GAVI ALLIANCE | 10 YEARS OF SAVING LIVES

www.gavialliance.org

# GAVI Alliance Progress Report 2009

10 YEAR DVD

**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.

unicef

BILL & MELINDA GATES foundation

World Health Organization

THE WORLD BANK

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.

# contents

# Message from the Chair of the GAVI Alliance

For millions of people, health is perhaps the most valuable of all human rights. 2009 marked the 20th anniversary of the Convention on the Rights of the Child, reminding us of the need to realise children's right to health, and of the fact that it is children, women and marginalised populations who continue to suffer the most from lack of access to basic health services.

**Mary Robinson**
Chair of the GAVI Alliance Board

The GAVI Alliance partners have had an impressive impact on improving immunisation coverage and strengthening health systems. Still, the unacceptable inequity suffered by developing countries in accessing new life-saving vaccines that are widely available in wealthier countries remains. To this day, whether or not a child survives to his or her fifth birthday depends on where they are born. We must strive to continue to bridge this gap.

Accelerating progress on rolling out vaccines against the diseases that kill or maim children in the developing world – particularly pneumonia and severe diarrhoea – is essential. While immunisation is critical to reducing child mortality, its benefits accrue across all the Millennium Development Goals (MDGs). Healthy children attend school and are able to reach their full potential, families are not burdened with crippling medical costs and women are freed of the burden of caring for ill children.

***"Equity of access to life-saving vaccines can only be achieved through strong leadership and effective partnerships."***

We must remember that equity of access to life-saving vaccines can only be achieved through strong leadership and effective partnerships. That is why the Partners' Forum in Hanoi in November was crucial. It brought together GAVI partners from the north and south, government and civil society, donors and developing countries to strengthen our collective will. I was delighted by the active engagement of civil society organisations, and the Call to Action for increased civil society engagement in working towards GAVI's mission.

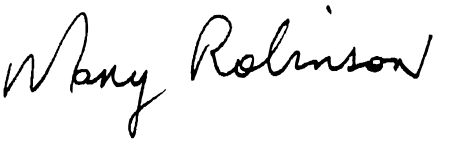
It is an honour and privilege for me to chair the GAVI Board, and I am proud to see how well GAVI has functioned through the first year of its new governance structure. Our successful Board retreat in April further reinforced the strength and commitment of the Alliance and its members.

The Board went through some significant changes in 2009. We were sad to see Graça Machel, one of the "mothers" of the GAVI Alliance, leave the Board, as well as the unaffiliated Board members Jean-Louis Sarbib and George Bickerstaff, and our former Board Vice-Chair, Denis Aitken from WHO.

In November Jaime Sepulveda from the Bill & Melinda Gates Foundation took on the role of Vice-Chair of the Board, and Daisy Mafubelu was appointed as the new WHO representative. In addition, four new Board members representing donor governments were appointed: Paul Fife for the UK, Norway and Ireland (replacing Gavin McGillivray); Fidel López Alvarez for Italy and Spain (replacing Alberto Mantovani); Anders Molin for the Netherlands, Sweden and Denmark (replacing Yoka Brandt); and Murray Proctor as the alternate Board member representing the USA, Canada and Australia.

In its first decade, the GAVI Alliance has already prevented 5.4 million deaths. Many millions have reduced chances of falling sick or suffering from disabilities. We now have the potential to almost double this impact and save over four million additional lives by 2015. At a time when resources are tight there are many competing calls for funding, but we have a compelling mission that I am convinced that donors and partners will continue to support.

I ask all of you, not only as the Chair of the GAVI Board, but as an advocate of human rights for all, to continue to advocate for immunisation and children's right to life-saving vaccines – no matter where they live. We owe it to every child who doesn't have a voice.



# Message from the Chief Executive Officer of the GAVI Alliance



2009 has been a year of contrasts. As the decade closed and we celebrated GAVI's 10-year anniversary, impressive delivery and an unprecedented level of demand by countries for new vaccines emerged just at a time when the impact of the financial crisis hit hardest.

**Julian Lob-Levyt**
Chief Executive Officer
of the GAVI Alliance

By the end of 2009, 5.4 million future deaths had been prevented and over 250 million additional children vaccinated. Just as impressive as the results delivered by countries with support from the Alliance, is the level of commitment and ownership they show. Almost 90% of countries expected to co-finance in 2009 did so. A strong and sustainable delivery platform has been built, reaching 80% of the world's poorest children.

Some progress has also been made on influencing vaccine markets. Since 2007, pentavalent vaccine has dropped in price by 18%. While the drop has not been as substantial or as swift as we had hoped, it nevertheless has a favourable impact on costs. Further, the launch of the Advance Market Commitment in June brought the assurance of a major price drop in pneumococcal vaccines. The vaccines will be available in developing countries at US$ 3.50 per dose, a 90% reduction on the price in industrialised countries.

Efficient and equitable health systems are essential for delivering vaccines to the children who need them. The benefits of investing in health systems multiply across reproductive, maternal, newborn and child health services. The announcement in September of US$ 1 billion to be channelled through IFFIm and a common funding platform for health system strengthening, to be developed by GAVI; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the World Bank; and managed by WHO, is therefore tremendous news.

***"At a time of a record number of applications... donors felt the economic and fiscal reverberations of the financial crisis."***

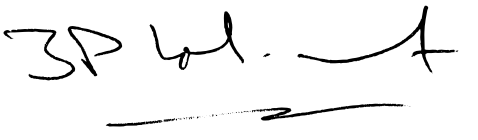
On the flipside, the global financial crisis played out in 2009. At a time of a record number of applications for GAVI funding, donors felt the economic and fiscal reverberations of the financial crisis. While predictions of major cuts in support to GAVI in 2009 did not materialise, the situation remains fragile and uncertain.

Despite the inflows from IFFIm, which has raised more than US$ 2 billion on the capital markets, an additional US$ 2.6 billion is needed over the next six years to meet the projected demand from countries and prevent a further 4.2 million future deaths – almost as many as have been prevented over the past decade. Without sufficient funding, GAVI will not be able to address the main childhood killers, pneumonia and diarrhoea, and thus make a significant contribution to the MDGs.

The GAVI Alliance Board had to take some tough decisions in 2009. In November, the Board paused new recommendations for funding. This will help ensure that there are sufficient funds to meet existing commitments, extensions and renewals, providing income remains at current levels. In order to ensure equity of access to vaccines for the poorest countries, the Board also reviewed the eligibility criteria.

Finally, 2009 saw GAVI's coming of age. The GAVI Alliance became an independent international organisation under Swiss law. I would like to thank the Swiss authorities on behalf of GAVI for making this possible. It was also the first year of our new governance structure with one consolidated board. The Secretariat remains small, administrative costs are kept low, and we continue to draw upon the expertise and country presence of our partners.

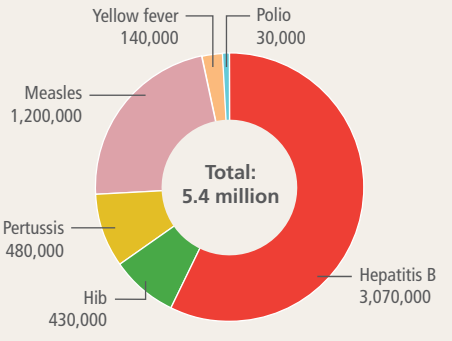
I am confident that GAVI will overcome the challenges with the same enthusiasm and commitment that launched the Alliance 10 years ago. Immunisation remains one of the most cost-effective public health interventions. We can make significant steps towards achieving the MDGs through the power of immunisation.



# Key indicators

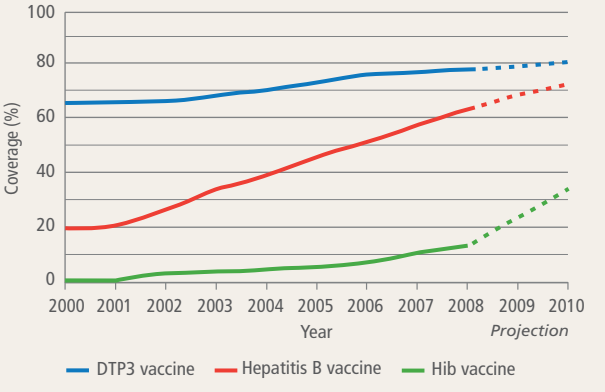
## GAVI's impact: GAVI-funded vaccines have prevented 5.4 million future deaths

### 5.4 million future deaths prevented with GAVI-funded vaccines




*Source: 1*

### Immunisation coverage at the highest level ever in GAVI-eligible countries




*Source: 2*

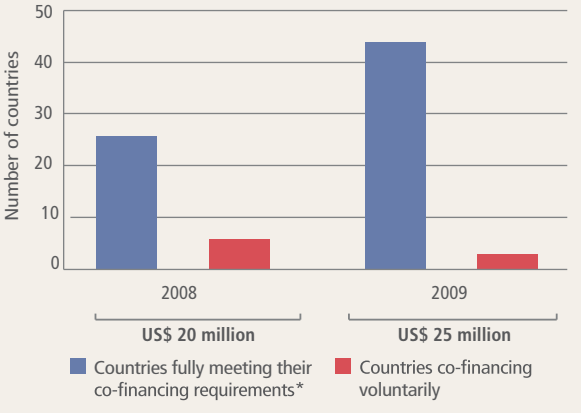
By the end of 2009, the GAVI Alliance had helped prevent 5.4 million future deaths through routine immunisation against hepatitis B, *Haemophilus influenzae* type b (Hib) and pertussis (whooping cough), and one-off investments in immunisation against measles, polio and yellow fever. Many more have been protected against debilitating illness and disability.

Immunisation coverage has climbed steadily in the last decade. Coverage for three doses of the diphtheria-tetanus-pertussis vaccine (DTP3) in GAVI-eligible countries in 2009 is projected at 79% – the highest level ever seen in the developing world.

From 2000 to 2009, more than 257 million additional children have been immunised with GAVI-funded vaccines.

## Increasing national ownership: countries showing commitment to immunisation

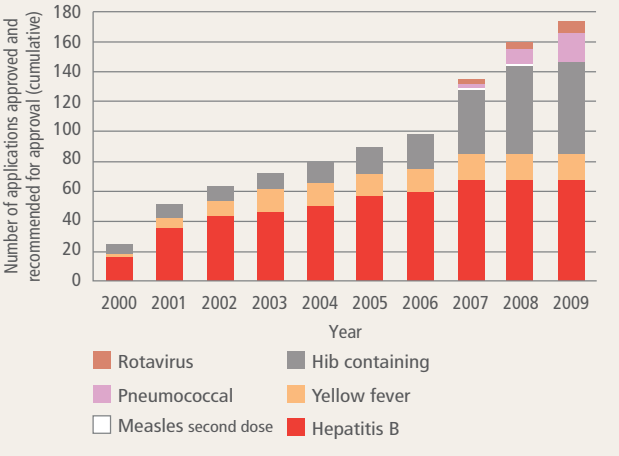
### Co-financing: countries meeting and exceeding commitments




* Nine countries were in default in 2008, all of which subsequently came out of default. Five countries were in default by the end of 2009.

*Source: 3*

### Rising demand for pneumococcal and rotavirus vaccines



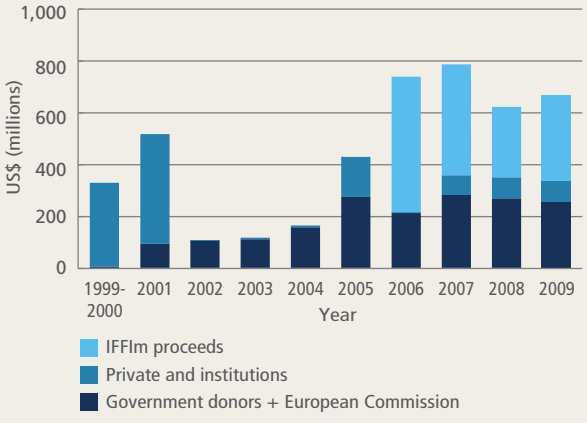

*Source: 4*

Developing countries are stepping up to the mark, with steadily increasing government spending on vaccines and immunisation since 2000. In 2009, 44 of the world's poorest countries – almost 90% of those required to co-finance – fully met their co-financing requirements for GAVI-supported vaccines. Seventeen countries chose to co-finance beyond the required levels.

There is strong country demand for the introduction of new vaccines, with 15 countries applying for pneumococcal and 8 for rotavirus vaccines in 2009. The platform is in place for their introduction, which between 2010 and 2015 would prevent more than one million children from dying.

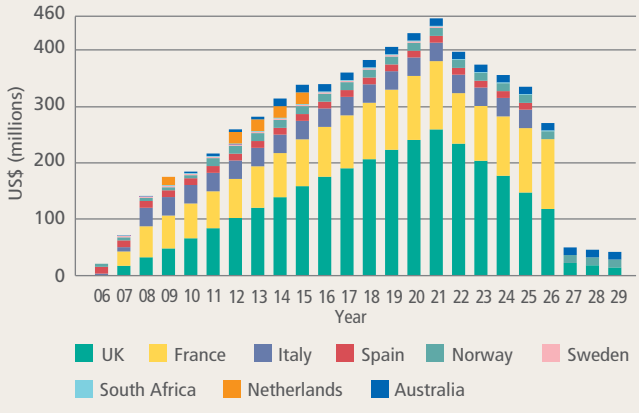
## IFFIm: innovative financing accelerates access to life-saving vaccines

### IFFIm proceeds boost GAVI funds




*Source: 5*

### Four donors pledge US$ 1 billion to IFFIm in 2009



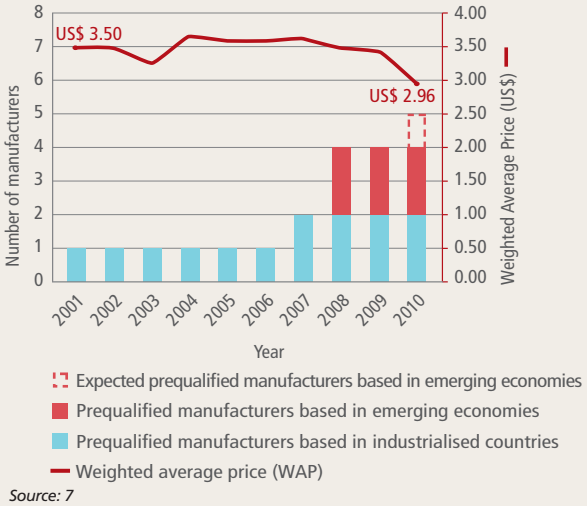

*Source: 6*

The International Finance Facility for Immunisation (IFFIm) Company issued four bonds in 2009, raising more than US$ 1 billion. IFFIm proceeds significantly boost disbursements to countries by frontloading long-term donor commitments.

In 2009, the United Kingdom, Norway and Australia made pledges to support health system strengthening through an expanded IFFIm, while the Netherlands made a new commitment of €80 million to IFFIm. This is a clear expression of donors' continued confidence in GAVI and in IFFIm as an innovative financing mechanism.

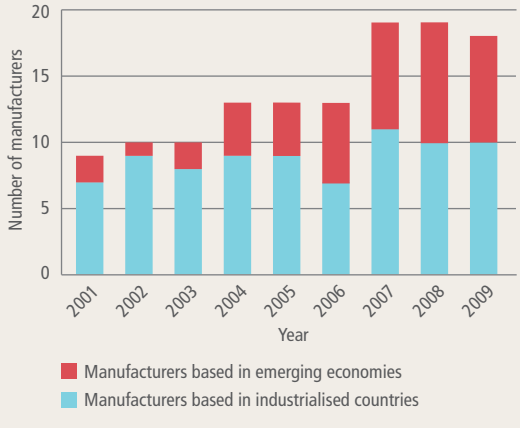
## Shaping the market for vaccines: increased competition drives down prices

### More manufacturers help reduce the price of pentavalent vaccine




*Source: 7*

### Increasing number of emerging market manufacturers supplying GAVI-funded vaccines




*Source: 8*

The GAVI business model fosters a healthy vaccine market by encouraging and pooling growing demand from developing countries, attracting new manufacturers and increasing competition to drive down prices.

In 2009 the weighted average price projection for pentavalent vaccine for 2010 fell below US$ 3 – a reduction of almost US$ 0.50 per dose compared with the year before. The price drop will allow the GAVI Alliance to vaccinate many more children against five deadly infections: diphtheria, tetanus, pertussis, Hib and hepatitis B.

