

The role of vaccine accelerators in expediting vaccine introductions in LMICs

Lessons and implications from seven case studies

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Executive Summary

Vaccine accelerators — multi-disciplinary, multi-partner initiatives that provide targeted support to expedite national vaccine introductions — have helped close a historically wide gap between when vaccines become available in high-income countries (HICs) and when they reach children in low- and middle-income countries (LMICs). The key functions of vaccine accelerators remain consequential: the COVID-19 pandemic cut new vaccine introductions worldwide from 48 in 2019 to just 15 in 2020 (5), and although the Big Catch-Up campaign has since reached 18.3 million previously under-vaccinated children, structural gaps in routine immunization persist (29). These pressures are now compounded by the steepest single-year drop in international development assistance on record (21) and by Gavi's most significant financing overhaul since its founding — a shift toward country-controlled, portfolio-wide vaccine budgets under its 2026-2030 strategy (18,19). Together, these forces are redefining not just how much external support is available for vaccine introduction, but what form that support should take.

This report examines what accelerators have offered in the past and what they may still offer in this changed vaccination landscape. Drawing on desk research and interviews with 38 experts who have funded, managed, implemented, or partnered with vaccine accelerators, we investigate seven case studies — the Meningitis Vaccine Project (MVP), Pneumococcal and Rotavirus Accelerated Development and Introduction Plans (ADIPs), Rotavirus Accelerated Vaccine Introduction Network (RAVIN), Typhoid Vaccine Acceleration Consortium (TyVAC), Global Task Force on Cholera Control (GTFCC), and HPV Vaccine Acceleration Program Partners Initiative (HAPPI) — to identify accelerators' core approaches, the conditions under which they succeed, the challenges they face, and their continued relevance for decision-makers navigating today's more constrained, more crowded vaccine introduction environment.

Accelerators have a credible track record and have laid the foundational infrastructure, policies, and operating practices that continue to accelerate new vaccine introductions today: they have shaped Gavi Board co-financing decisions, generated evidence underpinning WHO SAGE recommendations, cultivated LMIC-ready suppliers, and measurably shortened the interval between licensure and country introduction. But the vertical, single-antigen design that made early accelerators effective is increasingly mismatched to a landscape in which countries must prioritize across dozens of vaccines within fixed budget envelopes.

Looking ahead, we recommend applying a higher bar before standing up a new accelerator: dedicated, time-bound, vertical support seen more as the exception to the model, warranted only where a vaccine is genuinely deemed as high-impact; faces a demand, financing, or supply barrier that country and core partner systems cannot resolve on their own; and requires unique capability surge support. Where that bar isn't met — as is increasingly the norm



— the same underlying competencies are better delivered in line with the broader global health architectural shift towards localization: lighter, cross-cutting country-embedded support that helps governments prioritize across a full portfolio of antigens and available products, helps provide the decision making and technical support to drive more integrated vaccine uptake and coverage rather than introduction alone, and builds lasting local and regional capacity. We offer this review as a resource for the funders, partners, and countries navigating that transition.





Introduction

The development and trajectory of vaccine accelerators

Immunization has been an essential and extraordinarily impactful component of public health and disease control, contributing to the halving of child mortality in lower-income countries since 2000 (1). However, the gap between the availability of life-saving vaccines in high-income countries (HICs) and low- and middle-income countries (LMICs) has historically stretched for years: more than 15 years after marketing approval of the hepatitis B and haemophilus influenzae type b (Hib) vaccines in the US, less than 10% of children in Gavi-supported countries were receiving either vaccine (2). These substantial access lags for LMIC populations have often been ascribed to the high costs and limited availability of vaccines; lack of regulatory and policy recommendations; and uncertainty about the disease burden, potential impact of vaccination, and delivery channels in LMICs.

Since 2000, several global health initiatives have been deployed to unblock these barriers. In 2002, Gavi — whose primary role at the time was to serve as a global financing facility to increase equitable access to vaccines — commissioned two large, multi-partner initiatives to accelerate the availability of vaccines against pneumococcal and rotavirus disease in LMICs (2). These Accelerated Development and Introduction Plans (ADIPs) are among the first “vaccine accelerators.” In parallel, the Bill & Melinda Gates Foundation (BMGF) supported the development and introduction of the novel MenAfriVac vaccine through the Meningitis Vaccine Project (MVP) in the early 2000s, responding to calls from African health ministers for a more effective intervention against increasingly deadly epidemics (3).

Building on the lessons and successes of these early models, additional vaccine accelerators have been developed over the past two decades — and their scope has evolved in tandem with



the evolution of Gavi and development of standing global pathways to support vaccine introduction. In 2002, Gavi was a nascent organization with limited staff, and the ADIPs were given substantial budgets with a great degree of programmatic flexibility. They were notable in playing a coordinating role at the global level across early-stage activities, like engaging with manufacturers on producing dual-market vaccines, pioneering global regulatory pathways, supporting policy evidence needs, mobilizing global resources, and building political will. Since then, global channels have matured and taken on some of these functions: Gavi plays a stronger role in negotiating pricing and co-financing arrangements, as well as working more closely with country partners to forecast demand and support vaccine applications; UNICEF plays a critical role in managing supply chain and procurement at the country level; and the World Health Organization (WHO) has well-established processes and governing bodies to provide policy recommendations and country-level support. Accordingly, the timeline from vaccine licensure to introduction in LMICs has shortened (4), and recent vaccine accelerators have shifted toward more targeted geographic and functional scopes, with stronger focus on country-level introduction and delivery planning support.

A changing vaccination landscape

Since accelerators were first developed, the vaccine landscape has changed dramatically. Vaccine introductions declined sharply during the COVID-19 pandemic — with only 15 new introductions globally in 2020 compared to 48 in 2019 (5) — underscoring the need to accelerate both the introduction and uptake of vaccines to achieve the Immunization Agenda 2030's goals for equitable access. While the Big Catch-Up initiative delivered over 100 million vaccine doses to 18.3 million children across 36 countries between 2023 and 2025 (29) to address COVID-related declines, structural gaps and chronic under-immunization persist. These are now also compounded by the sharp foreign aid cuts of 2025 — a record 23% drop in official development assistance from major donor governments, driven primarily by a 57% cut in US funding (21) — which are projected to reduce external health funding by 30 – 40% relative to 2023 and are already disrupting vaccination services by up to 70% in some countries (23), threatening years of immunization gains.

