GAVI ALLIANCE | 10 YEARS OF SAVING LIVES

Financing Country Demand

for accelerated access
to new and underused vaccines
2010-2015

High-Level Meeting on Financing Country Demand

The Hague
March 25-26, 2010

Financing Country Demand

FOR ACCELERATED ACCESS
TO NEW AND UNDERUSED VACCINES

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CONTENTS

1. Executive summary

- Over the last 10 years, the GAVI Alliance (GAVI) has accelerated access to new and underused vaccines in developing countries, providing funding to immunise more than 250 million children against life-threatening diseases and preventing 5.4 million future deaths. This success demonstrates the effectiveness of the GAVI public-private partnership model, and illustrates the power of immunisation as a highly cost-effective life-saving public health intervention to meet the Millennium Development Goals (MDGs).

- In 2010-2015, the GAVI Alliance plans to introduce pneumococcal and rotavirus vaccines against the top two vaccine-preventable causes of child mortality: pneumonia and diarrhoea (together, they account for 40% of deaths under five), and the advancement of other vaccines prioritised by the GAVI Board: human papillomavirus (HPV), Japanese encephalitis, meningitis serogroup A, rubella, typhoid and yellow fever. While accelerating progress on the MDGs, this would avert another 4.2 million future deaths.

- Rigorous country demand estimates provided the basis of expenditure projections that defined cash inflow requirements. Those demand estimates reflect GAVI's progressive refocus from 72 countries to the 58 poorest countries, which encompass almost 80% of the world's extreme poor (i.e. those living on less than US$ 1.25 a day) and 81% of the world's unimmunised children.

- **The total cash inflow requirement for the period 2010-2015 amounts to US$ 7 billion, close to 40% of which will be disbursed in the first three years with the remaining 60% disbursed in the last three years.**

- **With almost 40% of this total cash inflow requirement of US$ 7 billion already contractually secured, additional contributions of US$ 4.3 billion are required.**

- Of the total US$ 4.3 billion in additional contributions required US$ 1.1 billion cash inflows would be needed in 2010-2012 and US$ 3.2 billion in 2013-2015. However, GAVI commitments to countries being through multi-year programmes, programmatic activity will be significantly slowed and hindered should this funding come in the form of annual, ad hoc contributions rather than as more predictable long-term funding.

- Current levels of annual direct contributions, if sustained, would provide US$ 1.7 billion of the US$ 4.3 billion, which would finance current programmes and their extensions but would not be sufficient to advance the programmatic agenda.

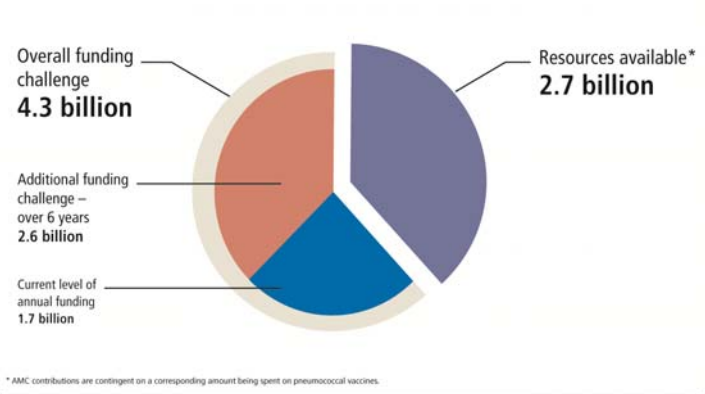
- An additional US$ 2.6 billion in direct contributions or IFFIm proceeds will be required, rising from US$ 300 million per year in 2012 to US$ 800 million a year for the period 2013-2015. The ability to foresee the anticipated contributions with multi-year firm pledges or contractual arrangements will be essential for the Board to make long-term commitments to country programmes.

- Vaccine costs amount to 80% of expenditures. Therefore vaccine price trends were carefully reviewed and assumptions were made on credible future price points for the vaccines. The proposed budget is net of anticipated vaccine cost savings of US$ 1 billion. GAVI's ability to deliver these savings will be dependent on donors' ability to signal long-term financing, key to enabling vaccine manufacturers to offer lower prices.

- In the outer years, a variety of new, innovative financing mechanisms and rising support from the private sector should become more prominent components of the GAVI Alliance's diversified financing strategy. However, these new strategies will require time to be deployed and will likely only marginally impact the 2010-2015 financing framework of the Alliance.

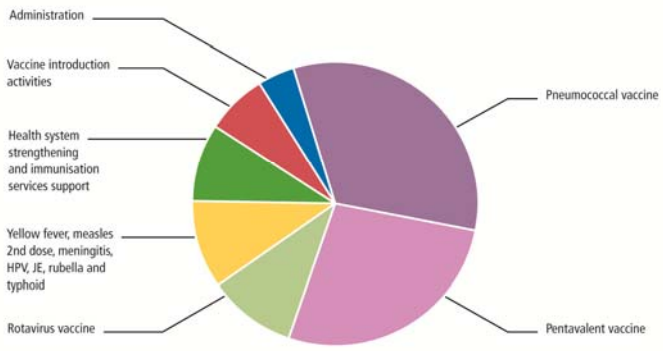
- Direct contributions from donors, contributions through mechanisms like the International Finance Facility for Immunisation (IFFIm), and new donations from a broad range of G20 countries will be critical to meeting the US$ 4.3 billion challenge and to delivering on the Millennium Development Goals while closing the immunisation gap.

2010 – 2015 Financing requirements (US$)



* AMC contributions are contingent on a corresponding amount being spent on pneumococcal vaccines.

2010 – 2015 Expenditure outflows (%)



2. Introduction

This paper outlines the anticipated country demand that GAVI will be asked to finance over the six years from 2010 through 2015, explores cost drivers, describes the public health impact of these investments, and considers how that demand may be financed.

It is intended to provide GAVI Alliance donors, potential donors, GAVI Alliance Board members and other stakeholders with an understanding of the extent of financial resources that would be required to maintain and expand the reach of GAVI-funded immunisation to those whose lives depend upon it.

The projections provided in this paper are indicative of expected country demand. The estimates for the individual items that comprise total demand (as detailed in Annex 1) may change as new information becomes available and as decisions are made by the GAVI Alliance Board, and should not be viewed as anticipating or constraining such decisions in any respect.

3. Country demand and cost drivers

In 2010-2015, the GAVI Alliance remains focused on catalysing the adoption of new, life-saving vaccines and influencing vaccine markets to benefit poor countries.

In this period, the GAVI Alliance will roll out pneumococcal and rotavirus vaccines and advance the vaccine investment strategy around vaccines selected by the GAVI Board as priorities: HPV, Japanese encephalitis, meningitis A, rubella, typhoid and yellow fever. Meanwhile, the GAVI Alliance will also complete the introduction of pentavalent vaccines that immunise against diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b (Hib) —causing meningitis and pneumonia—, and hepatitis B.

Demand and cash flow requirements

The GAVI Alliance expenditures needed to meet country demand between 2010 and 2015 and the necessary cash inflows amounting to **US$ 7 billion in 2010-2015** are presented in Table 1 and further detailed in Annex 1.

Table 1 ***Cash inflows needed to meet country demand***

	Total US$ millions	%	
Pneumococcal vaccine *	2,397	33%	$2.4 bn
Pentavalent (DTP-HepB-Hib) vaccine	2,015	27%	$2.0 bn
Rotavirus vaccine	748	10%	$0.7 bn
All other vaccines + INS	108	1%	
Meningitis - routine, campaign & stockpile **	257	3%	$0.6 bn
Yellow fever - campaign & stockpile **	186	3%	
HPV, JE, rubella & typhoid	179	2%	$0.2 bn
Health system strengthening	478	6%	
Immunisation services support	174	2%	$1.2 bn
Vaccine introduction activities	538	7%	
Administration	284	4%	$0.3 bn
Total	7,364	100%	$7.4 bn
add: Cash reserve requirement	1,000		($0.4 bn)
less: Cash at 1 January 2010	(1,392)		
Cash inflows needed in 2010-2015	6,972		**$7.0 bn**

