

GAVI Alliance Progress Report 2007

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Message from the Chairs of the GAVI Alliance and the GAVI Fund Boards



Margaret Chan
Chair of the
GAVI Alliance Board

The enhanced achievements possible through partnership are a fundamental concept of the GAVI Alliance. The decisions of 2007 have broadened that partnership, for example as civil society becomes a formally valued element of achieving our mission, and have moved us towards a re-statement of value, as we work out the best formulation of the public-private mix in our renewed Board structure. The historic decision in November to bring together the Alliance and Fund Boards both signalled GAVI's coming of age and set in place a solid foundation for our future endeavours.

Although some elements of the organisation are evolving, our mission remains unchanged: to save children's lives and protect people's health by increasing access to immunisation and strengthening service delivery in poor countries. Through GAVI's support, countries have averted 2.9 million premature deaths since 2000.

Immunisation is an engine for child survival and a pillar of public health, with vaccines long being one of its most consistent success stories. This is a significant contribution to the reduction of child mortality below 10 million per year for the first time – and a motivating stride towards achieving the Millennium Development Goals, where progress is still slow in too many other areas of poverty reduction.

2007 saw the first full year of IFFIm (International Finance Facility for Immunisation) support for GAVI's work. These funds allowed us to double programme spending in countries, and conclusively established our ability to provide long-term predictable financing. In addition they allowed countries and their partners to turbo-charge elimination and control initiatives in measles, yellow fever, and maternal and neonatal tetanus with a total of US\$ 428.6 million. IFFIm also supported polio: funds originally planned for a post eradication vaccine stockpile were very quickly re-directed into intensified polio eradication activities.

This year we approved the first country applications for our newest vaccines: rotavirus, protecting against severe diarrhoea, and pneumococcal, protecting against death or damage by meningitis or pneumonia. These vaccines build on the protection that Hib vaccine already offers against forms of meningitis and pneumonia and will accelerate action against major childhood killers. Successful introduction of these, and even newer products, with high coverage, is vital to making progress in child survival.

As important as providing vaccines against the major killers, is the need to make real progress in countries with the highest numbers of unimmunised children. Of the 26.3 million children currently unreached by immunisation globally, approximately 11 million live in India. The Board decision in 2007 to increase funding to India is an explicit commitment to catalyse change.

Although the majority of GAVI's investment continues to be in the purchase and stimulus of new vaccines, it also plays an important role in demonstrating new ways of doing international development.

The GAVI business model has at its core the principle of country-led development. Funding relates directly to countries' own proposals, with significant flexibility in the use of those funds. Evaluations of this approach in immunisation services support all endorse its success in stimulating increased immunisation coverage. This model of country-driven allocation of funds also forms the foundation of the new health system strengthening programme, which saw its first full year of operation in 2007.

The GAVI Alliance is uniquely positioned to harness the partnerships forged between the public and private sectors: the result is a mix of individuals, organisations and shared commitment to find new ways to get life-saving vaccines to the world's poorest children.



Graça Machel
Chair of the
GAVI Fund Board

Two handwritten signatures in black ink. The first signature is 'M. Chan' and the second is 'Graça Machel'.

Message from the Executive Secretary of the GAVI Alliance and CEO of the GAVI Fund



Julian Lob-Levyt
Executive Secretary
of the GAVI Alliance
and CEO of the GAVI Fund

2007 has been a landmark year. It was the initial year of GAVI's first Strategic Plan 2007–2010. The Plan sets ambitious performance challenges: to accelerate access, strengthen capacity, increase predictability, and add value. Our success in rising to those challenges will depend in part on our coherence as a public-private alliance. A further landmark in 2007 was the decision to merge our two boards and make the transition to a Swiss Foundation. That decision draws on our ability to grow through change.

The GAVI business model continues to evolve. We continue to test both how to do, and how to do better – usually both at the same time. Countries' results validate those choices and help us to refine them.

By the end of 2007, more than 80% of countries eligible for support had received funding for the first set of support programmes – for new and underused vaccines, for safe immunisation equipment, and for improving immunisation coverage.

All but two countries of those eligible for support for hepatitis B vaccine have already applied. The numbers of children protected against Hib and yellow fever continue to grow. In total 176 million children have been immunised with GAVI vaccines since 2000.

Our donors continue to provide vital support. Significantly, this year we received our first major donation from a European foundation, with a gift of €4 million from La Caixa, Europe's second largest corporate foundation.

The new programme of health system strengthening went into action in 2007. The merits of flexible, cash-based funding, already proved by the success of immunisation services support, have been quickly transposed into bottleneck-solving by countries. In this programme's first full year, 55% of GAVI countries applied for grants.

The gaps countries identified for support – primarily health workforce development and peripheral infrastructure – are telling. Without the people and equipment to deliver vaccines or other health

interventions, no programme will be sustainable over the long term.

At the global level, the International Health Partnership has focused attention on the central importance of health systems and of supporting countries to develop and implement their own plans for a sound health service delivery platform. GAVI's health system strengthening model is providing some practical experience of this in action.

A consensus is emerging of the need to further strengthen the links between the immunisation, HIV, and development communities, and to explore the ground level impacts of vaccines, and of improved health systems, to protect and care for immunocompromised children. We need to further explore the opportunities for other interventions when children and their families are in contact with the health system for immunisation.

With one exception, GAVI-supported vaccines now have the potential to tackle major childhood killers and accelerate progress towards MDG4. That exception remains malaria.

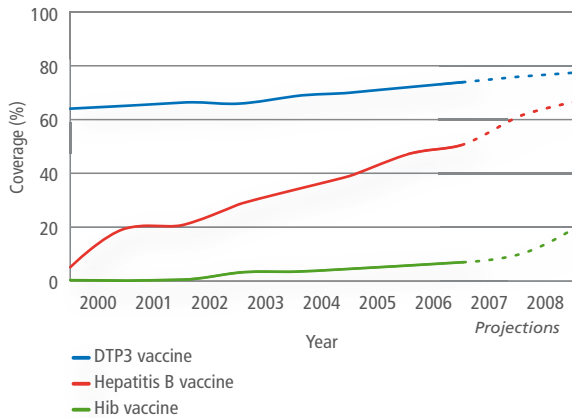
This report provides the detail of our results. It also shows the landscapes in which we work – the GAVI world – the challenges of terrain, of distance, of scale. Those views are of underserved communities, whether rural or urban, as well as of the most sophisticated capital markets. The country stories focus primarily on how challenges are being overcome – they are illustrations of personal ingenuity, entrepreneurialism, and the enterprise of a multitude of partnerships formed to respond persistently to obstacles.

This report also shows us a personal landscape – of how we are working together. The views in this report are those of our partners, from the mother in the clinic, to the Board member reflecting on policy. That variety of experience and expectation brings a diversity that is a source of strength for us. It is precisely that strength as an Alliance that we seek to take forward into the changes of 2008 and beyond, and to use in the service of the countries we support.

A handwritten signature in black ink, appearing to read 'Julian Lob-Levyt'.

Key indicators

Immunisation coverage in GAVI countries continued to rise in 2007

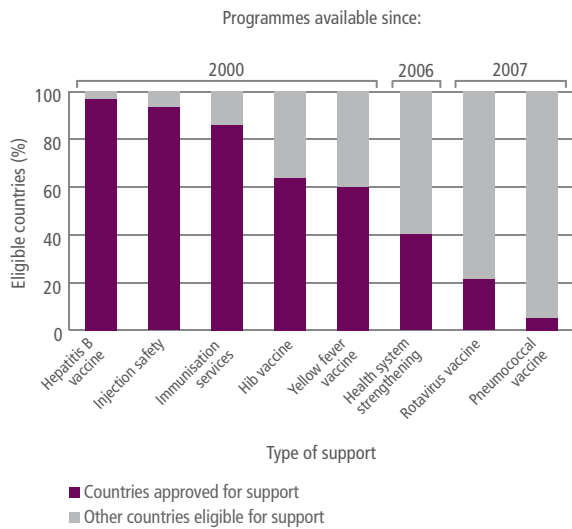


By the end of 2007, GAVI Alliance support will have averted 2.9 million premature deaths, and a total of 176 million children will have been immunised in the world's poorest countries, according to WHO projections.

Since GAVI's inception in 2000, 158 million children have been immunised against hepatitis B. A cumulative 28 million children have been vaccinated against severe meningitis and pneumonia caused by *Haemophilus influenzae* type b (Hib).

Source: 1

Countries are adding the new support programmes



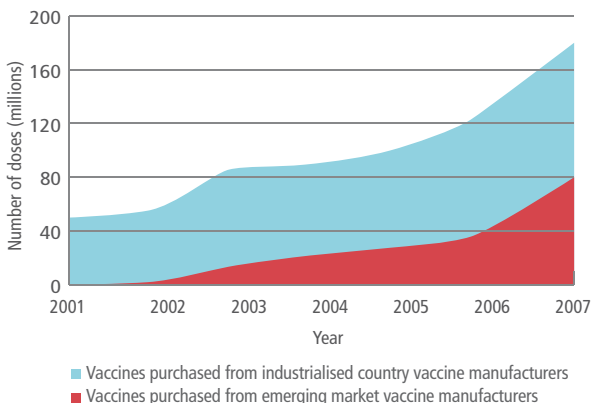
Since GAVI started to offer programmes, there has been a steady rise in the number of countries taking up support.

Nearly all countries eligible for hepatitis B vaccine, injection safety and immunisation services support are now receiving funding.

2007 saw steady growth in uptake of Hib vaccine and a rise in demand for yellow fever immunisation. Support for health system strengthening began in 2006, and for rotavirus and pneumococcal vaccines in 2007. In the first year HSS support was available, 55% of eligible countries applied, and 40% were approved for funding.

Source: 2

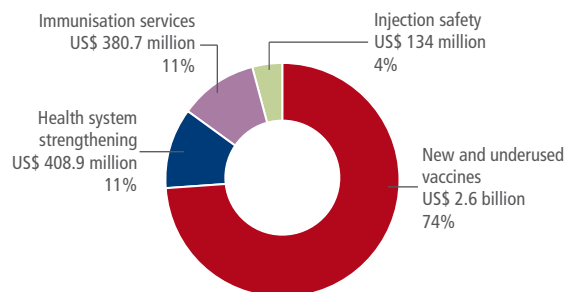
Emerging market vaccine suppliers represent a growing share of procurement



By 2007, 43% of vaccine funded by GAVI, procured by UNICEF, came from emerging market vaccine manufacturers. A larger number of producers and increasing volume of vaccines purchased supports a more stable market and vaccine price declines.

Source: 3

Steady increase in multi-year support to countries



GAVI programme commitments to countries 2000-2015

By the end of 2007, US\$ 3.5 billion had been approved for spending in countries up to 2015, up from US\$ 2.2 billion in 2006.

Overall, provision of new vaccines is by far the largest part of GAVI's support to countries (74%). Flexible cash support to increase access to immunisation services and strengthen health systems, including support to civil society organisations, accounts for 22% of the resources approved up to 2015.

Source: 4

Increase in donor multi-year support to GAVI

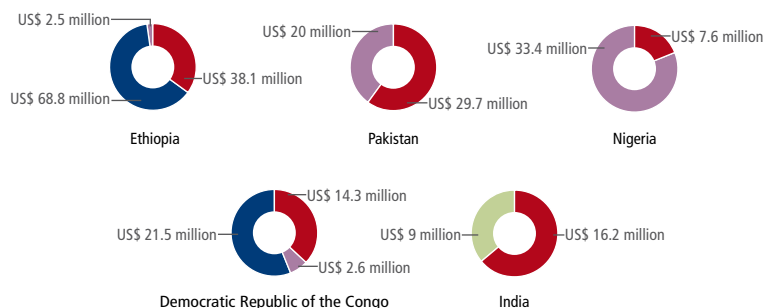
There has also been a steady increase in multi-year support to GAVI, matching the provision of long-term funding to countries.

By the end of 2007, 67% of direct government donors had made grant agreements of three years or more, up from 33% in 2005. GAVI received a total of US\$ 786.9 million in 2007, consisting of US\$ 358.6 million from direct government and private funding, and US\$ 428.3 million from IFFIm proceeds*.

Cash received (US\$)		
Source of funds	2007	Cumulative total 2000-2007
Australia	5,000,000	10,000,000
Canada	0	148,727,565
Denmark	4,737,540	17,051,196
European Commission (EC)	4,849,640	6,109,640
France	0	18,659,114
Germany	5,948,000	11,208,400
Ireland	8,311,200	18,829,160
Luxembourg	811,840	2,775,765
The Netherlands	33,547,469	120,664,898
Norway	86,156,761	292,606,694
Sweden	15,514,976	53,095,896
United Kingdom	48,113,952	121,562,308
United States	69,300,000	421,812,000
Total from governments + EC	282,291,378	1,243,102,636
Total IFFIm proceeds*	428,268,866	953,018,151
Bill & Melinda Gates Foundation	75,000,000	987,838,000
Other private donors	1,335,180	9,749,271
Total from private donors and institutions	76,335,180	997,587,271
Total contributions	786,895,424	3,193,708,058

Source: 6

* The IFFIm proceeds are received by the GAVI Fund Affiliate (see Annex 3) to fund disbursements to programmes.



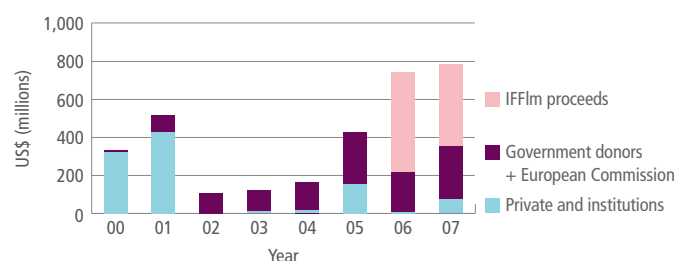
Top five countries supported by GAVI funding in 2007:

These individual profiles illustrate how each country's support from GAVI in 2007 differs according to country plans.

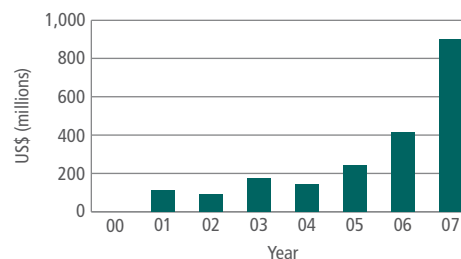
Source: 5

IFFIm income massively boosts overall disbursements

Funds received by GAVI



Programme disbursements by GAVI

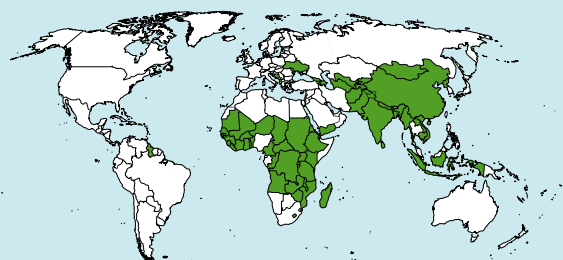


With bond issuance proceeds received from the International Finance Facility for Immunisation (IFFIm), the GAVI Fund Affiliate has provided a total of US\$ 862.3 million for programme disbursements. IFFIm money "frontloads" sovereign development aid, accelerating countries' access to catalytic resources.

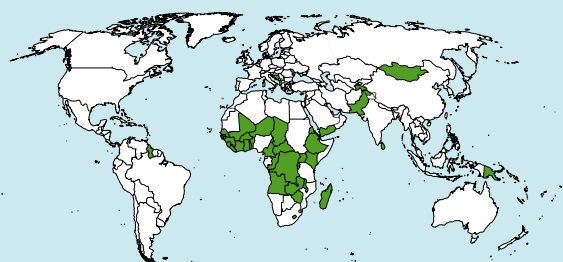
The funds have gone both to scale up GAVI's long-term support to country programmes and to give a critical boost to partners' time-limited specific disease control activities.

Source: 7

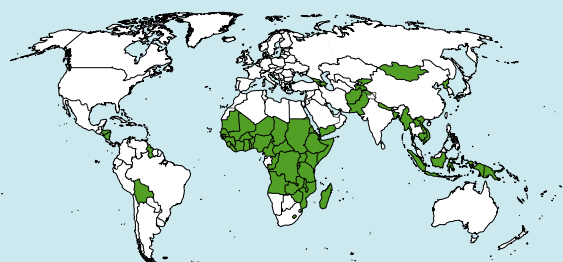
Countries implementing GAVI funds, 2000–2007



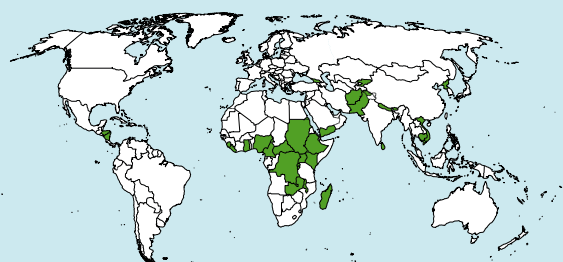
Countries approved for hepatitis B vaccine support, 2000–2007



Countries approved for *Haemophilus influenzae* type b vaccine support, 2000–2007



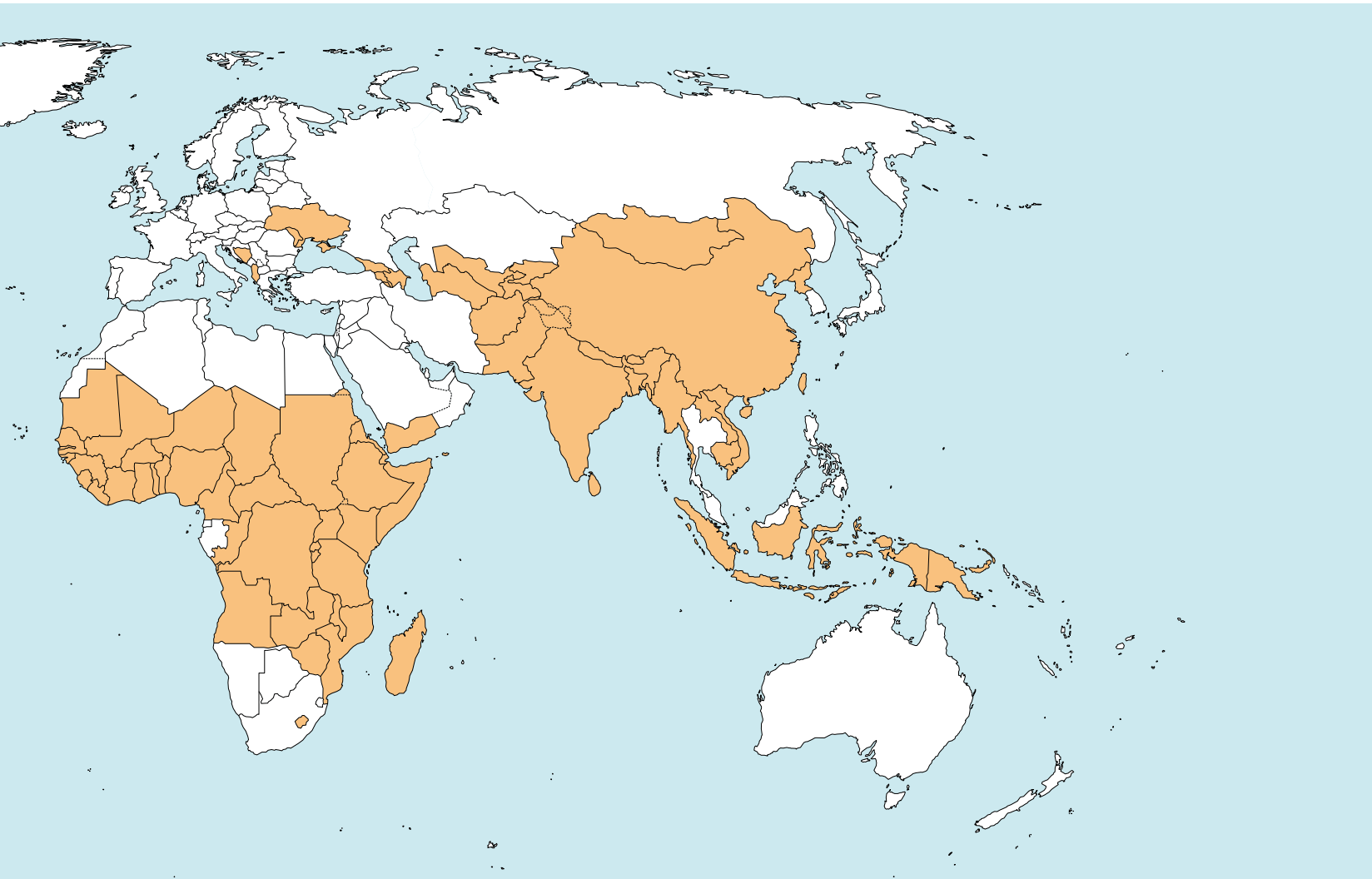
Countries approved for immunisation services support, 2000–2007



