Issue 4, Summer 2013

The Civil Society Dose

A Bi-Annual Newsletter of the GAVI CSO Constituency

Immunisation in the Broader Context: Strengthening Health Systems, Achieving Universal Health Coverage

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Note from the Editors:
Thank you, but not good bye

Dear Readers,

We'd like to begin this issue the way we begin every issue: by thanking you. The articles featured here come from our dynamic Constituency members and GAVI partners. That people proactively contact us with article ideas and proposals is testament to how much this newsletter is appreciated, and how much its needed. We're proud that *The Dose* is an unbranded, entirely volunteer effort, and that many organisations share our Constituency newsletter on their websites. We hope this practice will grow.

We wish to dedicate this, our fourth issue, to our colleagues on the GAVI CSO Steering Committee whose terms will conclude this June. Many of them have worked on our behalves for the past three years, lending their leadership, time, expertise and engagement to GAVI CSO. They are some of our founding Steering Committee members who provided the Constituency with its structure, foundations and Charter. To them we say thank you for your perseverance, thank you for your vision and thank you for all that you invested-- both professionally and personally-- in our Constituency. We hope you will remain highly engaged; as always, our work is just beginning.

With appreciation,

-Your editorial team

Introduction: Health System Strengthening, What's it Going To Take?

By **Mayowa Joel**
Programme Director, Communication for Development Center, Nigeria

Welcome to the new edition of "The Civil Society Dose". This issue focuses on framing immunisation in the broader contexts of Health Systems Strengthening and achieving Universal Health Coverage (UHC). UHC means different things to different people, but all countries have agreed that "universal health coverage means that all people have access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them." (WHO)

Each year, nearly seven million children die before their fifth birthday. Many of these deaths are easily preventable. We know that the solutions are simple and affordable: skilled birth attendants, clean water, nutritious food, proper sanitation and basic vaccinations.

The goal of reducing preventable child deaths and reaching the fifth child with basic immunisation services requires effective and efficient health systems. The recently released Report of the High-Level Panel on the Post-2015 Development Agenda states that "[t]he benefits of investing in health are immediate and obvious, both for specific interventions and for strengthening health systems more broadly."

Health Systems Strengthening has direct impact on immunization coverage, and to be effective, it will require effective leadership and governance, adequate human resources, equitable health service delivery, predictable and sustainable financing, effective information management systems, continuous research and development, investment in social determinants of health, effective accountability and monitoring systems, community participation and ownership, and partnership with all stakeholders. A long list that we must accomplish.

Interview: Harmonizing and Strengthening Civil Society Platforms in Africa: African CSO Platforms Meet With Global Health Partners in Geneva

An interview with **Rukia Cornelius**, Programme Manager, and **Rosemary Mburu**, Acting Executive Director, of World AIDS Campaign International (WACI), the initiative's organisers

Rukia Cornelius
Programme Manager
World AIDS Campaign International

Rosemary Mburu
Acting Executive Director
World AIDS Campaign International

Context: African civil society partners and global health agencies met in Geneva from the 19th -20th February, 2013, to define an initiative for improved collaboration among the work of global health partners and health-focused African CSO platforms. The meeting was hosted by the GAVI Alliance and included participation from GAVI, GFATM, Stop TB Partnership, UNAIDS, RBM, PMNCH, IHP+ and UNITAID and their African civil society constituents. GAVI CSO sent two representatives, Patricia Porekuu of the Ghana Coalition of NGOs in Health and Ernest Compaore of the Secretariat Permanent des ONGs du Burkina FASO (SPONG).

Q: What inspired this initiative, and why now?

World AIDS Campaign International (WACI) has been working on domestic resource mobilization for over five years now. Part of that work has meant strengthening and, in some cases, establishing health platforms at country level, which work through advocacy and campaigning not only to hold governments accountable on promises made on health and HIV, but also to mobilize required resources for the delivery of those promises. Inadequate political will by our leaders to sufficiently invest in health has greatly inspired us to pursue approaches through which the African civil society voice can be strengthened. Through this work, we identified the important role that global health partnerships play in supporting national-level initiatives in the region. It was then clear to us that improved collaboration and partnerships among African CS partners and global health partnerships, and between the two, is essential for strong health platforms, successful advocacy on domestic resource mobilization and attaining efficiency in utilization of available resources.