* Pneumococcal cost includes AMC funded part

** These figures include programmatic & implementation costs

Table 1a ***Cash inflows needed, by year***

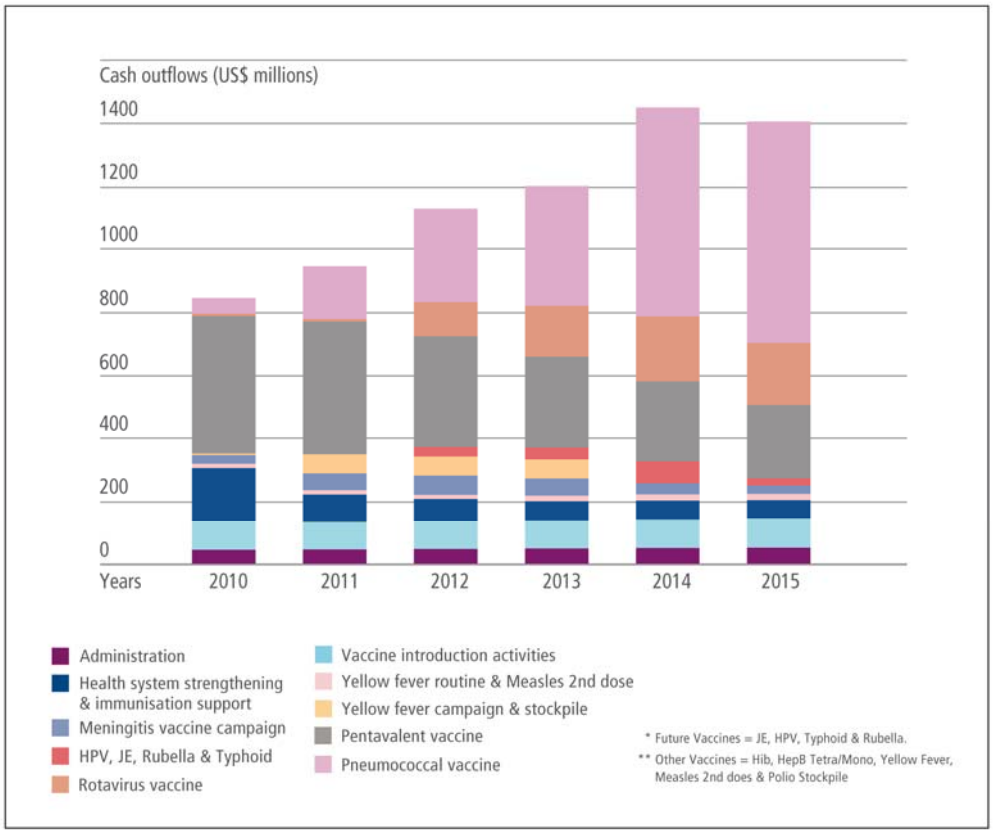
US$ millions	2010	2011	2012	2013	2014	2015	Total	
Cash Outflows	1,093	1,009	1,147	1,276	1,376	1,463	7,364	$7.4 bn
Adjustment for Cash Reserve Requirement	(719)	92	86	67	58	25	(392)	($0.4 bn)
Cash Inflow needed	374	1,101	1,233	1,343	1,434	1,488	**6,972**	**$7.0 bn**
	2010-2012: US$ 2.7 billion			2013-2015: US$ 4.3 billion				

- .The total cash inflow requirements are US$ 2.7 billion in the first three years (2010-2012) and US$ 4.3 billion in the last three years (2013-2015) as illustrated in Table 1a. The ability to foresee the anticipated contributions through multi-year firm pledges or contractual arrangements will be essential for the GAVI Alliance Board to make multi-year commitments to country programmes.

The expenditure projection breakdown is illustrated in Figure 1. It is important to note that:

- Administrative costs were US$ 45 million in 2009 or 5% of total expenditures. The enclosed projections assume that administrative costs remain stable but adjusted for inflation.
- Current projections for existing cash-based programmes – health system strengthening (HSS), immunisation services support (ISS) and civil society support – amount to 9% of total expenditures. Additional investments through the Health Systems Funding Platform are not included in this financial review, nor are the pledges made to IFFIm for HSS.
- Vaccine introduction activities represent 7% of total expenditure for the period. These encompass workplan expenses including the Accelerated Vaccine Initiative, procurement fees and vaccine introduction grants.
- **Vaccine purchases constitute 80% of total expenditures.** Vaccine costs are presented here net of co-financing contributions from GAVI-eligible countries.

Figure 1 ***Expenditures Projections – Programmatic Year 2010-15 (US$m)***



Cost Drivers

Since vaccine costs constitute the bulk of the expenditure, primary cost drivers for the GAVI Alliance budget are:

- **eligibility criteria, determining the size of the birth cohort and therefore the vaccine volumes,**
- **vaccine costs, i.e. the per-dose purchase costs of GAVI Alliance priority vaccines, and**
- **pace of adoption of new vaccines by countries (affecting volume) and the level of GAVI-eligible countries' contributions to co-financing vaccines (affecting net costs).**

Eligibility criteria: intensified focus on poorest countries

By defining the countries that can access GAVI-supported purchases of new and underused vaccines, and consequently the GAVI birth cohort, the eligibility criteria affect both the scope of the GAVI Alliance's impact and the scope of the financing it needs.

In November 2009, the GAVI Alliance eligibility policy was revised. To be eligible to apply for new support from 2011 onwards, a country's Gross National Income

(GNI) per capita must not exceed US$ 1,500 according to World Bank data released annually in July. [The GNI per capita threshold will be adjusted for inflation each year]. The new US$ 1,500 threshold is roughly equivalent to an inflation adjustment of the previous US$ 1,000 threshold, which was set in the year 2000. A further eligibility component includes DTP coverage.

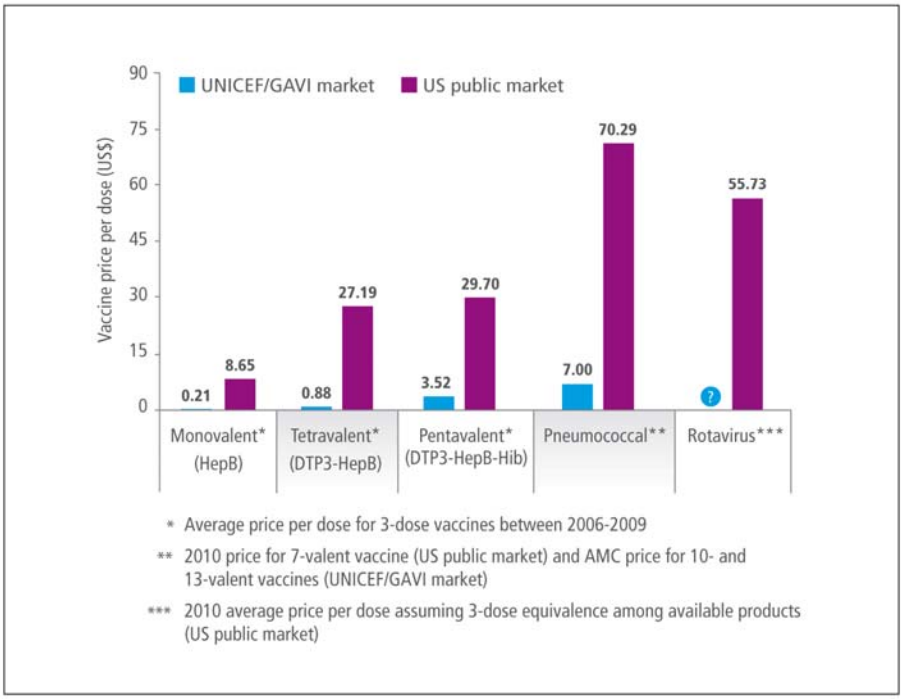
When the new criteria take effect in 2011, **the GAVI Alliance expects to progressively refocus funding from 72 countries to the 58 poorest countries, which encompass almost 80% of the world's extreme poor, i.e. those living on US$ 1.25 a day or less, and 81% of the world's unimmunised children.**

Vaccine costs: seeking affordable prices and supply security

As illustrated in Figures 3-4, GAVI has broadly been able to secure vaccines for eligible countries at significantly lower prices than those offered to other markets, and the clear aspiration remains that further price declines can be realised.

GAVI's strategic forecasting, pooled procurement mechanisms and reliable, anticipated funding stream provide an important signal to industry that there is a significant, long-term, reliable market for vaccines in GAVI-eligible countries. **This market-shaping effect encourages market entrants, including from developing countries, and has generally led to price declines over time.**

Figure 2 ***Tiered pricing: vaccine dose prices in different markets***



Source: UNICEF Supply Division, CDC Vaccine Price List[i]