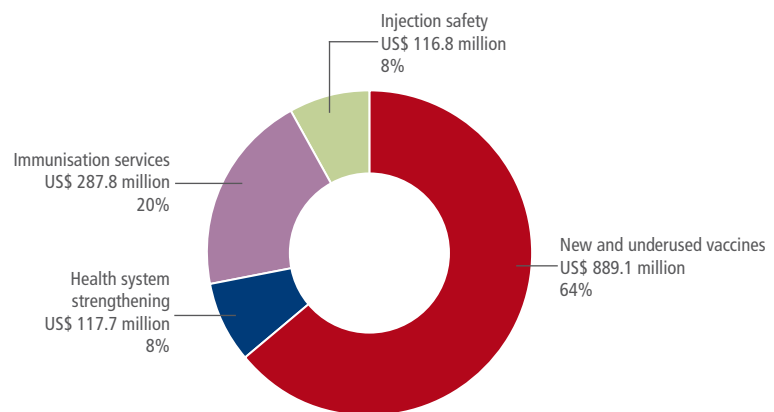
Countries approved for health system strengthening support including support for civil society organisations, 2007



Countries eligible for GAVI support



GAVI support to countries, 2000–2007



Accelerating Phase II: The GAVI Alliance's Strategic Plan 2007–2010

GAVI's Strategic Plan 2007–2010 is a natural extension of the GAVI Alliance mission: *to save children's lives and protect people's health by increasing access to immunisation in poor countries.*

It is firmly embedded in the wider environment of global health and development, which includes the Millennium Development Goals (MDGs), the OECD/DAC Paris Declaration on Aid Effectiveness, and WHO/UNICEF's joint Global Immunization Vision and Strategy (GIVS):

- **Millennium Development Goals**
The Strategy aims to contribute towards achievement of the goals to reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other communicable diseases, eradicate extreme poverty, promote gender equity and ensure universal primary education, as well as develop a global partnership for development.
- **Paris Declaration on Aid Effectiveness**
The Strategy takes the Paris Principles – of country ownership, alignment, harmonisation, managing for results and mutual accountability – as best practices for its engagement with national governments, donors and other development partners. The overall aim is jointly to provide the most effective aid possible.
- **Global Immunization Vision and Strategy (GIVS)**
GAVI's strategy is fully aligned with the GIVS objectives for 2015 of sustained immunisation coverage; reduced morbidity and mortality; ensured access to vaccines of assured quality; introduction of new vaccines; capacity for surveillance and monitoring; strengthened health systems; and assured sustainability at the country level.
- **Building on GAVI's early years**
The Strategy maintains and extends the Phase I (2000–2005) emphasis on child survival, focusing on defined global immunisation goals. To achieve these goals, GAVI will support country immunisation programmes and the necessary health services and community capacity to deliver them, as well as accelerate the introduction of new vaccines.

The GAVI Alliance Strategy 2007–2010: Four strategic goals:

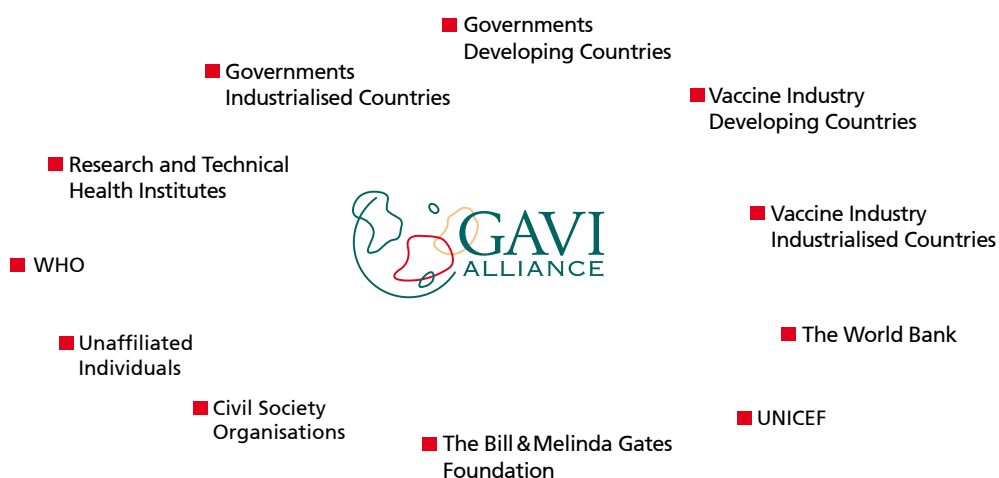
- Accelerate the uptake and use of underused and new vaccines and associated technologies, and improve vaccine supply security.
 - Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner.
 - Increase the predictability and sustainability of long-term financing for national immunisation programmes.
 - Increase and assess the added value of GAVI as a public-private global health partnership through improved efficiency, increased advocacy and continued innovation.
-



Phase II (2006–2015): new approaches

Significant new areas of focus for GAVI include:

- **Accelerated access to new vaccines** for children in poor countries, shaping markets and spurring increased production;
- **Strengthened health systems** with more capable national health services for improving child health and equitable, sustainable immunisation coverage;
- **Increased predictability of financing** to sustain immunisation programmes through direct and innovative financing, and funds raised from both international and domestic sources;
- **Strengthened partnerships** ensuring that more children are reached.



The GAVI Alliance works as an innovative international public-private partnership, which brings together various organisations and constituencies actively engaged in supporting immunisation in developing countries – such as governments, United Nations organisations, vaccine manufacturers, foundations, nongovernmental organisations and research institutes, as well as individuals with private sector and other experience, which together provide legitimacy, credibility and technical expertise.

Recognising and drawing on the mandates and responsibilities of all partners, the GAVI Alliance provides public and private finance and a broad diversity of perspectives, experience and skills to deliver existing vaccines and to accelerate access to new vaccines for people in the world's poorest countries.

Details of the GAVI Alliance governance structure are provided on page 64 and in Annex 1.





1

Accelerate vaccines



Accelerate vaccines

Strategic Goal: Accelerate the uptake and use of underused and new vaccines and associated technologies, and improve vaccine supply security

An increasingly broad and complex vaccine landscape is unfolding. New vaccines are becoming available to address many of the diseases threatening children of the developing world. Of prime concern are pneumonia and diarrhoea which together account for 36% of global child deaths. Progress in preventing these diseases is crucial to achieving the Millennium Development Goals.

2007 was the first year in which countries could apply for new vaccines against rotavirus (causing severe diarrhoea) and pneumococcal disease (causing pneumonia and meningitis).

Work to accelerate and extend access continued with the unique new partnership created with vaccine developers and suppliers through an advance market commitment (AMC) pilot for pneumococcal vaccine.

Countries have continued to request the three original GAVI vaccines – hepatitis B, *Haemophilus influenzae* type b (Hib) and yellow fever – with important progress

particularly in the number of countries applying for support to introduce Hib vaccine.

Experience gained through the Hib Initiative and the Accelerated Development and Introduction Plans (ADIPs) for rotavirus and pneumococcal vaccines, has contributed to a positive change in pace in vaccine introduction in many countries.

In addition, special one-time investments have accelerated disease control efforts through immunisation against measles, poliomyelitis, and maternal and neonatal tetanus.



New vaccines: new hope

Nicaragua, Guyana and Honduras were the first countries to apply and be approved for pneumococcal vaccine support in 2007. The first countries to apply for rotavirus vaccine support were Bolivia, Guyana and Honduras. Applications for both vaccines totalled US\$ 27.9 million.

A further two countries have expressed interest in introducing rotavirus vaccine and a further 25 in pneumococcal vaccine. In line with WHO scientific guidance, GAVI has adopted a two-phase strategy for rotavirus vaccine. In the first phase, the vaccine support will be available to countries in Latin America and Europe where the vaccine is already licensed for use. Roll-out in Africa and Asia awaits the results of large-scale safety and efficacy trials.

ADIPs: addressing childhood diseases

The Accelerated Development and Introduction Plans – or ADIPs – were conceived in GAVI's earliest days of operation to shorten the time between vaccine development and introduction in developing countries.

As a result, the time needed to introduce the new-generation vaccines to the developing world has been dramatically reduced.

This success is largely due to two GAVI-funded programmes: the Pneumococcal Vaccine Accelerated Development and Introduction Plan – or PneumoADIP – at Johns Hopkins

University Bloomberg School of Public Health, and the Rotavirus Vaccine Program, in partnership with PATH, the United States Centers for Disease Control and Prevention and WHO.

Pneumococcal vaccine was licensed for use in the United States in 2000, and might otherwise have taken up to 20 years to reach children in poorer parts of the world. Rotavirus vaccine is now being made available to eligible countries within two years of licensing in industrialised markets.

The PneumoADIP has gathered evidence to make the case for manufacturing vaccines for the developing world. It has increased the profile and understanding in countries about the severity of the disease and the need for immunisation.

For example, The Network for Surveillance of Pneumococcal Disease in the East Africa Region, based in Kenya, enabled a broad base of surveillance for pneumococcal disease in the region. This evidence drew the attention of regional, national and local health officials to the burden of disease and to the value of vaccination.

The ADIPs will conclude their programmes of work in 2008. Many of the important activities of the ADIPs will continue through Alliance partners and other institutions.

“I have saved what I believe is the most exciting and encouraging report for last. This is the global immunisation strategy... As we all know, childhood immunisation has long been one of the biggest success stories in public health... and the results have been spectacular.”

***Dr Margaret Chan, Director-General,
World Health Organization, speaking to the WHO Executive Board***

Reducing child deaths from pneumonia

Pneumonia kills more children than any other illness.

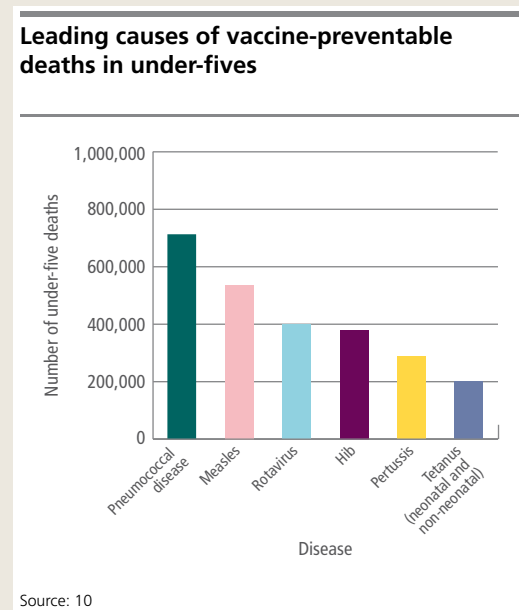
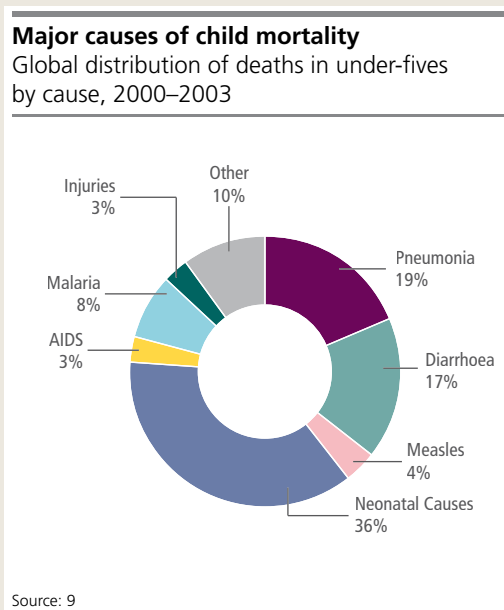
More than 2 million children die of pneumonia each year, accounting for 20% of deaths in children under the age of five. And yet, much of the incidence of pneumonia is preventable and treatable. Immunisation is a powerful tool in this.

The health and development community is targeting pneumonia as a key to reducing child mortality and achieving Millennium Development Goal 4. UNICEF's *World Fit for Children* calls for a reduction by one third in the number of deaths due to acute respiratory infections, primarily pneumonia.

Prevention of pneumonia through immunisation against several of its causes is a crucial component of GAVI's mission of reducing child illness and death.

“Achieving the MDG on child mortality will require urgent action to reduce childhood pneumonia deaths.”

UNICEF and WHO, 'Pneumonia: the forgotten killer of children', 2006



“For the PneumoADIP it was soon clear that this is an important life-saving vaccine for children. A challenge for the ADIP has been to make credible that this complex, multi-component vaccine can be manufactured and made available at an affordable price to developing countries.”

Jan Holmgren, Chairman of the ADIP management committee

What causes pneumonia?

The full range of causes of pneumonia in children remains unknown, but the leading cause – up to 50% – is the bacterium *Streptococcus pneumoniae* or “pneumococcus”. Another major cause is the bacterium *Haemophilus influenzae* type b (Hib), which is estimated to cause 2–3 million cases of severe illness per year. Together, these account for more than half of all pneumonia deaths in the under-fives. Pneumonia is also a serious complication of measles, and the most common cause of death associated with this childhood disease. The HIV epidemic has sharply increased the severity of impact of childhood pneumonia.

What’s the answer to lowering deaths from pneumonia?

The solution lies in comprehensive prevention and treatment, including:

- more widespread availability and use of existing and new vaccines;
- improved nutrition;
- improved case management and treatment;
- adequate HIV identification, prevention, treatment and care;
- improved indoor air quality.

What role do vaccines play in preventing pneumonia?

Vaccines exist for pneumococcal pneumonia, Hib and measles, and all are available to GAVI-eligible countries. These three vaccines have the potential to save millions of lives by reducing the incidence of pneumonia.

What is being done to make sure vaccines reach more children?

A vaccine for *Streptococcus pneumoniae* has been available to adults since 2000. The pneumococcal conjugate vaccine was recently developed for children and is now available as part of GAVI’s new and underused vaccine programme.

Contributions to accelerating access and availability of vaccines include:

- the Accelerated Development and Introduction Plan for pneumococcal vaccine (PneumoADIP);
- the Advance Market Commitment (AMC) pilot for pneumococcal vaccine;
- increased uptake of Hib vaccine;
- introduction of the new pentavalent vaccine which includes Hib along with four other common childhood vaccines;
- increased uptake of measles vaccine.

Expanding uptake of existing vaccines

2007 saw strong expansion and uptake of existing vaccines into countries' routine immunisation programmes.

For the first time, vaccine applications also included an additional grant of US\$ 0.30 per child to be immunised in the first year, to cover some of the costs associated with the introduction of a new product at country level, such as public information, health worker training and improvements to the national vaccine cold storage and transport infrastructure.

Five-in-one: pentavalent success

Pentavalent vaccine immunises against five infectious diseases in just one shot – diphtheria, tetanus, pertussis, Hib and hepatitis B.

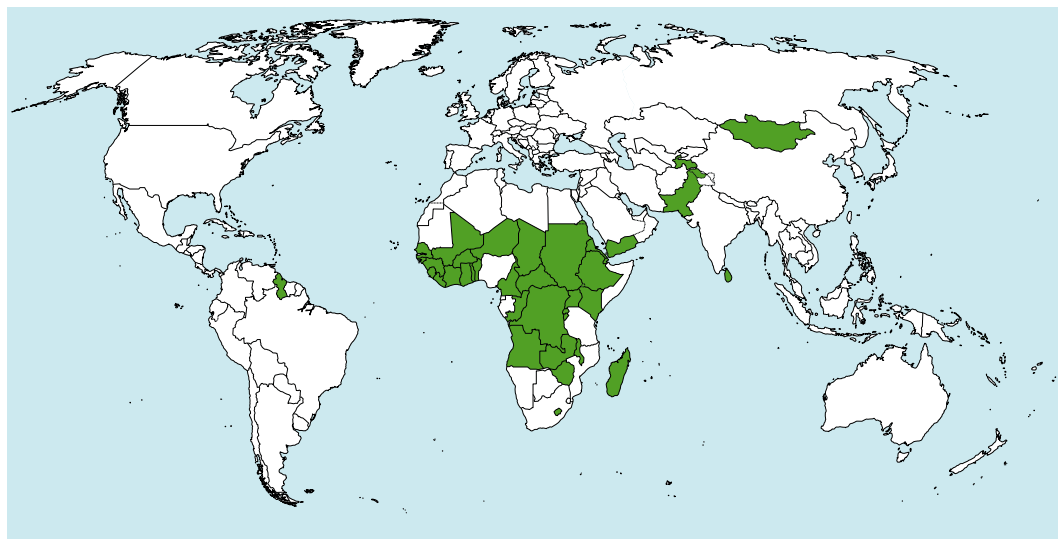
The easy-to-administer liquid formulation pentavalent vaccine has played a significant part in the increase in uptake of the Hib and hepatitis B vaccines. There are also impacts on ease of delivery of vaccines to children, as well as savings in the cost of equipment, delivery, disposal and programmes.

Pentavalent vaccine is being used or has been approved for introduction in 39 countries.

More than 28 million children worldwide are currently being immunised with the vaccine each year.

Significant uptake of pentavalent vaccine in GAVI-supported countries, 2000–2007

■ Approved for GAVI support



Major boost to Hib vaccine efforts

The year was also marked by strong uptake of Hib vaccine support. New funding support will go to 16 more countries, bringing the total to 44 GAVI-eligible countries. This is up from 13 countries receiving support in 2004. Eighty per cent of countries in Africa eligible for Hib funding have now applied.

In 2007, the largest proportion of GAVI funding went to countries immunising against Hib disease: a funding total of US\$ 369 million. According to WHO projections, a cumulative total of 28 million children had been vaccinated against Hib by the end of 2007.

Hib disease is estimated to cause 3 million cases of meningitis and severe pneumonia per year, which results in 386,000 deaths in children under the age of five.

Hib vaccine plays a crucial role in the global effort to reduce the incidence of pneumonia in children and reach the MDG goal of reducing child mortality.

Hib vaccine has been available in developed countries for 20 years. Financial constraints and lack of awareness among both the public and government officials about Hib disease and the benefits of the vaccine have meant that, until now, its use has been low in developing countries.

Assessment of the Hib Initiative confirms that strong communications and advocacy efforts, coupled with the availability of long-term predictable financing and a new convenient, liquid combination vaccine have all been significant factors in increased demand.

This GAVI-supported programme has assisted countries to access information to support decision-making with respect to the take up of the vaccine. It is a consortium of major health agencies and institutions including Johns Hopkins University, the United States Centers for Disease Control and Prevention, the London School of Hygiene and Tropical Medicine and WHO.

Eliminating Hib meningitis in Uganda

Just five years after *Haemophilus influenzae* type b (Hib) conjugate vaccine was introduced nationwide in Uganda, Hib meningitis has been virtually eliminated in children under five years of age. Five thousand child deaths from Hib disease are now prevented each year.

