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A New Compact for Financing Health Services

Opportunities for Gavi and Partner Countries

ALEC MORTON · JAMAICA BRIONES · ANASTASSIA DEMESHKO · PETE BAKER · TOM DRAKE

Abstract

As Gavi embarks on its next strategic phase, "Gavi 6.0," it faces multiple challenges: shifting donor priorities, rising costs of new vaccines, incomplete vaccine coverage, and economic constraints in supported countries. Additionally, health ministries face increasing pressures related to universal health coverage, complex disease burdens, and fragmented aid systems. This paper proposes that Gavi's transition approach would benefit from adopting a New Compact underpinned by a marginal aid framework. The New Compact is based on three pillars that reflect a shared responsibility between a country and its donors: (1) evidence-informed, locally led prioritization; (2) domestic-first resource allocation with donor support for marginally cost-effective interventions; and (3) consolidated supplementary aid. We suggest five policy shifts for Gavi to enhance the New Compact's effectiveness: focusing country financing on high-priority vaccines while using Gavi funds at the margins; ensuring comprehensive coverage for underserved populations; improving donor coordination; adapting pooled procurement; and strengthening market shaping through value-based commitments. We conclude with recommendations for Gavi's transition, emphasizing the need for strategic dialogue and adaptive policies to align with the New Compact and achieve sustainable vaccination outcomes.

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Contents

Figures

Boxes

Summary

Vaccines—both existing and yet to be invented—can have transformative impacts on population health. Through the 21st century, Gavi has led the movement to bring vaccination to the poorest people in the world. However, as it enters the next five-year strategic period, "Gavi 6.0," Gavi faces multiple challenges: funders with new priorities (e.g., a shift from acute to chronic disease financing), expensive new vaccine technologies that may require life-course approaches to immunisation, incomplete coverage of high-priority vaccines, and a client base that faces limited opportunities for strong and sustained economic growth. Moreover, ministries of health in Gavi-supported countries face their own challenges: ambitious universal health coverage (UHC) commitments, an increasingly complex burden of disease, and a fragmented aid ecosystem that works against efficient and coordinated policymaking at the national level. All of these complexities are evolving within the increasing momentum for rebalancing power in global health, a movement perhaps best captured in the Lusaka Agenda.

One of the distinctive features of Gavi's approach has been its transition pathway, which lays out how countries are expected to assume progressively greater responsibility for financing vaccination programmes. We propose in this paper that this approach to transition would be more effective and empowering if Gavi engaged countries in a New Compact based on the principles of the marginal aid approach. The New Compact is based on three pillars that reflect a shared responsibility between a country and its donors: (1) locally led, evidence-informed prioritisation; (2) domestic-first resource allocation to support the core package of high-priority services, with donors providing support for interventions that are only marginally cost-effective for the country; and (3) consolidated supplementary aid. It also provides a framework for dialogue between donors and partner countries about the transition pathway that makes the most sense for the country.

In this paper, we discuss five policy shifts for Gavi to consider in order to deliver a New Compact with partner countries most effectively. The set of related policy shifts centres on *reworking health service financing* by focussing country ownership on the highest priority vaccines, while Gavi financing would primarily be used to expand the range of vaccines at the margin. Complementary policy shifts include *ensuring comprehensive coverage* by supporting countries in developing outreach for their underserved populations and in purchasing commodities for marginalised groups, *advancing donor coordination* by simplifying donor management for countries, *adapting pooled procurement* to sustain the benefits of Gavi's current procurement practices, and *strengthening market shaping* by creating clear, value-based market demand commitment. We conclude by offering some next steps for Gavi's transition to the New Compact.

1. Challenges facing Gavi and partner countries

The evolving global health landscape threatens to derail progress in health improvements, especially in aid-recipient countries. In the aftermath of the COVID-19 pandemic, the world finds itself in a challenging scenario defined by growing conflict, fragility,[1] polycrisis regarding climate change, and worsening macroeconomic conditions.[2,3] Austerity measures are on the rise[4] as countries scale back expenditures in response to lower tax revenues and heightened debt obligations.[5] Coupled with the slowing growth of international donor assistance[6], this confluence of political and economic threats intensify the concerns about securing financing for universal health coverage (UHC).

While international donor assistance has been instrumental in bridging critical gaps in health service delivery in aid-recipient countries,[7] several significant issues with current donor practices undermine countries' efforts towards effective and sustainable health systems. These issues include funding volatility, aid fragmentation, displacement of domestic finance, ineffective prioritisation of health services, lack of transition planning, and insufficient country ownership.[8] These issues have collectively undermined the effectiveness of aid efforts, as extensively discussed in a previous Center for Global Development (CGD) paper.[8]

Moreover, the perspectives of aid-recipient countries have been significantly reshaped by the world's response to the COVID-19 pandemic, which exposed weaknesses and persistent inequities in the global health system. The pandemic highlighted issues of vaccine inequity, vaccine hesitancy, and the limitations of historically top-down, primarily donor-driven global aid.[9] The impetus for strengthened global cooperation sparked calls for a new public health order in Africa,[10] which sought to support the self-sufficiency of African public health systems and to address the current global imbalances by amplifying Africa's collective voice on global health issues. These sentiments are echoed in the Lusaka Agenda,[11] which supports countries' aspirations to return to the driver's seat by increasing their self-sufficiency and localised decision making.

Against this backdrop, Gavi, the Vaccine Alliance faces pressure to enhance operational efficiency. Addressing these challenges necessitates ambitious reforms given the evolving political, economic, and environmental landscapes. New strategies for addressing the challenges for global development and health financing outlined above are critical in order to maintain social and economic progress.

For nearly 25 years, Gavi has been dedicated to promoting equitable and sustainable vaccine use and has achieved success through its three primary levers:[12] (1) introducing new vaccines in eligible countries, (2) enhancing equitable immunisation coverage to address disparities, and (3) extending its reach to underserved communities through its income-based eligibility model and co-financing mechanism. Gavi's current co-financing policy[13] incentivises countries to incrementally increase

domestic financing for immunisation, thereby starting countries on a time-bound path to transition away from Gavi's support. Under the proposed recommendations in this paper, Gavi would need to rethink this model of health service financing in order to improve equitable coverage and strengthen health systems in countries in the long term.

CGD has previously proposed recommendations for Gavi to advance equitable and sustainable immunisation.[12] In this paper, we delve into one of the recommendations—to replace existing financing arrangements with an envelope financing approach driven by local priorities. The Alliance's next strategic period, Gavi 6.0, highlights the need for the programmatic and financial sustainability of immunisation programmes, including strengthened regional and national commitments and increased domestic public resources.[14] We present the New Compact as a viable strategy for Gavi and partner countries to address the challenges outlined above and emphasise how this approach can empower countries to take back control and make health aid more effective in fulfilling its mission.

2. A New Compact for financing health services

The New Compact,[8] as discussed in this paper, was introduced in a previous CGD publication[8] and is based on extensive research and commentary, incorporating collective insights from CGD, its partners, and associates.[8,15,16,17]

By addressing the shortcomings of conventional health aid, the New Compact proposes a framework to facilitate dialogues between donors and countries about the transition pathway that best suits the country, as well as conversations between multiple donors who are participating in a country's development journey. At its core is the idea that domestic finances should support essential health services, while health aid should primarily be used to expand the package of affordable services at the margins. Instead of targeting high-priority interventions, donors should support countries to have strong and effective prioritisation processes and direct any additional financial support to health services that would otherwise not be covered by domestic funds.

The New Compact is based on three pillars that reflect a shared responsibility between country and donors: (1) locally led, evidence-informed prioritisation, (2) domestic-first resource allocation, and (3) consolidated supplementary aid.

Locally led, evidence-informed prioritisation

Weak internal priority-setting mechanisms pose a major threat to national objectives for achieving UHC. When resources are not effectively directed to interventions that offer the greatest health gains for the most people at the lowest cost, national UHC initiatives often fail to deliver on their ambitions, leading to disappointment and cynicism.

In the New Compact, national institutions are supported in defining their health priorities by drawing on relevant available evidence. Glassman and Chalkidou[18] establish a strong case for the development of Health Technology Assessment (HTA) institutions in low–income and low– and middle–income country (LIC and LMIC) settings. HTA is based on clinical, epidemiological, and economic data and analysis, but also critically relies on inclusive processes to test and validate this analysis, as well as strong institutions that can ensure that decisions are informed by equitable social values.

A core technical component of HTA is cost-effectiveness, or the economic analysis of healthcare interventions. Cost-effectiveness takes many forms, but in essence involves making some sort of "bang for buck" calculation, by comparing the resource cost of an intervention with the health benefits gained by implementing it. A common measure of benefit is the quality-adjusted life year (QALY), which integrates both health improvement and survival benefits into a single metric. However, there are many possible measures of benefit, and the New Compact need not rely only on cost-effectiveness. What is most appropriate in any given setting depends on the decision maker's scope of authority and objectives—for example, does a country care only about aggregate population health, or also about economic performance? The most appropriate metric of value may, for instance, be reducing mortality and minimising life years lost, or closing the gap between the most and least deprived, some measure of economic productivity, or some combination of all of the above. What is important is that the country sends a clear signal about the role that it sees the health system playing in its development vision.

Domestic-first resource allocation

The New Compact highlights the central role of domestic resource mobilisation to support the core package of high-priority services. Countries are supported to allocate their own financial resources to prioritise core health services. This approach, in turn, leads to a more efficient use of resources as highly cost-effective services are sustainably financed, thereby maximizing overall health outcomes per unit of funding. As countries enhance their health financing, health aid focussed on the margins naturally diminishes, providing an aid exit strategy for thriving countries and ensuring that financing remains sustainable for those countries that continue to require support. Perhaps most fundamentally, the New Compact emphasises country ownership, empowering national decision makers and national policy processes to drive meaningful change.

Consolidated supplementary aid

The New Compact recognises that donors have a different role than countries, although they may also be concerned with the costs and benefits of the interventions they fund. First, the approach involves consolidating donor efforts and their collaborations with country leaders to harmonise

health aid provision, thereby reducing fragmentation. More cohesive financing arrangements may free up country leaders and administrators for managing their own health systems instead of aid arrangements. Second, the New Compact designs a top-up package with domestic financing at its core, while aid supplements health concerns at the margins, both in terms of financing additional health services and other crosscutting support. Under this arrangement, health aid would primarily be used to expand the package of affordable health services on the margins, thus protecting the highest priority services from fluctuations in aid investments and strain in domestic finances.