These pressures are coinciding with the most significant restructuring of global immunization financing since Gavi's founding. Under its 2026–2030 strategy (Gavi 6.0), the Alliance has moved away from antigen-by-antigen support toward country-controlled vaccine budgets, allocating nearly 90% of its vaccine procurement funding directly to countries, which now



submit a single, holistic application spanning their entire portfolio (18,19). Amid the sharp contraction in development assistance for health (21), countries must prioritize among an expanding menu of vaccines within fixed budget ceilings—precisely the kind of complex, portfolio-level decision that accelerators have historically helped to inform.

This report's contribution

To inform how decision-makers consider vaccine support initiatives within today's context, we examine seven vaccine accelerator case studies: MVP, Pneumococcal Accelerated Development and Introduction Plan (Pneumo ADIP), Rotavirus Accelerated Development and Introduction Plan (Rota ADIP), Rotavirus Accelerated Vaccine Introduction Network (RAVIN), Typhoid Vaccine Acceleration Consortium (TyVAC), Global Task Force on Cholera Control (GTFCC), and HPV Vaccine Acceleration Program Partners Initiative (HAPPI).

Through these examples, we articulate a definition of vaccine accelerators and identify their core offerings and approaches, conditions under which accelerators may be effective mechanisms for expediting vaccine introduction, success factors for implementation, and key challenges faced. We also present critiques of the antigen-specific accelerator model and explore its applicability in today's vaccine introduction landscape.

Methods

This analysis took place from October 2023 through March 2024, with light additions made in June 2026 to reflect updates since the conclusion of our review.

Case studies were selected to showcase the breadth of accelerator models deployed over time across multiple dimensions:

- *Time frames*, from the early 2000s to ongoing models
- *Funders*, including Gavi and the Gates Foundation
- *Delivery platforms*, including routine immunization, adolescent immunization, and campaigns
- *Geographic scope*, from a broad remit across LMICs to a selection of focus countries
- *Functional scope*, supporting different phases of the vaccine introduction lifecycle

Our inquiry followed a mixed-methods approach:

- We reviewed publicly available literature, grey literature, and investment documents provided by Gates Foundation for the five models it funded.
- We interviewed 38 experts, selected purposively and via referral sampling based on their expertise in vaccine introduction, engagement across the selected accelerators, and varying



Accelerators' Scope and Approach

Each case study accelerator focused on distinct portions of the vaccine introduction value chain, and accordingly pursued different activities and partners to enact its mission. Nevertheless, commonalities in objectives, partnerships, and overarching approach were observed across these models that facilitate a common definition of accelerators as they have been historically deployed:

A vaccine accelerator is a project-based approach — undertaken through global partnerships and led by an NGO or academic organization — that is initiated to expedite the timing of national introductions of safe and affordable vaccines where they are most needed, by streamlining the provision of multi-disciplinary, targeted functional support across both country-level and global activities.

Distinguishing elements include a project-based approach that is time-bound, target-oriented, and often backed by grant funding to supplement existing vaccine introduction processes. The lead organization is typically part of the extended disease-specific partner ecosystem as a grantee, working in close partnership with the core partners of Gavi, WHO, and UNICEF. Accelerators' primary objective is to speed the timing of national vaccine introductions, reducing the gap from product authorization to countries' decisions to introduce by supporting country- and global-level decision-making. They target geographies where timely introductions are warranted given the disease burden and epidemiologic profile, including demographic composition, risk indicators, and service utilization. Functionally, they unblock barriers across the vaccine introduction lifecycle that are unique to the specific antigen and geographies. They support both universally recommended vaccines (e.g., against rotavirus, HPV, and pneumococcal disease) and targeted vaccines (e.g., against meningitis group A, typhoid, and cholera). Typically, a vaccine product is already defined (with MVP as an exception). A critical feature of accelerators is their iterative approach, supporting multiple points along the value chain at once. Indeed, a unique strength is accelerators' ability to play an end-to-end coordination role across various activities, stakeholders, and milestones.

Case Studies

Meningitis Vaccine Project (MVP)

MVP was the earliest model examined, established by a 10-year grant from BMGF to PATH in 2001 to develop, test, and license an affordable, effective meningococcal conjugate vaccine to eliminate Group A infections, the leading cause of epidemics in the meningitis belt in Africa. While multivalent vaccines were licensed at the time, they were not affordable in LMICs. MVP



was a novel program and lauded for its role in all development aspects of the MenAfriVac vaccine, in addition to helping pioneer the evidence dossier needed for global recommendation and negotiating manufacturing and pricing agreements for LMIC markets. MVP was able to develop and license MenAfriVac in nine years and secure pricing at \$0.40 per dose in 2010 – approximately 50% of the cost of previous meningococcal vaccines (3). The program was also notable for its strong country-level engagement: it established relationships with country decisionmakers ahead of the vaccine's availability to lay the groundwork for introductions (3). Meningococcal A conjugate vaccines (MenA) have been introduced through campaigns in 24 of the 26 meningitis belt countries, with 15 countries including MenA in their routine immunization schedules. As a result of MVP's efforts, meningitis due to Group A has been virtually eliminated in vaccinated countries (3).

Pneumococcal and Rotavirus Accelerated Development and Introduction Plans (ADIPs)

The Pneumo and Rota ADIPs were commissioned by Gavi in 2002 with a \$30 million commitment each, targeting pneumococcal conjugate vaccines (PCVs) and rotavirus vaccines (RVVs), respectively, given high burdens in LMICs and the existence of defined products (2). At the time, uncertain demand among LMICs inhibited manufacturers' investment in the development and supply of products for LMIC markets. The ADIPs were tasked with accelerating access to these vaccines in LMICs by generating and forecasting country demand and ensuring affordable and sustainable supply (6). They invested heavily in surveillance studies to demonstrate disease burden; advocacy and communications to assert the value of the vaccine to country and global policymakers, financiers, and politicians; and supply strategies, working with manufacturers on regulatory pathways and clinical trials. The ADIPs received a shared \$200M envelope to support an additional year of engagement, primarily for vaccine purchase and technical activities (2). Through their efforts, the ADIPs paved the way for market entry for vaccine producers targeting LMIC markets, including among emerging suppliers, and contributed to the Gavi Board's approval to co-finance both PCV and RVV. The Pneumo ADIP supported Wyeth through the WHO prequalification process and its pricing and supply strategy (2). The demand forecasts generated by the Pneumo ADIP were also instrumental in the design of the Advance Market Commitment for pneumococcal vaccines, launched in 2009 with a \$1.5 billion commitment to accelerating the development and uptake of PCVs (7). Rota ADIP supported early RVV introductions in Latin America, and introductions increased rapidly in the years following: by 2008, RVVs were licensed in over 100 countries and introduced in 17 countries (8).