Q: What kind of leadership is needed from African CSOs to ensure this initiative moves forward? In your opinion, has that leadership been forthcoming?

The most immediate and urgent leadership needed from African CSOs is on mapping the current status of Africa civil society organizing at country level, as well as the current initiatives on domestic resource mobilization. This will ensure that we are leveraging existing processes and initiatives and not duplicating efforts. The second level of leadership is on increased collaboration and coordination among African CSOs, which means real-time information sharing, leveraging each other's achievements, and deliberately pursuing other areas of collaboration for efficiency. This leadership is currently not at a satisfactory level but there is progress and unquestionable potential and capacity among African CSOs. There is need therefore for us, African CSOs, to step up commitment in this initiative and provide the required leadership.

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Q: What do you see as the greatest challenges to improved cooperation and coordination among the various African CSO Constituencies of the major global health partnerships? How can civil society counterparts in the rest of the world help?

A major challenge of African CSO constituencies is that most of our activities and organizing has traditionally centered on the specific diseases that we work on and the streams of funding available to us. The shift that this initiative proposes calls for a change of mind-set and practice, which is possible, but gradually so.

Civil Society counterparts in the rest of the world can help by pursuing improved cooperation and coordination among CSOs in their regions. This will send the right message not only on collaboration and coordination among African CSOs but also among the major Global Health Partnerships. This global solidarity at these two levels is vital in achieving a strong CS voice on resource mobilization for health.

Technical Feature: Bridging the Gap of Immunisation Coverage Efforts Through Technology: GIS and Immunisation Strategy

By **Victor Imuwahen Igharo**
Programme Associate, Health, Communications for Development Centre, Nigeria

Victor Imuwahen Igharo
Programme Associate, Health Communications for Development Centre, Nigeria

Technology in healthcare over the years attempts to solve some of the problems associated with access, safety, quality and cost. ICT tools such as the Geographical Information Systems (GIS) have been used to map out communities susceptible to specific and emerging disease conditions; this facilitates planning on mobilisation of resources, consumption and health commodity need assessment.

GIS, a computer system used to store, manipulate, analyse, model, and display spatially and non-spatially referenced data sets, has been a cornerstone in public health practice especially supporting the process of identifying focal areas for public health intervention.

This is valuable in predicting outcomes, maintaining situational awareness, assessing risks and evaluating threats, as well as pivotal in constructing, modelling and monitoring strategic plans for the health system and services including immunisation.

Some of the major issues identified for immunisation inefficiency can be attributed to a cascade of social, geographical and operational factors such as lack of pre-survey of eligible infants for immunisation sessions; non-existent post-immunisation follow-up; weak logistics maintenance; poor monitoring and evaluation system; and poorly defined population mix.

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GIS tools and databases make it easy to create, analyse, maintain and retrieve information on spatial preferences relevant to immunisation programs through geo-coding of patient addresses for mass notification system, emergency management, quarantine and isolation, post-administration surveillance of new pandemic vaccines, as well as monitoring and evaluation of immunisation impact and progression.

In addition to selection of sentinel sites and vaccination stations; geographical analysis models and geo-referenced demographic data can be used to visualised, prioritize and manage vaccines distribution especially in resource limited settings. Immunisation interventions can take a cue from trypanosomiasis treatment monitoring in DRCongo using HealthNet, malaria outbreak monitoring in India, communicable disease warning system in Uganda using mobile devices, and Health information systems for HIV/AIDS services in Rwanda with TRACNet. As part of efforts to completely eradicate polio, Nigeria has started using GIS to improve geographical mapping and immunisation planning; and GPS technology to track immunisation progress.