Before the Hib vaccine was introduced in Uganda, approximately one in every two hundred children suffered from Hib meningitis or pneumonia, and nearly one in a thousand children died as a result. After introduction, the incidence of infection in one district of Uganda dropped by 85% within four years, and to zero in the fifth year.

The Government of Uganda has now committed national resources to procure Hib vaccine for the infant immunisation programme, in line with the GAVI co-financing policy.

Elimination of Hib meningitis in Uganda, 2002–2007



— *H. influenzae*, Mulago Hospital, Kampala, Uganda

Source: 12

Improving hepatitis B vaccine coverage

The deadly consequences of hepatitis B virus infection usually strike during adulthood. However, initial infection typically occurs during infancy or childhood. For this reason, hepatitis B vaccine is the most popular vaccine currently offered by GAVI: it prevents infection at a young age and therefore protects against adult death from liver disease, including liver cancer.

The hepatitis B vaccine has now been incorporated into routine child immunisation in 63 GAVI countries. Only two countries eligible for support have not yet applied. WHO projects that more than 158 million children have been immunised against hepatitis B through GAVI support since 2000.

“Experience gained from introduction of hepatitis B, yellow fever and Hib vaccines has shown the need for predictable long-term support.”

An estimated 2 billion people alive today have been infected with the hepatitis B virus and 350 million people worldwide are chronically infected. Of those, approximately 600,000 will die of cirrhosis or cancer of the liver.

Transmission of the virus from mother to newborn infant is a major factor in regions such as Asia and the Pacific Rim where infection is widespread.

A timely ‘birth dose’ of hepatitis B vaccine is advocated by WHO for all infants in high-risk countries and is about 90% effective in preventing transmission. GAVI has supported hepatitis B birth dose immunisation in 18 countries which have perinatal immunisation recommendations, for example in China and Indonesia.

Expanding yellow fever vaccine uptake

Countries can apply for support to introduce yellow fever vaccine into their routine immunisation programmes.

In 2007, two more countries were funded: Guinea-Bissau and Niger. This brings the total number of countries that receive GAVI support to 17 of the 28 countries eligible. WHO projections indicate that, since GAVI’s inception, more than 26 million children have been immunised against yellow fever.

Applying lessons learnt

Experience gained from introduction of hepatitis B, yellow fever and Hib vaccines has shown the need for predictable long-term support. Making a vaccine available does not, in itself, mean that countries will take it up.

By ensuring a stable market, pricing and supply, uptake has accelerated. However, the lesson learnt and which needs to be applied is that countries need information on disease-burden, vaccine cost-effectiveness and affordability in order to make the decision on whether to introduce.

The success of the Hib Initiative and other similar efforts to boost uptake provide a strong road-map for the support needs of countries. WHO, UNICEF and others continue to play critical roles, working with countries to develop their vaccine plans, financing strategies and other key elements required for successful applications.

Challenges remain

Continued progress with Hib vaccine uptake will need further technical and financial support to enable countries to make evidence-informed decisions about the vaccine. Countries with large birth cohorts which have yet to introduce the vaccine are of particular concern.

Although hepatitis B coverage is fairly stable at 60% worldwide, uptake could be improved by accessing hard-to-reach populations. Birth doses must be expanded to protect more children at a vulnerable age. Efforts are underway to increase immunisation of adolescent children and adults at risk.

Hepatitis B immunisation in China: progress in reaching children

Infection with hepatitis B virus is a leading cause of death in China and represents up to 50% of all hepatitis B deaths worldwide. Approximately 60% of the Chinese population has been infected: nearly 10% are chronically infected and at risk of death from liver disease.

Mothers who are infected risk passing the virus to their baby in childbirth. Giving hepatitis B vaccine to infants beginning at birth is more than 90% effective in preventing transmission.

China has undertaken a nationwide effort to ensure infants receive a birth dose of hepatitis B vaccine as well as complete the three-dose routine immunisation series. Hepatitis B vaccine has been added to the national immunisation programme with the goal of reducing chronic infection in children under age five to less than 1% by 2010.

GAVI has co-funded a project since 2002 with the Chinese Government to target newborns and children under five in the economically disadvantaged western and middle provinces. The aim is to immunise babies born in hospitals as well as those born at home or in remote mountain villages. The project received US\$ 76 million over five years from both GAVI and the Government. Technical guidance from WHO and UNICEF has been critical to the success of the project.

This is an important example of the catalytic role GAVI funding can play as it illustrates the “taking to scale” of a co-funded pilot project. The objective was to accelerate integration of hepatitis B vaccine into the national immunisation programme and to ensure injection safety. In 2005, the central government issued a new regulation declaring that all EPI vaccines, including hepatitis B, would be provided at no charge, and eliminating administration fees for all EPI vaccines.

Progress has been swift. National coverage with the timely birth dose has increased from 29% of children born in 1997 to 82% in children born in 2005. In the targeted provinces, timely birth dose coverage rose from less than 50% in 2002 to 81% in 2006, while coverage with the complete series increased from 57% to 92% in the same time period.

It is estimated that more than 42 million children nationwide and 15 million children living in the areas covered by the China-GAVI project received the full three-dose hepatitis B series between 2003 and 2006.

Stronger markets and significant gains for immunisation

Thomas Sorensen
Chief, Immunisation Centre, UNICEF Supply Division

Over the course of 2007 we've seen an accelerated demand for pentavalent vaccine. At the same time the global production capacity is increasing and we see a promising pipeline of manufacturers soon to become WHO prequalified. It's very satisfying to see how the markets actually unfold. This is what GAVI partners were hoping for at the time of introduction of hepatitis B and Hib vaccines in 2001.

Still, the current pentavalent vaccine market remains quite fragile. With only a few manufacturers in the market, the supply situation is vulnerable to such variables as commercial decisions by manufacturers and to batch failures in production. As such, we constantly strive for a stronger balance between demand and suppliers and we are therefore welcoming the stronger supply base which is about to emerge.

The joint effort of the GAVI Alliance partners has been a major driver of this positive development. It has, so to speak, catalysed and accelerated the maturity of the market. The long-lasting focus on these vaccines and the security of the funding have been important factors in encouraging industry to take the risk of developing the vaccine.

In short: to ensure vaccine security in a fragile market and gradually create incentives for a more healthy market development, we've really seen the importance of accurate demand forecasting, secure, long-term funding and appropriate contracting – including multi-year firm contracts.

The experience with pentavalent development has also shown that it's possible to gradually phase in new emerging manufacturers while respecting the existing ones.

In the case of hepatitis B and Hib-containing vaccines we've seen that the more complex the product, the longer it takes for the market to mature. As such, we expect to see a price decline for the pentavalent vaccine as we saw with the tetavalent (DTP-Hep B) vaccine as more manufacturers come on stream in the next procurement round 2010–2012.

The successful introduction of pentavalent vaccines in so many countries can hardly be overestimated. Besides ensuring improved and safe immunity for children in low-income countries, we've learnt valuable lessons on how to stabilise new vaccine introduction through shared partner expectations on timelines, means and measures.

This successful upgrade of the EPI programme in many of the poorest countries in the world is truly an important and remarkable landmark.

Shaping markets for vaccine development

Developments in various elements of vaccine supply dynamics clearly demonstrate the positive interface between public and private areas of knowledge. For example, the vaccine industry's role in the partnership has brought instructive knowledge of industry workings and business requirements.

Working closely with UNICEF – the GAVI Alliance's principal procurement agent – has enabled improved vaccine procurement processes and reduced supply constraints. Industry input has clarified the lead time needed for vaccine manufacturing, which has resulted in revised ordering processes.

Investment in combination vaccines has acted as a pull mechanism – drawing new manufacturers into vaccine production and diversifying the supplier base, as well as reducing prices. The encouragement of multiple suppliers enhances vaccine market security.

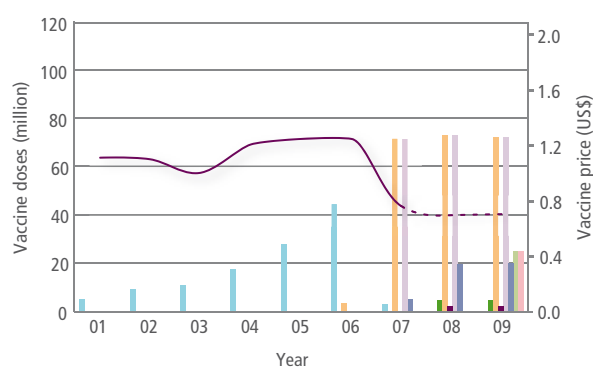
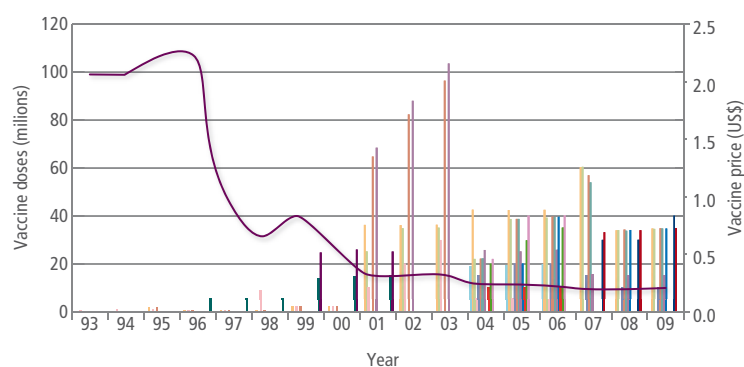
For example, the combination DTP-hepatitis B vaccine now has two emerging market suppliers, and the pentavalent vaccine will likely also see similar changes.

The concept of an advance market commitment takes market-shaping to the next level. The success of the pilot AMC for pneumococcal vaccine will be measured by increased manufacturing capacity and accelerated access to new vaccines by the poorest countries.

Rising global demand has led to increased competition and decreasing prices for hepatitis B vaccine and the DTP-hepatitis B tetravalent vaccine

Global price changes in monovalent hepatitis B vaccine, 1993–2009

Global price changes in tetravalent DTP-hepatitis B, 2001–2009



— Vaccine price Note: number of bars = number of manufacturers

Injection safety and vaccine packaging: catalysing change

Supporting and promoting safe injection use and practices are critical to preventing disease transmission through repeated use of a single syringe.

Countries have been eligible for three years of funding towards autodisable (AD) syringes for single use, as well as safety boxes for their disposal, and activities to ensure their proper and widespread application.

By 2007, 58 countries had completed three years of funding, and six more ended their cycle within the year: Benin, Guinea Bissau, India, Moldova, Mongolia, and Nicaragua. Seven countries continue to receive such GAVI support, while five countries remain eligible to apply.

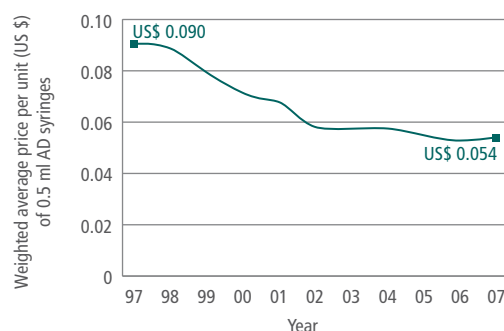
In total UNICEF procured and distributed more than 2 billion AD syringes globally. In 2007, GAVI country demand represented 46% of UNICEF's global procurement. Evaluation of the sustainability and impact of the programme is ongoing.

The GAVI vaccine presentation and packaging advisory group is working with WHO and the vaccine and injection technology industries to make products that are appropriate for use in immunisation programmes.

The aim is to reduce the packed volume of vaccine doses, product packaging and injection supplies where refrigeration facilities and transport are limited. For example, efforts are underway with vaccine manufacturers to optimise vaccine vial presentation for the pneumococcal conjugate vaccine and to reduce package size and volume for the rotavirus vaccines.

In total UNICEF procured and distributed more than 2 billion autodisable syringes globally.

Decrease in price of AD syringes procured by UNICEF, 1997–2007



Source: 14



Planning for the future: GAVI Alliance Vaccine Investment Strategy

The landscape of vaccine development has changed dramatically since GAVI's creation in 2000. Then, vaccines were relatively low priorities for research and few of the new vaccines were of relevance to the developing world.

Today there are in place a number of initiatives for vaccine innovation, including the accelerated development and introduction plans (ADIPs), the Advance Market Commitment (AMC) and the International Finance Facility for Immunisation (IFFIm). Together they have stimulated the field. There are now several new vaccines in development and many other possibilities on the horizon.

This wealth of potential creates its own challenges. Resource and system constraints at the country level mean it is not feasible or practical to pursue all possibilities simultaneously. Also, some new vaccines present unique concerns that may make their introduction more complex than earlier vaccines.

Priorities are needed for investment and programme choices. The Vaccine Investment Strategy currently under development is intended to provide a long-term solution. It will provide a portfolio of vaccines that balance impact, timing and risk with the future requirements of technical partners, donors and implementing countries.

Based on a disease priority list developed by WHO, the Strategy will define priority vaccines for GAVI's investments with a timeframe and associated activities that require support. Together with proposed financial obligations, this strategy will determine which vaccines GAVI is able to support for countries in the years to come.

At the GAVI Board meeting in June of 2008, a decision will be made on a strategic portfolio of vaccines which GAVI will consider for support. This will be based on input from a broad range of GAVI stakeholders and an independent review committee. Following this, in October, the Board will review a strategy for that portfolio and a detailed implementation plan will be provided that will spell out the activities and timing of vaccine support in more detail.



Sri Lanka has faced its share of crises, from internal conflict to the tsunami of 2004. But despite these challenges, Sri Lanka's immunisation programme has been a major success, even in affected areas.

According to WHO estimates, by 2005, with an effective health care system and support from GAVI for hepatitis B vaccine, the island state was maintaining 99% coverage for DTP3 and hepatitis B.

Demand for vaccines is so strong in Sri Lanka that the new pentavalent vaccine scheduled to be introduced in 2008 will be rolled out to the whole country at once, not phased in gradually.

But where does this strong demand for childhood vaccines and quality health services come from? Sri Lanka's chief epidemiologist says it lies in women's education and equality. "One of the main reasons is our culture", Nihal Abeysinghe explains, "where women and men are equal and receive good education. This teaches them the importance of healthy living, including making sure that children get their vaccines."

Chandi Swarnandi Wyaye and her husband, Nuwran, have brought their six-month old baby, Saiinu Charmithan to the Pittakotte clinic for his regular check up and shots. Chandi is 27 years old, and an insurance sales consultant.

She says she was keen to know all about child health when her son was born. "I borrowed books from the library about pregnancy and birth and there I remember reading about the importance of vaccines", says Chandi. "Also at the hospital after the delivery, we were given information about vaccines."

Sri Lanka has provided strong political commitment and government funding for health, with free health services available for all. The Government finances 90% of its immunisation services. But the call for high-quality and accessible health services has been generated by a highly educated and health-conscious population – particularly among women and supported by their husbands.

Ministry of Health officials recognise that the strength of both supply and demand for good health care are critical to sustaining high vaccine

coverage. The strong health system can enable quick and effective response to shocks such as natural disasters and conflict.

Empowered women, government commitment to health care and education for everyone: all add up to improved health for children. They, in turn, are better equipped to be educated and contribute to society.

This is the upward spiral of women's equality, improved health and education, leading to economic development that is envisaged by the Millennium Development Goals. GAVI is committed as well to improving gender equality in access to health care and vaccines.

Chandry says for her it's a simple equation. "I think vaccines are important because they promote good health in our child so he can stay healthy. Isn't that what all parents want for their children?" She adds, "When our son grows up, I hope that he is able to get a good education and qualifications in the field that he chooses, as long as he does something he is happy with."

Sri Lanka

Educated women, healthier children: Sri Lanka's keys to success

FACT FILE

- Total population:** 19,121,000¹⁵
- Surviving infants:** 291,000¹⁵
- Infant Mortality Rate:** 11 per 1,000 live births¹⁵
- Under-five mortality:** 13 per 1,000 live births¹⁵
- Per capita Gross National Income:** US\$ 1,310¹⁶
- Per capita government expenditure on health:** US\$ 19.4¹⁹
- Health worker density:** 2.63 per 1,000 population¹⁸
- DTP3 coverage:** 99%¹⁷
- Percentage of districts with more than 80% DTP coverage:** 100%¹⁷
- GAVI funding disbursed by type of support (US\$):** Total: 3,340,494
- New and underused vaccines support (NVS):** 2,598,116
- Immunisation services support (ISS):** n/a
- Injection safety support (INS):** 742,378
- Health system strengthening support (HSS):** n/a







2

Strengthen capacity



Strengthen capacity

Strategic Goal: Contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner

Strong health systems that reliably provide their communities with equitable access to immunisation and other health services are vital to sustained improvements in health. Building and supporting these systems are central to increased immunisation coverage and to ensuring that life-saving vaccines reach the world's children.

There is now a global focus on strengthening health systems. GAVI and the wider development community are working in a coordinated way through initiatives like the International Health Partnership to support countries to tackle weaknesses and bottlenecks in service provision.

GAVI financially supports strengthened capacity for immunisation in three ways: through immunisation services support, health system strengthening support and support to civil society organisations.

Immunisation services support was pioneered in GAVI's early years. It allows countries to flexibly allocate funds to improve immunisation programmes. Recent evaluations of ISS demonstrate how flexible funding allows countries to improve their immunisation services.

In 2007, new financial support for broader health system strengthening was made available to countries. This is to address weaknesses and constraints that affect immunisation, as determined by the country. The funding is flexible and long term, allowing countries to plan improvements that best suit their needs.

Funding support is now also available to civil society organisations (CSOs). In many countries CSOs are an essential resource for delivering health services: they are often able to reach populations that are difficult to access for immunisation, to strengthen and support the health infrastructure, and to raise awareness.

Health systems and integrated services are the vehicles that bring life-saving vaccines and other critical interventions to the world's children; the goal of reaching every child will not be achieved if that system is weak or broken.



Performance-based funding: immunisation services support

GAVI's immunisation services support (ISS) is an innovative approach to development. The goal is to stimulate countries to increase their immunisation coverage through a performance-based 'reward' system. Countries receive US\$ 20 for each additional child vaccinated with three doses of diphtheria-tetanus-pertussis (DTP3) vaccine over and above national targets.

Lessons learnt from immunisation services support

Two independent evaluations conducted in 2006 and 2007 based on rigorous modelling and several years of data have provided definitive proof that ISS works to increase coverage. In the five years from 2001 to 2005, it is estimated that 2.4 million additional children were immunised as a result of ISS funds.

These funds are 'flexible'. The country itself determines how best to address system constraints and priorities in the Expanded Programme on Immunization (EPI) to ensure DTP3 coverage rates continue to rise. The

ISS funds can be put towards any aspect of immunisation services and delivery that the country makes a priority in its national immunisation plan.

Countries can use this funding to support their plans in a variety of ways, for example, to train health workers, buy refrigerators and vehicles, improve the data collection system, or fund outreach to remote villages.

The most recent study in 2007 also confirmed that the majority of the funding was spent at the district level where it has the potential for greatest impact. Countries generally allocated money to their lowest performing or underfunded districts where support was most needed.

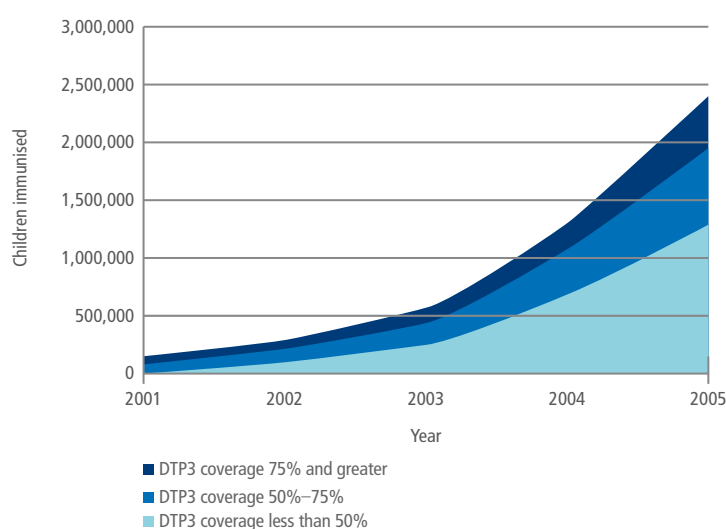
The studies recommended that GAVI continue with its successful ISS strategy, urging that funding remain flexible and country-driven.