Figure 3 ***Pentavalent vaccine price trends 2001-2010***

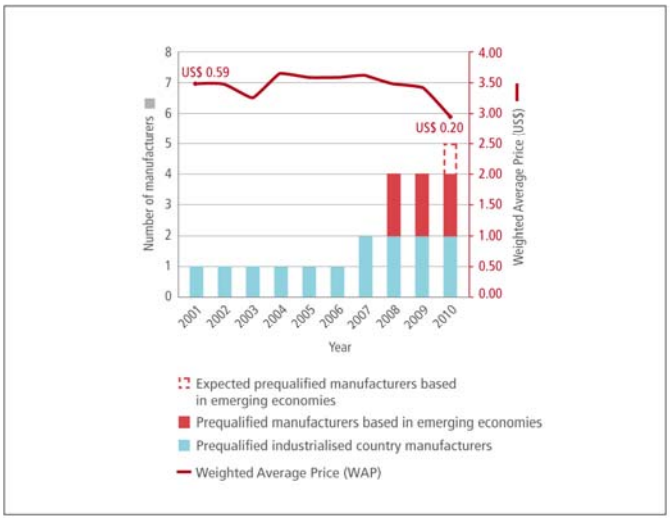
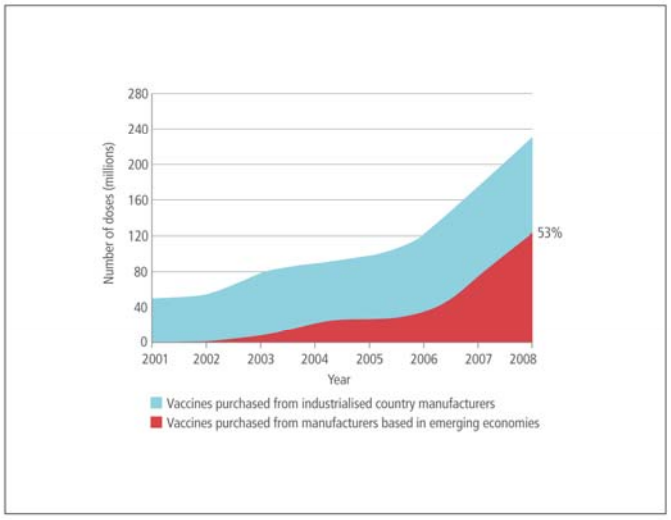


Figure 4 ***More emerging economy manufacturers increase competition and lower price***



Source: UNICEF Supply Division, 2009

The GAVI Alliance's potential impact on vaccine markets is strongly influenced by a number of factors including the stage of market development of a particular vaccine, the vaccine complexity, the purchased volumes, etc. To develop the financial projections for 2010-2015 presented in this document, **assumptions were made as to the potential scope of price declines for each vaccine that led to overall cost reductions of more than US$ 1 billion.**

GAVI's ability to deliver the anticipated vaccine costs will be commensurate with the scope and predictability of the Alliance's resources for this period, as **predictable and long-term financing is key to enabling vaccine manufacturers to offer lower prices.**

Rising country demand and co-financing ability

Since the GAVI Alliance is demand-driven, eligible country demand for new and underused vaccines determines the scope of financing. Countries approved for funding also invest in their own health infrastructure and often co-finance the vaccine costs, reducing eventually the vaccine costs borne by GAVI.

Since GAVI's inception, country demand for existing and new vaccines has grown steadily as have co-financing commitments from GAVI-eligible countries.

GAVI's initiative to help countries develop **financial sustainability plans** (FSPs) was a global effort to openly discuss and attempt to address the need to build national capacity in this area. The FSP process demonstrates how responsibility for immunisation financing can be assumed by government and other donor financing and involves both the Ministries of Health and Finance.

A remarkable 100% of countries required to co-finance complied with co-financing requirements in 2008, and other countries co-financed voluntarily. Feedback on the policy is positive: it has helped raise the profile of vaccines and immunisation within the government, improved planning, and generated recommended improvements in several areas.

A preliminary analysis shows that further co-financing flows would be unlikely to make a significant difference to GAVI's expenditure projections for 2010-2015 as the roll out of a new policy under development by the GAVI Alliance Board would have to provide ample planning time to recipient countries to prepare their co-financing scale-up and would likely not impact GAVI Alliance budgets until 2012 or 2013. Furthermore, the impact of the economic crisis on GAVI-eligible countries will likely hinder the acceleration of voluntary or compulsory co-financing.

4. The funding challenge

4.1 Projected needs

Cash inflows of US$ 7 billion **are needed to meet country demand in 2010-2015.**

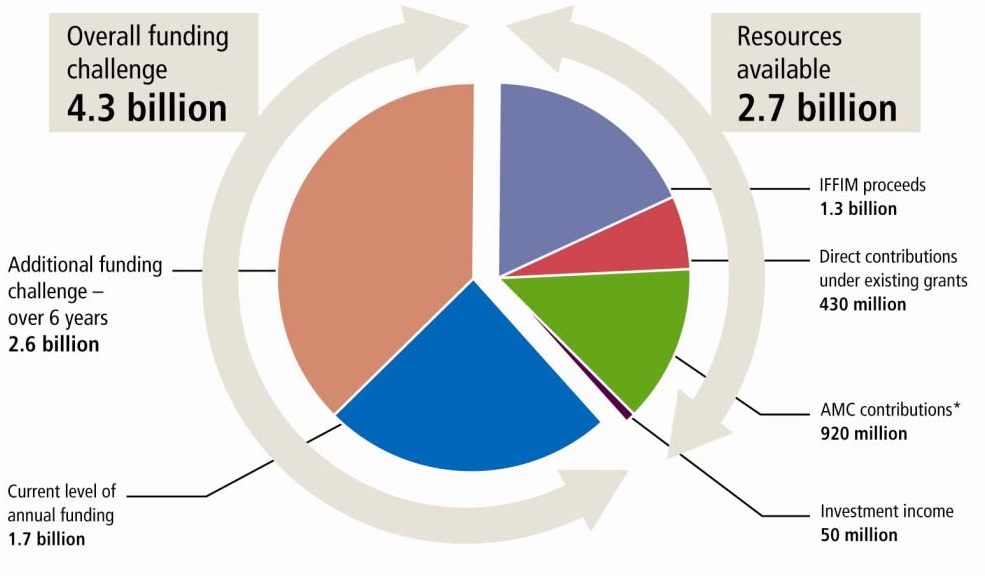
- As illustrated in Figure 6 and Table 2, expected country demand will produce cash outflows of US$ 7.4 billion in 2010-2015 (see Annex 1 for details). After taking into account the cash reserve requirement of US$ 1 billion at the end of 2015 and the cash and investment assets of US$ 1.4 billion available at the start of 2010, there is a need for cash inflows of **US$ 7 billion** in 2010-2015.

With almost US$ 2.7 billion already assured, additional contributions of US$ 4.3 billion **would be required to meet the US$ 7 billion needed.**

- Almost US$ 2.7 billion will be available under already signed multi-year agreements (including direct contributions as well as IFFIm and AMC proceeds), leaving **US$ 4.3 billion** yet to be secured.
- Direct contributions, if maintained at their current overall level, would provide US$ 1.7 billion. Further contributions of US$ 2.6 billion would be required to fully meet the US$ 4.3 billion funding challenge.

Figure 5

2010 – 2015 Financing requirements (US$)



* AMC contributions are contingent on a corresponding amount being spent on pneumococcal vaccines.

Table 2 ***Cash needed in 2010-2015 to meet projected demand***

(Note)	Summary of Resource Needs 2010-2015	US$ m	
	Cash Needs		
	Cash outflows for programmes (per Annex 1)	**7,364**	**$7.4 bn**
1	add: Cash reserve requirement	1,000	
2	less: Cash at 1 January 2010	(1,392)	
A	**Cash inflows needed in 2010-2015**	**6,972**	**$7.0 bn**
	Resources Available		
3	IFFIm proceeds through GFA, excluding HSS	1,271	
4	Direct contributions (under existing multi-year grants)	431	$0.4 bn
5	AMC contributions	920	
6	Investment Income	51	
B	**Resources available in 2010-2015**	**2,673**	**$2.7 bn**
(A-B)	**Additional Contributions Required**	**4,299**	**$4.3 bn**
	Totals may appear not to add because of rounding		

Notes for Table 2

1. ***Cash reserve requirement –*** *In accordance with the GAVI Alliance policy, an amount of cash and investments is held at all times sufficient to cover eight months' future cash flow needs. This is estimated at 8/12 of the 2015 cash outflows of US$ 1.5 billion.*

2. ***Cash at 1 January 2010*** *- This figure best reflects "available" cash and investments and includes amounts held by the GAVI Alliance (excluding monies transferred to the procurement account), the GAVI Fund and the GAVI Fund Affiliate (GFA). Cash held by IFFIm is not included.*

3. ***IFFIm proceeds through GFA*** *– The maximum amounts of cash that will be available for programmatic use in cash terms for the period 2010-15 based on existing pledges. It does not include the benefit of the 2009 HSS-specific pledges for programmes yet to be considered, the cost of which is not included in projected cash outflows. (See Annex 2, the IFFIm Key Numbers Table).*

4. ***Direct contributions*** *– The amount of contributions expected under already signed multi-year grant agreements.*

5. ***AMC contributions*** *– The amount of Advance Market Commitment (AMC) funds that could be drawn down by the GAVI Alliance (from funds held by the World Bank) to pay for pneumococcal vaccine programmes. The draw down is contingent on a corresponding amount being spent on pneumococcal vaccines.*

6. ***Investment income*** *– GAVI Alliance realised and unrealised investment income.*

4.2 Timing of additional contributions needed

Of the total US$ 4.3 billion additional contributions required, cash inflows of US$ 1.1 billion would be needed in 2010-2012 and US$ 3.2 billion in 2013-2015 as illustrated in Table 2a.

However, given the multi-year nature of the supported programmes and in order for the GAVI Alliance to be able to deploy the vaccines as planned, it is essential that GAVI can be assured of its future cash inflows through multi-year contribution agreements or other forms of long-term commitments.

