GAVI ALLIANCE | 10 YEARS OF SAVING LIVES

Resource needs 2010-2015

Saving children's lives

A call for action and resources for the GAVI Alliance

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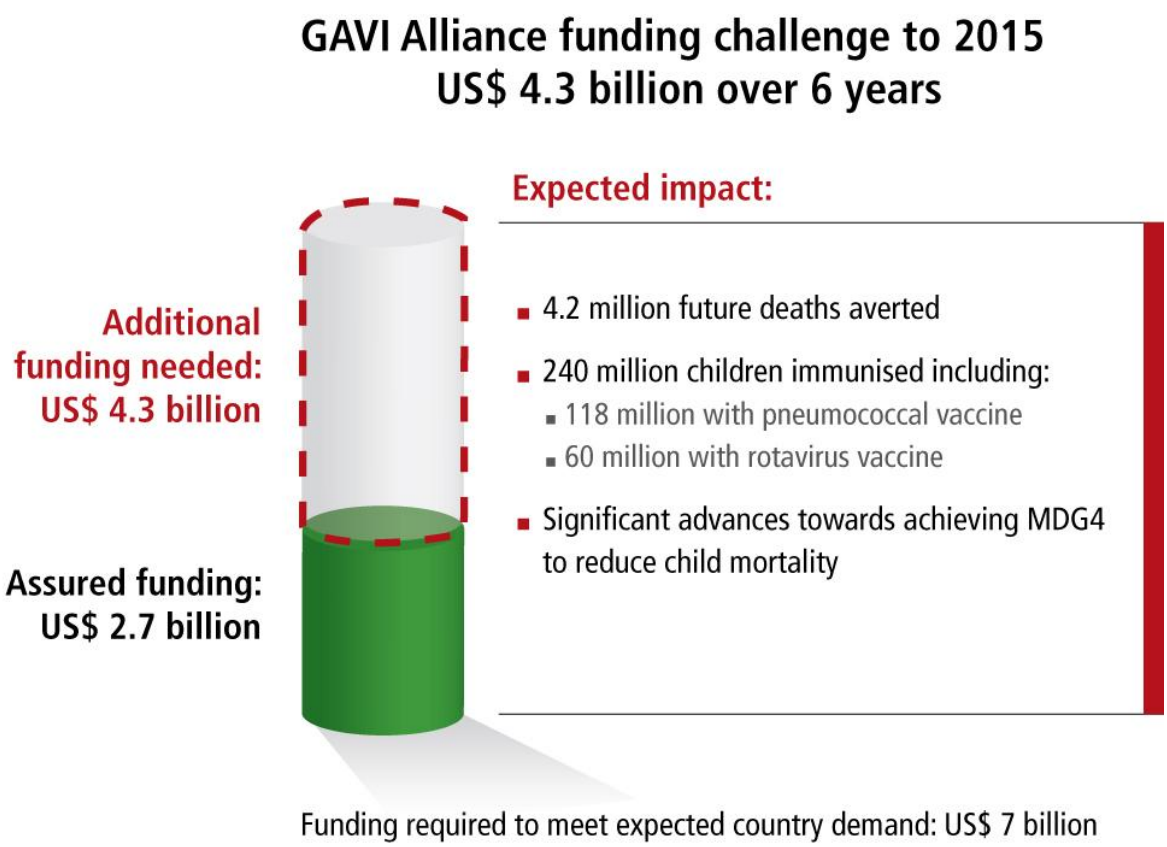
Resource needs 2010-2015

GAVI estimates total cash flow needed between 2010 and 2015 of **US$ 7.4 billion** for existing programmes and new vaccines. This requires approximately **US$ 4.3 billion** in new donor contributions.

With full funding, GAVI can support the immunisation of approximately **240 more children**, including **118 million with pneumococcal vaccines** and **60 million with rotavirus vaccines** in more than 40 countries. In addition, the complete roll-out of **pentavalent vaccine** can be accomplished. This could prevent an estimated **4.2 million future deaths** by 2015.

Figure 1



In addition, GAVI has identified the future opportunity to introduce new vaccines against human papillomavirus (HPV) which causes cervical cancer in women, Japanese encephalitis, meningitis, rubella and typhoid.

Sustaining GAVI's currently funded programmes and the Alliance's ability to fund new vaccines are dependent on securing the necessary donor pledges. Alliance partners, donors and stakeholders are working together to maximise the potential impact of immunisation on global health and to make specific commitments necessary to accomplish GAVI's ambitious goals through 2015.