Defining the scope of a New Compact

According to the original concept, a New Compact is between a particular country and the donor organisations offering support to that country. However, an alternative, or perhaps complementary, model involves a single donor organisation adopting relevant policy shifts in a New Compact with one or more partner countries. A New Compact approach could potentially be adopted in any context but is likely to be particularly relevant for countries on a path to transitioning out of donor support. For such countries, health aid can play an important role not only in meeting current needs, but also in supporting countries along their development pathways.[5] The burden of disease in Gavi's client countries will continue to evolve as these countries progress through demographic, economic, and epidemiological transitions, and countries may need other forms of support in order to deal with the emerging burdens of chronic disease and demographic change.

However, not all development aid is a tool of development policy, and some development aid is purely humanitarian in nature. Given that large populations live in conflict-affected regions or are controlled by failed, failing, or extremely fragile states, there will be continuing need for purely humanitarian assistance. The New Compact is not intended as an approach in these situations—and indeed, Gavi has a tailored response for such scenarios.[19]

3. How a New Compact could work

Operationally, the New Compact adopts the marginal aid approach as a health financing strategy and a method for prioritising and allocating development aid resources. The core of the marginal aid approach lies in dividing the set of potential services into three buckets: *national services*, *aid-supported services*, and *excluded services*. *National services* represent the highest priority programmes and form the most valuable core package funded by domestic resources. *Aid-supported services,* which have intermediate priority, may be either partially or entirely funded by donors. *Excluded services*, on the other hand, are neither prioritised nor funded.

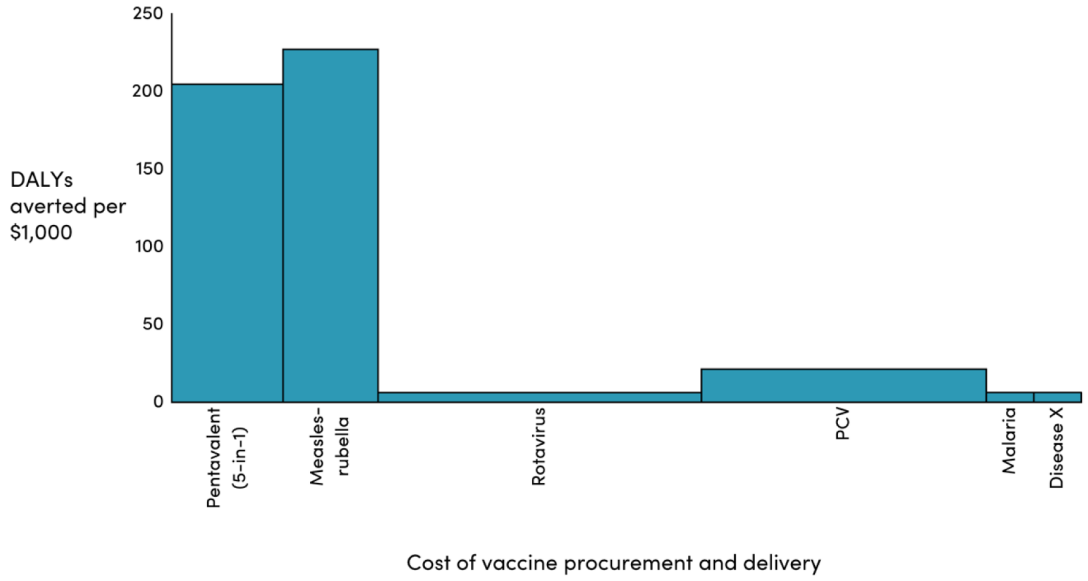
To illustrate the New Compact and how it could work for Gavi, Figure 1 presents a practical example showcasing how the approach can be incorporated into current Gavi support for vaccine introduction in a country with a mixed co-financing model for its vaccine portfolio. The x-axis represents the combined value of Gavi support and country co-financing for the cost of vaccine procurement and delivery, while the y-axis signifies the population health benefit as disability-adjusted life years (DALYs) averted per dollar.[20] Taller bars are therefore the more cost-effective interventions. The population health benefit was computed by multiplying the total number of vaccinated individuals for each vaccine type[21] by the DALYs averted and subsequently dividing by the overall cost of vaccine procurement and delivery.[20]

In Panel A of Figure 1, the vaccine programmes are not prioritised. In Panel B of Figure 1, vaccine programmes are prioritised according to the marginal aid approach. The marginal aid approach suggests that countries will gradually assume responsibility for the high-priority vaccine(s) represented by the green zone. Simultaneously, aid provides support for vaccines in the yellow zone but no support for those in the red zone. The example in Figure 1 will be used as the context for subsequent discussions in this paper.

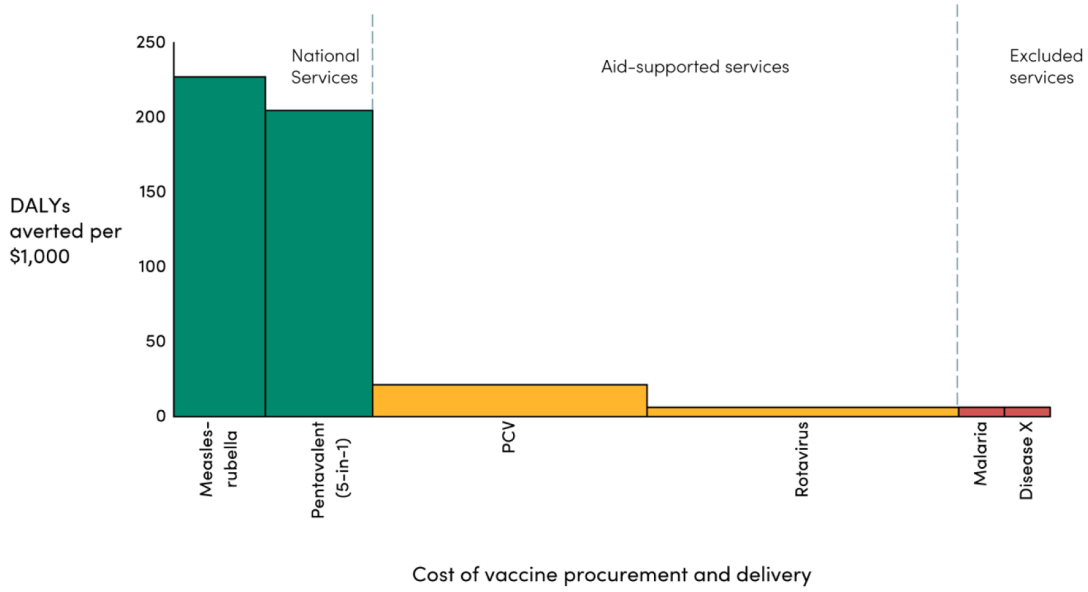
The marginal aid approach is intended to support transitioning health services out of *excluded services* into the *aid-supported services* bucket and finally into *national services*. Thus, it encourages countries to have firmly embedded financing arrangements for high-priority services. It also facilitates the strategic use of donor funding to expand the package of affordable services along the margins for services that may be a harder sell internally or for which there may be genuine uncertainty about long-term deliverability and value.

FIGURE 1. Example of vaccine prioritisation and financing based on cost-effectiveness

Panel A: Current status of vaccine prioritisation



Panel B: Vaccine prioritisation through the marginal aid approach



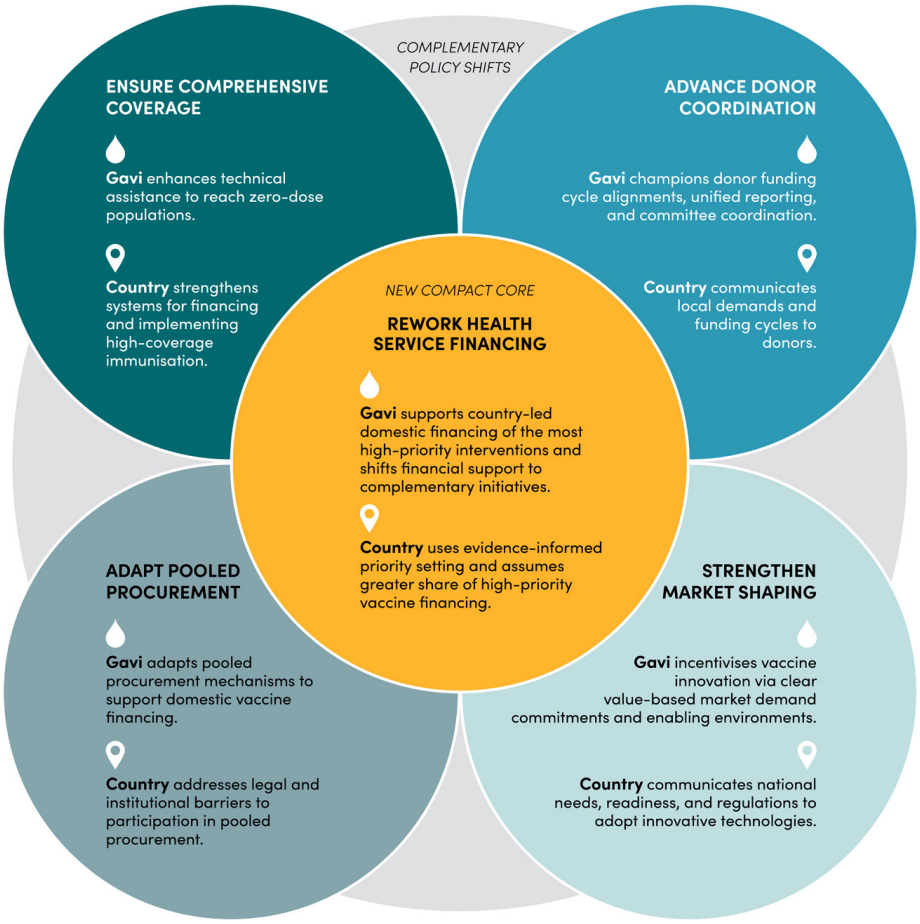
1. Pentavalent vaccine (combination of diphtheria, tetanus, pertussis, hepatitis B, and *haemophilus influenzae* type b vaccine); Pneumococcal Conjugate Vaccine (PCV).

