

The Global Alliance for Vaccines and Immunization: Is It a New Model for Effective Public–Private Cooperation in International Public Health?

The Global Alliance for Vaccines and Immunization (GAVI) has in many ways been remarkably successful in revitalizing the international coalition of institutions and organizations concerned with getting vaccines to the children of the poorest countries. Many have seen this high-profile venture in public–private cooperation as a model for other groups concerned with more effectively helping to solve health problems in the developing world.

We examined major flaws in the GAVI and argue that in fact the alliance does not represent a new paradigm for international public health. However, the experience of the GAVI may suggest an alternative, and more effective, way to conceptualize future global initiatives. (*Am J Public Health*. 2004;94:1922–1925)

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AT THE END OF 1999, AN alliance of international health agencies, private industry, bilateral donors, philanthropic foundations, and other parties concerned with the health of children in the poorest nations was formed to both finance and speed the delivery of new and improved vaccines to children in the developing world. The coalition was called the Global Alliance for Vaccines and Immunization (GAVI)—and it was backed up by a heavily endowed entity called the Vaccine Fund (for a more intensive treatment of this subject, see Muraskin¹).

Despite its laudable efforts to pioneer a new and more effective model of international cooperation, the GAVI is handicapped by 2 fundamental flaws and thus runs a high risk of ultimate failure, with the danger of hurting other efforts as well (such as alliances like the Global Fund for AIDS, Malaria and Tuberculosis, which has considered the GAVI a model for dealing with developing countries' problems). First, the GAVI, as currently constituted, has failed to achieve a balance between “top-down” and “bottom-up” in its relations with countries, a fact that continues to plague and undermine the initiative. A second and closely related flaw is that the international public health community has still not been able to reach a genuine consensus on the exact role that immunization should play in pro-

tecting the health of children in developing countries.

Top-down globalism plays a necessary and powerful role in initially moving the public health community forward, but it cannot succeed in the long run without genuine bottom-up input and support. Unfortunately, global initiatives are handicapped in generating support, because conflict so frequently arises between the priorities of the founders of global initiatives and those of the countries the initiatives purport to assist. In the absence of genuine grassroots espousal, pressure is placed on global organizers to seduce participants and manipulate enthusiasm rather than actually develop it.

Although the creation and commencement of innovative programs simultaneously in many countries appears to make organization at the global level indispensable, such high-level initiation often lacks, and in fact undermines, local support. Can we solve this problem? The answer is yes, but the solution requires a radically different conceptualization of the proper role of individuals and groups working at the global level. It requires a greater degree of humility than now exists and a radically changed sense of what constitutes “service” to developing countries. Those aspiring to exert global “leadership” will need to see themselves more as facilitators than as movers and shakers. This

change in perspective will require more effort than the lip service currently paid to the bottom-up approach; such a transformation will require finding a way to generate real bottom-up initiation.

Supporters of this new approach do not deny that global initiatives have a vital role to play. Getting truly bottom-up initiatives organized and running will be difficult, and top-down assistance will be required. However, the legitimate global role of top-down initiatives requires a markedly greater level of restraint and a genuine willingness to subordinate global initiatives to the priorities of the people they are intended to help than is currently apparent. We can see this need very clearly in the case of the GAVI.

The GAVI was the creation of deeply committed and morally energized people working at the top level of the international health community. Such dedicated individuals were especially important at the Bill and Melinda Gates Children's Vaccine Program; the Program for Appropriate Technology in Health (PATH), which housed it; the International Federation of Pharmaceutical Manufacturers Association; the World Bank; the Gates Foundation; US Agency for International Development headquarters in Washington, DC; World Health Organization (WHO) headquarters in Geneva, Switzer-

land; UNICEF headquarters in New York, NY; and the Rockefeller Foundation. People in these organizations were global players, with both the strengths and the weaknesses that accompany that position. Although they benefited from seeing the big picture, they were too often severely handicapped by their lack of familiarity with the details on the ground. Not only were in-country field workers from UN agencies, bilateral donors, nongovernmental organizations, and indigenous governments not part of the core group advocating the creation of the GAVI, these workers were to a remarkable extent not consulted by those who created the GAVI. Part of this lack of participation was structurally caused—that is, high-level globalists communicate primarily with their peers rather than with those working at other levels of the system. However, part of the problem was a conscious choice: people focused on the big picture do not want to be bogged down and nitpicked to death by localists who raise a barrage of “parochial” and country-specific objections. Global activists are by nature interested in hearing what can be done, not in hearing about the myriad obstacles to rapid and effective action.