Results and opportunities

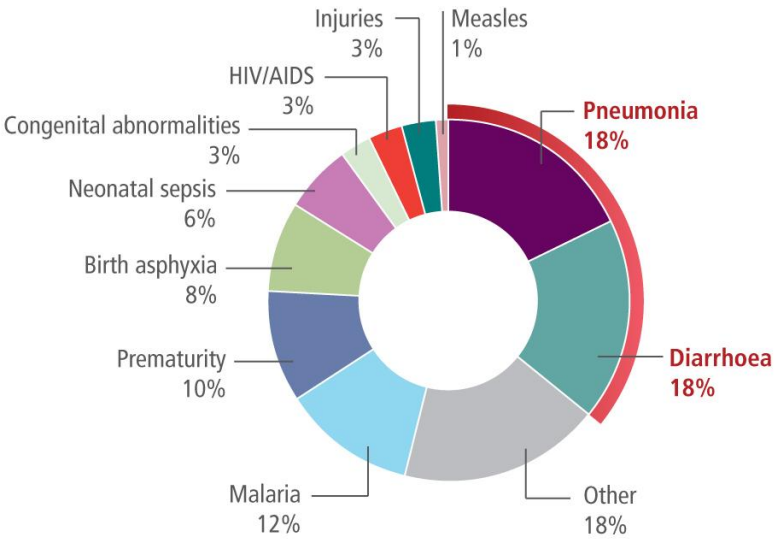
GAVI is working in **72 countries** and is progressively focusing on the **58 poorest countries,** which comprise almost 80% of the world's extreme poor (those living on less than US$ 1.25 a day) and 81% of the world's unimmunised children.

Over the last decade, GAVI has committed **US$ 4 billion** in funding to country-led initiatives in the world's poorest regions. This performance-driven funding has accelerated access to new and underused vaccines in developing countries.

As a result, more than **250 million children** have been immunised against life-threatening diseases and **5.4 million deaths** have been prevented.

Despite significant progress made in reducing childhood mortality, more than two million children continue to die each year from vaccine-preventable diseases. Most of these deaths occur in low-income countries. **Pneumonia** and **diarrhoea** are the two leading killers, causing nearly 40% of all childhood deaths.

Figure 2: Causes of under-5 child deaths in low-income countries



Source: WHO, World Health Statistics 2010

Both pneumonia and diarrhoea can be reduced significantly with new vaccines against pneumococcal disease and rotavirus. However, neither vaccine is widely available in poor countries despite the increasing demand by their governments.