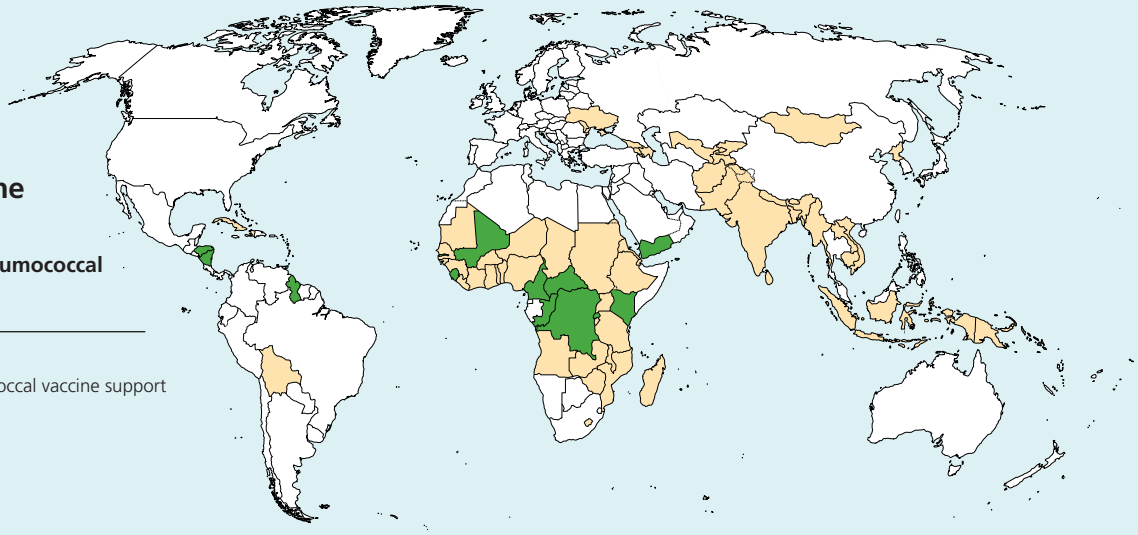
The number of emerging market manufacturers supplying GAVI-funded vaccines has increased steadily since 2000. These manufacturers are entering the market with more affordable, yet equally effective, products.

# Rising country demand for new and underused vaccines

By the end of 2009, immunisation coverage for DTP3 in GAVI-eligible countries was projected at 79%, while country demand continued to rise. This provides a strong platform for the introduction of new life-saving vaccines.

## Pneumococcal vaccine

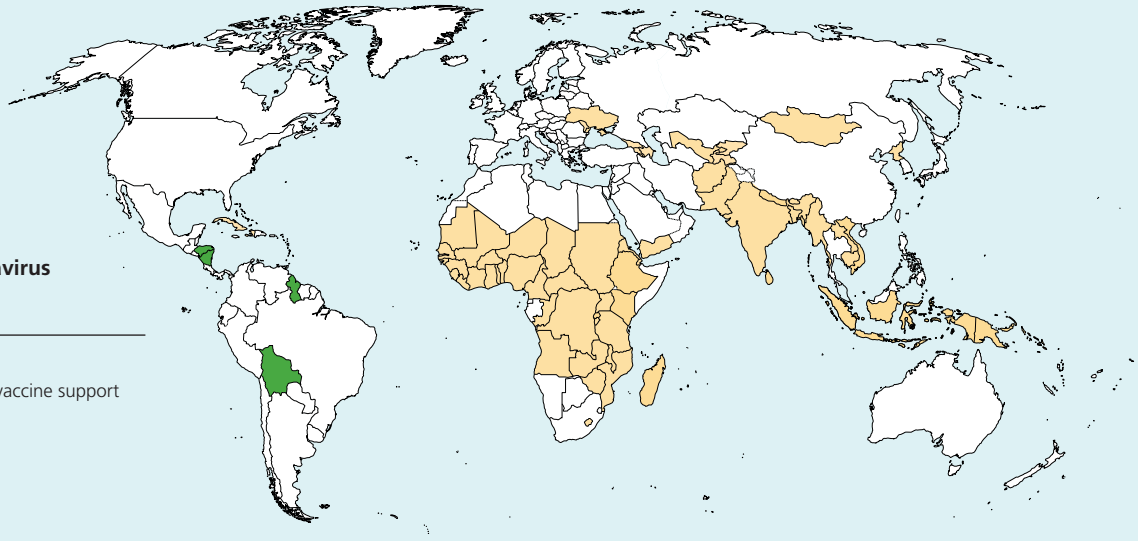
**Countries approved for pneumococcal vaccine support, 2007–2009**



- Approved countries
- Countries eligible for pneumococcal vaccine support

## Rotavirus vaccine

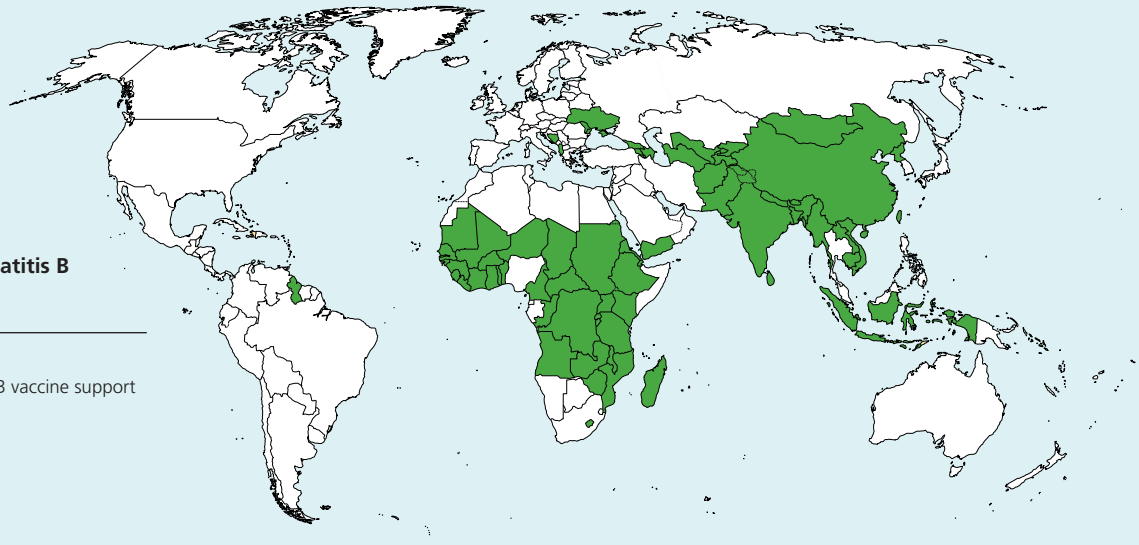
**Countries approved for rotavirus vaccine support, 2007–2009**



- Approved countries
- Countries eligible for rotavirus vaccine support

## Hepatitis B vaccine

**Countries approved for hepatitis B vaccine support, 2000–2009**



- Approved countries
- Countries eligible for hepatitis B vaccine support

*Source: 9*

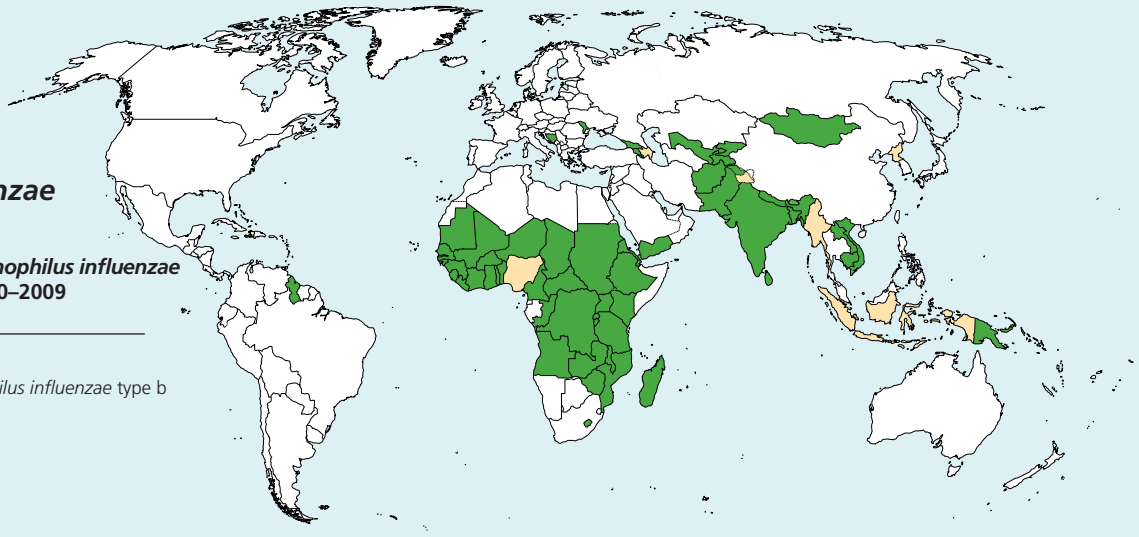
## GAVI funding put to work where it is most needed

GAVI works with the countries with the lowest Gross National Income (GNI) in the world, based on World Bank data. These are also the countries with the highest burden of vaccine-preventable diseases. Countries with less than or equal to US$ 1,000 per capita GNI in 2003 are considered eligible for support.

There are currently 72 GAVI-eligible countries, representing half of the world's population. In order for a country to qualify for vaccine support, its DTP3 coverage must be at least 50%, and the government must not already be funding the vaccine. Yellow fever vaccine is exempted from this requirement.

### *Haemophilus influenzae* type b vaccine

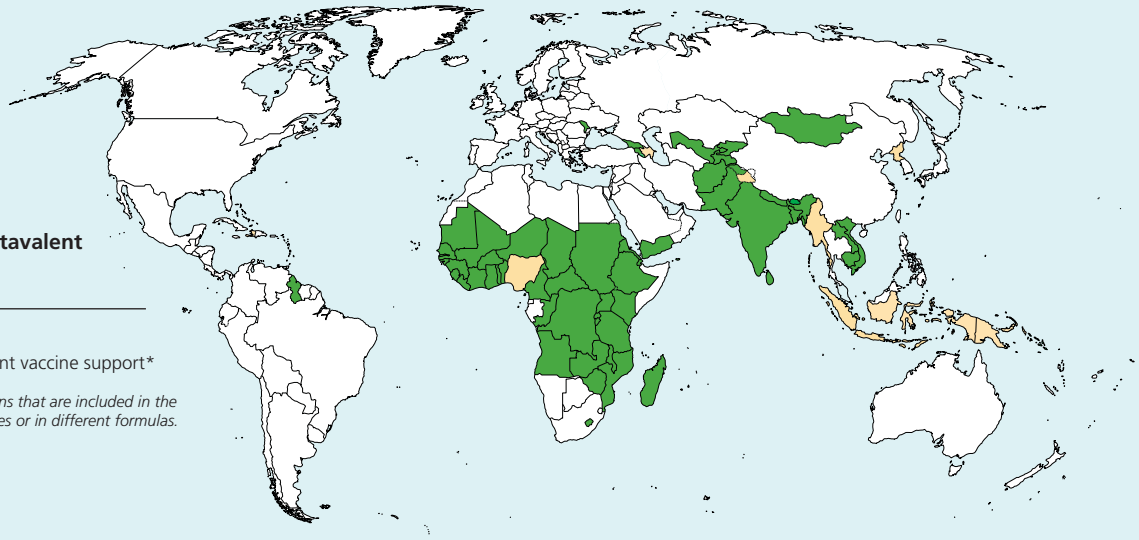
**Countries approved for *Haemophilus influenzae* type b vaccine support, 2000–2009**



- Approved countries
- Countries eligible for *Haemophilus influenzae* type b vaccine support

### Pentavalent vaccine

**Countries approved for pentavalent vaccine support, 2000–2009**

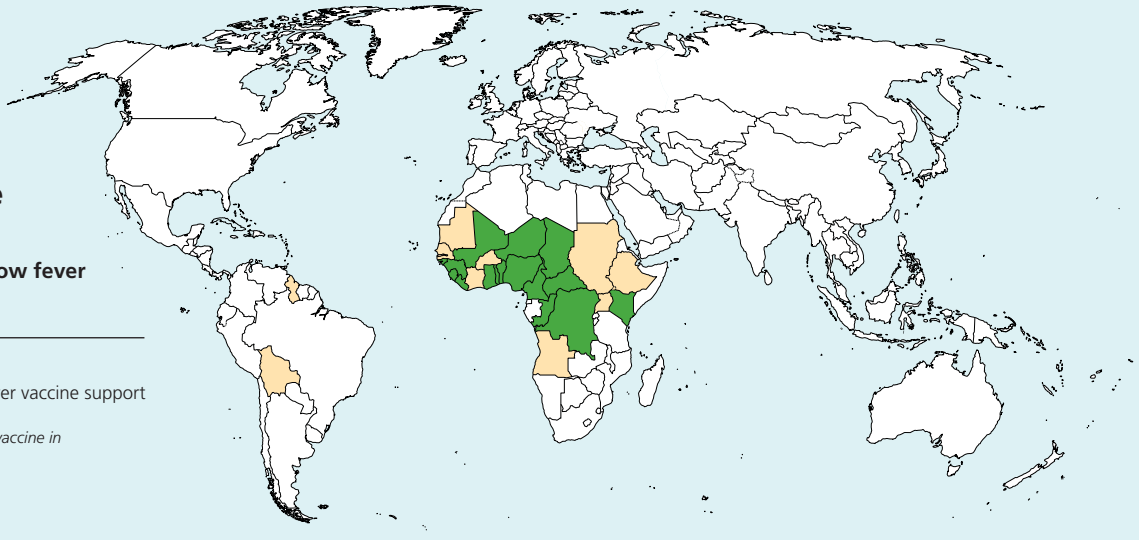


- Approved countries
- Countries eligible for pentavalent vaccine support*

** Some countries provide the five antigens that are included in the pentavalent vaccine as separate vaccines or in different formulas.*

### Yellow fever vaccine

**Countries approved for yellow fever vaccine support, 2000–2009**



- Approved countries
- Countries eligible for yellow fever vaccine support

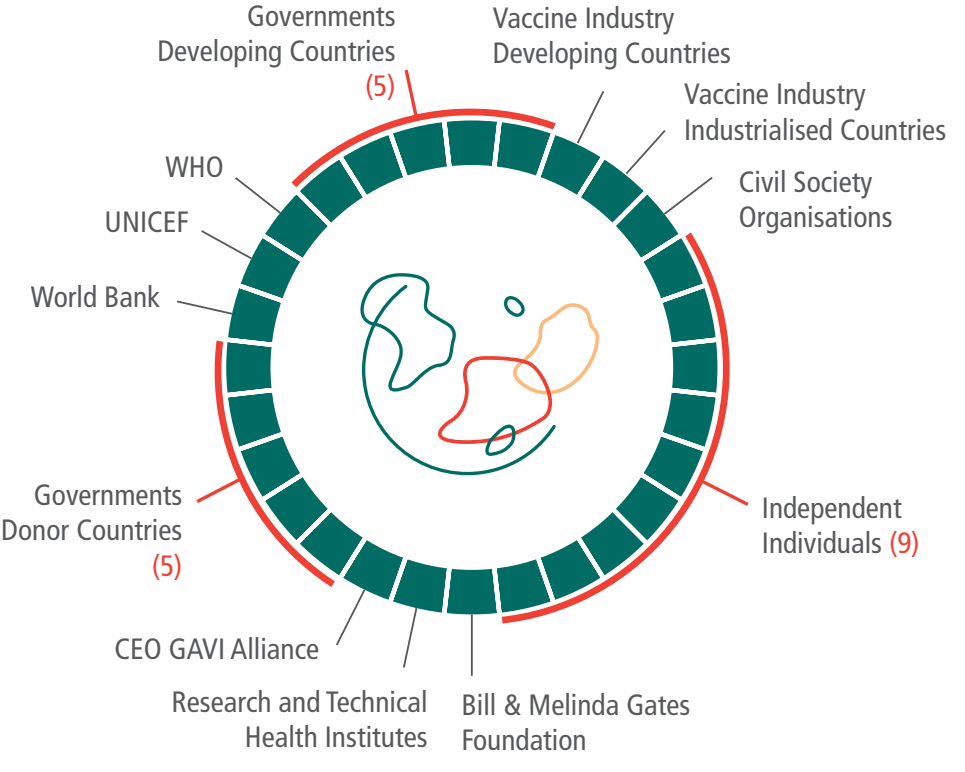
*WHO recommends routine yellow fever vaccine in 28 GAVI-eligible countries*

**Note:** In 2009, the GAVI Alliance reviewed its eligibility criteria. From 2011, an eligibility threshold of US$ 1,500 per capita GNI will apply. Adjusted for inflation, this is approximately equivalent to US$ 1,000 in 2000, when the eligibility policy and threshold were first applied. In order for a country to qualify for vaccine support, its DTP3 coverage will have to be at least 70%. Existing support to countries will be honoured through to the end of multi-year commitments and, for vaccine support, at least until 2015.

# The GAVI Alliance: an innovative partnership that delivers results

GAVI's mission: to save children's lives and protect people's health by increasing access to immunisation in poor countries.

## The GAVI Alliance Board structure




### The partnership model

Bringing together developing country and donor governments, WHO, UNICEF, the World Bank, the vaccine industry in developing and industrialised countries, research and technical agencies, civil society and philanthropic organisations, as well as prominent individuals, the GAVI Alliance model provides an innovative approach to development.

Over the past 10 years, the Alliance has helped boost access to new and underused vaccines in the developing world, successfully implemented innovative financing mechanisms, helped drive down immunisation costs and supported health system strengthening to meet developing countries' viable demand for life-saving vaccines.

By pooling their diverse skills and resources, the GAVI partners generate results that are beyond the capacity of any agency alone. The role and commitment of each Alliance partner is vital to the success of the partnership.

**See also:**

Annex 1: GAVI Alliance governance structure, p. 54

www.gavialliance.org/about/governance


**The Bill & Melinda Gates Foundation** is one of the founding partners of the GAVI Alliance. Its initial grant helped establish the Alliance, and it continues to support GAVI programmes.

**Civil society organisations** deliver a large portion of health and immunisation services in many developing countries. They also play a pivotal role in advocacy and policy development.

**Developing country governments** identify their immunisation and health system strengthening needs, proactively apply for GAVI funding, implement programmes, and ensure effective and sustainable planning.