A strong case can be made for employing a bird’s-eye view of the world, and Tore Godal, the executive secretary of the GAVI, has made this case. Workers close to developing countries “see the differences and not the commonalities,” he says, but without some “simple global principles,” one is forced into bilateral negotiations, which consume time, severely slow down the process, and are so country-specific that it is hard to generate usable lessons (interview by the author, Decem-

ber 2000). As a result, a globalist approach is the only way to speed things up. In a world that is increasingly globalized, the legitimacy of this global perspective must be taken into account.

THE LOCAL VS THE GLOBAL

However, workers with long familiarity with conditions in the field are painfully aware of the problems facing any large-scale and ambitious new venture originating on the international level. They have had a great deal of experience with global interventions, not only in trying to actually implement them but also in dealing with the aftermath when donors have moved on to newer, hotter issues. In her classic study of Nepal, *Politics, Plans, and People: Foreign Aid and Health Development*,² Judith Justice of the University of California, San Francisco, has documented the constant changes in global priorities—the flavor-of-the-month—club types of interventions—that have been forced on developing countries over time. She has highlighted the disarray, wasted effort, skewed priorities, and disillusionment that have followed in their wake. Field workers are well aware of that sorry legacy of global activism and are anxious not to relive it. They are forced to know intimately—in a way that global leaders simply cannot, or will not, understand—the limitations of local government, infrastructure, finance, and human resources that plague the developing world and what they mean in practice.

In the case of the GAVI, one of its initial flaws was that its vision came from leaders who were inadequately informed regarding field workers’ opinions

about what could realistically be accomplished within a relatively short space of time—the imbalance of “top-down” and “bottom-up” referred to in the introduction.

Bjorn Melgaard, who was head of the WHO’s Expanded Programme on Immunization, and subsequently of its entire combined vaccine division, has expressed his sympathy with the anxieties of in-country workers confronted with new global initiatives (interview by the author, December 2002):

My major criticism . . . of the [Vaccine] Fund, the GAVI and the Global Fund [for AIDS, Malaria and Tuberculosis] . . . [is that they] operate . . . as new donors on the block and require new formats for planning, implementation, monitoring, reporting, etc. [This] imposes a tremendous burden on countries. . . . New alliances demand their own new systems, and [such demands] undermine the implementation capacity of the Ministries of Health.

What one hears over and over again from those working in-country, whether with the WHO, UNICEF, the nongovernmental organizations, the bilateral donors, or others, is that at the provincial (and often the national) level only a handful of skilled people manage to “do everything.” The pool is small, and global initiatives keep placing the burden of ever-shifting priorities onto the shoulders of the same small group of people. This limitation of human capacity makes it difficult to take on even generously funded programs. Godlee, in a 1994 critique of the WHO in *BMJ*,³ highlighted the importance of the problem—and her words apply even better to the impact of global initiatives in general than to that of one organization:

It may seem harsh to suggest that WHO’s impact on countries may be not just minimal but negative. Such a suggestion is, however, widely acknowledged. The phrase is “donor robbery.” By this, people mean that WHO—and other international agencies—rob countries of precious expertise. Skilled and effective professionals are in short supply in some areas and are therefore snapped up by the international organizations.^{3(p1636)}

Just as field-savvy expatriate agency workers in developing nations were not part of the global groups creating the GAVI, neither were governments in the developing world participants in the process. The GAVI was designed *for* the countries’ good but not *by* the countries. It is vital to realize that the demand for this initiative did not emanate from the designated beneficiaries. Rather, the countries as a group have had to be wooed, “educated,” and financially enticed to accept the GAVI’s goals as their own.