These fundamental principles also inform decisions regarding the new health system strengthening (HSS) funding which similarly offers highly flexible cash-based resources and works synergistically with ISS.

When ISS was pioneered, GAVI made the conscious decision to rely upon and support countries' own reporting systems, while recognising that these systems can be weak. The Alliance has developed tools such as the Data Quality Audit to safeguard GAVI investments while helping countries address these weaknesses. This is an ongoing effort; GAVI continually works to support both partners and countries to improve data collection and reporting standards, while improving upon tools like the DQA.

By the end of 2007, 62 countries had been approved for ISS support. Of these, 54 countries received rewards for increasing the number of children reached with DTP3. Together, this represents a total investment of more than US\$ 379 million.

Estimated cumulative number of immunisations attributable to immunisation services support, illustrated by coverage categories



Source: 20

Proof of concept: flexible funding works

When GAVI pioneered ISS funding in 2000, it was based on a simple principle: create incentives for countries to improve their immunisation performance with flexible cash funding and rewards for achievement. It was recognised as taking a risk. Critics said countries would not use the funding wisely, and that it would not have any impact on immunisation coverage.

The 2007 independent evaluation of the ISS programme looked at 53 countries approved for ISS support from 2000 to 2005. This is one of the first evaluations of a performance-based funding mechanism for health.

Among its key findings, the evaluation concluded that:

- **GAVI now has 'proof of concept' that ISS works:** The report states: "ISS expenditure had a significant, positive impact on immunisation coverage." ISS helped boost coverage in countries with both low and high starting baseline coverage rates, not just those with coverage below 50%.
- **Countries spent ISS funds where they were needed most:** The flexibility of the ISS funding mechanism allowed countries to finance critical, underfunded areas in their national immunisation plans.
- **Countries integrate ISS into national immunisation plans:** Country expenditures of ISS funds were clearly reflected in national immunisation plan budgets.
- **ISS had a positive effect on immunisation systems as a whole:** The programme's focus on DTP3 did not negatively influence immunisation with other antigens. In fact, coverage with measles vaccine mirrored increases in DTP3 rates.
- **ISS enhanced partner coordination for immunisation:** The collaborative mechanism used to plan and monitor ISS stimulated greater partner participation at the country level and helped partners to better coordinate their activities with those of the government and others.
- **Strong technical support is critical to success:** The highest performing countries had consistent and reliable technical support from partners.

Recommendations for the future

With clear evidence that ISS has had a positive impact on immunisation coverage, the evaluation strongly recommended that GAVI continue providing the funding, using the same flexible and country-driven approach, and relying upon DTP3 as the progress indicator.

The evaluation also proposed several key adjustments to make ISS even more effective in the years to come. These recommendations are currently under review by Alliance partners, and will be presented to the Alliance Board for final decision in June 2008.

Improving immunisation coverage through strengthened health systems

GAVI has invested an initial US\$ 500 million for health system strengthening (HSS) to run from 2006 to 2015.*

Countries' proposals for HSS support detail measures that will improve the health sector and increase immunisation coverage. In collaboration with other stakeholders, the ministry of health determines its health systems needs as they relate to the delivery of immunisation and other maternal and child health interventions. The proposal must identify and prioritise bottlenecks and obstacles which have the greatest impact at the service-delivery level.

The support provided is one of a potentially wide range of financing options available to countries for health system strengthening, primarily domestic resources, in some cases from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank or bilateral donors.

Strong country response: funding approvals

By the end of 2007, 40 of 72 (55%) countries eligible for GAVI support had applied for HSS funding. This far exceeds the target of 35% by 2009.

Twenty-nine countries have been approved for multi-year funding. This represents a total disbursement of US\$ 403 million. The average length of support is 3.8 years, with some countries supported until 2013.

An analysis of HSS proposals conducted by WHO, UNICEF, UNFPA and the University of Queensland shows 40 countries intend to use HSS funding to address a wide range of health system constraints.

Nearly three quarters of funds are targeted at interventions for improving service delivery, leadership and governance, as well as the health workforce through training and financial incentives. Seventy five per cent of activity is at the district level or below.

GAVI will evaluate the first wave of approved funding in 2009–2010. This will help guide future investments.



* The funding envelope for health system strengthening was increased to US\$ 800 million at the GAVI Board meeting in February 2008, Geneva.

**Strengthening collaboration:
increasing relevance**

The proposal preparation and review process supports alignment across the health-care sector, requiring a match between proposed HSS activities and a country's national health plan and comprehensive multi-year plan (cMYP) for immunisation.

This aligns HSS with existing government policies, frameworks and budget cycles, and strengthens linkages with other health initiatives. There is strong evidence that the collaborative nature of the proposal process has strengthened cooperation and coordination between stakeholders, and significantly increased the clarity and relevance of the proposals.

**Harmonising efforts:
coordination of the GAVI HSS process**

- **Global level:** The HSS task team has contributed to coordination, cooperation and information flow between the major partners on health system strengthening issues.

The team includes representation from WHO, UNICEF and the World Bank, the United Kingdom's DFID, Norway's NORAD, the United States' USAID, as well as developing countries, civil society organisations, Bill & Melinda Gates Foundation, and the United States Centers for Disease Control and Prevention.

- **Regional and country mechanisms:**

Regional mechanisms rely on existing immunisation-specific working groups and regional forums for HSS such as the Harmonising Health in Africa group. Country mechanisms use the existing coordination mechanisms of the health sector coordination committee (or its equivalent). The emphasis is on using existing coordination mechanisms rather than generating new ones.

**Monitoring and accountability:
the risks and the challenges**

One of the major challenges is to develop robust monitoring and evaluation processes which reduce fiduciary risk, while continuing to ensure maximum flexibility of funding, country control of decision-making, and minimal reporting burdens for countries.

The Independent Review Committee (IRC) on monitoring oversees countries' annual progress reports to ensure that they achieve their stated objectives and targets.

Monitoring and evaluation is also being developed through a working group within the International Health Partnership framework, and with the Health Metrics Network (HMN) with inputs from the Global Fund for AIDS, TB and Malaria (GFATM), Canada's CIDA and the Partnership for Maternal and Neonatal Child Health.

“As we travel the world Melinda and I see the importance of strengthening health systems. Many countries lack the basic infrastructure for health, such as skilled people, properly equipped hospitals, and well-functioning drug supply chains. The absence of any of these things can defeat the goal of saving lives.”

Bill Gates, co-chair, Bill & Melinda Gates Foundation



VIEW POINT

Health system strengthening funding: difficult to get, easy to use

Dr Tatul Hakobyan,
Deputy Minister of Health, Armenia
Member of the Board, GAVI Alliance

Armenia faces challenges related to ongoing and much needed reform of our health system. We are moving from a Soviet-style model, which is vertical and centralised and focused on treatment and care, to a decentralised system that includes prevention – and that of course includes immunisation.

In fact, the nation's health indicators are relatively good: low infant mortality rate, high life expectancy and DTP3 coverage of more than 85%. And our economy is growing, which means the health budget is growing by an average of 25% per year, to about 8% of our budget.

But the old system used doctors for most of the service provision. Now the country has excess capacity of facilities, but these are deteriorating and outdated.

There are also disparities between urban and rural areas, and the country is struggling with natural disasters such as an earthquake, an imposed war and poverty.

Our health sector reforms started over a decade ago, but have been difficult to implement for a range of reasons. For example, health-care providers are used to treat illnesses, not prevent them.

There is also a challenge on the part of the population, because they are used to seeing specialists directly. In the new system they should first see a general practitioner. Only if the GP can't handle the problem will they be referred.

After experiencing reforms we may conclude that the health system should avoid the drawbacks of shifting from a planned to a market economy. Introduction of market driven forces and decentralisation in the health sector may result in disintegration, increased prices, low quality and low levels of cooperation. The regulatory role of the Government is critical and essential for sustainable development of the health sector.

We have learnt that there is no simple solution for any country. Health system reforms will need to continue to be refined and adapted to each country and its own situation.

Armenia has determined that a crucial factor in achieving our much-needed health-care reform is GAVI funding for health system strengthening. As we see it, it is difficult to get, but easy to use! By that I mean that the requirements in the proposal process are tough, but the flexibility and alignment to our own priorities means that it is easy to use once we have it.

The HSS funds will support existing immunisation activities by mobilising system resources, and supporting the health sector in planning and implementing the turn-around in Armenia's health service provision in a rapidly changing political, social and economic context.

In particular, we will use the HSS funds to extend our services further into remote, mountainous and border areas. HSS funds will also be used to strengthen health worker supervision and surveillance for communicable diseases.

Learning through health system strengthening:

Work is underway to develop a knowledge bank of lessons learnt and best practices. This will contribute to the body of evidence around health system strengthening, as well as provide links with other current health systems work. Knowledge management and GAVI's "learning as we go" approach are critical to the success of the HSS programme as it moves to the implementation phase.

Lessons learnt in the first year:

- **The need for quality technical support:** Many countries have asked for help in developing proposals, and ultimately in implementing and monitoring them. More sustainable ways are being explored of providing technical support through national and regional institutes.
- **No 'one-size-fits-all':** Each country is different and has its own challenges in delivering health services. Putting the countries at the centre of the process has helped strengthen partner support, as well as ensuring that the approach remains flexible and adapts to what works and what does not. It also helps GAVI put aid effectiveness into practice by sharing lessons learnt about other country applications and other initiatives.
- **Staying flexible:** There is no perfect way of reviewing the proposals, which are complex and individual. The IRC on proposal review has had to strike a balance between an academic, technically robust method, and a pragmatic need to invest in proposals that can be implemented in the world's poorest countries. This method of review has had to be adaptive and responsive to needs.



Drawing on the strength of civil society organisations

Civil society organisations (CSOs) have been working in the field of public health for many years, complementing government programmes, raising resources, delivering health and immunisation services and advocating for improved health outcomes. They have been particularly effective in reaching people and children in remote or under-served areas, with poor health infrastructure or who are marginalised.

Country	Routine immunisation delivered by CSOs
Cambodia	30% to 40%
Bangladesh	8% to 12%
Ghana	Up to 40%
Kenya	45% to 65% (northern Kenya)

Source: 21

In Africa and parts of Asia, it is estimated that CSOs deliver up to 65% of immunisation services through their outreach and community-based strategies. Through the efforts of these global and local organisations, millions of additional children have been immunised and protected from disease and early death.

Strengthening that role will help countries meet the MDG targets, as well as increase national and community ownership and sustainability.

Supporting health systems through CSOs

The Board has approved a new US\$ 30 million investment in supporting civil society organisations through direct government partners.

There are two types of GAVI CSO support. The first, called type "A", is available to all GAVI-eligible countries, and is intended to strengthen the role and representation of civil society in country-level coordination.

The second, or type "B" support, is available for CSO direct involvement in implementing the country's HSS proposal and/or comprehensive multi-year plan. This funding channel is through the HSS application and review processes.

A pilot project for type B funding will run for two years in 10 countries: Afghanistan, Bolivia, Burundi, Georgia, the Democratic Republic of the Congo, Ethiopia, Ghana, Indonesia, Mozambique and Pakistan. There are more than 5 million unimmunised children in these countries, which include five least-developed countries and three fragile states.

The guidelines on how to apply for CSO support were ready in May, 2007. The CSO task team visited countries during the year to support implementation of the CSO support at country level. The first five visited were the Democratic Republic of the Congo, Ethiopia, Indonesia, Mozambique and Pakistan.

Approving the first funding

Three countries – the Democratic Republic of the Congo, Afghanistan and Pakistan – have been approved for type A funding to strengthen CSO coordination and representation in their countries.

The Democratic Republic of the Congo is additionally the first of the pilot countries to receive type B funding of US\$ 5.3 million to assist in implementation of its HSS programme.

It is expected that by the end of 2008, all 10 pilot countries will have completed applications, and several more will have applied for funds to strengthen coordination and representation.

This pilot phase of GAVI CSO support will be evaluated in 2009–2010.

The Democratic Republic of the Congo is a land of challenges. Emerging from years of civil war, the country is still struggling to recover from the humanitarian crisis made worse by the influx of refugees from neighbouring countries also in conflict.

As the third largest country in Africa by landmass, it is the size of western Europe, about a quarter of the size of the United States, with a population of just under 60 million people.

It contains the world's second largest rainforest, dense and tropical. The vast Congo River runs through its heart, with high mountain ranges to the east.

With less than 3,000 km of paved roads, the remaining 150,000 km of unpaved roads are vulnerable to heavy rains, often impassable by small vehicles and further ravaged by the heavy trucks needed to navigate them.

Much travel and transport is done by plane, although less than 10% of airports have paved runways. Much of the country is accessible only by foot or bicycle, or by canoe.

The health infrastructure is in desperate need of repair, with clinics and hospitals damaged and dilapidated.

The task of getting vaccines out to children in rural villages under these conditions is daunting. Despite the hurdles, however, the Ministry of Health was successful in keeping up routine vaccination during the conflict. WHO projects that DTP3 coverage has climbed to 80% from 49% at the inception of GAVI support in 2003. This was possible thanks to a well-established infrastructure for polio vaccination, supported by Rotary International and other partners.

As one of the countries at risk for yellow fever, the Democratic Republic of the Congo has received GAVI support for yellow fever vaccine since 2003. The latest numbers show that the coverage of this vaccine is on the same level as that of DTP3.

It has been a triumph of collaboration and partnership, ingenuity and perseverance.

Bonny Sumaili is a health officer for UNICEF. "One of the largest challenges

"Children who would otherwise have been missed out now get all the shots."

we face is logistics. There are 11 provinces in this country, and only one of them can receive the necessary supplies by road. The rest have to be supplied by plane and then by whatever means are available, because the infrastructure is so poor and the country so big and inaccessible."

Vaccines and related products such as auto-disposable syringes and safe syringe disposal boxes arrive in the capital city, Kinshasa, from abroad. From the cold store in Kinshasa, the vaccines are sent by regular flights, which get the vaccines to the provincial capitals swiftly. The vaccines are distributed from the cold stores in the provincial capitals: then some by flights within the province if the infrastructure is bad, or by truck, canoe, bicycle or by foot according to the conditions in that particular area.



Vast and daunting obstacles to vaccination:

the Democratic Republic of the Congo



In the Dibindi health zone, Fortunat Mbuyi is a supervising nurse. He emerges from a regional storage facility with a cold-chain insulated box over his shoulder, and walks towards his new transportation. "This morning we will take the motorbike and the coolbox, and requisition the vaccines" he says. "Then I'll bring the vaccines to a health facility in the field for today's routine vaccination session."

Bonny Sumaili says it is crucially important to keep the vaccines cool in the equatorial heat. "The GAVI funds have helped us make sure all the parts of the cold chain have constant access to power to keep the vaccines at the right temperature. This means that children who would

otherwise have been missed out now get all the shots. Since our traditional support remains, GAVI's funds come on top. They let us record both the increase in coverage and a reduction in deaths from the diseases these vaccines prevent."

Christine Nyali Lomata brings her youngest son to the Barumbu mother and child centre in Kinshasa province for vaccination. "I have three children. There is a big difference between what the first and last child received," she notes. "The first one, born in 1998, only got one vaccine against measles. This one, born this year, now gets vaccines against measles and yellow fever and some other diseases, and also vitamin A."

The Ministry of Health works closely with civil society organisations and welcomes their instrumental role in the delivery of health and immunisation services. This is the first country to be approved for GAVI's support to CSO activities. The funding will support CSO efforts to strengthen cold chain and logistics.

"CSOs are important all at levels" says Joaquim Lubiba, who is with the CSO AXxes. "Locally, they reinforce capacity through awareness-raising, social mobilisation, and service provision. They also play an important role in health worker training and cold chain maintenance. They are an important part of the network needed to bring services to this vast country."

The country received both HSS and CSO funding in 2007. This will help repair damaged buildings and build other infrastructure needed to deliver immunisation and other child health services.

"Good collaboration makes sure that we use our resources wisely. It lets us accomplish a lot in the field" according to Shodu Lomani, Minister of Health in Kasai Oriental province. "We have enormous problems that are outside our control. If we were to try to address them alone, we wouldn't get very far."

FACT FILE

Total population: 58,741,000²²

Surviving infants: 2,679,000²²

Infant Mortality Rate: 114 per 1,000 live births²²

Under-five mortality: 296 per 1,000 live births²²

Per capita Gross National Income: US\$ 130²³

Government expenditure on health /person: US\$ 1.3²⁶

Health worker density: 0.69 per 1,000 population²⁵

DTP3 coverage: 77%²⁴

Percentage of districts with more than 80% DTP3 coverage: 44%²⁴

GAVI funding disbursed by type of support (US\$): 46,558,776

New and underused vaccines support (NVS): 24,506,065

Immunisation services support (ISS): 19,338,780

Injection safety support (INS): 2,713,931

Health system strengthening support (HSS): n/a





3

Increase predictability



Increase predictability



Strategic Goal: Increase the predictability and sustainability of long-term financing for national immunisation programmes

The strategic goal for 2007–2010 is to ensure increased and growing direct donor support, both public and private, while continuing to develop innovative and flexible instruments of long-term predictable financing such as the International Finance Facility for Immunisation, or IFFIm.

IFFIm has established its effectiveness as a source of development funding. The first year has seen funds disbursed tactically for vaccine and country support and health development.

The Advance Market Commitment (AMC) is a new financing mechanism designed to shape vaccine markets. Its goal is to shorten the time between release of a new vaccine in the developed world until it reaches people in developing countries in a formulation adapted to their needs. The aim of the pilot is to accelerate the development and availability of a new vaccine against pneumococcal disease.

In addition to the existing support from direct government donors, a new campaign seeks to bring new thinking and funds to the GAVI partnership. Additional private sector resources – both in terms of funds and expertise – are sought through philanthropic giving.

Hand-in-hand with predictability, countries are working with GAVI towards greater programme ownership and sustainability through cost sharing, where countries co-finance vaccine purchases.

Impact after one year: the International Finance Facility for Immunisation (IFFIm)

The International Finance Facility for Immunisation (IFFIm) inaugural bonds in aggregate principal amount of US\$ 1 billion were issued on 14 November 2006. Initially launched by founding governments as a pilot project arising from the 2005 New York Millennium Review Summit, IFFIm is on track to pursue additional bond issuances over the years to come.

visible. The first-ever global bond issuance for development has proved its value in concrete gains for health.

By the end of 2007, US\$ 862 million had actually been disbursed to third parties – almost 90% of the total proceeds of the first bond issuance. The IFFIm funding supported both the “core” GAVI programmes for immunisation and health development, and a range of special one-time investments in disease eradication or control through operations run by partners.

IFFIm funds are provided as grants – not loans – through the GAVI Alliance. IFFIm’s anticipated investment of up to US\$ 4 billion from 2006 to 2015 (inclusive) is expected to provide immunisation for an additional half a billion people.

Approvals and disbursements, 2006–2007 (US\$)

Total approved by IFFIm Boards	1.047 billion
Disbursements by end 2007	862.3 million
<ul style="list-style-type: none"> ■ 50% to GAVI partners ■ 29% to GAVI programmes (NVS/INS/ISS/HSS) ■ 21% to pentavalent procurement 	<ul style="list-style-type: none"> 428.5 million 252.7 million 181.1 million

Source: 27

The financing strategy

IFFIm was one of the first innovative financing mechanisms for development. It uses the strength of the capital markets to raise funds, based on binding donor payment obligations, in support of GAVI and partner programmes.