**Industrialised country governments** provide steady, predictable funding through Official Development Assistance (ODA).

**Research institutes** bring their knowledge and experience to the Alliance Board, keep the research community abreast of GAVI policy decisions and help build capacity for research and development.

**Unaffiliated Board members** bring independent scrutiny to Board deliberations and provide expertise in a range of areas, including investment, auditing, advocacy and fundraising.

**UNICEF** sources and procures vaccines, provides technical assistance, and helps raise awareness of and support for child immunisation at the national, regional and international level.

**The vaccine industry** ensures the development of and market access to high-quality vaccines for developing countries, and provides technical support from an industry perspective.

**WHO** works at the national, regional and global level to develop policies and strategies for immunisation and vaccine use; provide normative guidance, quality assurance and quality control of vaccines; and give technical health support.

**The World Bank Group** plays a key role in innovative financing, and helps implementing governments develop sustainable financing for health systems, including immunisation services.

## Four strategic goals

**The GAVI Alliance Strategy 2007–2010 has four strategic goals:**

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

In 2009, the Alliance started preparing a new strategy for 2011–2015, through consultations with a wide range of partners and other stakeholders. The development of the new five-year strategy will continue in 2010.

**See also:**
www.gavialliance.org/vision/strategy

# Donor contributions to the GAVI Alliance

## Direct contributions received in 2009 (in US$)

| Donors to the GAVI Alliance | 2009 | Total |
|---|---|---|
| Australia | 5,000,000 | 20,000,000 |
| Canada | 0 | 148,727,565 |
| Denmark | 9,098,396 | 26,149,592 |
| European Commission (EC) | 28,630,130 | 57,868,884 |
| France | 0 | 18,659,114 |
| Germany | 5,721,380 | 16,929,780 |
| Ireland | 3,540,000 | 26,210,480 |
| Luxembourg | 1,191,240 | 5,389,905 |
| Netherlands | 31,205,790 | 190,755,989 |
| Norway | 82,800,325 | 440,856,502 |
| Spain | 0 | 40,536,200 |
| Sweden | 13,801,000 | 86,048,871 |
| United Kingdom | 0 | 121,562,308 |
| United States | 75,000,000 | 568,725,000 |
| **Government donors + EC** | **255,988,260** | **1,768,420,190** |
| **IFFIm proceeds** | **330,027,000** | **1,555,683,284** |
| Bill & Melinda Gates Foundation | 75,000,000 | 1,137,838,000 |
| La Caixa Foundation | 5,856,800 | 11,878,044 |
| Other private | 1,011,366 | 11,277,698 |
| **Private and institutions** | **81,868,166** | **1,160,993,742** |
| **Total contributions** | **667,883,426** | **4,485,097,216** |

*Contributions recorded on a cash basis.*

*Source: 10*

## Innovative financing mechanisms: AMC and IFFIm

| AMC commitments | US$ millions |
|---|---|
| Italy | 635 |
| United Kingdom | 485 |
| Canada | 200 |
| Russian Federation | 80 |
| Bill & Melinda Gates Foundation | 50 |
| Norway | 50 |
| **Total** | **1,500** |

*Source: 11*

| Donors to IFFIm | Length of commitment | Amount in millions | Equivalent in US$* in millions |
|---|---|---|---|
| United Kingdom | 20 years | £1,380.0 | 2,594.5 |
| France | 20 years | €1,240.0 | 1,750.3 |
| Italy | 20 years | €473.5 | 602.0 |
| Spain | 20 years | €189.5 | 241.0 |
| Netherlands | 7 years | €80.0 | 115.0 |
| Sweden | 15 years | SEK 276.2 | 37.9 |
| Norway | 5 years | US$ 27.0 | 27.0 |
| South Africa | 20 years | US$ 20.0 | 20.0 |

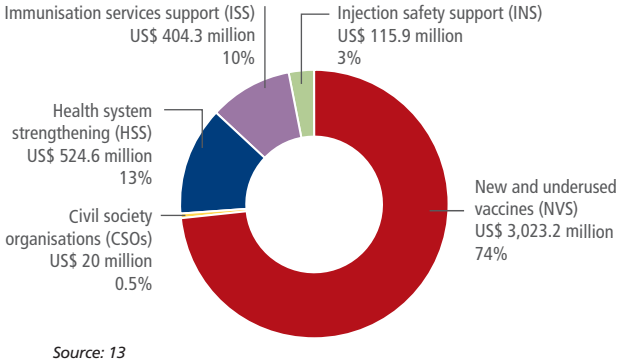
*Based on exchange rates on date of contribution

*Note: In addition, the United Kingdom, Norway and Australia have pledged to commit £250 million, 1.5 billion Norwegian kroner and Australian $ 250 million respectively to IFFIm.*

*Source: 12*

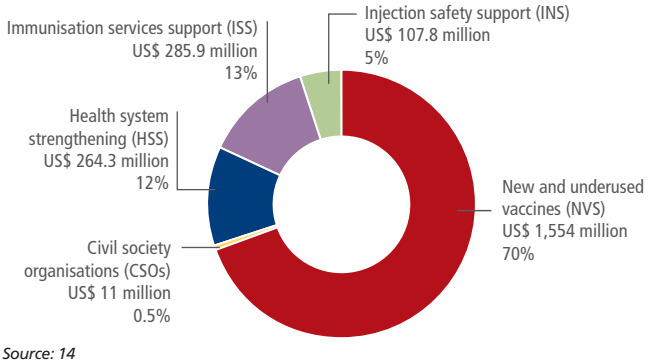
# GAVI Alliance commitments and disbursement to countries as at the end of 2009

## US$ 4.1 billion committed to countries until 2015




*Source: 13*

## US$ 2.2 billion disbursed to countries




*Source: 14*

**See also:**
Ch 3: Increase predictability, p. 34
Annex 2: Donor contributions and commitments, p. 56
Annex 3: Board approvals for programme expenditure 2000–2009, p. 58
www.gavialliance.org/support/donors

# 1 Accelerate vaccines

## STRATEGIC GOAL:

Accelerate the uptake and use of underused and new vaccines and associated technologies and improve vaccine supply security.

## KEY RESULTS 2009:

- By the end of 2009, over five million future deaths have been prevented with GAVI-funded vaccines
- DTP3 immunisation coverage in GAVI-eligible countries projected at 79% – the highest level ever in the developing world
- Country demand for new vaccines continues to rise, with 15 countries applying for pneumococcal vaccine and 8 for rotavirus vaccine
- Pentavalent vaccine, protecting against five deadly diseases, is introduced in 18 additional developing countries

# Accelerate vaccines

Vaccine coverage in GAVI-eligible countries is at the highest level ever, and country demand for new and underused vaccines is growing rapidly. The commitment of developing countries to immunisation is clear, and the potential is there to save millions more lives with new vaccines.

Projected immunisation coverage for DTP3 climbed to 79% in GAVI-eligible countries in 2009 – the highest coverage ever recorded in the developing world. With financial support from the GAVI Alliance and other partners, and through developing countries making good use of the support, more children are being immunised than ever before – over 100 million per year in recent years.

By the end of 2009, GAVI had directly supported the immunisation of a cumulative additional 257 million children in the world's poorest countries. Some 233.2 million children have been immunised against hepatitis B; 59.7 million children have received Hib vaccine; and 41.6 million are now protected against yellow fever through routine immunisation.

## Rising country demand

Country demand for vaccines continues to be strong. The Independent Review Committee (IRC) assessed 29 new proposals for vaccines in 2009. The demand is particularly high for new vaccines, with country proposals for pneumococcal vaccines having nearly doubled in 12 months. The IRC also assessed eight new proposals for rotavirus vaccine in 2009, compared with just one the year before. Eight countries applied for both pneumococcal and rotavirus vaccines.

Many of the poorest countries have started co-financing GAVI-supported vaccines, some at higher levels than required – yet another demonstration of their commitment to immunisation. Co-financing helps to engage finance ministries and ensure evidence-based decision-making in countries, and is an important step towards securing financial sustainability for immunisation programmes.

According to WHO projections, by the end of 2009 GAVI support to routine immunisation programmes had prevented four million deaths caused by hepatitis B, Hib and pertussis. A series of one-off investments in interventions against measles, polio and yellow fever have prevented an estimated additional 1.4 million future deaths. Many millions more lives could be saved with vaccines against the two biggest killers of children under five, pneumonia and diarrhoea, as well as with other new vaccines.

## Addressing major child killer diseases: pneumonia and diarrhoea

Pneumonia, the leading cause of child deaths, accounts for nearly 20% of deaths in under-fives worldwide. The burden of pneumococcal disease is particularly high in the developing world. According to WHO and UNICEF, the average death rate from pneumonia is over 200 times greater in low-income countries than it is in high-income countries.

Diarrhoea is the second most common cause of child mortality worldwide. Rotavirus, which causes the majority of cases of severe diarrhoea, is responsible for more than half a million diarrhoeal deaths and two million hospitalisations annually among children, most of which occur in the developing world. Children under five are most vulnerable to the

**See also:**
www.gavialliance.org/pneumococcal
www.gavialliance.org/rotavirus

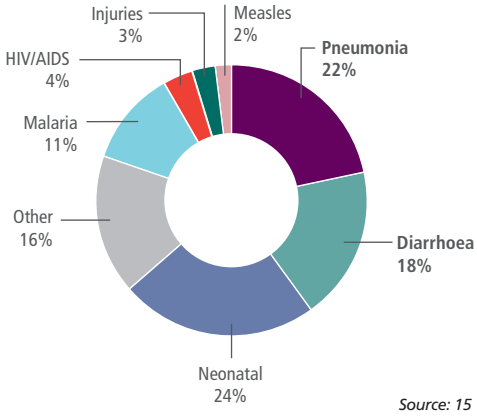
disease. As rotavirus cannot be treated with antibiotics or other drugs, immunisation is an important way to avoid severe outbreaks.

However, not all cases of diarrhoea and pneumonia are vaccine preventable. The number of lives saved could be substantially higher if vaccination was integrated with other interventions for pneumonia and diarrhoea control. These include early and exclusive breastfeeding, hand-washing with soap, adequate nutrition, appropriate home-care and prompt care-seeking in response to danger signs, as well as oral rehydration therapy, vitamin A and zinc supplementation, improved safe water supply and sanitation services (for diarrhoea) and reduced indoor air pollution (for pneumonia).

## Paving the way for pneumococcal and rotavirus vaccines

In June 2009, WHO recommended that rotavirus vaccine be included in all national immunisation programmes, a decision based on clinical trials of vaccine efficacy in countries with high child mortality. The new policy paves the way for more low-income countries to apply to GAVI for rotavirus vaccines, just a few years after the vaccines became available in most industrialised countries.

### Causes of under-five deaths in low-income countries




*Source: 15*

Three Latin American countries, Guyana, Honduras and Nicaragua, rolled out rotavirus vaccine in 2009, shortly after it was introduced in Bolivia in late 2008. In April 2009, Rwanda became the first developing nation to introduce pneumococcal vaccine in its routine vaccination programme, with the Gambia following closely after.

The pilot Advance Market Commitment (AMC) for pneumococcal vaccine became operational in 2009. As a result of the AMC, GAVI-approved countries could get access to a new generation of pneumococcal vaccines, at virtually the same time as they are introduced in industrialised countries but at a much reduced price.

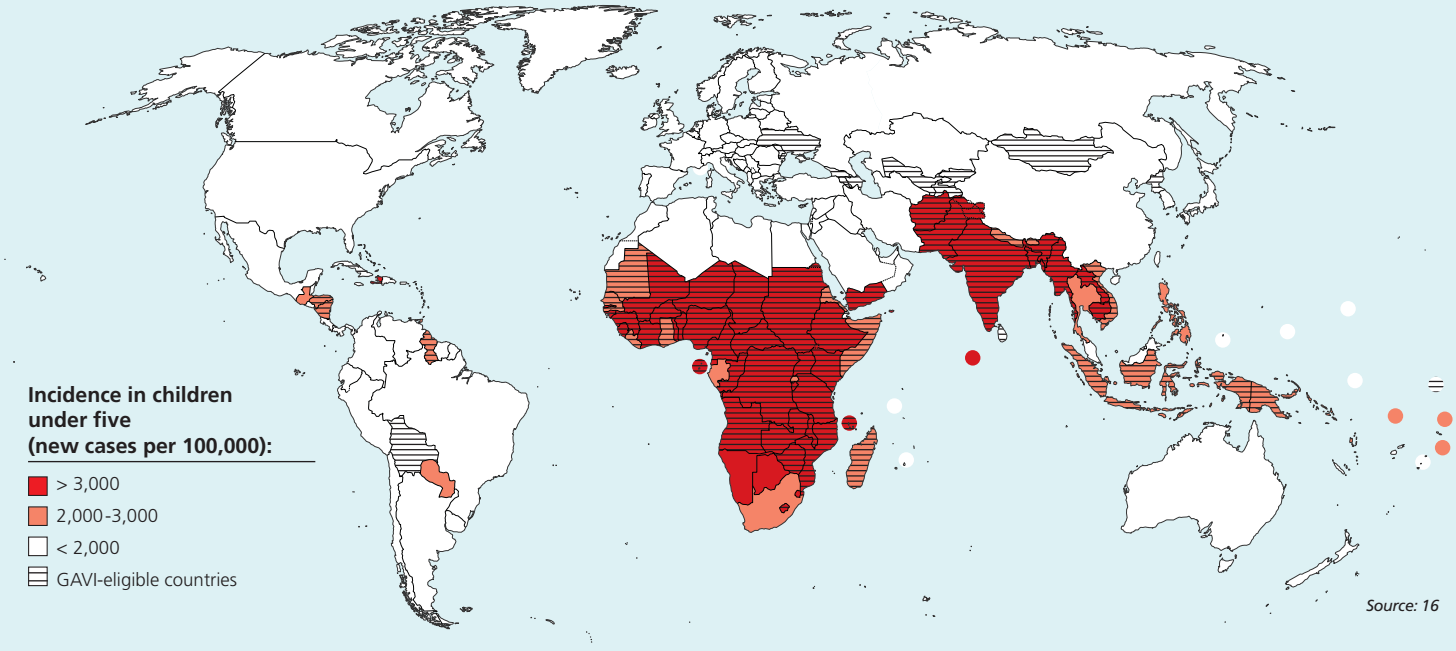
The GAVI Alliance partners currently plan to introduce pneumococcal vaccine in 47 countries and rotavirus vaccine in 41 countries by 2015. This could help prevent over one million deaths, thus making a significant impact on the Millennium Development Goals (MDGs). However, the plans to deliver these life-saving vaccines, while continuing to expand immunisation coverage, will be slowed down without adequate donor investment.

**See also:**
Ch 3: Increase predictability: AMC: affordable pneumococcal vaccines for developing countries, p. 39

## GAVI provides support where it is needed most

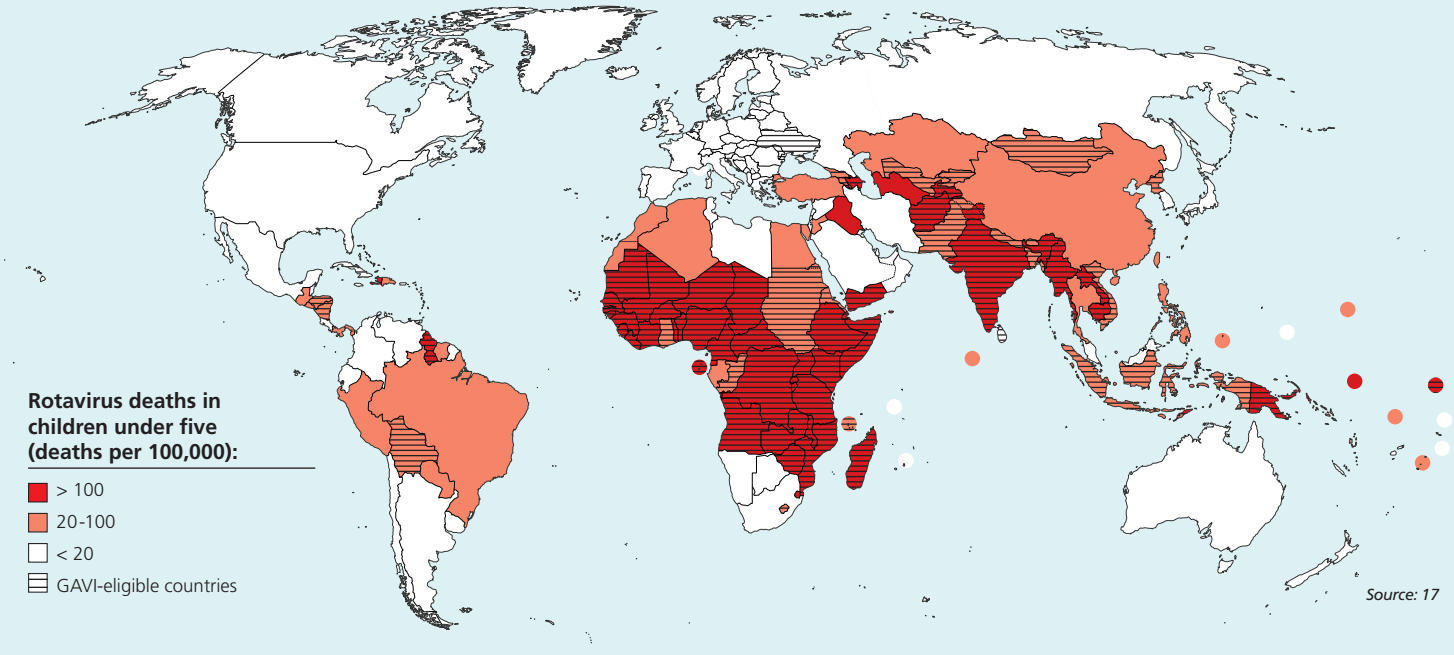
There is a strong correlation between the burden of pneumococcal disease and rotavirus diarrhoea, and GAVI country eligibility.