Therefore, to continuously track the progress of supplementary immunisation activities (SIAs) ensuring treatment protocols completion, and in furtherance of the attainment of strategic area 3 of the Global Immunisation Vision and Strategy (GIVS), there is need to scale-up immunisation intelligence. For example, mobile technologies can be used to request immunisation interventions, report adverse events, and track vaccine-related issues such as emergence and resurgence of vaccine-preventable diseases, vaccination rates and coverage levels.

Erin Fry Sosne
Policy Officer, PATH

Adenike Grange
Past President, International Pediatric Association

Case Study: How a Network of Advocates Helped Protect Vaccine Access in a Global Treaty

Erin Fry Sosne, Policy Officer, PATH
Mayowa Joel, Programme Director, Communication for Development Center
Adenike Grange, Past President, International Pediatric Association

In August of 2011, members of the GAVI Alliance Civil Society Organisations (CSO) Constituency learned of a pending environmental treaty being developed to protect human health by limiting environmental exposure of mercury. But that same treaty, in development by the United Nations Environment Program, could also potentially have a devastating impact on global immunisation programs. Many multidose vaccine vials contain the preservative thiomersal, which includes the mercury-based ingredient ethylmercury. Scientific studies show that the amount of thiomersal used in vaccines is safe for children and adults.

After two years of dedicated efforts, advocates successfully protected access to thiomersal-containing vaccines in the final treaty decided in January 2013.

An essential component of vaccines
Thiomersal has been used for more than 50 years to prevent contamination of vaccines in multi-dose vials. Multidose vials are often the most appropriate option in limited-resource settings and tropical regions, and no viable substitute for thiomersal exists today.

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Thiomersal-containing vaccines are responsible for averting an estimated 1.4 million child deaths each year. "Thiomersal-containing vaccines are safe, essential, and irreplaceable components of immunisation programs, especially in developing countries, and removal … would disproportionately jeopardize the health and lives of the most disadvantaged children worldwide." – World Health Organisation Expert Panel, April 2012

The challenge
Without the robust presence of public health experts at the treaty negotiations, delegates—especially those from developing countries—received incorrect information from anti-thiomersal activists who had been engaged early in the treaty discussions. To shift the delegates' attention to scientifically accurate evidence that could help drive their decision-making, members of GAVI CSO, including representatives from PATH, MSF, Red Cross/Red Crescent National Societies and others, attended meetings and shared resources. The group helped garner support from the delegates, most of whom represented environmental ministries, to ensure that thiomersal-containing vaccines were not restricted through the treaty.

The invaluable role of strong networks
While PATH took the lead on organizing advocacy efforts, engagement with global networks—specifically the GAVI CSO and International Pediatric Association—played a critical role in achieving this success.

The GAVI CSO listserv became a vital tool for disseminating information around the globe and receiving feedback, and the group helped identify key advocates in specific geographies. The broad engagement of the pediatric community through the International Pediatric Association and the American Academy of Pediatrics lent credence to the scientific basis needed for negotiation. Allies and advocates from developing and developed countries also played critical roles during the treaty-negotiation process through social media and reaching out directly to their government delegates.

A successful outcome
In January 2013, government delegates agreed to exclude vaccines containing the preservative thiomersal from regulation. The treaty focuses instead on restricting major sources of mercury released into the environment and that pose a serious health risk.
The success of the treaty outcome is in part a testament to the strength of global networks of advocates like GAVI CSO. As a result of our outreach, delegates shifted their conversation from looking for ways to restrict thiomersal to looking forward to protect it. While the constituency was not created to serve this purpose, this is only one of many examples where it has stretched beyond its scope to promote evidence-based public policy.

UNEP-INC Geneva

UNEP-INC Punta Del Este

Constituency News: Focus on Results: GAVI CSO's HSS Country Platforms

Catholic Relief Services
GAVI CSO HSS project management

Oversight Advisory Group
For GAVI CSO HSS project

Each year, 22 million children lack access to the most basic vaccines. Weak health systems hinder the delivery of vaccinations to those who need them; strengthening these systems is vital to improving immunisation coverage. Civil society organisations have a long history of involvement in public health and play an important role in implementing immunisation programs and strengthening health systems.