IFFIm’s particular appeal comes from bridging the world of international finance and a specific development challenge.

The original bond sale reached a wide variety of investors in a range of markets, from institutional to retail. The response from this investor base has been very encouraging.

Solid advances

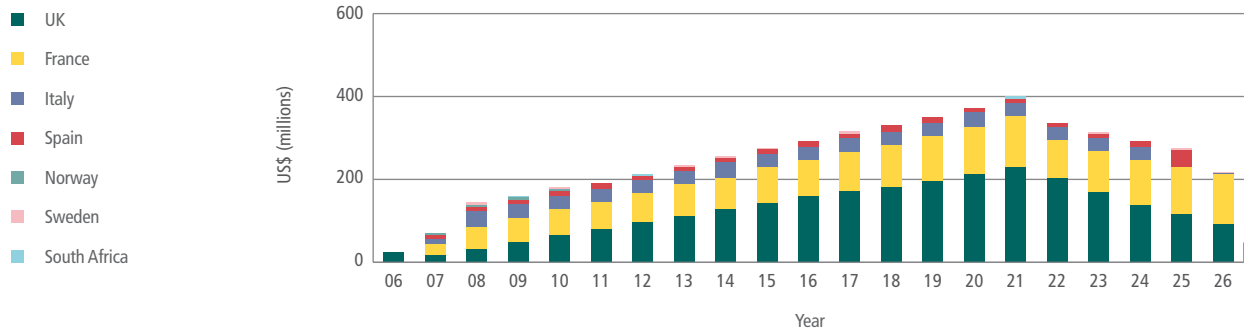
One year after the launch of its inaugural bond issuance, the impact of IFFIm is clearly

Committed support

IFFIm relies on legally binding payment obligations from its founding and future donors. IFFIm’s founding donors are France, Italy, Norway, Spain, Sweden, and the United Kingdom. South Africa joined IFFIm as a donor in March 2007. Brazil’s commitment to support the IFFIm is before its parliament.

IFFIm's financial base consists of legally binding grant payments from its sovereign donors, on the basis of which IFFIm issues AAA/Aaa/AAA-rated bonds in the international capital markets.

International Finance Facility for Immunisation : profile of payment obligations by sovereign sponsors (US\$ millions as at 31 December 2007)



Source: 28

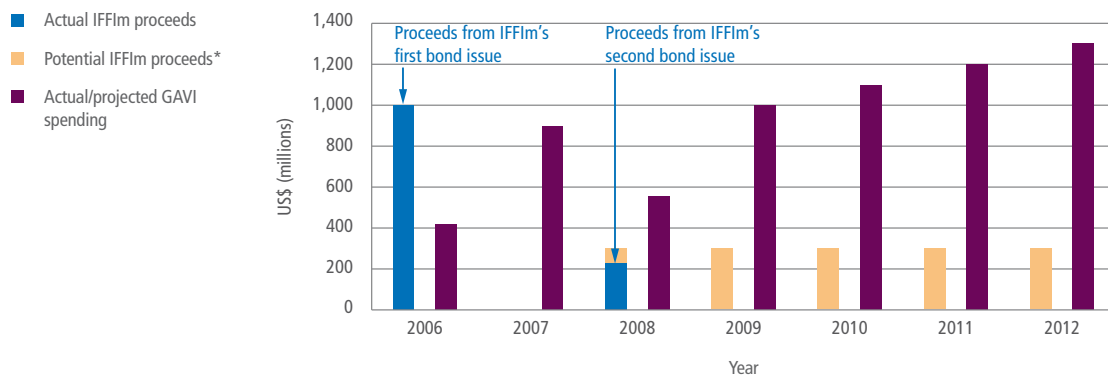
IFFIm donor commitments

Government	Commitment in national currency
United Kingdom	£ 1,380,000,000
France	€ 1,239,960,000
Italy	€ 473,450,000
Spain	€ 189,500,000
Sweden	SEK 276,150,000
Norway	US\$ 27,000,000
South Africa	US\$ 20,000,000

Source: 29

The GAVI Secretariat expects that annual programme spending could be as much as US\$ 1.3 billion by 2012, depending on Board decisions.

IFFIm realises significant funds for GAVI, 2006–2012 (US\$ millions)



* "Potential IFFIm proceeds" presumes that IFFIm successfully raises funds in the international capital markets or by borrowing under loan facilities, and disburses them to fund GAVI programmes approved by IFFIm

Source: 30

IFFIm and GAVI have delivered on the following key fronts:

- **A massive boost to the country programme portfolio:** GAVI almost doubled support to countries, with disbursements rising from US\$ 206 million per year in 2005 to US\$ 394 million in 2007 for the range of country-specific programmes supporting strengthened immunisation services, new vaccines, and immunisation safety.

An important lesson learnt in the first full year of IFFIm operations has been that faith has been well placed in the ability of countries to rise to the challenge of scaling up their applications for support.

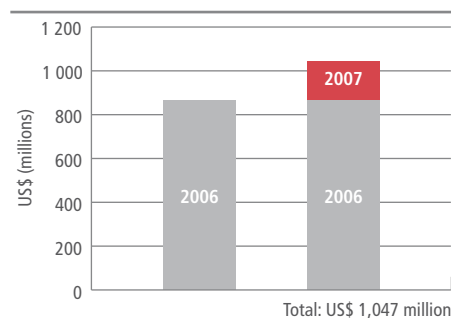
- **Security for implementing countries:** The scale and predictability of funding are essential parts of IFFIm's value. IFFIm has made it possible for GAVI to commit to support countries for as long as 10 years, providing them with an extraordinary level of assurance of continued support. This in turn makes it possible for health ministries to plan effectively, secure higher and longer internal budgetary commitments and to frontload investment.

Predictable, long-term financing can help a country to decide to expand its immunisation programme. It can also empower a country to strengthen its service delivery capacity, for example by building its health workforce through investing in institutions that increase the production of appropriately skilled health personnel. Assured financing enables long-term vision.

- **Security of vaccine supply:** The availability of IFFIm funds over a decade enhances the security of supply of vaccines. It increases incentives to new manufacturers to enter the market. It signals stability and committed financing, stimulates markets, accelerates vaccine development, and promotes increased production, availability and lower prices.

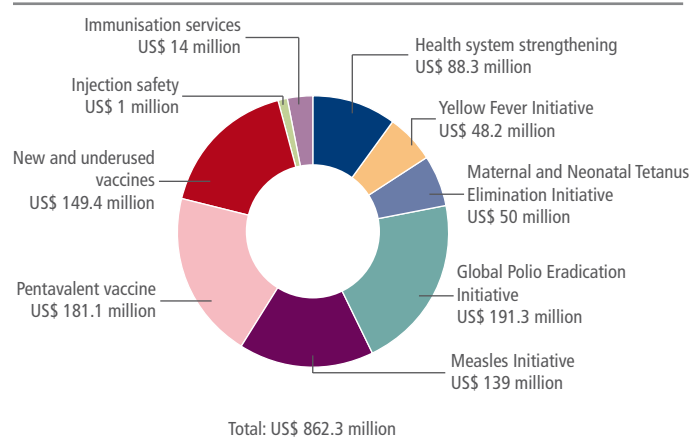
- **Frontloading disease control:** IFFIm funding supports a more focused vaccination effort and favours plans to immunise the population intensively over five years, rather than more sporadically over 20 years or so. This more focused vaccination effort creates a 'herd immunity' for the entire population, which drives down the incidence and burden of a disease. Increased vaccination and the resultant lower disease burden are prerequisites for higher economic growth in a country.
- **Demonstrated flexibility in action:** IFFIm funds can be reallocated to address the immediate financing needs of the international development community.
- **Tested and proved the governance and financial systems:** With the World Bank as its Treasury Manager, IFFIm has demonstrated strong treasury management, good governance standards and maintained a triple-A rating with the three major rating agencies.
- **Recognised as an innovative financing tool:** IFFIm is recognised as an important and influential new way to finance development by key international partners and participants. It is seen as a vital new approach to addressing the Millennium Development Goals. IFFIm has received acknowledgement at the highest levels, including from the G8 and the United Nations.
- **Acknowledged as an attractive investment:** 2007 saw turbulent financial markets and a flight to quality. IFFIm's triple-A rated status is a mark of a prudent investment option with secure backing from the donor grants. Recognition of excellence was reinforced by two awards from the capital markets in 2006 and two in 2007.

IFFIm approvals, 2006–2007



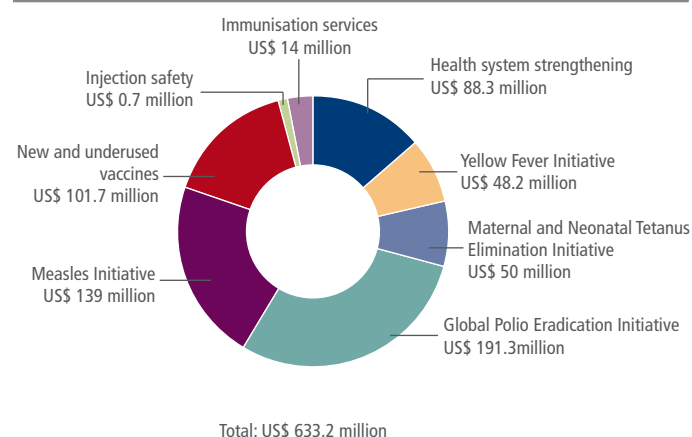
Source: 31

GAVI disbursement of IFFIm funds, 2006–2007



Source: 32

GAVI disbursement of IFFIm funds, 2007



Source: 33

Disbursing funds for immunisation

Country-specific support: In total in 2007, US\$ 204.7 million went to support GAVI's efforts to radically scale up access to vaccination in the poorest countries. US\$ 101.7 million of IFFIm funds went in 2007 to support country applications for new vaccines. In 2007, US\$ 14.7 million went to country programmes that support immunisation safety and routine immunisation services.

In addition, IFFIm funds are helping countries to address as quickly as possible broad health system "bottlenecks" that currently limit their ability to get vaccines to children.

In 2007, US\$ 88.3 million went to GAVI's health system strengthening programme to support immunisation delivery and coverage. This represents a substantial portion – nearly 20% – of GAVI's initial funding estimate of US\$ 500 million for the HSS programme from 2006 to 2015.

Pentavalent vaccine: In 2006–2007, US\$ 181 million of IFFIm funds were disbursed to purchase or secure supply of the combination pentavalent vaccine. This 5-in-1 vaccine immunises children against diphtheria, tetanus and pertussis (the traditional DTP vaccine), hepatitis B and Hib. Encouraged by the additional supply and secure funding of this vaccine, the number of countries applying for GAVI support for Hib vaccine has almost doubled since 2006 to 44.

Because of the long-term stabilising effect of IFFIm, GAVI has been able to make a long-term purchase commitment of pentavalent vaccines, of which by end 2007 US\$ 49.6 million had been drawn down.

The availability of IFFIm funding until 2015 is supporting security of future supplies. This is an incentive to new manufacturers to enter the market in the coming years, a move which is expected to further reduce vaccine price.



VIEW POINT

The value of IFFIm to countries

**Michèle Boccoz, IFFIm Board Member,
International Communication Director
for Veolia Environnement
Former Director of International Affairs
for the Institut Pasteur**

In my many discussions with ministers of health through the years, including when I was with the Institut Pasteur, I realise that they want to secure funding with vision. By that I mean not one-time, short-term funding, but longer term financial security. They want to be assured of a financial plan and strategy, to know what assistance they can rely on, and then take decisions on their own.

IFFIm is providing that longer-term perspective for investment, funding and country planning. For health ministers, IFFIm means better financial planning. As a result, it is a very efficient tool for frontloading and launching vaccines – both new and old. Developing countries have found new vaccines too expensive, as prices were high without market guarantees. Both IFFIm and the Advance Market Commitment pilot for pneumococcal vaccine are playing key roles in providing the longer-term perspective for vaccine manufacturers as well.

IFFIm was structured to inspire confidence in the markets, and after one year, it has been incredibly successful in that. The second challenge was to ensure the money actually reaches those it needs to get to, and we've achieved that. It was far from easy to organise. I've been involved since the beginning, with a few countries, with Goldman Sachs and with GAVI's lawyers and financial staff. It has been challenging, but I'm proud that I've been involved, and able to help make a difference to children being immunised. It's fabulous!

“IFFIm brings together sovereign capital, World Bank expertise and the GAVI immunisation programmes to make a difference to millions of lives. For IFFIm’s future bond issuances, plans are underway to build on the success and visibility of the inaugural bond and expand to other markets around the world. The World Bank Treasury, as IFFIm’s Treasury Manager, is in the process of exploring potential funding products, with a particular focus on individual investors.”

**Doris Herrera-Pol,
Director, Capital Markets,
World Bank**

Tactical investments: Approximately 50% of IFFIm disbursements were allocated to a number of one-time tactical investments in disease prevention and control through partners. Each targets a disease which is constraining progress towards the MDG global goals of improved child and maternal health. The aim is to provide immediate acceleration to partners’ efforts to combat mortality and illness.

IFFIm funding has benefitted the Measles Initiative, the Yellow Fever Initiative, the Global Poliomyelitis Eradication Campaign, and the Maternal and Neonatal Tetanus Elimination Campaign.

- **Measles:** Measles kills some 245,000 people globally, and of those, most are children under the age of five. The Measles Initiative is a partnership between global health and development agencies to address this major childhood disease. Acting on evidence that early robust action is most effective, US\$ 139 million of IFFIm support has gone to the Measles Initiative to strengthen measles campaigns.

IFFIm’s funding represented about 80% of the total amount of all external funding available to high-burden countries for measles in 2007. This allowed rapid scale-up, providing 194 million children in 32 countries with life-saving measles vaccine.

The Measles Initiative announced in November 2007 that deaths from measles in Africa had fallen by 91% between 2001 and 2006, achieving the goal to cut measles deaths on the continent by 90%, four years early. These major gains in Africa spurred a global decline in measles deaths, which fell 68% worldwide in the same time frame.

- **Poliomyelitis:** In June 2007, IFFIm funds helped avert a potentially devastating setback to the 20-year effort to consign polio to the history books. US\$ 105 million in IFFIm funds were re-programmed from a post-eradication polio vaccine stockpile into intensified polio eradication activities.

In the second half of 2007, IFFIm funding helped to immunise more than 100 million children under the age of five, some of them multiple times, in 11 polio-affected countries, and has supported surveillance activities and technical assistance in four WHO regions.

There has been sustained headway globally in curbing transmission of type 1 poliovirus – the most dangerous remaining serotype. There has been a decrease of 84% in cases over 2006.

A number of key landmarks have also been reached. For example, there has been a reduction in ‘missed’ children in northern Nigeria where the proportion of children never immunised halved in 2007 over 2006, and no reported cases of polio for 12 months in western Uttar Pradesh, India. This has been one of the most entrenched reservoirs of type 1 polio.

In total, US\$ 191.3 million was fast-tracked into pre-existing polio eradication efforts and vaccine stockpiles in 2007.

- **Maternal and neonatal tetanus:** Maternal and neonatal tetanus (MNT) kills the poorest of the poor in the developing world. However, global MNT elimination is possible through vaccination.

IFFIm provided US\$ 50 million for maternal and neonatal tetanus elimination from a total of



US\$ 62 million approved in 2007. IFFIm funds represented 90% of the resources allocated in 2007 for the campaign's activities up to 2009. These resources constitute a 60% boost over those raised for the initiative from other sources between 1999 and 2006.

The effect is a projected doubling, to 26 million, of the number of women targeted with tetanus vaccine in 2007 and early 2008. IFFIm will have enabled each of the 21 high-burden target countries to complete their planned activities for 2007, without exception. This is vital for elimination efforts and has bolstered several otherwise faltering MNT immunisation programmes.

- **Yellow fever:** Yellow fever is a lethal, highly infectious viral disease, causing devastating epidemics in 33 countries in Africa and 14 countries in the Americas. Through the Yellow Fever Initiative, IFFIm funded US\$ 48.3 million for yellow fever activities in 2007 in most countries in west Africa. This included the provision of stockpiles which make vaccine available for outbreaks.

IFFIm funding has not just provided protection: it has supported the discovery of previously unrecognised populations at risk which can now be protected. The initial plan anticipated the need for 12 million doses of yellow fever vaccine for four countries in 2007. Following a yellow fever risk assessment exercise, that total has been revised upwards to 23 million doses – nearly double.

IFFIm funds are going to preventive campaigns in the 12 west African countries most at risk. WHO predicts that this work will prevent approximately 687,000 deaths between now and 2050 in these high-risk countries.

Commitment, confidence and partnership

**Arunma Oteh, IFFIm Board Member,
Vice President, Corporate Services
African Development Bank Group**

I am delighted to be associated with IFFIm, a ground-breaking initiative that uniquely leverages donor contributions and capital markets to save lives, thereby positively impacting the future of the 70 developing countries that it covers.

On the back of 20-year pledges by its seven donor countries including South Africa, IFFIm has raised US\$ 1 billion from capital markets for immediate use for national immunisation and health system strengthening programmes. IFFIm therefore not only reflects a partnership between developed and emerging countries, but also associates investors in international capital markets with addressing urgent health and development issues. I am certain that 'doing good', while earning attractive returns was the reason why each of IFFIm's bond issues was very quickly snapped up by bond investors.

IFFIm has in a short time made a significant impact on our society, whether it is in terms of being at the cutting edge of innovation in capital markets and development finance or with respect to facilitating an urgent response to addressing a basic need.

I commend the donors for their vision and GAVI and the World Bank for their hard work in realising this dream.

Yellow fever halted in Cameroon



In 2007, IFFIm funds were directed in part to an emergency reserve stockpile for yellow fever outbreaks. This enabled the purchase of 6 million doses annually for three years.

This was immediately put to use in Cameroon after one suspected case of yellow fever was confirmed in October 2007. The Minister of Public Health of Cameroon enlisted the help of an international partnership of WHO, UNICEF, GAVI, Médecins sans Frontières, and the Cameroon Red Cross. They quickly launched an emergency vaccination mass campaign against yellow fever in two health districts for two weeks from the end of October through November.

IFFIm provided some 147,000 doses of bundled vaccine and US\$ 33,000 for the campaign's operational costs. The Cameroon Ministry of Health shared the cost of the campaign, providing US\$ 32,000.

Shaping markets for new vaccines: advance market commitment

The Advance Market Commitment is a new approach to public health funding designed to stimulate the development and manufacture of vaccines for developing countries. Donors commit money to guarantee the price of vaccines once they have been developed, thus creating the potential for a viable future market. Decisions about which diseases to target, criteria for effectiveness, price and long-term availability are made in advance through recommendations of various independent advisory groups group. The donor commitments provide vaccine makers with the incentive they need to invest the considerable sums required to conduct research, train staff and build manufacturing facilities.

Market-driven incentive

The AMC establishes a financial commitment by donors for future purchases of a targeted new vaccine – up to a pre-determined price per dose and market size, and for a fixed period of time. Conditions apply: the vaccine must be in demand by developing countries, and the manufacturer may apply only once the vaccine has been developed and has met strict criteria. As such, the AMC is a market-driven incentive.

Industry takes the initial risk of investing in research and development and in setting up large-scale manufacturing plants. The donors to the AMC pay only when the right product is ready.

AMC commitments	US\$ million
Italy	635
United Kingdom	485
Canada	200
Russia	80
Bill & Melinda Gates Foundation	50
Norway	50
Total	1,500

Source: 34

Improving childhood survival: addressing pneumococcal disease

In February 2007, Canada, Italy, Norway, Russia, the United Kingdom and the Bill & Melinda Gates Foundation pledged US\$ 1.5 billion for the first advance market commitment to accelerate the development and availability of a new vaccine for pneumococcal disease – the leading cause of child pneumonia deaths and the second leading cause of childhood meningitis deaths. It is anticipated that the first payments will begin as early as 2009 and last for 9–10 years. The new vaccine is expected to save the lives of more than 5 million children by 2030.