### Global burden of pneumococcal disease




*Source: 16*

### Global burden of rotavirus diarrhoeal disease




*Source: 17*

## Vaccine forecasting underpins country decision-making

In January 2009 GAVI launched the Accelerated Vaccine Introduction initiative (AVI) to speed up the introduction of pneumococcal and rotavirus vaccines in GAVI-eligible countries.

The AVI works as a consortium, which includes the GAVI Secretariat, WHO and UNICEF, as well as PATH, the US Centers for Disease Control and Prevention (CDC), and the Johns Hopkins University Bloomberg School of Public Health. Other partner organisations are the Aga Khan University in Pakistan, the International Vaccine Institute in the Republic of Korea, the Norwegian Institute of Public Health and the University of the Witwatersrand/National Institute for Communicable Diseases in South Africa.

The joint AVI work plan includes activities such as special studies, communications and advocacy, and strategic vaccine forecasting.

By forecasting demand and supply across all vaccines, and translating the forecasts into actions on the operational side, the AVI supports developing countries in making evidence-based decisions on the introduction of new vaccines. In 2009, strategic forecasts for pneumococcal and rotavirus vaccines were carried out for all GAVI-eligible countries. From 2010, the forecasts will be extended to the entire GAVI vaccine portfolio.

## Pneumococcal vaccine and HIV/AIDS

Pneumococcal vaccines have proven to be an effective measure for protecting HIV-infected children and adults against worsening or secondary disease. As children with HIV/AIDS are up to 40 times more likely to contract pneumococcal disease than HIV-negative children,[a] immunisation is an important way of keeping them healthy.

A trial in Malawi has found that immunisation with pneumococcal vaccine prevented three out of four cases of pneumococcal disease in HIV-infected adults. This further confirms that the vaccine is a powerful intervention for improving the health of people living with HIV/AIDS.[b]

## Rwanda pioneers pneumococcal vaccine introduction in the developing world

Rwanda's sustained efforts to strengthen its immunisation services – as part of a wider integrated health system development plan – has already transformed the health of its children. According to UNICEF, the mortality rate among children under five declined by over one third between 1990 and 2008. Since 2000, when Rwanda introduced the Hib vaccine, it has invested consistent effort in strengthening its routine immunisation programme. As a result, immunisation coverage, which has exceeded 80% since 2003, is now around 95%.

Building on that success, in 2009 Rwanda became the first developing country to roll out pneumococcal vaccine to help prevent pneumonia, which alone accounts for nearly a quarter of child deaths in the country.

A vaccine donation enabled Rwanda to pioneer the integration of pneumococcal vaccine into its national immunisation programme. Rwanda planned to immunise all children under the age of one in 2009 and thereafter provide routine immunisation free of charge to all children in the country.

The selection of Rwanda to pilot the launch of pneumococcal vaccine attests to the success of the country's earlier work in building up health infrastructure and capacity. A network of 415 health centres across the country with well-functioning cold chain management systems helps ensure the correct storage and use of the vaccine. Moreover, demand-driven community-based health care is well established.

The Ministry of Health laid the foundations for the successful launch of pneumococcal vaccine. Government-initiated training for health centre staff, including those at the local level, familiarised polyvalent health workers with how to handle, use and store the new vaccine, and provided them with the knowledge, skills and communications tools to be able to inform parents and the community. Information about the new vaccine was disseminated by community health workers and broadcast over the radio, to ensure a wide reach.

Pneumococcal vaccine is now part of Rwanda's routine immunisation programme and has been well received in the community. Another 12 countries, which have been approved by GAVI to receive assistance for introducing the vaccine, will be able to draw on Rwanda's experience.

## Bolivian children receive life-saving rotavirus vaccine

Bolivia has a track record of successful immunisation to protect its children against diseases that kill and cripple. It moved these efforts up a gear in August 2008 when it became the first GAVI-eligible country to start immunising against rotavirus, a major cause of morbidity and death among children under five. Rotavirus is estimated to have hospitalised almost 2,000 Bolivian children in the period 2006–2008, accounting for almost half of all hospitalisations for diarrhoea.

Bolivia was well placed to take a lead in deploying the rotavirus vaccine. Earlier immunisation efforts freed the country of measles and polio. Diphtheria, pertussis and neonatal tetanus have been reduced to low levels and the incidence of yellow fever has also fallen. Most of the essential infrastructure, such as cold chain capacity, was already in place, although in need of some expansion. Moreover, success in these efforts had boosted public confidence in health services.

"Immunising children with the rotavirus vaccine marks another crucial step towards strengthening public health and that makes it a vital investment in the country's future welfare and development," says Dr Walter Selum Rivero, Bolivia's Minister of Health.

The results have been impressive. By early 2010, Bolivia had exceeded its targets, having already achieved 80% coverage with the first dose of rotavirus vaccine and 64% with the second. In just one year, the number of reported cases of rotavirus diarrhoea was reduced by 10%. Immunisation is offered free of charge at government health centres, and more than 200,000 children received the vaccine in 2009.

At the same time, Bolivia has taken a pro-active approach to funding rotavirus immunisation and phasing out GAVI financial support. The country has co-financed the vaccine at US$ 3.50 per dose or nearly half of the total price, the highest level of co-financing among countries receiving GAVI support. Bolivia plans to end GAVI's support entirely by 2015.

"This initiative is too important to leave unsecured," says Dr Rivero. "With national funding we can guarantee its sustainability for the long term."

## Elizabeth: illustrating the power of immunisation

Five-year-old Elizabeth was immunised against polio, diphtheria, whooping cough (pertussis), tetanus and tuberculosis as a baby. Although her mother was only able to breastfeed her for one month, Elizabeth has grown into a bright and healthy girl. She loves riding a bicycle, her favourite food is pasta and she aspires to become a teacher when she grows up.

Elizabeth lives in Debre Zeit, a village on a hectic, bustling road between the Ethiopian capital Addis Ababa and the Red Sea port of Djibouti. She enjoys playing with her cousins and pet kitten and is blossoming into a lively child who loves climbing. "My favourite food is macaroni and spaghetti," she says. "And I like drinking milk. I like cycling when I am at home, but I don't have a bicycle." Elizabeth, who attends school five days a week, says she likes to learn Amharic, the national language. "I have good results at school, out of 74 pupils I am number seven. I would like to be a teacher when I grow up."

Elizabeth has generally been a healthy child. In a country where one in six children dies before reaching their fifth birthday, vaccinations are crucial to meeting MDG4, a reduction in child mortality by two thirds by 2015.

Elizabeth is a vibrant example of what immunisation can achieve: a healthy life that allows children not only to survive, but also to flourish and be educated.

## Women's health and immunisation

GAVI is committed to helping to achieve the MDGs related to gender equality and maternal health, both through the potential offered by immunisation and through the wider benefits of strengthening health systems that accrue to women.

Cervical cancer kills more than 270,000 women every year. Over 80% of these deaths occur in developing countries, where women are more likely to die from the disease because of late detection and lack of treatment. Most deaths are among women in their 40s and 50s, at a time when their contribution to a family's finances and care of children is vital.

Cervical cancer is the most common type of cancer among women in the developing world and is linked to human papillomavirus (HPV), a highly transmissible virus that infects most sexually active men and women. A new vaccine provides effective protection against HPV and, recognising the public health benefits, governments of many industrialised countries have immunised adolescents in an effort to protect them before sexual debut.

However, owing to its high cost, the HPV vaccine has not yet been introduced in developing countries. Tragically, these are the countries with the highest burden of cervical cancer. Recognising the value of HPV vaccine to the health of women in low-income countries, the GAVI Alliance Board has prioritised the vaccine for future support.

The immunisation of girls is of critical importance to GAVI. While there is generally high equity in GAVI immunisation programmes, a study is being conducted to determine whether there are any specific disparities in immunisation rates between boys and girls in GAVI-eligible countries. Among other things, the study will look at evidence of sex differences in immunisation coverage and burden of disease; feasibility of collecting and using sex disaggregated data; and gender aspects relating to the introduction of new GAVI-supported vaccines.

But it is not only the direct benefits of immunisation that contribute to the health and well-being of women. Beyond the toll of illness and death averted from vaccine-preventable diseases are the indirect benefits of immunisation. Women are usually the primary care-givers and providers of health in families. Having healthy children liberates a mother's time and avoids the often crippling burden of family debt created by medical treatment costs.

Immunisation is also a key entry point for women to access health services. Health workers who immunise children usually perform a basket of maternal and child health tasks. This means that when a woman brings her child for immunisation, she makes contact with a range of services, from family planning to maternal health. Recognising this valuable leverage point, GAVI-funded health system strengthening has broadened its scope to include improving the quality of maternal and child health service provision, in particular by addressing the critical scarcity of health workers.

**See also:**
Add value: Key policies in place, p. 46

## GAVI at 10: promises made and kept

**Dr Gro Harlem Brundtland**
**Former Chair, GAVI Alliance Board**

Ten years ago, global leaders from politics, finance, business, health and children's rights, gathered at the World Economic Forum. Together, we launched a truly public-private initiative aimed at reversing a decline in immunisation in the world's poorest countries. The promises made at the time were bold. Now, with the benefit of hindsight, I want to recall some of the promises made – and kept.

As Director-General of the World Health Organization at the time, I knew the numbers well. Every year, 30 million children were missing out on basic vaccines, and more than three million children were dying of vaccine-preventable diseases. Poor nations had yet to receive vaccines that could prevent diseases such as yellow fever and hepatitis B.

Today we can say that we reversed that trend and inspired the creation and supply of new affordable vaccines that promise to save the lives of another two million children a year, every year.

Since 2000, the GAVI Alliance has dramatically increased the introduction of new and underused vaccines, reaching over 257 million additional children and averting more than five million deaths, according to WHO. Vaccines against diphtheria, tetanus, pertussis, polio, measles, hepatitis B and Hib disease are preventing 2.5 million future deaths each year.

Now it's time to ask what the world will do to make sure that what we've started will live up to its potential – particularly as we enter the final uphill stretch on the road to meeting the Millennium Development Goals by 2015.

The recent *State of the World's Vaccines and Immunization* report warned of danger if the world slid behind in its commitment to save lives in the poorest nations, as a consequence of the global financial crisis. The authors pointed to successes, many of them thanks to GAVI and its partners, but they also wrote that scientific breakthroughs in the last 10 years will make a difference only with the "continued commitment of governments and the international community to sustain and build on their efforts to improve child survival and meet the MDGs".

Ten years ago, then President of Mozambique, Joaquim Chissano, joined me on the panel at the World Economic Forum, along with Bill Gates, Carol Bellamy of UNICEF and Jim Wolfensohn of the World Bank, to announce the creation of GAVI. It was a bold step at the time but we all recognised that in order to accelerate the introduction of life-saving vaccines we needed to innovate.

The GAVI Alliance has demonstrated the power of innovation and, 10 years later, the results – counted in millions of lives saved – are there for everyone to see.

VIEWPOINT

## Five-in-one vaccine boosts uptake of underused vaccines

The surge in uptake of DTP vaccine, as well as the increase in the number of children vaccinated against hepatitis B and Hib, is largely attributable to the pentavalent vaccine, which protects against five infections – diphtheria, tetanus, pertussis, hepatitis B and Hib, which causes deadly meningitis and pneumonia – in a single vial.

In 2009, pentavalent vaccine was introduced in an additional 18 GAVI-eligible countries. According to WHO projections, almost 60 million children had received the vaccine by the end of 2009. The five-in-one vaccine reduces the number of injections needed and is easy to administer. As a result, it improves the experience of the baby, the parent and the health worker, and also has logistical and cost-saving benefits.

**See also:**
www.gavialliance.org/pentavalent

### Protecting against life-threatening *Haemophilus influenzae* type b

*Haemophilus influenzae* type b (Hib) causes serious, often life-threatening, meningitis and pneumonia in young children. It can be treated with antibiotics, but lack of access to adequate medical facilities and increasing levels of antibiotic resistance lead to high mortality rates.

Hib causes some three million serious illnesses worldwide every year, resulting in nearly 400,000 child deaths, most of which occur in low-income countries. It is the third most common vaccine-preventable cause of death in children under five. The majority of survivors suffer paralysis, deafness, mental retardation and learning disabilities.

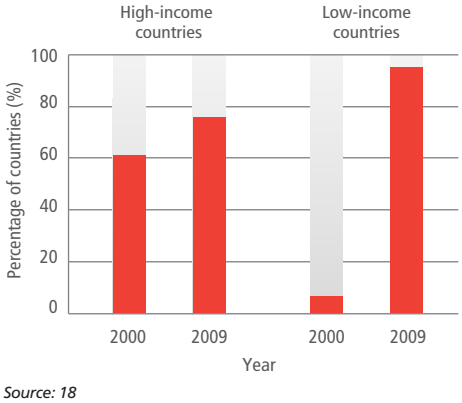
By 2009, 61 of the 72 GAVI-eligible countries had introduced or were planning to introduce Hib vaccine into their routine immunisation programmes. According to WHO estimates, the number of cumulative additional children immunised against Hib increased from approximately 39 million at the end of 2008, to almost 60 million in 2009.

### Hepatitis B vaccine coverage almost universal in GAVI-eligible countries

Hepatitis B, a virus that attacks the liver and can cause both acute and chronic disease, puts its victims at risk of death from cirrhosis of the liver and liver cancer later in life. More than two billion people are infected with hepatitis B worldwide. Of these, some 350 million suffer from chronic hepatitis B infection, which is highly prevalent in all GAVI-supported countries. Infants and young children are most vulnerable to infection.

To date, 67 GAVI-eligible countries have been approved for support for hepatitis B vaccine. WHO estimates that by the end of 2009, more than 233 million children had been immunised against hepatitis B with support from GAVI, an additional 39 million since 2008.

**Inequity addressed: routine use of hepatitis B vaccines in high- and low-income countries**




*Source: 18*

## Halting and preventing yellow fever epidemics

Yellow fever, an acute viral haemorrhagic disease transmitted by mosquitoes, causes an estimated 30,000 deaths worldwide every year. Vaccination is the single most effective preventive measure against yellow fever, as it protects against the disease for 10 years or more.

The GAVI Board has approved US$ 103.6 million for the Yellow Fever Initiative, which is led by WHO and UNICEF. The funding, disbursed over a five-year period ending in 2010, is used to stockpile 90 million doses of yellow fever vaccine for emergency outbreaks and preventive campaigns.

By the end of 2009, GAVI had supported the immunisation of almost 41 million people against yellow fever through preventive campaigns in eight countries: Benin, Burkina Faso, Cameroon, Liberia, Mali, Senegal, Sierra Leone and Togo. In November, stockpiled vaccines funded by GAVI were used to respond to an outbreak affecting Benin, Liberia and Sierra Leone.

GAVI also funds routine yellow fever immunisation where it is recommended by WHO. Seventeen countries are currently receiving support from GAVI for routine immunisation against yellow fever.

**See also:**
www.gavialliance.org/yellowfever

**"Immunisation is a right that must be respected, protected and fulfilled... Only when all children of the world enjoy the right to immunisation will social justice be achieved."[c]**

***Alan Hinman, alternate GAVI Alliance Board member, CSO constituency***

## Afghanistan introduces vaccine against five deadly diseases

Afghanistan is a fragile country heavily dependent on civil society organisations for the delivery of immunisation services. Despite the political instability and unrest, Afghanistan has successfully introduced pentavalent vaccine, which protects against diphtheria, tetanus, pertussis, hepatitis B and Hib disease in one single shot.

After the vaccine was introduced in January 2009, coverage rates climbed to a remarkable 83% by the end of the year. All of Afghanistan's 1,210 public health facilities now provide newborn children with pentavalent vaccine.

Afghanistan has one of the highest underfive mortality rates in the world, over 250 per 1,000 live births. Although DTP3 coverage has been fairly high (reaching 90% in 2007), Hib vaccine has not been part of the routine immunisation programme. With the introduction of pentavalent vaccine, children are now protected against deadly pneumonia and meningitis caused by the Hib bacterium.

"GAVI support for the introduction of this new vaccine represents a golden opportunity for preventing around 100,000 cases of Hib-related diseases and saving about 15,000 children's lives each year in Afghanistan," said Dr Fatimie, Minister of Public Health in Afghanistan.

## Meningococcal vaccine: responding to emergency outbreaks

In 2009, the GAVI Alliance fast tracked a US$ 55 million contribution to stockpile meningococcal vaccines and pay for emergency outbreak responses in the African "meningitis belt", which stretches from Senegal in the west to Ethiopia in the east.

GAVI's contribution will fund 45 million doses of vaccines until 2013, ensuring sufficient stock to deal with outbreaks of deadly meningococcal disease.

The emergency stockpile was called into use during a severe outbreak affecting Burkina Faso, the Central African Republic, Chad, Côte d'Ivoire, Mali, Niger, Nigeria and Togo in 2009 – an outbreak that reportedly hit earlier, faster and harder than in any of the previous five years.

