

2013 PROGRESS REPORT



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Public–private global health partnership

The GAVI Alliance is a public-private global health partnership committed to saving children’s lives and protecting people’s health by increasing access to immunisation in poor countries.



BILL & MELINDA
GATES *foundation*



The Alliance brings together developing country and donor governments, the World Health Organization, UNICEF, the World Bank, the vaccine industry in both industrialised and developing countries, research and technical agencies, civil society organisations, the Bill & Melinda Gates Foundation and other private philanthropists.



Donors to the GAVI Alliance:

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Executive messages



*Seth Berkley, MD,
Chief Executive Officer
of the GAVI Alliance*

Message from the Chief Executive Officer of the GAVI Alliance

2013 has been a truly great year and remarkable chapter in the history of the GAVI Alliance. We witnessed the acceleration of vaccine introductions, country demand and price reductions, all on an unprecedented scale. We have also seen encouraging signs that investment in strengthening countries' health systems is starting to improve equity in immunisation. And in 2013, the Alliance opened the door to no fewer than three new vaccines.

Pentavalent vaccines have now been introduced in 72 of the 73 GAVI-supported countries, with South Sudan approved for rollout in 2014. There were also record numbers of pneumococcal and rotavirus vaccine introductions, extending protection against the causes of the two biggest killers of under-fives, pneumonia and diarrhoea.

We announced three new price agreements with manufacturers for pentavalent, pneumococcal and human papillomavirus (HPV) vaccines. Each represents a significant price reduction. Together, they equate to a dramatic decrease in the cost of fully immunising a child, making the vaccines more sustainable and enabling us to reach more children.

With the Board's decision to approve a funding window for a Japanese encephalitis (JE) vaccine, 2013 also saw the expansion of our supply base into China. This followed a detailed analysis from the Alliance's Vaccine Investment Strategy and WHO's first-ever prequalification of a Chinese-produced vaccine.

Women and girls' health also received a significant boost, with GAVI Alliance support approved for HPV vaccine demonstration projects in 10 countries. When scaled up through national rollouts, this will provide protection

against cervical cancer. The Alliance also began its rollout of rubella. Four countries conducted measles-rubella campaigns, the latter part providing pregnant women with protection for their unborn child against a serious cause of congenital abnormalities and early deaths.

We still have much to do. Strengthening country health systems to fulfill our goal of reaching every child with life-saving vaccines remains a significant challenge, and, in 2013, we continued active reform efforts to improve performance and close the gap.

The country-tailored approach was introduced in recognition that one size does not always fit all, particularly in fragile states, allowing us to adapt support during emergencies or civil conflict. And performance-based funding will help us improve vaccine delivery by rewarding countries that link health system strengthening support to equity and coverage.

As ever, we won't stop there. We will continue to look for new ways to improve access to vaccines. In early 2013, the Alliance brought together 25 leading global health experts in Annecy, France, to examine the benefits of vaccines beyond saving lives and preventing illness. We already knew vaccines are one of the best investments in health. It turns out the return on investment is likely to be even greater than we thought.

All this makes for an exciting future for the GAVI Alliance. I thank you all for your partnership. Please feel free to get in touch if you have any questions, ideas or suggestions.

A handwritten signature in blue ink that reads "Seth Berkley". The signature is fluid and cursive, with a long, sweeping tail on the final letter.



*Dagfinn Høybråten,
Chair of the
GAVI Alliance Board*

Message from the Chair of the GAVI Alliance Board

For the GAVI Alliance, 2013 was about delivering on our promises. In October we met in Stockholm for our Mid-Term Review (MTR). During this event, co-hosted by the Swedish government and HE John Dramani Mahama, the President of Ghana, all our partners came together to take stock and assess the progress we have made together towards our target of immunising 243 million children and saving nearly four million lives.

It was a vivid reminder of the important role the GAVI Alliance is playing in improving the lives of the world's poorest children. With more than 150 delegates attending, we saw how the Alliance is largely on track to achieve its ambitious strategic goals, as laid out in June 2011 when donors committed US\$ 7.4 billion to support vaccine programmes until 2015. It was also a chance to learn about some compelling impact stories recounting the tireless efforts being deployed by countries and GAVI Alliance partners.

Shortly after the MTR I had the opportunity to witness this first hand in Cambodia. Just outside the bustling capital of Phnom Penh in the small village of Koh Dach, I met children, parents and health workers, and saw the important role vaccinations play in protecting that fundamental human right which we call health.

To extend this protection in 2013 our Board also approved funding for new vaccines, including JE, cholera and the inactivated poliovirus vaccine (IPV). The latter will not only play a critical role in the polio endgame strategy, but it represents a crucial opportunity to increase coverage rates through the

strengthening of routine immunisation services.

But our work is not done and challenges remain, particularly in relation to improving supply chains and in-country data collection. We also have to find ways to ensure the sustainability of immunisation programmes for graduating countries, and make sure that countries, whose wealth has increased to the point that they are no longer eligible for GAVI Alliance support, still have access to affordable vaccines.

None of our achievements would be possible and not one of these challenges will be overcome without partnership. And so it is with thanks to donors and partners for their continued commitment and support that we start to look beyond this strategic period toward our next replenishment and five-year strategy that is currently being compiled.

Both will carry us to 2020 and what we hope will prove to be an era of unprecedented acceleration of childhood vaccination. I am delighted to share this Progress Report and hope that it serves as a roadmap on how to get there. The GAVI Alliance has demonstrated its ability to deliver on its promises and to do so transparently, ranking second out of 67 in the Publish What You Fund's 2013 Aid Transparency Index. Together we can deliver.

A handwritten signature in blue ink, reading 'Dagfinn Høybråten'. The signature is fluid and cursive, written in a professional style.

What the GAVI Alliance does

Our mission, to save children’s lives and protect people’s health by increasing access to immunisation in poor countries, is supported by the 2011–2015 strategy, which includes four strategic goals:



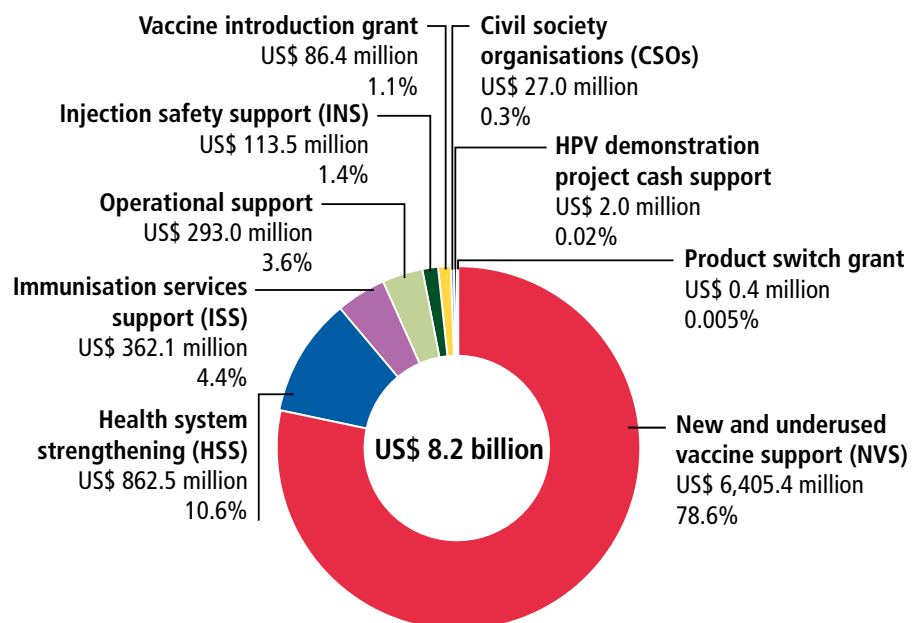
The GAVI Alliance exists to redress global inequities in access to new and underused vaccines. Since 2000, with generous support from donors and strong commitment from countries, the Alliance has helped immunise 440 million boys and girls which will save six million lives.

Drawing on the individual strengths of its members, the GAVI Alliance model aggregates country demand, guarantees long-term, predictable funding and brings down prices, helping to ensure that generations of children in poor countries do not miss out on life-saving vaccines.

As a public-private partnership, the GAVI Alliance represents the key stakeholders in global immunisation: implementing and donor governments, WHO, UNICEF, the World Bank, the Bill & Melinda Gates Foundation, civil society, the vaccine industry, research and technical health institutes and the private sector.

Our funding supports 11 vaccines, including those against pneumococcal disease and rotavirus – the leading vaccine-preventable causes of pneumonia and diarrhoea – and HPV, which causes cervical cancer.

Commitments to countries by type of support, 2000–2013*



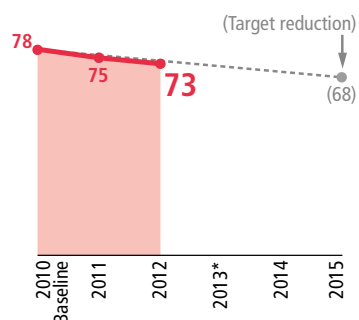
Source: 1

*This graph presents the commitments that have been made to countries by type of support as of 31 December 2013. These commitments cover programme years up to and including programme year 2017.

Mission indicators

The GAVI Alliance relies on three indicators, each with specific targets, to measure progress towards fulfilling our mission.

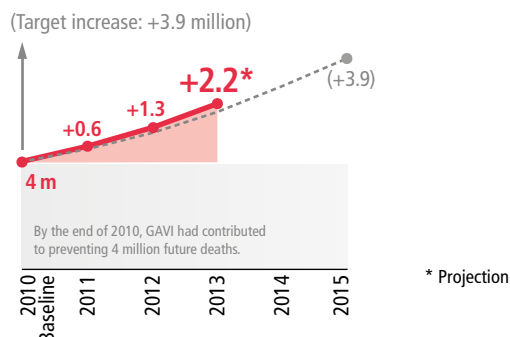
Under-five mortality rate in GAVI-supported countries (per 1,000 live births)



Source: 2

Child mortality in GAVI-supported countries fell from 78 to 73 deaths per 1,000 live births between 2010 and 2012, with vaccines responsible for part of the drop. As a result of the unprecedented number of vaccine introductions and increasing vaccine coverage, the Alliance is on track to reduce child mortality to 68 per 1,000 live births by 2015.

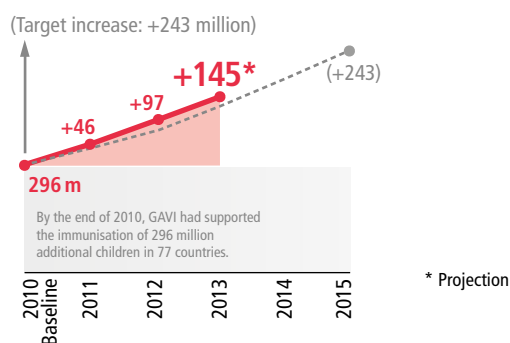
Number of future deaths averted (millions)



Source: 3

Projections indicate that by the end of 2013 vaccines from the GAVI Alliance will have averted more than 2.2 million future deaths. The Alliance expects to meet its target of averting 3.9 million future deaths from 2011 to the end of 2015. In addition, 500,000 future deaths averted are projected through GAVI-funded measles vaccine campaigns between 2013 and 2015.

Number of children immunised with GAVI Alliance support (millions)



Source: 4

In 2013, projections indicate approximately 48 million children were immunised with GAVI-supported vaccines. Estimates will be finalised after 2013 WHO/UNICEF immunisation coverage estimates are released in July 2014.

The GAVI Alliance expects to meet its target of immunising 243 million children between 2011 and 2015 across all of its approved vaccine programmes.

2013: delivering on the promise

2013 was marked by an unprecedented acceleration in country demand for vaccines, with more GAVI-supported introductions and campaigns than in any single year since the Alliance started in 2000.

From January to December, the GAVI Alliance funded a total of 41 new vaccine introductions, campaigns and demonstration projects, helping developing countries immunise millions of children and adults.

In 2000, only one low-income country had introduced both *Haemophilus influenzae* type b and hepatitis B vaccines into its routine immunisation programme. By the end of 2013, all low-income countries bar one had introduced the pentavalent vaccine, which also protects against diphtheria, tetanus and pertussis. South Sudan had its application for pentavalent vaccine support approved in 2013, and it plans to introduce the vaccine in 2014. The Alliance also supported a record 14 pneumococcal vaccine launches and six rotavirus vaccine introductions, providing protection against the main vaccine-preventable causes of pneumonia and diarrhoea.

The GAVI Alliance also started funding two vaccines destined to have a significant impact on women and children's health in 2013. By the end of the year, six countries had been approved for HPV vaccine demonstration projects to combat cervical cancer. In March, Rwanda became the first GAVI-supported country to introduce the measles-rubella vaccine.

By the end of 2013, WHO estimates that GAVI-funded meningitis A vaccine campaigns had immunised 150 million people against the deadly meningitis epidemics that haunt Africa's "meningitis belt".

By the end of 2013, the GAVI Alliance had:

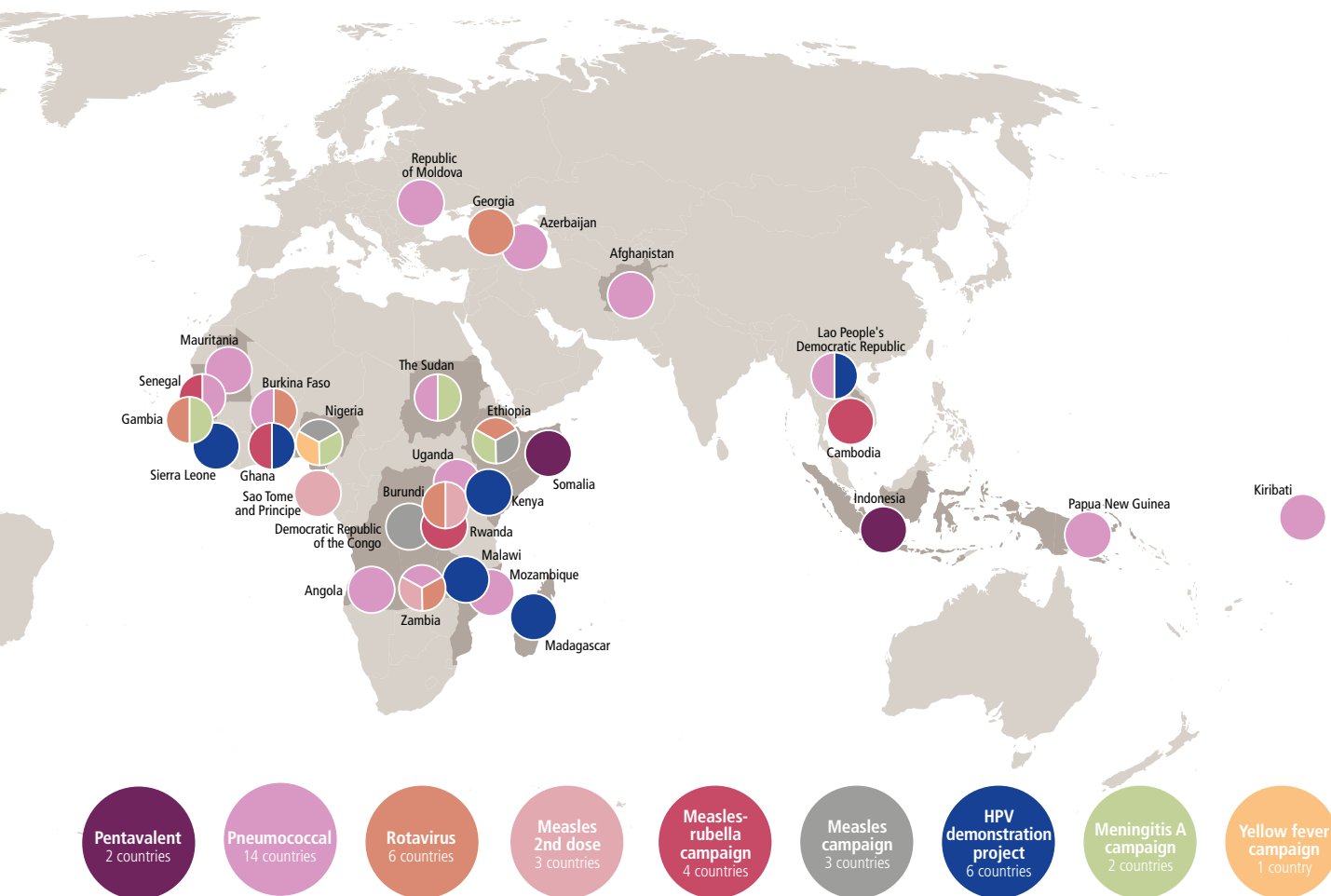
- supported the immunisation of an estimated 440 million children – equivalent to the combined populations of France, the United Kingdom and the United States of America;
- contributed to the prevention of more than six million future deaths caused by preventable infectious diseases;
- committed US\$ 8.2 billion to all GAVI Alliance programmes including new and underused vaccines and health system strengthening programmes in the world's poorest countries.



Source: 5



GAVI-supported vaccine introductions and campaigns in 2013



KEY EVENTS IN 2013

An additional US\$ 12.5 million to fund life-saving vaccines, which was matched through the GAVI Matching Fund, was announced by Bill Gates, Co-Chair of the Bill & Melinda Gates Foundation, and Justine Greening, UK Secretary of State for International Development, at the GAVI Alliance CEO breakfast, World Economic Forum in Davos, Switzerland.

Vaccine launches and campaigns

Burundi: measles second dose **R**

An independent evaluation called the pilot Advance Market Commitment (AMC) for pneumococcal vaccines a “promising solution to the challenge of accelerating access to life-saving medicines”.

The GAVI Alliance and the Islamic Development Bank signed an agreement to work together to accelerate the introduction of vaccines in the Bank’s member countries.

The “la Caixa” Foundation announced that it would donate an additional € 1 million to the GAVI Alliance to purchase vaccines for children in Latin America.

Vaccine launches and campaigns

Georgia: rotavirus vaccine **R**

Rwanda: measles-rubella vaccine **C**

Lions Clubs International Foundation pledged to raise US\$ 30 million for measles immunisation. This will be matched by US\$ 30 million from the United Kingdom (UK) Government and the Bill & Melinda Gates Foundation.

The UK Government’s Multilateral Aid Review Update 2013 said that the GAVI Alliance provides “highly cost-effective health interventions” and “effective financial oversight”.

Vaccine launches and campaigns

Zambia: measles second dose **R** and pneumococcal vaccine **R**

Vaccine launches and campaigns

The Gambia: rotavirus vaccine **R**

Indonesia: pentavalent vaccine **R**

Sudan: pneumococcal vaccine **R**

Vaccine launches and campaigns

Afghanistan: pneumococcal vaccine **R**

Azerbaijan: pneumococcal vaccine **R**

Burundi: rotavirus vaccine **R**



On World Cancer Day, the GAVI Alliance announced that countries plan to protect 180,000 girls in eight developing countries against the leading cause of cervical cancer through vaccination against HPV.

The GAVI Alliance secured a 30% reduction in the previous lowest price for pentavalent vaccine from a manufacturer in India, enabling it to pay up to US\$ 150 million less for the vaccine over four years.

Vaccine launches and campaigns

Mozambique: pneumococcal vaccine **R**

Somalia: pentavalent vaccine **R**

Uganda: pneumococcal vaccine **R**

A deal was struck allowing the purchase of HPV vaccine for GAVI Alliance countries at a record low price.