2. *Panel B: Cost of vaccine procurement and delivery (x-axis):* This cost includes the total cost of Gavi support and the country's agreed-upon co-financing arrangements. It covers only routine vaccination costs for 2021, such as the price of vaccines, safety boxes, syringes, and freight charges, based on a country's request for Gavi's support; cost in the figures does not include catch-up campaigns.[22] *DALYs averted per $1,000 (y-axis):* This figure was calculated by multiplying the WHO/UNICEF estimates of national immunisation coverage for each vaccine type[21] by the total DALYs per 1,000 vaccinated individuals in LMICs between 2000 and 2030,[20] and then dividing by the overall cost of vaccine procurement and delivery. Note that while this figure draws on real data, it is for illustration purposes only, since prioritisation would need to be carried out at the country level.

4. Policy shifts for a New Compact

Building on the three pillars underpinning the New Compact, Gavi and partner countries could explore a set of policy shifts organised into five themes, as depicted in Figure 2 (see also Annex 1 for a more detailed table), where we outline how Gavi and a partner country could contribute to these kinds of policy shifts. The theme at the core of the New Compact is *reworking health service financing*. Flowing from this core theme, the subsidiary themes—*ensuring comprehensive coverage*, *advancing donor coordination*, *adapting pooled procurement*, and *strengthening market shaping*—reflect the particularities of Gavi's business model and operating environment, and are complementary policy shifts that would support the effective implementation and mitigate the potential risks of the New Compact.

FIGURE 2. Policy shifts for Gavi and partner countries to adopt the New Compact



Rework health service financing

Proposed policy changes

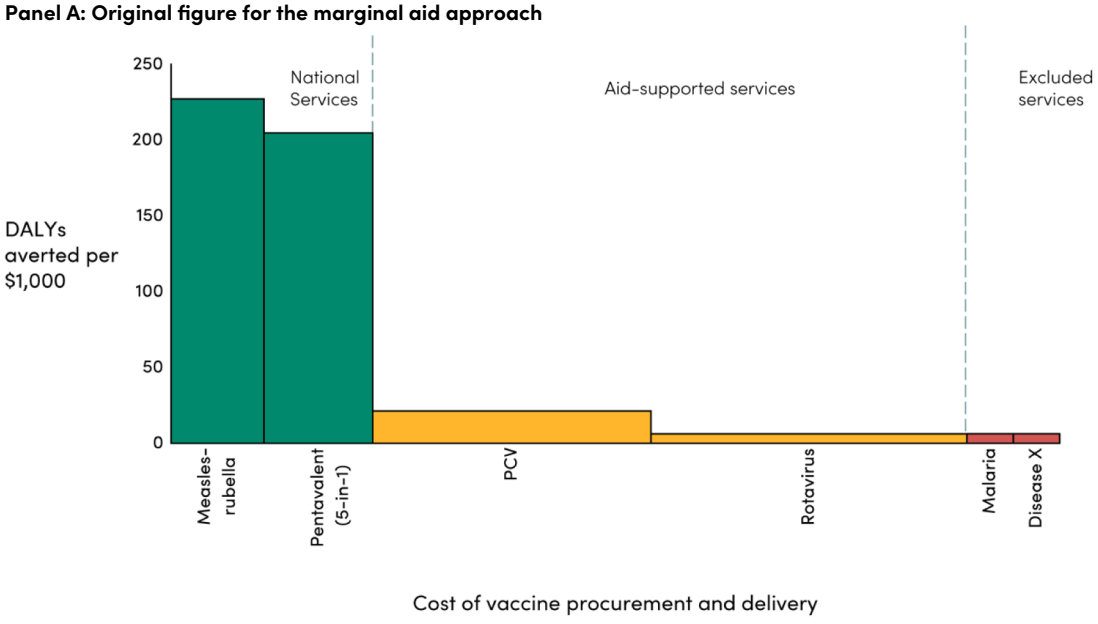
At present, Gavi offers a range of vaccines based on countries' requests for additions to their existing portfolios through the Vaccine Investment Strategy (Box 1), with an increase in co-financing commitment as countries transition towards financial independence. The New Compact emphasises that countries would have firmly embedded financing arrangements for core, high-priority vaccines, with Gavi's financing or co-financing[13] expanding the range of vaccines at the margin. Countries will progressively take over funding responsibilities informed by local priority setting processes based on cost-effectiveness or other kinds of evidence according to their preferences. This shift is a natural extension to Gavi's Full Portfolio Planning (FPP) model[23] adopted as part of the Gavi 5.0 strategy, which aims to ensure that Gavi support is catalytic, built upon country co-financing commitments, and aligned with national immunisation priorities.

Recognising that implementing the New Compact will require a substantial shift in how funds are allocated, Gavi may consider offering technical assistance to countries. This support may involve strengthening evidence-to-policy processes, integrating vaccine policy functions with the wider health system,[24] and supporting improvements in public financial management.[25]

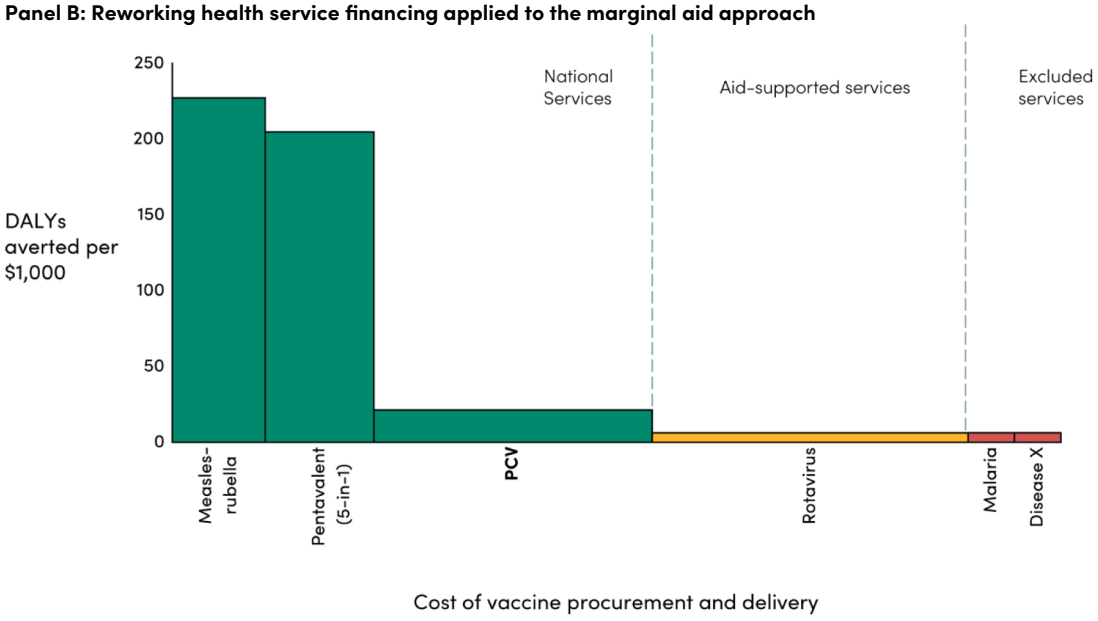
Shifting Gavi financing could mean introducing new vaccines or increasing support for other priorities, such as efforts to strengthen health systems. For an example of how the marginal aid approach can facilitate discussions on Gavi and country co-financing schemes, see Figure 3 and compare Panels A and B. According to this model, countries would progressively take over financing each vaccine, and the increase in domestic financing would reallocate the Pneumococcal Conjugate Vaccine (PCV) to *national services*. This shift towards domestic financing for high-value vaccines represents a strategic approach for ensuring the long-term sustainability for key vaccination programmes.

FIGURE 3. Example of vaccine prioritisation for reworking health service financing

Panel A: Original figure for the marginal aid approach



Panel B: Reworking health service financing applied to the marginal aid approach

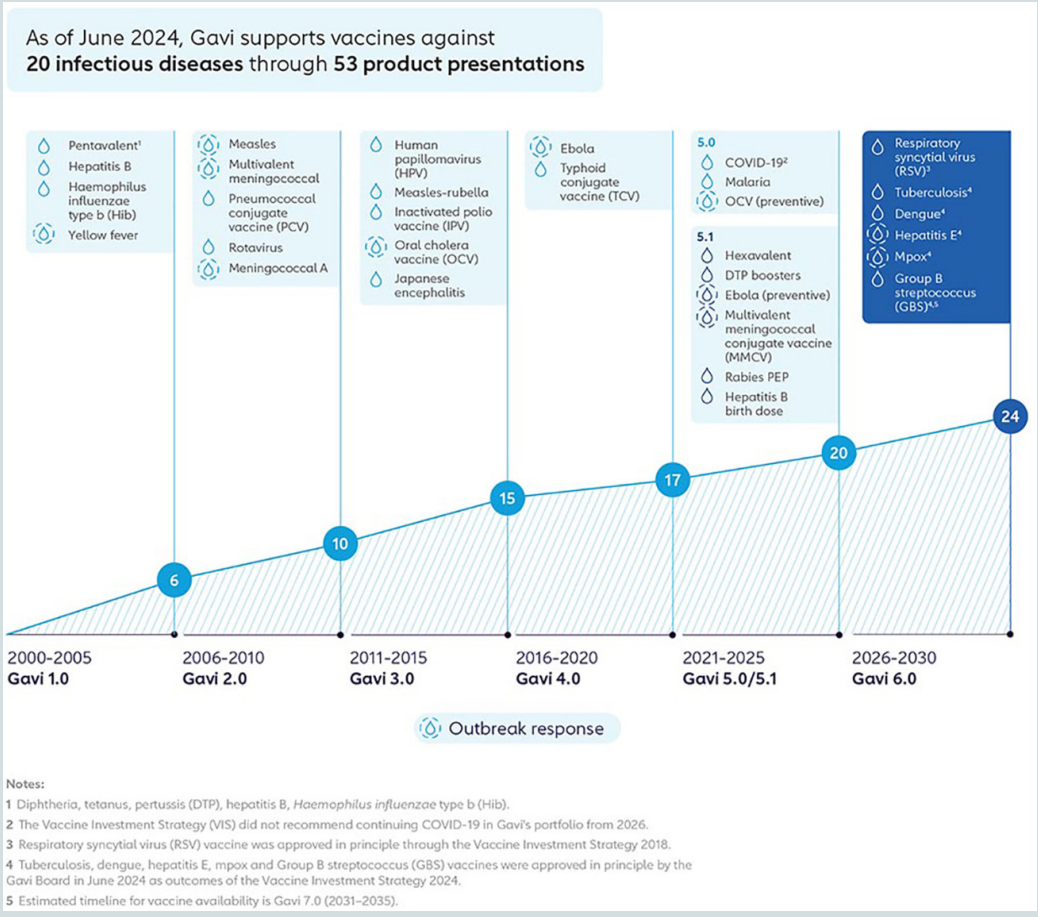


BOX 1. Gavi's vaccine investment strategy

Every five years, Gavi reviews the vaccine landscape through the Vaccine Investment Strategy (VIS) in order to include new and under-utilised vaccines crucial for the countries it supports. Through VIS, Gavi conducts a thorough assessment of vaccine value, considering factors like its impact on mortality and morbidity, as well as evaluating the associated social, economic, and population health benefits.