Table 2a ***Additional contributions required, by year***

US$ millions	2010	2011	2012	2013	2014	2015	Total	
1 Direct contributions to maintain current level	237	270	262	275	275	350	1,670	$1.7 bn
2 Further contributions required	0	0	303	767	774	786	2,630	$2.6 bn
Total additional contributions needed	237	270	565	1,042	1,049	1,136	**4,299**	**$4.3 bn**
	2010-2012: US$ 1.1 billlion			**2013-2015: US$ 3.2 billion**				

Contributions to maintain current level *– Direct contributions averaged US$ 350 million per year in 2007-2009. This level, if maintained over the six years 2010-2015, would amount to US$ 2.1 billion. Of this amount, US$ 0.4 billion is already assured under multi-year grant agreements, hence a further US$ 1.7 billion would be needed.*

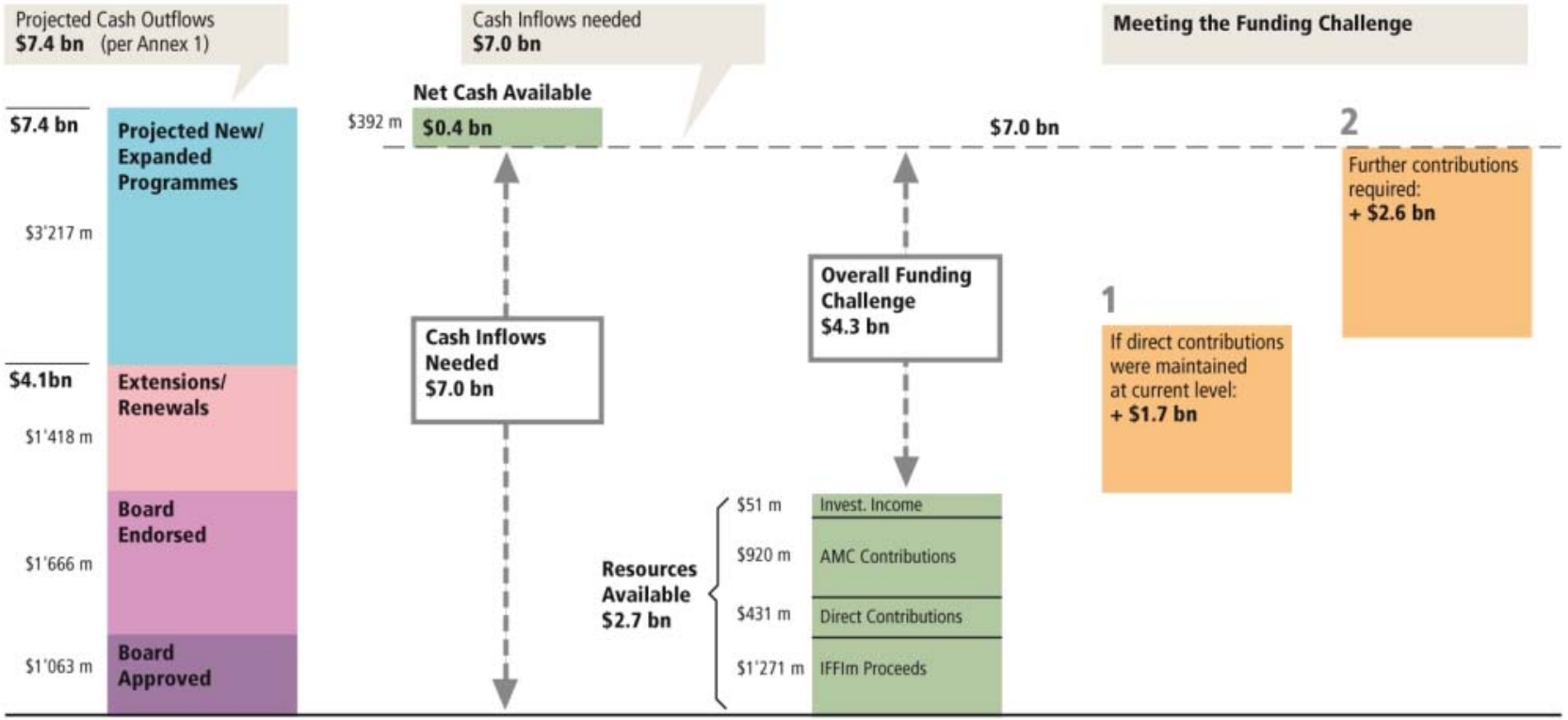
4.3 Composition of demand and two-step funding challenge

Step 1: If direct contributions are maintained at the current level (US$ 350 million per year), resources would be sufficient to cover demand from all existing programmes through 2015.

- Direct contributions, if stable at their US$ 350 million per year average level of 2007-2009, would amount to US$ 2.1 billion for the six years 2010-2015. Of this amount, US$ 400 million is already assured under signed multi-year grant agreements, so **an additional US$ 1.7 billion** would need to be contributed to maintain the current level.

- As illustrated in Table 3, in such a relatively conservative funding scenario, cash inflows in 2010-2015 would be more than sufficient to meet the demand from existing programmes (meaning those programmes that have been already approved or endorsed by the Board, and their eventual extension/renewal through 2015) and leave US$ 800 million towards funding anticipated new or expanded programmes.

Figure 6 **Overview of Projected Demand and Resources 2010-2015**



Step 2: A further US$ 2.6 billion (US$ 440 million per year, on average) would fully fund the expected demand for new and expanded programmes, as illustrated in Table 4. Taking this second step to fully meet the funding challenge will enable the roll out of the GAVI Alliance programmes as set out in section 6.

Table 3 ***Meeting demand from programmes approved/endorsed and their renewal***

		Projected Demand from Existing Programmes in 2010-2015	**US$ m**	
A	(Note)	**Demand from programmes already approved/endorsed and renewal thereof**		
	1	Board approved	1,063	
	2	Board endorsed	1,666	
	3	Extensions & Renewals	1,418	
		Total cash outflows	**4,147**	
	4	add: Cash reserve requirement	300	
	5	less: Cash at 1 January 2010	(1,392)	
		Cash inflows needed in 2010-2015	**3,055**	$3.1 bn
B		**Projected cash inflows**		
		Direct contributions, assured under existing multi-year grants	431	$0.4 bn
		Direct contributions, additional needed to maintain current level	1,669	**$1.7 bn**
	6	Direct Contributions, if current overall level is maintained	2,100	$2.1 bn
	7	IFFIm proceeds through GFA, from pledges to date, excluding HSS	1,271	
	8	AMC contributions	406	
	9	Investment Income	51	
		Total cash inflows projected in 2010-2015	**3,828**	$3.8 bn
C (A-B)		**Cash projected to be available after funding existing programs**	**773**	$0.8 bn
		(Available towards funding New/Expanded programs)		
		Totals may appear not to add because of rounding		

Table 4 ***Meeting demand from new/expanded programmes***

		Projected Demand from New Programmes in 2010-2015	**US$ m**	
D	(Note)	**Demand from New/Expanded programmes** (Balance of Expected Demand)**:**		
	10	Projected New/Expanded Programmes	3,217	
	4	add: Cash reserve requirement	700	
		Cash inflows needed in 2010-2015	**3,917**	$3.9 bn
E		**Cash available**		
		Cash available after funding existing programs (per C above)	**773**	$0.8 bn
	8	AMC contributions	514	
		Total cash available in 2010-2015	**1,287**	$1.3 bn
F (D-E)		**Additional cash required for New/Expanded Programmes**	**2,630**	**$2.6 bn**
		Totals may appear not to add because of rounding		

Notes to Tables 3 & 4

*1. **Board approved** – This consists of two groups of expenditures: (1) legally binding contracts; and, (2) other Board approved programmatic costs.*

*2. **Board endorsed** - Each time a new country programme is recommended for approval by an independent review committee (IRC), the Board (or Executive Committee) is asked to endorse the programme and its associated multi-year budget. These endorsements do not constitute a liability to pay but instead send a positive signal that GAVI intends to fund a programme over its entire lifespan, subject to performance and availability of funds.*

*3. **Extensions and renewals** – Projections of existing commitments through 2015.*

*4. **Cash reserve requirement**– In accordance with GAVI Alliance policy, an amount of cash and investments is held at all times sufficient to cover eight months' future cash flow needs. In Table 3, this relates to the cash flow needs of existing programmes (as described in notes 1, 2 & 3). In Table 4, this relates to the cash flow needs of new/expanded programmes (as described in note 10).*

*5. **Cash as at 1 January 2010** - This figure best reflects "available" cash and investments and includes amounts held by the GAVI Alliance (excluding monies transferred to the procurement account), the GAVI Fund and the GAVI Fund Affiliate (GFA). Cash held by IFFIm is not included.*

*6. **Direct contributions** – The annual average of 2007-2009 actual contributions of US $350 million per year, multiplied by 6 years (2010-2015). Of the total $2.1 billion projected for 2010-2015, $0.4 billion is assured under already signed multi-year grant agreements.*

*7. **IFFIm proceeds through GFA** – The maximum amounts of cash that will be available for programmatic use in cash terms for the period 2010-15 based on existing pledges. It does not include the benefit of the 2009 HSS-specific pledges for programmes yet to be considered, the cost of which is not included projected cash outflows. See Annex 2, the IFFIm Key Numbers Table, for more information.*

*8. **AMC contributions** – The amount of Advance Market Commitment (AMC) funds that could be drawn down by the GAVI Alliance (from funds held by the World Bank) to pay for pneumococcal vaccine programmes. The draw down is contingent on a corresponding amount being spent on pneumococcal vaccines. In Table 3, this relates to the pneumococcal vaccines component of existing programmes (as described in notes 1, 2 & 3). In Table 4, this relates to the pneumococcal vaccines component of new/expanded programmes (as described in note 10).*

*9. **Investment income** – GAVI Alliance realised and unrealised investment income.*

*10. **New/expanded programmes** – Expected demand from programmes not yet approved or endorsed by the Board.*

5. Meeting the funding challenge

Raising the necessary **US$ 7 billion** for the next six years is an ambitious objective, especially in the current economic context. But overcoming the short-term financing challenge will enable the GAVI Alliance to significantly contribute to achieving the health Millennium Development Goals and save millions of lives. How can we achieve this ambition?