Vaccine launches and campaigns

Ethiopia: measles **C**

Kenya: the first GAVI-supported country to run a demonstration project for HPV vaccine

Kiribati: pneumococcal vaccine **R**

The International Finance Facility for Immunisation (IFFIm) announced that it had raised US\$ 700 million through the sale of bonds to support the GAVI Alliance’s programmes.

Vaccine launches and campaigns

Angola: pneumococcal vaccine **R**

The Global Citizen Festival in New York’s Central Park and featuring performances by Alicia Keys and Stevie Wonder kicked off a new partnership between the Global Poverty Project and the GAVI Alliance.

Vaccine launches and campaigns

The Democratic Republic of Congo: measles vaccine **C**

Ghana: measles-rubella vaccine **C**

Malawi: HPV vaccine demonstration project

Halfway through the GAVI Alliance five-year strategy (2011–2015), partners gathered in Stockholm, Sweden, for the Alliance’s Mid-Term Review to assess progress.

The GAVI Alliance was ranked second out of 67 international development organisations, including UN agencies and donor governments, by Publish What You Fund’s 2013 Aid Transparency Index – currently the only global measure on aid transparency.

WHO prequalifies a JE vaccine for paediatric use produced by a Chinese manufacturer. The Alliance prepares to issue guidelines inviting countries to apply for support for JE catch-up campaigns so children across south Asia can be protected against the devastating illness.

Canada pledged US\$ 20 million to help accelerate the Alliance’s measles immunisation programme.

Vaccine launches and campaigns

Burkina Faso: pneumococcal and rotavirus vaccines **R**

Cambodia: measles-rubella vaccine **C**

Ethiopia: meningitis A vaccine **C**

The Lao People’s Democratic Republic: pneumococcal vaccine **R** plus HPV vaccine demonstration project

Nigeria: measles vaccine **C**

The Republic of Moldova: pneumococcal vaccine **R**

Sierra Leone: HPV vaccine demonstration project

The GAVI Alliance Board decided new support would be made available for additional mass campaigns with yellow fever vaccine and approved a contribution to the global cholera vaccine stockpile.

The GAVI Alliance announced its support for IPV introduction as part of the polio endgame strategy.

Vaccine launches and campaigns

Ethiopia: rotavirus vaccine **R**

The Gambia: meningitis A vaccine **C**

Ghana: HPV vaccine demonstration project

Madagascar: HPV vaccine demonstration project

Mauritania: pneumococcal vaccine **R**

Nigeria: yellow fever vaccine **C**

Papua New Guinea: pneumococcal vaccine **R**

Senegal: pneumococcal vaccine **R** plus measles-rubella vaccine **C**

São Tomé and Príncipe: measles second dose vaccine **R**

Zambia: rotavirus vaccine **R**

R = vaccine introduced into routine immunisation programme **C** = vaccination campaign



Gates Foundation
@gatesfoundation

*Great news:
@GAVIAlliance is on track to immunize an addition 250 million children by 2015.*

Mid-Term Review of 2011–2015 strategy

More than 150 GAVI Alliance partners, including high-level donor and implementing country representatives, gathered in Stockholm on 30 October 2013 to take stock of the Alliance’s progress in reaching its goals halfway through its five-year strategy (2011–2015).

Jointly hosted by Sweden’s Minister for International Development Cooperation, Hillevi Engström, and Ghanaian President HE John Dramani Mahama, the Mid-Term Review (MTR) demonstrated that the GAVI Alliance is on track to achieve its 2015 mission goals: immunising 243 million children, often with several vaccines, which will save close to four million lives.

The MTR report provided data and examples to underline the momentum built across all of the Alliance’s strategic goals.

From 2011 to September 2013, highlight achievements included:

- the rise in vaccine introductions and campaigns, with record growth for GAVI-funded programmes;
- evidence that increased investments in vaccines have revolutionised the global vaccine market, attracting new suppliers of high-quality vaccines at reduced prices;
- increases in countries’ investment in their own health systems.

Despite this progress, the report also acknowledged that the Alliance is falling short of fully achieving some of its ambitious targets for 2011–2015 due to a number of challenges.

Vaccine supply constraints and limited country preparedness are jeopardising targets for pentavalent, pneumococcal and rotavirus vaccine coverage rates. Likewise, while most countries have





increased immunisation coverage rates, weaknesses in a few large countries mean there has been limited progress on ensuring the basic package of childhood vaccines (three doses of diphtheria-tetanus-pertussis vaccines) is reaching everyone, regardless of sex, income or geographical location.

In a series of individual statements at the MTR meeting, donors and other participants recognised the GAVI Alliance's leadership in forging an innovative model that aims to help countries towards self-sufficiency. By investing in the Alliance model, donors can expect a clear return on investment from contributions. Developing countries are also stepping up investment in their routine immunisation programmes. As national

prosperity grows, countries eventually "graduate" from GAVI Alliance support.

The availability of long-term, predictable funding for immunisation, coupled with increased demand from developing countries, is also encouraging manufacturers to supply vaccines at more affordable prices.

Underlining donors' continued commitment to the Alliance, the Republic of Korea and Sweden announced an increase in their respective contributions, while the European Commission agreed to host the launch of the GAVI Alliance replenishment process in Brussels, Belgium, in 2014.



As part of the MTR update, a series of real-life stories from the front lines of immunisation were published on the GAVI Alliance and partner websites.

From the babushka midwife single-handedly keeping vaccination coverage high in a remote Kyrgyzstan village to the Nigerian father who dropped his anti-vaccine stance after nearly losing his daughter to pneumonia, the stories highlighted the efforts of implementing countries and Alliance members to ensure that vaccines reach the children who need them, wherever they live.

Contributions and commitments to the GAVI Alliance*

Cash received by the GAVI Alliance (in US\$ millions) as of 31 December 2013

Donor governments and the European Commission	2013	Total 2000–2013
Australia	48.3	182.2
Canada	39.0	226.6
Denmark	4.6	45.7
European Commission (EC)		70.4
France	34.9	108.2
Germany	35.4	100.6
Ireland	3.0	41.2
Japan	9.1	27.5
Luxembourg	1.1	9.8
Netherlands	34.4	290.8
Norway	126.9	832.7
Republic of Korea	1.0	2.0
Spain		43.2
Sweden	70.9	286.1
United Kingdom	447.9	877.3
United States	138.0	1,004.5
Sub-total	994.3	4,148.9
Foundations, organisations and corporations		
Bill & Melinda Gates Foundation	283.1	2,028.8
His Highness Sheikh Mohammed bin Zayed Al Nahyan	10.1	33.0
OPEC Fund for International Development (OFID)	0.7	0.7
Sub-total	293.8	2,062.5
Anglo American plc	1.0	3.0
Absolute Return for Kids (ARK)		1.6
Comic Relief	6.9	10.1
Dutch Postcode Lottery	3.2	3.2
JP Morgan		2.4
"la Caixa" Foundation	2.0	23.7
LDS Charities	2.5	4.0
Prudential	0.2	0.2
Statoil	0.2	0.2
The Children's Investment Fund Foundation (UK)	2.2	6.5
Other private**	1.2	15.2
Sub-total	19.3	69.9
IFFIm disbursed funds***	200.0	2,475.7
AMC funds****	214.4	609.0
Total contributions*****	1,721.9	9,365.9

*As GAVI's financing mechanisms enable the innovative use of donor contributions over time, the amount of donor contributions (as detailed in Annex 2) may differ from the amount of cash received by GAVI (as detailed above) in a given year.

**Some contributions received via the GAVI Campaign.

***IFFIm disbursed funds: cash disbursements from the World Bank to the GFA (2006-2012), to the GAVI Alliance (2013).

****AMC funds: cash transfers from the World Bank to the GAVI Alliance.

*****In 2013, total funding received amounted to an unprecedented US\$ 1.7 billion.

Source: 6

Innovative finance mechanisms: AMC and IFFIm

AMC commitments	2009–2020 (US\$ millions)
Italy	635
United Kingdom	485
Canada	200
Russian Federation	80
Bill & Melinda Gates Foundation	50
Norway	50
Total	1,500

Source: 7

IFFIm commitments*	Length of commitment	Amount (in millions)	Total (equivalent in US\$ millions**)
United Kingdom	20 years	£ 1,380.0	2,979.9
	20 years	£ 250.0	
France	15 years	€ 372.8	1,719.6
	19 years	€ 867.2	
Italy	20 years	€ 473.5	635.0
	15 years	€ 25.5	
Norway	5 years	US\$ 27.0	264.5
	10 years	NOK 1,500.0	
Australia	20 years	A\$ 250.0	256.1
Spain	20 years	€ 189.5	240.4
Netherlands	7 years	€ 80.0	114.4
Sweden	15 years	SEK 276.2	37.7
South Africa	20 years	US\$ 20.0	20.0
Total			6,267.6

*The United Kingdom and Brazil made new pledges to IFFIm in 2011. Negotiations are currently under way to formally sign these grant agreements.

**IFFIm pledges by donors in US\$ and US\$ equivalent amounts of national currency pledges calculated using prevailing exchange rates around the time of signing of the grant agreement.

Source: 8

Country co-financing commitments

	2013	2000–2012
Voluntary (US\$ million)*	–	31
Co-financing (US\$ million)**	69	183

*Voluntary payments prior to the implementation of the co-financing policy (2000–2007).

**Co-financing since the implementation of the co-financing policy (2008–2013).

Source: 9





01

Accelerate vaccines

Accelerate the uptake
and use of underused
and new vaccines



[gaviprogressreport.org/2013/
accelerate-vaccines](http://gaviprogressreport.org/2013/accelerate-vaccines)

Record numbers of vaccine introductions and campaigns

- **41 introductions of new vaccines or vaccine campaigns took place in 2013 (up from 30 in 2012).**
- **14 countries introduced pneumococcal vaccine.**
- **6 countries introduced rotavirus vaccine.**
- **6 countries started demonstration projects for human papillomavirus (HPV) vaccine against cervical cancer.**
- **4 countries conducted measles-rubella campaigns.**

In 2013, the GAVI Alliance responded to an unprecedented surge in country demand for new vaccines by supporting 41 introductions and campaigns – a record number for a single year – often in the world’s most challenging environments.

National commitment to immunisation was underlined by several milestone achievements: the largest ever introduction of rotavirus vaccine (in Ethiopia), Somalia’s first new vaccine rollout in 35 years (of pentavalent vaccine) and the start of Indonesia’s delivery of pentavalent vaccine across its 6,000 inhabited islands – using a national WHO accredited vaccine supplier. The latter two introductions mean that 72 out of 73 GAVI-supported countries have now introduced the five-in-one pentavalent vaccine.

During 2013, the level of demand for new vaccines led to supply constraints for particular products and formulations, and also highlighted issues related to country preparedness.

GAVI Alliance partners are working with manufacturers to secure sufficient supply (see page 63) and coordinating technical assistance to resolve implementation issues (see page 39).

In 2013, the GAVI Alliance also started to provide funding for two vaccines that will affect the health of women and children: HPV vaccine against cervical cancer, one of the largest cancer killers of women in the developing world; and the combined measles-rubella vaccine, a two-in-one shot against the causes of congenital abnormalities and early deaths.

The 2013 acceleration underlines the success of the GAVI Alliance model in bringing partners together – UNICEF, WHO, civil society and others – to support countries. Following the GAVI Alliance Board’s 2013 decision to open a funding window for inactivated poliovirus vaccine (IPV), the partnership model will play a critical role in the polio endgame strategy.

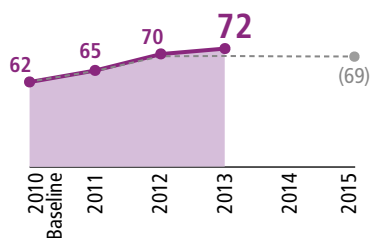


Nurse Oyunchime, on the last leg of her journey, will immunise children and girls with measles-rubella vaccine in a remote area of Mongolia.

Country introductions of new and underused vaccines

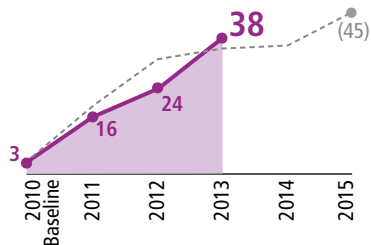
Pentavalent vaccine

Number of countries



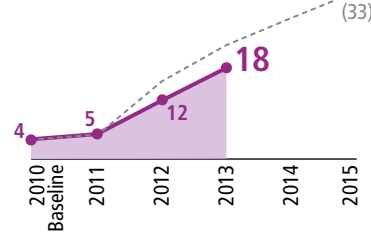
Pneumococcal vaccine

Number of countries



Rotavirus vaccine

Number of countries



Source: 10

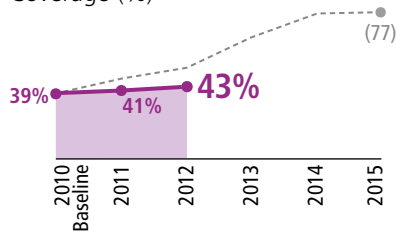
By the end of 2013, the pentavalent vaccine had been introduced in 72 of 73 GAVI-supported countries, exceeding the 2015 target of 69. The cumulative number of pneumococcal vaccine introductions reached 38, slightly above expectations for the year. Rotavirus introductions

were slightly below 2013 expectations due to constraints on supplies of preferred product formulations. As the supply issue will be resolved in 2014, the number of introductions is expected to be back on track to meet 2015 targets.

Coverage of new and underused vaccines*

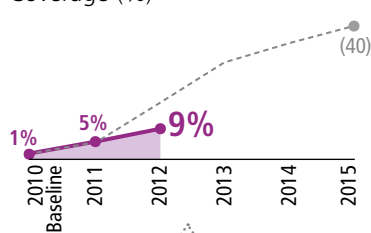
Pentavalent vaccine, 3rd dose

Coverage (%)



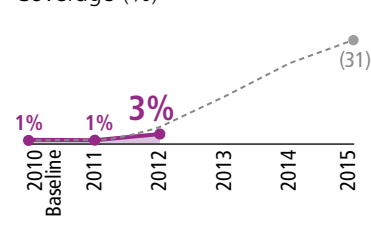
Pneumococcal vaccine, 3rd dose

Coverage (%)



Rotavirus vaccine, last dose

Coverage (%)



Source: 11

Delays in introductions related to vaccine supply constraints and countries' readiness meant that in 2012 the GAVI Alliance fell short of its annual coverage targets for all

vaccines. The Alliance expects to gain ground against the coverage targets, especially for pneumococcal vaccine.

*GAVI Alliance estimates depend on the availability of WHO and UNICEF data for vaccine coverage. At the time of publication, 2013 data were not available.



*Without support from GAVI, Pakistani children would not have access to new, life-saving vaccines like *Haemophilus influenzae* type b and pneumococcal vaccines.”*

Dr Quamrul Hasan,
Medical Officer, WHO,
Pakistan

Vaccine updates: preventing major killers

In 2013, demand for GAVI-supported vaccines that can thwart major infectious diseases threatening the lives of young children reached record heights.

Pentavalent vaccine

At the end of 2013, 72 of the 73 GAVI-supported countries had introduced pentavalent vaccine into routine immunisation, with the remaining country (South Sudan) scheduled to launch in 2014. Somalia – a country in the grip of internal conflict – introduced the vaccine in 2013, as did Indonesia, which plans to immunise all the country’s children using a locally produced vaccine (see page 61).

This has brought the GAVI Alliance to the brink of fulfilling one of its original objectives: ensuring all poor countries have access to vaccines against hepatitis B (hepB) and *Haemophilus influenzae* type b (Hib) – a bacterium that causes meningitis, pneumonia and septicaemia.

Pentavalent vaccine protects children against five major infections with

a single shot: diphtheria-tetanus-pertussis (DTP), hepB and Hib. This makes the experience of immunisation easier for babies and more efficient in ensuring life-saving vaccines reach remote, hard-to-reach communities as quickly as possible.

Inclusion of the hepB vaccine is a critical element because this disease causes hundreds of thousands of deaths every year through acute and chronic illnesses, including liver cancer and cirrhosis. The hepB vaccine is 95% effective in preventing infection and its chronic consequences, and was the first vaccine to provide protection against a major cause of cancer.

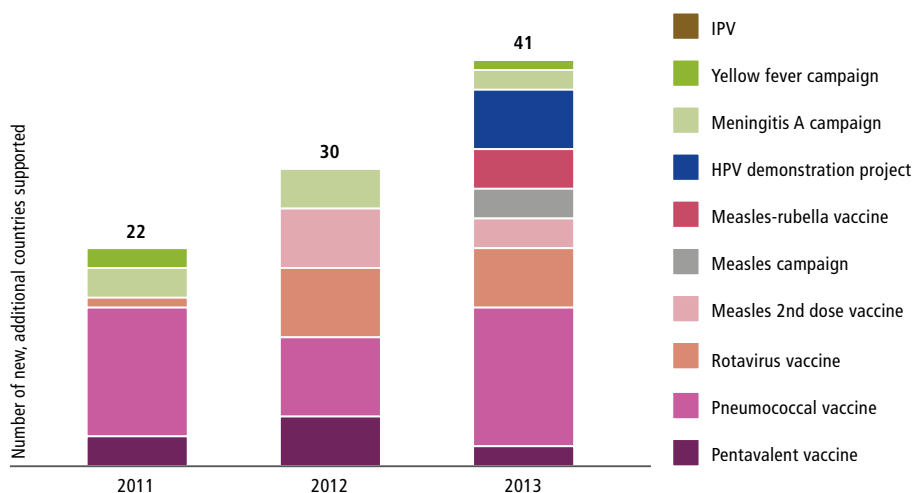
Pneumococcal vaccine

Pneumonia, a severe infection of the lungs, continues to be one of the leading causes of death in children under five years of age worldwide. Infection with the pneumococcal bacterium is the main cause of pneumonia, which takes the lives of more than half a million children in this age group each year.



Yusuf Ibrahim and his children.

New GAVI Alliance vaccine support, 2011–2013: routine programme introductions and campaigns



Note: only the first phase of introductions and campaigns is included.

Source: 12

In 2013, thanks to funding support from the GAVI Alliance and the Alliance's role in securing additional doses, 14 of the world's poorest countries were able to introduce the pneumococcal vaccine.

Since the GAVI Alliance first started rolling out the pneumococcal vaccine in 2010, a total of 40 GAVI-supported countries have now added the vaccine to their routine immunisation programmes. WHO estimates that close to 11 million children worldwide

have been protected against pneumococcal disease.

In 2013, WHO and UNICEF published the integrated Global Action Plan for Pneumonia and Diarrhoea, which proposed a cohesive approach to ending the two major preventable causes of child death. In the case of pneumonia, pneumococcal vaccination, exclusive breastfeeding for six months and the reduction of household air pollution are key approaches. The GAVI Alliance



An enlightened father: changing hearts and minds

Yusuf Ibrahim is a Muslim. He is also a convert: not in his religious faith, but in his beliefs about immunisation. Rumours that vaccinations are the product of a Western plot to "control the Muslim population" abound in Nigeria, although no one is entirely sure of their origins. Growing up in a tiny farming village an hour from Minna, in northern Nigeria, Yusuf was told this as fact. It took a near tragedy to change his heart and mind. His first-born daughter Saratu, then two years old, nearly died of pneumonia. He began to talk his beliefs through with physicians at the hospital where she was treated. They gradually convinced him that they were there simply to preserve life, and that had his child been given the right vaccination she would have been spared this ordeal. A decade later and now the father of four, Yusuf is an advocate. He goes door to door through the streets and orange-dusted back alleys of Unguwar Daji, explaining to families why immunisation is so important.