A good example of such seduction can be found in Uganda. In an unpublished report to USAID on immunization written in 1999, right at the time that the GAVI was being formed, Justice states the following:

“Although the National Immunization Program had earlier been given the highest priority in Uganda, current priorities were stated to be malaria among the infectious diseases, followed by respiratory conditions and pneumonia, malnutrition and kwashiorkor, and diseases related to water and sanitation such as severe diarrhea. . . . Hepatitis B [which would be the first GAVI-supported vaccine] does not have a champion, no one who is passionate about it or interested enough to commit time and energy to its promotion and, therefore, it is most unlikely to be placed on the health agenda in the near future. . . .”⁴

Nevertheless, within an astonishingly short period of time after new money for hepatitis B vaccine became available, Uganda had applied for, and received, hepatitis B vaccine funds.

A GAVI BLIND SPOT

The full implications of this situation have been very difficult for the most committed GAVI supporters to assimilate fully. Many of these supporters insist that the mission of the GAVI is simply to carry out aims that the countries themselves have voted for on numerous occasions in the World Health Assembly and elsewhere. For example, the World Health Assembly, with the support of all of its member countries (99% of the countries in the world), voted for making hepatitis B a universal childhood vaccine. Developing countries have supported the concept of 80% diphtheria, pertussis, tetanus vaccine coverage in 80% of all country districts, with a specific date agreed on by everyone. Both targets and dates are core GAVI goals. Nevertheless, such broad statements of goals, or even narrowly set timetables, often have little connection to what developing countries' governments can muster the desire or political will to stand behind.

Many scientists who support the GAVI have explained the obvious reluctance of many countries to actually champion immunization goals as their own by arguing that if the leaders "really understood" the importance of those objectives, they would change their minds and support them—all they need is to be given "the facts." This may be true, but the need for such "education" is the key point—the countries remain pupils who need to be helped to see the light

and change their actual—as opposed to rhetorical—priorities.

VACCINATION ABOVE ALL ELSE

This brings us to the second major flaw of the GAVI: the nonnegotiable status of immunization as the initiative's core goal. Most in-country workers and most developing countries' governments—even their ministries of health—would not place a series of new children's vaccines at the top of their priorities without a major financial enticement. For everyone familiar with conditions in the field, child immunization is only one of a back-breaking press of challenges, and the introduction of new and improved children's vaccines has by no means been the most urgent.

The GAVI champions immunization, and yet its core constituencies—field workers and developing countries' governments—have been unenthusiastic supporters of that goal. And when it comes to questioning the centrality of vaccination, they are joined by a third group, the European bilateral donors. Although bilateral donors have been among the nations most committed to the struggle for equity for all children of the developing world, they have entertained very strong doubts about whether vaccination is the best means of achieving that goal. That very same reservation alienated the bilateral donors from a previous vaccine alliance, the Children's Vaccine Initiative,⁴ and made them its chief critic.

THE BILATERAL DONOR POSITION

The bilateral donor position was clearly presented by Jorn

Heldrup of Dandida, the Danish foreign aid agency, who was present at the GAVI board meeting in November 2002. As he put it in an interview in November 2002:

There are good things to support about the GAVI. . . . The problem is [that] it . . . may undermine the health in developing countries. In Tanzania, for example, there are 10—only 10 people—in the whole country who can deal with the various international initiatives that are thrown at the country. They must deal with them all . . . [and the] GAVI is only one of them. They are pulled one way, then another. What should be important is the countries' own priorities and their looking at all the possibilities [available to them] and [then their] choosing priorities with the limited resources that they have. But that is not possible when these initiatives come down [from on high].

And so Dandida and the other European bilateral donors have pushed for a method that would avoid undermining local decisionmaking. The bedrock on which bilateral donors stand is the "systems approach" to health development, which emphasizes allowing countries to set their own priorities. From that perspective, the donors have been concerned with the entire health system and careful not to overemphasize one type of intervention (such immunization) at the expense of others. They have also strongly emphasized the vital importance of developing countries' governments setting their own priorities—not simply within the health sector, but also in the trade-offs between health, housing, education, industrial development, and so forth. The commitment of bilateral donors to this approach is at odds with the basic assump-

tions of the globalists who created the GAVI.

CAN BOTH APPROACHES WORK?