Rotavirus Accelerated Vaccine Introduction Network (RAVIN)

RAVIN was launched in 2016, responding to lagging RVV uptake relative to other age-indicated vaccines: only 80 of 193 WHO member states had introduced RVV into national immunization schedules at the time. RAVIN aimed to support country-led RVV introduction decision-making among six high-population, Gavi-eligible countries, and two additional smaller countries also requested support. RAVIN provided technical advocacy on the potential impact of RVVs, synthesized evidence to support various actors' decision-making needs, supported the submission of Gavi applications, provided technical assistance for immunization planning, and facilitated the exchange of lessons learned between countries. RAVIN also supported WHO's revision of its position paper on RVV. By the project's close in 2020, five of the eight focus countries had introduced RVV into their routine immunization programs, two had submitted Gavi applications and introduced after the accelerator concluded, and one was engaged but did not make an introduction decision (9). While RAVIN initially planned to provide post-introduction support, delays were faced due to COVID-19-related disruptions and supply challenges that required some countries to switch RVV products.

Typhoid Vaccine Acceleration Consortium (TyVAC)

TyVAC was established in 2016 to accelerate the development, regulatory approval, and introduction of typhoid conjugate vaccines (TCVs), which were in late-stage development. Two typhoid vaccine products had been internationally licensed but were not widely used in lower-resourced settings given challenges with administration regimens and a short duration of protection. TyVAC's first phase primarily supported the case for TCV introduction through efficacy trials in Nepal, Malawi, and Bangladesh, alongside the 2017 recommendation by the WHO Strategic Advisory Group of Experts on Immunization (SAGE), 2017 Gavi Board decision to support TCVs, and 2018 WHO position paper. TyVAC's Phase I goal was for 10 countries to introduce TCV by 2023, but only four introduced, in part due to COVID-19-related disruptions in immunization functions. TyVAC's second phase focuses on recovering from these delays by providing country-level support and scaling TCV introductions, which have averaged only one introduction annually. This slow pace can be partly attributed to the low political profile of typhoid among global core partners, compounded by increasingly overwhelmed country Expanded Programme on Immunization (EPI) programs.

Global Task Force on Cholera Control (GTFCC)

GTFCC was established in 2020 as a broad partner consortium to support the design and implementation of global strategies for cholera prevention and control, including oral cholera vaccines (OCVs), water, sanitation, and hygiene interventions (WASH), and global and country-level advocacy and resource mobilization. OCVs had been authorized and available since 2013



through the WHO International Coordination Group on Vaccine Provision global stockpile at no cost to Gavi-eligible countries, but countries were not readily applying for them. GTFCC was established in part to support and accelerate the uptake of OCVs through the OCV working group. It established a country support platform initially focused on Bangladesh, DRC, Nigeria, Zambia, and Mozambique to support the development of National Cholera Plans and submissions for OCV prevention campaigns. GTFCC supports national and OCV trainings for campaign management. As of 2024, GTFCC faced several challenges including supply and stock-out issues, as OCV production had fallen by almost 50% due to historically low demand and COVID-19-related disruptions. Within this constrained environment, the partnership and its broad remit was perceived as fragmented between prioritizing outbreak and preventative efforts, OCV and other WASH interventions, and global versus country-level advocacy and support.

HPV Vaccine Acceleration Program Partners Initiative (HAPPI)

HAPPI was launched in 2022 to capitalize on an opportunity for accelerating HPV vaccine coverage after WHO's 2021 recommendation allowing for a single dose regimen and supply levels rebounding from shortages during the COVID-19 pandemic. Its objectives are to increase and sustain equity and program quality, and to accelerate vaccine coverage toward Gavi's goal of 86 million adolescent girls vaccinated by 2025 and the global goal of 90% coverage by 2030. Beyond targeted technical assistance to countries on implementation and service delivery, key features of the consortium are its emphasis on learning and information exchange, evaluation of programs and pilots, and translation of evidence to policy to inform adolescent vaccination strategies. In its first phase, HAPPI supported preparations for HPV vaccine introduction in four countries – one of which has introduced nationally and three of which have introduced sub-nationally – and targeted technical assistance to improve coverage among four additional countries that had already introduced. HAPPI is currently implementing its second phase.

