kyrgyzstan, Armenia, Lao PDR, Malawi, Zambia, Rwanda, United Republic of Tanzania, Burundi, Comoros, Pakistan, Guyana, The Gambia, Haiti, Sierra Leone, and Guinea;
- **UNICEF:** FSP workshops support; bridge financing country consultations, in-country FSP development and implementation technical support to all 55 countries that developed FSPs.

At least as early as 2002, as part of the management structure imposed by GAVI, the FTF developed a costed plan of work each year for funding by the GAVI Board and by the partner institutions. Each partner representative was expected to be able to commit his or her own institutional resources to implement some part of the work plan. This aligning of FTF and partner commitments was difficult in principle, because it implied that the institutional representa-

⁸ Further described in paper 2 of this series.

⁹ China, India, and Indonesia developed the concept to fit the needs of their individual situations; India did not do an FSP as such, for example, but costed their Multi-Year Plan, so their plans are not included. The Bangladesh and Pakistan plans were also omitted from the analysis.

Table 2
Accomplishments and weaknesses of the FTF's FSP process

Category	Accomplishments	Weaknesses
Defining a process	Opened space for discussion of FS and ways to achieve it, including increasing program efficiency Useful definition of FS to guide work Standardized method and financing tools	Developing country inputs not systematically and effectively solicited FSP process came too late in GAVI cycle Much emphasis on development of processes in the first 3 years, which impeded the ability of timely implementation of FSPs
	Financing tool can help identify costs for advocacy Folder on financing options, other publications and guidelines	GAVI IRC process tended to reward quality end products rather than good processes in country
	Put FS planning “on the map”	Perceived as a globally driven process by GAVI and the FTF resulting in limited regional and country ownership to the process
Institutionalizing the process	Systematic collection of data through the immunization financing database Significant amount of quantitative information now in GAVI database Other programs are now using this approach	Dependent on the availability, ability and willingness of regional and country institutions to take on the FSP agenda Activity institutionalization not yet achieved
	WHO developing a background that can be used for sustainability of all health initiatives	Inadequate connection between immunization FS and broader trends in health financing and donor practice Monitoring and evaluation process not systematized
		Regional structure not systematically in place in all regions FSPs did not look at all program options FSPs did not focus enough on benefits of an intervention Capacity building not enhanced to intended levels
Developing a collaboration	FTF unleashed innovation in vaccine financing including new approaches FTF process empowered partners	FTF could not sustain the effort when it came to daily work
	There was buy-in from a range of institutions The process catalyzed information sharing and joint planning among UN agencies and among different regions	Little buy-in or knowledge from bilaterals or regional development banks
Impacting FS in countries	High level of advocacy for immunization Set up dialog in countries between health and finance ministries	Varied country ownership resulted in varied impact Did not always engage highest authority level in countries
	Has resulted in changes in funding patterns as countries use FSPs to leverage funds	FS definition may remove national responsibility No way to measure impact in countries

tives on the FTF had the power to actually commit institutional funds, and became even more difficult when institutional agendas had deviated from the original GAVI ones. The intent was to support sharing of implementation responsibilities for a multi-partner activity.

2.3.4. *Influencing national financing decisions and GAVI policies*

The FTF work had an impact at the country level by strengthening communications between the health and finance ministries, thus facilitating future immunization financing decisions. The financial sustainability planning process was an opportunity to strengthen and build capacity in costing, financing, planning, and budgeting at regional and country levels. It also presented an opportunity to collect detailed information from GAVI eligible countries that could be used to populate the immunization financing database developed to inform global, regional, and national understandings of immunization financing flows and trends.

The FTF provided the GAVI Board with a number of deliverables up to and after its dissolution. Much of this work related to the fact that though countries had developed FSPs, they were not able to assure sufficient financing for GAVI-supported vaccines in the initial 5-year period. Thus the FTF was called on to develop new strategies to deal with this reality, including bridge financing, co-financing, and the change from FSPs to costed multi-year plans (cMYPs), which better integrated national health sector and immunization planning with the financing process.

In practice, the assumptions on which the entire FSP process were based were not borne out. Often donors were not able to change their funding patterns in an institutional way. Prices for the first round of combination vaccines have not yet dropped. Thus, the financing model shown in Fig. 1 could not happen. The implications of these flawed assumptions are discussed further in paper 2 of this series.

We can classify the FTF's work on FS into four general areas as shown in Table 2.

During its existence in GAVI Phase 1, the FTF regularly provided analyses and updates on financing issues and challenges to the GAVI Board which spurred changes in GAVI's vaccine financing policy, such as (Table 3):

Table 3
FTF FS Outputs and impact on GAVI policies

Key FTF FS activity	GAVI policy change
Definition of FS, development of guidelines	Basis for measuring FS
Costing and financing tool	Method to track country expenditures and financial flows for immunization
Immunization financing database and analyses	Cost implication of new vaccine introduction Indication that financial sustainability was far from assured with large financing gaps despite GAVI support period spread over 8 years Bridge financing concept developed Co-financing proposal called for

- Permitting countries to spread the initial 5 years grant over an 8-year period;
- Recognizing and quantifying the difficulties countries faced in transitioning to government and donor support, after first receiving vaccines by donation, culminating in a policy change to vaccine co-financing;
- Developing alternative financing strategies to specifically assist countries sustain the benefits of new and more expensive combination vaccines. Two capital market mechanisms, the International Finance Facility on Immunization (IFFm), and Advance Market Commitments (AMCs), now being implemented, were developed from initial FTF contributions.