In the long term, a variety of new, innovative financing mechanisms and rising support from the private sector should become more prominent components of the GAVI Alliance's diversified financing strategy. However these new strategies will require time to be deployed and will likely not impact significantly the 2010-2015 financing framework of the Alliance.

In the next few years, direct contributions and contributions through mechanisms like IFFIm will be critical to meeting the US$ 4.3 billion challenge — to secure financing of the total demand and therefore roll out of new vaccines.

Direct cash contributions

As presented above, the level of contribution (direct and through IFFIm proceeds) provided by donors to GAVI on average in the last three years was US$ 350 million/year and, if sustained, would yield US$ 2.1 billion over the 2010-2015 period.

This conservative scenario would fall short by US$ 2.6 billion of meeting total demand. The GAVI Alliance would require incremental funding of US$ 450 million per year over six years. Can this additional US$ 2.6 billion be raised?

- Current donors may be able to extend their contributions either in cash or through IFFIm. Despite budgetary constraints, a number of countries are still aiming to raise their ODA share of GNI. **Donors could consider the countdown to the Millennium Development Goals as an imperative to invest in such cost-effective interventions as vaccination for the top killers of children under 5, while also advancing other MDGs.**

- Resource mobilisation efforts have to go beyond the GAVI's current donor base (16 governments, the European Commission, the Bill & Melinda Gates Foundation, La Caixa and private donors). This base is relatively narrow, with six donors providing 84% of aggregate commitments to date. **To overcome the inherent risks associated with this concentration, the GAVI Alliance has taken steps to broaden its donor base** to all G8 countries and beyond. The Russian Federation participates in the first Advance Market Commitment (AMC). Several G20 countries have joined the GAVI Alliance donor ranks:

many European countries but also South Africa who joined IFFIm and Brazil who has pledged to do so. Emerging economies from the G20 and other groups have expressed an interest in joining the GAVI Alliance. The development of these relationships is underway.

Since it takes time to build trust and partnership and eventual financial support, the expansion of the donor base will only impact the GAVI Alliance's resources over the medium to long term. The collective ability of current donors to muster the resources needed for the immediate scale up will determine GAVI's ability to deliver on the MDGs.

The additional support that is required does not need to be all direct ODA contributions to GAVI. Longer-term pledges to IFFIm that extend beyond 2015 can yield contributions prior to that year.

The GAVI Alliance's innovative financing vehicle: IFFIm

The GAVI Alliance's innovative financing vehicle, IFFIm, raises funds by issuing bonds in the capital markets that convert long-term government pledges into immediately available cash resources. The long-term government pledges are used to repay the IFFIm bonds. IFFIm was established with the purpose of providing GAVI with a new method of grant capital:

- It offers a long dated and predictable capital flow.
- Bonds can be issued when funding is required for programme needs, so that money is available at the right time. This reduces the negative impact of donor country fiscal constraints on the immunisation requirements of poor countries.

Just as it has served previous initiatives (in support of GAVI's immunisation programmes, and more recently as the channel for pledges to support a Health Systems Funding Platform), **IFFIm can be an efficient vehicle for a new round of initiatives related to the GAVI Alliance and immunisation. It can accommodate new donors and new disbursement initiatives, while tapping the benefits of its original design.**

For donors with immediate cash constraints, providing a sizeable cash contribution in the short term may be a challenge that inevitably limits the scope of possible contributions to the GAVI Alliance; however, regular, long-term contributions through an IFFIm vehicle can deliver the funds needed to support GAVI programmes in 2010-2015 faster.

- **A donor commitment of US$ 1 million each year for 15 years from 2010 would enable IFFIm to release US$ 10.25 million to the GAVI Alliance in**

the period 2010-15[1]. This, or multiples of this type of sustained grant funding, is an achievable target for many G20 countries.

- **In this regard, a target of raising US$ 1 billion for 2010-2015 would require pledges over 15 years of US$ 97.5 million per annum.** This amount is reduced to US$ 88.5 million per annum if the grant period is extended to 2031 for the same payout during the period 2010-15.

- If current donors were to extend their current pledges to 2031, the GAVI Alliance could secure an additional US$ 720 million of resources during the period 2010-2015 and an additional US$ 534 million during the period 2016-2031.

G20 countries interested in supporting the GAVI Alliance may benefit from the experience of other G8 & G20 donors via IFFIm: Australia, France, Italy, the Netherlands, Norway, South Africa, Spain, Sweden, and the United Kingdom. **For non-AAA donors, an AAA-rated IFFIm can create additional value, as it is able borrow at lower rates than these countries are able to by themselves.**

Further initiatives in innovative financing

For the GAVI Alliance, innovative financing makes the application of donor funding flows more efficient and helps access new funding sources. To this end, GAVI seeks to increase public and private sector donor investments in innovative financing mechanisms that are capable of matching donors' and investors' financial abilities and preferences with the time profile of GAVI Alliance programme funding needs. Several directions have emerged as likely priorities:

- Expanding and extending IFFIm to make it an ongoing issuer in international bond markets, with ongoing donations, from an expanded group of donors.
- Creating a vehicle in which public sector and private sector supporters of the GAVI Alliance can invest, rather than to which they donate. Such investments would not count against governments' development assistance budgets nor corporations' social responsibility budgets.
- Structuring products and relationships that would enable the GAVI Alliance to access private sector contributions in contexts where there are large transaction volumes and large financial flows.

The international financial transaction levy, the "De-Tax" project, voluntary solidarity contributions and other new and potential initiatives in innovative financing[2] may emerge as solid, novel and additional sources of funding for global health. GAVI donor governments committed to scaling up **GAVI Alliance programmes could advocate for new innovative financing vehicles to help**

1 *Assuming leverage is raised in years 2013, 2014 and 2015*

2 *See High Level Taskforce on Innovative International Financing and Leading Group on Innovative Financing for Development*

sustain financing in later years. The GAVI Alliance Secretariat and its partners stand ready to support such initiatives while exploring new innovative strategies with private partners.

Private sector

In the long term, support from the private sector should become a more prominent component of the GAVI Alliance's diversified financing strategy. Corporate partnerships, private philanthropy and campaign partnerships will be core strategies for 2010-2015.

Corporate partnerships

Since its inception, the GAVI Alliance has engaged the private sector primarily as a business partner for heath product innovation and innovative financing solutions. The financial industry has been engaged in the design and operation of IFFIm[3] and the vaccine industry are partners in advancing availability and affordability of new technologies. Most of these partners were not actively solicited as philanthropic contributors to GAVI. Yet, the financial industry, among other sectors being explored, ought to find interest in associating with GAVI in broader partnerships.

Initiated in 2008, GAVI's partnership with La Caixa, Spain's leading savings bank and Europe's second largest foundation stands as a model for GAVI's future private sector strategy: a multi-faceted engagement and giving programme. This unique and noteworthy corporate social responsibility initiative has four important components:

- an annual, and renewable, grant from the La Caixa Foundation;
- a campaign to engage La Caixa's 26,000+ member employee group;
- an engagement strategy for La Caixa's 400,000+ corporate depositors;
- a broader outreach strategy to inform and engage all Spanish citizens.

Within its first two years of existence, the partnership with La Caixa, has provided GAVI with over US$ 12 million.

As GAVI's public-private partnerships evolve, an opportunity exists to leverage significant new funding by collaborating with high profile private sector actors. It is important to remember, however, that securing and structuring participation will be a long process of identification, cultivation, persistent dialogue, and trial and error. And, as with more traditional philanthropy, the macroeconomic picture will inhibit quick success.