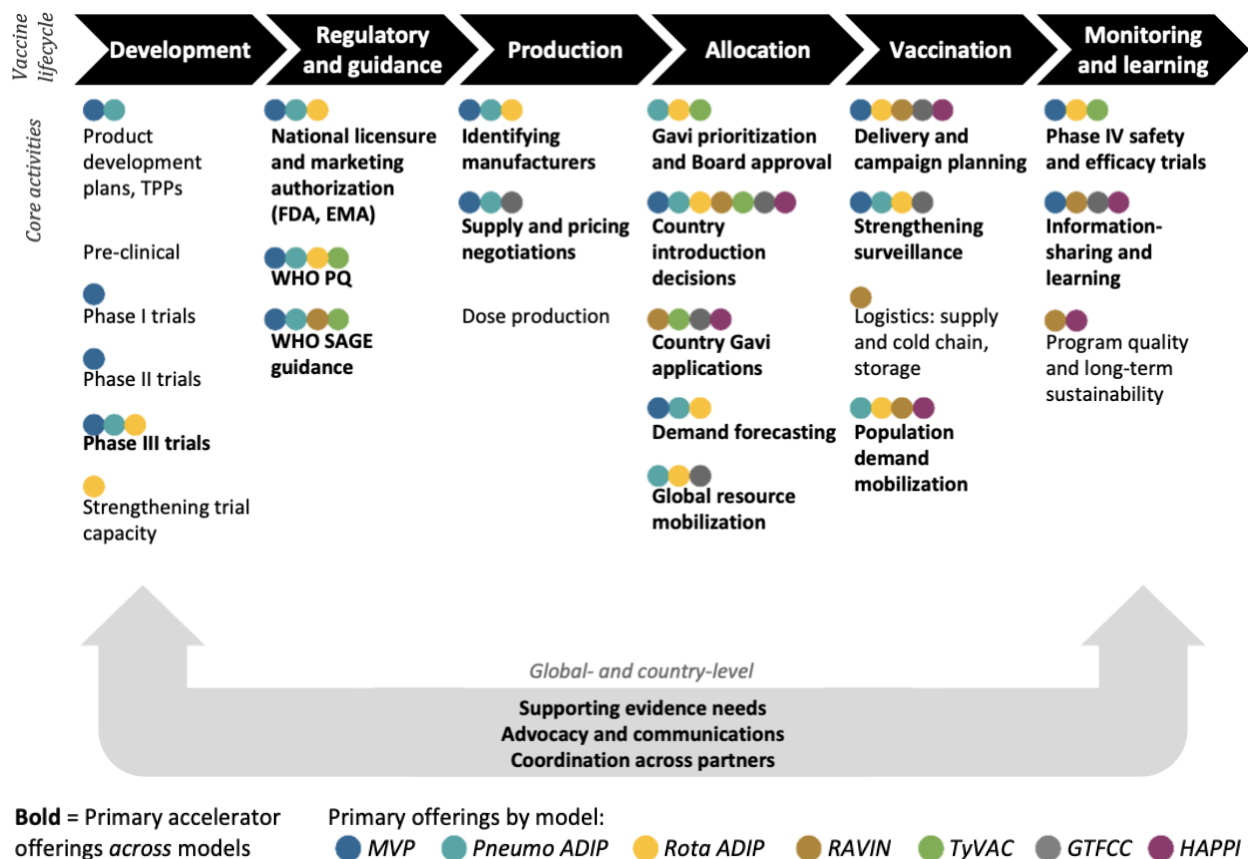
Updates as of 2026

Several of these case studies have continued to evolve since our review concluded. The meningitis effort seeded by MVP reached a new milestone in 2024, when Nigeria became the first country to introduce Men5CV, a pentavalent conjugate vaccine (serogroups A, C, W, X, Y) and the first to protect against serogroup X (24). Typhoid conjugate vaccine introductions accelerated, with four countries introducing in 2025 and campaigns reaching more than 80 million children over the year (27). Oral cholera vaccine supply, whose shortfall had constrained GTFCC's efforts, roughly doubled as new products and manufacturers entered the market, allowing preventive campaigns to resume in 2026 after a multi-year pause (28). HAPPI's goal of reaching 86 million adolescent girls with HPV vaccines was met ahead of schedule, aided by the single-dose schedule now used in most introducing countries (26). In parallel, the rollout of



malaria vaccines across some two dozen African countries — amid complex delivery requirements and constrained supply — has become a live test of the crowded-portfolio dynamics this report describes (25).

Vaccine introduction value chain and primary accelerator offerings



Successes and Impact

Isolating the impact of accelerators is difficult in the absence of clear counterfactuals, given parallel evolutions in the vaccine landscape and the necessarily heterogenous nature of each accelerator. However, segmenting accelerator models by the vaccine's stage in its development and introduction lifecycle — e.g., before a vaccine product is licensed, when global policy and guidance are needed, and/or when country introduction support and implementation planning are needed — illuminates key milestones by which accelerators' success can be examined.

For example, case study vaccines that were the focus of earlier-stage accelerators saw shorter timelines between first WHO-recognized national regulatory authority (NRA) licensure and



achieving global milestones like WHO prequalification, a universal SAGE recommendation, Gavi Board approval, and first Gavi country introduction. Time from first licensure to first Gavi-funded introduction was 2.4, 2, and 0.6 years for RVV, PCV, and MenA, respectively, while the time for HPV and TCV — for which accelerators were not launched until years after the vaccine's availability — was 7.7 and 7 years, respectively. RVV, PCV, and MenA benefitted from accelerators that were in place prior to first licensure (though the Pneumo ADIP focused on preparatory activities for introduction of a 7-valent PCV, which laid the groundwork for the 2008 licensure of PCV 10/13 products that comprise the majority of Gavi country introductions). MVP, for example, developed an investment case for Gavi, resulting in Board approval of the vaccine prior to its licensure — a factor that other analyses have found to accelerate the timeline between key milestones (4). Both ADIPs also supported successful Gavi investment cases that unlocked global financing. Other reviews have also concluded that the ADIPs contributed to shorter timelines between licensure and introduction and greater program readiness than was the case for the Hib vaccine at a comparable point in its lifecycle prior to the establishment of the Hib Initiative — in part due to the ADIPs' work to successfully communicate the value of PCVs and RVVs to countries ahead of WHO policy recommendations (2,10).