Sustainable supply, predictable prices

The pilot AMC encourages sustainability. Even when the AMC's funds have been spent, each participating manufacturer is obliged to continue to supply the vaccine at a low price for an established period. Sustainable post-AMC supply and prices are vitally important, and are factored into negotiations with the manufacturers.

Measuring success, testing the concept

The pilot is intended to demonstrate the feasibility of this new finance mechanism and its impact on accelerating vaccine development, production and scale-up for new vaccines against other priority diseases.

This is very much a partnership project. The World Bank is playing a strong role in overseeing the pilot's functions. WHO will be responsible for the normative and prequalification functions and UNICEF will act as procurement agent. Donors, pharmaceutical vaccine and biotech firms, developing countries, civil society organisations, are all critical to the implementation and success of the AMC.

All partners will be evaluating this new venture closely, and reporting back on their results. The hope is that advance market commitments will become another successful global finance mechanism to improve immunisation, health and development.

Improving health and saving lives with donor support

By 31 December 2007, the GAVI Alliance had received a total of US\$ 3.2 billion in funding since inception.

US\$ 786.9 million was received in 2007, consisting of US\$ 358.6 million from direct government and private funding and US\$ 428.3 million from IFFIm proceeds.

A predictable, multi-year funding platform

The profile of direct government support continues to shift to multi-year funding commitments. By the end of 2007, 67% of direct government donors had entered into grant agreements of three years or more, up from 33% in 2005.

Predictable long-term financing for countries is a cornerstone of the business model. The Alliance operates multi-year programmes and makes multi-year commitments to GAVI countries, aligning with countries' own planning cycles, in some cases up to 2015. Current and longer-term programme commitments to countries need a predictable funding base.

Impact goes beyond support to countries, to the acceleration of vaccine introduction on both the demand and the supply side. GAVI promotes increased access to sensitive products which require a long lead time to be developed. Experience has shown that a predictable multi-year funding base is required to signal market potential to vaccine producers, and to realise efficiencies in vaccine prices by catalysing new entrants into the market.

GAVI plays an essential role in providing confidence to countries and manufacturers in an otherwise uncertain funding environment.

Stable, long-term donor financing is a prerequisite for GAVI to act as an effective "pull mechanism" on the vaccine market, to stimulate country demand, and influence scale-up decisions to introduce and co-finance new vaccines. It will also be needed to ensure security of funds to underpin Board decisions in anticipation of investments in new vaccines as they become available.

The spending forecast: rising demand

GAVI's direct programme spending is projected to rise significantly in the coming years, while retaining the principle of approximately two thirds of funding going to vaccines and one third to immunisation systems support.

GAVI's annual spending levels have already surged from approximately US\$ 220 million in 2005, to US\$ 889 million in 2007.

This anticipated increase in programme funding is driven by key undertakings, including continued growth in country applications for new vaccine support as well as for more expensive vaccines such as the pentavalent DTP-Hep B-Hib vaccine; the cost (not including AMC funding) of pneumococcal and rotavirus vaccines, as initial applications are received for these two new vaccines over the next several years; and continued strong growth in HSS applications and funding requirements.

Expanding direct government and private funding

To ensure that funds are available to sustain the continued scale up of programme activities, and underpin the Board decisions to invest in support for new vaccines, the

multi-year donor base needs to be expanded. It currently consists of direct government, innovative, and private funding sources. Those sources need to be broadened to ensure the sustainability of programmes beyond the lifespan of IFFm bond proceeds.



Raising private funds for the global public good: *The Immunize Every Child Campaign*

Visionary philanthropy was integral to GAVI's creation and has helped ensure its continued success. The initial investment of US\$ 750 million over five years by the Bill & Melinda Gates Foundation was catalytic to the creation of the GAVI Alliance. A subsequent contribution of US\$ 750 million over 10 years is enabling GAVI to continue to be an innovator on a global scale, take risks, create new financing programmes, and frontload monies to accelerate results.

Extensive further private investment can help GAVI reach its long-term goals of improving service delivery and scaling up of access to immunisation.

The challenge now is to do more.

Most of the Campaign's initial efforts focus on the United States, calling on private individuals to invest in immunisation for every child through The GAVI Fund, which is a 501 c (3) US-based charitable organisation.



“The Immunize Every Child Campaign is about one child and every child, what every child deserves and what each child means to its mother, father and family – something precious beyond compare. Immunisation is central to basic health care, and basic health care is a building block for healthy and solid communities.”

HRH La Infanta Princess Cristina of Spain (seen above, far right, in Mozambique) spoke at the launch of the Immunize Every Child Campaign in New York as an honorary founding member of the Every Child Council.

GAVI is inviting broad-based support from the ranks of venture philanthropists, business leaders, entrepreneurs, wealth managers and donor advisors who want to help build on the strengths of GAVI's public-private partnership.

Such individuals will recognise the power of the GAVI business model. They want to help to develop its full potential for the world's poorest children. They want to engage with a cause, but one with a proven track-record and an approach that makes sense.

"The GAVI approach is unique", says Paul-O'Connell, a Boston-based business leader who, with his wife, Elaine, contributed to the GAVI Alliance in 2007 and 2008. "It is goal-oriented and results-based, and singularly focused on the long-term sustainability of the outcomes."

O'Connell was able to witness GAVI's work first-hand during field visits and strategy meetings with government leaders in the Lao People's Democratic Republic in February 2008. "It was striking to observe how the various stakeholders are working together to energise the Lao PDR vaccination programme", said O'Connell. "It was also interesting to see how GAVI has learnt and taken to heart the lessons of earlier international efforts to tackle the problem of disease, and to improve on those efforts."

Launching the campaign

On 24 September 2007, in the former New York home of philanthropist Andrew Carnegie, GAVI launched its Every Child Council leadership society and introduced the Immunize Every Child private philanthropy campaign. More than 140 leaders from the business and philanthropic communities took part.

The Every Child Council is made up of a diverse group of prominent people from public and private life. The common thread: each one has set an example by making or securing significant commitments to the GAVI Alliance.

Honorary founding members of the Every Child Council include Her Majesty Queen Rania Al-Abdullah of Jordan; Her Royal Highness La Infanta Cristina of Spain; and Mary Robinson, former President of Ireland and UN High Commissioner for Human Rights. Founding members are John Corzine, Governor of the State of New Jersey; Mel Karmazin, CEO of SIRIUS Satellite Radio; George W. Wellde, Jr., Vice-Chairman of Securities Division (Retired), Goldman Sachs & Co.

Global interest, individual giving

Philanthropists in Spain, India, the United Kingdom and the United States are expressing keen interest in GAVI's new Immunize Every Child campaign, with a doubling of donors and gifts received in 2007 over 2006 – a trend strongly continuing into 2008.

In Spain, La Caixa bank's private foundation (the largest corporate foundation in Spain, second largest in Europe, and fifth worldwide) is creating a philanthropic agenda around the GAVI mission. La Caixa Foundation is working now with GAVI's private philanthropy team to reach out to the bank's thousands of employees and hundreds of thousands of depositors to amass additional funds for immunisation.

This support from the Spanish private sector builds upon GAVI's existing engagement with the Government of Spain. In 2006, Spain committed € 189.50 million over 20 years to IFFIm. As one of the first and largest donors to IFFIm, the Government of Spain is actively taking part in the GAVI Alliance Board as alternate member, and is represented on the Monitoring and Evaluation Task Team.

Isidro Fainé, president of the La Caixa Bank and La Caixa Foundation, said: "It is very satisfying for La Caixa to join with the GAVI Alliance and thus contribute to illness prevention and the improvement of countries' health systems".

Sharing the challenge: co-financing vaccines

GAVI is committed to supporting the sustainability of immunisation programmes over the long term. A crucially important element of achieving financial sustainability and increasing access to vaccines is to introduce country co-financing of vaccines.

Co-financing promotes country ownership in accordance with the Paris Principles for increased aid effectiveness. It also supports GAVI's efforts to have a positive influence on pricing and market dynamics.

Fifteen countries are now co-financing their vaccine costs. That number will increase to 28 in 2008, including a number of countries which have chosen to co-pay beyond the required minimum.

From 2008, all countries applying for vaccine support will share the cost per dose of vaccine, according to their ability to pay and the number of different vaccines deployed. The only exception is the measles second dose as introduced into routine immunisation.

Some countries were co-financing prior to 2007, but those who were not will begin as they introduce new vaccines, or existing vaccines beyond the first five years of GAVI support.

GAVI will review the co-financing experience, and payment levels, country groupings and as a result eligibility criteria may be revised in 2010.

Minimum co-financing levels per dose of vaccine (US\$)

(single or combination, including yellow fever)

Examples	Poorest	Intermediate	Least Poor	Fragile States
1 st vaccine, single or combination (including yellow fever)	0.20	0.30	0.30 (+15% annually)	0.10
2 nd and 3 rd additional vaccine (single or combination)	0.15	0.15	0.15 (+15% annually)	0.15

Balancing accountability and flexibility

As direct financial support to countries for health system strengthening and to civil society organisations expands, it is time to take stock of fiduciary risk management. Is it fit for purpose in the changing environment?

The challenge is to strike the right balance between ensuring robust accountability for how funds are spent on the one hand, and on the other, using and developing countries' own capacities, reducing their burden of reporting, and maximising spending flexibility and aid effectiveness.

The best way forward builds on comparative advantages, while working in harmony with other players to explore pooled mechanisms and coordination of oversight.

GAVI's fiduciary risk methods were established when cash support relative to vaccine supply to countries was relatively small. Under current arrangements countries propose financial management arrangements, and take responsibility for reporting through annual progress reports. External bodies provide oversight, including each country's health sector coordination committee or inter-agency coordination committee. An Independent Review Committee assesses each country's annual progress report, but relies on the financial information provided.

This means that countries and country-level coordination mechanisms have the flexibility to deploy their resources according to their preferences. This is in line with the principles of aid effectiveness. For GAVI, this also means low administrative costs without the need for in-country capacity.

This model has performed adequately so far. However, with increased funds come increased requirements for ensuring they are properly accounted for and audited. It is clear that the current approach cannot continue to provide a sufficiently robust level of fiduciary oversight.

A number of possible methodologies are being explored that build on the strengths of the existing arrangements, while bolstering the necessary fiduciary accountability and reducing risk. Work is ongoing to finalise and implement this strengthened approach in 2008.

This challenge faces all our partners in the health and development field. The best way forward builds on comparative advantages, while working in harmony with other players to explore pooled mechanisms and coordination of oversight.





4

Add value



Add value

Strategic Goal: Increase and assess the added value of GAVI as a public-private global health partnership through improved efficiency, increased advocacy and continued innovation

The power of the public-private partnership continues to develop. Changes to GAVI governance are intended to strengthen and build on the advantages of its dual character: public sector expertise in health and development with the acumen of private individuals and organisations.

Increasing aid effectiveness underlies all GAVI policies and programmes. Evaluations confirm the added value of GAVI's work and provide lessons in improving impact.

Ongoing growth and self assessment are hallmarks of an innovative learning organisation. Development of new policies on gender, transparency and accountability, and evaluation is underway.

GAVI's added value as a public-private partnership

The GAVI partnership encompasses many different players. It is an outreach worker from a faith-based organisation biking cold boxes full of chilled vaccines to a remote village in Africa. An international banker holding a video conference on new ways to use capital markets to finance immunisation. A research scientist in a Brazilian vaccine development company working on a formulation that meets the needs of developing countries. A UNICEF social mobilisation expert working with a community nurse to teach mothers about the importance of vaccination at birth. It is top health and development experts gathered in Geneva to evaluate country funding proposals.

The partnership is all these and more. Developed country donors, recipient governments, research and technical institutes, civil society organisations, and vaccine industries partner with international organisations, private sector philanthropists and international financiers to find ways to fund and support immunisation in the world's poorest countries.

An added ingredient in 2007 has been a strengthening of engagement with civil society organisations. With their reach, experience and knowledge of delivering health and

immunisation services on the ground, they bring important resources and perspective to the Alliance and its work. Civil society organisations can also play a very productive role as watchdogs, helping to ensure that government and international actors are accountable to the people and communities they serve.

In bringing together the resources and skills of both public and private sectors, GAVI has developed innovative mechanisms and approaches to international health and development such as IFFIm, ADIPs and the pilot AMC. Some of these initiatives have, in turn, sparked the formation of other task-oriented partnerships.

Partners contribute to the Alliance through participation in strategy and policy-setting, advocacy, fund-raising, vaccine development and procurement, country support and immunisation delivery.

Independent board members also contribute their viewpoints, challenging expectations and the status quo. This dialogue sparks debate and innovation. New balances emerge from testing the boundaries.

Public-private partnering: enabling vaccines for infants in Indonesia



The Bio Farma plant in Bandung, Indonesia produces 1.5 million doses each year of hepatitis B vaccine in the Uniject autodisable injection device. The vaccine producer combines the Uniject syringes that come from Singapore with the hepatitis B vaccine from Korea.

With GAVI funding, Indonesia's immunisation programme includes the important birth dose of hepatitis B for all newborns. National demand for the vaccine is fully met by Bio Farma's supply. Bio Farma has the additional capacity to produce Uniject vaccines for export to international markets, including many other countries eligible for GAVI funding.

But behind the current operation lies a story of public and private partnership that stretches back 20 years. It began as an idea for a single

dose safe-injection syringe at the Seattle-based non-profit organisation, PATH. In collaboration with the United States Agency for International Development, WHO and others, the idea became reality as the Uniject device. It was licensed for production to BD, the largest syringe manufacturer in the world, under agreement that the Uniject device would be made available to vaccine and pharmaceutical producers, such as Bio Farma, at preferential prices for developing countries' immunisation programmes.

The Uniject device makes it easier and safer to reach newborns with the birth dose of hepatitis B vaccine, which is crucial because infants are more vulnerable to the virus and can be infected at birth by their mothers. The one-dose disposable syringe reduces the risk of transmission and is easier for health workers to use and to transport to remote or isolated children, and those born at home. It also reduces wastage of vaccines: too often any vaccine left over in an opened multi-dose vial is lost, even if only one or two children received a dose.

In Indonesia, the Uniject device, coupled with GAVI support of US\$ 17.5 million to support introduction of Uniject, has meant that many more infants are being immunised.

With a prevalence rate for hepatitis B in the Indonesian population at 5–10%, up to 450,000 children are at risk of infection. Now, with the Uniject syringe in use and secure funding in place, Indonesia estimates hepatitis B vaccine birth dose coverage has reached 42%, which is remarkable for a country with many logistical challenges regarding vaccine delivery.

Increasing aid effectiveness: a core GAVI value

The establishment of GAVI took place at the time when the Paris Declaration on Aid Effectiveness was also in development. Aid effectiveness is a core value and the Paris principles are fundamental tenets of GAVI's way of doing business.

Aid effectiveness is achieved through a combination of country ownership of immunisation programmes; multi-year support that is aligned with the duration of national health and immunisation plans; and secure long-term affordability of vaccines achieved by shaping markets and assuring supply. Additionally, contributions are increasingly reported transparently on national budgets and accounts.

GAVI's programme is focused squarely on results. Board reporting and programme planning are guided by WHO and UNICEF annual coverage data, which provide immunisation rates in GAVI countries for new and underused vaccines.

One way that GAVI explicitly manages for results is with incentives for achievement. The immunisation services support programme has demonstrated innovation by adopting a simple but effective idea: when a country succeeds in immunising more children than planned, it receives a reward which grows for each additional child immunised. In 2007 an external evaluation documented the success of this approach (see "performance-based funding: immunisation services support").

Policy and programme harmonisation with other organisations is ongoing through the Alliance and external bodies. For example, GAVI has worked with the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, the Fast-track Initiative for Education and other global programmes, to better harmonise approaches and further improve the system of monitoring aid effectiveness.

The Paris Declaration on Aid Effectiveness is grounded on five mutually reinforcing principles:

- **Ownership:** Partner countries exercise effective leadership over their development policies and strategies.
- **Alignment:** Donors base their overall support on partner countries' national development strategies, institutions, and procedures.
- **Harmonisation:** Donors coordinate their activities and minimise the cost of delivering aid.
- **Managing for results:** Partner countries and donors orient their activities to achieve the desired results.
- **Mutual accountability:** Donors and partners are accountable to each other for development results.

Civil society organisations: a vital role

CSOs range from large international humanitarian organisations to local faith-based charities relying on volunteers.

Whatever their size, they play an important role in supporting the achievement of the GAVI Alliance strategic goals and the Millennium Development Goals by:

- Reaching the hardest-to-reach populations that remain unimmunised including: the stigmatised and rejected, people in the most remote communities and areas, in fragile states and countries in crisis, and where government infrastructure is sub-optimal, for example, in urban informal settlements.
- Strengthening health systems to deliver vaccines and other child health packages to millions of children and families every year.
- Providing technical assistance to national immunisation and child health programmes, teaching and training health professionals.
- Providing community mobilisation and advocacy to influence decision-makers.
- Holding governments and international actors accountable to the communities they serve.

GAVI in the changing global health landscape

2007 saw important new leadership initiatives in the global health and development environment, in which the GAVI Alliance and its partners played a central role.

Clearly, health is now firmly at the centre of the international development landscape. It is now recognised that health is not just a consequence of economic development, but a critical contributor. Healthy populations are a cornerstone of economic development and help contribute to poverty alleviation. Sickness and poor health can drive families into poverty.

There is renewed focus and a collective commitment across a broad range of international actors to effect real, measurable change with a shared sense of urgency.

The GAVI Alliance welcomes these significant new global health opportunities and has been closely involved in the efforts to better weave together the threads of international health assistance.

The International Health Partnership, launched in September 2007, is supported by more than 20

developing and developed country governments as well as all of the major global health bodies. It aims to improve how all those involved work together to marshal resources and effort behind developing countries as they plan and implement ways to address their health system needs.

GAVI is working with WHO and the World Bank in the IHP's eight pilot countries. Six of these eight countries have already been approved for health system strengthening funding, and the other two are expected to apply in 2008.

Another significant development was Dr Margaret Chan's initiative (WHO Director-General and GAVI Alliance Board Chair) to bring together leaders from the eight main global health organisations including GAVI (H8) to enhance coordination, commitment and shared accountability for reaching the health Millennium Development Goals.

A number of donor countries have shown leadership through initiatives to catalyse efforts to reach the Millennium Development Goals. Norway, for example, has spearheaded the Global Campaign for the Health MDGs.

"As development partners, we must now mobilise behind this important new initiative to strengthen health systems, and build on the existing political will and coordination at the country level to help communities and their governments achieve long-term, sustained good health."

Joy Phumaphi, Vice President and Network Head, Human Development, World Bank, at the launch of the International Health Partnership, 2007

Developing policy

Important policy development is underway in three areas: gender equity, transparency and accountability, and evaluation.

Focusing on gender

Women's socioeconomic status is directly related to the health of their children. In reality, many women and girls are still denied adequate access to health care simply because they are female. There is a general, if misguided, assumption that girls are receiving health care in equal measure to boys.

Gender inequality must be measured and addressed in a meaningful way if equity in health and the MDGs is to be achieved. More needs to be known about how immunisation services in poor countries affect boys and girls so that the gender impact can be assessed and factored into programme planning and delivery.

In 2007, the GAVI Secretariat initiated work to develop a comprehensive gender policy and implementation strategy. Its aim is to incorporate the gender perspective in all

policies and programmes as well as in the Secretariat's work practices.

Increasing transparency and accountability

The transparency and accountability task team is working to develop guidelines for policy to ensure funds are spent in accordance with programme goals. A range of possible policy options are being explored and discussed which will ensure consistency with the principles of aid effectiveness.

Assessing impact, monitoring progress

Evaluation is an ongoing process for GAVI and part of being a learning organisation. Evaluations are currently underway of the first five years of GAVI's programmes, and of the sustainability of injection safety.