**See also:**
www.gavialliance.org/pentavalent

# Strengthen capacity

# 2


## STRATEGIC GOAL:

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

## KEY RESULTS 2009:

- Evaluation and tracking study show early results from health system strengthening (HSS) grants
- GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank jointly develop new coordinated health systems funding platform
- Three donors – UK, Norway and Australia – pledge a total of almost US$ 1 billion for HSS
- New Transparency and Accountability Policy helps manage risk in cash grant programmes

# Strengthen capacity

**Weak and depleted health systems are a critical barrier to reducing vaccine-preventable deaths and disabilities. GAVI helps boost the capacity of health and immunisation services through health system strengthening support; funding for civil society involvement in immunisation planning and delivery; and immunisation services support.**

By the end of 2009, 45 countries had been approved for HSS funding, and a further nine had been recommended for approval to the GAVI Alliance Board. HSS funding addresses key system bottlenecks to delivering vaccines, identified by the countries themselves. Support is provided for the duration of each country's national health plan.

In addition, GAVI has allocated US$ 30 million between 2007 and 2009 to strengthen the role of civil society organisations (CSOs) in immunisation and other child health services. To date, 10 countries have been approved for type A support, which aims to strengthen CSO representation and coordination. Seven countries have been approved for type B funding, which supports CSO involvement in the implementation of HSS and immunisation plans.

The immunisation services support (ISS) programme, which offers initial investment payments and subsequent reward payments based on the number of children immunised, has had a positive effect on immunisation coverage. A study in 2007 identified some weaknesses in the quality of coverage data, which GAVI is addressing together with partners and implementing countries.

## Evaluation and tracking study show early results from HSS grants

In 2009, an independent mid-term evaluation of GAVI's HSS programme and a complementary tracking study were conducted. The tracking study sought to dig deeper into the end use of GAVI's support by highlighting implementation issues in DR Congo, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia.

The evaluation described GAVI's decision to fund HSS as "bold and innovative". The flexible and predictable funding for country-identified priorities was seen as an attractive alternative to support that was heavily earmarked and burdensome to use.

However, the report also identified a number of challenges, including the variable quality of technical support available for implementation and monitoring, and the need for processes to assess and manage risk, and align funding with country cycles. As a learning organisation, GAVI is taking the recommendations on board to inform the next phase of HSS.

Measures to strengthen the HSS programme are already under way. A financial management assessment process under GAVI's Transparency and Accountability Policy was rolled out in 10 countries in 2009. The new platform for funding health systems, which GAVI is designing together with the World Bank; the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund); and WHO, will also build on the HSS programme.

**See also:**

www.gavialliance.org/HSS/principles

www.gavialliance.org/performance/evaluation

## A holistic approach to immunisation

The GAVI HSS model encourages partnership and coordination of health system strengthening, as the development, implementation and monitoring of HSS proposals require close consultation between government departments and multilateral, bilateral and civil society partners. By promoting broad, integrated health plans that are aligned with country planning cycles, the programme promotes a holistic approach to immunisation delivery.

Examples of countries where GAVI support forms part of integrated health interventions for women and children include Malawi and Nepal. In Nepal, GAVI HSS funds are helping to upgrade the skills of more than 2,000 village health workers in pneumonia and diarrhoea management, including immunisation. GAVI's HSS funding to Malawi is used to train health assistants and other health workers in delivering basic health services and address neglected tropical diseases, using immunisation delivery as a platform.

## Health systems funding platform: "more health for the money"

GAVI's HSS programme was recognised as one of the pathfinders in global health in May 2009, when the International Health Partnership (IHP) and the High Level Task Force for Innovative International Financing for Health Systems recommended GAVI, the Global Fund and the World Bank, with the support of WHO, to explore a more coordinated approach to health system strengthening.

The concept is based on the principles of aid effectiveness agreed in Paris and Accra and outlined by the IHP, and is designed to bring "more money for health, and more health for the money" to developing countries. By harmonising donor mechanisms and modalities for assessment, funding, monitoring, procurement, fiduciary oversight and technical support, and better aligning them with country systems, the initiative will help reduce transaction costs for implementing countries and thus accelerate progress towards national health goals and the MDGs.

The platform will provide partners with a channel for financing health systems in a long-term, predictable and results-focused manner. It will be flexible and country-driven and involve a range of key stakeholders, including civil society and the private sector.

In September 2009, three donors – the UK, Norway and Australia – pledged £250 million, 1.5 billion Norwegian kroner and Australian $ 250 million respectively to HSS, to be channelled through the health systems funding platform. The platform will be rolled out in 2010.

**See also:**
www.gavialliance.org/hss

## Strengthening maternal health in Cambodia

Every year nearly 350,000 women and girls die while giving birth. Almost all of these deaths occur among poor women in developing countries, where complications in pregnancy and childbirth are the leading cause of death and disability among young women aged 15–19 years.

Scarcity of midwives and health facilities, and lack of hospitals offering emergency obstetric services are just a few of the obstacles to safe delivery. At the global level, advancement towards achieving MDG 5, to reduce maternal mortality by three quarters, has been stymied by a lack of political commitment, cohesive leadership and financial resources.

Achieving this target will not be easy. One critical barrier is the underlying weakness of health systems in high burden countries. GAVI is responding to this challenge by supporting health system strengthening so that countries are better geared to meet the needs of women and children. GAVI provides countries with funds to implement national plans that deliver reproductive, maternal, newborn and child health services at the peripheral level. One such example has been Cambodia.

Cambodia has enjoyed huge successes in child health, achieving just under a 30% decline in infant and child mortality rates between 2000 and 2005. Disappointingly, improvements in women's health have not kept pace with child health, and the maternal mortality ratio is one of the highest in the region.

In 2002, Cambodia became one of the first countries to receive funds from GAVI for health system strengthening. At that time, the focus of GAVI HSS support was on the delivery of immunisation, the introduction of hepatitis B vaccine and injection safety. HSS has broadened since those early days. With additional support provided by the United Nations Population Fund (UNFPA ) and a

contribution by AusAID in July 2008, the Health System Strengthening 2 (HSS 2) programme aims to support the delivery of an integrated package of services along a continuum of reproductive maternal and child health care.

The programme has achieved some promising results in a short time. In addition to reaching or even surpassing immunisation targets for DTP3 and measles, antenatal care coverage increased dramatically, and the number of deliveries in health facilities has risen.

Despite the successes, much more needs to be done. The scarcity of midwives in rural areas remains a constraint. Strengthening the referral system between communities and health facilities and hospitals is critical, and overcoming barriers to the integration of services is a priority.

> **"Getting the vaccines in Dar es Salaam is not the same as getting them to the people who need them. So GAVI has provided us with vehicles, and they have helped us train our people."[d]**
>
> ***David Mwakyusa, Tanzanian Minister of Health and Social Welfare***

## Immunisation services support: improving data quality

GAVI's ISS programme aims to improve immunisation coverage in the world's poorest countries through flexible reward payments for immunisation system strengthening.

An independent evaluation in 2007 showed that the ISS programme had been a successful pathfinder in performance-based funding for immunisation. Since its inception in 2000, the programme has helped increase basic DTP3 coverage, thus providing a solid foundation for the introduction of underused and new vaccines in developing countries.

However, the evaluation also identified discrepancies between implementing countries' own data on national immunisation coverage and data from other sources. At the end of 2008, GAVI decided on a temporary suspension of ISS grants. A Data Task Team of independent experts was commissioned to assess the metrics used to measure ISS delivery and performance, and review data collection sources and systems.

Recognising the value of the performance-based funding system, the team recommended that GAVI continue to implement the ISS programme, as well as to use estimates from WHO and UNICEF to monitor immunisation progress and calculate reward payments.

However, the experts also recommended a number of improvements, including increased support to strengthen country administrative data systems.

Building on the recommendations of the Task Team, GAVI has introduced new checks and balances to the ISS window to ensure that decisions on rewards to countries are based on the most current and robust data available. GAVI is also revising the Data Quality Audit tool, and developing new tools for countries to assess and improve data quality and analyse immunisation data from different sources.

GAVI has committed to ensuring that HSS funding is used to help improve the capacity for analysis, synthesis, validation and use of health data in implementing countries. This should enable countries to better monitor and evaluate their progress.

In 2009, GAVI lifted the temporary suspension of ISS in all but six countries. The GAVI Alliance, in particular through WHO and UNICEF, continues to work with countries to address the data issues identified. However, it was recognised that no misuse or misappropriation of ISS funds had been noted in any of the countries.

## New policy manages risk in HSS and ISS

At the beginning of 2009, the GAVI Alliance introduced a new Transparency and Accountability Policy (TAP). The TAP applies to all existing and new cash-based programmes, with particular focus on HSS and ISS. While the policy is geared to substantially reduce fiduciary risk, it is flexible and emphasises country ownership.

Countries will now submit basic financial information annually, using country reporting systems, and follow up with independent audit reports. This will enable more informed recommendations on future support.

As part of the TAP, GAVI undertook 10 financial management assessments (FMAs) in 2009, focusing especially on countries with new or very large existing cash grants. In some countries the FMA process revealed strong government financial management systems with high levels of accountability and assurance. In others, the FMA pinpointed weaknesses and provided practical solutions on how to strengthen grant financial management.

The support of in-country development partners has been fundamental to the introduction of the FMA process.

**See also:**

www.gavialliance.org/iss

www.gavialliance.org/vision/policies/tap

## Door-to-door health services in rural Vietnam

Vietnam's far northern province of Ha Giang is home to more than 20 ethnic minorities, each with their own traditions and languages. In this remote mountainous region, the first contact with health care often comes on foot, from village health workers like Nguyen Thi Xuan.

This 45-year-old grandmother is one of hundreds of volunteers who go door to door in their communities to offer basic medical treatment and information.

For 10 years, Xuan has been conducting check-ups and providing down-to-earth advice on all kinds of health matters. In Xuan's village, her prompt intervention can often mean the difference between life and death.

Xuan spends about a quarter of her time undertaking health work, and she attends a monthly meeting at the commune clinic. She is responsible for 266 people in 55 households in her village Na Pong, about 5 km from the commune health clinic.

"Before, there was no health worker in our village. I was interested in volunteering to be a village heath worker so I could care for my community's health as well as the health of my own family," she explains.

Xuan and dozens of other village health workers have been selected to take part in a residential training course specifically designed to upgrade their skills and give them a broader understanding of the health services provided by the province's commune clinics and hospitals. Her previous training was 10 years ago and lasted only a month.

Dr Dang Van Huynh, Deputy Director of Health in Ha Giang Province says the training programme started in 1995. In 2008, Ha Giang Province received US$ 1.6 million in funding for HSS from GAVI to help pay for 14 activities over three years. The support from GAVI has enabled his department to extend the training from two months to nine months.

"Thanks to GAVI's support we can now focus on the quality of training," he says.

Ha Giang's Health Department aims to strengthen and extend their health system to serve every community. The GAVI-supported HSS activities include training courses for village health workers, special bags for health workers containing basic health equipment, and computers to help gather data. More than 240 people were trained in 2009, and more than 2,000 bags have been distributed.

The basic training course for village health workers runs for 36 weeks in total. This includes 21 weeks at a residential training school, 13 weeks of on the job training at the district level and 2 weeks at a district hospital.

With 22 different minority languages spoken in the province, it is vital to train people from each community. The trainees need to have at least a primary education and speak Vietnamese. One or two are selected from each village for training, and they have to commit to going back to their communities after the training.

When it comes to preventive health, Vietnam's immunisation programme is a good example of what can be achieved. The country eradicated polio in 2000 and eliminated neonatal tetanus in 2005.

With support from the GAVI Alliance and other development partners, Vietnam started using the hepatitis B vaccine in 2002, and plans to introduce Hib vaccine in 2010 as part of its pentavalent introduction.

Locally-produced auto-disable syringes are widely used and funding for health system strengthening will help increase management capacity and monitoring at all levels.

In communities across Vietnam, volunteers like Nguyen Thi Xuan are hard at work playing their role in helping ensure that mothers and children receive care in even the most remote communities.

"Before taking this course I was a birth attendant and I helped deliver dozens of babies. Having done the course, I now know more about diseases. Now people come to me with many questions about diseases, and I am able to help them," says Xuan.

## Intensifying cooperation with civil society organisations

Civil society organisations (CSOs) play a key role in immunisation, as they often have access to communities that are beyond the reach of government services. In some countries, up to 60% of immunisation services are delivered by CSOs. Civil society is also an effective mechanism for mobilising communities and creating demand for immunisation and other health services, as well as advocating to influence decision-makers, donors and the media, at the local, national and global levels.

GAVI's support to CSOs aims to strengthen civil society involvement in immunisation, child health and health system strengthening, and to encourage the public sector and civil society to work more closely together in delivering immunisation services.

### Civil society support: two types of funding

Between 2007 and 2009, the GAVI Alliance supported CSOs through two funding streams: type A and type B. Type A support, which is available to all GAVI countries, aims to strengthen the representation and coordination of CSOs at country and regional levels, and stimulate cooperation between civil society and the public sector. In 2009, approximately US$ 89,000 of type A support was disbursed to three countries: Cameroon, Georgia and Togo.

Type B funding, which supports direct CSO involvement in countries' HSS proposals and multi-year immunisation plans, is available in 10 pilot countries: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan. In 2009, over US$ 6 million was disbursed to Afghanistan, Ethiopia and Pakistan.

Examples of how CSO funding is used include community awareness activities to improve the health status of mothers and children in Ethiopia; recruitment and training of female health workers in Afghanistan; and maternal and health services in hard-to-reach communities in both rural and urban Pakistan.

In 2009, GAVI recognised the need to restructure the type A support, as country demand was low. In addition, requests for a window for direct CSO funding, as well as support to local grass-root and indigenous CSOs, were raised during the year, notably at the GAVI Alliance Partners' Forum in Hanoi in November. These discussions will provide important input into decisions to be taken in 2010 on future support to CSOs.



**See also:**

Ch 4: Add value: Strengthening collaboration with civil society partners, p. 47.

www.gavialliance.org/cso

## Strengthening Mali's health system through solid partnership

**Oumar Ibrahima Touré**
**Minister of Health, Mali**

In Mali, the development of a solid partnership, strengthened dialogue and better coordination of the interventions of the state, civil society and local authorities, are starting to pay off in the form of a strengthened health system. In this vast country, the Ministry of Health is working closely with a range of partners to deliver a package of essential health services, with a particular focus on immunisation, especially in poor and rural areas.

Further, the commitment of both the Government and the GAVI Alliance to implementing the Paris Declaration on Aid Effectiveness and the International Health Partnership and related initiatives (IHP+) is making us better able to monitor the strengthening of the health system and immunisation services, and will thus help speed up our progress towards the health-related Millennium Development Goals.

Although Mali only started implementing GAVI health system strengthening support a year ago, some important progress is already being made. The GAVI funding helps finance activities that target bottlenecks in services and roadblocks in the system, and enables us to improve access to immunisation and other mother-and-child health services. As a result, it will contribute to reducing infant and maternal mortality in the long term.

The partnership between the different actors is central to these efforts. Civil society organisations are particularly key, as they are strongly involved in the implementation of GAVI HSS support at all levels.

At the national level, CSOs are actively participating in the entire HSS proposal development process through the Malian National Federation of Community Health Associations (Fenascom). They are also involved in supervising the preparation of proposals, as well as the monitoring and evaluation of the implementation of the support.

At the local and district level, CSOs are working in close cooperation with public health workers to conduct HSS activities aimed at boosting health staff engagement and motivation, improving service delivery and monitoring community health services. CSOs also play a pivotal role in providing health and immunisation services, child health care and information, especially to populations that are vulnerable and difficult to reach; taking part in local dialogue on health service improvement; and helping to boost awareness and demand through social mobilisation and advocacy.

With the help of the HSS support from GAVI, we have also adopted a system of incentive bonuses to nurses and midwives in community health centres, which helps ensure the retention and motivation of qualified staff, especially in inaccessible and extremely poor areas. This boosts the quality of the services and serves to increase the demand for mother-and-child health care, which is currently low in these areas.

Despite the important progress made in strengthening our health and immunisation system, the achievements have yet to translate into long-term health benefits for the majority of the population. If we really want to create a better world in health care – a world worthy of the children – we recognise the need for sustained and strengthened efforts over a very long period of time.

# VIEWPOINT

**"Innovation can be the key to making significant progress on reaching the MDGs, strengthening health systems and improving million of lives – especially the lives of women and children. A good example is our partnership with the GAVI Alliance, the Global Fund and the WHO to develop a platform to coordinate and channel aid to health systems."**

***Robert Zoellick, World Bank President***

## Strengthening the role of civil society

In 2009, GAVI reinforced its commitment to strengthening the role of CSOs in the Alliance, an effort that was underlined by the strong presence of civil society organisations at the GAVI Alliance Partners' Forum in November.

At the Partners' Forum, a group of civil society organisations issued a joint Call to Action, requesting increased CSO influence and engagement in GAVI Alliance governance and programmes.

**See also:**
Ch 4: Add value: Strengthening collaboration with civil society partners, p. 47
www.gavialliance.org/in_partnership/vietnam
www.gavialliance.org/in_partnership/cso

## Health care delivery through civil society: DR Congo as a successful model

With a health system scarred by decades of neglect, devastating conflict and deep poverty, the DR Congo receives CSO support from the GAVI Alliance as a fragile state. Providing any health service in DR Congo is a monumental challenge for the Ministry of Health, and can only be met through the engagement of CSOs. From 2007 to 2010, US$ 5.4 million has been approved by GAVI for CSO support to DR Congo.