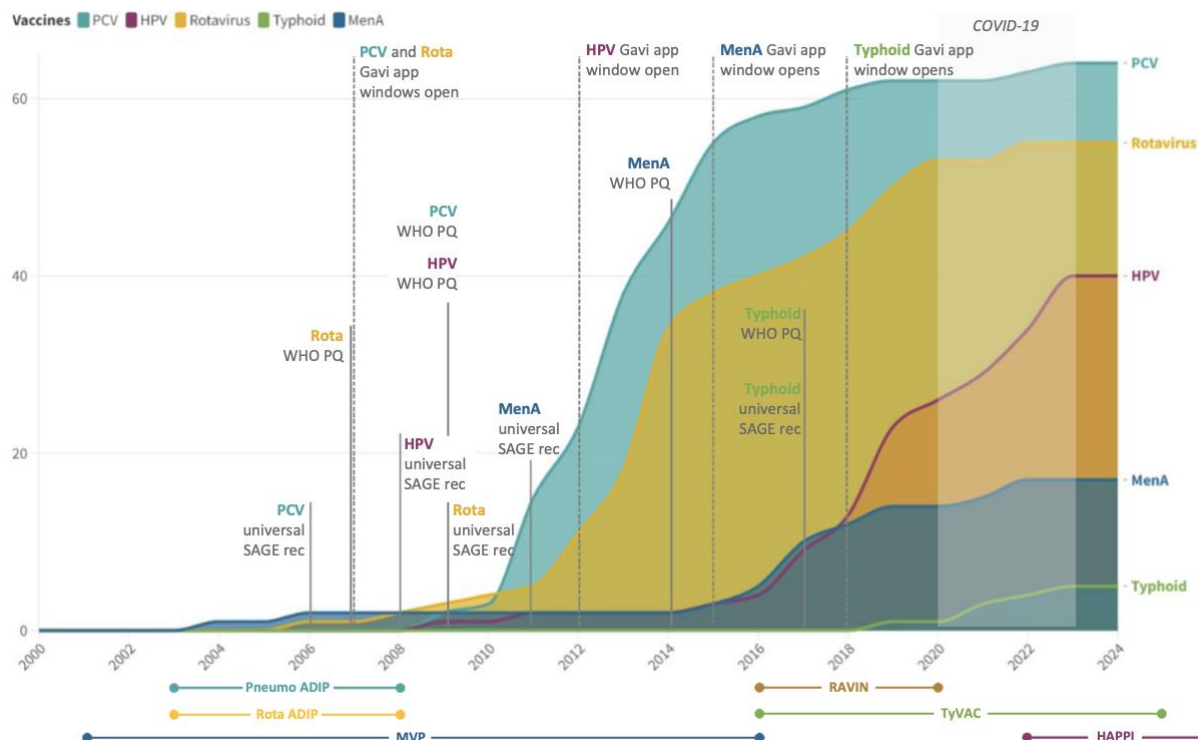
When global policy guidance and recommendations for vaccine use are lacking or insufficient, accelerators can also be assessed by their ability to accelerate these milestones. The ADIPs and TyVAC 1.0 supported the release or updating of WHO SAGE recommendations, which are critical to countries' decisions to introduce. For example, scientists with the Rota ADIP demonstrated that, despite trials showing lower point efficacy of RVVs in LMICs than in HICs, the integration of even moderately effective RVVs within high burden countries would have substantial health impact, warranting a recommendation for universal introduction (11).

For GTFCC, RAVIN, and HAPPI, vaccine licensure and policy guidance already existed for their target vaccines, and these accelerators, along with TyVac 2.0, primarily support country-level vaccine introduction decision-making and delivery planning. RAVIN and TyVAC have each supported the submission of successful Gavi applications and the introduction of the vaccines in target geographies, and GTFCC has supported campaigns in 15 countries as of 2020. Grants for such accelerators are often structured around a target number of countries introducing the vaccine into their national schedules, and RAVIN achieved this for 7 of 8 while TyVAC 1.0 achieved this for 4 of 10. However, interviewees emphasized a more holistic view of success in which countries make the right introduction decisions for their context, underpinned by strong, sufficient, and timely information — regardless of whether the country decides to introduce within the accelerator lifespan.



Relative to their unique goals, the case study models we examined each contributed to vaccine introductions that have increased over time.

Cumulative introductions over time among Gavi-eligible countries



Introductions among the 76 countries that have ever received Gavi assistance. Data sources: VIEW-hub by IVAC (for PCV, Rota, HPV, and Typhoid introductions through 2024), WHO Immunization Data Portal (for meningitis introductions – all strains, routine vaccine administered throughout the entire country, through 2022)

Critiques of the accelerator approach

Although vaccine accelerators have contributed greatly to expanding access to vaccines, several critiques are worth noting, including insufficient country leadership and representation.

Accelerators have often been Global North-led initiatives, with a HIC-based organization as the prime grant recipient driving toward global goals set by global partners and funders around specific targets for country introductions. Respondents noted that, due to their global scope, accelerators often select leaders from HICs who have had the ability to build strong global profiles, even as there is substantial underutilized expertise in the geographies most affected by these diseases. Regional and country-level engagement and ownership in the design and



execution of accelerators was described as insufficient overall, echoing themes from a 2007 review of the ADIPs (2).

Moreover, accelerators are a highly vertical intervention. Their focus on specific antigens, although crucial for their success, is also criticized for its narrow scope and opportunity costs, potentially diverting resources from other vital vaccines and integrated health interventions. This concern is increasingly salient amid today's extensive vaccination agendas.

Since our review concluded in 2024, the verticality critique has been increasingly centred in global health policy. The Lusaka Agenda (2023) named the "verticalization of aid" as a core problem and called for disease-specific initiatives to strengthen, rather than bypass, primary health care (22); in 2025, as health financing contracted sharply (21), the WHO urged countries to integrate externally funded, disease-specific services into comprehensive primary care and to accelerate the transition toward domestic self-reliance (23). For an antigen-specific model, this tide shift raises the bar: any future accelerator will need to demonstrate not only that it expedites a given introduction, but that it creates synergies, working across—rather than at the expense of—integrated immunization leading to higher overall coverage rates and broader health system priorities.