Private philanthropy

[3] *Goldman Sachs served as IFFIm's financial; advisor, on a pro bono basis. Daiwa Securities arranged offerings to Japanese retail investors and provided GAVI with philanthropic contributions on this occasion.*

The GAVI Alliance was able to engage generous individuals in philanthropic support, an initiative primarily focused on the United States. By 2009, private philanthropic support had contributed more than US$ 11 million in GAVI's first nine years. Despite these modest beginnings, this effort is encouraging: GAVI experienced in 2009 a 28% increase over 2008 and a 60% increase over giving in 2007, even in the midst of the economic downturn. The average gift also increased, to US$ 3,124 from US$2,489 in 2008 and US$ 2,132 in 2007. While continued year-to-year growth in giving is expected, it is likely to continue at a rate restrained by GAVI's limited brand recognition and the economic downturn. The sharp decline in foundation and corporate giving and the virtual evaporation of endowments held by many leading donors are certain to constrain contributions for years to come. Nevertheless, these activities will be sustained and expanded with the cultivation of high-net worth and affluent prospective funders, initially focusing on eight metropolitan areas in the United States, and the structuring of a robust donor pipeline through marketing and advocacy activities.

Other partnerships

In September 2009, the GAVI Campaign, GAVI's dedicated private fundraising arm in the United States, initiated the exploration of the partnership development landscape, supported by an expert committee. The objective is to assess the potential for major collaborations with a select number of faith communities, prominent membership/service organisations, and institutional funders. Priority is placed on developing mutually attractive arrangements with organisations bringing considerable capacities in advocacy and donor mobilisation to support the roll out of pneumococcal and rotavirus vaccines.

Overall private sector perspective

GAVI's efforts are difficult to benchmark against those of peer institutions whose programmes were commenced many years ago and grew during periods of strong economic expansion. Likewise, the ability of other "name brand" organisations in the global health arena to mobilise celebrity spokespersons and mount cause marketing campaigns puts GAVI —a relatively low profile newcomer— at a disadvantage. Simply put, while GAVI's foray into the private philanthropic landscape has begun to yield results, and there is evidence of greater potential, this potential will be realised over many years and will likely be but one part of a comprehensive solution to GAVI's funding challenge.

It is, therefore, difficult to assess the possible scope of private sector financing that may contribute to GAVI's US$ 4.3 billion funding challenge over the next six years. Given the time required to design and nurture partnerships and philanthropic relationships, and in line with the experience of other organisations such as the Global Fund, the financial impact will likely remain limited. Yet it will be critical to plan for sustained and accelerated progress in this area, and ensure that the proper infrastructure is in place to maximise returns.

6. Seizing the new vaccines opportunity

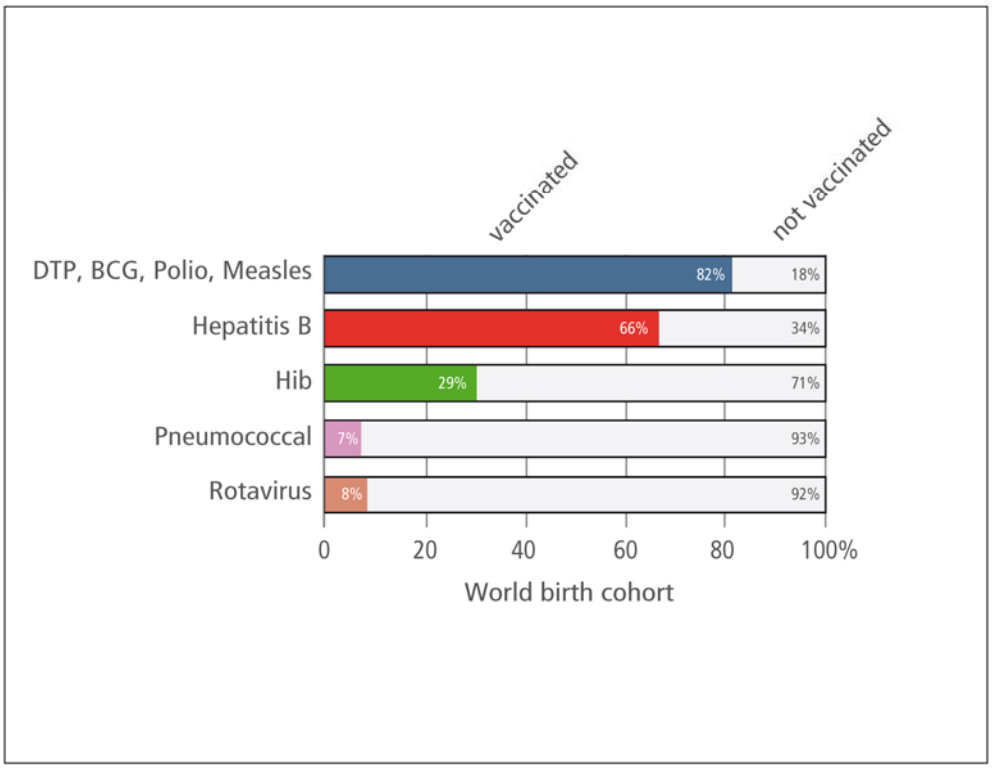
For decades, while high-income countries incorporated new technological advances into their immunisation programmes, most developing countries were only able to provide six antigens (diphtheria, tetanus, pertussis, BCG, measles, and polio).

Since its inception, the GAVI Alliance has been able to significantly reduce the lag between high- and low-income country introductions of new vaccines, especially Hib and hepatitis B (now through pentavalent vaccination). The access gap remains acute, however, for newer vaccines such as pneumococcal and rotavirus, introduced in high-income and middle-income countries, but out of reach for children in developing countries.

Pneumococcal and rotavirus vaccines

A unique opportunity exists to rapidly accelerate progress towards Millennium Development Goal 4 in the next five years: new pneumococcal and rotavirus vaccines can at last help tackle pneumonia and diarrhoea, accounting together for 40% of mortality in children under five. The overwhelming majority of children, especially in the developing world, are unimmunised and therefore at risk, as illustrated in Figure 7.

Figure 7 ***The pneumococcal and rotavirus vaccination gap***



Source: Johns Hopkins School of Public Health, IVAC, Vaccine Information Management System

The GAVI Alliance estimates that rolling out these vaccines by meeting the demand forecast presented in Figure 1, will deliver the following results by 2015:

PNEUMOCOCCAL VACCINES

- 47 countries will have introduced pneumococcal vaccines with GAVI support.
- More than 110 million children will have been immunised with pneumococcal vaccines.
- Some 3,000,000 cases will have been averted.
- Approximately 840,000 deaths from pneumococcal disease will have been prevented.

ROTAVIRUS VACCINES

- 41 countries will have introduced rotavirus vaccines with GAVI support.
- 58 million children will have been immunised with rotavirus vaccines.
- Some 8,000,000 cases will have been averted.
- Approximately 200,000 deaths from rotavirus diarrhoea will have been prevented.

Preparing for new vaccines

In 2010-2015, the GAVI Alliance also plans to advance its vaccine investment strategy around five new vaccines selected as priorities: HPV, Japanese encephalitis, meningitis (serogroup A), rubella and typhoid. A strategy for lower cost vaccines (rubella, typhoid, and meningitis A) will be to support countries with catch up activities enabling them to finance routine vaccination.

HPV

The human papillomavirus causes cervical cancer which affects nearly 500,000 women around the world every year and kills more than 300,000 – of which 85% are in developing countries. It is a leading killer of women in GAVI eligible countries. There are highly effective HPV vaccines now available; however, the price of the vaccines today and introduction challenges remain key barriers for widespread introduction. The GAVI Alliance is working with manufacturers and partners to overcome these barriers.

Japanese encephalitis

This seasonal endemic hits parts of China, the Russian Federation's South-East, and South and South-East Asia. Estimated annual mortality ranges from 10-15,000 deaths, while the total number of clinical cases may be as high as 50,000. There are new vaccines available with different product profiles and different prices, some of which are expected to be highly affordable, at less than US$ 0.50 per dose.

Meningitis serogroup A (MenA)

This epidemic affects Sub-Saharan Africa on average every five to seven years. With each cycle, mortality has been recorded at around 25,000 deaths and clinical cases reached 250,000. Historically there have been no ideal vaccines.

However an investment project to take new conjugate technology and transfer it to a developing country supplier with high production capacity will result in a low-cost, long-lasting vaccine being made available to protect against MenA outbreaks. This long-lasting vaccine will also protect infants. The vaccine will be available at less than US$ 0.50.

Rubella

Women infected early in their pregnancy with the rubella virus are 90% likely to pass the virus onto the foetus. This can cause the death of the foetus, or it may cause congenital rubella syndrome (CRS) - an important cause of severe birth defects in the ears, eyes, heart and brain. It is estimated that there are 110,000 cases of CRS each year. Rubella vaccination can be easily combined with measles vaccine (referred to as MR vaccine) and provided for less than US$ 0.30 per dose.

Typhoid

Typhoid remains a serious public health problem around the world, with an estimated 16-33 million cases and 216,000 to 600,000 deaths annually. New, conjugate vaccine technology is under development with a vaccine expected as early as 2012. This vaccine is projected to be available at a price below US$ 0.50.