The grant is channelled through an already established network of CSOs, which has formed a consortium comprising the Association of Rotary Clubs of DRC, the Rural Health Programme of DR Congo (SANRU), Catholic Relief Services, the National Council of Health NGOs, and the Red Cross.

Rotary, SANRU and Catholic Relief Services have divided their activities according to different regions, while the health NGOs and the Red Cross are responsible for cross-cutting activities, such as advocacy.

The five GAVI-funded CSOs have completed 80% of the principal activities planned in the first year, including support for local census

and micro-planning; training of health personnel in the management of the national immunisation programme and data quality self-assessment; supply of transport, gas and kerosene for the cold chain; administration of performance contracts for health staff; and training of local CSOs, community mobilisers and Red Cross volunteers.

As a result, vaccination coverage for DTP3 in districts covered by the CSOs increased from 74% to 83% in one year, despite long strikes and numerous vaccine stock-outs. Volunteers are increasingly succeeding in mobilising communities, enabling more than 10,000 unimmunised children to be reached with vaccines within the first year.

"We were able, as a group, to mobilise Members of Parliament to advocate for more funds from the Government to vaccinate more children. Also, CSOs within the national consortium complement each other. For example, the Red Cross is strong in using volunteers whereas SANRU has a great deal of experience in primary health care," says Dr Leon Kintaudi, Project Director of SANRU and CSO coordinator for DR Congo.

**See also:**
www.gavialliance.org/cso

## STRATEGIC GOAL:

Increase the predictability and sustainability of long-term financing for national immunisation programmes.

## KEY RESULTS 2009:

- Four IFFIm bond issuances in Japan and the UK raise over US$ 1 billion
- Advance Market Commitment pilot for pneumococcal vaccine becomes operational with the signing of legal documents
- Over 40 of the world's poorest countries co-financing vaccines, many at higher levels than required
- Pentavalent vaccine price drop of almost US$ 0.50 per dose will enable GAVI's partners to immunise many more children

# Increase predictability 3

# Increase predictability

Thanks to steady donor contributions and innovative financing mechanisms, the GAVI Alliance is able to ensure long-term commitments to implementing countries. GAVI provides multi-year funding, covering the duration of countries' health and immunisation plans, to make a lasting contribution to the Millennium Development Goals.

The International Finance Facility for Immunisation (IFFIm) issued four bonds in 2009, raising over US$ 1 billion. The pilot Advance Market Commitment (AMC), which has the potential to save an estimated seven million lives by 2030, was officially launched in June when the partners signed the legal documents in Lecce, Italy.

Throughout the global financial crisis, both donors and implementing countries have remained committed to investing in vaccines. Despite significant pressures on domestic budgets in 2009, the vast majority of GAVI's donors have maintained, and in some cases expanded, their support for the Alliance and its programmes.

## Predictable funding central to country ownership

Long-term commitments from donors are fundamental to GAVI's ability to provide predictable funding to developing countries. GAVI's donors have been driving efforts to further strengthen the predictability of GAVI's programme funding through multi-year agreements, IFFIm and the AMC.

By the end of 2009, GAVI had committed US$ 4.1 billion through to 2015 for immunisation and health programmes in 72 of the world's poorest countries.

The demand from developing countries, especially for the new pneumococcal and rotavirus vaccines, is increasing rapidly. Countries are showing their commitment to immunisation by increasingly co-financing vaccines, many at higher levels than required.

However, GAVI's future ability to meet country demand will depend on how donors allocate limited resources in the next few years. While GAVI has the funds to fulfil its existing commitments to countries, an additional US$ 2.6 billion is needed over the next six years in order to keep the momentum, sustain the support for existing vaccines and introduce new life-saving vaccines.

### Funding to GAVI in 2009

Overall funding to GAVI totalled US$ 668 million in 2009. The cumulative total funding for the period 2000–2009 reached US$ 4.5 billion.

**Direct contributions:**

- Contributions from donor governments and the European Commission amounted to US$ 256 million in 2009, with a cumulative total of US$ 1.77 billion for the period 2000–2009.
- In the same year, foundations, private individuals and organisations contributed US$ 82 million. The cumulative total for the period 2000-2009 amounted to US$ 1.2 billion.

**Innovative funding mechanisms:**

- In 2009, IFFIm proceeds amounted to US$ 330 million, while the cumulative total for the period 2006-2009 was US$ 1.6 billion. By the end of 2009, US$ 1.5 billion had been pledged to the pilot AMC for pneumococcal vaccine.

**See also:**

Donor contributions to the GAVI Alliance, p. 10

Annex 2: Donor contributions and commitments, p. 56

www.gavialliance.org/support/donors

## Deepening and broadening the donor base to meet country demand

In order to respond to the dramatic increase in country demand for new and existing vaccines, resource mobilisation was at the forefront of GAVI's activities in 2009. Securing additional resources is essential to sustain GAVI's ability to boost access to life-saving vaccines for developing countries.

GAVI's new Resource Mobilisation Strategy, which was approved by the Board in June 2009, recognises 2010 as a pivotal year for resource mobilisation and encourages GAVI to broaden its donor base. The current donor base includes 16 governments, the European Commission, the Bill & Melinda Gates Foundation, La Caixa Foundation and private donors. The funding is concentrated, with six donors providing 84% of aggregate commitments to date.

A number of G20 donors are already contributing to GAVI programmes. Australia, South Africa and Spain are all participating in IFFIm, while the Russian Federation has made a commitment to the AMC. However, developing relations with potential new donors takes time, and significant results may only be expected in the medium term.

In order to meet short-term programme demand from implementing countries, GAVI is intensifying its resource mobilisation efforts with existing donors. GAVI has strengthened its outreach to Members of Parliament, parliamentary groups and civil society organisations in donor countries. Mobilising political will is essential for GAVI to be able to make a significant contribution to the MDGs by 2015.

## Co-financing: empowering countries to contribute to immunisation costs

Co-financing is the contribution of developing countries to the cost of purchasing vaccines with the GAVI Alliance. Evidence-based decision-making on vaccine introduction and long-term sustainability are the overall objectives of GAVI's current co-financing policy.

Financial sustainability has been a core principle of the Alliance since its inception. In 2005, GAVI decided that all countries would be required to contribute to the cost of vaccines through co-financing.

Three years later, the country co-financing policy shifted in favour of a broader approach that encourages countries to make evidence-based decisions on which vaccines to introduce, and helps them achieve financial sustainability for new vaccines and institutionalise vaccine spending in their national budgets and health planning.

The level of the contribution by developing countries to the purchase of vaccines is based on their expected ability to pay. The least poor GAVI-eligible countries are required to gradually increase their co-financing contributions over time.

In 2009, 44 of the world's poorest countries – almost 90% of those required to co-finance – co-financed GAVI-supported vaccines, with co-payments totalling over US$ 25 million. Seventeen countries, including Bolivia, Cameroon, the Democratic Republic of the Congo and Rwanda, chose to finance beyond the required levels, leading them to progress more rapidly on the path towards financial sustainability. Three countries, Senegal, Yemen and Zambia, are exceeding expectations by deciding to co-finance ahead of the required starting date.


**See also:**
www.gavialliance.org/cofinancing

> **After wars, plagues and natural disasters, financial crises kill the poor the most.**[f]
>
> ***Liliana Rojas-Suarez,***
> ***Senior Fellow, the Center for Global Development***

## IFFIm: frontloaded funding enables GAVI to double immunisation spending

IFFIm is the first aid-financing mechanism in history that has managed to attract legally-binding commitments of up to 20 years from donor governments, thus significantly contributing to long-term predictability in GAVI-supported immunisation programmes.

At the beginning of 2009, IFFIm entered the UK market for the first time, with a bond issuance in March and April raising the equivalent of US$ 400 million from retail and institutional investors. Another three IFFIm bonds, issued in the Japanese market in February, May and June, raised a total of over US$ 700 million.

Since its launch in 2006 until the end of 2009, IFFIm has raised a cumulative US$ 2.3 billion in bonds and approved US$ 2 billion to GAVI programmes. Of that amount, US$ 1.3 billion has already been disbursed to fund the purchase and delivery of vaccines in GAVI-eligible countries.

IFFIm funding is used to support the introduction of new and underused vaccines, including the five-in-one pentavalent vaccine, as well as immunisation services support, injection safety and health system strengthening (HSS). Funds raised through IFFIm bonds are also used to support targeted immunisation campaigns against deadly diseases.

By the end of 2009, IFFIm funding had contributed to preventing 1.4 million future deaths caused by yellow fever, polio, measles, maternal and neonatal tetanus, and meningitis. IFFIm funding has effectively allowed GAVI to double its spending since 2006.

### New pledges to IFFIm

Four donors made new or additional pledges to IFFIm in 2009 – a testament to their continued confidence in GAVI and in IFFIm as an innovative funding mechanism.

In December, the Netherlands made its first payment under its new commitment of €80 million over eight years, to be disbursed through an expanded IFFIm to GAVI's immunisation programmes. Earlier in the year, the UK, Norway and Australia pledged an additional £250 million, 1.5 billion Norwegian kroner and Australian $ 250 million respectively to the expanded IFFIm. These contributions will help support the new harmonised platform for funding health system strengthening, which GAVI, the Global Fund and the World Bank are developing with the support of WHO.

Altogether, eight donors have committed over US$ 5 billion to IFFIm over 20 years. This solid financial base has secured a triple-A rating for IFFIm from three major rating agencies.

IFFIm has proved to be an efficient and cost-effective way of mobilising long-term resources for health. GAVI and its partners are looking to expand and extend IFFIm by obtaining further contributions from existing donors as well as attracting new donors to IFFIm.

**See also:**

www.gavialliance.org/iffim

## IFFIm recognised as leading innovative financing mechanism

UN Secretary-General Ban Ki-moon acknowledged the crucial role of IFFIm and seven other innovative financing initiatives at the World Health Assembly in Geneva in May 2009, when he convened the first meeting of I-8 Group/L.I.F.E. (Leading Innovative Financing for Equity). "The economic crisis makes innovative financing even more important," Mr Ban said. "Your task is to identify the most successful mechanisms".

IFFIm and the other seven initiatives gathered for the meeting are considered to be among the most successful of their kind. Collectively they reflect the progress that has been made in finding innovative financing mechanisms, hence the tag I-8 or "innov-eight".

Ban also highlighted a key finding of the United Nations Conference on Financing for Development in Monterrey, Mexico, which called for the urgent development of new, innovative funding sources as a means of attaining the MDGs.

Successful bond issues by IFFIm in 2009 underscore the compelling allure of innovative investment that is strengthening global health. Even in the challenging conditions created by the global economic crisis, IFFIm drew enthusiastic support among private and institutional investors for GAVI's drive to deliver vaccines that will save the lives and health of millions of children.

IFFIm bonds leverage the ground-breaking commitment to long-term development financing made by eight governments that to date have committed US$ 5.3 billion for up to 20 years. On the basis of those legally-binding commitments, IFFIm raised the equivalent of US$ 1.1 billion from bond issues in Japan and the UK in 2009, on top of the US$ 1.2 billion raised from two earlier bond issues in 2006 and 2008.

IFFIm's ability to harness public funds and private capital is dramatically accelerating delivery of life-saving vaccines. The funds raised by IFFIm are enabling GAVI to double its spending on immunisation programmes in 70 developing countries.

These are funds that have been quickly put to work with immediate effect. The support has catalysed a sharp rise in vaccine use among the poorest countries, which are making dramatic inroads against such leading child killers as diphtheria, pneumonia and Hib disease.

This is a mission that institutional and private investors are showing they want to support. Launching its first fundraising effort in the UK, IFFIm hoped to raise £50 million in 2009. Such was the interest from investors that IFFIm added a second tranche and raised a total of £266 million. Even then the issue was heavily oversubscribed, attracting 40 investors including many with a commitment to ethical investing.

**"The vaccine bond is a good idea. I never really thought about the possibility of gaining good returns and contributing to society at the same time."**

***Mr Noburo Sakurai, retired railway worker, Chiba Prefecture***

## AMC: affordable pneumococcal vaccines for developing countries

In June 2009, the Governments of Italy, the UK, Canada, the Russian Federation and Norway, together with the Bill & Melinda Gates Foundation, formally launched the pilot Advance Market Commitment (AMC) against pneumococcal disease with a collective commitment of US$ 1.5 billion.

The GAVI Alliance partners are working together on the AMC pilot. The World Bank manages AMC funds and disbursements, WHO has established the minimum technical criteria for the vaccines, and UNICEF is responsible for vaccine procurement and distribution, while GAVI acts as the secretariat and manages the initiative. In 2009, the GAVI Alliance Board acknowledged that an additional potential budget of up to US$ 1.3 billion would be necessary to help fund the vaccines.

Thanks to the AMC, new pneumococcal vaccines could be available in GAVI-eligible countries as early as 2010, at a fraction of the price paid in industrialised countries. Through the AMC, vaccines will be available at no more than US$ 3.50 per dose, subject to inflation adjustments. This is a more than 90% reduction on the price of the same vaccines sold in the EU and the USA. For approximately 20% of the doses supplied, companies will receive an additional payment of US$ 3.50 per dose, paid for through donor commitments.

As the AMC pilot encourages production from multiple manufacturers, the heightened competition is likely to drive prices down even further.

The AMC allows developing country governments to budget and plan for their immunisation programmes, knowing that vaccines will be available in sufficient quantity and at an affordable price.

**See also:**
www.gavialliance.org/amc

## Changing the mindset of the pharmaceutical industry

**Andrew Witty**
**Chief Executive Officer, GlaxoSmithKline**

There is no doubt in my mind that the GAVI Alliance has absolutely captured the imagination of the pharmaceutical industry. It has acted as a catalyst for change in the way that key players deal with the opportunities and challenges that exist in the developing world, and I don't think there's anybody in the industry who is not conscious of these issues now.

In the past, the pharmaceutical industry, and society generally, have often been rigid, trying to apply the same business models to many different issues. I believe that this is changing, and that innovative thinking is starting to break down old barriers. For nearly a decade, GAVI has worked very diligently to create alternative models and facilities that will help us deliver more vaccines faster to the developing world. And I think the AMC is the best possible example of that.

The AMC provides a crucial platform for strengthening vaccine delivery because it binds all parties – donors, developing country governments, GAVI and industry – together in a long-term partnership. It's no longer a matter of "I feel like making a contribution this year, maybe I'll be here next year, maybe I won't". That changes the dynamic between the parties. For me, the AMC is a very clever approach because it achieves the secret to partnership, which is balance.

I am absolutely convinced that the AMC is the right approach to get life-saving vaccines to the developing world quickly and at an affordable price. We won't know for sure until it's all implemented and successful. But if it is, I think it will fundamentally change the potential, not just of pneumococcal vaccine and other vaccines we have today, but also that of new vaccines against diseases like dengue and malaria. That would make the four million lives that GAVI has saved so far really look like the prologue for a phenomenal legacy.

The AMC, in effect, has produced a strategic shift in the thinking of industry that changes everything. The potential it offers for further breakthroughs imposes an obligation on all of us to try to make it work. But it is also critically important that we do not allow the financial setbacks of the past two years to derail this or other GAVI initiatives. However severe the impact of the economic downturn, it is important for GAVI not to lose sight of its strategy. It would be better to scale back the ambition than to allow the lasting gains that GAVI promises for global health to be jeopardised by a passing economic cycle.

# VIEWPOINT

**"I like the idea of investing in something that will help children. With bonds offered by other banks, you never really know how your money will be used. It's a good idea, because the investment will be used for human good."**

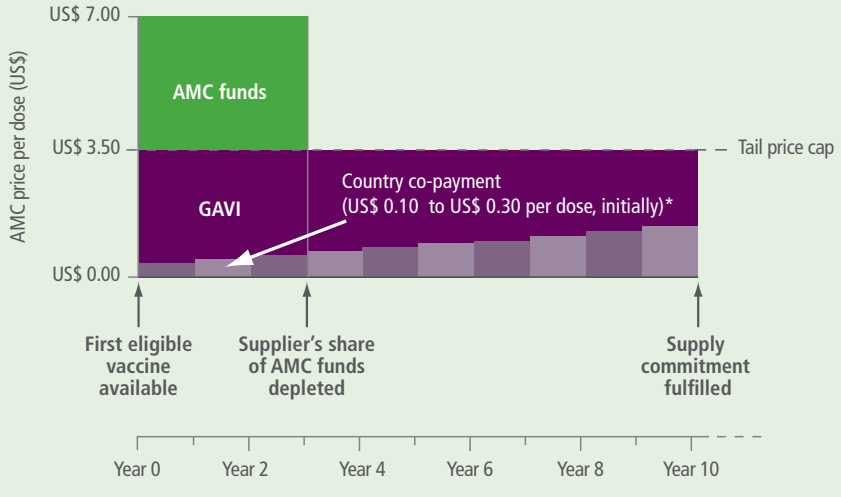
***Mrs Keiko Aoshima, mother of four, Tokyo***

## How the pneumococcal AMC works

The aim of the AMC is to stimulate the development and manufacture of affordable vaccines, tailored to the needs of developing countries.

Through the AMC, donors commit funds to guarantee the price of vaccines once they have been developed.

These financial commitments provide vaccine manufacturers with the incentive to invest in vaccine research and development, and expand manufacturing capacity. In exchange, companies sign a legally-binding commitment to provide the vaccines at a price that is predictable and affordable to the world's poorest countries.