When to consider an accelerator approach for vaccine introduction

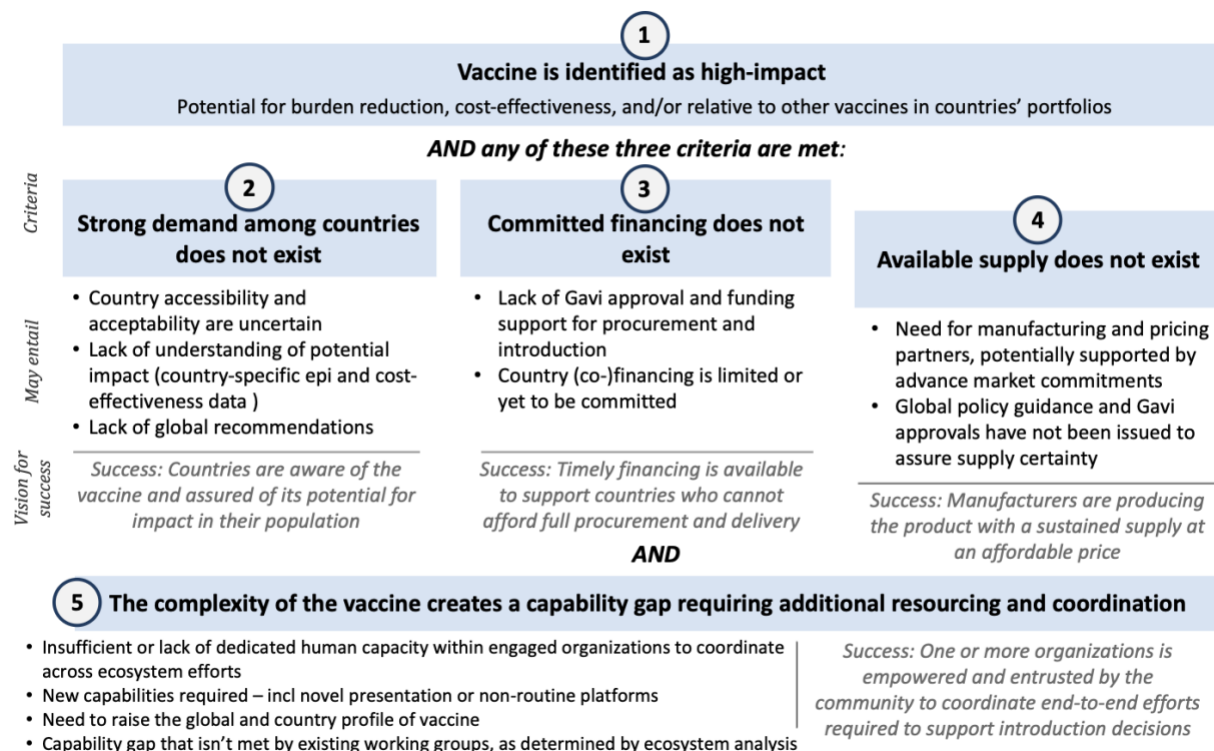
A central objective of our review was to identify conditions under which accelerators may be an effective mechanism for supporting vaccine introduction. First, the vaccine candidate must be high-impact in terms of potential for burden reduction and cost-effectiveness relative to other vaccines in countries' portfolios or the forthcoming pipeline. Second, the vaccine should be facing insufficiency in one or more of: country demand (countries are not aware of the vaccine or its potential for impact in their population), financing (an absence of financing to support countries that cannot afford procurement and delivery), or supply (there is no clear manufacturer producing the product with a sustained supply at an affordable price). Finally, there should be capability gaps relative to the complexity of the vaccine — including novel presentation, delivery outside of routine platforms, etc. — that require additional resourcing and targeted coordination. For example, supporting delivery platforms outside of routine immunization, like for adolescents or pregnant women, for targeted vaccines, or across multiple doses, may warrant novel capabilities.



Accelerators will not be feasible or practical for all upcoming vaccine products, and these criteria are a starting point for further landscape analysis to evaluate the use of an accelerator relative to alternative structures.

In a more constrained fiscal environment, the opportunity cost of a dedicated, single-antigen accelerator is higher than when many of our case studies were launched. The financing-insufficiency criterion increasingly applies not only to individual products but to the immunization envelope as a whole, as countries weigh new introductions against the cost of sustaining existing programs. Where these conditions do hold, a lighter and more integrated form of support—embedded in country decision-making rather than organized around a single antigen—may deliver comparable value at lower cost.

Framework for considering the use of a vaccine accelerator



Critical success factors

When accelerators are deployed, several key features enable their effectiveness in supporting informed country decision-making on introduction.

Unified mission

The accelerator should work toward a cohesive mission grounded in a clear understanding of the challenges to be addressed for the given vaccine and its relevant geographies. A clear problem statement also determines when the accelerator should conclude, with a transition plan for any continuing needs (2).

A unified mission allows the accelerator to maintain programmatic focus with a prioritized workplan and to harmonize and clarify each partner's roles, pre-empting the pursuit of independent organizational incentives. This cohesion can be reinforced through regular convenings and relationship-building among partners.

The HAPPI consortium comprises organizations with a longstanding history.

"We're competitors, but once we came together as a consortium, it wasn't really hard for us to work together because we already had this relationship and partnership that preceded the project... That's really critical when you can take out the self-interest and ensure you have that common goal."

Partnership approach

A unified mission enables the identification of fit-for-purpose partners who are best placed to meet the specific needs of a vaccine's introduction. As introductions are multidisciplinary endeavours, expertise is often required in surveillance, clinical trials, regulation, health economics, delivery planning, advocacy and communications, and more. No single organization can meet all needs, so the accelerator should leverage each partner's complementary capabilities and track records in the target geographies. For example, RAVIN established early relationships with key experts and long-standing initiatives like the ROTA Council, which they were able to rapidly activate in response to support requests.

The accelerator should also engage core Alliance partners like WHO, Gavi, and UNICEF early and effectively given their roles in specific vaccine introduction activities and the high level of trust that countries have in these actors. Respondents described challenges related to perceived missteps or a lack of cohesion in the partnership approach — for example, when accelerators did not engage WHO or Gavi country-level stakeholders effectively, or when they endeavoured to take public credit for specific activities rather than facilitate needed work behind the scenes.



Flexibility to adapt to emerging needs and country context

The unified approach must also be balanced with the flexibility to tailor activities to country specificity and dynamic circumstances, like supply issues, turnover among decisionmakers, capacity gaps among partners, or emerging local needs. For example, RAVIN was able to pivot to provide ad hoc support for countries navigating RVV product switches when faced with unexpected supply constraints; it also leveraged its team to support more comprehensive decision-making, like supporting Gavi applications for both RVV and HPV and coordinating with non-immunization partners in response to local priorities (9). TyVAC had supported a phased introduction of TCV in Pakistan, but after significant flooding and population movement, its flexible funding structure allowed it to again shift resources to the country. This agility requires respecting countries' sovereignty in decision-making and having staff on the ground who are familiar with local priorities. It can be facilitated by flexible funding mechanisms that can be rapidly activated to meet time-sensitive needs, such as HAPPI's reserve for flexible technical assistance.