Gavi's commitment to disease prevention has evolved over time, shifting from a primary emphasis on vaccines for routine infant immunisation to a broader spectrum that includes vaccines tailored for various age groups, such as the HPV vaccine. Additionally, Gavi has expanded its scope to include vaccines designed to support outbreak, epidemic, and pandemic preparedness and response by establishing global stockpiles. Notable milestones in this expansion include the approvals for the Ebola vaccine in 2019, COVID-19 vaccine in 2021, and malaria vaccine in 2022.[26] Gavi's vaccine portfolio now includes support for 19 vaccines.

Growth of Gavi's vaccine portfolio (illustration from Gavi Vaccine Investment Strategy[26])



Notes:

1 Diphtheria, tetanus, pertussis (DTP), hepatitis B, *Haemophilus influenzae* type b (Hib).

2 The Vaccine Investment Strategy (VIS) did not recommend continuing COVID-19 in Gavi's portfolio from 2026.

3 Respiratory syncytial virus (RSV) vaccine was approved in principle through the Vaccine Investment Strategy 2018.

4 Tuberculosis, dengue, hepatitis E, mpox and Group B streptococcus (GBS) vaccines were approved in principle by the Gavi Board in June 2024 as outcomes of the Vaccine Investment Strategy 2024.

5 Estimated timeline for vaccine availability is Gavi 7.0 (2031–2035).

Benefits and challenges

Initiating much-needed systemic change in financing global health services, the New Compact has the potential to create space for country-led development of comprehensive, long-term immunisation systems. The underlying intention is to empower countries to establish a strong foundation for their immunisation initiatives while fostering transparency and predictability throughout the process. The New Compact also provides a clearer understanding of which programmes are jointly funded and which are fully the responsibility of the country at any given point in time, with more programmes passed to the country over time in a predictable manner. This method aligns with the Gavi 6.0 strategy, which advocates for country-led efforts to ensure sustainable transitions, and supports country ownership and the ability to prioritise.[27] Additionally, the New Compact offers a cleaner and more logical approach to transitioning financing than one in which the entire portfolio is the joint responsibility of donor and country up to the cliff-edge of graduation from donor support.

With this proposed change, there is a clearer compact between national public providers and their constituent populations on the provision of vaccines. The New Compact also responds to calls for vaccination programmes to be driven by the unique health challenges, demographic considerations, and public health priorities of each nation, rather than by external forces. By allowing countries to shape their priorities, the New Compact encourages a more context-specific approach to vaccination, enhancing the overall effectiveness of immunisation efforts.

However, the approach would represent a major change in how funds are allocated and comes with challenges that require careful management. There is a risk of ineffective implementation or insufficient financing from the government, potentially leading to vaccine shortages, under-vaccination, and a loss of herd immunity, particularly during the transition to the New Compact. This concern is heightened amid challenges in securing financing for UHC, with governments expected to reduce expenditures, as projected in 59 out of 125 LMICs in 2024.[28]

Careful implementation of the New Compact will thus be crucial, given the varying constraints across countries and the need to allocate resources to other national priorities. It is well understood that vaccines are public goods, and this understanding should remain a priority when transitioning to the New Compact approach. It will therefore be important for countries to be aware of their own specific shortfalls in capacity and seek targeted support. For example, while the New Compact aims to foster country ownership, some countries might have limited institutional capability for the transition in financing, which may lead to temporary gaps in vaccination without careful planning and perhaps support from development partners in managing this change.

Ensure comprehensive coverage

Proposed policy changes

Equity is an organising principle for Gavi and a key feature of the New Compact. Countries and Gavi might agree that achieving high vaccination coverage—which includes reaching underserved or hard-to-reach populations—is a priority. Gavi could provide technical assistance to countries throughout the New Compact transition for achieving universal coverage, including identifying, prioritising, and monitoring marginalised communities' access to vaccines. Examples of this kind of support include capital investments in vaccine delivery infrastructure or technical support in using equity assessment frameworks such as Distributional Cost-Effectiveness Analysis (DCEA).

This idea aligns with the mission under Gavi 6.0, which aims to strengthen health systems to increase equity in targeted vertical vaccination programmes for populations that are not always prioritised or effectively reached by governments,[14] such as zero-dose or refugee populations. Developing mechanisms like those implemented by the Democratic Republic of Congo—such as tracking vaccinations using global positioning systems (GPS) and short messaging services (SMS), identifying zero-dose children via community healthcare workers, and implementing door-to-door outreach[29]—to identify underserved communities when allocating resources for vaccination programmes may be effective.

Figure 4 demonstrates how the marginal aid approach can contribute to discussions on coverage gaps and marginalised populations within the context of efforts to reach marginalised communities for the pentavalent vaccination programme in a country. If the pentavalent vaccine is seen as a single "book" on the marginal aid bookshelf, it may belong within the nationally supported programmes (upper panel of Figure 4). However, as Gavi channels additional funding to support reaching marginalised communities for the pentavalent vaccine, a distributional breakdown of the benefits yields the display shown in the lower panel. The cost-effectiveness of vaccinating zero-dose children for pentavalent vaccine may be less than that of the PCV, as targeting zero-dose children can be extremely expensive.

This example illustrates a critical challenge: targeted programmes aimed at marginalised populations often present the dual challenge of balancing efficiency and equity. In the example below, there is an efficiency as well as an equity trade-off for offering targeted programmes to address coverage gaps among marginalised groups. This is where DCEA can be particularly useful, as it offers a distributional breakdown of who benefits the most and who bears the greatest burden based on equity-relevant social variables.[30] DCEA can provide clear information on instances

in which routine vaccination programmes can inadvertently neglect certain marginalised communities, such as zero-dose children, and thus worsen health disparities, even though they benefit the general population. By using DCEA, policymakers can thoroughly explore the opportunity costs of allocating additional funding to target such marginalised groups. The crucial question then becomes whether this trade-off between efficiency and equity is justifiable, given the potential to either alleviate or exacerbate existing health disparities.

In the medium term, a New Compact framework should support countries to develop or strengthen systems for financing high vaccination coverage, especially for vaccines being transitioned from Gavi to domestic financing. A key benefit to a New Compact approach is a stronger connection between national institutions and the public, so that communities are clear on what services to expect from the public health system. This clear communication, in turn, can benefit political leaders, as populations recognise that key healthcare benefits come from national institutions rather than foreign donors.

FIGURE 4. Example of vaccine prioritisation with measles-rubella programme disaggregated

Panel A: Original figure for the marginal aid approach

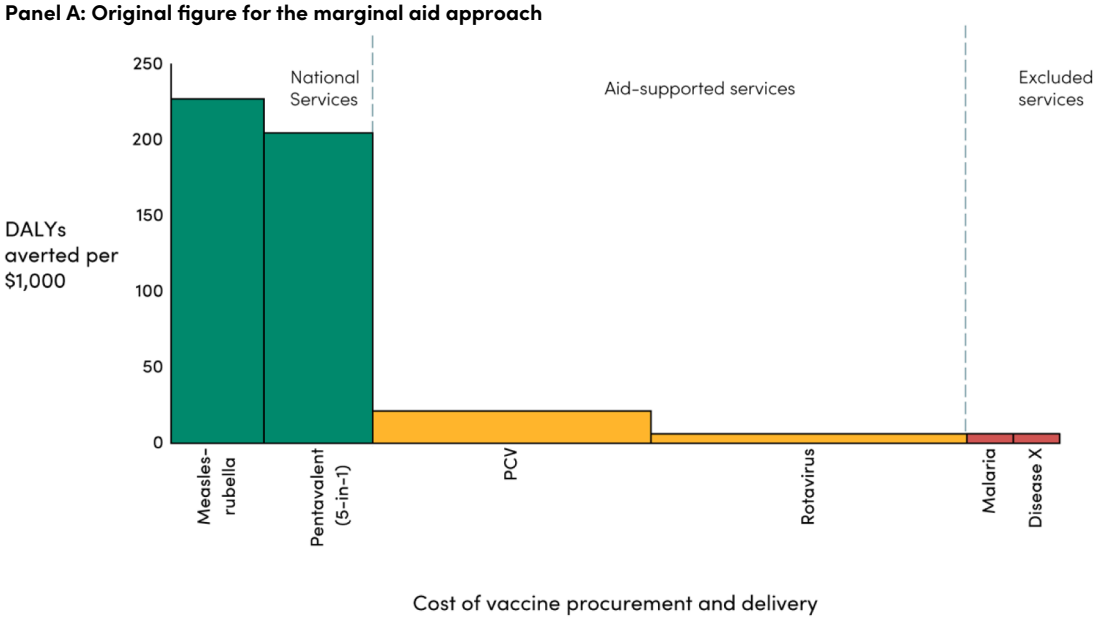
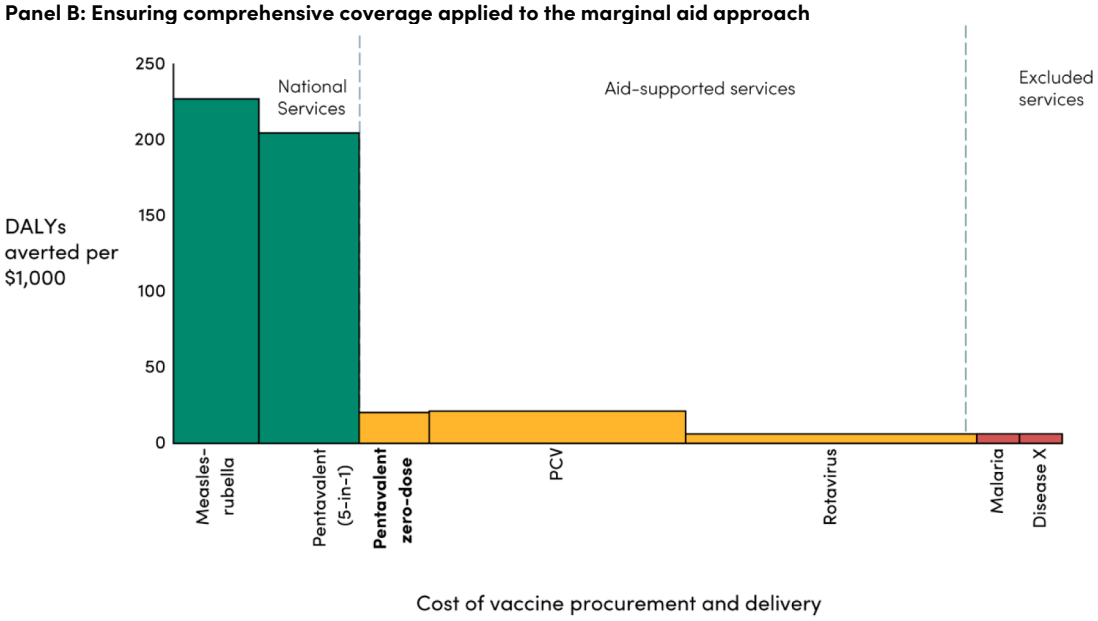