*Source: 19*

* Co-financing levels will be in line with the applicable GAVI co-financing policy.

**See also:**
www.gavialliance.org/amc

## Shaping the market: making vaccines more accessible to the developing world

The GAVI business model is based on the assumption that GAVI's predictable support to countries' demand for vaccines provides an incentive to vaccine manufacturers to enter the market, or increase their production. This helps stabilise vaccine supply, and eventually contributes to reducing prices for developing countries.

In 2009, the weighted average price projection for pentavalent vaccine for 2010 fell to below US$ 3 per dose, a reduction that will make the delivery of the vaccine more sustainable for the world's poorest countries. Pentavalent vaccine is projected to be GAVI's single biggest expenditure through to 2015, accounting for some 40% of total vaccine spending.

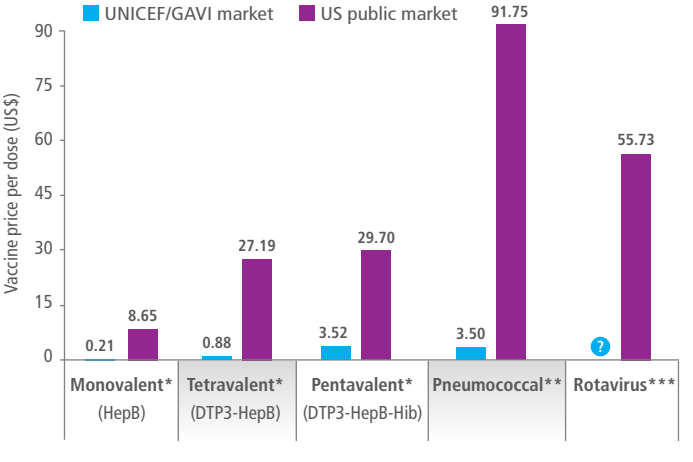
Further, by aggregating demand from GAVI countries and providing resources to fund this demand, GAVI has contributed to the establishment of an accepted low-income pricing tier for vaccines. Tiered pricing means that manufacturers offer the same product to low-income countries at a lower price than what is charged in higher-income countries.

Through the AMC, the price of pneumococcal vaccine will drop to, at the most, 5% of the current price in the USA.

In addition, the number of manufacturers based in emerging markets supplying GAVI-funded vaccines has increased steadily since 2000. These manufacturers are entering the market with more affordable, yet equally effective, products.

Immunisation is generally considered to be one of the most cost-effective measures to improve health in the long term, and thus reduce the burden on already stretched health systems. While newer vaccines are more expensive than "traditional" vaccines, such as those protecting against measles, BCG, tetanus toxoid and polio, all GAVI-supported vaccines have proven to be cost-effective compared with many other interventions.

### Tiered pricing: vaccine prices in different markets




* Average price per dose for 3-dose vaccines between 2006–2009.

** 2010 price for 13-valent vaccines (US public market) and price for AMC vaccines (UNICEF/GAVI market). Under the AMC, companies will receive an additional payment of US$ 3.50 per dose for approximately 20% of the total number of doses they provide. This additional payment is funded by donor commitments.

*** 2010 average price per dose assuming 3-dose equivalence among available products (US public market). Price through UNICEF not yet available.

*Source: 20*

## GAVI, IFFIm and AMC on BBC World News

In July and August 2009, the BBC World service broadcast three documentaries featuring GAVI's work and innovative financing programmes as part of its *Kill or Cure* series on global health issues. One film highlighted the potential of the HPV vaccine to save lives in Uganda, another the IFFIm and GAVI's programme in Sierra Leone, and a third the pilot AMC for pneumococcal vaccine. The films aired four times each to a global audience of approximately 280 million homes each time.

**STRATEGIC GOAL:**

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

**KEY RESULTS 2009:**

- First full year of operation for consolidated, more efficient governance structure
- The GAVI Alliance is recognised as an international organisation under Swiss law
- Fourth GAVI Alliance Partners' Forum attracts over 400 participants
- Civil society organisations sign Hanoi Call to Action for increased engagement in GAVI governance and programmes

# 4 Add value

# Add value

The GAVI Alliance is an innovative health partnership, which draws on the strengths of each Alliance member. Private- and public-sector partners from both the developing and industrialised worlds join forces to contribute to the GAVI mission.

The result of this blend is an efficient funding mechanism, which puts developing countries' needs first. The Alliance has been a frontrunner in exploring new approaches to development funding and programming, which have helped save millions of lives.

The year 2009 was the first full year of GAVI's consolidated governance structure, and of its new status as an independent international organisation under Swiss Federal Law. While operating legally as a Swiss foundation, GAVI is preserving the fundamental qualities of the partnership and the Alliance. Further, 2009 marked the continued maturing of the organisation with the implementation of core policies for gender equality, transparency and accountability, as well as the appointment of key senior staff members.

In November, more than 400 participants from 83 countries, representing the diverse mix of GAVI partners, gathered for the fourth GAVI Alliance Partners' Forum. The Forum particularly highlighted the strengthened role of civil society through the wide participation of civil society organisations (CSOs), as well as the announcement of a Call to Action for increased CSO engagement with the Alliance.

## Consolidated governance structure: increased efficiency

Over the years, GAVI has adapted its governance structure to respond to the evolving needs of the partnership. At the end of 2008, the GAVI Alliance Board and the GAVI Fund Board reorganised their functions into the new GAVI Alliance Board, contributing to a more integrated approach.

The new governance structure has allowed GAVI to consolidate its programmatic and financial activities under the oversight of a single Board. Furthermore, decision-making has been enhanced by a robust committee structure that supports the Board in the development of key policies, oversees specific activities, and enables intensive discussion and consideration of issues prior to their elevation to the Board.

Bringing together experts from developing and donor country governments, CSOs, multilateral development agencies, the vaccine industry and the academic community, the consolidated GAVI Alliance Board represents the GAVI Alliance partnership. Independent individuals with experience in the private sector bring an innovative perspective to Board discussions.

In November 2009, the GAVI Alliance Board appointed Dr Jaime Sepulveda, Senior Fellow in the Bill & Melinda Gates Foundation's Global Health Program, as its new Vice-Chair. Dr Sepulveda replaced Denis Aitken from WHO.

**See also:**

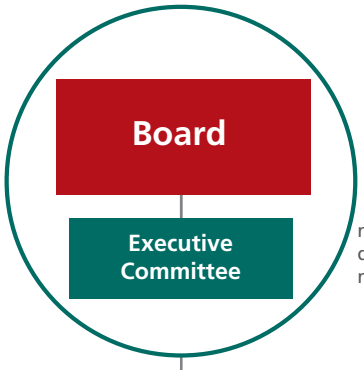
Annex 1: The GAVI Alliance governance structure, p. 54

www.gavialliance.org/about/governance

www.gavialliance.org/boardmembers

www.gavialliance.org/boardcommittees

## The GAVI Alliance Board's committee structure




makes critical, time-sensitive decisions between Board meetings

| Audit/Finance Committee | Fundraising Committee | Governance Committee | Investment Committee | Programme/Policy Committee | Evaluation Advisory Committee |
|---|---|---|---|---|---|
| advises the Board in the areas of corporate accounting, reporting practices, and the quality and integrity of the financial reports | advises the Board on fundraising and resource mobilisation efforts | ensures effective operations of GAVI's governance bodies, serving as nominating body for new Board members, and overseeing the functioning of other committees | advises the Board on investment policies and objectives, asset allocations and portfolio construction | advises the Board on all GAVI programme areas and leads the development of new policies | advises the Board on the oversight of GAVI's evaluation activities |

## A maturing organisation

The GAVI Alliance, which since its launch in 2000 was hosted by UNICEF, became an independent international institution in June 2009, when it signed a Headquarters Agreement with the Swiss Government. The agreement, which was retroactive to 1 January, was the first of its kind to be signed under the Federal Act on Privileges, Immunities and Facilities as well as Financial Aid granted by Switzerland as Host State.

The GAVI Alliance now enjoys similar privileges and immunities as other intergovernmental organisations in Switzerland, including inviolability of premises, archives, documents and data support; immunity of jurisdiction and execution; exemption from direct and indirect taxes; and exemption from Swiss social security regulations.

During the year the GAVI Alliance Secretariat made a number of appointments to key senior positions, including the new Deputy CEO, Helen Evans; the combined head of the Washington DC office and Managing Director of Innovative Financing, David Ferreira; the Managing Director of Finance and Operations, Barry Greene; and Joëlle Tanguy, Managing Director of External Relations. Cees Klumper was appointed to the newly created position of Director of Internal Audit.

**See also:**

Strengthen capacity: New policy manages risk in HSS and ISS, p. 27

Accelerate vaccines: Women's health and immunisation, p. 19

www.gavialliance.org/vision/policies

*Dr Julian Lob-Levyt, GAVI CEO (left) and Ambassador Paul Seger, Director of Public International Law, after signing the Headquarters Agreement.*

## Strengthening governance and risk management

In November 2009, GAVI established an independent internal audit function to evaluate and strengthen risk management, control and governance processes in the organisation. The work of the internal audit function extends not only to the Secretariat but also to the programmes and activities of GAVI's grant recipients and partners.

The Director of Internal Audit reports to the CEO and the Board, which has the mandate to appoint and terminate the Director upon the recommendation of the Audit and Finance Committee.

The Audit and Finance Committee also assesses the organisational structure, mandate and operating budget of the internal audit function to ensure that these are appropriate and sufficient to meet agreed activities. In addition, the Director of Internal Audit serves as compliance officer for GAVI's Whistleblower Policy, together with the Chair of the Audit and Finance Committee.

## Key policies in place

Another important measure for strengthening risk management was the adoption of the Transparency and Accountability Policy (TAP) in January 2009. While the internal audit function extends across the organisation and its operations, the TAP aims at managing fiduciary risk in GAVI-supported countries.

In November, the GAVI Alliance Board approved a revised vaccine donation policy, which determined that GAVI would only accept in-kind donations of vaccines under exceptional circumstances. These include donations for stockpiles to address emergencies, in cases of severe supply shortage, and in situations where GAVI would have funded vaccines from the manufacturer even in the absence of a donation.

The implementation of the GAVI gender policy, which was approved by the Board in June 2008, continued with the adoption of a gender implementation plan in early 2009. The policy recognises equal access to immunisation as a key factor in ensuring expanded, equitable vaccine coverage and strengthened health services.

All GAVI guidelines and application forms now include a gender component, and countries are strongly encouraged to use health system strengthening support to address any gender-related barriers to immunisation.

A review on gender and immunisation, led by the WHO Immunization Vaccine Research cluster with funding from GAVI, was initiated in the first half of 2009. The results and recommendations of the analysis will be presented to the WHO Strategic Advisory Group of Experts (SAGE) on Immunization in 2010.

## Strengthening collaboration with civil society partners

Civil society organisations present at the GAVI Alliance Partners' Forum in November issued a joint Call to Action, calling for a strengthened role for CSOs in working towards the GAVI mission.

The Call to Action urges GAVI to require a prominent role for civil society in all GAVI funding to countries, create an application process to provide direct funding to CSOs at national and sub-national levels, allocate two seats for CSO representation on the GAVI board, and involve CSOs in the development of the new GAVI Alliance Strategy and the health systems funding platform, which will be coordinated by GAVI, the Global Fund and the World Bank, together with WHO.

GAVI made significant progress on intensifying its engagement with CSOs in the latter part of 2009. Further decisions on how to meet specific action points will be taken during 2010.

### Hanoi Call to Action

The Call to Action was signed by representatives of civil society organisations at the GAVI Alliance Partners' Forum in Hanoi, Vietnam in November 2009. The action points in the Call to Action are:

We, the undersigned members of civil society organisations, urge the GAVI Alliance to:

- facilitate civil society engagement as a constituency in the governance of the GAVI Alliance, including allocation of two seats for CSO representation on the GAVI Board – one each for northern and southern CSOs.
- require a meaningful role for civil society in all GAVI funding to countries, including health system strengthening, with a specific focus on linking communities to the formal health system.
- create an application process to provide direct funding to CSOs at national and sub-national levels.
- fully involve civil society in the development of all aspects of the 2011-2015 GAVI Strategic Plan and the GAVI-Global Fund-World Bank health system strengthening platform.

**See also:**

Ch 2: Strengthen capacity: Strengthening the role of CSOs, p. 31

www.gavialliance.org/in_partnership/cso


## Partners' Forum awards country leadership in immunisation

The GAVI Alliance bi-annual Partners' Forum provides governments, donors and civil society with a platform to learn from experience, recognise achievement and build strategies for moving forward. More than 400 participants from 83 countries met in Hanoi, Vietnam, on 18–20 November 2009 at the end of GAVI's first decade. While immunisation rates are at the highest level ever, GAVI faces a funding gap that leaves millions of children at risk.

"We must maintain and increase immunisation rates. We must continue to answer the call from countries for life-saving vaccines," Mary Robinson, Chair of the GAVI Board, told the Forum. She urged partners to "keep the focus, to advocate for the power of vaccines, to renew our common commitment and to recognise the opportunity – and the challenges – that lie ahead," Robinson said. "We owe it to every child who does not have a voice."

To support those aims, the forum offered technical briefings on the IFFIm and AMC, country eligibility for GAVI support and the Accelerated Vaccine Introduction (AVI) initiative and on myGAVI, a new web tool. Plenary sessions examined lessons learned from the past decade, the role of civil society and achieving financial stability for health services. Parallel workshops considered seven key thematic areas ranging from new vaccine development and deployment to designing health delivery systems.

Country leadership has been key in giving impetus to immunisation. During the Forum, 15 health ministers from developing countries received awards honouring such achievements as the highest average annual reduction in child mortality since 1990, the best performance in routine immunisation, the highest level of co-financing of vaccines and increasing immunisation rates.

Vietnam, the host country of the Partners' Forum, and Nepal both received the "Child Survival Award" for highest average rate of reduction of child mortality among all GAVI-eligible countries since 1990.

The awards acknowledged the efforts that developing countries are making, at times in extremely challenging circumstances, to provide immunisation services to mothers and children.

**See also:**
www.gavialliance.org/in_partnership/vietnam

## Aid effectiveness in the health field: GAVI's role

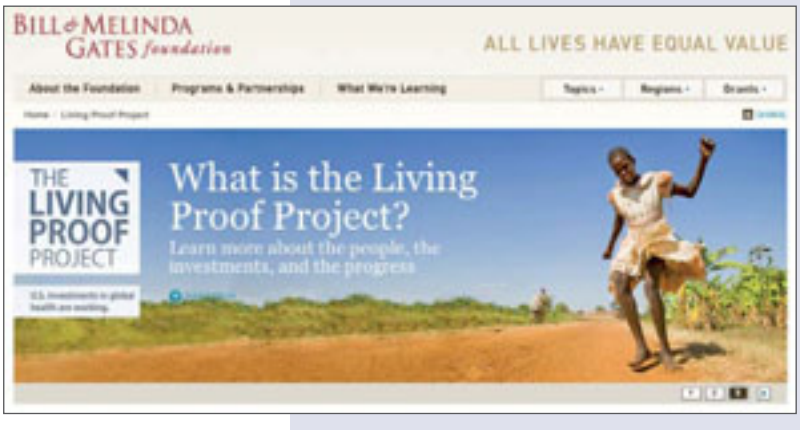
GAVI is committed to implementing the principles of the Paris Declaration on Aid Effectiveness to make development funding as effective as possible for developing countries. In recent OECD reports and in the Accra Agenda for Action, GAVI and other global programmes have been recognised as good models of harmonised and aligned support.

The Alliance uses country-based systems and works with partners with field presence to deliver its programmes, thus avoiding increased transaction costs for implementing countries. This also enables the Secretariat to keep its administrative costs low relative to the size of its operations.

In April 2009, Mali followed Mozambique, Ethiopia and Nepal as the fourth GAVI-supported country to sign a national compact for the International Health Partnership (IHP). The IHP, which GAVI helped to launch in 2007, brings together developing countries, donors, and leaders from major health agencies to improve coordination and support national health systems in some of the world's poorest countries. It aims to make health aid work better for poor countries by focusing on improving health systems as a whole, providing better coordination among donors, and developing and supporting countries' own health plans.

Following recommendations from the High Level Task Force for Innovative International Financing for Health Systems, GAVI, the Global Fund, the World Bank and the WHO are coordinating a platform for harmonised programme support for health system strengthening, an effort that will make the support more effective for implementing countries. GAVI is also looking at how internal processes could become better aligned with aid effectiveness principles.

GAVI started reporting fund flows directly to the OECD DAC Creditor Reporting System database (CRS) in 2009, thus increasing transparency around funding.




## Launch of the Living Proof Project

In September, the GAVI Alliance featured in a launch by the Bill & Melinda Gates Foundation of a public awareness campaign highlighting successes in improving health around the world.

A new website, www.livingproofproject.org and TV advertisements aired in Washington DC, cover success stories in global health.

**See also:**
www.gavialliance.org/performance/harmonisation

## Strengthening the voice of Pakistan's civil society

Pakistan counts 12,000 Civil Society Organisations (CSOs) and the private sector, including CSOs, provides a large proportion of community health care in the country. The CSOs work in communities where public sector facilities are not available. They have gained the trust of the people in remote and poor communities where the Government has not been able to provide care.

As a result of historically weak coordination between the Government and CSOs, the latter have not been able to generate more demand for health services. Only in emergency situations following natural disasters or displacement of refugees have the Government and CSOs worked together in the affected regions. However, until recently this model had not been replicated in the routine provision of health care.