UNICEF
@UNICEF

Good news from @GAVIAlliance: a quarter of a billion children will be immunised by 2015, which will avert 4m deaths.

recognises the central role of vaccination in this broader context, and is committed to leveraging new vaccine introduction opportunities to strengthen an integrated approach.

Rotavirus vaccine

Millennium Development Goal (MDG) 4 specifically addresses the need to revitalise efforts against diarrhoea and has emphasised the importance of rotavirus vaccination, since rotavirus infection is a leading cause of serious diarrhoea in children aged five and under. Since there is no effective medication available to treat rotavirus infection, vaccination offers the best hope for reducing the devastating impact of diarrhoea, which, according to WHO estimates, claims the lives of nearly half a million young children each year.*

Recognising the importance of rotavirus vaccine in preventing diarrhoeal deaths in young children, more and more countries are seeking to introduce this life-saving intervention. By the end of 2013, 34 GAVI-eligible countries had been approved for rotavirus vaccine support from the Alliance. During

**Source: 13*

2013 six countries introduced the vaccine, including Ethiopia, which accounts for 6% of all rotavirus-related deaths globally. Ethiopia's Ministry of Health underlined its commitment to immunisation by expanding its cold-chain facilities nationwide and deploying health extension workers to ensure that rotavirus vaccine reached every village in a country spread across 1.1 million square kilometres.

According to WHO estimates, the Alliance has now contributed to the immunisation of more than four million children against rotavirus.

Yellow fever vaccine

The GAVI Alliance supports both routine immunisation and mass campaigns against yellow fever. From 2000 to 2012, WHO calculates that close to 64 million children had been vaccinated against yellow fever in 17 countries through GAVI-supported routine immunisation programmes.

From the start of the programme through to the end of 2012, mass yellow fever vaccination campaigns supported by the Alliance have reached more



A baby in Ghana is immunised with the rotavirus vaccine, which children nationwide receive with GAVI Alliance support.



Sister Sofia Benti makes her rounds, vaccinating children in a pastoralist community in the remote region of Afar, Ethiopia.



ETHIOPIA

travelling vaccinators

At the last recording, only 23% of the children living in Ethiopia's remote pastoralist region of Afar had been vaccinated against DTP. This is a far cry from the 84% coverage rate in the nation's capital, Addis Ababa. Ethiopia's Government has recognised that the only way to improve immunisation rates among children in these pastoralist communities is through routine outreach programmes.

"Once we recognised that coverage was low – through a recent review by the Ethiopian Government and its partners and because of the emergence of outbreaks, which provided further evidence – we revitalised our entire immunisation programme," says Dr Kurkie Abdissa, Director, Urban Health Promotion and Disease Prevention and National Coordinator for Maternal and Child Health and Immunisations Services, Ethiopia. "We have developed a special approach for pastoralist regions: we use not only fixed posts but also an outreach service. This is more fitting because some pastoralist communities move seasonally, so you have to follow them and make sure boys and girls get the antigens that they need."

Reaching every child with measles immunisation also remains an issue in Ethiopia. In 2013, GAVI Alliance support helped the country to fund a wide-reaching measles campaign.



The HPV vaccine will help prevent cervical cancer, one of the highest causes of cancer-related deaths in Lao women.”

Dr Eksavang Vongvichit,
Health Minister of the Lao
People's Democratic Republic

than 70 million people at risk in Benin, Burkina Faso, Cameroon, the Central African Republic, Côte d'Ivoire, Ghana, Guinea, Liberia, Mali, Nigeria, Senegal, Sierra Leone and Togo.

Meningitis A vaccine

Some 450 million people, especially children and young adults, are at risk of becoming ill during seasonal meningitis A epidemics in the African meningitis belt. The disease is often rapidly fatal, and survivors can face brain damage, deafness and other disabilities.

From 2010 to 2013, Alliance-supported campaigns reached over 150 million people aged 1 to 25 years in Benin, Burkina Faso, Cameroon, Chad, Ethiopia, the Gambia, Ghana, Mali, Niger, Nigeria, Senegal and Sudan.

In Burkina Faso, Mali and Niger, the number of confirmed cases of meningitis A went down from a collective 1,512 in 2009 to 0 in 2013.*

Japanese encephalitis vaccine

In November 2013, the GAVI Alliance Board approved the opening of a funding window for a Japanese encephalitis (JE) vaccine, inviting

countries to apply for GAVI Alliance support from 2014. JE can be fatal, killing 30% of patients, with approximately 60,000 cases each year.

The GAVI Alliance's 2008 Vaccine Investment Strategy had recommended that the Alliance provide support for a JE vaccine, pending the prequalification of an appropriate vaccine. In October 2013, WHO added a JE vaccine, developed by Chengdu Institute of Biological Products, to its list of prequalified vaccines, opening the door for United Nations agencies to procure the vaccine. It is the first Chinese-produced vaccine to be prequalified by WHO and is also the first prequalified JE vaccine for paediatric use.

In line with WHO recommendations, the GAVI Alliance will provide support for JE catch-up campaigns, targeting children aged nine months up to 15 years. Given the low cost of the vaccine, and to encourage sustainability, countries are required to self-finance the introduction of the vaccine in their routine immunisation programmes.

Strengthening the focus on women and children: now and for future generations

Two recent developments have broadened the world's appreciation of the impact vaccines can have on girls and women today, as well as on future generations of children and adults of both sexes.

The first is the advent of the HPV vaccine. There is evidence that 70% of all cervical cancer – the cause each year of more than 250,000 deaths, most of them among women in developing countries – can be prevented by vaccinating girls and young women against HPV before they are exposed to the virus. In 2013, the Alliance made important strides

towards universal immunisation of girls against HPV: demonstration projects took place in six countries with GAVI support. The projects pave the way for countries to build the infrastructure and capacity necessary to vaccinate girls nationwide. Rwanda has had a national HPV programme launched with a donated vaccine since 2011, for which it will start receiving GAVI Alliance support in 2014.

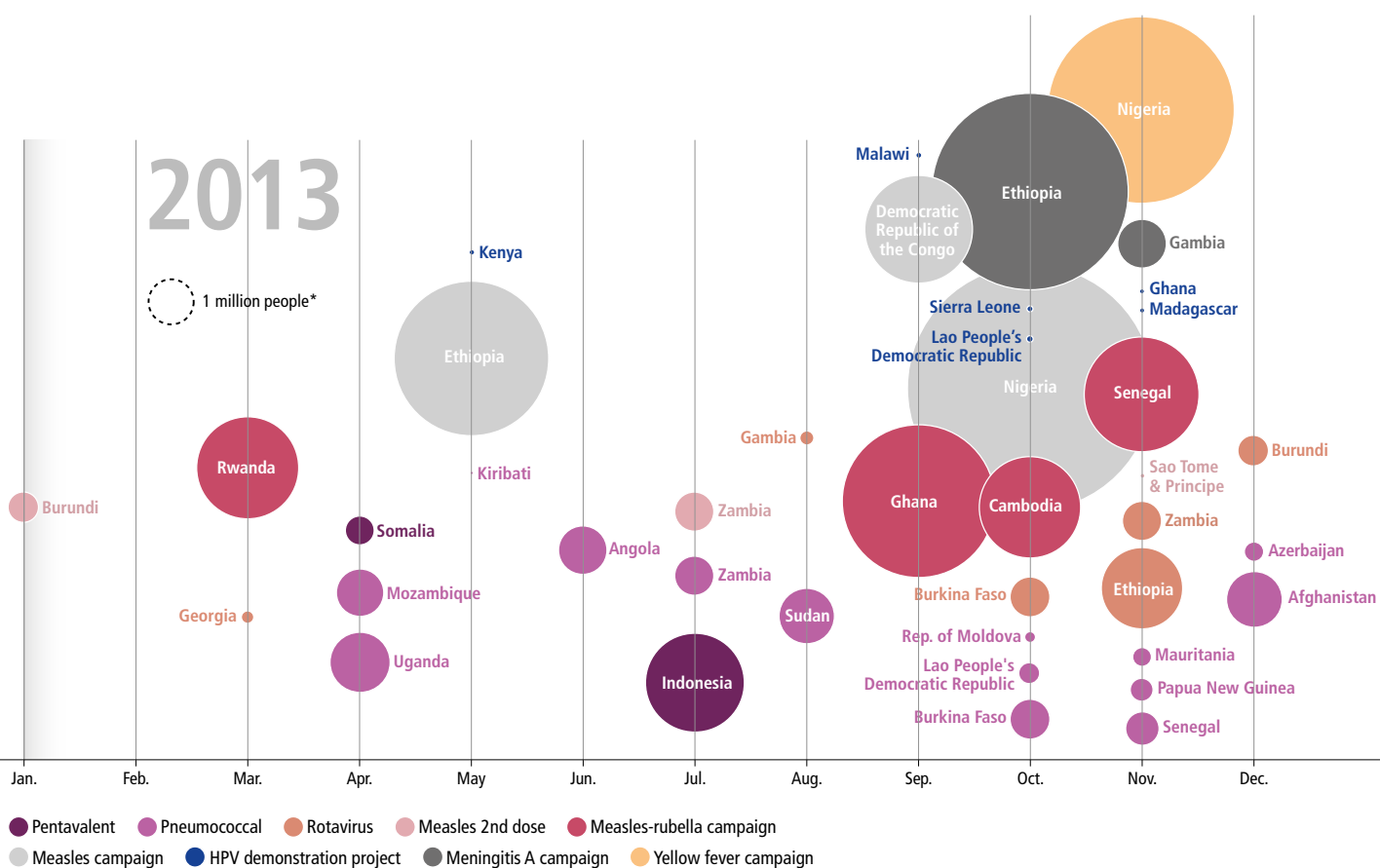
The Alliance is partnering with cancer, reproductive health and women's organisations to integrate HPV vaccine delivery with other important health interventions for adolescent girls,

*Source: 14



Girls gather at a clinic in Zanzibar, the United Republic of Tanzania – one of six countries the Alliance supported in 2013 for an HPV demonstration project.

GAVI-supported vaccine launches and new campaigns in 2013



* Refers to annual birth cohort (for vaccine introductions) or target population (for vaccine campaigns or supplementary immunisation activities).

Source: 15



GAVI's objective is to make vaccines, which are underused or underutilised because of their cost, available to poor countries, and they've played a major part in Ghana."

Dr KO Antwi-Agyei,
Disease Control Unit
Programme Manager for
the Ghana Health Service

such as guidance on adolescent reproductive health, HIV prevention, nutrition, family planning and safe motherhood.

The second development is broad acknowledgement worldwide that developing countries should have the same opportunity as industrialised countries to prevent the devastating malformations and disabilities (deafness, blindness and heart defects) in babies caused by rubella infection during the first three months of pregnancy.

Today, an estimated 110,000 children are born with congenital rubella syndrome worldwide, 80% of them in

GAVI-supported countries. Universal rubella vaccination would put a stop to this unnecessary suffering. In 2013, one year after the GAVI Alliance first invited countries to apply for support to introduce the measles-rubella vaccine, four countries (Cambodia, Ghana, Rwanda and Senegal) conducted measles-rubella campaigns targeting the next generation of mothers and children aged nine months to 14 years with GAVI support. Within a year, these countries are expected to introduce measles-rubella vaccine into the national immunisation programme to help sustain high coverage and prevent congenital rubella syndrome.



CAMBODIA

a pathfinder on measles and rubella

In October 2013, Cambodia's Ministry of Health launched the biggest nationwide immunisation campaign in the country's history to protect children against two disabling and deadly diseases – measles and rubella – with support from the GAVI Alliance.

Over three months, more than four million children aged nine months to 15 years received the combined measles-rubella vaccine. The Ministry took steps to ensure that every child would be vaccinated even in the hardest to reach villages and districts.

Cambodia was the first Asian country to introduce the measles-rubella vaccine, which will not only stop the transmission of rubella from mother to child during pregnancy, preventing children from being born with severe birth defects, but also protect children against measles, which is highly contagious.

The combined measles-rubella vaccine is an example of the GAVI Alliance's catalytic support for immunisation. The Alliance provides support for catch-up campaigns on the basis that within a year countries self-finance the introduction of the vaccine to their routine immunisation programmes.



GHANA

new focus on protecting girls against cervical cancer

In November, Ghana's Ministry of Health launched a demonstration project for the HPV vaccine. In four districts in the Northern and Greater Accra regions, 6,000 schoolgirls aged nine to 11 began receiving the first dose of the vaccine against the leading cause of cervical cancer, with support from the GAVI Alliance.

Ghana was the fifth country to run demonstration projects for the HPV vaccine in 2013, following Kenya, the Lao People's Democratic Republic, Malawi and Sierra Leone. The projects gave each country the opportunity to demonstrate their ability to put in place the systems needed to run national HPV programmes.

By 2020, the Alliance expects more than 30 million girls in more than 40 of the world's poorest countries to have been immunised with the HPV vaccine. Ghana has one of the best-performing immunisation programmes in the developing world applying for support to introduce all GAVI Alliance vaccines, and is increasingly a model for its neighbours.



More than 6,000 school girls in the Accra region of Ghana received the first dose of the HPV vaccine in November 2013.



THE ALLIANCE IN ACTION:

beginning of the endgame for polio

The GAVI Alliance has a strong track record in helping countries introduce life-saving vaccines rapidly into their routine immunisation systems. As a result, the Alliance is assisting countries in partnering with the Global Polio Eradication Initiative (GPEI) – a public-private partnership led by national governments and spearheaded by WHO, Rotary International, the US Centers for Disease Control and Prevention and UNICEF – in implementing a critical element of the new polio endgame strategy: the rollout of IPV.

Despite high hopes and enormous progress in eradicating polio, seven countries had illnesses generated by vaccine type 2 poliovirus in 2013. Each of the 62 polio cases resulted from the rare situation in which the weakened but live virus in the oral vaccine can cause polio.

To eliminate the risk of vaccine-derived polio cases, the Polio Eradication and Endgame Strategic Plan, endorsed by the World Health Assembly in May 2013, calls for a phased replacement of oral polio vaccine containing the type 2 virus with a version based on virus types 1 and 3 by 2016.

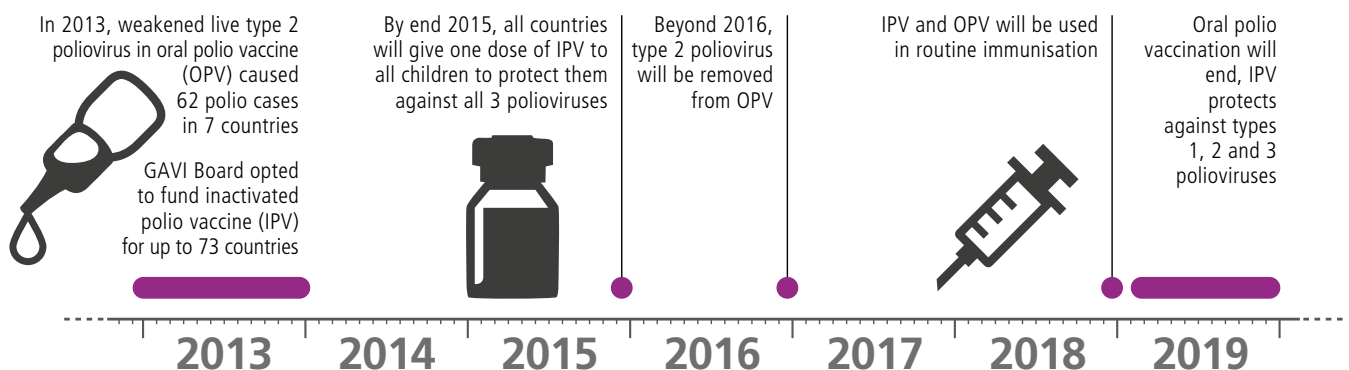
To minimise the risks associated with this transition, WHO has recommended that all countries introduce at least one dose of IPV, which protects against all three virus types, into their routine immunisation schedule before the end of 2015. This will lay the foundations for the phasing out of all oral polio vaccines by 2019 – a critical step to completing polio eradication.

Adding IPV to routine immunisation programmes will not only increase immunity but also hasten eradication of wild poliovirus serotypes in the three countries in which transmission of the virus has never stopped: Afghanistan, Nigeria and Pakistan.

The collaboration with GPEI also represents an opportunity to draw on innovative techniques commonly used to ensure polio campaigns reach every child – micro-planning, mobilisation, monitoring and data analysis – to strengthen the routine immunisation programme.

In November 2013, the GAVI Alliance Board agreed to open an IPV funding window from December 2013 to June 2015, which is being supported by supplemental funds from Alliance donors. Given the global health priority of polio eradication, funding will be offered not only to all GAVI-supported countries but also to countries graduating from the Alliance's support.

The GAVI Alliance and inactivated polio vaccine



Source: 16



UK Prime Minister
@number10gov

PM: Delighted
@GAVIAlliance is on
track to immunise
243m children by
2015, preventing
nearly 4m deaths,
following ambitious
London conf.

Vaccine investment strategy, 2014–2018

Every five years, the GAVI Alliance takes stock of potential new vaccines to add to its portfolio. In November 2013, following analysis and consultations with partners, experts and civil society, the GAVI Alliance Board approved a new vaccine investment strategy for the period 2014–2018.

Cholera

A cholera vaccine is available but there is uncertainty about the best way to use it in settings where people are vulnerable to the disease. The Alliance decided not to open a window for country support and to re-evaluate the investment case for cholera in the next vaccine investment strategy, scheduled for 2018. In the meantime, the GAVI Alliance Board approved a contribution to the global cholera vaccine stockpile to fight cholera outbreaks and to gain experience with the vaccine.

Malaria

Trials of the most advanced malaria vaccine candidate are expected to

finish in 2014. In 2013, the GAVI Alliance Board decided to await these trial results before assessing the case for funding a vaccine. The Board will reconsider support following a recommendation for use of the vaccine, likely in 2015, by WHO's Strategic Advisory Group of Experts and the Malaria Programme Advisory Committee.

Yellow fever, rabies and maternal influenza

The GAVI Alliance Board agreed that following a resurgence and spread of yellow fever in some parts of Africa, the Alliance will fully support additional mass campaigns in high-risk areas. It will also fund an observational study to address critical knowledge gaps around access to the important rabies vaccine and to closely monitor the evolving evidence base for maternal influenza vaccination.



The fully immunised child

In 2013, the international community turned its attention to shaping a development agenda that will represent the next step beyond the 2015 MDGs. Two landmark documents underlined the critical role of routine immunisation in achieving post-2015 goals.

First, a report by a High-Level Panel on the Post-2015 Development Agenda underlined the value of vaccines and called for a target to increase the number of people fully vaccinated.

Then, five months later, the UN Secretary-General issued a report entitled A life of dignity for all: accelerating progress towards the Millennium Development Goals and advancing the United Nations development agenda beyond 2015, urging Member States to improve their immunisation coverage.

The proportion of boys and girls reached with three doses of the most basic vaccines – diphtheria-tetanus-pertussis – is currently used to calculate immunisation coverage rates. The GAVI Alliance is proposing that a new indicator be developed to measure how many children receive the 11 vaccines globally recommended by WHO. That would address not only the reach of vaccines and the strength of health and immunisation systems, but also equity and human rights. Fully immunised children will have improved prospects for living up to their full potential, allowing them to contribute to their nation's economic growth.