Many people of goodwill have tried to bridge the gap between those who support a systems approach and those who champion a vaccine-centric focus. Unfortunately, an inherent contradiction between the worldviews of the 2 groups cannot be reconciled, at least at this time.

The heart of the problem is that creators and core supporters of the GAVI have never believed that immunization is just one among many contending programs that should "freely compete" with one another for commitments from developing countries. The GAVI's assertion that vaccines are extremely cost-effective and could easily outdo other interventions in any competition for funds is an attractive rhetorical claim that nevertheless has not been tested. Although the creators of the GAVI have perfunctorily recognized the desirability of countries' setting their own priorities, the supporters of the systems approach have seen local decisionmaking as a paramount value. Saving lives through immunization, not having countries set their own priorities, has always been the GAVI's supreme goal.

For the small and dedicated cadre that enables the GAVI to function, and that constitutes its indispensable human infrastructure, the primacy of immunization is *nonnegotiable*. Immunization is the rock upon which the GAVI and its Vaccine Fund are built. Such is absolutely not the case for the individuals and groups that support the systems approach.

THE PROBLEM WITH INVERTED PYRAMIDS

Ultimately the GAVI is a partnership of organizations, countries, and individuals, almost all of whom have substantial reservations about its goals. Its core base of support is located in the Bill and Melinda Gates Children's Vaccine Program (the name of the project has been changed to the Children's Vaccine Program at PATH), the Vaccine Fund, the Gates Foundation, the key GAVI infrastructural units (the secretariat, working group, and task force on finance), and scattered individuals in the international agencies and developing countries. These people have been the driving force of the GAVI and the cadre that has energized it and made it a dynamic and pioneering initiative. Yet the majority of the GAVI's partners have remained only lukewarm adherents. Most countries that partner with the GAVI have been supporters primarily because of the substantial new money available for the initiative—starting with the \$750 million from the Gates Foundation. Although bilateral donors have cooperated to varying degrees, as a group they have shown no desire to pledge themselves to pick up the long-term costs of the new vaccines, without which the short-term benefits of the GAVI's Vaccine Fund money are not sustainable. The field workers remain skeptics, and the WHO and UNICEF continue to be distracted with a host of other pressing priorities and remain keenly aware that their own institutional self-interests often differ significantly from that of the GAVI.

The bottom line is that the GAVI is a giant inverted pyramid

that rests on the backs of a very small committed base. For its core supporters, the GAVI is a mission, a cause, and a grand experiment. For everyone else, however, it is merely one of numerous initiatives—many of them more urgent. As a consequence, it is dubious that the GAVI represents a model of private–public effective action and that it can serve as a useful guide for other high-level initiatives.

TO MAKE THE GAVI SUSTAINABLE

The GAVI on the surface looks healthy and strong. It continues to move ahead at a breakneck pace with continuous milestones reached and goals achieved. But under the surface, the GAVI suffers from fundamental flaws, some of which pose a potentially fatal threat both to the GAVI and to its long-term goals. What, if anything, can be done?

An indispensable part of any solution would involve openly and purposefully turning the existing inverted pyramid of the GAVI on its head so that the supporters of a systems approach to health development—who constitute a large majority of the international public health community—become core supporters of the GAVI. This cannot happen as long as the GAVI overly privileges immunization in fact as well as in name.

The quite laudable goal of introducing new and improved vaccines would not have to be totally abandoned, but it would have to be integrated with, and subordinated to, broader systems objectives. Where an irresolvable conflict arises, the timetable for vaccine introduction would have to be determined by its effect on the overall mission of strengthening

the entire health system. The continued active engagement of vaccine-centric groups and individuals within the GAVI, despite their inability to dominate it, would guarantee that the importance of immunization was never lost from sight—a danger of the systems approach.

A reformulation of the goals of the GAVI to emphasize building strong foundations that will support lasting achievements can be the start of a painful but necessary way out of the dilemma. Donors (governments, philanthropies, and the general public that supports them both) must face up to the fact that short-term gains, no matter how much they lend themselves to public relations sound bites or fit neatly into donor funding cycles, do not achieve their stated humanitarian objectives. It is time to try another approach. ■

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