Evaluation methods for new programmes are being studied and improved, especially for the health system strengthening programme, the advance market commitment pilot and the civil society organisation initiative.



Evaluating effectiveness

The ability to learn and adjust, as well as the flexibility that comes from learning by doing, are important strengths. A commitment to ongoing evaluation of work and programmes gives insight into what works well, what can be improved, and what can be shared as a good practice.

During 2007, GAVI conducted important evaluations including the first five years of immunisation services support, the Accelerated Development and Introduction Plans (ADIPs) and the Hib Initiative.

ISS and its lessons for harmonised development assistance

Lessons learnt from the experience of five years of immunisation services support help build a case for flexible, harmonised development finance and for funding for health system strengthening.

The success of the ISS window demonstrates that flexible, integrated funding works when countries are expected to manage for results. The ISS evaluation also highlights the critical importance of coordinated donor support at the country level.

The success of ADIPs

Assessment of the PneumoADIP shows it has developed sound disease burden data, and has communicated that information effectively. The result is increased demand for the vaccines from developing countries, and emerging suppliers investing in significant new production capacity.

The pneumococcal vaccine will be available for these markets at least five years sooner than would otherwise be expected.

Two rotavirus vaccines are now authorised for marketing and have already begun to be introduced in a number of countries as a result of the RotaADIP. Evaluation confirmed that the ADIP has worked with existing and emerging manufacturers to ensure competition and supply.

Hib uptake

In terms of future vaccine introductions, the lessons for GAVI identified by the assessment of the Hib Initiative include the need to scan the pipeline for early development projects; address the issues of capacity, demand and pricing strategies that make a vaccine 'programme ready'; and address implementation issues for the vaccines in order to best manage the life-cycle of new vaccines under consideration.

Taking GAVI forward: governance changes

GAVI's governance reflects the strengths of public-private partnership. The mix of private sector unaffiliated individuals and representatives of partner organisations has been an important component of success.

The unique mix creates a dual character which combines the knowledge and business acumen of the private sector with the vision, expertise and reach of development organisations. Recognising and drawing on the mandates and responsibilities of all partners, the GAVI Alliance provides public and private finance and a broad diversity of perspectives, experience and skills. In setting policies and assessing country proposals, GAVI draws on scientific knowledge and technical expertise from the health, vaccine and science communities.

The public GAVI Alliance Board and private GAVI Fund Board, which have been meeting jointly since 2005, decided at their joint meeting in November 2007 to create a single public private board which brings the strengths and best qualities of private and public sectors into one new entity. It is a logical evolution that will streamline the operational structure while allowing GAVI to maintain presences in Geneva and Washington, DC.

The new Board will include two thirds representative seats – to engage the institutions and constituencies which have a stake in the Alliance – and one third unaffiliated individuals – to secure required expertise as well as a challenge function which can only come from independent voices.

The large board of 28 members (including the CEO) will be supported by a robust committee structure to ensure efficiency and appropriate oversight and decision-making.

This move is intended to bring greater efficiencies of operation, and reinforce the vital assets of the public-private mix. The new governance structure will bring together financial and programmatic decision-making and streamline accountabilities.

Though in many ways this is a momentous move and one of the greatest structural changes yet experienced in the Alliance, it is a natural evolution. It will not impact or alter GAVI's working relationship with developing country partners, donor partners or technical partners such as WHO or UNICEF. The Boards have been meeting jointly throughout 2007.

In 2007, the Boards reviewed a management study examining the organisation's administrative platform. The review took into account the need to move administrative services from UNICEF as well as changes to Swiss law that introduced a new regime for international institutions.

A new administrative identity along with a change-management plan will be designed through 2008 and come into effect in January 2009. The goal will be to ensure GAVI's identity and values are carried forward into the new administrative arrangements, with minimal disruption to relations with partners, stakeholders and staff. From 2009 the GAVI Alliance will have a legal identity as a Swiss Foundation.

Partnership: adding value to country reporting and applications

The combined efforts of all the parties involved in supporting country proposal preparation and reporting have brought tangible improvements.

One clear indicator of this change is the proportion of proposals for funding that pass strict scrutiny by the Independent Review Committee (IRC). In October 2007 the IRC recommended 85% of proposals for immunisation services and new and underused

vaccines support for Board approval. This compares with an approval rate of only 13% of the proposals reviewed in the May 2007 meeting.

According to the IRCs, the quality of the annual progress reports prepared by countries is improving, as is the quality of data supplied by countries.



VIEW POINT

The value of the Independent Review Committee

Dr Beena Varghese
Senior Health Economics Specialist
Public Health Institute of India

I've been part of the Independent Review Committee (IRC) since 2004. I've evaluated countries' annual progress reports, financial sustainability plans, and funding proposals for vaccine introduction and health system strengthening.

The IRCs meet several times a year in Geneva and bring together people with a wide variety of expertise – epidemiologists, health economists, public health experts – and from varied backgrounds and nationalities. It's fascinating to sit in a room with them all, and hear their different points of view.

As a result of the application and review process, the IRCs have contributed tremendously to building capacity in countries. We ask countries, for example, to think about the resources they will need for the introduction of a vaccine, where they will get the money from, what the funding gaps are, and how they will sustain it in the long term. Often they haven't thought about it in this detail, but following recommendations and comments of the IRC, they bring back improved proposals.

The financial sustainability plans, or FSPs, started off this process and now the costing of comprehensive multi-year plans have made this a more integrated process enabling better planning of the EPI programme. This has been a big contribution that WHO and GAVI have made at the country level.

We find, in fact, that often this planning process has not only triggered a wider understanding of economics, planning and costing for immunisation, but has also led to sustaining of programmes started through GAVI funds. A good example of this is the injection safety programme initiated through GAVI funds in many countries and which has now become part of many national EPI programmes.

We've also found that this process has strengthened the role of the country coordinating committees, because the IRCs insisted that they oversee the annual reports and immunisation services support funding. The committees are made up of representatives from all the donors and partners, headed by the national government. This has meant that everyone knows where the money is coming from, and where it is going. It has greatly increased aid harmonisation.

This has been a wonderful experience for all of us involved in the IRCs to actually see the change in quality of applications and annual progress reports, all pointing to increased capacity in countries. I hope that IRCs have contributed as much to country capacity and planning process as it has to my own learning and development.



Two decades of war in Afghanistan have taken their toll on the country, its people and their health. Life expectancy is a mere 44 years. WHO and UNICEF estimate that maternal mortality reached a staggering 1,600 deaths per 100,000 live births, with infant mortality at 165 deaths per 1,000 live births. One remote mountainous district had a maternal mortality rate of 6,500 deaths per 100,000 live births, the highest ever recorded anywhere.

Afghanistan's population is hard to reach at the best of times. Three quarters of its 25 million people are sparsely dispersed in rural settings across a vast and harsh landscape. It is a country divided by the high Hindu Kush mountain range, its snow-capped peaks rising in places

to over 7,000 metres and slashed through with deep valleys. By the end of the conflict in 2002, only 9% of the rural population had access to health services, leaving the rest with no access to health care at all.

Immunisation in these conditions has been very difficult. A survey of the 14 provinces with the lowest immunisation coverage revealed that efforts were hampered by difficult terrain, seasonal blockages of roads and the scattered nature of settlements that are hard to reach. Security has also been a major challenge in many places.

The Afghan Ministry of Public Health recognised that the limited and damaged health infrastructure couldn't guarantee even minimal health services. In 2003 the Government

undertook sweeping reforms with support from donors and health partners. They began by defining a Basic Package of Health Services (BPHS), focusing on the most critical and cost-effective services, including immunisation and reproductive and child health, and how best to deliver them.

The solution was to build on the aspects of the health infrastructure that were functioning well. Civil society organisations have played an active role in Afghanistan's health service delivery since the 1980s. Dr Abdul Wali is the Health System Strengthening Coordinator in the Ministry of Public Health, and endorses the important role of the CSOs in health service delivery. "They have a long history of involvement in public health, and they

Partnering with civil society organisations to deliver health care: the Afghanistan approach

Afghanistan

have proved to be particularly valuable in reaching marginalised populations and people in remote areas, and in community mobilisation. Through their work, millions of children have been immunised.”

At the district and local levels, for example, CSOs have been contracted to manage the vaccine cold chain. They are responsible for providing refresher training to health-care workers, and monitoring the quality of services such as fridge maintenance.

Dr Abdul Majeed Siddiqi is the head of mission for the non-profit organisation Health Net TPO in Afghanistan and Pakistan. He is also the elected interim Afghan representative for CSOs to GAVI. “Cold chain is of course a huge challenge,” says Dr Siddiqi. “Sometimes we carry vaccine by donkey and camel – whatever it takes.”

With their strong track-record in health and immunisation, the Government is collaborating with CSOs to deliver health services. In 31 of 34 provinces implementing the plan, the Ministry of Health has contracted CSOs to deliver it.

Results are already clearly evident. According to a 2006 Household Survey,

BPHS coverage has risen from 9% in 2002 to more than 80% in 2007. The same survey indicates that infant mortality has dropped to 129 per 1,000 live births translating into 80,000 fewer infant deaths per year.

In addition to ongoing GAVI support for immunisation services, injection safety and new vaccine, the Afghanistan Government was awarded US\$ 34.1 million for health system strengthening in 2007. In its application, Afghanistan proposed to strengthen service delivery through this existing public-private partnership.

Nearly 70% of planned activities will be contracted out to CSOs, including establishment of mobile health teams and health sub-centres to improve access to quality health services and to overcome physical barriers. Efforts will focus on training health workers as well as educating the population about immunisation and maternal and child health (MCH) in order to increase demand for vaccines and MCH services.

Different CSOs or consortiums of CSOs will be directly responsible for implementation, with oversight handled by the Consultative Group on Health and Nutrition. The Group is made

up of senior ministry officials, donor and United Nations agencies and representatives of the CSOs.

Dr Wali says the changes in health care in his country are striking with this new system and thanks to partners’ support. “The partners bring different resources” he says. “Our model is that the Ministry plays the stewardship role, the partners contribute according to our mutual agreements, and a third party evaluates. This has really helped, not only to bring services to people, but also to feed information from communities back to the Ministry so we can make better plans for the future.”

Dr. Siddiqi agrees. “Before we had no system, no structure, no facilities. Now nearly all the population has health care, there are more qualified people, and the system is more effective. For example, I was at a meeting in the Ministry of Health, and we discussed an outbreak of disease in a remote province, and we were able to respond within 10 days. Before, we would take one month to find out about the outbreak, one month to verify, and to get the people and materials together and travel there. By the time you arrive, there is no longer any outbreak!”



FACT FILE

- Total population:** 25,067,000³⁵
- Surviving infants:** 1,068,000³⁵
- Infant Mortality Rate:** 157*/129***** per 1,000 live births³⁵
- Under-five mortality:** 235*/191***** per 1,000 live births³⁵
- Per capita Gross National Income:** n/a³⁶
- Government expenditure on health /person:** US\$ 2.3³⁹
- Health worker density:** 0.45 per 1,000 population³⁸
- DTP3 coverage:** 77%³⁷
- Percentage of districts with more than 80% DTP3 coverage:** 44%³⁷
- GAVI funding disbursed by type of support (US\$):** 26,189,589
- New and underused vaccines support (NVS):** 10,093,289
- Immunisation services support (ISS):** 7,719,800
- Injection safety support (INS):** 1,676,500
- Health system strengthening support (HSS):** 6,700,000

annexes



Annex 1: Governance structure and membership

The GAVI Alliance consists of five separate entities. Each plays a specific and unique role.

- The GAVI Alliance
- The GAVI Fund
- The International Finance Facility for Immunisation
- The GAVI Fund Affiliate
- The GAVI Foundation

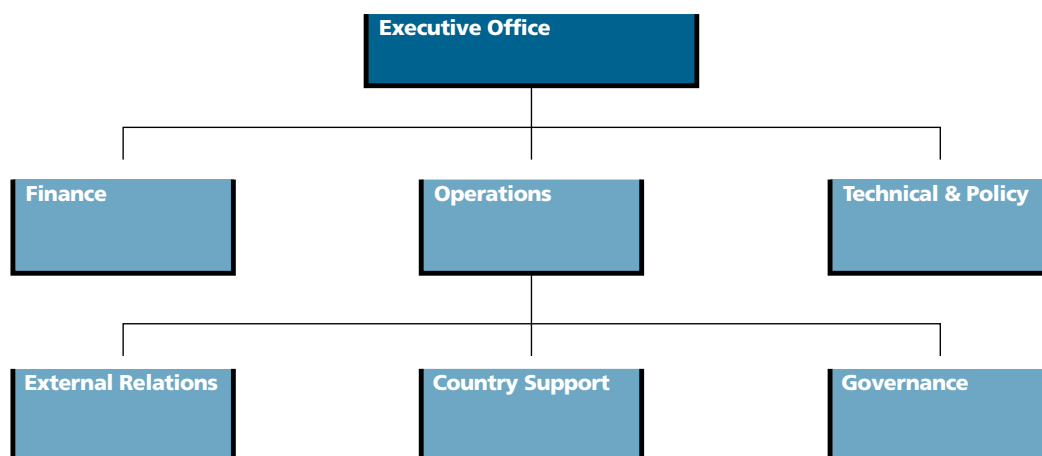
In addition, a number of committees, working groups and task teams support the work of these entities.

The GAVI Alliance

The Alliance is an unincorporated public-private partnership launched in 2000. It comprises partners including UNICEF, WHO, the Bill & Melinda Gates Foundation, the World Bank, developing country governments, donor country governments, the vaccine industry, civil

society organisations, and research and technical health institutes. A secretariat, based in Geneva and Washington DC, coordinates Alliance activities including policy development and support to countries.

GAVI Secretariat Organisation Chart



The GAVI Alliance Board

governs policy development and implementation, and monitors and oversees all programme areas. The Board includes four renewable members: UNICEF, WHO, the Bill & Melinda Gates Foundation, and the World Bank. In addition, there are 12 rotating

seats: four for developing country governments, four for donor country governments, and one each for research and technical health institutes, industrialised country vaccine industry, developing country vaccine industry, and civil society organisations.

The GAVI Fund

The GAVI Fund is a not-for-profit organisation based in the United States of America, created to be the financing arm of the Alliance. The Fund coordinates the finance of Alliance activities from a variety of sources as well as providing certain fiduciary activities including budget oversight, internal control, accounting, reporting, auditing and investment management.

The GAVI Fund Board

shapes the Alliance financial strategy to support implementation of the GAVI Strategic Plan as developed by the GAVI Alliance Board. In this capacity, the Fund Board monitors GAVI income received from multiple sources, validates budgets, certifies availability of funding, and determines funding sources for programmes. In addition, the Board monitors investments and asset liabilities to ensure financing is available as needed. The Board also provides strategic guidance and support to the US-based private fund-raising work of the Alliance.

The GAVI Fund Affiliate

The GAVI Fund Affiliate was established to enter into pledge agreements with IFFIm donors and assign these pledges to the IFFIm Company for eventual programme disbursement. The GAVI Fund Affiliate is registered in England and Wales as a company limited by guarantee.

GAVI Fund Affiliate Board

is comprised of experts in global health, investment, auditing and accounting. The Board reviews and approves programme funding requests, and makes subsequent requests for funding to the IFFIm.

International Finance Facility for Immunisation (IFFIm)

The International Finance Facility for Immunisation (IFFIm) is a multilateral development institution established as a charity with the Charity Commission for England and Wales. IFFIm has been designed to accelerate the availability of funds to be used for health and immunisation programmes through the GAVI Alliance by “frontloading” donors’ pledges through the sale of AAA-rated bonds.

The IFFIm Board

is composed of independent directors with expertise in the areas of finance, investment, international law, global health and development. The Board oversees each bond issuance and develops funding, liquidity and other operating strategies to safeguard and maximise the value of IFFIm proceeds. The Board also reviews and approves requests for IFFIm funds to be used for Alliance programmes.

The GAVI Foundation

The GAVI Foundation is a Swiss foundation registered in the Geneva Register of Commerce. The Foundation’s charitable mission involves providing support for GAVI Alliance programmes and the GAVI Secretariat in Geneva.

The GAVI Foundation Board

ensures that the Foundation complies with Swiss law and maintains its charitable status.

**GAVI Alliance Board
(as at 31 December 2007)**

Renewable members

Dr Margaret Chan **(Chair)**
Director-General
World Health Organization

Ms Daisy Mafubelu
Assistant Director-General
Family and Community Health
World Health Organization

Mr Saad Houry
Deputy Executive Director
UNICEF

Ms Joy Phumaphi
Vice President and Network Head
Human Development
World Bank Group

Dr Jaime Sepulveda
Director
Integrated Health Solutions Development
Bill & Melinda Gates Foundation

Developing country governments

Prof. Eng Huot
Secretary of State for Health
Cambodia

Dr Tedros Ghebreyesus
Minister of Health
Ethiopia

Major (Rtd) Courage Emmanuel Kobla
Quashigah
Minister of Health
Ghana

Dr Tatul Hakobyan
Deputy Minister of Health
Armenia

Industrialised country governments

Dr Kent R. Hill
Assistant Administrator of the Bureau
for Global Health
US Agency for International Development
(USAID)
United States of America

Mr Gavin McGillivray
Head, Global Funds & Development
Finance Institutions Department
Department for International Development
(DFID)
United Kingdom

Prof. Alberto Mantovani
School of Medicine
University of Milan & Scientific Director
Istituto Clinico Humanitas
Italy

Dr Gustavo Gonzalez Canali
Special Health Adviser
Department for Development Policies (DPDEV)
Ministry of Foreign Affairs
France

Mrs Yoka Brandt
Deputy Director-General for International
Cooperation
Ministry of Foreign Affairs
The Netherlands

Research and technical health institutes

Dr John Clemens
Director-General
International Vaccine Institute

Industrialised country vaccine industry

Ms Margie McGlynn
President
Merck Vaccines

Developing country vaccine industry

Dr Akira Homma
Director
Bio-Manguinhos/Fiocruz

Civil society organisation

Dr Jane Schaller
Executive Director
International Pediatric Association (IPA)

GAVI Fund Board

Mrs Graça Machel **(Chair)**
President
Foundation for Community Development

Mr Nelson Mandela **(Chair Emeritus)**
Former President of South Africa and
Founder of the Nelson Mandela Foundation

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Annex 2: Donor contributions and commitments

The following national governments and institutions have made direct contributions to the GAVI Alliance and/or commitments to the International Finance Facility for Immunisation (IFFIm).

* Sums are approximate as changes may occur from year to year due to fluctuations in exchange rates.