FIGURE 4. (continued)

Panel B: Ensuring comprehensive coverage applied to the marginal aid approach



Panel B: Cost of pentavalent zero-dose (x-axis): The cost reflects additional funding for Gavi support to reach zero-dose children, assumed for illustration purposes. *DALYs averted per $1,000 for the pentavalent zero-dose (y-axis):* Calculated by multiplying the total number of zero-dose children in 2022 (430,912)[31] by the total DALYs per 1,000 vaccinated individuals in LMICs between 2000 and 2030,[20] and then dividing by the assumed cost in the x-axis.

Benefits and challenges

With the New Compact, donors can more specifically target their financing to situations in which it will make a difference. In addition to immediate gains, these efforts serve a long-term purpose—to build a connection between underserved populations and the public health system. The ultimate goal is to create a healthcare landscape that is not only more accessible but also inherently inclusive.

However, achieving this vision demands thoughtful planning. We recognise that prioritising the needs of marginalised and vulnerable populations within Gavi's portfolio is a persistent and complex challenge as national programmes usually face competing mandates: improving immunisation efficacy versus increasing equity. Insights from cost analyses in Pakistan underscore the finding that prioritising equity, even under resource constraints, can achieve nearly optimal immunisation coverage.[32] The strategic deployment and targeted delivery of resources to specific populations make a substantive difference.[32] This insight underscores the critical need to establish a robust and defensible framework for allocating resources when transitioning to the New Compact.

In addition, transitions in vaccine financing pose the risk of disruptions for hard-to-reach populations who already face significant barriers to accessing healthcare. When transitioning to a New Compact, it is crucial for countries to carefully plan their funding strategies in order to maintain service continuity and accessibility for these populations.

Advance donor coordination

Proposed policy changes

The underpinning philosophy of the New Compact is that countries should be in the driver's seat, articulating what makes most sense for them in their visions of development for their health systems. This approach, however, presents a challenge to the donor community as a whole. In order to address inter-donor duplication and differences, donors may seek to align funding cycles and standardise application and reporting requirements to reduce the burden on countries, in line with the Lusaka Agenda. Creating or strengthening country-level multi-donor coordinating committees could also help to ensure that donor efforts are coordinated at the national level.

Gavi cannot implement this agenda unilaterally but has the standing and credibility to play a leading role. Gavi's sphere of activity brings it into contact with other multilaterals (e.g., Global Fund to Fight Aids, Tuberculosis and Malaria; Global Financing Facility; UNICEF), who have interests in vaccine-preventable diseases and in the primary population available for vaccination, namely children. Thus, any changes in Gavi's financing approach will have an impact across the multilateral landscape.

Panel B of Figure 5 shows an example in which multiple donors contribute to the aid-supported services bucket—the portfolio of activities that countries have requested (different donors are indicated by different colours on the blocks). In this illustration, all donors have signed on to the New Compact; therefore, the coordination of donor contributions through the marginal aid approach can simplify discussions about both what should be financed and who should bear the costs.

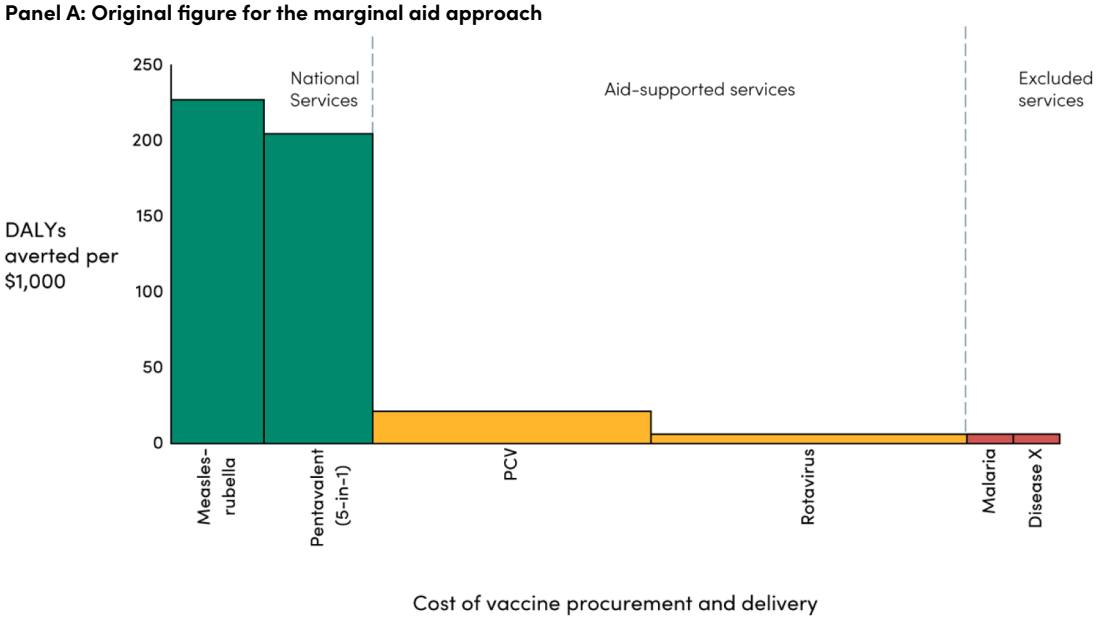
Operationally, donors often have formulae for calculating the amount of funding to which a country is entitled based on its level of economic development and disease burden. Generally, this is a sensible way of ensuring that funds are allocated by individual donors in a fair, transparent, and equitable manner. However, from an economic point of view, there is risk of misallocating resources in situations in which the focus of the donor's mission does not align with the area of greatest need for the country.

The New Compact can bring these conflicts to the fore and encourage various inter-donor and donor-government funding relationships. In Figure 5 Panel B, the programmes funded by different donors are shown in different colours. For example, if World Bank (Donor A) wishes to give an international development loan to cover PCV, and the Foreign, Commonwealth, and Development Office (Donor B) wishes to fund a vertical rotavirus routine vaccination campaign, both initiatives can be incorporated into the New Compact (Figure 5). The key requirement is that donors agree to coordinate through this mechanism to ensure that gaps in funding are filled, particularly by those donors with more flexible funding mechanisms. This approach promotes synergy and coherence among different donor-funded initiatives and maximizes their collective impact on strengthening health systems and optimising vaccine delivery.

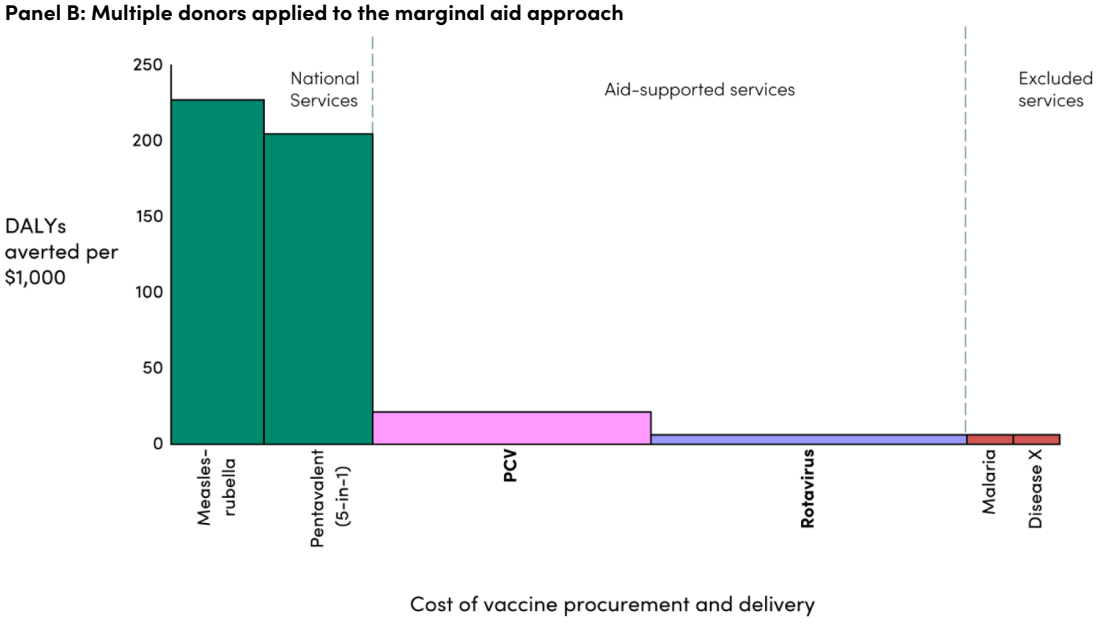
In the longer run, one could imagine "aid swaps," in which Donor A recognises that Donor B has a comparative advantage in a given country, given the country's most pressing needs, and funds Donor B to provide additional services, in exchange for the opposite arrangement elsewhere.