Ongoing programmes

The GAVI Alliance's support to pentavalent vaccine adoption will be sustained in 2010-2015, following major investments in recent years that, among GAVI-supported vaccines, have provided the most significant contribution to averting deaths. The roll out of pentavalent —a combined vaccine against diphtheria, tetanus, pertussis, Hib and hepatitis—, has also been instrumental in raising DTP3 coverage in GAVI-eligible countries by providing sustainable finance for the introduction of new and more efficient combination vaccines (adding hepatitis B and Hib to DTP) and by providing cash-based support for strengthening immunisation services [4].

Other programmes —measles second dose, yellow fever, and meningitis stockpile —are expected to continue. These cost-effective interventions address key regional concerns.

These efforts will be strengthened with continued investments in health systems and cash-based support for vaccine introduction, as well as with an expanded effort to engage civil society. Altogether these additional programmes represent only 9% of GAVI's total expenditures, they constitute critical activities to enable the success of the broad vaccine portfolio while, in the case of heath system strengthening, advancing other MDGs.

[4] *An independent assessment in 2006 showed that GAVI's ISS programme contributed to increases in DTP3 coverage, in particular in countries starting with the lowest levels of coverage. Lancet. 2006 Sep 23; 368(9541):1088-95.*

Annexes

ANNEX 1
Expenditures Projection by Programme Year and Cash Flow Year

Expenditure Projection by Programme Year and Cash Flow Year

All figues in US$ Millions

	Expenditures - Programmatic Year									Expenditures - Cash Outflows								
	2009	2010	2011	2012	2013	2014	2015	2009-15	**2010-15**	2009	2010	2011	2012	2013	2014	2015	2009-15	**2010-15**
Board Approved (legally binding)																		
- Meningitis - routine, campaign & stockpile *	44	24	6	5	5			85	40	18	24	6	5	5			59	40
- Yellow Fever - campaign & stockpile *	43	5						48	5	21	5						26	5
- ADIPs and HIB	10	6						16	6	2	6						8	6
- Procurement Fees	9	4	2	3				18	9	7	2	3	0				12	5
- Vaccine Introduction Activities/Work Plan	83	76	2					160	78	81	66	2					150	69
- Administration	45	44						89	44	41	44						85	44
	234	**159**	**11**	**8**	**5**	**0**	**0**	**416**	**182**	**171**	**148**	**11**	**5**	**5**	**0**	**0**	**339**	**169**
Board Approved (Subject to funding)																		
- *Vaccines and INS (Verticals)*																		
- Pentavalent (DTP-HepB-Hib) vaccine	455	440						895	440	271	385	22					678	407
- Pneumococcal vaccine	8	99						107	99	1	106	5					112	111
- Rotavirus vaccine	6	9						15	9	6	8	0					15	9
- Routine yellow fever, Measles 2nd dose +INS	21	17						39	17	13	19	1					33	20
- *Cash Based Programmes (Verticals)*	490	565						1,055	565	291	519	28					837	547
- Immunisation services support	16	31						48	31	5	88	3					95	91
- Health system strengthening	111	109						220	109	34	185	11					230	196
- Civil society organisations	11	4						15	4	6	9	0					16	10
	139	144						282	144	45	282	14					341	296
- Procurement Fees	5	6	7	6	9	9	9	51	46	0	12	7	6	9	9	9	51	51
	633	**716**	**7**	**6**	**9**	**9**	**9**	**1,389**	**755**	**335**	**812**	**49**	**6**	**9**	**9**	**9**	**1,230**	**894**
Board Endorsed (Subject to funding)																		
- *Vaccines and INS (Horizontals)*																		
- Pentavalent (DTP-HepB-Hib) vaccine			268	147	103	86	80	683	683		67	246	152	101	85	60	711	711
- Pneumococcal vaccine			133	13	4	4	4	158	158		33	91	17	4	4	3	153	153
- Rotavirus vaccine			6	3	2	2	2	15	15		2	5	3	2	2	2	16	16
- Routine yellow fever, Measles 2nd dose			10	9	10	10	11	50	50		3	9	9	10	10	8	50	50
			417	172	119	102	97	907	907		104	352	181	117	102	73	930	930
- *Cash Based Programmes (Horizontals)*																		
- Immunisation services support			17	7	0	0	0	24	24			16	8	1	0	0	24	24
- Health system strengthening			53	8	1	1	1	65	65			48	13	2	1	1	65	65
- Civil society organisations			0	0	0	0	0	0	0			0	0	0	0	0	0	0
			70	15	2	1	1	89	89			63	21	3	1	1	89	89
- Vaccine Introduction Activities/Work Plan			76	80	82	84	86	408	408			76	80	82	84	86	408	408
- Administration			45	47	48	49	51	240	240			45	47	48	49	51	240	240
	0	**0**	**608**	**314**	**250**	**236**	**234**	**1,643**	**1,643**	**0**	**104**	**536**	**328**	**250**	**236**	**211**	**1,666**	**1,666**
Total Board Approved & Endorsed	**868**	**874**	**626**	**328**	**264**	**245**	**243**	**3,448**	**2,581**	**506**	**1,064**	**596**	**340**	**264**	**245**	**220**	**3,235**	**2,729**
									$2.6 bn									**$2.7 bn**
Expected Applications																		
- Extensions and Renewals																		
- Pentavalent (DTP-HepB-Hib) vaccine			151	188	173	157	149	818	818		38	153	182	170	156	112	810	810
- Pneumococcal vaccine			40	150	150	134	132	607	607		10	66	144	146	134	99	600	600
- Rotavirus vaccine			2	2	2	1	1	8	8		1	2	2	2	1	1	8	8
- Health system strengthening			0	0	0	0	0	0	0		0	0	0	0	0	0	0	0
	0	**0**	**194**	**339**	**325**	**293**	**282**	**1,432**	**1,432**	**0**	**48**	**220**	**328**	**317**	**292**	**212**	**1,418**	**1,418**
									$1.4 bn									**$1.4 bn**
Total Board Approved & Endorsed, plus Expected Extensions & Renewals	***868***	***874***	***819***	***668***	***589***	***538***	***525***	***4,881***	***4,013***	***506***	***1,112***	***817***	***668***	***581***	***537***	***432***	***4,653***	***4,147***
									$4.0 bn									**$4.1 bn**
- Balance of Expected demand																		
- *Vaccines*																		
- Pentavalent (DTP-HepB-Hib) vaccine		-6	0	15	10	9	4	32	32		-6	3	13	10	8	58	87	87
- Pneumococcal vaccine		-50	-7	134	227	525	565	1,394	1,394		-36	26	150	296	474	623	1,532	1,532
- Rotavirus vaccine		-1	0	103	157	202	193	654	654		-1	26	111	166	197	216	716	716
- Measles 2nd dose		2	4	4	8	9	9	35	35		2	4	5	8	9	10	38	38
- Meningitis - routine, campaign & stockpile *		3	47	55	49	35	26	217	217		3	47	55	49	35	26	217	217
- Yellow Fever - campaign & stockpile *			60	60	60	0	0	180	180			60	60	60	0	0	180	180
- HPV, JE, Rubella & Typhoid				30	38	69	23	160	160			8	31	45	56	40	179	179
- *Cash Based Programmes*																		
- Immunisation services support		0	8	8	10	10	10	46	46			7	8	10	10	10	45	45
- Health system strengthening		16	11	49	50	49	47	222	222		15	11	45	50	49	47	218	218
- Civil society organisations **		4	0	0	0	0	0	4	4		3	1	0	0	0	0	4	4
	0	**-32**	**123**	**459**	**610**	**909**	**877**	**2,945**	**2,945**	**0**	**-19**	**192**	**479**	**695**	**839**	**1,031**	**3,217**	**3,217**
									$2.9 bn									**$3.2 bn**
Total Expenditure	**868**	**842**	**942**	**1,127**	**1,199**	**1,447**	**1,402**	**7,826**	**6,958**	**506**	**1,093**	**1,009**	**1,147**	**1,276**	**1,376**	**1,463**	**7,870**	**7,364**

Programmatic Commitments made in 2010-2015: **$7.0 bn**

Cash Outflows in 2010-2015: **$7.4 bn**

* These figures include programmatic & implementation costs;