02

Strengthen capacity

Contribute to strengthening the capacity of integrated health systems to deliver immunisation



gaviprogressreport.org/2013/strengthen-capacity

Strong health systems are critical to ensuring access to vaccines for all children

- 56 countries were receiving GAVI Alliance health system strengthening (HSS) support by the end of 2013.
- HSS support expanded in 2013 to double the spend level in the previous year.
- New application process reinforces the need to link Alliance HSS grants to improved immunisation outcomes as part of an integrated health system.
- New performance-based funding (PBF) approach applied to all new HSS grants.

Accelerating country introductions of new and underused vaccines is only the first step in the GAVI Alliance's mission. One in five children are still missing out on even the most basic vaccines. One fifth of all child deaths are caused by vaccine-preventable diseases. In 2013, working closely with UNICEF, WHO and other partners, the Alliance intensified its efforts to strengthen country health systems and ensure life-saving vaccines reach all children.

By the end of the year, the Alliance had doubled its year-on-year disbursements for HSS. At the same time, the revised HSS guidelines and application materials are encouraging countries to focus their programmes on improving coverage and equity issues in the delivery of health and immunisation services.

As other supporters of development assistance also recognise, strengthening country health systems is challenging. Data suggest an

improvement in equity in immunisation in GAVI-supported countries, but more time is needed to confirm the trend. The Alliance is currently not on track to meet the other two strategic goal indicators on coverage for three doses of diphtheria-tetanus-pertussis vaccine (DTP3) and drop-out rates.

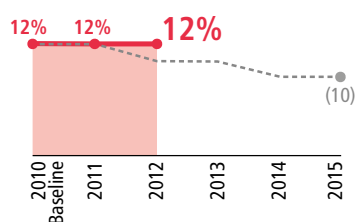
The Alliance's commitment to addressing these challenges is reflected in several new measures: PBF rewards countries for linking HSS support to coverage and equity targets; the country-tailored approach rolled out in 2013 adapts support to the specific needs of fragile states and emergency situations; and intermediate indicators, which are used to track HSS results and support countries to measure health system performance.

The Alliance also intensified its cross-partner efforts to strengthen vaccine supply chains and improve data quality and availability.



In Kyrgyzstan, the GAVI Alliance has funded training on immunisation practice using a curriculum developed by WHO.

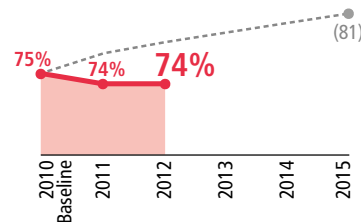
Drop-out rate between DTP1 and DTP3 (% points)



Source: 17

The drop-out rate measures the percentage of children that have received the first but not the third dose of diphtheria-tetanus-pertussis (DTP)-containing vaccines. According to WHO/UNICEF estimates for 2012, the value for this indicator has remained flat at 12 percentage points, and the GAVI Alliance is not on track to meet the 2015 target of 10 percentage points.

Coverage of three doses of diphtheria-tetanus-pertussis-containing vaccine (DTP3) (%)



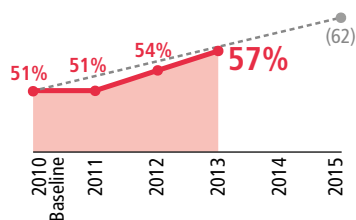
Source: 18

This indicator measures the strength of the routine system in reaching children with three doses of DTP-containing vaccine at the appropriate times. Average DTP3 coverage in GAVI-supported countries has stagnated in recent years.

This trend is driven by weaknesses in routine immunisation systems, particularly in large-population countries that have the greatest influence on the weighted average coverage level across the 73 GAVI-supported countries. For example, the five countries with the largest numbers of unimmunised children saw their DTP3 coverage drop by a weighted average of 3 percentage points between 2010 and 2012, while coverage in the other 68 countries increased by 3 percentage points over the same period despite population growth.

Equity in immunisation coverage (%)

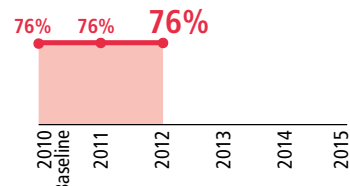
Proportion of countries meeting the minimum equity benchmark



Source: 19

Data for 2013 showed an increase in the percentage of countries that are closing gaps in immunisation coverage between children in the poorest – and most vulnerable – households and those in least poor households. This suggests an improvement in equity in immunisation in GAVI-supported countries, although more time and accelerated efforts are needed to determine whether the GAVI Alliance will be able to meet the 2015 target.

First dose of measles vaccine (MCV1) coverage (%)



Source: 20

The GAVI Alliance is taking measures to help raise measles vaccine coverage through its new PBF approach to HSS. The Alliance's support to measles vaccine campaigns focuses on activities that also help strengthen routine immunisation services.



Given that we have so much catching up to do, the foremost challenge for Pakistan is to strengthen its health system so as to improve routine immunisation.”

Dr Saadia Farrukh,
Health Specialist,
UNICEF Pakistan

Acceleration in HSS support

Strong health systems are essential to ensuring that no one misses out on the benefits of life-saving vaccines, even if they live in the remotest village or the poorest community. The GAVI Alliance's HSS support is designed to increase the capacity of health systems to deliver immunisation.

HSS disbursements accelerated significantly in 2013, with the total of US\$ 119 million representing double the amount spent in the previous year. In 2010, the GAVI Alliance Board agreed that cash-based programmes (including HSS, immunisation services support and vaccine introduction grants) should represent 15-25% of Alliance cash-based investments as a three-year rolling average of total programme expenditures. In 2013, this average reached 16%; the average for HSS was 7% of GAVI Alliance investments.

By the end of the year, the GAVI Alliance was funding HSS programmes in 56 countries, with support including health information systems, procurement and supply chain management, health worker training, community engagement and cold chain equipment.

At end of 2013, the GAVI Alliance engaged John Snow Inc (JSI) and

Agence de Médecine Préventive (AMP) to work in coordination with UNICEF and WHO in selected countries. JSI will primarily focus on vaccine introductions in Madagascar, Niger and South Sudan, while AMP will target immunisation coverage and equity improvements in Cameroon, Central African Republic, Côte d'Ivoire, Guinea and Mauritania.

The technical advisory group on HSS continued to provide guidance to the Alliance throughout 2013 on how to improve the quality and impact of investments in HSS, better support implementing countries and work more closely with the principles of the International Health Partnership (IHP+). A final report was made available in 2014.

Focus on equity

Following 2013 changes in application guidelines, countries are expected to further emphasise equity issues in their HSS proposals. Examples of how countries are using GAVI Alliance HSS support to ensure equal access to health and immunisation services include:

- Afghanistan – training community health workers for nomadic communities;
- Kyrgyzstan – organising meetings between health workers and local

Improving grant management processes

In June 2013, the Board approved changes to the Alliance's grant management processes. These are designed to enhance the quality of funding proposals, reduce the administrative burden on countries, strengthen ties between HSS and vaccine support, and improve the performance of GAVI Alliance grants through closer monitoring.

Programme monitoring will increasingly draw on existing country review processes to ensure GAVI Alliance support takes into account local challenges and opportunities. The roles of the in-country Inter-agency Coordinating Committee and Health Sector Coordinating Committee will be also be strengthened. A website will help implementing countries and partners chart progress against GAVI Alliance targets for each type of support.

To strengthen interaction with countries and to improve the accountability of the Alliance's grant management, a High-Level Alliance Review Panel, supplemented with members of the Independent Review Committee (IRC), will replace the monitoring IRC to make recommendations to the Chief Executive Officer on the annual renewal of GAVI Alliance support. To align with country financial cycles, the Panel will meet three times annually.



DEMOCRATIC REPUBLIC OF CONGO

cold comfort for vaccines

02

Strengthen capacity

The Democratic Republic of Congo (DRC) – which is four times the size of France – is the second largest country in Africa. Yet the country's problem with reaching boys and girls with immunisation goes beyond size alone. Its geography, extreme climate and poor transportation infrastructure all present formidable barriers to moving vaccines from the central refrigeration facility in Kinshasa to 11 provinces, 44 districts and 515 administrative health zones. There are routine power failures and stock-outs of the kerosene needed to power 66% of refrigerators.

The GAVI Alliance has made these challenges a special priority. With the Alliance's support, the country is gradually modernising its cold chain to ensure vaccines are transported nationwide at the right temperature while maintaining their quality.

In 2013, DRC received support from the GAVI Alliance for investment in new infrastructure – notably a new depot at Kinshasa Airport and new equipment, including solar refrigerators, aimed at keeping vaccines cold in remote health centres – for the so-called last mile of immunisation. Alongside this material innovation, the Alliance is funding training for health logistics specialists throughout the country.



A health worker carrying vaccines walks his bicycle along a dirt road in DRC, where poor transportation infrastructure is a major challenge to increasing immunisation coverage.

- religious leaders to answer questions about immunisation;
- Yemen – sensitisation workshop for religious leaders;
- Myanmar – installing solar cold-chain equipment in 20 hard-to-reach townships.

Revised gender policy

Following the GAVI Alliance Board's 2013 approval of a revised gender policy, countries are encouraged to use HSS support to address gender-related barriers to accessing immunisation services. Examples of activities supported with Alliance HSS grants include:

- Bangladesh – filling vacant female health-worker posts to permit gender-appropriate provision of services;

- Somalia – introducing an SMS service to remind mothers to bring their children for immunisation sessions;
- across several countries – changing clinic opening hours to accommodate working mothers' schedules.

Revisions to the original 2008 gender policy follow a comprehensive review of its impact and incorporate new evidence on the links between immunisation rates and gender. The policy increases the Alliance's accountability for gender-related results and reaffirms its continued commitment to encouraging countries to disaggregate their immunisation coverage data by sex, where possible.



THE ALLIANCE IN ACTION: *an integrated approach to immunisation*

The GAVI Alliance is playing a leading role in forging a more integrated approach to immunisation that ensures all types of vaccine support, such as supplementary immunisation activities, are mutually supportive and contribute to strengthening routine immunisation programmes. Increasingly, the Alliance is focusing on strong partnerships with implementing countries and other organisations that recognise the important role campaigns can play in achieving the objective of full immunisation.

The Alliance is working closely with the Measles & Rubella Initiative to develop a more integrated approach to protecting girls and young women against rubella, which combines campaigns and routine immunisation.

GAVI Alliance support for rubella vaccination is delivered through a catalytic programme. Countries receive funding for large-scale catch-up campaigns for the combined measles-rubella vaccine on the condition that the vaccine is concurrently introduced into the routine national programme at the country's expense. Long-term delivery integrated into the routine immunisation programme is the most sustainable approach.

For the first time in its history, the Alliance is also planning to ask countries applying for measles, Japanese encephalitis and other vaccines delivered by campaigns to include specific activities related to campaigns, which will also strengthen routine immunisation.

The Global Polio Eradication Initiative has relied heavily on campaigns in many countries. To complement this approach, the GAVI Alliance will support the Polio Eradication and Endgame Strategic Plan through coordinated efforts to strengthen routine immunisation and by supporting the introduction of inactivated poliovirus vaccine.



AFGHANISTAN

civil society strives to immunise all children

Decades of conflict have ravaged Afghanistan's health facilities and seriously impaired access to health services. Immunisation stands out, however, as an exception. Dr Suraya Dalil, Afghanistan's Health Minister, recently noted that even during very active fighting in her country, immunisation was one of the few life-saving services provided to children.

Today, civil society organisations (CSOs) are closely engaged in implementing GAVI Alliance HSS grants, which fund centres to integrate immunisation into a broader package of essential health services. The Government has allocated more than 70% of its HSS budget for implementation by CSOs and plans to invest in increasing its cold-chain capacity and training more than 5,500 community health workers.

In Purchuman village in the Farah province, a midwife in private practice named Gulsoma formerly represented the sole source of healthcare. Although her skill was widely reputed in Purchuman and the surrounding villages, Gulsoma struggled with a lack of supplies and on-the-job training. Now, thanks to funding from the GAVI Alliance, Gulsoma's clinic is receiving better equipment, helpful visits from supervisors, training on immunisation and a steady stream of supplies from local NGOs and Afghanistan's Ministry of Health, with technical support from WHO for the overall HSS grant.



In Afghanistan, a nurse-midwife travels by donkey to remote communities to distribute polio vaccines.

Supporting civil society

GAVI Alliance CSO partners include academic and research institutions, community and faith-based organisations and other types of non-governmental organisations. The Alliance's support to CSOs is an integrated part of HSS support channelled through governments. Of the 15 countries approved for Alliance HSS funding in 2013, all worked with CSOs to develop their applications for support; 10 of these

countries budgeted for CSO-related activities. In exceptional circumstances caused by country fragility, the Alliance engages directly with global or national CSOs.

CSO support through GAVI Alliance HSS grants ranges from national advocacy and community mobilisation for immunisation to health-worker training and service delivery.



DFID
@DFID_UK

Immunisation programme could avert 4m child deaths by 2015 < Follow @GAVIAlliance #VaccinesWork for latest progress

In 2013, Catholic Relief Services received US\$ 1.7 million on behalf of the GAVI CSO constituency to work through local CSOs to engage

in national health policy dialogue in Chad, Guinea, Haiti, India, Liberia, Nigeria and Uganda.

Data quality

The GAVI Alliance continues to work closely with countries and global partners to improve immunisation delivery and to strengthen and monitor the quality of immunisation coverage data. For example, the Alliance is providing direct country support to all PBF countries (see page 40) for strengthening monitoring and evaluation and improving data quality.

In January 2013, the Alliance held a data summit to find innovative ways to address discrepancies between national immunisation coverage data reported by countries, estimates from WHO/UNICEF and the results of household surveys. Partners including WHO, UNICEF, the Centers for Disease Control and Prevention, the Institute for Health Metrics and Evaluation (IHME) and the World Bank are already moving forward with the summit's recommendations. Five countries have finalised plans to assess the level of population protection

against vaccine preventable diseases through use of biomarker assessments; a further nine countries have completed assessments of data quality.

Working jointly with IHME, PATH and local university partners, the GAVI Alliance is also conducting full country evaluations in Bangladesh, India, Mozambique, Uganda and Zambia to collect real-time data on immunisation programmes, vaccine-related issues and the contribution of Alliance support in these five countries. These assessments will draw on a range of data sources and methods, including health facility and household surveys, vaccine impact studies and innovative analysis.

All these initiatives will help GAVI Alliance partners improve data quality and availability and identify key bottlenecks in improving immunisation coverage and service delivery.



KYRGYZSTAN health worker training

Kyrgyzstan, a former Soviet republic, is the second poorest country in central Asia, and much of the population still depends on farming methods that have not changed for generations. Yet the country can claim one of the highest immunisation rates in the world, sustained despite internal conflict and two revolutions.

It has achieved this through a well-organised system, maintained to a large extent by paramedic workers based in feldsher-midwife posts, which were created during the Soviet era to provide basic healthcare, even in the most remote rural areas. There are still 1,600 of them in the country.

In 2013, the Alliance funded training for these health workers on immunisation practice, using a curriculum developed by WHO, along with broad training on maternal and child health. GAVI is also funding mobile immunisation teams in remote villages, immunisation calendars for distribution country-wide and development of technical guidelines for CSOs.



Clerks input data for the GAVI Alliance-funded pneumococcal vaccine impact study at the Kenya Medical Research Institute in Kilifi.

Immunisation supply chain strategy

The immunisation supply chain is a system that moves temperature-sensitive vaccines on their journey from the point of manufacture to the point of administration. It links people, organisations and supplies in all GAVI-supported countries. Applied in developing countries, where supply chains can be inefficient and outdated, vaccines are often not kept at the optimum temperature or pass their expiry date, and consequently stockpiles run low in clinics.

During 2013, GAVI Alliance partners, the Bill & Melinda Gates Foundation, UNICEF and WHO, came together in a special taskforce to develop an overall strategy for strengthening immunisation supply chains. The strategy encourages country

investment in four key components of supply chain management: cold-chain equipment, personnel and their preparation, data management and the system itself. In another example of the Alliance's business model, public sector partners are drawing on private sector innovation, such as solar-powered refrigerators, barcode systems to track vaccines and best practice in service delivery.

In 2013, the GAVI Alliance also announced the piloting of the Supply Chain Fund (SCF). The SCF is a rapid response mechanism, designed to help support countries faced with unexpected bottlenecks in their immunisation supply chain that require urgent intervention to allow new vaccine introductions.

Addressing the challenges

In 2013, the Alliance introduced several new approaches and took a number of measures to adapt to the challenges of strengthening health systems and meeting its targets.

Introducing intermediate indicators to track HSS grants

The Alliance is putting in place intermediate indicators to enable it to

track HSS results. For example, in 2013, Liberia reported that retaining trained health workers was a major obstacle to the successful implementation of its HSS grant.

To address the issue, Liberia's new HSS grant includes performance-based incentives for health workers. Intermediate indicators are now



GAVI is a partner who understands everything, who looks ahead to develop new technologies, examines thoroughly how these technologies work, and then implements them.

Oskon Moldokulov,
WHO Representative,
Kyrgyzstan



UN Foundation
@unfoundation

VIDEO: #Vaccines do more than protect health.

in place that measure not only the number of trained health workers but also their retention by tracking the proportion of Liberian health facilities with at least one available vaccinator.

Supporting countries on performance-based funding

During 2013, the Alliance helped guide countries on its new PBF approach to HSS, first introduced in 2012, through PBF-focused workshops in Egypt and Ethiopia and through other WHO regional workshops. PBF aims to make a more direct link between HSS support and better immunisation outcomes by calculating a portion of HSS support according to country performance against equity and immunisation coverage indicators. HSS application guidelines were revised in 2013 to take account of this.

Roll-out of country-by-country approach

In 2013, DRC and Nigeria became the first countries to benefit from

the GAVI Alliance's country-tailored approach policy. Designed to improve immunisation coverage in GAVI-supported countries facing exceptional systemic challenges, the new approach demonstrates the Alliance's flexible business model by adapting support to special country needs.

In Nigeria, for example, where the federal system of government has led to inequities in healthcare and immunisation coverage, the Alliance is tailoring its support to the country's immunisation system on a state-by-state basis.

The policy is also designed to protect immunisation systems and programmes in GAVI-supported countries facing short-term emergencies.

In 2013, the GAVI Alliance was able to adjust its support to Mali to ensure uninterrupted movement of vaccines during the most intense period of the country's crisis.



NIGERIA

country-tailored approach

Nigeria is a large country with a federal system of government, in which each state organises and delivers healthcare autonomously. Partly due to the nation's large population and partly a reflection of inequality between its states, there are marked differences in immunisation coverage across the country. Some states perform very well on immunisation while others lag behind, with the percentage of children vaccinated varying from 10% to 80%.

The GAVI Alliance is applying its country-tailored approach to help Nigeria address these discrepancies, developing strategies based on successful high-performing states such as Ondo State.

Since Dr Olusegun Mimiko was elected Ondo State Governor in 2009, he has made health a priority for his administration and embarked on revolutionising the system through the Abiye programme – the Yoruba word for motherhood. Pregnant women are the major target of the Abiye programme. Each woman gets a smart card containing biographical data, which allows health workers to track the medical history of her family. The card makes it easier to schedule postnatal care, including vaccinations for babies. Vaccination coverage in the state is now among the highest in Nigeria.

The GAVI Alliance is now working with Ondo State to explore how its successful immunisation strategy can be used in other Nigerian states.



On a local train heading to Delhi, India, a woman watches as a vaccinator gives oral polio vaccine to her son.