FIGURE 5. Example of vaccine prioritisation across multiple donors

Panel A: Original figure for the marginal aid approach



Panel B: Multiple donors applied to the marginal aid approach



Benefits and challenges

The New Compact presents an opportunity to move beyond fragmented donor approaches and promotes more cohesive and nationally relevant financial support for countries, in a way that more efficiently utilises funds, eliminates duplication, and capitalises on economies of scale. Moreover, by relieving some of the burden of fragmented aid, the New Compact creates space for the country to strengthen its priority setting and public financial management systems through the transition process. This method better positions the country to assume full control at the point of graduation from financial aid, thereby ensuring a smoother and more predictable transition and reducing the risk of coinciding financial shocks as multiple donors withdraw support.

The approach is at odds with the current organisation of development aid. In the current landscape, Gavi operates amid a multitude of actors, which creates hurdles for effective coordination. Half-hearted attempts to implement the New Compact in the absence of high-level leadership from donors would exacerbate these challenges, resulting in frequent meetings but limited tangible change. Gavi and country leaders would need to ensure that there is strong commitment from multi-donor coordinating committees.

Additionally, while the current system of multiple multilaterals can create problems of coordination and duplication, it at least ensures that there are a number of multilateral players with clear and distinct missions. If the New Compact blurs the boundaries between multilaterals' distinct roles, there is a danger that support from upstream national and philanthropic sources may be diminished, which would result in reduced overall aid for health.

Adapt pooled procurement

Proposed policy changes

An integral component of Gavi's operational model is its partnership with UNICEF. UNICEF Supply Division (UNICEF SD) procures vaccines for Gavi through a pooled procurement system. This approach leverages large-scale buying power and predictable demand to access fair prices and generate a reliable vaccine supply. As countries increase domestic financing for vaccination, new procurement models may be needed to sustain these benefits. This new phase could involve adapting Gavi's current procurement practices, thereby enabling the use of recipient country commitments in addition to donor funds.

Gavi may consider supporting the development of regional pooled purchasing consortia[33] such as that of the Pan American Health Organization (PAHO) and the one recently proposed by Africa Centres for Disease Control and Prevention (Africa CDC),[34] which would link plans to the nascent African Vaccine Manufacturing Accelerator (AVMA).[35] This mechanism may be an alternate or complementary pathway to help create predictable and consolidated demand, enabling manufacturers to plan for the long term and fostering a viable vaccine manufacturing ecosystem.[34]

Additionally, Gavi may explore flexible options for continued participation with their collaborating partners or even expand pooled procurement arrangements with partners such as UNICEF SD for countries after transition or for Gavi-ineligible countries.[36] Notably, middle-income countries (MICs) and target populations for innovative vaccines (i.e., adolescents or adults for diseases such as malaria and tuberculosis) may benefit from Gavi support. During the Gavi 6.0 Alliance workshop, many country representatives advocated for extending support to MICs and ensuring equitable access to Gavi/UNICEF vaccine pricing for all countries.[14] This is crucial because some MICs are paying higher vaccine prices than those prices offered to Gavi-eligible peers, especially for newer or self-procured vaccines.[33]

An example of how Gavi has supported similar efforts includes UNICEF SD's Access to COVID-19 Tools Accelerator Supplies Financing Facility—a global collaboration developed in 2020 that works to accelerate the development of, production of, and equitable access to COVID-19 tests, treatments, and vaccines.[37] Notably, as UNICEF is a major global procurer, it has expertise in engaging with LICs and MICs to establish the relevant supply chains (e.g., those that require temperature control within secure cold chains).

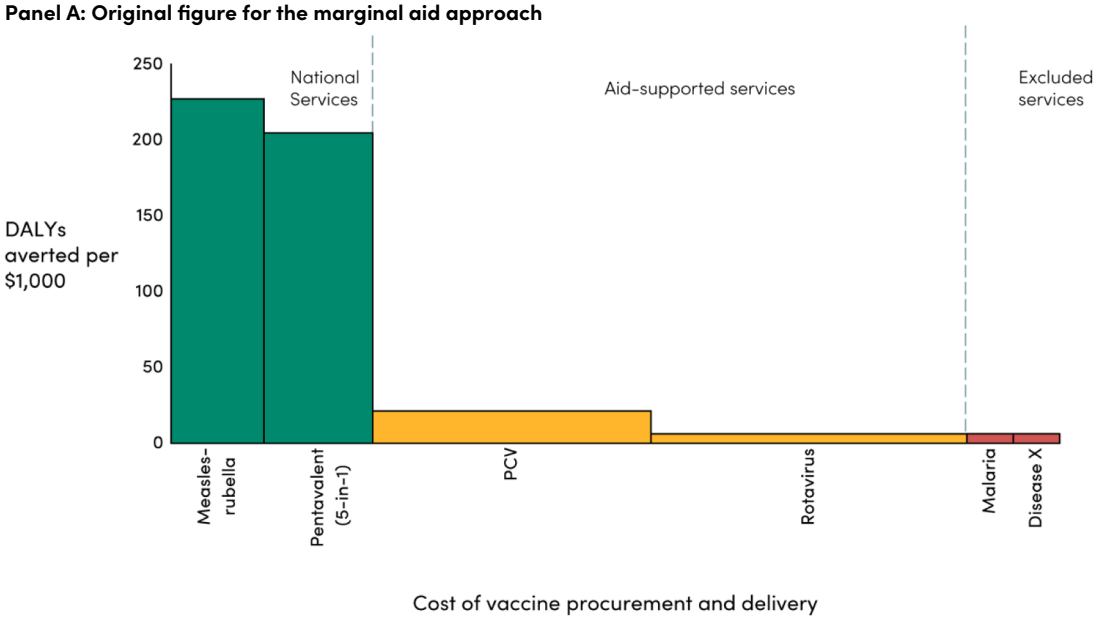
As they can adapt pooled procurement in this way, Gavi/UNICEF are well-positioned to facilitate pricing agreements with manufacturers[38] to help countries access price reductions for newer vaccines. Facilitating opt-in framework agreements with centrally negotiated tiered pricing for the cohort of former and never Gavi-eligible countries could also increase the support provided by Gavi.[33] Furthermore, the New Compact approach may help address the challenges that come with establishing pooled procurement mechanisms, particularly at a regional level, where the current interest lies in Africa CDC.[34]

However, repatriating pooled procurement to country consortia comes with the risk of fragmenting existing pooled procurement into regional pools, resulting in lower efficacy. Previous efforts for regional pooled procurement in the Middle East, Eastern Europe, and Southern Africa have been unsuccessful, often challenged by political barriers preventing implementation.[39,40] The proposed complementary policy changes under the New Compact could help mitigate these risks, as the New Compact can facilitate transparency and encourage discussions about jointly acceptable solutions.

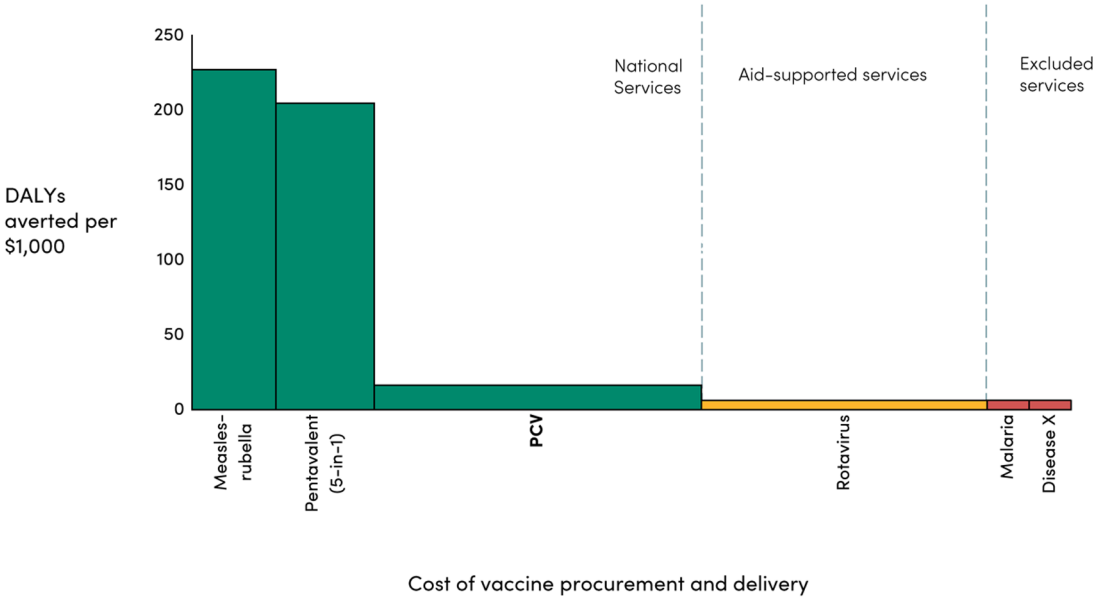
Consider Figure 6, for example: Gavi hands back the PCV programme to the country, but the country then loses access to the negotiated price for the Gavi-supported vaccine (Panel B of Figure 6). The vaccine then becomes more expensive, as depicted by the wider PCV block in Panel B, and the country is left funding an unnecessarily costly intervention. A negotiated solution might be to give the country access to Gavi-pooled purchasing facilities until its neighbours also transition out of Gavi support for PCV and it becomes possible to form a regional purchasing consortium.