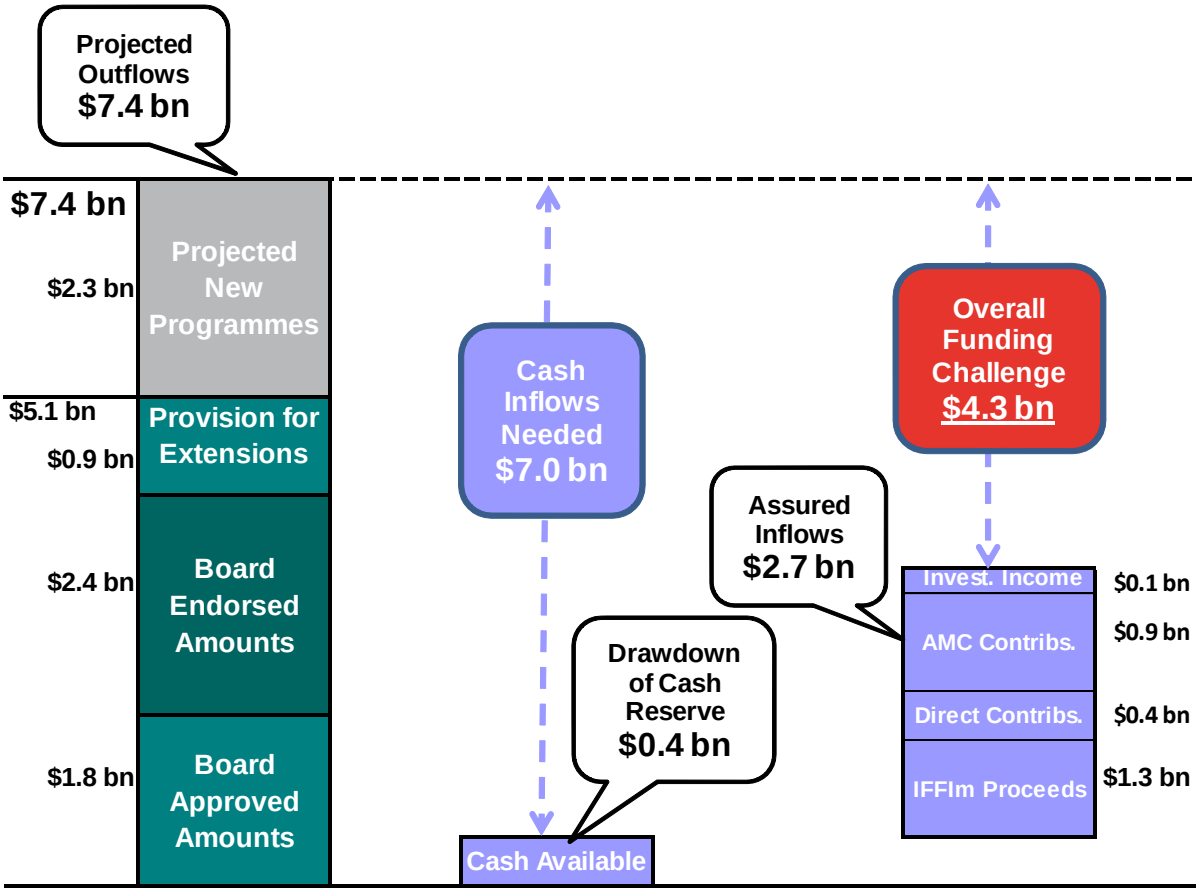
With new vaccines now available against the world's top two childhood killers, GAVI has the historic opportunity to accelerate its impact. This would make a significant contribution towards achieving the **Millennium Development Goals**, and move the international community closer to achieving the G8 leaders' **Muskoka Initiative** aimed at improving maternal, newborn and child health. According to the accountability formula agreed by the G8, contributions to GAVI count 100% towards donors' commitments to the Muskoka Initiative.

Projected demand and resource needs 2010-2015

Country demand for GAVI support in 2010-2015 is projected at **US$ 7.4 billion**. Of this, US$ 5.1 billion is for existing programmes that have already been approved or endorsed by the Board, plus a provision for the extension of these programmes through 2015. A further US$ 2.3 billion is estimated for demand from new (or expanded) programmes that will seek support from GAVI through 2015.

The demand estimate will be updated in October 2010 to reflect the latest strategic demand forecast and expectations of vaccine supply availability.

Figure 3: Financial overview 2010-2015



Of the **US$ 7.4 billion** projected cash outflows, 80% is for vaccines – mainly for the roll-out of pneumococcal vaccine and pentavalent. A further 17% is for vaccine introduction and other programme activities, immunisation services support and health systems strengthening, and 3% is for administrative costs.

Table 1: Composition of country demand 2010-2015

US$ billion	**Existing Programmes**	**Estimate for New Programmes**	**Total**	
Pneumo	1.7	0.7	2.4	33%
Pentavalent	1.8	0.2	2.0	27%
Rotavirus	0.1	0.6	0.7	10%
Other vaccines	0.1	0.6	0.7	10%
Programme activities	0.6		0.6	8%
Health systems strengthening	0.3	0.2	0.5	6%
Immunisation services support	0.1	0.1	0.2	2%
Administration	0.2		0.2	3%
Total	**5.1**	**2.3**	**7.4**	100%
	69%	31%		

The US$ 4.3 billion funding challenge

Cash and investments totalled US$ 1.4 billion at the start of 2010. This balance can be reduced to US$ 1 billion while still maintaining the Board-mandated reserve to cover eight months' expenditure, allowing for an annual expenditure level of $1.5 billion by 2015. With this **US$ 0.4** billion drawdown available towards meeting demand of US$ 7.4 billion, cash inflows of US$ 7.0 billion are needed in 2010-2015 (see Figure 3).

Cash inflows of US$ 2.7 billion were already assured in March 2010, comprised of direct contributions under multi-year grants, AMC contributions, IFFIm proceeds from pledges to date and a conservative estimate of investment income. Thus, the overall funding challenge is to raise additional income of **US$ 4.3 billion** in 2010-2015 from direct contributions, innovative financing mechanisms or other sources. Of this US$ 4.3 billion, US$ 2 billion is for existing programmes, while US$ 2.3 billion is the estimated (future) demand from new programmes, yet to be considered for approval by the Board (see Table 2).