“

The cornerstone of our health programme is the routine immunisation programme, which is boosted by national immunisation days – none of which would be possible without GAVI’s support.”

Dr Dayo Adeyanju,
Ondo State Commissioner
for Health, Nigeria

India

There were encouraging signs in 2013 that the GAVI Alliance can play an important role in helping India reduce the estimated 6.8 million children who miss out on childhood vaccines – nearly a third of the national birth cohort of 25 million infants. In October, India’s National Technical Advisory Group for Immunisation approved the national scale-up of pentavalent vaccine to all states, beyond the initial eight that have already launched the vaccine. This

opens the door for the Alliance to support a national roll-out.

In addition, the Alliance finalised an agreement with India’s Ministry of Health that will see HSS funds used both to strengthen routine immunisation and to tackle health system bottlenecks in states with less than 60% immunisation coverage. The GAVI Alliance is looking to build upon the innovative approaches used in India’s polio campaign to help boost routine immunisation coverage.

Mitigating risk in cash-based programmes

The GAVI Alliance employs a number of safeguards to prevent the misuse of its cash-based support. A transparency and accountability policy governs the management of all cash support to countries.

the same year, five cash programme audits and nine monitoring reviews were also completed.

By the end of 2013, the GAVI Alliance Secretariat had conducted detailed financial management assessments in 58 GAVI-supported countries, including 11 new assessments in 2013 alone. In

Since the Alliance was created, eight cases of misuse of cash-based support have been identified. One investigation was conducted in 2013, while the remaining seven had already been concluded. To date, 70% of the misused funds have been recovered with plans in place for the remaining 30%.





03

Increase predictability and sustainability

Increase the predictability of global financing and improve the sustainability of national financing for immunisation



gaviprogressreport.org/2013/increase-predictability

Donor support lays foundations for sustainability of immunisation programmes

- Country co-financing commitments increased to US\$ 69 million in 2013.
- Direct contributions received from 14 donor governments amounted to US\$ 994.3 million, the highest amount for a single year to date.
- Foundations, private individuals and organisations contributed a further US\$ 313.2 million in 2013.
- Advance Market Commitment (AMC) funding allowed 38 countries to introduce pneumococcal vaccines.

Despite a challenging financial climate, in 2013 implementing and donor country contributions reached their highest levels since the start of the GAVI Alliance.

Countries continued to step up efforts to share the cost of GAVI-supported vaccines with public sector donors – a fundamental principle of the GAVI Alliance funding model’s goal of long-term, sustainable immunisation programmes. Countries contributed 11% of the total value of vaccine support by the Alliance – an increase of two percentage points on the 2012 figure.

With 22 countries projected to graduate from GAVI Alliance support by 2020, taking on full national financing of their immunisation programmes, Alliance partners are providing assistance to ensure a smooth transition.

Within three years of the Alliance’s pledging conference in June 2011, donors have already committed 98% of the funding target. Most significantly, the funding provided by donors, the vast majority in the form of multi-year

pledges, has set in motion a dynamic resource mobilisation model (see page 47). During the year, a number of existing donors increased their contributions to the GAVI Alliance, which maintained efforts to expand its funding by extending existing contributions and seeking new public and private pledges.

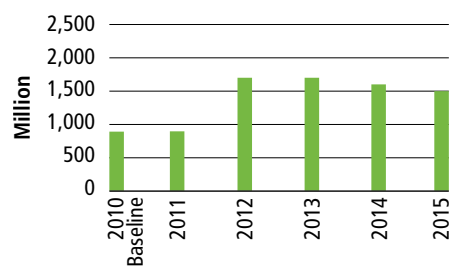
Private sector partners continue to play a dual role in supporting the Alliance, both through cash contributions and by leveraging their expertise to address key immunisation challenges such as modernising the cold chain and improving data collection. In 2013, three additional private sector partners were secured: the A & A Foundation, the Dutch Postcode Lottery and Lions Clubs International Foundation.

Innovative finance mechanisms continue to yield predictable financing for the Alliance. By the end of 2013, the International Finance Facility for Immunisation (IFFIm) had raised US\$ 4.5 billion on the capital markets, and 38 countries had started introducing pneumococcal vaccines, thanks to the AMC.



In Sri Lanka, a senior nurse trains younger nurses on vaccination techniques and educates them on diseases.

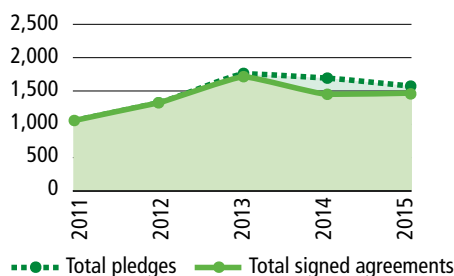
Total resources available to meet demand (US\$ millions)



Source: 21

The GAVI Alliance has to date mobilised 100% of the resources required to finance country demand in the current strategy period.

Signed grant agreements versus total pledges, 2011–2015 (US\$ millions)



Source: 22

By the end of 2013, 98% of the donor pledges made for the period 2011–2015 had been signed as formal grant agreements.

Country investment in vaccines per child
Average expenditure per child (US\$)

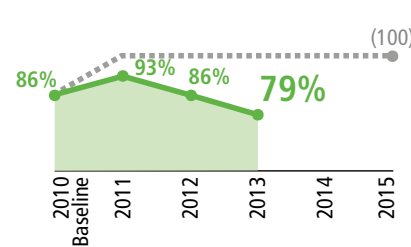


* 2013 data will be available after June 2014.

Source: 23

Country investments in vaccines per child increased from US\$ 3.80 in 2010 to US\$ 4.80 in 2012. Due to an ongoing shift to a more robust method and source for tracking this indicator, for now, there is no specific target. Progress is still tracked each year against the general target of demonstrating an increasing trend.

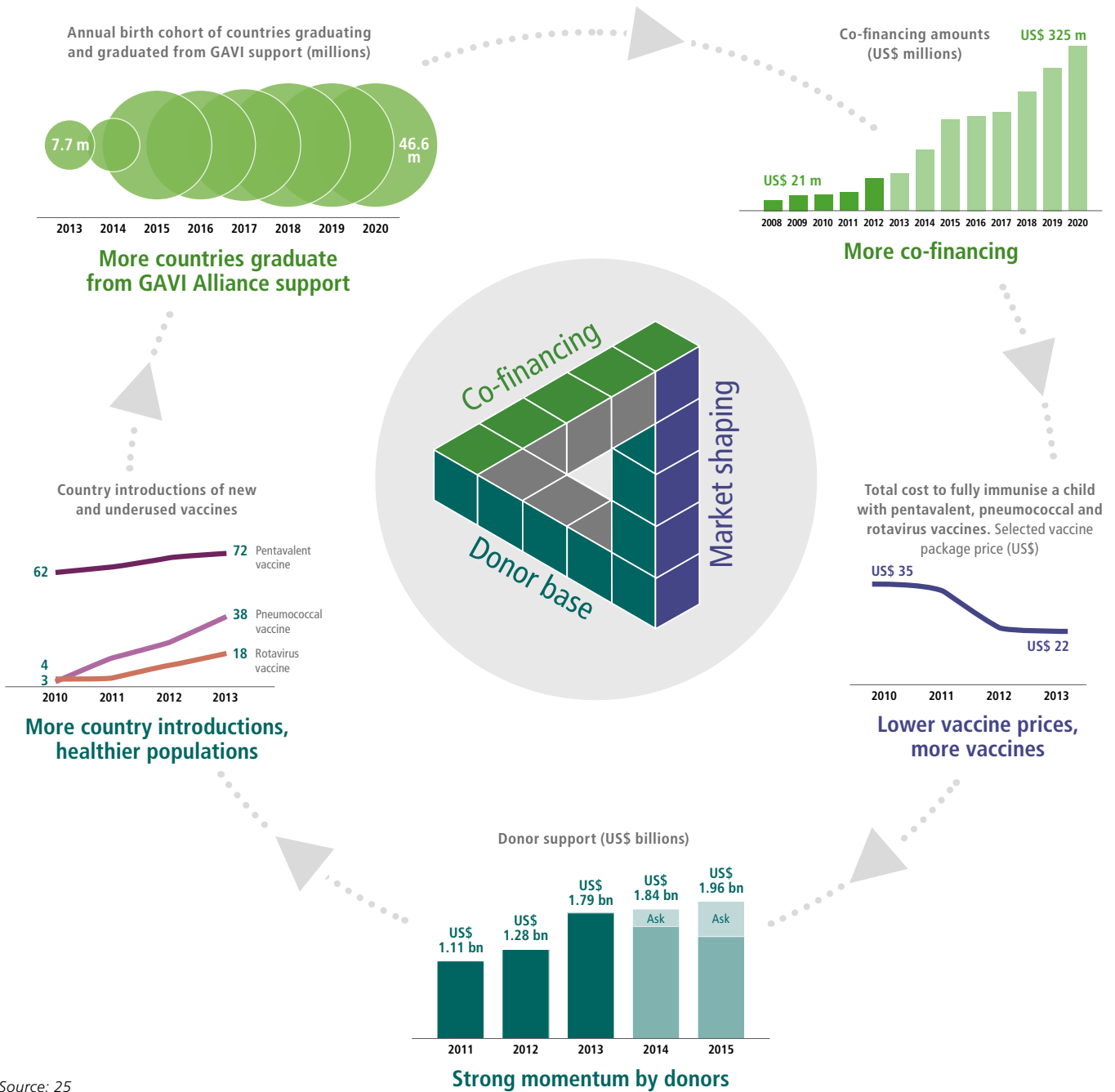
Fulfilment of co-financing commitments
Proportion of countries (%)



Source: 24

The fulfilment of co-financing commitments dropped in 2013, with 14 countries in default by the end of the year. However, only four countries (6%) did not make any contribution towards their co-financing costs in 2013. The remaining 10 made partial payments. Despite the underlying trend, funds transferred by countries towards their co-financing commitments in 2013 were 10% higher than the total in 2012.

The GAVI Alliance: a dynamic resource mobilisation model



Source: 25



THE ALLIANCE IN ACTION:

helping Bhutan prepare for graduation

The Royal Government of Bhutan has a unique ambition: gross national happiness. This philosophy guarantees the right to healthcare, including immunisation.

To underline Bhutan's commitment to financing its own immunisation programme, in 1998 the government launched the Bhutan Health Trust Fund to raise funds to cover the cost of essential drugs and related equipment. Two years later, thanks to contributions from both the Government and donors, the Fund's capitalisation reached its target of US\$ 24 million.

In 2013, based on a 2012 country visit to help Bhutan prepare for graduation, GAVI Alliance partners including WHO made recommendations on optimising the Health Trust Fund's structure and using interest accrued to purchase vaccines and supplies. Partners are confident that with the Alliance's recommended management changes, the Health Trust Fund will guarantee sufficient income to keep graduation on schedule for the end of 2015.

GAVI Alliance funding model

Donor support has helped lay the foundations for a dynamic funding model. Thanks to the strong momentum built through donor contributions, mainly in the form of multi-year agreements, implementing countries are able to embark on sustainable immunisation programmes. In turn, their efforts are improving immunisation coverage leading to healthier, more productive populations.

As national prosperity grows, countries begin to graduate from GAVI Alliance support and move towards full national financing of their immunisation programmes. The availability of long-term, predictable funding for immunisation coupled with aggregated demand enables manufacturers to supply vaccines at more affordable prices.

Co-financing update: countries taking increasing ownership

All countries introducing GAVI-supported vaccines into their routine schedules are required to share the cost through co-financing. This encourages implementing countries to take ownership of their immunisation programmes over time and to scale up investment as their national prosperity grows.

In 2013, the GAVI Alliance's total co-financing requirement increased by 20%. A total of 68 countries were required to co-finance their vaccines, and 52 had fulfilled their commitments by the year's end. Of the 14 countries that failed to fully meet their obligations, only four made no contribution towards their co-financing costs during the year; the remaining 10 paid arrears from the previous year or made part payments towards their 2013 obligation. In addition, two countries were given special consideration because of national crises.

Funds transferred by countries towards their co-financing commitments amounted to US\$ 69 million in 2013, accounting for 11% of the total value of vaccine support by the Alliance, compared with 9% in the previous year. Despite a number of countries not having yet completed their requirements, the amount transferred in 2013 was 10% higher than the total in 2012.

Co-financing levels depend on each country's gross national income per capita, as defined by the World Bank. Low-income countries contribute the least, at US\$ 0.20 per dose, while intermediate countries must increase their payments by 15% per year.



Aid is only successful if it has a sell-by date. Countries need to match the generosity of donors like the GAVI Alliance. And over time, they should take over the financing altogether.”

Dr Donald Kaberuka,
President, the African
Development Bank

Graduating countries are expected to take over the full cost of their vaccines after five years of incrementally increasing their contributions. Measles second dose and preventive campaigns with inactivated polio, measles-rubella, meningococcal A and yellow fever vaccines are exempt from co-financing.

Graduation update: new approach

As their national prosperity grows, countries begin scaling up their investment and start a five-year transition of “graduating” from GAVI Alliance support. By the end of 2013, 22 countries were projected to graduate by 2020.

The GAVI Alliance works in a variety of ways to help countries prepare for graduation, identifying and addressing potential bottlenecks to full financing of their immunisation programmes. Partners regularly monitor performance and support, and seek

to secure continued access to low-priced vaccines after vaccine support has ended.

In November, the GAVI Alliance Board underlined its commitment to assisting countries on the road to self-sufficiency by strengthening the approach to graduation. This includes conducting assessments that do not just focus on financial sustainability but also address the performance of immunisation programmes and support catalytic investments in graduation plans. These initiatives will be piloted and applied in 2014.

During the year, the GAVI Alliance, in collaboration with the Sabin Vaccine Institute and parliamentarians, committed to a programme that will support advocacy for immunisation financing in four countries in the European region: Armenia, Georgia, the Republic of Moldova and Uzbekistan.

Donor funding base

Donor funding to the GAVI Alliance amounted to US\$ 1.7 billion in 2013, bringing the total amount received since its inception in 2000 to US\$ 9.37 billion. Long-term commitments channelled through direct support agreements, IFFIm and the AMC are at the core of the predictable funding required to support GAVI Alliance programmes.

Direct and GAVI Matching Fund contributions

In 2013, direct contributions received from 14 donor governments (Australia, Canada, Denmark, France, Germany, Ireland, Japan, Luxembourg, the Netherlands, Norway, the Republic of Korea, Sweden, the United Kingdom and the United States) amounted to US\$ 994.3 million. The cumulative value of direct contributions received from national governments and the European Commission for the period 2000–2013 totalled US\$ 4.15 billion.

Foundations, private individuals and organisations contributed an additional

US\$ 313.2 million to the Alliance in 2013. The GAVI Alliance received contributions from the Bill & Melinda Gates Foundation (BMGF) (US\$ 283.1 million), His Highness Sheikh Mohamed bin Zayed Al Nahyan (US\$ 10.1 million) and the OPEC Fund for International Development (OFID) (US\$ 650,000).

New GAVI Matching Fund commitments were received from the A & A Foundation, the Dutch Postcode Lottery and Lions Clubs International Foundation. Renewed pledges or pledge payments were received from Anglo American, the Children’s Investment Fund Foundation, Comic Relief, the “la Caixa” Foundation, and LDS Charities.

IFFIm funding

The Alliance drew down US\$ 200 million in IFFIm funds in 2013, bringing the cumulative total funds received from IFFIm for 2006–2013 to US\$ 2.5 billion. Australia, France, Italy, the Netherlands, Norway, South Africa, Spain, Sweden and the United Kingdom (UK) have all contributed to IFFIm.



HONDURAS

a sustainable success story

Honduras stands out as a great performer on immunisation and sustainability, despite years of political instability, economic crisis and internal violence. As well as maintaining about 88% coverage – not only on reaching children with a third dose of diphtheria-tetanus-pertussis-containing vaccines (DTP3) but also pneumococcal and rotavirus vaccines – Honduras has met all its co-financing commitments since first receiving GAVI Alliance support.

Now poised to graduate, the Central American state offers a unique example of how countries can capitalise on GAVI Alliance support to improve their health services overall.

In 2008, Honduras was approved for health system strengthening (HSS) support of US\$ 2.5 million. Originally, Honduras agreed to also invest the equivalent of 10% of the grant (US\$ 250,000) from its own national budget. In 2013, the Government went further, agreeing to invest US\$ 633,000 of its own funds (equivalent to US\$ 250,000 per year) in strengthening its health system for the delivery of immunisation services.

Part of the HSS funding supported the training of auxiliary nurses at regional levels throughout the country – an important step, given the poverty and isolation of Honduras's rural population. When HSS support was phased out, the government continued to invest its own funds in the training programme, directly addressing long-term sustainability issues.

AMC funding

Canada, Italy, Norway, the Russian Federation, the UK and the BMGF have collectively pledged US\$ 1.5 billion towards the AMC for pneumococcal vaccines. By the end of 2013, the

Alliance had received a cumulative total of US\$ 609 million in AMC funds via the World Bank, US\$ 214.4 million of which was received in 2013.

Innovative finance

Three innovative finance initiatives continue to help the GAVI Alliance secure long-term, predictable funding for immunisation and HSS programmes: IFFIm, the AMC and the GAVI Matching Fund. The World Bank plays a key role in innovative finance and provides the financial platform for IFFIm and the AMC.

noted “the case for further investment through IFFIm is strong.”

With the World Bank as its treasury manager, IFFIm continued its work in 2013, maintaining strong access to the capital markets and issuing two successful transactions in March and June.

IFFIm: flexible financing

IFFIm uses long-term donor pledges to issue vaccine bonds on the capital markets. The money raised from investors helps fund GAVI Alliance programmes to meet immediate country demand for vaccines.

The latter financing was IFFIm's largest since its 2006 inaugural benchmark, raising US\$ 700 million in a transaction jointly led by Daiwa Securities Group and Deutsche Bank. It was IFFIm's first floating rate offer, and its first benchmark since 2010. IFFIm's ratings were adjusted by Fitch in April (from AAA to AA+) and Standard & Poor's in November (from AA+ to AA). The rating agencies cited downgrades of IFFIm's two largest donors, the UK and France respectively, as prompting their ratings actions. Despite these changes, IFFIm's ability to sell bonds and approve new programme funding to the GAVI Alliance has not been affected.

By the end of 2013, IFFIm had raised US\$ 4.5 billion from investors, helping the Alliance shift through time-predictable funding from IFFIm donors.