FIGURE 6. Example of vaccine prioritisation for pooled procurement

Panel A: Original figure for the marginal aid approach



Panel B: Pooled procurement applied to the marginal aid approach



Benefits and challenges

Under this policy shift, countries can leverage economies of scale for access to a reliable supply of key vaccines at fair prices through pooling resources and collective negotiation. Pooled procurement also establishes predictable demand for manufacturers, encouraging them to invest in stockpiling and to expand production capacity, thereby ensuring a stable and reliable vaccine supply for the future.

However, one key concern for this policy shift is the potential destabilisation of the entire pooled procurement mechanism as larger countries with significant purchasing power exit consortia. As buyers' characteristics diverge more and more, their motivations and goals for participating are more likely to differ or even conflict.[39] If such countries leave the pool to pursue individual "sweetheart deals" with vaccine manufacturers, collective bargaining power would be weakened, potentially causing the pooled procurement mechanism to fail. In addition, a regional (as opposed to global) procurement pool may have weakened bargaining positions compared to the Gavi pool, and this weakened position can result in price drift, in which vaccine prices gradually increase over time.

Furthermore, as noted in a separate CGD article exploring opportunities to enhance vaccine access in ineligible MICs,[33] numerous countries are unable to procure vaccines through central procurement facilities such as UNICEF SD because of various factors, such as laws prohibiting external procurement agents, industrial policies that favour procurement from local producers, and the inability to meet UNICEF SD's prepayment requirement.[41] Although some efforts from the UNICEF financing mechanism seek to address these barriers, countries can help facilitate pooled procurement by enacting reforms to address legal, institutional, and administrative barriers and inefficiencies in order to enable their participation in pooled procurement initiatives.[42]

Strengthen market shaping

Proposed policy changes

The capacity for global vaccine innovation is a scarce resource. Although new vaccines will benefit everyone, it would be a major blow to human welfare if affluent countries' preoccupations dominate the struggle for scarce research dollars and human talent. Gavi's unique role has been to ensure that LICs' needs are represented, in particular by ensuring that there is a market for innovative technologies that meet their needs at the end of their development journeys. The New Compact aims to maintain and potentially create more space for Gavi to step up its role in market shaping and to ensure sufficient resourcing vaccine financing as guided by its Vaccine Investment Strategy[26] (Box 1).

Unlike the delivery of national vaccination programmes, innovation in the vaccine space is a global public good: national governments cannot be expected to deliver this public good. We anticipate that Gavi will continue to possess this leverage on new product development and market shaping under the New Compact. By channelling and consolidating statements of needs from LIC and LMICs and by sending a clear message to manufacturers about their potential return on investment, Gavi can encourage manufacturers to ensure that their innovations address these challenges. Carefully designed "pull" financing mechanisms such as the market-driven, value-based advance commitments (MVAC)[43,44] can play a role in this effort. More proposed actions can be found in a separate CGD piece.[45]

Country-driven requests can clearly communicate national needs and may facilitate the sustainable use of innovation and greater country ownership. A notable example is India's request to Gavi for funding to scale up national real-time monitoring of cold chain equipment and vaccine supplies. Gavi responded by addressing the government's articulated needs.[46] This strategy empowered innovators to focus on the government's stated priorities and built domestic demand for innovation in the process.[45]

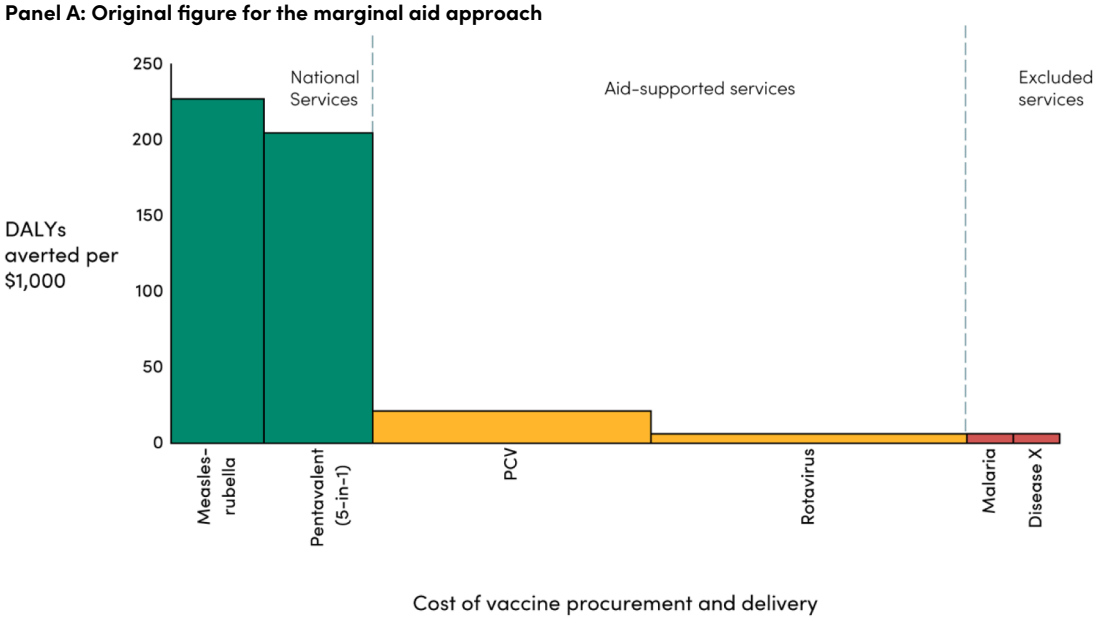
Simultaneously, streamlining regulatory environments conducive to innovation and market entry also signals that countries are ready to adapt these innovations. Regional health technology assessment (HTA) networks and National Immunisation Technical Advisory Groups (NITAGs) may align their efforts to create a standardised evaluation framework across countries, reducing market access burdens for manufacturers. These efforts may address manufacturers' need for a clear path to the market, especially for innovative products.

To illustrate how the New Compact approach can facilitate discussions on driving vaccine innovation, see Figure 7. Gavi recently included the malaria vaccine in its portfolio after recognising the significant burden in six Gavi-eligible countries, predominantly LICs, that collectively account for 50 percent of global mortality for malaria. With a significant demand projected for malaria vaccines and the limited supplies within the Gavi programme, establishing a robust market for these vaccines is crucial.[47]

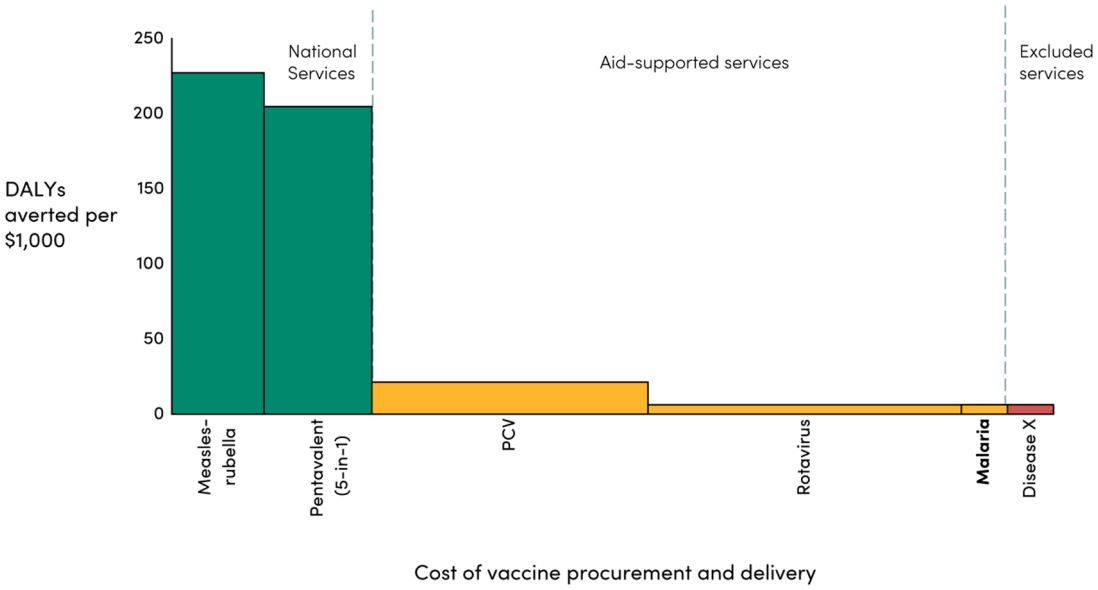
Gavi then incentivises manufacturers to invest in producing new vaccines at affordable and sustainable prices for LIC and LMICs, addressing the market failure for malaria vaccines.[47] In the example, Gavi fosters a healthy market for countries affected by endemic malaria, as it integrates malaria vaccines into its roster of aid-supported services (Figure 7, Panel B).

FIGURE 7. Example of vaccine prioritisation for market shaping

Panel A: Original figure for the marginal aid approach



Panel B: Market shaping applied to the marginal aid approach



Benefits and challenges

The New Compact clarifies the roles of both country financing of essential vaccines and in this case, of donor innovation. This distinction allows Gavi to focus on market shaping activities and to allocate more resources and time to finding a more organised and long-term approach to vaccine funding and development.

In a world where countries have more lead responsibilities for purchasing vaccines, ensuring that there is a path to market and return for investments for innovations will require complex choreography. Multilateral procurement facilitation mechanisms such as those through Gavi/UNICEF SD may struggle with the complexity of securing commitments from partner countries.