Capabilities of the lead organization

Respondents described the necessity of the lead organization's strength in project management, technical knowledge, communications and advocacy, and partner coordination, particularly as the accelerator addresses multiple activities and audiences in parallel. When the organization and its staff have strong technical expertise but are not known and trusted among core partners and country-level decision makers, they face challenges with the many tasks that involve relationship-based collaboration.

Respondents also described the value of the organization being independent, which affords them a greater degree of focus on a specific product and the ability to move faster and with less bureaucracy than the core partners, who represent many products and multiple member states at once. For example, nonprofits and academic institutions can often externally contract work faster. TyVAC's structure provides an example, with the University of Maryland able to subgrant to the University of Oxford to extend vaccine development expertise and to PATH for targeted country level engagement.

Strong leadership

The director of the accelerator should have strong technical and relational credibility, including the ability to diplomatically engage a variety of stakeholders. This credibility comes from a track record building trust with country-level decision makers, enabling the director to make connections that facilitate the accelerator's work. Respondents emphasized that both the director and key staff should have substantial time dedicated to the accelerator. For example,



Pneumo ADIP started with 8 staff each committed at 100%, and directors of other accelerators are resourced closer to 40%.

Common implementation challenges

The challenges that these accelerators faced reveal critical design choices, particularly around country-level decision making and engagement, which future accelerator-like models should consider particularly as decision making and support becomes more localized and shifts in the global health ecosystem present the opportunity to build and establish new operating norms. Incorporating these elements during the early stages of planning — when the structure of partnerships, incentives, and overall scope are still malleable — can mitigate challenges and address criticisms more effectively.

With a tightening fiscal space for vaccine introductions, countries often face difficult choices in deciding which vaccines they can afford to introduce, and these trade-offs may not align with the accelerator's antigen-specific goals. Countries are juggling an increasing number of vaccine options with limited budgets and other factors like disease burden, cost of vaccination and illness, disease management capabilities, political support, and more. These financial constraints are particularly felt among countries graduating from Gavi support, as their EPIs are faced with multiple priority requests with tighter budgets.

Decisionmakers desire country-specific cost-benefit data to support these difficult decisions, but such data is not always readily available or easy to obtain, and there may be gaps in country-level surveillance or cost data. Overcoming data constraints and synthesizing available information effectively is a key requirement of accelerators. Respondents described, for example, selecting trial sites strategically to ensure that results could be credibly extrapolated to neighbouring geographies, as conducting trials in every country would be financially infeasible.

Moreover, there is often misalignment between the goals of funders, global initiatives, and countries, especially when accelerator targets focus on metrics like the number of countries introducing a vaccine, rather than on coverage, informed decision making, or other indicators of success. Tension can arise when the objectives of the accelerator do not align with a country's health or population priorities, and interviewees underscored the importance of a flexible approach that sufficiently conveys the potential benefits of vaccines while respecting countries' autonomy in decision-making.

Even when a country decides to introduce a new vaccine, shifting market and epidemiological dynamics can still pose challenges, and it is important for accelerators to address, or at least



plan for, such realities. For example, in some cases accelerators supported vaccine introductions only to face subsequent product shortages (e.g., OCV and RVV), which underscores the importance of flexible support mechanisms. This can be further complicated by accelerators' short grant timelines and milestones, which may limit the capacity to adapt to new requirements or logistical changes, such as those seen during the COVID pandemic.

Finally, while the financial surge support accompanying accelerators can be a critical enabler for country introduction, it can also create sustainability issues or funding gaps between the end of an accelerator investment and linkage with traditional mechanisms for program implementation support.

Under Gavi 6.0, these trade-offs have become explicit. Country vaccine budgets set fixed, multi-year ceilings within which governments must decide which vaccines to introduce, sustain, or adjust, including a defined discretionary portion to allocate across the portfolio (18,19). This formalizes the very tension our respondents described: an accelerator organized around a single antigen may find its goals in direct competition with a country's own prioritization process, rather than merely adjacent to it. Designing future support to align with — and strengthen — these country-led budgeting and prioritization processes will be essential to both its effectiveness and its credibility.

Implications: the role of vaccine accelerators moving forward

Accelerators have achieved numerous successes contributing to increased vaccine introductions in LMICs: they have prepared investment cases informing Gavi Board approval to co-finance vaccines; generated and interpreted evidence to support WHO SAGE recommendations; cultivated suppliers for LMIC markets and supported them to attain WHO prequalification; provided information to support country-level decision-making; aided the submission of successful Gavi applications; and provided technical support for post-introduction planning. Notably, vaccines with accelerators in place prior to licensure experienced shorter timelines between licensure and first Gavi country introduction than vaccines without.

However, the landscape has evolved substantially over the past two decades, and the way accelerators are defined, designed, and deployed must evolve as well. As core Alliance partners have taken on more responsibility for supporting vaccine supply and financing, accelerators may still have a meaningful role to play in clarifying and stimulating country demand by facilitating evidence-based prioritization and decision-making amid increasingly complex and



crowded portfolios. Specifically, post-COVID-19 marks a new era of vaccine introduction — one in which schedules are much fuller, as Gavi now supports vaccines against 20 antigens with others in the pipeline, and the fiscal space for new vaccines is tightening at both country and global levels (12). This leaves health systems and EPI teams increasingly capacity-constrained, while still recovering from stalled immunization during the COVID-19 pandemic (5).

Countries value the role accelerators have played in the generation, synthesis, and communication of evidence on the technical attributes and health economics of vaccines, and this function will remain essential as countries consider more vaccines and determine which constitute high-impact products within their unique epidemiological, social, and political context.

Since this review was conducted, that evolution has accelerated. Confronting a steep contraction in development assistance for health (21) and a replenishment that fell short of its target, Gavi has restructured its operating model around greater country ownership, with countries now submitting a single, holistic application spanning their full portfolio rather than applying antigen by antigen (18,19). In effect, the field has begun to institutionalize the shift our respondents anticipated — away from a model that pushes individual products and toward one in which countries prioritize across a portfolio within a fixed envelope. The question is no longer whether prioritization will occur, but how well countries are equipped to do it.