This flexibility greatly enhances the efficiency of GAVI Alliance operations and provides predictability for countries' vaccine programmes. An independent evaluation of IFFIm, published in 2011,



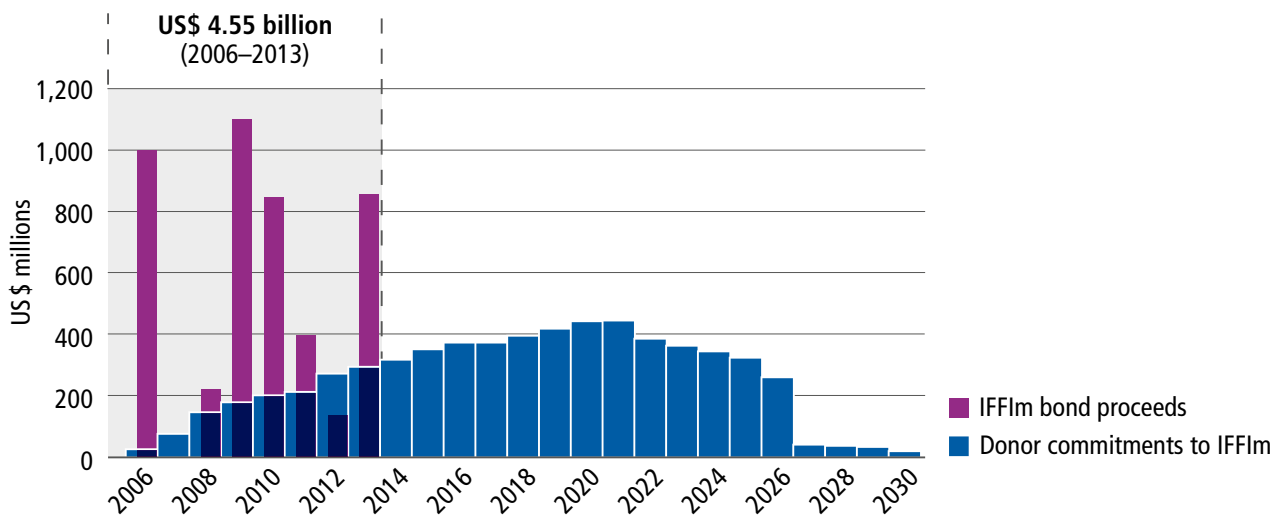
Having predictable, long-term funding in place will help us ensure that the world's most vulnerable children have access to healthcare, and that is a critical step in achieving the goal of ending extreme poverty by 2030.

Jim Yong Kim,
President of the World Bank Group, IFFIm Treasury Manager



A vaccine transporter is handed a cold box by a nurse as he prepares to journey to a rural community in Mongolia.

IFFIm accelerates donor funding as needed



Source: 26

IFFIm Board continues to focus on capital market activities

During 2013, the IFFIm Board, led by René Karsenti, has continued to oversee activities in international capital markets. In addition to its responsibilities, the IFFIm Board has also continued to work with the GAVI Alliance Secretariat in deepening its engagement with IFFIm donors. With the support of both the IFFIm Board and GAVI Alliance Board, the financing facility remains an important

cornerstone of the Alliance's long-term funding strategy.

One of IFFIm's unique features is that it uses the capital markets to aid global development, and, as such, offers investors a socially-responsible investment opportunity with a very strong credit rating. Throughout 2013, René Karsenti and the IFFIm Board have utilised various international events and conferences to promote IFFIm as a leading model for socially-responsible investments.



MONGOLIA

no immunisation without taxation

Despite the challenge of reaching 2.7 million people spread across 1.5 million square kilometres, Mongolia has made impressive progress on immunisation, reaching 99% of children in 2012 with DTP3. To ensure that all Mongolians are vaccinated, the Government has set up a special immunisation fund, which draws on multiple sources – most notably income taxes.

Realising that most people had not made the link between taxes and their children's health, the Government ran a nationwide poster campaign. This highlighted the power of vaccines to save lives and the importance of paying taxes to pay for the immunisation of every child.



IFFIm's reputation in this market continues to grow: in February 2013, the facility was recognised by the news, data and analytics provider mtn-i as "SRI Innovation of the decade."

The AMC contributes to unprecedented demand for pneumococcal vaccines

An independent evaluation of the pneumococcal AMC process and design, published in 2013, confirmed that the pilot project had contributed to increasing the supply and use of pneumococcal vaccine in developing countries. The evaluation also acknowledged the international development community's role in designing and rolling out an AMC.

The pneumococcal AMC uses US\$ 1.5 billion in donor commitments to incentivise production of pneumococcal vaccine. Manufacturers, guaranteed the price of a share of the doses sold through the AMC, enter into legally binding commitments to supply the vaccine for developing countries for at least 10 years at a fraction of the cost to industrialised countries.

In 2013, 14 countries started introducing the pneumococcal vaccine, with the total number of countries approved for

the vaccine's roll-out reaching 51 by the end of the year. Two new supply agreements signed in 2013 helped mitigate short-term supply constraints resulting from this unprecedented demand; the agreements included the first decrease in the AMC tail price.

The GAVI Alliance, through the AMC, only funds vaccines that meet stringent criteria defined by an independent group of experts. For example, manufacturers participating in the AMC must provide vaccines that offer protection against the most deadly disease strains prevalent in GAVI-supported countries.

The GAVI Matching Fund: private sector funds, expertise and advocacy

Private sector partners offer not just financial contributions but also expertise, services and products to address operational challenges and increase the visibility of immunisation and the GAVI Alliance's life-saving work.

Under the GAVI Matching Fund, set up in 2011, the UK Government and the BMGF have collectively pledged approximately US\$ 130 million to match contributions from corporations, foundations, their customers, employees and business partners.



The GAVI-Lions partnership will be a game-changer in protecting kids from measles-rubella.”

Lions Clubs International
Foundation Chairperson
Wayne Madden



The meningitis A vaccine was introduced in Burkina Faso in December 2013 with GAVI Alliance support.



The funds raised by Lions Members and matched by the UK will mean that millions of children will lead healthier and happier lives, able to better contribute to their communities.”

Justine Greening,
the UK's Secretary of State
for International Development

By the end of 2013, the GAVI Matching Fund included 11 partners: Absolute Return for Kids (ARK), the A&A Foundation, Anglo American plc, the Children's Investment Fund Foundation, Comic Relief, the Dutch Postcode Lottery, J.P. Morgan, the "la Caixa" Foundation, LDS Charities,

Lions Clubs International Foundation and Vodafone. The cumulative total raised through the GAVI Matching Fund through 2013 amounts to US\$ 74 million. This figure does not include matching pledges from the UK Government and the BMGF.

Transparency and value for money

In 2013, the Publish What You Fund Aid Transparency Index ranked the GAVI Alliance second out of 67 international development organisations, including UN agencies and donor governments – up from 13th in 2012. The report congratulated the GAVI Alliance for making significant improvements in the amount and quality of data made publicly available in line with International Aid Transparency Initiative standards. The Alliance was also commended for its ambitious transparency implementation schedules.

In December 2013, the UK Multilateral Aid Review awarded the GAVI Alliance its highest rating – ahead of 37 other development agencies – based on the Alliance's ability to deliver value for money in driving reform to achieve multilateral aid effectiveness. Started in 2011 to ensure that the UK's development budget has the greatest possible impact, the review compares value for money among 43 different multilateral organisations receiving UK aid. Its findings strongly influence the government's decisions.

Reaching new audiences through private sector support

Private sector partners help raise awareness of immunisation among their employees and business partners, the general public and governments.

The "la Caixa" Foundation, one of the largest foundations in Europe and the GAVI Alliance's first corporate partner, has contributed over US\$ 22 million. In 2008 it launched a unique and



Increasing access to immunisation through volunteer networks

Generating demand for vaccines through education and awareness is crucial to the success of vaccine introductions. Two private sector partners, each with extensive experience, are supporting vaccine launches in GAVI Alliance countries.

Both the Lions Clubs International Foundation and LDS Charities can draw on a network of members on the ground to work with local leaders and raise awareness of vaccination. They help coordinate community-level awareness campaigns and offer volunteer support at health centres. Together, the two organisations have a combined membership of nearly 17 million.

“Vaccines can’t save lives if children don’t receive them, so Lions work with the community to make sure boys and girls are being vaccinated,” said Dr Tebebe Yemane-Berhan, a member of the Lions Clubs International Foundation Steering Committee from Ethiopia. “We look forward to a future where every child has access to life-saving vaccines.”

innovative programme – the Business Alliance for Child Vaccination – under which more than 350 Spanish companies have contributed over US\$ 2 million to the Alliance’s fight against child mortality. The “la Caixa” Foundation has also encouraged contributions from employees and individuals. The total contributions from these different sources has exceeded US\$ 24.3 million.

Comic Relief, a UK charity whose mission is to drive positive change through the power of entertainment, is also a public advocate, providing enormous visibility for global immunisation in the country through its well-publicised and

televised Red Nose Day and Sport Relief campaigns. Comic Relief has committed nearly US\$ 17 million to the Alliance to date.

Political support is critical to the GAVI Alliance’s success, and both the Lions Clubs International Foundation and LDS Charities have helped advocate for government support through one-on-one meetings and special events, including in the United States Congress.

In 2013 alone, Lions Clubs have supported measles-rubella vaccine campaigns in Ghana and Senegal, and two measles vaccine campaigns in Nigeria.

Reassessing the full value of vaccines

In January 2013, 25 leading health economists, epidemiologists and global health specialists gathered at a GAVI-hosted meeting in Annecy, France, to examine evidence of additional benefits of vaccines and identify a future research agenda.

Besides preventing illness, vaccines make a broader contribution to human and economic development, and some aspects of this are already well understood. Healthy children, for example, can benefit from education, freeing up health services; they also do not require medical treatment or care,

both of which cost money, so their families are more able to work and have money to spend in other ways.

But while there is evidence to show that vaccines can also improve cognitive development, educational attainment and future economic prospects of families and communities, knowledge gaps remain on how to best measure this impact. Summarising their findings in a subsequent journal article, published in *The Lancet Global Health*, participants concluded that while there is much work to be done the potential rewards are huge.



04

Shape the market

Shape vaccine markets to ensure adequate supply of appropriate, quality vaccines at low and sustainable prices for developing countries



[gaviprogressreport.org/2013/
shape-the-market](http://gaviprogressreport.org/2013/shape-the-market)

Market-shaping activities secure price reductions for three vaccines

- The prices of pentavalent and pneumococcal vaccines decreased.
- Human papillomavirus vaccine (HPV) was procured for the first time.
- Supply and procurement roadmaps for pentavalent, yellow fever, inactivated poliovirus and rotavirus vaccines were completed.
- Indonesia introduced pentavalent vaccine produced by a local manufacturer.
- The Alliance worked with vaccine manufacturers and UNICEF to address short-term supply constraints for pneumococcal and rotavirus vaccines.

In addition to contributing a share of the cost of their vaccines through co-financing, a country's successful transition to self-sufficiency in immunisation also relies on a secure supply of appropriate vaccines at affordable prices.

In 2013, the GAVI Alliance was able to purchase pentavalent, HPV and pneumococcal vaccines at significantly lower prices, thanks to three agreements with vaccine manufacturers. The price agreements show how the Alliance's efforts to create a healthy global vaccine market that generates an adequate supply of vaccines at affordable prices for developing countries are paying off.

Vaccine roadmaps are fundamental to this market-shaping success story, allowing the Alliance to adapt its efforts to the characteristics of each vaccine market. By the end of 2013,

the GAVI Alliance had published four roadmaps providing a long-term overview of the pentavalent, yellow fever, inactivated poliovirus and rotavirus vaccine markets.

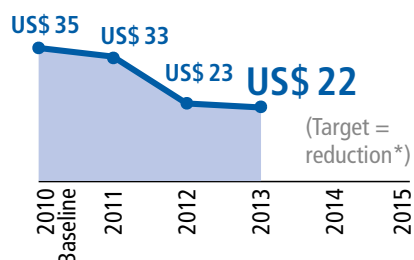
There was further evidence of how the GAVI Alliance is helping to expand the vaccine manufacturer base. With Alliance support, Indonesia started introducing a pentavalent vaccine produced by its own national manufacturer. The first ever WHO prequalified vaccine produced in the People's Republic of China has also allowed the Alliance to open a window of support for Japanese encephalitis (JE) vaccine. In addition, working closely with manufacturers and partners, the Alliance has made significant progress towards overcoming supply issues with pneumococcal and rotavirus vaccines.



Indonesian health specialists and scientists at a vaccine/serum manufacturing plant

Total cost to fully immunise a child with pentavalent, pneumococcal and rotavirus vaccines

Selected vaccine package price (US\$)

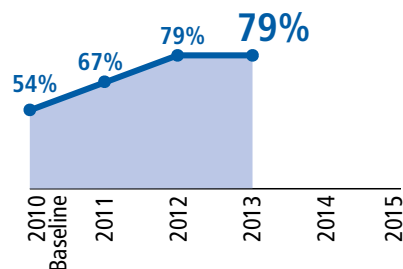


* Future targets are not publicised to avoid setting a minimum price.

Source: 27

The total vaccine cost of fully immunising a child with pentavalent, pneumococcal and rotavirus vaccines fell from US\$ 35 in 2010 to US\$ 22 in 2013.

Security of supply (number of products offered as % of 5-year target)



Source: 28

By tracking the number of products offered in response to tenders for the GAVI Alliance market, the Alliance measures vaccine supply security. Since 2010, the number of products has increased from 54% to 79% of the target. While the number of products offered did not change from 2012 to 2013, the Alliance remains on track to nearly double the number of products offered in response to tenders for supply between 2010 and 2015.



We are proud that our work to provide affordable prices for a variety of countries means life-saving vaccines can reach the most underprivileged children in the world.”

Mahima Datla, Managing Director of Biological E, an Indian company that reduced the price of pentavalent vaccine by half in 2013

Market-shaping success story: three vaccine price reductions

Compared with pharmaceuticals, vaccines are far more complex to manufacture, requiring significant investments in research and process development, together with complex production requirements. As a result, there are fewer vaccine manufacturers and sometimes a less competitive market.

Despite these challenges, in 2013, the GAVI Alliance secured price decreases for three vaccines.

This success demonstrates the catalytic impact of the Alliance’s market-shaping strategies. By adapting strategies to each vaccine market, providing long-term predictable funding, aggregating demand and sharing demand

forecasts, the GAVI Alliance has attracted new manufacturers and lower prices.

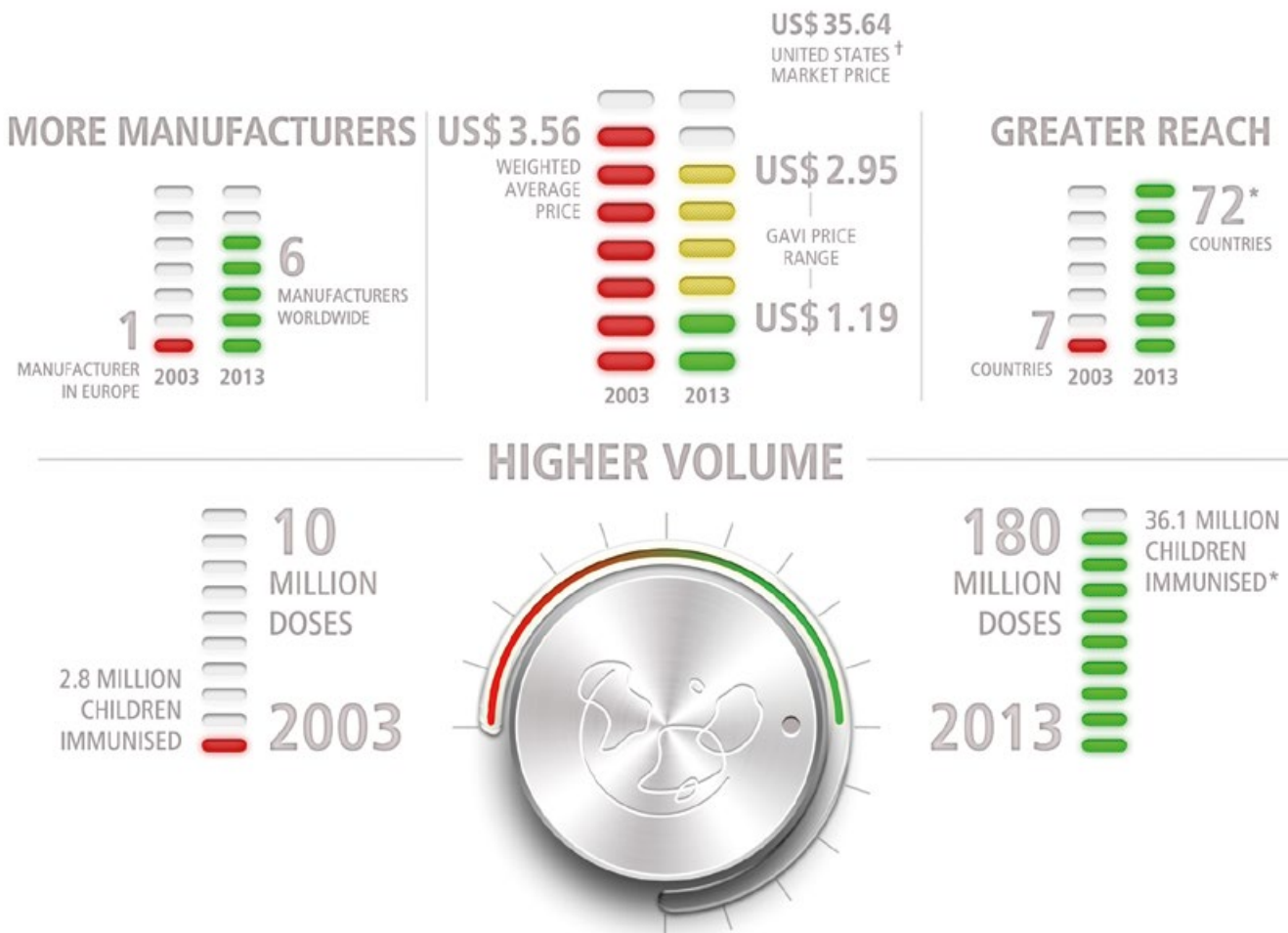
Pentavalent vaccine

The record low price of US\$ 1.19 per dose for pentavalent vaccine, secured by a tender in April 2013, represented the combined efforts of Alliance partners.

When the Alliance started supporting pentavalent in 2001, the vaccine was procured from a single European manufacturer. Over the past 10 years, the Alliance has attracted new suppliers and secured lower prices. By 2013, the GAVI Alliance had pentavalent vaccine price agreements with five manufacturers: Biological E, Crucell, GlaxoSmithKline, Serum

Lower prices for GAVI countries:

10 years of turning up the volume on the pentavalent vaccine



* 2013 year-end projection.

Source: United States Market Price: lowest total public price per dose for separate diphtheria-tetanus-pertussis, hepatitis B and Haemophilus influenzae type b vaccines and reflects the cost of acellular pertussis vaccine. (2013 data).

Source: 29



A health worker gives pentavalent vaccine to a school girl on the day that Laos introduced the vaccine into its national immunisation programme.

Institute of India and LG Life Sciences of the Republic of Korea.

The new price – the result of a supply agreement with Biological E of India – is a reduction of more than 65% compared with the 2003 weighted average price per dose of US\$ 3.56. This will have a potential impact of up to US\$ 150 million over the next four years compared with previous lowest cost alternatives.

HPV vaccines

HPV vaccines, which protect against the main causes of cervical cancer, are available as part of routine immunisation to girls in most high-income countries, but their price has been prohibitively high for developing countries.

In May 2013, following a public tender process, the GAVI Alliance announced that it could procure a sustainable supply of HPV vaccines at a record low price of US\$ 4.50 per dose. The same vaccines can cost more than US\$ 100 in industrialised countries and the

previous lowest public sector price was US\$ 13 per dose.

With a price agreement now in place, the GAVI Alliance Secretariat is working with partners to implement the GAVI Alliance HPV Vaccine Programme. Stakeholders include WHO, PATH, UNICEF, UNFPA, the National Cancer Institute (United States), the World Bank, the Union for International Cancer Control, Pink Ribbon Red Ribbon, UNAIDS, the International Agency for Research on Cancer and the U.S. Centers for Disease Control. By 2020 the Alliance expects to reach more than 30 million girls in more than 40 countries with HPV vaccine.