The GAVI Civil Society Constituency (GAVI CSO), with the support of the GAVI Alliance, is working in 14 countries to strengthen civil society participation in immunisation and Health-System Strengthening (HSS) efforts as part of the GAVI Business Plan. The GAVI CSO HSS project-- which responds to the needs and priorities of Ministries of Health, CSOs, and in-country partners supporting the Expanded Program on Immunisation-- is managed on the Constituency's behalf by Catholic Relief Services (CRS). It began in 2012 with seven focus countries; Burkina Faso, DRCongo, Ethiopia, Ghana, Kenya, Malawi, and Pakistan, extending into seven additional countries through a second phase that began in 2013: Chad, Guinea, Haiti, India, Liberia, Nigeria and Uganda.

How the project works
In each of the 14 project countries, the local CRS office creates an enabling environment for the lead CSO to coordinate a functional civil society platform capable of engaging in immunisation and health system strengthening discussions and processes. Platforms are able to influence and engage with country governments and development partners, ultimately linking communities with immunisation and health systems. Ideally, these country CSO platforms will also be key partners in implementing the Global Vaccine Action Plan (GVAP) at the country and community levels. CRS' role as grant manager is to strengthen participating countries' CSOs' capacity in financial management, reporting, advocacy, coordination and project monitoring. The project is also supported by a five-member Oversight Advisory Group (OAG), comprised of senior civil society representatives and currently serving members of the GAVI CSO Steering Committee.

Results to date
The GAVI CSO HSS country platforms have already made significant progress. In the 14 target countries:

- 14 country-level civil society organisation networks have been established.
- 128 civil society organisations are actively playing leadership roles, mapping exercises have identified a wider membership of 694.
- The focus of existing networks on health systems informs parents of the benefits and encourages them to immunize their children.
- Civil society organisations have highlighted barriers to immunisation that hamper vaccine delivery and proposed workable solutions.

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- Civil society organisation platforms have increased their members' advocacy capacity and activities.
- Increased civil society organisation involvement in Immunisation Coordinating Committees (ICCs) and Global Fund Country-Coordinating Mechanisms (CCMs), as well as Health Sector Coordinating Committees (HSCCs).
- Civil society organisations have strengthened their relationships with stakeholders and development actors, including WHO.
- Civil society organisations have improved workplans, budgets and fund management skills.

Looking ahead
This three-year project has an operating budget of US $4,661,331.

The project aims to achieve one of GAVI's strategic objectives: strengthen civil society engagement in the health sector. CRS is helping participating civil society organisations to acquire increased capacity, tools and skills to influence the development and implementation of national immunisation policies and related, wider health strategies. The project also supports civil society organisation networks and coalitions to strengthen their collaboration with UNICEF and WHO, access technical assistance and create linkages to funding streams and resources available from bilateral development agencies with a local presence. In turn, this will further strengthen the GAVI civil society constituency at the country level, making it a more robust supporter of the GAVI Alliance and enabling it to address major constraints in delivering immunisations to underserved populations.

Research Corner: Immunisation for All: Making Equitable Progress

Kirsten Mathieson
Health Policy and Research Officer, Save the Children UK

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Senior Associate, ACTION!

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Vaccination works and every child has the right to benefit from it as part of their right to health. Various global targets have been adopted to increase immunisation coverage and clear progress is being made. By 2011, 83% of the world's children had received basic vaccines, compared with 71% two decades earlier.[1]

Despite this impressive progress, there is still a long way to go until the full benefits of immunisation are realised by *all* children. One in every five children is still not receiving even the most basic vaccines.[1] The distribution of unimmunised children is not random, but corresponds to large inequalities both across and within countries.

But which countries are performing well and which are lagging behind? And more importantly, where progress is being made, is it equitable – i.e. are *all* children being reached?