3. Discussion

3.1. Appropriateness of collaborative structures to the FTF mission

The collaborative structure of both GAVI and the FTF was best suited to developing initial policies, setting agendas, and ensuring agreement among the partners, needed in the initial period of this work. The characteristics of the FTF membership at its inception supported this: dynamic and motivated individuals who had the backing of their institutions to move forward in designing a new partnership. Even in the later stages of GAVI Phase 1, such structures worked well (AMC development, for example) when the focus was exploring and developing concepts and assuring consensus.

In the second stage of FTF activities, which involved actually developing FSPs, the collaborative structure functioned well in the initial stages, which served to develop the methodology, but was eventually weighed under by the sheer number of plans that needed to be developed. At this point a transition needed to be made to a structure more institutionalized and better able to ensure implementation and follow-up, and such a transition was difficult to engineer, possibly because the need for transition was not fully understood. In addition, “hand-off” structures, for example, at the regional level, did not yet exist. Although the FTF attempted to approach this through a project management team concept, the task was so huge that such a team was not sufficient to the task. There was no GAVI collaborative partnership available to do the job. On the other hand, the use of a project management team for the immunization financing database worked well and achieved the desired oversight and implementation.

A key lesson learned was that FS is not a one-time activity—development of a plan is a first step, but the plan must be implemented, resources must be mobilized, and this needs to occur on a continuous basis. Despite the initial success in developing FSPs in the vast majority of countries receiving GAVI support, providing support for the implementation of these plans was less effective. Implementation activities were largely focused on developing and refining strategies for FS, with limited input into support to actual implementation and follow-up of these strategies. The regional structure was not yet in place and the process could not be effectively managed from global level.

As GAVI moves forward there is a strong need to find the best structure for implementation. There is a need for direct in-country follow-up which has not yet been addressed. It is not clear from the support model at which level this should be done: by the GAVI secretariat, by a group of partners charged with financing issues, at the regional level, or by the countries themselves. GAVI has now assembled an Immunization and Financial Sustainability Task Team (I&FS) that may take over this role. Although it is recognized that country staff are in the best position to implement and follow-up implementation, it is not clear how best to integrate this into the GAVI infrastructure: through the secretariat as a coordi-

nating and follow-up body, through a specific partner, or through RWGs.

3.2. How can a partnership change to reflect changing needs across a life cycle?

The examples above have shown the needs for an evolving collaborative partnership across the life cycle of an alliance, but to date no model of how this can be done has been successfully implemented. There appear to be three distinct stages, each of which requires a different collaborative structure. The first stage, which is the concept development stage, is one which most collaborative partnerships use, and which was used productively by the GAVI FTF. If the activities had stopped there, the FTF would have been seen as a successful partnership.

The second stage is an oversight group, or a project management team approach. Again, in at least one instance, the FTF did this, the Immunization Database Oversight Team. Such a structure, how it worked, and its outputs are described in paper 2 of this series: through paid staff located in one or more of the partner institutions charged with implementation of a specific well-defined project, assisted by a selected representation of experts drawn from other partner organizations, with the project team reporting back at regular intervals to the FTF and to the GAVI Alliance Board.

The third stage, which is institutionalization, is appropriate for activities which need to be incorporated into the work plans of partner organizations and to be funded and staffed by them at the appropriate level. An alternative model would be that the GAVI Alliance itself expands its secretariat to oversee these tasks through its own specific staff and funded work plan. In neither case is the activity truly a collaborative activity at this point; an institutionalized activity is no longer an activity of the collaborative partnership. Thus, the collaborative structure needs to evolve when activities become institutionalized and are then replicated at the country level to best suit the needs of the task at hand and the needs of the countries involved.

4. Conclusions

Although there were flaws in the FS process in retrospect, particularly regarding the implementation and monitoring at country level, the results have shown that the impact of the FTF as a collaboration in the area of FS has been significant. It should also be clear that all the partners were needed in this process, not only in the original brainstorming and planning work, but also in the later phases, albeit in a new type of partnership collaboration.

The FTF was a vibrant, dynamic, innovative, and productive structure in its assigned role, which was to assess the immunization financing situation, identify issues, and devise ways to address them. There will continue to be areas in health financing that will need this kind of approach, and the FTF provides an excellent model of how this system can work.

At this point in the GAVI life cycle, large amounts of funding for vaccine purchase are assured. Vaccine development for the developing market is proliferating, manufacturers increasingly have individually agreed to mechanisms that can assure accessible prices to countries under conditions where the market has been quantified, sufficient production capacity has been installed from the outset, and competition from emerging suppliers is a foreseen eventuality. Countries receiving GAVI funding will have begun some level of co-financing commencing from the start of GAVI support. As a result of the FTF work, countries have a basic understanding

of the FS process. The lessons learned from developing FSPs will improve future work in this area.

GAVI Phase 2 is going ahead with a significantly changed structure. Many secretariat functions have now been institutionalized within GAVI, rather than being managed by partners. This is one alternative to transitioning collaboration through the institutional life cycle. Another could be a restructured alliance where partner commitment and support at regional and national levels are more specifically defined. The international community has yet to achieve such a structure.

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