Through 2012, additional income of US$ 1.1 billion is needed, including US$ 0.6 billion in 2012. This need increases to US$ 1 billion per year from 2013, due mainly to growth in demand, declining proceeds from IFFIm and the inability to further draw from the cash reserve.

The amount of US$1.3 billion for IFFIm proceeds expected in 2010-2015 and included in "Assured Inflows" in Figure 1 does not include a separate HSS-specific amount of US$ 474 million expected from IFFIm in the same period. The amount of US$ 2.3 billion for projected new programmes and included in 'Projected Cash Outflows' in Figure 1 currently includes US$ 179 million for future HSS programmes. This is the amount as yet unallocated from a prior estimate of HSS demand, and future HSS demand through 2015 is likely to exceed this amount. The IFFIm HSS-specific funding will be available towards meeting future HSS demand.

Table 2: Timing of resource needs

	US$ billion	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
	Existing programmes	1.1	0.9	1.0	0.8	0.7	0.6	5.1
	New Programmes		0.2	0.2	0.4	0.6	0.8	2.3
A	**Total outflows**	1.1	1.0	1.2	1.3	1.4	1.5	**7.4**
	Direct contributions under signed agreements	0.1	0.1	0.1	0.1	0.1		0.4
	Expected from IFFIm, AMC & investment income	0.7	0.5	0.2	0.2	0.3	0.4	2.2
	Drawdown of Cash & Investment Reserve	0.1	0.2	0.3	(0.1)	(0.1)	(0.0)	0.4
B	**Resources Available**	0.8	0.7	0.6	0.2	0.3	0.3	3.1
A-B	**Additional Resources Required**	0.2	0.3	0.6	1.0	1.0	1.1	**4.3**
	Additional Resources Required - Cumulative	***0.2***	***0.5***	***1.1***	***2.1***	***3.2***	***4.3***	
	Of which:							
	- For existing programmes (cumulative)	*0.2*	*0.4*	*0.7*	*1.3*	*1.7*	*2.0*	
	- For new programmes (cumulative)		*0.2*	*0.4*	*0.8*	*1.5*	*2.3*	

Approval in 2011 requires visibility on resources through 2013

Need for visibility on future contributions

In accordance with the GAVI programme funding policy, at the time of approving additional programmes, sufficient 'Qualifying Resources' must exist to cover cash outflows arising in that year and the following two calendar years. So, in order to approve new programmes in 2011, sufficient Qualifying Resources must exist at the time of approval to cover cash outflows (for the new and existing programmes) through 2013. As indicated in Table 2, additional Qualifying Resources of US$ 1.3 billion are required through 2013 to cover existing programmes, and a further US$ 0.8 billion for expected future demand from new programmes.

Accordingly, it is very important that at the time of approving new proposals for funding in 2011, contributions for 2011 and ideally through 2013 will have been confirmed. As well as cash and investments and assured future inflows, Qualifying Resources also include the current level of direct contributions. Hence, to the extent that future contributions have not yet been confirmed at the time of approval of new proposals in 2011, the 2011 level of direct contributions, if considered unlikely to decline, may be assumed to continue in 2012 and 2013 when assessing the amount of Qualifying Resources through 2013. For these reasons, it is critical for the approval of new programmes in 2011 that multi-year contributions are pledged, to the greatest extent possible.

Seizing the opportunity

The GAVI Alliance's plans to address the two biggest childhood killers and to roll out pentavalent and additional priority vaccines can be realised, but their implementation will be slowed if GAVI does not receive new investments. Now is the time to make a difference.

If programmes are fully funded, it is estimated that the GAVI Alliance will:

- by 2015, have saved nearly **10 million lives** since its inception
- greatly contribute to **progress on MDG4** by providing vaccines to reduce the top two causes of child mortality: **pneumonia and diarrhoea**
- ensure the routine use of **pentavalent (5-in-1) vaccine** in all GAVI-eligible countries, which would avert an additional 3 million future deaths between 2010 and 2015
- through its health system strengthening work, help **advance MDG4 and MDG5** that aims at reducing by three quarters the maternal mortality rate
- accelerate **equitable access to new vaccines**, including meningitis, Japanese encephalitis, typhoid, rubella, and HPV.

We must keep up the momentum.

Millions more lives can be saved.

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