Pneumococcal vaccine

2013 saw an important movement in the price of pneumococcal vaccine, which was introduced in a record 14 countries during the year. The lowest price offer to the Alliance in 2013 was US\$ 3.40 per dose, US\$ 0.10 less than the previous price. From 2014, this will drop further to US\$ 3.30 per dose.



Pentavalent vaccines produced by Indonesian manufacturer Bio Farma will protect children nationwide from five serious diseases.

Expanding the manufacturing base

The GAVI Alliance's investments in immunisation have changed the face of the global vaccine market, convincing manufacturers to view developing countries as an important market. The result: product innovation and an expanding manufacturer base of quality vaccines.

In its early years, the Alliance purchased vaccines from just five

manufacturers, only one of which was based in a developing country. By 2013, this had increased to 13 of which 8 are based in Africa, Asia and Latin America. The Alliance plays an active role in encouraging manufacturers based in emerging market economies to enter the vaccine market.



The Serum Institute of India is providing the GAVI Alliance with WHO-prequalified measles-rubella vaccine.



INDONESIA

self-supplies pentavalent vaccine

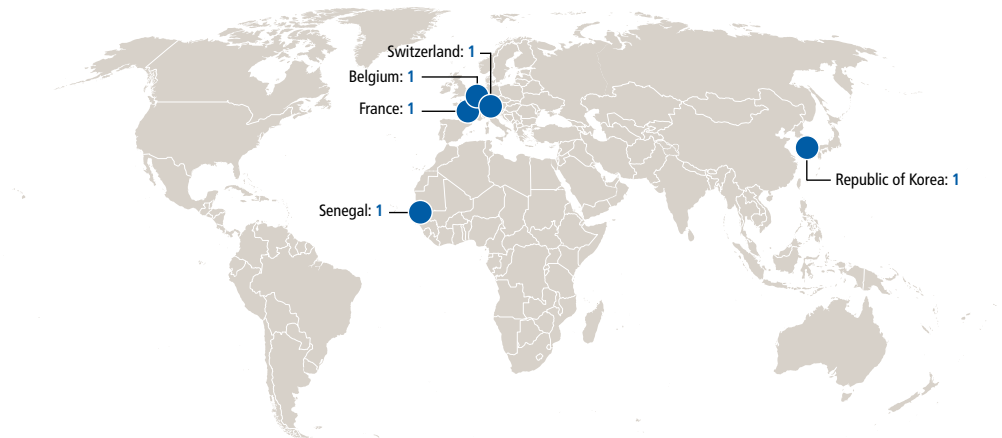
In August, Bio Farma – a national vaccine supplier based in Bandung, 100 miles from Jakarta – started manufacturing enough pentavalent vaccine to reach children across Indonesia's 6,000 inhabited islands.

The vaccine, which contains five antigens in one shot and protects against diphtheria-tetanus-pertussis, hepatitis B and *Haemophilus influenzae* type b, reduces the number of separate injections required for protection and minimises the number of health centre visits required. Indonesia previously used tetravalent vaccine, which does not protect against Hib.

The GAVI Alliance is supporting Indonesia's plan to introduce the vaccine nationwide as quickly as possible. The Government plans to deliver the vaccine in three phases. Four provinces began immunising children immediately; a further nine provinces were scheduled to begin in January 2014, with all other regions expected to start immunisation in July 2014.

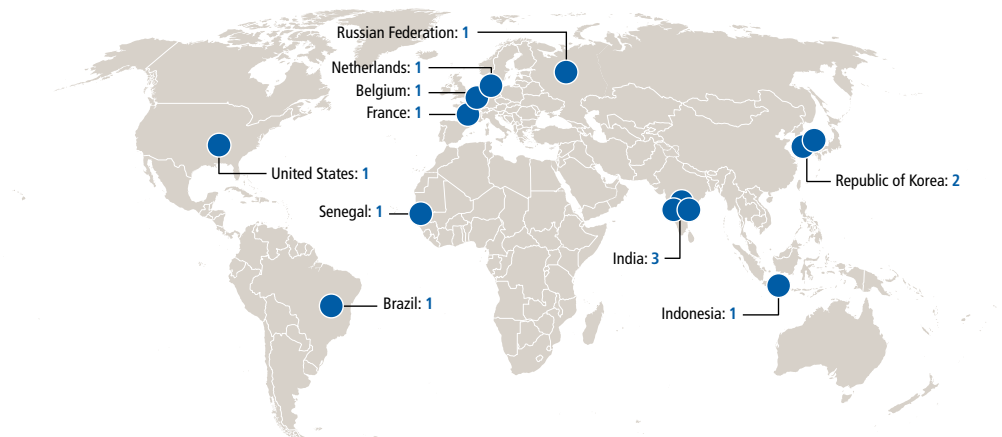
2001

5 vaccine manufacturers in 5 countries



2013

13 manufacturers in 10 countries



Source: 30



The return on investment for many vaccines appears, conservatively, to be at least as high as the return on investment for spending on primary education.”

David Bloom,
Professor of Economics
and Demography,
Harvard University



Children in Asia who are vulnerable to Japanese encephalitis will now be protected through immunisation with a vaccine produced in China.



THE ALLIANCE IN ACTION: **vaccine roadmaps**

Vaccine roadmaps, which set out the GAVI Alliance’s long-term vision for each vaccine, are critical to shaping markets. They also epitomise the Alliance’s ability to coordinate the key players in the vaccine market around a single goal.

Drawing on the expertise of WHO, UNICEF and The Bill & Melinda Gates Foundation, each roadmap includes: an analysis of current and future products available, product characteristics, cost and price drivers, a prioritisation of the Alliance’s objectives and options for how to achieve them and a time frame for the Alliance’s engagement. In 2013, four roadmaps were finalised.

The **pentavalent vaccine** roadmap predicts that GAVI Alliance demand for the vaccine from 2013–2016 will represent 84% of global pentavalent volume.

With **yellow fever vaccine** supply not adequately meeting demand, the related roadmap’s main objectives are closing the gap by 2016 and ensuring no major manufacturer exits the market over the next 10 years.

The **inactivated polio virus vaccine (IPV)** supply and procurement roadmap paved the way for the GAVI Alliance Board decision to open an IPV funding window from December 2013 to June 2015. Given that global demand for IPV is expected to increase from approximately 80 million doses in 2013 to 190 million in 2016, balancing supply and demand, reducing costs and finding new manufacturers are top priorities.

The **rotavirus vaccine** roadmap predicts an average annual growth in demand of 15% from 2012–2020 and concludes that there will be a critical need for at least one new manufacturer by 2017.



CHINA

expanding the manufacturer base

In late 2013, the Chengdu Institute of Biological Products received the first-ever WHO prequalification for a vaccine produced in China. It was for an important vaccine providing protection against JE to children. Prequalification means WHO gave the vaccine its stamp of approval for safety and efficacy, and UN procuring agencies can now source the JE vaccine. The historic moment reflected strong partnership between the manufacturer, WHO, PATH and the Bill & Melinda Gates Foundation.

JE, a mosquito-borne flavivirus infection, is a severe disease that involves inflammation of the brain. It is a major public health threat in parts of China, the southeast region of the Russian Federation, and South and South-East Asia. There is no specific treatment for the disease – which is why prevention is so critical.

Following WHO prequalification, the GAVI Alliance issued guidelines inviting countries to apply for support for JE vaccine catch-up campaigns from 2014. The campaigns will target children aged nine months up to 15 years and ensure sustainability by embedding JE vaccine into routine immunisation programmes. This catalytic support will have a sustainable and positive impact on JE control efforts.

Working with partners to address supply challenges

At the start of 2013, the unprecedented acceleration in demand for pneumococcal and rotavirus vaccines had created short-term supply constraints. By working closely with vaccine manufacturers and UNICEF's supply division throughout the year, the Alliance has secured additional supplies.

In July 2013, the Advance Market Commitment (see page 51) concluded its third tender for pneumococcal vaccine, securing 500 million additional doses for 10 years and allowing 14 countries to introduce the vaccine during the year. It is expected that all 51 countries approved for GAVI Alliance support for pneumococcal vaccine by the end of 2013 will receive sufficient doses to proceed with their introductions in 2014. Despite this progress, a 2013 production

issue delayed vaccine launches in Bangladesh and Nigeria.

Six countries introduced rotavirus vaccine in 2013 but, with most countries preferring a specific product formulation, it was not possible to meet all demand. By the end of the year and thanks to close collaboration with the Alliance, the relevant manufacturer had accelerated production and will be able to deliver 10% more doses than previously estimated.

UNICEF and the GAVI Alliance could not access the supply of two manufacturers of yellow fever vaccine for portions of 2013 because the vaccines' prequalification were suspended. Consequently, there is an acute short-term supply issue, and some campaigns will have to be postponed.

Annex 1:

The GAVI Alliance governance structure

as of 31 December 2013

The GAVI Alliance Board

There are 28 seats on the Board:

- 4 permanent members representing UNICEF, WHO, the World Bank, and the Bill & Melinda Gates Foundation
- 5 representing developing country governments
- 5 representing donor country governments
- 1 member each representing civil society organisations, the vaccine industry in developing countries, the vaccine industry in industrialised countries, and research and technical health institutes (4 in total)
- 9 independent individuals with a range of expertise
- The CEO of the GAVI Alliance (non-voting)

Institutions

UNICEF

Geeta Rao Gupta,
Vice Chair of the Board

WHO

Flavia Bustreo

The World Bank

Tim Evans

The Bill & Melinda Gates Foundation

Orin Levine

Independent members

Dagfinn Høybråten,
Board Chair

Wayne Berson

Maria C. Freire

Ashutosh Garg

H.R.H. The Infanta Cristina
of Spain

Yifei Li

Richard Sezibera

George W. Welde Jr.

One seat is vacant

Non-voting member

Seth Berkley, CEO, GAVI

Constituencies*

Developing country government representatives

Constituency 1

Suraya Dalil (Afghanistan)

Constituency 2

A.F.M. Ruhul Haque
(Bangladesh)

Constituency 3

Andrei Usatii (the Republic of
Moldova)

Constituency 4

Awa Marie Coll-Seck (Senegal)

Constituency 5

Ruhakana Rugunda (Uganda)

Donor government representatives

USA/Australia/Japan/ Rep. of Korea

Jenny Da Rin (Australia)

Canada/Ireland/United Kingdom

Donal Brown (United Kingdom)

Italy/Spain

Angela Santoni (Italy)

France/Luxembourg/ European Commission/Germany

Walter Seidel (European
Commission)

Denmark/Netherlands/ Norway/Sweden

Anders Nordström (Sweden)

Research and technical health institutes

Zulfiqar A. Bhutta (Aga Khan
University, Karachi, Pakistan)

Developing country vaccine industry

Mahima Datla (Biological E
Limited)

Industrialised country vaccine industry

Johan Van Hoof (Crucell)

Civil society organisations

Joan Awunyo-Akaba (Future
Generations International)

* For the full list of constituency members please refer to: www.gavialliance.org/about/governance/gavi-board/composition/developing-country-governments

Other GAVI Alliance-related governance structures

The International Finance Facility for Immunisation (IFFIm) Company

René Karsenti (Chair)

President

The International Capital Market Association (ICMA)

Sean Carney

President

Na Makani Eha

Didier Cherpitel

Former Secretary General International Federation of Red Cross and Red Crescent Societies

Cyrus Ardalan

Vice Chairman

Barclays

Marcus Fedder

Former Vice Chair

TD Securities

Christopher Egerton-Warburton

Partner

Lion's Head Capital Partners

The GAVI Fund Affiliate (GFA)

Wayne Berson (Chair)

CEO and Partner

BDO USA, LLP

André Prost

Former Director of Government and Private Sector Relations World Health Organization

Bo Stenson

Former Deputy Executive

Secretary

The GAVI Alliance

Stephen Zinser

CEO and Co-Chief Investment Officer

European Credit Management Ltd.

GAVI Campaign

Paul O'Connell (Chair)

President and Founding Member

FDO Partners, LLC

Steven Altschuler

President and CEO

The Children's Hospital of Philadelphia

Daniel Schwartz

CEO

Dynamica, Inc.

Seth Berkley (Honorary)

CEO

The GAVI Alliance

Annex 2:

Donor contributions and pledges 2000–2033

as of 31 December 2013 (US\$ millions)

	Contributions													Pledges					2011–2015 unallocated Matching Fund	2000–33 total		
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016–2033					
Absolute Return for Kids (ARK)													1.6			1.6						3.3
Matching Fund													1.6			1.6						3.3
Anglo American plc												1.0	1.0	1.0								3.0
Matching Fund											1.0	1.0	1.0									3.0
Australia							5.0	5.0	5.0	5.0	8.6	51.8	61.2	99.4	5.1	14.9	222.8					483.7
Direct contribution							5.0	5.0	5.0	5.0	8.6	48.8	56.5	94.9								228.8
IFFIm												2.9	4.7	4.5	5.1	14.9	222.8					254.9
Bill & Melinda Gates Foundation	325.0	425.0		3.5	5.0	154.3		75.0	75.0	85.0	85.0	227.2	287.3	308.0	225.6	245.0	15.0		8.5			2,549.4
AMC										10.0	10.0	10.0	10.0	10.0								50.0
Direct contribution	325.0	425.0		3.5	5.0	154.3		75.0	75.0	75.0	75.0	214.1	268.8	283.1	225.6	245.0						2,449.4
Matching Fund												3.1	8.5	14.9			15.0		8.5			50.0
Brazil															0.0	1.0	1.0		18.0			20.0
IFFIm															0.0	1.0	1.0	18.0				20.0
Canada			1.9	4.8	9.1	130.9	5.2			105.3	19.8	44.6	39.5	55.5	10.2	9.4						435.9
AMC										105.3	19.8	23.9	24.4	16.5	10.2							200.0
Direct contribution			1.9	4.8	9.1	130.9	5.2					20.7	15.1	39.0		9.4						235.9
Children's Investment Fund Foundation													4.3	2.2								6.5
Matching Fund													4.3	2.2								6.5
Comic Relief													3.2	6.9	1.6							11.7
Matching Fund													3.2	6.9	1.6							11.7
Denmark		1.1			3.3	3.4	4.4	4.7		9.1	1.8	8.8	4.4	4.6								45.7
Direct contribution		1.1			3.3	3.4	4.4	4.7		9.1	1.8	8.8	4.4	4.6								45.7
Dutch Postcode Lottery															3.2							3.2
Matching Fund															3.2							3.2
European Commission (EC)				1.3				4.8	23.1	28.6				12.5	27.4	13.8						111.6
Direct contribution				1.3				4.8	23.1	28.6				12.5	27.4	13.8						111.6
France					6.0		12.6	24.7	52.4	56.2	57.3	92.9	74.6	88.3	85.6	120.8	1'150.7					1,822.1
Direct contribution					6.0		12.6					34.5	20.1	34.9	7.6	37.9						153.7
IFFIm								24.7	52.4	56.2	57.3	58.4	54.5	53.4	78.1	82.9	1'150.7					1,668.4
Germany							5.3	5.9				5.7	5.1	8.5	34.7	35.4	41.3	68.8				210.8
Direct contribution							5.3	5.9				5.7	5.1	8.5	34.7	35.4	41.3	68.8				210.8
His Highness Sheikh Mohamed bin Zayed Al Nahyan												14.1	8.8	10.1								33.0
Direct contribution												14.1	8.8	10.1								33.0
Ireland			0.5	0.6	0.7	0.8	7.9	8.3	3.8	3.5	3.6	4.9	3.5	3.0	0.8							42.0
Direct contribution			0.5	0.6	0.7	0.8	7.9	8.3	3.8	3.5	3.6	4.9	3.5	3.0	0.8							42.0
Italy							3.7	7.3	83.3	87.7	83.1	84.4	88.6	90.4	88.7	89.4	561.0					1,267.4
AMC									50.2	55.7	52.3	52.4	52.7	53.2	53.6	54.3	210.5					635.0
IFFIm							3.7	7.3	33.1	32.0	30.8	32.0	35.9	37.3	35.0	35.0	350.4					632.4
Japan												9.3	9.1	9.1								27.5
Direct contribution												9.3	9.1	9.1								27.5
JP Morgan												2.4										2.4
Matching Fund												2.4										2.4
"la Caixa" Foundation									5.8	5.9	4.0	3.1	3.0	1.8								23.7
Direct contribution									5.8	5.9	4.0											15.7
Matching Fund												3.1	3.0	1.8								8.0
LDS Charities													1.5	2.5								4.0
Matching Fund													1.5	2.5								4.0
Lions Clubs International Foundation (LCIF)															7.5	7.5	15.0					30.0
Matching Fund															7.5	7.5	15.0					30.0

Source: 31

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016–2033	2011–2015 unallocated Matching Fund	2000–33 total
Luxembourg						0.6	1.3	0.8	1.4	1.2	1.1	1.2	1.1	1.1	1.1	1.1			12.1
Direct contribution						0.6	1.3	0.8	1.4	1.2	1.1	1.2	1.1	1.1	1.1	1.1			12.1
Netherlands	24.1	13.4	16.5	17.3	15.9	0.0	33.5	38.9	45.2	25.1	26.3	32.9	52.6	54.4	73.7	20.0			489.8
Direct contribution	24.1	13.4	16.5	17.3	15.9		33.5	38.9	45.2	25.1	26.3	32.9	52.6	54.4	73.7				378.9
IFFIm						0.0	0.0	0.0	14.0	0.0	0.0	18.7	18.2	20.0	20.0	20.0			110.9
Norway	17.9	21.3	21.8	40.9	39.5	72.6	91.3	70.6	88.0	99.1	111.7	144.2	156.6	172.9	187.1	118.7			1,454.3
AMC										2.1	25.0	15.0	7.9			0.0			50.0
Direct contribution	17.9	21.3	21.8	40.9	39.5	67.4	86.2	65.4	82.8	76.5	79.2	106.9	126.9	149.1	163.4				1,145.1
IFFIm						5.2	5.2	5.2	5.2	20.5	7.6	22.3	21.8	23.7	23.7	118.7			259.2
OPEC Fund for International Development (OFID)														1.1					1.1
Direct contribution														1.1					1.1
Other private donors			1.6	2.6	1.8	0.5	1.9	1.1	0.8	1.0	1.0	0.8	0.8	1.2					15.2
Direct contribution			1.6	2.6	1.8	0.5	1.9	1.1	0.8	1.0	1.0	0.8	0.8	1.2					15.2
Prudential														0.2					0.2
Direct contribution														0.2					0.2
Republic of Korea										0.4	0.3	0.3	1.0	1.0	1.0	2.0			6.0
Direct contribution										0.4	0.3	0.3	1.0	1.0	1.0	2.0			6.0
Russian Federation										8.0	8.0	8.0	8.0	8.0	8.0	8.0	32.0		80.0
AMC										8.0	8.0	8.0	8.0	8.0	8.0	8.0	32.0		80.0
South Africa							1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	11.0		19.8
IFFIm							1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	11.0		19.8
Spain						11.6	11.7	52.3	11.5	11.1	13.4	10.3	12.6	12.0	12.0	120.2			278.6
Direct contribution								40.5			2.7								43.2
IFFIm						11.6	11.7	11.7	11.5	11.1	10.7	10.3	12.6	12.0	12.0	120.2			235.4
Statoil														0.2					0.2
Direct contribution														0.2					0.2
Sweden	1.9	1.1	2.4	4.9	12.7	14.6	18.0	21.6	16.3	38.9	95.0	2.2	73.0	56.6	41.1	15.1			415.2
Direct contribution	1.9	1.1	2.4	4.9	12.7	14.6	15.5	19.2	13.8	36.5	92.7		70.9	54.0	38.6				378.8
IFFIm						0.0	2.4	2.5	2.5	2.4	2.3	2.2	2.1	2.5	2.5	15.1			36.5
United Kingdom	4.5	15.0	5.6	18.5	6.6	23.2	65.1	31.2	44.9	97.0	209.6	307.6	597.5	627.7	571.5	2'385.6	48.5		5,059.5
AMC										22.2	52.9	18.2	65.5	119.4	60.8	145.9			485.0
Direct contribution	4.5	15.0	5.6	18.5	6.6	23.2	48.1			15.9	81.7	199.0	433.5	361.3	342.7	26.7			1,582.3
IFFIm						0.0	16.9	31.2	44.9	58.9	71.6	83.4	94.3	138.5	157.9	2'213.0			2,910.4
Matching Fund											3.4	6.9	4.3	8.6	10.2		48.5		81.8
United States	48.1	53.0	58.0	59.6	64.5	69.3	69.3	71.9	75.0	78.0	89.8	130.0	138.0	175.0					1,179.5
Direct contribution	48.1	53.0	58.0	59.6	64.5	69.3	69.3	71.9	75.0	78.0	89.8	130.0	138.0	175.0					1,179.5
Vodafone (contribution in kind)														0.6	0.6	0.6			1.7
Matching Fund														0.6	0.6	0.6			1.7
Grand total	329.5	518.1	107.9	117.0	167.2	429.7	238.5	427.6	538.1	676.1	628.9	1,110.2	1,277.1	1,793.2	1,591.6	1,455.5	4,687.0	57.0	16,150.1

Non-US dollar contributions for 2000–2013 are expressed in US dollar equivalents using the exchange rates on the dates of receipt.