** Additional support will be considered after the evaluation of the pilot

ANNEX 1.1
Cash Flows by Commitment Level, 2010-2015 Summary

Cash Flows by Commitment Level, 2010-2015 Summary

US$ millions	Board Approved	Board Endorsed	Expected applications Extensions	Expected applications New	Total US$ millions	%	
Pneumococcal vaccine *	111	153	600	1,532	2,397	33%	$2.4 bn
Pentavalent (DTP-HepB-Hib) vaccine	407	711	810	87	2,015	27%	$2.0 bn
Rotavirus vaccine	9	16	8	716	748	10%	$0.7 bn
All other vaccines + INS	20	50		38	108	1%	
Meningitis - routine, campaign & stockpile **	40			217	257	3%	$0.6 bn
Yellow fever - campaign & stockpile **	5			180	186	3%	
HPV, JE, rubella & typhoid				179	179	2%	$0.2 bn
Health system strengthening	196	65		218	478	6%	
Immunisation services suport	100	24		49	174	2%	$1.2 bn
Vaccine introduction activities	130	408			538	7%	
Administration	44	240			284	4%	$0.3 bn
Total	**1,063**	**1,666**	**1,418**	**3,217**	**7,364**	100%	$7.4 bn
	14%	23%	19%	44%			
add: Cash reserve requirement					1,000		($0.4 bn)
less: Cash at 1 January 2010					(1,392)		
Cash inflows needed in 2010-2015					**6,972**		**7.0 bn**

* Pneumococcal cost includes AMC funded part

** These figures include programmatic & implementation costs

ANNEX 2
Cash Flows from IFFIm

Cash Flows from IFFIm

All values in $ millions	Notes	2006-07 Pledges	Netherlands Pledge	Total	Additional Pledges (HSS)	Total incl HSS Pledges	*The recent $1 billion announcement*
		A	C	C=A+B	D	E=C+D	*F=B+D*
Donor Pledges to IFFIm (2006-29)							
in **CASH VALUE** terms	1	5,229	114	**5,344**	890	**6,234**	*1,004*
in **PRESENT VALUE** terms	2	3,186	94	3,280	566	3,847	
Bonds issued to date (2006-09)	3						
For programmatic use		2,156					
For re-financing purposes		223					
		2,379					
Monies available for Programmatic use by GAVI							
(IFFIm to GFA transfers in cash terms)							
2006 - 2015	3, 4, 5	2,724	103	**2,827**	474	**3,301**	
of which							
Disbursed to GFA (2006-09)	3	1,556		**1,556**			
Remaining to be disbursed to GFA (2010-15)	6	1,169	103	**1,271**			
2016-2026	5, 6	923	7	930	188	1,119	
* Total to 2026		3,648	110	**3,757**	**662**	**4,420**	

Notes

(1) Local currency pledge values converted to USD at balance sheet rates at signing of Grant Agreements
(2) PV at inception
(3) As of December 31, 2009
(4) The Finance Framework Agreement (FFA) today currently stipulates a maximum $4,000 million of programmes can be approved up to 2015
(5) Section 5.5 of the FFA states that a disbursement schedule for monies to be disbursed post 2015 will be made in conjunction between the Donors and World Bank
(6) Estimated based on the current interest rates, gearing ratio limit and donor grant payment reduction amount level

ANNEX 3
Cash Flow by Year

Cash Flow by Year

	in US$ millions	2010	2011	2012	2013	2014	2015	Total	
	Cash outflows								
	Approved & Endorsed								
	- Programmes	940	464	207	125	103	74	1,913	
	- Work plan, procurement fees & admin.	124	132	132	139	142	146	816	
		1,064	596	340	264	245	220	2,729	
	Expected - Extensions / Renewals of Programmes	48	220	328	317	292	212	1,418	
	Expected - New Programmes (balance of demand)	(19)	192	479	695	839	1,031	3,217	
	Procurement Fees (appr/endorsed)	14	9	6	9	9	9	56	
	Work Plan (appr/endorsed)	66	78	80	82	84	86	476	
	Administration (appr/endorsed)	44	45	47	48	49	51	284	
A	**Total cash outflows**	**1,093**	**1,009**	**1,147**	**1,276**	**1,376**	**1,463**	**7,364**	**$7.4 bn**
	Cash inflows - assured								
	Direct contributions under multi-year grants	113	80	88	75	75	0	430	
	IFFIm proceeds through GFA	600	370	73	56	78	94	1,271	
	AMC contributions	25	85	151	170	232	258	920	
	Investment Income	26	25	0	0	0	0	51	
	Total assured inflows	**764**	**559**	**312**	**301**	**385**	**352**	**2,672**	**$2.7 bn**
	Additional inflows to meet the funding challenge								
1	Direct contributions to maintain current level	237	270	262	275	275	350	1,670	$1.7 bn
2	Further contributions required			303	767	774	786	2,630	$2.6 bn
	Total additional inflows	**237**	**270**	**565**	**1,042**	**1,049**	**1,136**	**4,299**	**$4.3 bn**
B	**Total cash inflows**	**1,001**	**830**	**877**	**1,343**	**1,434**	**1,488**	**6,972**	**$7.0 bn**
C (=A-B)	**Net Cash Inflows / (Outflows)**	(92)	(179)	(270)	67	58	25	(392)	
D	**Cash & Investments - Opening Balance**	1,392	1,300	1,121	851	917	975	1,392	
E (=C+D)	**Cash & Investments - Closing Balance**	1,300	1,121	851	917	975	1,000	**1,000**	**$1.0 bn**

ANNEX 4
IFFIm update

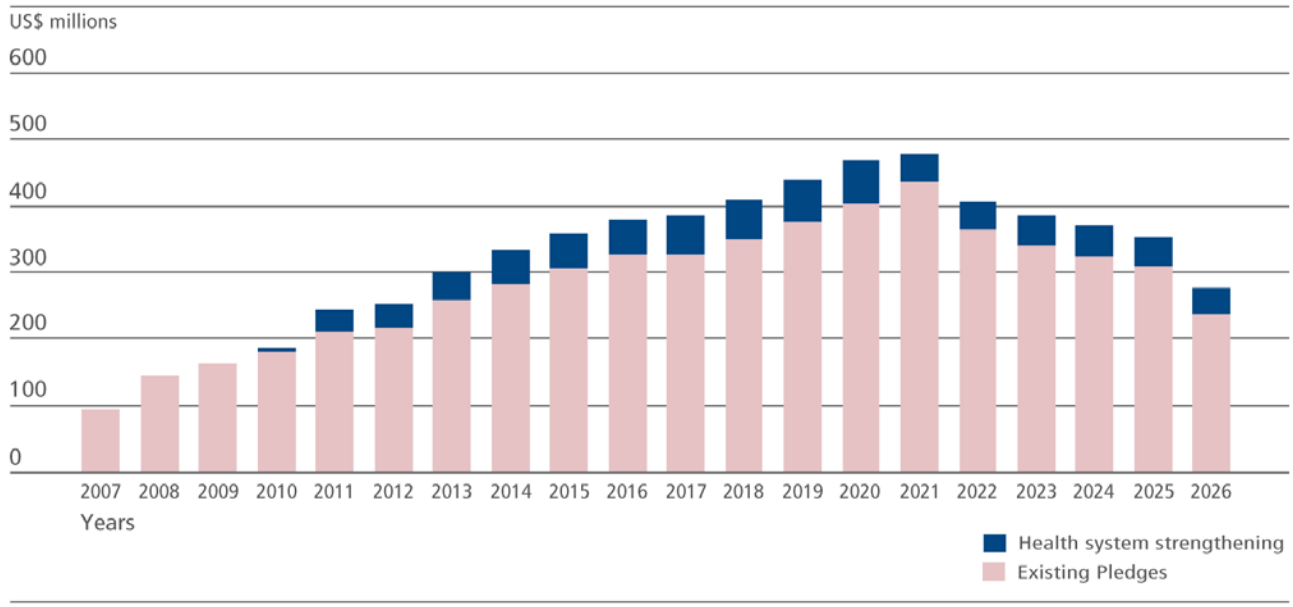
IFFIm is now an established issuer in the international capital markets having executed 10 transactions totalling US$ 2.32 billion in US dollars, UK pounds sterling, South African rands, Australian dollars and New Zealand dollars, with the potential to remain part of the international capital markets for many years to come.

IFFIm has successfully attracted a large number of new investors including Japanese retail and, with its ISA bond in the United Kingdom, engineered a pioneering transaction in the field of social investment.

IFFIm has also proved to be a highly efficient borrower with an average cost of debt of Libor -3.9bps, which compares with a theoretical cost of L-4.5bps had its constituent donors borrowed the same funds themselves at the same time as IFFIm.

With US$ 5.344 billion in pledges for immunisation and a further US$ 890 million for the Health Systems Funding Platform, IFFIm's asset base is expected to total US$ 6.23 billion[5] with the signing of these latest grants. This will enable IFFIm to provide GAVI with resources totalling approximately US$ 4.42 billion (depending on the spending profile) of which US$ 662 million is directed towards the new Health Systems Funding Platform. Of this sum US$ 1.56 billion has been paid from 2006 to 2009, US$ 1.75 billion is available in the period 2010-2015 (including US$ 1.271 billion for GAVI programmes) and US$ 1.12 billion[6] will be available from 2016-2026.

Profile of IFFIm's current pledges and an estimate of the HSS increment (US$m)



[5] *Original local currency pledge value converted to US$ at balance sheet rates at signing of Grant Agreements. The present value at inception is estimated at $ 3.85 billion.*

[6] *Estimated based on the current interest rates, gearing ratio limit and donor grant payment reduction amount level.*

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