In fact, one recommendation is that accelerators shift from their traditionally vertical focus to provide more comprehensive decision-making assistance across a portfolio of antigens and interventions, helping decision makers to interpret policy guidance and evaluate anticipated costs, impacts, and practicalities of product rollouts. Respondents largely supported the idea of evolving accelerators toward a multi-antigen, multi-tool approach that takes a holistic disease control lens including other preventative interventions, diagnostics, and treatments, and that is responsive to emerging local priorities (2,9). Such an approach will be more relevant as new vaccines against antigens like malaria, tuberculosis, and respiratory syncytial virus (RSV) are rolled out alongside other interventions, and for vaccines with more complex delivery implications. Decision-making support on these potential trade-offs will be critical as more countries transition toward domestic financing, as well.

This is precisely where the accelerator experience remains instructive. To support these decisions, Gavi and its Alliance partners have introduced a country-led approach to vaccine portfolio optimization and prioritization — distinguishing between optimizing the existing portfolio, through changes to products, presentations, or schedules that improve efficiency or coverage, and prioritizing which new vaccines to introduce, and in what sequence, through structured, evidence-informed processes (20). ***The competencies our case studies surface — synthesizing burden and cost-effectiveness evidence for a specific context,***



convening the right partners, and translating global guidance into country-level decisions — are the same ones this portfolio-level work demands, now applied across antigens rather than to a single product.

At the same time, distributing prioritization across many individual country decisions introduces a coordination challenge that accelerators once addressed centrally: fragmented demand can weaken the market signals and economies of scale that underpin affordable, sustainable supply. A portfolio-era successor to the accelerator model may therefore add the most value not by championing a single vaccine, but by strengthening the evidence base and the connective tissue that allow country-led choices to add up to healthy markets and sustained coverage.

While past models have served largely as introduction accelerators, uptake accelerators will also be a high value-add in some contexts particularly as the field continues to generate evidence and perspectives on when, where, and what types of delivery integration are both impactful and economic— working within countries to increase population coverage, including among hard-to-reach and underserved populations. Especially with a greater number and diversity of vaccines, including regionally and sub-nationally targeted products, practicalities like storage, workforce management, demand generation, and service delivery will be increasingly costly and complex. All case study models (apart from HAPPI and GTFCC, which are ongoing) were directly succeeded by grants to continue some degree of country support, suggesting ongoing needs for delivery planning. While Gavi funding is available to support introduction, resources are fewer for post-introduction and ongoing program sustainability, which can help countries to navigate challenges posed by supply volatility, competing priorities, and other unexpected dynamics (9). HAPPI and GTFCC may serve as examples, given their focus on program quality and sustained coverage.

Another hallmark of the post-COVID era of new vaccine introductions will be novel product types, including combination vaccines aiming to streamline immunization regimens, and accelerators may have a continued role in partnering with developers, manufacturers, regulatory and policy bodies, and other actors to navigate and accelerate the novel regulatory and policy environment for these products (12). For example, accelerators can proactively engage vaccine manufacturers to ensure that demand forecasts are updated, and regulatory and policy pathways and evidence needs are clear — which will inform manufacturers' ability to scale production in a timely manner. Even as Gavi and UNICEF have taken on larger roles in demand forecasting over the years, manufacturers emphasized that closer partnership will be increasingly critical amid the complexity of novel product types.

Finally, any future accelerators should also ensure greater localization and regionalization of efforts, particularly to translate the gains from vaccination surge support into long-term, sustainable immunization and health system strengthening. More intentionality will be required



to better leverage and build local expertise — for example, funders selecting Africa-based organizations and staff to lead accelerators in full or in part. With TyVAC, for example, many of PATH's staff during Phase I were based in HICs, but in Phase 2 the majority are locally based. Investments should also be made to strengthen local and regional networks, such as EPI systems, Regional Technical Advisory Groups on Immunization (RITAGs), National Immunization Technical Advisory Groups (NITAGs), surveillance and research networks, and other technical working groups — who are all tasked with critical roles in vaccine introduction but are too often under-resourced to execute on them effectively.

Conclusion

This work presents the first of its kind review across vaccine accelerators and assessment of their continued applicability in a post-COVID era characterized by many high-impact vaccines and a sharp retraction of global development assistance. By drawing from the multi-disciplinary expertise of dozens of stakeholders who have funded, managed, implemented, and partnered with accelerators over time — and across multiple geographies and antigen contexts — this review identifies important trends in vaccine accelerators' characteristics, approaches, challenges, and success factors. It builds on prior reviews of vaccine introduction progress and success factors (4,10,13 – 15) and of individual accelerators' performance (2,3,16,17).

This review is not comprehensive of all vaccine accelerators that have been deployed historically, nor does it focus on multi-antigen or multi-tool efforts, of which there are few. We do not comprehensively evaluate the impact of the individual accelerators given the absence of a clear counterfactual and accelerators' heterogeneous nature, but we highlight their key successes relative to their stated goals and identify corresponding design decisions and enabling factors that can inform future vaccine introduction support.

These lessons will be applicable to future decision-making and design of accelerator-like models both within and beyond the immunization space. While accelerators will not be necessary or feasible for all upcoming essential vaccine products, new adaptations of accelerators may still provide value within today's landscape: critically, we emphasize the continued need for tailored engagement to support evidence-based decision making at the country level, the diminishing utility of a highly verticalized approach relative to portfolio-level planning, the potential for accelerators not only to increase introductions but also coverage within countries, and the imperative for supporting the localization of vaccine introduction support, including through concerted capacity-strengthening efforts and sustainability planning.



For decision-makers weighing these models today, the implication is not that accelerators have outlived their usefulness, but that the threshold and the form have changed. In an era of country-controlled budgets and constrained financing, a dedicated vertical accelerator is warranted only where a vaccine is genuinely high-impact, faces a barrier that country and core-partner systems cannot readily resolve, and merits dedicated coordination that would not otherwise occur. Where that bar is not met—as will increasingly be the case—the enduring functions of accelerators are likely better delivered through lighter, country-embedded support that helps governments prioritize across their portfolios, accelerate uptake, and build lasting local and regional capacity. Since the conclusion of this initial research in 2024 and 2026, Camber Collective has led PMU effort to bring together Alliance partners on VPOP and also on the downstream delivery, continues to support the Health Campaign Effectiveness Coalition. We offer this review as a resource for the funders, partners, and countries now navigating that transition.

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