Manufacturers may also hesitate to invest in innovation without clear commitments and may seek explicit guarantees on the continued funding for vaccines. Consider the case of the malaria vaccine, in which the manufacturer was uncertain about production continuity due to the limited funding secured only for the 2019 programme pilot. The situation was resolved in 2021 when Gavi secured an innovative financing agreement in which MedAccess agreed to cover costs if Gavi could not later approve a vaccination programme. The replicability and sustainability of such efforts remain uncertain, and creative thinking may be required in order to maintain Gavi's ability to provide long-term assurances.[48]

5. Recommendations for implementing a New Compact pilot

How might Gavi then get started on implementing the New Compact? Gavi has done a good job of ensuring that financing for countries is stable and predictable, and we do not recommend a wholesale switch to a new and untested methodology. However, implementing a pilot of the New Compact approach in a subset of countries with the goal of assessing and learning what works best may help to operationalise Gavi 6.0. Laying the groundwork for such an approach could generate insights to inform a gradual transition and potential scale-up in subsequent strategic periods, including Gavi 7.0. Key steps on this journey may proceed as follows:

1. **Engage partner countries.** Countries in preparatory transition, as well as those growing quickly or that are in the early stages of accelerated transition who have strong existing functions for evidence-informed priority setting, may be well suited for piloting the New Compact. Qualifying countries can be invited to apply to be part of the pilot. Suitable countries can express interest on a "no detriment" basis, ensuring they are guaranteed not to receive less funding—and may receive more—than they would under existing Gavi rules, as a result of participating in the pilot.
2. **Clarify terms of engagement.** Terms of engagement may include agreement on timelines, deliverables, scope (e.g., is all Gavi funding included or are some programmes exempted?), and management arrangements on both sides. Part of clarifying the terms of engagement should be agreeing on, or at least getting a sense of, the budget limits that divide national services from aid-supported services and from excluded services.
3. **Formulate joint budget.** In the New Compact, dialogues between country and donor should discuss an order for national priorities and clarify what falls within national services and aid-supported services, and what falls outside the funded portfolio altogether. Countries

and Gavi should also consider budget scenarios in these dialogues, drawing on the country prioritisation process and real-world public financial practicalities.

A policy framework is also essential to articulate how country-led evidence-informed prioritisation would inform vaccine financing and to clarify links to current frameworks—such as the Vaccine Funding Guidelines[49] and the health system and immunisation strengthening policy[50]—to ensure that sufficient technical assistance and other kinds of support beyond vaccine financing are available. Regional HTA networks and NITAGs are likely to play a crucial role in this effort. These organisations can provide the necessary expertise and local insights to ensure that the policy framework is tailored to the specific needs and contexts of different countries.

4. **Develop transition plan.** To ensure that the New Compact is conducted on the basis of common understanding, we recommend that changes to be implemented by both country institutions and Gavi are developed and agreed upon at all stages of the supply and delivery chain.
5. **Implement the agreed-upon New Compact.** Although we see the first implementation of the New Compact as a "pilot," it is important that it is not a "shadow" prioritisation exercise that does not have bearing upon decision making. Such exercises typically fail because the parties involved cannot generate enthusiasm for an endeavour unlikely to have any real impact. A distinctive feature of the New Compact in contrast to the traditional Gavi approach is that vaccination programmes are passed in their entirety to the country to manage when they pass into national services. Therefore, it is not only the amount of the award that will be affected, but also the conditions of the award for many vaccines that will change.
6. **Review lessons learned.** Analysing the outcomes and process effectiveness involves evaluating the final distribution of expenditure. After all, if the expenditure pattern under the New Compact does not significantly differ from that expected under Gavi's existing transition model, switching to a new model may seem unnecessary. From a process standpoint, the intention behind the New Compact is to empower the country to articulate its own priorities, thereby including it in dialogues with donors. In order to understand whether this benefit has been realised, opinions from the country and donor teams engaged in the pilot must be gathered and the results compared against a predefined standard of success or failure. Success of the pilot may be assessed through an adapted version of the evaluation framework in Gavi's Vaccine Investment Strategy,[26] which assesses the impact of the vaccine programme and its influence on stakeholder perceptions. Potential adaptations to the model could also be considered in order to determine whether to proceed further in other countries.

6. Charting the next steps

Gavi faces tough choices in the next strategic cycle. Despite the current challenges, Gavi's goal remains to ensure that the poorest countries emerge with better and stronger vaccination programmes in the next five years. This objective may mean that some programmes currently funded by Gavi are instead funded by other donors or by domestic public funds. Achieving this goal requires collective effort, with Gavi collaborating with donors and countries to ensure that the funds (and commodities) provided deliver the maximum possible benefit to populations.

Coherent, catalytic, and country-driven efforts can be achieved through the New Compact. Centralising the voices of individual countries to lead and finance high-priority health services makes it possible to strengthen institutions while simultaneously expanding immunisation programmes. In other words, it allows for a dual focus on both short- and long-term health goals.

Additionally, as core interventions would be financed through domestic avenues, the New Compact potentially frees up some resources for other ways for Gavi to support countries, potentially including accelerating new vaccine introductions, providing further support for strengthening both new and existing architecture of health systems, stepping up market shaping activities, and expanding a lighter footprint of services to a wider base of countries. Similarly, Gavi's supporting and complementary role should ameliorate the risks of countries' transition out of Gavi support.

Meanwhile, the complementary shifts towards adapted pooled procurement and strengthened market shaping offer scalable solutions and could allow Gavi to serve a much wider base of partner countries—potentially including countries not currently eligible for Gavi support. Notably, these are also areas where Gavi has a clear advantage in being able to fulfil a function that countries cannot as effectively.

Policy reform of the kind outlined in this brief would require significant operational change for Gavi. As a prominent multilateral Global Health Initiative with broad-based support and a strong reputation for effective global health leadership, Gavi has the opportunity to determine its own ways of working while also championing and leading efforts for wider donor coordination.

For systemic change, the response to calls from countries to rebalance power dynamics and rework complex financing arrangements requires coordinated action. This paper provides an outline and key principles for a policy framework, but further work is needed to develop policy specifics in close consultation between Gavi and partner countries in order for such a framework to be implemented. We envisage that under the New Compact, there would be much closer collaboration both with other development partners and with recipient countries to work out what gets funded on the ground and how transition can be managed to maximize sustainability. Stakeholders—including decision makers in LIC and LMICs, academics, researchers, global health donors, and multilateral organisations—all have a role to play in realising a New Compact for global health financing.

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Annex 1. Summary of policy shifts for a New Compact between Gavi and partner countries

Policy Area	Policy Specifics		Benefits	Challenges/Risks
	Gavi	Country		
Rework health service financing	• Agree on new co-financing policies to support country-led domestic financing of high-priority interventions • Provide technical assistance to support both domestically and Gavi-financed vaccines • To complement country efforts, progressively reallocate resources to other Gavi priority areas • Provide additional financing and technical assistance for new vaccine introductions	• Adopt or strengthen evidence-informed priority setting processes to define priority national health services • Progressively assume a greater or full share of financing and delivery of high-priority vaccines	• Domestic financing for high-value vaccines ensures consistent, sustainable support for key vaccination programmes. • There is a clearer compact between national public providers and their constituent populations on the provision of vaccines. • Domestic financing of high-priority vaccines may mean more Gavi resources are available for new vaccine introductions. • Countries will gradually transition towards responsibility for high-priority vaccines. • Approach to priority setting is locally driven and based on context-specific challenges. • Coordination and collaboration between Gavi and countries in strengthening health systems are improved.	• Ineffective implementation or insufficient financing from governments could leave populations under-vaccinated and at risk. • Public financing for vaccines could be redirected from other important public services, including non–health services. • Limited institutional capability could mean that inadequate planning for the financing transition leads to temporary gaps in vaccination. • Pooled procurement could be disrupted, resulting in high vaccination costs.
Ensure comprehensive coverage	• Enhance technical assistance to ensure continued progress towards reaching zero-dose populations (for both domestically and Gavi-financed vaccines)	• Develop or strengthen systems for health financing and for the transition of high coverage immunisation from Gavi to domestic financing, including underserved or hard-to-reach populations	• The New Compact enables equitable prioritisation. • Links between underserved populations and the public health system are strengthened. • Gavi financing can be better targeted to contexts outside the country's responsibility or control (e.g., refugees or displaced persons).	• Given the high level of need in marginalised communities, it may be challenging for Gavi to develop a robust and defensible prioritisation procedure for applications. • Countries may be unable to incorporate marginalised communities in political decision making and economic development, and this inability may be persistent and long-lasting.

(Continued)

Policy Area	Policy Specifics		Benefits	Challenges/Risks
	Gavi	Country		
Advance donor coordination	• Lead other donors to align funding cycles, standardise application and reporting requirements to reduce the burden on countries, and create country-level multi-donor coordinating committees	• Clearly communicate local demands and funding cycles to enable Gavi to align with country-level progress and leadership	• Financial support for countries is better coordinated and nationally relevant. • Funding is more efficient, as duplication is reduced and economics of scale are extracted. • There is a smoother and more predictable transition towards independent country-driven health financing, with less risk of coinciding financial shocks as multiple donors withdraw support simultaneously.	• High-level leadership may be absent, resulting in operational inefficiencies (e.g., many meetings but few actual changes). • Misalignment between donors and countries may lead to disputes, distracting officials from national priorities. • Distinctiveness between donors could be weakened, leading to less support from upstream national and philanthropic sources and less overall funding.
Adapt pooled procurement	• Reform existing platforms or consider supporting new platforms for pooled procurement to enable domestic financing • Consider including former or never Gavi-eligible countries such as MICs to maintain or even increase the pool	• Introduce reform to address legal, institutional, and administrative inefficiencies regarding and barriers to participating in pooled procurement	• Partner countries have access to a reliable supply of key vaccines at fair prices. • Former/never Gavi-eligible countries could potentially also benefit from adapted platforms for pooled procurement. • Reliable demand is established for manufacturers, promoting market efficiency and incentivising innovation.	• Pooled procurement could fail as wealthier countries cut sweetheart deals with industries. • Leadership and administration of pooled procurement may become politicised and ineffective. • Weaker bargaining power may lead to price drift upwards.
Strengthen market shaping	• Step up role in incentivising vaccine innovation by creating clear value-based market demand commitments • Increase support in creating enabling environments for new vaccine introductions (e.g., through supporting regulatory reform)	• Clearly communicate national needs and readiness for innovative technologies • Consider designing a regulatory environment conducive to support the uptake of innovative technologies	• Domestic financing of high-priority vaccines leads to an increased budget for new vaccines in Gavi's Vaccine Investment Strategy. • The roles of the country (financing of essential vaccines) and of multilaterals (incentivising innovation) are made clearer. • Clear returns on innovation investment for manufacturers are made available.	• Multilateral procurement facilitation mechanisms (either through Africa CDC or Gavi and its core partners) may struggle with the complexity of securing commitments from partner countries. • Investing in innovation is, in some sense, a gamble on future gains, with an opportunity cost of higher coverage with existing effective technologies.