Who is missing out?
As highlighted in *Finding the final fifth: Inequalities in immunisation*, children born in low-income countries are least likely to be immunised, on average falling 15 percentage points behind high-income countries in DTP3[1] coverage. In some countries, coverage is much worse: for instance, in Nigeria only 47% of children have access to basic vaccines, and in Ethiopia only 51%.[1] Over half of all unimmunised children are located in just three countries – India, Nigeria and the Democratic Republic of Congo (DRC).[1]

Inequalities within countries are even wider. In countries where inequalities based on wealth are most acute, the poorest children are three times less likely to receive DTP3 than the richest.[1] Coverage is most unequal in Nigeria, where the ratio between poorest and richest children was 1:9 in 2008. In Somalia, for every child vaccinated against DTP3 in the poorest households, five children from the richest households are immunised; in Sudan, the DRC and the Central African Republic, this ratio is about 1:3.

Progress for whom?
Increases in national immunisation coverage do not necessarily translate into improvements for all. Patterns of progress varies widely across countries, with inequalities widening in some countries despite increased national coverage – for example, in certain countries, progress is concentrated among the wealthy households, leaving the poor and most in need behind.[1]

For the 42 countries with data available for multiple years[1], these trends over time are shown in **Error! Reference source not found.**1. The top right quadrant presents the best scenario – i.e. countries where national coverage has increased and the inequality gap has narrowed; the bottom left shows decreasing coverage and widening inequality.

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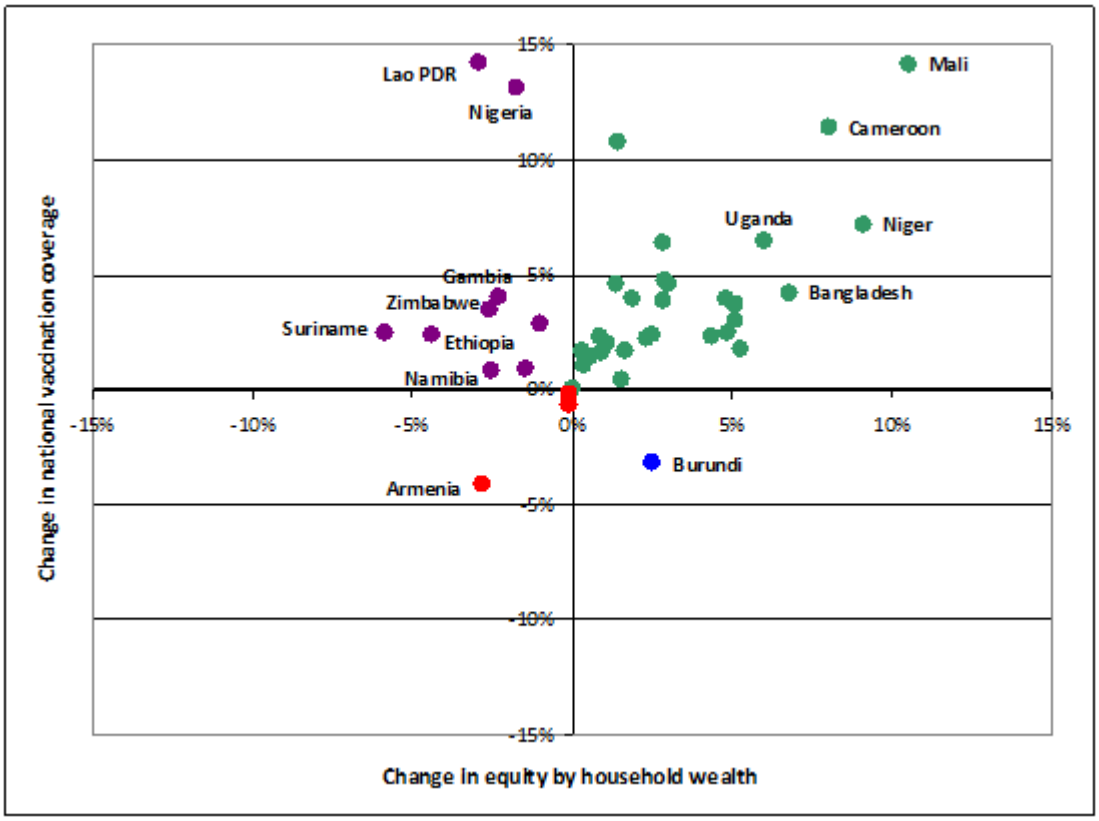
Figure 1: Trends in DTP3 coverage over time: inequalities between the poorest and richest 20% and national rates