Australia	<p>US\$ 20.00 million over 4 years In 2006 Australia made its first contribution of US\$ 5.00 million to the GAVI Alliance, pledging to provide annual grants of US\$ 5.00 million to the end of 2009.</p>
Brazil	<p>US\$ 20.00 million to IFFIm over 20 years In March 2006, Brazil announced its intention to join IFFIm with a commitment of US\$ 20.00 million over 20 years. Formalisation of this commitment is pending.</p>
Canada	<p>US\$ 148.73 million over 5 years Canada made its first contribution to the Alliance in 2002, with a donation of US\$ 1.88 million, and by the end of 2007 had contributed US\$ 148.73 million.</p>
Denmark	<p>US\$ 36 million over 11 years One of GAVI's original six donors, with a contribution of US\$ 1.15 million in 2001, Denmark committed a total of US\$ 17 million by end 2007, with an additional commitment to provide US\$ 4.7 million annually to the end of 2011.</p>
European Commission	<p>€ 43.00 million over 6 years Since 2003, the European Commission has committed a total of up to € 43.00 million spanning a period of 6 years. € 23.00 million has come from the Development Co-operation Instrument (DCI), and € 20.00 million from the intra African Caribbean and Pacific countries envelope in the ninth European Development Fund for the benefit of African Caribbean and Pacific countries.</p>
France	<p>€ 15 million over 3 years France made a three-year commitment to GAVI in 2003 of € 5 million per year for the next 3 years, bringing France's direct government contribution total to US\$ 18.66 million by 2006.</p> <p>€ 1.24 billion to IFFIm over 20 years In 2006, France made an initial commitment to IFFIm of € 372.80 million over 20 years in 2006. An additional pledge in 2007 for 19 years brings France's total commitment to IFFIm to € 1.24 billion.</p>
Germany	<p>€ 8.00 million over 2 years Germany made its first contribution to GAVI at the end of 2006 of € 4.00 million and another € 4.00 million at the end of 2007. Germany is preparing for this pledge to be renewed until the end of 2012.</p>
Ireland	<p>US\$ 18.83 million over 7 years Ireland made its first contribution in 2002 of US\$ 0.51 million. Additional contributions bring the total to US\$ 18.83 million by end 2007. Ireland's commitment for 2008 is € 6 million, this is the last tranche of a 3-year grant that began in 2006.</p>
Italy	<p>€ 473.45 million to IFFIm over 20 years In 2005, the Italian Government committed € 473.45 million to IFFIm over 20 years..</p>
Luxembourg	<p>€ 3.1 million over 5 years Luxembourg has supported GAVI since 2004, starting with a € 0.5 million contribution. In 2008, Luxembourg will increase its support to € 0.9 million, bringing total contributions over 5 years to € 3.1 million.</p>
The Netherlands	<p>€ 156 million over 10 years As one of GAVI's original six donors, the Dutch government began contributing to GAVI in 2001 with annual payments of approximately \$17 million per year. In 2007, the Netherlands increased its support with a new 4-year commitment of € 100 million or € 25 million annually.</p>
Norway	<p>US\$ 1.00 billion to GAVI over 15 years One of GAVI's original six donors, Norway initially gave US\$ 17.89 million in 2001 with a total contribution of US\$ 291.89 million up to 2007. In addition, Norway made a pledge in 2005 to provide NOK 500 million a year over 10 years which would bring the total support from Norway to US\$ 1.00 billion to the end of 2015.</p> <p>US\$ 27.00 million to IFFIm over 5 years Norway committed US\$ 27.00 million to IFFIm over 5 years.</p>
South Africa	<p>US\$ 20.00 million to IFFIm over 20 years South Africa is the most recent country to join the IFFIm donor group (March 2007) committing US\$ 20.00 million over 20 years.</p>

Spain	<p>€ 189.50 million to IFFIm over 20 years Spain became a donor to IFFIm in 2006 with a commitment of € 189.50 million over 20 years.</p>
Sweden	<p>US\$ 53.1 million to GAVI over 7 years One of the Alliance's original six donors, Sweden initially contributed US\$ 1.89 million in 2001 and substantially increased funding to a total of US\$ 53.1 million to the end of 2007.</p> <p>SEK 276.15 million to IFFIm over 15 years Sweden also committed funds to IFFIm with a total of SEK 276.15 million to be paid over 15 years.</p>
United Kingdom	<p>US\$ 121.56 million over 9 years One of GAVI's original six donors, with a contribution of US\$ 4.46 million in 1999, the United Kingdom has committed US\$ 121.56 million between 1999 and 2008.</p> <p>£ 1.38 billion to IFFIm over 20 years The United Kingdom has committed a total of £ 1.38 billion to IFFIm over 20 years.</p>
United States	<p>US\$ 421.81 million over 7 years One of GAVI's original six donors, with a contribution of US\$ 48.09 million in 2001, the United States has increased its annual contributions resulting in a total of US\$ 421.81 million over 7 years.</p>

Private donors

The Bill & Melinda Gates Foundation	<p>US\$ 1.51 billion over 15 years The Bill & Melinda Gates Foundation is a founding partner of the GAVI Alliance. Its initial 5-year grant in 1999 helped establish the GAVI Fund. The Foundation pledged a further US\$ 750 million in 2005 to support GAVI's work, committing a total of US\$ 1.51 billion to the end of 2014.</p>
Other private donations	<p>US\$ 8.03 million over 8 years Philanthropists, foundations and individual donors have contributed US\$ 8.03 million to the GAVI Alliance between 1999 and 2007.</p>

Advance Market Commitment

Italy	US\$ 635 million
United Kingdom	US\$ 485 million
Canada	US\$ 200 million
Russian Federation	US\$ 80 million
The Bill & Melinda Gates Foundation	US\$ 50 million
Norway	US\$ 50 million

Annex 3: GAVI use of IFFIm funds, 2007

New and underused vaccines support

Country	Programme	Total (US\$)	Number of			Safety boxes
			Doses	Autodisable syringes	Reconstitution syringes	
Comoros	DTP-HepB	33,761.00	41,700	24,800	–	275
Afghanistan	DTP-HepB 10ds	3,988,741.00	4,028,000	6,743,400	–	74,850
Cambodia	DTP-HepB 10ds	1,269,397.00	1,574,500	1,007,400	–	11,200
Cameroon	DTP-HepB 10ds	1,602,197.00	1,988,500	340,600	–	3,800
Congo	DTP-HepB 10ds	332,162.00	361,100	642,700	–	7,150
Congo DRC	DTP-HepB 10ds	4,409,197.00	5,177,000	4,899,700	–	54,375
Lao PDR	DTP-HepB 10ds	218,490.00	280,000	21,100	–	250
Madagascar	DTP-HepB 10ds	906,573.00	1,102,000	759,500	–	–
Pakistan	DTP-HepB 10ds	28,852,142.00	22,619,000	10,367,300	–	115,075
Tanzania	DTP-HepB 10ds	1,516,120.00	1,239,800	650,700	–	7,225
Guinea Bissau	DTP-HepB+Hib	335,086.00	84,700	184,400	–	2,050
Sri Lanka	DTP-HepB+Hib	3,353,731.00	870,800	–	–	–
Benin	DTP-HepB+Hib 2ds	4,387,764.00	1,205,600	1,206,000	669,200	20,825
Burkina Faso	DTP-HepB+Hib 2ds	9,349,032.00	2,372,600	2,223,300	–	24,700
Djibouti	DTP-HepB+Hib 2ds	162,364.49	44,400	45,400	24,700	800
Ethiopia	DTP-HepB+Hib 2ds	30,344,280.00	8,042,200	4,591,500	–	50,975
Ghana	DTP-HepB+Hib 2ds	8,899,466.00	2,444,800	2,535,800	1,356,900	43,200
Kenya	DTP-HepB+Hib 2ds	13,277,307.00	3,638,200	4,036,700	2,227,100	69,550
Malawi	DTP-HepB+Hib 2ds	6,222,280.00	1,714,000	1,560,200	892,800	27,225
Mali	DTP-HepB+Hib 2ds	5,319,160.00	1,452,400	1,778,000	981,300	30,650
Mongolia	DTP-HepB+Hib 2ds	313,013.68	83,600	168,100	92,800	2,900
Senegal	DTP-HepB+Hib 2ds	5,271,154.00	1,411,600	–	–	–
Sierra Leone	DTP-HepB+Hib 2ds	2,542,353.00	667,400	357,600	–	3,975
Yemen	DTP-HepB+Hib 2ds	1,787,985.00	453,800	1,836,500	1,007,400	31,575
Zambia	DTP-HepB+Hib 2ds	2,160,405.00	553,000	–	–	–
Papua New Guinea	DTP-Hib 10ds liquid	2,527,939.00	710,600	854,800	–	9,525
Azerbaijan	HepB 10ds	172.85	–	–	–	–
Guinea	HepB 10ds	149,618.00	527,000	480,300	–	5,350
India	HepB 10ds	6,301,325.00	29,239,200	–	–	–
Mali	HepB 10ds	16,463.00	60,400	41,900	–	475
Sri Lanka	HepB 10ds	302,245.00	1,030,600	977,300	–	10,850
Uzbekistan	HepB 10ds	230,754.00	789,600	738,900	–	8,200
Azerbaijan	HepB 2ds	–	65,000	68,800	–	775
Lao PDR	HepB 2ds	13,746.00	39,800	29,600	–	350
Sri Lanka	HepB 2ds	111,159.00	336,000	338,900	–	3,775
Benin	YF 10ds	136,373.90	137,500	65,200	15,300	900
Cameroon	YF 10ds	551,126.00	634,700	109,000	15,200	1,400
CAR	YF 10ds	86,898.00	95,900	48,700	6,200	625
Chad	YF 10ds	248,745.00	253,500	295,900	41,500	3,775
Congo	YF 10ds	101,652.00	97,900	178,500	21,900	2,250
Togo	YF 10ds	31,968.00	18,700	186,200	239,100	13,250
Congo DRC	YF 5ds	2,662,611.00	3,192,000	1,886,000	523,400	26,775
Ghana	YF 5ds	600,815.00	735,900	651,300	163,400	9,050
Guinea	YF 5ds	104,245.97	166,400	161,500	37,000	2,225
Mali	YF 5ds	226,103.00	294,500	210,200	71,800	3,125
Subtotal⁽ⁱ⁾		101,651,572.89	101,875,900	53,303,700	8,387,000	685,300

(i) Please note that this includes use of funds for pentavalent vaccine amounting to US\$ 49,606,548

Injection safety support

Country	Total (US\$)	Number of			Safety boxes
		BCG syringes	Autodisable syringes	Reconstitution syringes	
Benin ⁽ⁱⁱ⁾	(17,130.39)	–	–	–	–
Côte d'Ivoire	233,309.00	391,600	2,308,000	393,800	47,725
Madagascar	289,481.00	480,600	2,689,600	354,600	48,450
Malawi	213,189.85	797,800	1,825,600	264,000	32,075
Mongolia	297.60	–	–	–	–
Subtotal	719,147.06	1,670,000	6,823,200	1,012,400	128,250

(ii) Adjustment made by UNICEF to reflect a previous year's purchase.

Immunisation services support

Country	Total (US\$)
Afghanistan	2,850,620.00
Azerbaijan	118,000.00
Benin	91,250.00
Bolivia	71,875.00
Burkina Faso	1,312,500.00
Cameroon	479,000.00
Chad	1,284,000.00
Djibouti	100,000.00
Gambia	91,500.00
Ghana	355,000.00
Guinea	398,500.00
Honduras	46,500.00
Kenya	448,500.00
Madagascar	449,500.00
Malawi	992,000.00
Pakistan	3,000,000.00
Papua New Guinea	217,000.00
Sri Lanka	100,000.00
Tanzania	1,184,380.00
Togo	405,500.00
Subtotal	13,995,625.00

Health system strengthening support

Country	Total (US\$)
Afghanistan	6,700,000.00
Cambodia	1,850,000.00
Cameroon	1,858,000.00
Ethiopia	68,840,803.00
Georgia	69,000.00
Kyrgyzstan	424,000.00
Rwanda	2,174,000.00
Vietnam	3,648,000.00
Yemen	376,000.00
Zambia	2,344,500.00
Subtotal	88,284,303.00

Investment cases

Programme	Total (US\$)
Yellow Fever Initiative	48,266,322.00
Maternal and Neonatal Tetanus Elimination Initiative	49,990,083.00
Global Polio Eradication Initiative	191,280,000.00
Measles Initiative	139,000,000.00
Subtotal	428,536,405.00

Grand total (US\$) **633,187,052.95**

Annex 4: Cumulative approved support to countries, 2000–2007

as at 31 December 2007

	Country	New and underused vaccines	Injection safety	Immunisation services	Health system strengthening	Total (US\$)
1	Afghanistan	8,803,495	1,676,500	10,397,300	6,700,000	27,577,295
2	Albania	601,000	101,000	–	–	702,000
3	Angola	15,034,501	1,476,000	4,584,500	–	21,095,001
4	Armenia	567,912	57,000	79,860	–	704,772
5	Azerbaijan	1,080,289	154,000	749,380	–	1,983,669
6	Bangladesh	20,828,135	8,117,000	21,898,700	–	50,843,835
7	Benin	16,709,220	418,896	91,250	–	17,219,366
8	Bhutan	572,800	25,500	–	–	598,300
9	Bolivia	–	873,500	71,875	–	945,375
10	Bosnia & Herzegovina	768,843	48,291	–	–	817,134
11	Burkina Faso	17,612,044	947,400	5,764,140	–	24,323,584
12	Burundi	17,167,521	420,000	2,043,000	2,704,000	22,334,521
13	Cambodia	7,236,565	688,100	1,337,200	1,850,000	11,111,865
14	Cameroon	12,154,068	1,029,300	5,969,120	1,858,000	21,010,488
15	Central African Republic	580,017	140,900	1,611,360	–	2,332,277
16	Chad	948,038	413,500	2,637,000	–	3,998,538
17	China	22,753,235	15,925,729	–	–	38,678,964
18	Comoros	361,028	33,000	60,000	–	454,028
19	Congo	1,357,849	263,500	1,120,000	–	2,741,349
20	Côte d'Ivoire	12,559,148	–	3,223,000	–	15,782,148
21	Cuba	–	272,000	–	–	272,000
22	Democratic Republic of the Congo	23,611,417	3,258,400	21,931,280	21,526,000	70,327,097
23	Democratic People's Republic of Korea	5,103,410	798,800	1,681,300	450,500	8,034,010
24	Djibouti	262,827	33,900	112,800	–	409,527
25	Eritrea	2,603,708	144,500	436,540	–	3,184,748
26	Ethiopia	72,952,264	3,287,800	15,818,820	68,840,803	160,899,687
27	Gambia	4,444,315	126,500	457,800	–	5,028,615
28	Georgia	750,143	65,600	135,500	69,000	1,020,243
29	Ghana	43,926,269	855,300	3,676,300	–	48,457,869
30	Guinea-Bissau	200,000	113,000	405,860	–	718,860
31	Guinée	1,780,654	650,500	2,918,900	–	5,350,054
32	Guyana	1,044,600	–	15,000	–	1,059,600
33	Haiti	–	397,500	1,256,000	–	1,653,500
34	Honduras	–	457,000	46,500	–	503,500
35	India	33,126,500	25,929,319	–	–	59,055,819
36	Indonesia	16,029,000	11,227,000	12,636,000	–	39,892,000
37	Kenya	82,177,233	1,245,000	4,217,180	3,741,500	91,380,913
38	Kyrgyzstan	1,607,754	178,000	68,000	424,000	2,277,754
39	Lao People's Democratic Republic	3,682,548	258,000	1,431,200	–	5,371,748
40	Lesotho	385,264	110,500	199,100	–	694,864
41	Liberia	736,981	172,500	2,054,500	1,022,500	3,986,481
42	Madagascar	15,629,420	524,754	3,243,500	–	19,397,674
43	Malawi	48,790,597	552,605	993,000	–	50,336,202
44	Mali	13,838,719	710,600	5,376,560	–	19,925,879

Continued

Country	New and underused vaccines	Injection safety	Immunisation services	Health system strengthening	Total (US\$)
45 Mauritania	614,690	210,100	992,000	–	1,816,790
46 Mongolia	1,252,710	107,691	15,250	–	1,375,651
47 Mozambique	19,029,500	892,800	924,000	–	20,846,300
48 Myanmar	14,098,500	3,100,300	4,598,080	–	21,796,880
49 Nepal	13,956,243	1,287,800	3,312,520	–	18,556,563
50 Nicaragua	–	462,500	–	–	462,500
51 Niger	–	1,025,500	9,041,600	–	10,067,100
52 Nigeria	13,540,125	–	47,324,000	–	60,864,125
53 Pakistan	67,270,772	9,075,500	35,596,740	–	111,943,012
54 Papua New Guinea	1,615,197	–	434,000	–	2,049,197
55 Republic of Moldova	499,847	88,000	–	–	587,847
56 Rwanda	23,634,788	369,500	2,863,700	2,174,000	29,041,988
57 São Tomé et Príncipe	168,384	21,002	60,000	–	249,386
58 Senegal	13,357,633	783,500	2,605,740	–	16,746,873
59 Sierra Leone	3,465,900	339,500	1,964,440	–	5,769,840
60 Somalia	–	311,100	1,218,000	–	1,529,100
61 Sri Lanka	2,679,504	841,800	–	–	3,521,304
62 Sudan	3,538,142	1,987,900	6,562,725	–	12,088,767
63 Tajikistan	1,558,888	347,093	1,042,000	–	2,947,981
64 Togo	649,276	379,100	2,153,400	–	3,181,776
65 Turkmenistan	1,083,000	155,500	–	–	1,238,500
66 Uganda	76,282,137	1,385,000	9,230,520	–	86,897,657
67 Ukraine	3,003,854	792,000	–	–	3,795,854
68 United Republic of Tanzania	27,024,250	1,494,600	7,990,880	–	36,509,730
69 Uzbekistan	4,575,547	853,300	–	–	5,428,847
70 Viet Nam	13,001,944	3,226,000	510,750	3,648,000	20,386,694
71 Yemen	23,843,501	1,199,400	3,440,500	376,000	28,859,401
72 Zambia	28,909,556	771,000	3,864,060	2,344,500	35,889,116
73 Zimbabwe	100,000	1,080,000	1,274,000	–	2,454,000
Grand total (US\$)	889,133,219	116,765,680	287,768,230	117,728,803	1,411,395,932

Source: 42

Annex 5: sources and references

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1. Source: WHO-UNICEF coverage estimates for 1980–2006, as at August 2007; WHO-ICE T coverage projections for 2007–2008, as at November 2007. Note: Numbers of future deaths prevented among children reached during this period through support provided in full or in part by the GAVI Alliance
2. GAVI Alliance Secretariat, 2008
3. UNICEF Supply Division, 2008

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4. GAVI Alliance Secretariat, 2008.
5. GAVI Alliance Secretariat, 2008
6. GAVI Fund, 2008
7. GAVI Fund, 2008

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12. Source: Lewis R, et al, Action for child survival: Elimination of meningitis due to *Haemophilus influenzae* type b following introduction of Hib vaccine in Uganda, WHO Bulletin, April 2008

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13. UNICEF Supply Division, 2008

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14. UNICEF Supply Division, 2008

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15. World Population Prospects: The 2006 Revision, United Nations, 2007
16. World Development Indicators 2007 database (World Bank)
17. WHO/UNICEF vaccination coverage estimates for 2006 as of August 2007. Data provided by Member States through WHO-UNICEF Joint Reporting Form on Immunization and WHO Regional Offices
18. Calculation based on data from World Health Report 2006 (WHO)
19. World Health Report 2007 (WHO). International dollar rate (actual spending adjusted for purchasing power parity)

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20. GAVI Alliance Secretariat, 2008

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21. A Review to Identify the Role of Civil Society Organizations In Immunization, Prepared for the GAVI Secretariat and the GAVI CS Task Team, Allan G. Bass, May 2006

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24. WHO/UNICEF vaccination coverage estimates for 2006 as of August 2007. Data provided by Member States through WHO-UNICEF Joint Reporting Form on Immunization and WHO Regional Offices
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Back cover (left to right)

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GAVI/Mithra Weerakone

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Annex 7: Abbreviations/commonly used terms

ADIP	accelerated development and introduction plans
AD syringes	autodisable syringes
AMC	advance market commitment
cMYP	comprehensive multi-year plan for immunisation
CSO	civil society organisation
EPI	Expanded Programme on Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIVS	Global Immunization Vision and Strategy
Hib	<i>Haemophilus influenzae</i> type b
Hep B	Hepatitis B
HSS	health system strengthening
IFFIm	International Finance Facility for Immunisation
INS	injection safety support
IRC	Independent Review Committee
ISS	immunisation services support
MDGs	Millennium Development Goals
NVS	new and underused vaccine support
OECD/DAC	Organisation for Economic Co-operation and Development/Development Assistance Committee of the OECD
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

NOTE

The 2007 GAVI audited, consolidated accounts will be available on the GAVI website on or before September 30, 2008:

www.gavialliance.org

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