Non-US dollar direct, Matching Fund and AMC pledges for 2013–2033 are expressed in US dollar equivalents using the exchange rates at 31 December 2013, except for those pledges for which contributions have already been received (these are expressed in US dollar equivalents using the exchange rates on the dates of receipt) and non-US dollar pledges that have been hedged to mitigate currency risk exposure (these are expressed in US dollar equivalents using the exchange rates stated in the hedge agreements).

Signed non-US dollar IFFIm pledges for 2014–2033 are expressed in US dollar equivalents using the exchange rates at the time of signing the respective donor grant agreements.

Unsigned non-US dollar IFFIm pledges are expressed in US dollar equivalents using the exchange rates at 31 December 2013. These contributions have not been reduced by a notional 3% provision to allow for any potential reduction arising from the High Level Financing Condition of the IFFIm Finance Framework Agreement.

The yearly amounts shown under 'Matching Fund' for the Bill & Melinda Gates Foundation (BMGF) and the United Kingdom correspond to equal amounts of contributions/outstanding pledges from private donors for those years under the Matching Fund programme, but do not necessarily reflect the timing of funds received from BMGF and the United Kingdom under the programme.

As part of France's June 2011 pledge of € 100 million, € 67 million (equiv. US\$ 89.6m) has already been contributed. The donor plans to contribute a further € 11 million (US\$ 15.1m) between 2014 and 2015, but the contribution schedule for the remaining € 22 million (US\$ 30.3m) has not been decided yet. For calculation purposes, the € 22m has been included in 2015, although the effective contributions will be made over the 2014–2015 period.

Annex 3:

Commitments for country programmes 2000–2017*

as of 31 December 2013 (US\$ millions)

Country	NVS	HSS	ISS	Operational support	INS	Vaccine introduction grant	CSO	HPV demo. cash support	Product switch grant	Grand total
Afghanistan	127.4	50.0	14.0		1.7	1.7	3.6			198.4
Albania	2.1				0.1	0.3				2.5
Angola	95.7		3.0		1.3	1.8				101.8
Armenia	4.3	0.3	0.1		0.1	0.4				5.1
Azerbaijan	9.7	1.2	0.7		0.2	0.3				12.2
Bangladesh	421.5	13.7	23.3	33.6	6.1	5.8				504.0
Benin	81.7	2.7	0.2	1.7	0.4	0.2				86.9
Bhutan	1.1	0.2			0.0	0.2				1.5
Bolivia	19.5	2.1	0.3		0.9	0.3				23.1
Bosnia & Herz.	2.1				0.1	0.1				2.3
Burkina Faso	109.1	10.2	9.8		0.9	1.3				131.3
Burundi	65.1	20.3	3.7		0.4	0.9	0.5			90.9
Cambodia	29.5	10.3	2.2	3.2	0.6	0.6				46.5
Cameroon	130.9	8.0	8.0	2.5	1.0	1.4				151.8
Central African Rep.	22.2	3.2	1.9		0.1	0.4				27.8
Chad	30.8	5.0	2.6	3.7	0.4	0.2				42.8
China	22.0				15.9	0.8				38.7
Comoros	1.2	1.8	0.1		0.0	0.2				3.3
Congo	19.4		1.7		0.2	0.5				21.8
Congo DRC	352.1	56.8	25.8	9.7	2.7	2.7	7.6		0.4	457.9
Côte d'Ivoire	71.5	8.2	8.9	2.7	1.6	0.9				94.0
Cuba		2.4			0.4					2.7
Djibouti	3.6		0.2		0.0	0.3				4.1
Eritrea	10.3	2.8	0.4		0.1	0.4				14.1
Ethiopia	506.6	137.9	23.4	45.6	2.7	3.5	3.3			723.0
Gambia	20.2	0.7	0.7	0.7	0.1	0.9				23.3
Georgia	4.8	0.4	0.1		0.1	0.4				5.8
Ghana	180.6	9.7	5.3	9.5	0.9	1.9	0.4	0.2		208.4
Guinea	24.5	2.1	2.9		0.3	0.2				30.2
Guinea Bissau	4.1	1.9	0.5		0.1	0.4				7.1
Guyana	3.6		0.1			0.3				4.0
Haiti	24.5	3.3	1.3		0.4	0.7				30.2
Honduras	29.5	2.5	0.1		0.5	0.2				32.8
India	191.5	107.0			18.4	0.4				317.3
Indonesia	68.7	24.8	12.6		9.9	3.9	3.9			123.8
Kenya	328.9	9.9	6.4		1.1	1.8		0.2		348.3
Kiribati	0.3					0.2				0.5
Korea DPR	19.6	4.4	2.2		0.7	0.3				27.2
Kyrgyz. Rep.	8.8	1.2	0.8		0.2	0.2				11.2

* Commitments represent endorsements of multi-year programme budgets made by the GAVI Alliance Board (or Executive Committee). These endorsements do not constitute a liability to pay but instead send a positive signal that the GAVI Alliance intends to fund a programme over its entire life span subject to performance and availability of funds.

Source: 32

Country	NVS	HSS	ISS	Operational support	INS	Vaccine introduction grant	CSO	HPV demo. cash support	Product switch grant	Grand total
Lao PDR	18.1	2.5	1.4		0.3	0.5		0.2		23.0
Lesotho	4.8		0.1		0.1	0.3				5.4
Liberia	17.4	8.8	2.2		0.4	0.4				29.1
Madagascar	102.8	11.2	4.1		0.6	1.6		0.2		120.5
Malawi	137.5	25.8	2.0		0.7	0.9		0.2		167.2
Mali	132.4	4.6	5.0		0.7	0.9				143.5
Mauritania	12.6	2.4	0.7		0.2	0.3				16.2
Moldova, Republic of	4.6				0.1	0.4				5.1
Mongolia	5.2	0.5	0.5		0.1	0.1				6.4
Mozambique	123.6		1.7		0.8	1.2		0.2		127.5
Myanmar	61.6	32.8	7.7		2.1	2.5				106.7
Nepal	71.0	23.2	3.3		1.2	1.5				100.1
Nicaragua	27.1	3.2	0.4		0.5	0.2				31.3
Niger	99.9	4.0	8.1		0.9	2.1		0.3		115.3
Nigeria	410.4	44.7	47.3	102.1	12.6	10.0				627.3
Pakistan	704.5	23.5	48.8	21.7	7.4	6.8	7.7			820.2
Papua NG	19.3	3.1	0.4			0.4				23.2
Rwanda	108.7	15.9	3.0	3.3	0.4	1.1				132.4
São Tomé	0.9		0.1		0.0	0.4				1.3
Senegal	73.7	3.6	2.6	6.7	0.6	0.9				88.1
Sierra Leone	41.9	6.9	2.7		0.3	0.4		0.2		52.4
Solomon Isl.	1.1	2.0				0.1				3.2
Somalia	7.6	11.5	1.2		0.2	0.3				20.9
Sri Lanka	20.1	4.5			0.7	0.2				25.5
Sudan South	9.6	5.3	5.9		0.2	0.4				21.4
Sudan, Republic of	158.9	16.2	11.2	31.3	1.3	1.6				220.6
Tajikistan	14.7	1.3	2.4		0.3	0.2				18.9
Tanzania	250.9	13.5	11.4		1.0	5.4		0.2		282.4
Timor-Leste	0.8	3.0				0.1				3.9
Togo	28.2	4.9	3.0		0.3	0.7				37.1
Turkmenistan	1.0				0.2	0.1				1.2
Uganda	198.9	19.2	9.2		1.2	1.5				230.1
Ukraine	2.7				0.7	0.1				3.5
Uzbekistan	39.8		0.0		0.7	0.8				41.3
Vietnam	104.7	40.7	1.9	14.9	3.2	2.1				167.5
Yemen	165.3	6.3	5.0		1.2	0.7				178.6
Zambia	104.4	6.4	3.9		0.7	1.8				117.1
Zimbabwe	69.5	5.8	1.6		0.9	0.5		0.2		78.6
Grand total	6,405.4	862.5	362.1	293.0	113.5	86.4	27.0	2.0	0.4	8,152.3

Note 1: GAVI Alliance Phase I (2000–2006) approval values have been adjusted to the final actual disbursement values.

Note 2: CSO Type A not included as these approvals are not country specific.

Annex 4:

Board approvals for country programme expenditure 2000–2015*

as of 31 December 2013 (US\$ millions)

Country	NVS	HSS	ISS	Operational support	INS	Vaccine introduction grant	CSO	HPV demo. cash support	Product switch grant	Grand total
Afghanistan	99.7	50.0	14.0		1.7	1.7	3.6			170.7
Albania	2.1				0.1	0.3				2.5
Angola	82.6		3.0		1.3	1.8				88.7
Armenia	3.5	0.3	0.1		0.1	0.4				4.4
Azerbaijan	7.4	1.2	0.7		0.2	0.3				9.8
Bangladesh	276.7	13.7	23.3	33.6	6.1	5.8				359.2
Benin	71.2	0.9	0.2	1.7	0.4	0.2				74.5
Bhutan	1.0	0.2			0.0	0.2				1.5
Bolivia	16.8	2.1	0.3		0.9	0.3				20.4
Bosnia & Herz.	2.1				0.1	0.1				2.3
Burkina Faso	86.8	6.6	9.8		0.9	1.3				105.5
Burundi	61.2	18.8	3.7		0.4	0.9	0.5			85.4
Cambodia	27.3	9.8	1.8	3.2	0.6	0.6				43.4
Cameroon	109.6	8.0	8.0	2.5	1.0	1.4				130.4
Central African Rep.	15.2	3.2	1.6		0.1	0.4				20.5
Chad	27.4	5.0	2.6	3.7	0.4	0.2				39.4
China	22.0				15.9	0.8				38.7
Comoros	1.1	0.6	0.1		0.0	0.2				2.0
Congo	17.1		1.7		0.2	0.5				19.5
Congo DRC	279.9	56.8	25.8	9.7	2.7	2.7	7.6		0.4	385.7
Côte d'Ivoire	53.3	5.7	8.9	2.7	1.6	0.9				73.2
Cuba		1.3			0.4					1.7
Djibouti	2.8		0.2		0.0	0.3				3.4
Eritrea	8.5	2.8	0.4		0.1	0.4				12.3
Ethiopia	463.5	82.7	23.4	35.8	2.7	3.5	3.3			615.0
Gambia	16.6	0.4	0.7	0.7	0.1	0.9				19.3
Georgia	3.4	0.4	0.1		0.1	0.4				4.5
Ghana	173.7	9.7	5.3	9.5	0.9	1.9	0.4	0.2		201.4
Guinea	21.3	1.6	2.9		0.3	0.2				26.5
Guinea Bissau	3.7	1.6	0.5		0.1	0.3				6.2
Guyana	3.4		0.1			0.3				3.7
Haiti	10.8	1.1	1.3		0.4	0.7				14.3
Honduras	27.4	2.5	0.1		0.5	0.2				30.7
India	191.5	68.4			18.4	0.4				278.7
Indonesia	48.0	15.4	12.6		9.9	3.9	3.9			93.7
Kenya	290.8	9.9	6.4		1.1	1.8		0.1		310.1
Kiribati	0.2					0.2				0.4
Korea DPR	17.6	4.4	2.2		0.7	0.3				25.2
Kyrgyz. Rep.	8.0	1.2	0.8		0.2	0.2				10.3

* Approvals are a subset of commitments that have been approved by the Board. Only such approved amounts can be disbursed subject to all other conditions for disbursement being met by the countries. Approvals are typically granted for the current year and one further year.

Country	NVS	HSS	ISS	Operational support	INS	Vaccine introduction grant	CSO	HPV demo. cash support	Product switch grant	Grand total
Lao PDR	14.8	1.9	1.4		0.3	0.5		0.2		19.1
Lesotho	3.1		0.1		0.1	0.3				3.7
Liberia	13.7	7.3	2.2		0.4	0.4				23.9
Madagascar	97.6	7.7	4.1		0.6	1.6		0.2		111.7
Malawi	133.6	19.3	2.0		0.7	0.9		0.2		156.6
Mali	97.7	4.6	5.0		0.7	0.9				108.8
Mauritania	9.9	0.8	0.7		0.2	0.3				11.9
Moldova, Republic of	4.0				0.1	0.4				4.5
Mongolia	5.0	0.5	0.5		0.1	0.1				6.2
Mozambique	90.3		1.7		0.8	1.2		0.2		94.2
Myanmar	41.3	18.6	7.7		2.1	2.5				72.3
Nepal	46.2	23.2	3.3		1.2	1.5				75.3
Nicaragua	24.2	2.6	0.4		0.5	0.2				27.8
Niger	71.8	4.0	8.1		0.9	2.1		0.2		87.0
Nigeria	212.1	44.7	47.3	69.3	12.6	10.0				396.1
Pakistan	577.5	23.5	48.8	21.7	7.4	6.8	7.7			693.3
Papua NG	15.4	1.1	0.4			0.4				17.3
Rwanda	89.3	10.0	3.0	3.3	0.4	1.1				107.0
São Tomé	0.7		0.1		0.0	0.4				1.2
Senegal	57.4	3.6	2.6	6.7	0.6	0.9				71.8
Sierra Leone	35.1	4.2	2.7		0.3	0.4		0.2		42.8
Solomon Islands	1.0	0.5				0.1				1.6
Somalia	5.1	5.8	1.2		0.2	0.3				12.7
Sri Lanka	20.0	4.5			0.7	0.2				25.4
Sudan South	3.7	5.3	5.9		0.2	0.4				15.4
Sudan	158.9	16.2	11.2	22.1	1.3	1.6				211.3
Tajikistan	13.3	1.3	2.4		0.3	0.2				17.6
Tanzania	196.0	3.8	11.4		1.0	5.4		0.2		217.8
Timor-Leste	0.7	0.4				0.1				1.1
Togo	20.9	3.7	3.0		0.3	0.7				28.6
Turkmenistan	1.0				0.2	0.1				1.2
Uganda	186.8	4.5	9.2		1.2	1.5				203.3
Ukraine	2.7				0.7	0.1				3.5
Uzbekistan	33.2		0.0		0.7	0.8				34.7
Vietnam	96.2	37.1	1.9	14.9	3.2	2.1				155.4
Yemen	142.0	6.3	5.0		1.2	0.7				155.3
Zambia	84.1	2.7	3.9		0.7	1.8				93.2
Zimbabwe	50.2	1.9	1.6		0.9	0.5		0.2		55.4
Grand total	5,211.7	657.8	361.4	241.2	113.5	86.3	27.0	1.8	0.4	6,701.1

Note 1: GAVI Phase I (2000–2006) approval values have been adjusted to the final actual disbursement values.

Note 2: CSO Type A not included as these approvals are not country specific.

Note 3: Approvals by year: Cumulative through 2013 = US\$ 5,495.5 million, 2014 = US\$ 1,205.2 million, 2015 = US\$ 0.4 million

Annex 5:

Commitments for investment cases 2003–2018*

as of 31 December 2013 (US\$ millions)

Programme	Vaccines	Operational costs	Total
Measles	60.4	115.6	176.0
Meningitis	60.5	28.2	88.7
Maternal and neonatal tetanus	16.3	45.3	61.6
Polio	143.3	48.0	191.3
Yellow Fever	123.2	34.0	157.2
Cholera	114.5		114.5
Other		0.5	0.5
Total	518.1	271.6	789.7

Board approvals for investment case expenditure 2003–2014**

as of 31 December 2013 (US\$ millions)

Programme	Vaccines	Operational costs	Total
Measles	60.4	115.6	176.0
Meningitis	60.5	28.2	88.7
Maternal and neonatal tetanus	16.3	45.3	61.6
Polio	143.3	48.0	191.3
Yellow Fever	123.2	34.0	157.2
Cholera	8.5		8.5
Other		0.5	0.5
Total	412.1	271.6	683.7

* Commitments represent endorsements of multi-year programme budgets made by the GAVI Alliance Board (or Executive Committee). 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 life span subject to performance and availability of funds.

** Approvals are a subset of commitments that have been approved by the Board. Only such approved amounts can be disbursed subject to all other conditions for disbursement being met by the countries. Approvals are typically granted for the current year and one further year.

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Abbreviations

AMC	Advance Market Commitment	IDQA	immunisation data quality assessment tool	OPEC	Organization of the Petroleum Exporting Countries
APPG	All-Party Parliamentary Group	IFFIm	International Finance Facility for Immunisation	OPV	oral polio vaccine
ARK	Absolute Return for Kids	IHP+	International Health Partnership	SIA	supplementary immunisation activities
CEO	Chief Executive Officer	INS	injection safety support	TAP	Transparency and Accountability Policy
CIFF	Children's Investment Fund Foundation	IPV	inactivated poliovirus vaccine	UNFPA	United Nations Population Fund
CSO	civil society organisation	IRC	Independent Review Committee	UNICEF	United Nations Children's Fund
DTP3	three doses of the diphtheria-tetanus-pertussis vaccine	ISS	immunisation services support	WHO	World Health Organization
EC	European Commission	MDG	Millennium Development Goal	WUENIC	WHO and UNICEF Estimates of National Immunization Coverage
Hib	<i>Haemophilus influenzae</i> type b	MR	measles-rubella vaccine		
HPV	human papillomavirus	NVS	new and underused vaccine support		
HSS	health system strengthening	OFID	The OPEC Fund for International Development		
ICMA	The International Capital Market Association				

Notes

The 2013 GAVI (audited) Annual Financial Report will be available on the GAVI website in or before October 2014:

www.gavialliance.org/funding/financial-reports.

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Universe Enebong is a Nigerian community health worker based at the rural clinic of Ikang in Cross River State.

Universe must often travel by motor boat to reach the more remote villages in her district.



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