Source: Save the Children UK and ACTION, 2012[1]

Overall, countries with declining national coverage may be worse off – ice. those below the x-axis. Yet in countries where the gap between the rich and poor in DTP3 coverage has widened despite rising national coverage, progress is regressive and efforts must be made to reach the hard-to-reach. Nine countries fall into this category.[1]

On the right-hand side of the chart, we see countries where immunisation inequalities between the rich and poor have reduced – most significantly in Mali. In the majority of these countries, reductions in inequality coincide with an increase in national coverage. Burundi is the only country where the immunisation gap between rich and poor households narrowed despite a decline in national coverage rates.

Even where the inequality gap is narrowing, there is a long way to go to close coverage gaps in many countries. For example, in Niger, the gap decreased by nearly 27 percentage points between 1998 and 2006, yet remains at 32% between the richest and poorest. Similar results were found in an earlier study by Delamonica et al., whereby declines in relative gaps were minimal, leaving large poor populations still without the benefits of immunisation.[1]

Progress without addressing inequalities can actually exacerbate gaps in coverage. All countries should be striving to increase national immunisation coverage while also reducing inequalities across the population. Strategies and investment that address inequalities and strengthen routine systems are essential to progressively and sustainably expand coverage. Our recent report, *Immunisation for All: No child left behind*, identifies potential strategies to do so, calling for equitable progress towards universal access to the full benefits of immunisation, integrated with other essential health services.

200+: Getting to know GAVI CSO: GAVI CSO Steering Committee Welcomes 10 New Members

The GAVI CSO Steering Committee in June welcomes ten new organisational members and their representatives:

The CORE Group Polio Project, India, represented by Dr. Roma Solomon

Health, Education and Literacy Programme (HELP), Pakistan, represented by Dr. Dure-Samin Akram

World AIDS Campaign and the Africa Regional Civil Society Platform on Health, Kenya/South Africa, represented by Ms. Rukia Cornelius

BRAC, Bangladesh, represented by Dr. Sharmin Akhter Zahan

Global Health Advocates, France, represented by Mr. Patrick Bertrand

Program for Appropriate Technology in Health (PATH), Switzerland/USA, represented by Ms. Billie-Jean Nieuwenhuys

The American Academy of Pediatrics, USA, represented by Dr. Meg Fisher

About Civil Society in Malaria Control, Immunization and Nutrition (ACOMIN), Nigeria, represented by Mr. Ayo Ipinmoye

ACTION Network, USA/UK/Canada/Australia/Japan, represented by Ms. Kolleen Bouchane

Orphans Relief Services (ORES), Tanzania, represented by Dr. Hermengild Mayunga

The SC also extends its sincere appreciation to members whose terms conclude in June, but whose continued engagement we greatly look forward to:

Catholic Relief Services, USA/International, represented by Dr. Elena McEwan

HealthNet TPO, Afghanistan, represented by Dr. Majeed Siddiqi

World Vision, Germany, represented by Mr. Marwin Meier

International Pediatric Association, represented by Professor Adenike Grange

Médecins Sans Frontières (MSF) Access Campaign, USA/International, represented by Ms. Kate Elder (with previous representation by Mr. Daniel Berman and Ms. Julia Hill)

Aga Khan Health Services, Pakistan, represented by Dr. Ranomal Kotak (with previous representation by Dr. Rozina Mistry)

Health and Rights Education Program (HREP), Malawi, represented by Mr. Maziko Matemba

Oxfam GB, Ghana, previously represented by Ms. Rosemary Anderson-Akola

Task Force for Global Health, USA, represented by Dr. Alan Hinman

Communications for Development Center, Nigeria, represented by Mr. Mayowa Joel

Thank you for all of your hard work on behalf of GAVI CSO, and a very warm welcome to new GAVI CSO SC members!

Civil Society Health News: Groundswell of Civil Society Support for Action Plan on Pneumonia & Diarrhea

PATH and **World Vision International**

On April 12, the World Health Organization and the United Nations Children's Fund launched the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD). This is the first-ever global plan to simultaneously tackle pneumonia and diarrhea—diseases that take the lives of almost two million children each year. Over 100 nongovernmental organizations (NGOs) and civil society organizations (CSOs), joined by dozens of leading experts, signed a community statement welcoming the GAPPD and urging governments and their partners to make the plan a reality.

The GAPPD provides strategies and evidence needed to significantly reduce childhood death and illness from pneumonia and diarrhea and calls on national governments and their partners to integrate their approach to fighting these diseases, for which the interventions to protect against, prevent, and treat are complementary.

For the GAPPD to have a substantial impact on child survival, the focus now shifts to national governments to translate this global framework into reality in the clinics, communities, and families that battle childhood diarrhea and pneumonia every day. A GAPPD advocacy toolkit provides tips and resources for NGOs and CSOs to advocate for successful implementation of the GAPPD in the countries and communities where children are most at risk.

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[1] Based on global Diphtheria-tetanus-pertussis (DTP3) coverage. UNICEF and WHO, 2013. Immunisation summary: A statistical reference containing data throu gh 2011, The 2013 edition. Available at: http://www.childinfo.org/files/immunisation_summary_2012_en.pdf [Date accessed: 9 April 2013]

[1] This refers to the 22 million children worldwide aged 12–23 months who have not received three doses of the diphtheria-tetanus-pertussis (DTP) vaccine. Source: WHO, 2012. *Global and regional immunisation profile*. Geneva: WHO. Available at: http://apps.who.int/immunisation_monitoring/en/globalsummary/GS_GLOProfile.pdf

[1] Three doses of the diphtheria-tetanus-pertussis (DTP) vaccine

[1] Based on global Diphtheria-tetanus-pertussis (DTP3) coverage. UNICEF and WHO, 2013. Immunisation summary: A statistical reference containing data through 2011, The 2013 edition. Available at: http://www.childinfo.org/files/immunisation_summary_2012_en.pdf [Date accessed: 9 April 2013]

[1] Save the Children and ACTION, 2012. *Finding the final fifth: Inequalities in immunisation*. London: Save the Children Fund. Available at: http://www.savethechildren.org.uk/resources/online-library/finding-final-fifth-inequalities-immunisation

[1] Using the 12 countries with biggest inequalities defined as those with the highest ratios for DTP3 coverage between the richest and poorest wealth quintiles, based on available DHS and MICS data.

[1] Delamonica, E., Minujin, A. and Gulaid, J., 2005. Monitoring equity in immunisation coverage. *Bulletin of the World Health Organisation*, 83(5).

[1] Disaggregated by wealth quintile.

[1] Save the Children and ACTION, 2012. *Finding the final fifth: Inequalities in immunisation.* London: Save the Children Fund.

[1] Ethiopia, Gambia, Indonesia, Lao PDR, Mongolia, Namibia, Nigeria, Suriname.

[1] Delamonica, E., Minujin, A. and Gulaid, J., 2005. Monitoring equity in immunisation coverage. *Bulletin of the World Health Organisation*, 83(5).

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About the Constituency

The GAVI CSO Constituency consists of a broad network of over 200 CSOs. The Constituency – which adopted a Charter in December 2010 outlining how it functions – consists of two layers: a broad civil society forum and a core CSO Steering Committee. Find us on the web at http://www.gavicso.org/.

The forum functions through periodic in-person meetings and a general email listserv at gavi-cso-constituency@googlegroups.com where ideas, information and new developments are exchanged and debated. Any immunisation- or health-focused organisation is welcome and encouraged to join this group.