With GAVI's CSO grant, which amounts to US$ 7.69 million for 2009–2010, this is changing. A new partnership between the Ministry of Health and civil society organisations was accomplished through activities such as joint workshops, and the formation of a national CSO Consortium which is intended to become a long-term network. The application process for GAVI's CSO support helped further to break down barriers between the Government and CSOs, as CSOs were actively participating from the outset for the first time.

The new partnership is manifesting itself in different aspects. The Ministry is asking for support from CSOs in other activities, including polio eradication campaigns and the development of "training of trainers" manuals. CSOs are now even participating in planning for public activities related to tuberculosis and hepatitis.

The Participatory Village Development Program (PVDP) is a non-profit organisation engaged in improving health among the poor communities of Tharparkar, the largest desert area of Pakistan. With GAVI CSO support, PVDP is working in Mirpurkhas, Islamkot and Nagarparkar in Sindh, a southern province of Pakistan, to ensure immunisation and reduce infant and maternal mortality. In the first phase of the project, PVDP found through a baseline survey, going from house to house, that not a single child was vaccinated in the cluster of villages of Seengaro and Virawah. The PVDP team immediately informed the district Health Department.

"In a six-day campaign, our staff helped the Government vaccinators in social mobilisation, data compilation and provision of deworming tablets to children. All children and women in their reproductive years could be vaccinated," says Dr Ramesh Kumar, a manager with PVDP.

The Health Foundation (THF) is a non-profit public service organisation with special focus on viral hepatitis. With GAVI support it works to increase immunisation coverage and strengthen the health system in selected areas of Karachi. THF had planned to vaccinate about 50,000 children between the ages of 5 and 15 who come from low-income groups, are deprived of basic health facilities or have missed routine vaccinations.

However, since Pakistan had introduced the pentavalent vaccine that includes hepatitis B in 2009, they were unable to attain monovalent hepatitis B vaccine. Through tight coordination with the public sector, THF managed to engage the Health Department of Sindh, which finally provided the CSO with the required number of vaccines from their own hepatitis control programme.

**See also:**
www.gavialliance.org/cso

## Social media: boosting support for the GAVI mission

In 2009, GAVI ventured further into the world of social media, both to support the day-to-day work of the GAVI Alliance and to help extend the community of advocates for GAVI's mission. At the Partners' Forum in Hanoi in November, GAVI piloted myGAVI, a password-protected online space for Alliance partners.

It is hoped that myGAVI will become a key meeting place for global health advocates, inside and outside of the Alliance, to share information and discuss new opportunities to further the cause of better access to life-saving vaccines.

During the year GAVI also strengthened its presence on websites such as Facebook, LinkedIn, Youtube and Twitter. All GAVI's external announcements, from press releases and media statements to video and images, are now posted on the GAVI Alliance Facebook page, as well as on the websites of partner organisations.

## Bringing the CSOs on board

**Joan Awunyo-Akaba**
**Executive Director, Future Generations International**
**Volta Regional Chairperson,**
**Ghana Coalition of NGOs in Health**

If you've ever held a baby in your arms, you know that there's nothing worse than him or her being sick and unable to articulate the pain. To see a child die, especially from a preventable disease, is heartbreaking. Not just for the mother and father, but for all of us. If babies could talk, I'm sure they would get up and demand vaccines.

There may be millions of children in the world, but every one of them is precious. We can't afford to lose a single one. That's why it's so tragic that there are still more than 24 million children who don't have access to basic immunisation. Many of them are in communities that are marginalised and difficult to access.

At the GAVI Alliance Partners' Forum in Vietnam in November, 49 members of southern and northern CSOs signed the Hanoi Call to Action. One of the things we urged the GAVI Alliance to do was to create a window for direct support to CSOs. This would enable civil society to step up and take on a more prominent role in reaching those millions of children. It would be a major breakthrough that other donor organisations and countries could follow.

Civil society has a vital role to play in many aspects of immunisation, especially at the community level. We have the necessary skills to educate, inform and engage communities. The umbrella organisation that I work with, the Ghana Coalition of NGOs in Health, has member organisations in the most difficult-to-reach parts of the country. If they were given the information and resources they need, they could create awareness and make way for the public sector health workers. Most of those who work for the organisations live in these communities themselves. Their views are respected and they can act as sounding boards and role models.

Another great concern that I have is for what I see as a forgotten group: adolescents. That's one of the reasons why promoting access to HPV vaccine is so important to me. Children and teenagers are becoming sexually active at an earlier age, and they need to be educated, protected and vaccinated against disease in order to grow up to become healthy adults. Again, CSOs have a key role to play.

I would like governments in all countries to be innovative and open enough to work in tandem with CSOs to get to those millions of unimmunised children and adolescents. Government and civil society are not enemies; we are partners in protecting the health of our people. To those who say that civil society is too weak in transparency and accountability to work with immunisation, I say: if you find weaknesses, help us build our skills so we can work together.

I want to call for a paradigm shift, and ask both governments and civil society to realise that we are partners in development. Let's try a new approach – let's bring the CSOs on board.

VIEWPOINT

**"In Afghanistan, 80 per cent of the money that we receive from GAVI goes to civil society organisations. By working with CSOs at the grassroots level, our work is owned by the people and sustained by the people."**[9]

***Dr Sayed Mohammad Amin Fatimie, Minister of Public Health, Afghanistan***

# annexes

# Annex 1: The GAVI Alliance governance structure

## 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 academic, finance and public health expertise
- The CEO of the GAVI Alliance (non-voting)

### Representative Board members (as at 31 December 2009)

The Board's representative members ensure that institutions and constituencies provide input into the development of GAVI's policies, and to the management of its operations.

#### Institutions

**UNICEF**
Saad Houry

**WHO**
Daisy Mafubelu*

**The World Bank**
Julian Schweitzer

**The Bill & Melinda Gates Foundation**
Jaime Sepulveda (Vice-Chair of the Board)**

#### Constituencies

**Developing country governments**

Armenia
Tatul Hakobyan

Ethiopia
Tedros Adhanom Ghebreyesus

Rwanda
Richard Sezibera

Vietnam
Trinh Quan Huan

Yemen
Abdulkarim Yehia Rasae

**Donor governments**

USA/Canada/Australia
Gloria Steele (USA)

United Kingdom/Norway/Ireland
Paul Fife (Norway)***

Italy/Spain
Fidel López Alvarez (Spain)****

France/Luxembourg/European Commission
Gustavo Gonzalez-Canali (France)

Netherlands/Sweden/Denmark
Anders Molin (Sweden)*****

**Research and technical health institutes**
John Clemens (International Vaccine Institute)

**Developing country vaccine industry**
Suresh Jadhav (Serum Institute India)

**Industrialised country vaccine industry**
Jean Stéphenne (GlaxoSmithKline Biologicals)

**Civil society organisations**
Faruque Ahmed (BRAC)

* Replaced Denis Aitken in November 2009.
** Replaced Denis Aitken as Vice-Chair in November 2009.
*** Replaced Gavin McGillivray (UK) in November 2009.
**** Replaced Alberto Mantovani (Italy) in November 2009.
***** Replaced Yoka Brandt (Netherlands) in November 2009.

### Unaffiliated Board members (as at 31 December 2009)*

Unaffiliated Board members are private individuals with no professional connection to GAVI's work. Thus, they are able to bring independent and balanced scrutiny to all of the Board's deliberations. These individuals also provide expertise in a number of critical areas such as investment, auditing, advocacy and fundraising.

Mary Robinson, Board Chair
Wayne Berson
Dwight Bush
Ashutosh Garg
Dagfinn Høybråten
Graça Machel
Jean-Louis Sarbib
George W. Wellde, Jr.

The CEO of the GAVI Secretariat, **Julian Lob-Levyt**, also serves on the Alliance Board in a non-voting seat.

Note: Unaffiliated Board member George Bickerstaff left the Board in November 2009.
*One seat was vacant by 31 December 2009.

**The GAVI Alliance Board is supported by six committees and one advisory committee:**

- **Executive Committee:** makes critical, time-sensitive decisions between Board meetings.
- **Audit/Finance Committee:** advises the Board in the areas of corporate accounting, reporting practices, and the quality and integrity of the financial reports.
- **Fundraising Committee:** advises the Board on all fundraising and resource mobilisation efforts.
- **Governance Committee:** ensures effective operations of GAVI's governance bodies, serving as nominating body for new Board members and overseeing the functioning of other committees.
- **Investment Committee:** advises the Board on investment policies and objectives, asset allocations and portfolio construction.
- **Programme/Policy Committee:** advises the Board on all GAVI programme areas and leads the development of new policies.
- **Evaluation Advisory Committee:** advises the Board on the oversight of GAVI's organisational and programmatic evaluation activities.

## Other GAVI Alliance-related governance structures

**The International Finance Facility for Immunisation (IFFIm) Company**
IFFIm securitises long-term donor pledges and provides frontloaded resources for GAVI programmes. It is a multilateral development institution established as a charity in England and Wales. The IFFIm Board, working with the IFFIm Treasury Manager, oversees bond issuances and develops funding, liquidity and other strategies to safeguard and maximise the value of IFFIm proceeds.

**The IFFIm Board members:**

Alan R. Gillespie, CBE (Chair)
Former Chairman
Ulster Bank Group

Sean Carney
Executive Director, Finance and Operations
The Children's Investment Fund Foundation

Didier Cherpitel
Former Chairman and Managing Director
JPMorgan

John Cummins
Group Treasurer
The Royal Bank of Scotland

Dayanath Chandrajith Jayasuriya
Senior Partner
Asian Pathfinder Legal Consultancy and Drafting Services

Arunma Oteh
Director-General
Securities and Exchange Commission of Nigeria

**The GAVI Fund Affiliate (GFA):**
Enters into pledge agreements with sovereign IFFIm donors and makes requests on behalf of the GAVI Alliance Board to the IFFIm Company for eventual programme disbursement. The GFA is registered in England and Wales as a company limited by guarantee. The GFA Board is comprised of experts in global health, investment, auditing and accounting.

**The GAVI Fund Affiliate Board members:**

Wayne Berson (Chair)
Partner and National Director of Not-for-Profit Services
BDO Seidman, 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
Chief Investment Officer
European Credit Management Ltd.

**See also:**
The GAVI Alliance: an innovative partnership that delivers results, p. 8
www.gavialliance.org/boardmembers

# Annex 2: Donor contributions and commitments

## as at 31 December 2009

### Government and EC contributions 2000–2026 (US$, in thousands)

| Donor | 1999-2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| Australia | | | | | | | 5,000 |
| Canada | | | 1,880 | 4,755 | 6,033 | 130,869 | 5,190 |
| Denmark[1] | | 1,147 | | | 3,339 | 3,416 | 4,411 |
| European Commission (EC)[2] | | | | 1,260 | | | |
| France[3] | | | | | 6,029 | | 12,630 |
| Germany | | | | | | | 5,260 |
| Ireland[4] | | | 511 | 624 | 650 | 831 | 7,902 |
| Italy | | | | | | | |
| Luxembourg | | | | | | 645 | 1,319 |
| The Netherlands | | 24,060 | 13,375 | 16,493 | 17,330 | 15,859 | |
| Norway[5] | | 17,895 | 21,326 | 21,791 | 40,925 | 39,535 | 64,979 |
| Russian Federation | | | | | | | |
| South Africa | | | | | | | |
| Spain[6] | | | | | | | |
| Sweden | | 1,892 | 1,115 | 2,385 | 4,931 | 12,663 | 14,594 |
| United Kingdom[7] | 4,463 | | 15,048 | 5,606 | 18,492 | 6,625 | 23,214 |
| United States of America | | 48,092 | 53,000 | 58,000 | 59,640 | 64,480 | 69,300 |
| **Subtotal** | **4,463** | **93,087** | **106,255** | **110,914** | **157,368** | **274,924** | **213,800** |

* Exchange rates as at 31 December 2009

### Private contributions and commitments 2000–2014 (US$, in thousands)

| Donor | 1999-2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| Bill & Melinda Gates Foundation[9] | 325,000 | 425,000 | | 3,500 | 5,000 | 154,338 | |
| La Caixa Foundation | | | | | | | |
| Other private | 20 | | 1,630 | 2,581 | 1,805 | 473 | 1,904 |
| **Subtotal** | **325,020** | **425,000** | **1,630** | **6,081** | **6,805** | **154,811** | **1,904** |

1–year agreement

2–to 3–year agreement

4–year or longer agreement

**Notes:**

1. The contributions from Denmark for 2008 and 2009 were both received in 2009.
2. The contributions from the European Commission are in the form of reimbursable grants that cover activities over more than one year.
3. The contribution from France for 2005 was received in 2006.
4. The remaining contribution from Ireland of €525,000 for 2006–2008 is expected in 2010.
5. In December 2005, Norwegian Prime Minister, Mr Stoltenberg pledged an annual contribution of NOK 500 million towards global immunisation efforts between 2006 and 2015.
6. The contribution from Spain for 2008–2009 was received in one installment in 2008.
7. The contribution from the UK for 2006–2008 was received in two installments in 2006 and 2007.
8. IFFIm commitments do not include additional amounts for health system strengthening.
9. The Bill & Melinda Gates Foundation made an initial five-year pledge of US$ 750 million and a pledge of US$ 75 million per annum from 2005 up to 2014.

## Commitments

Converted as at date of contribution

| 2007 | 2008 | 2009 | 2010* | 2011* | 2012* | IFFIm commitments 2006-26[8] | AMC commitments | Total government & EC contributions and commitments |
|---|---|---|---|---|---|---|---|---|
| 5,000 | 5,000 | 5,000 | | | | | | 20,000 |
| | | | | | | | 200,000 | 348,728 |
| 4,738 | | 9,098 | 4,815 | 4,815 | | | | 35,779 |
| 4,850 | 23,129 | 28,630 | | | 13,616 | | | 71,484 |
| | | | | | | 1,750,295 | | 1,768,954 |
| 5,948 | | 5,721 | | | | | | 16,930 |
| 8,311 | 3,841 | 3,540 | 752 | | | | | 26,963 |
| | | | | | | 602,039 | 635,000 | 1,237,039 |
| 812 | 1,423 | 1,191 | | | | | | 5,390 |
| 33,547 | 38,885 | 31,206 | 27,066 | | | 114,952 | | 332,774 |
| 86,157 | 65,449 | 82, 800 | | | | 27,000 | 50,000 | 517,857 |
| | | | | | | | 80,000 | 80,000 |
| | | | | | | 20,000 | | 20,000 |
| | 40,536 | | | | | 240,968 | | 281,504 |
| 15,515 | 19,152 | 13,801 | 6,955 | | | 37,900 | | 130,904 |
| 48,114 | | | | | | 2,594,538 | 485,000 | 3,201,100 |
| 69,300 | 71,913 | 75,000 | | | | | | 568,725 |
| **282,291** | **269,329** | **255,988** | **39, 588** | **4,815** | **13,616** | **5,387,692** | **1,450,000** | **8,664,131** |

| 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | AMC commitments | Total private donor contributions and commitments |
|---|---|---|---|---|---|---|---|---|---|
| 75,000 | 75,000 | 75,000 | 75,000 | 75,000 | 75,000 | 75,000 | 75,000 | 50,000 | 1,562,838 |
| | 6,021 | 5,857 | | | | | | | 11,878 |
| 1,335 | 517 | 1,011 | | | | | | | 11,278 |
| **76,335** | **81,538** | **81,868** | **75,000** | **75,000** | **75,000** | **75,000** | **75,000** | **50,000** | **1,585,994** |

# Annex 3: Board approvals for programme expenditure 2000–2009*

## as at 31 December 2009

| Country | Civil society organisations | Health system strengthening | Injection safety | Immunisation services | New and underused vaccines | Total (US$) |
|---|---|---|---|---|---|---|
| Afghanistan | 2,183,000 | 18,613,000 | 1,676,500 | 14,359,800 | 28,567,344 | 65,399,644 |
| Albania | | | 110,377 | 300,000 | 1,480,923 | 1,891,301 |
| Angola | | | 1,252,610 | 3,088,000 | 35,207,952 | 39,548,562 |
| Armenia | | 139,500 | 64,942 | 279,860 | 803,502 | 1,287,805 |
| Azerbaijan | | 582,000 | 151,040 | 849,380 | 1,007,832 | 2,590,252 |
| Bangladesh | | 7,243,500 | 6,144,414 | 24,727,200 | 76,475,311 | 114,590,426 |
| Benin | | | 358,664 | 282,500 | 25,044,063 | 25,685,227 |
| Bhutan | | 76,000 | 31,741 | 200,000 | 734,261 | 1,042,002 |
| Bolivia | | 1,046,000 | 873,500 | 387,500 | 5,015,183 | 7,322,183 |
| Bosnia and Herzegovina | | | 54,928 | 100,000 | 1,387,871 | 1,542,799 |
| Burkina Faso | | 4,313,000 | 931,560 | 8,485,640 | 36,392,098 | 50,122,298 |
| Burundi | | 6,732,000 | 390,294 | 2,758,500 | 24,193,863 | 34,074,656 |
| Cambodia | | 3,697,000 | 587,653 | 1,709,200 | 9,316,123 | 15,309,976 |
| Cameroon | | 5,737,500 | 992,844 | 7,794,620 | 22,203,847 | 36,728,811 |
| Central African Republic | | 2,484,000 | 119,651 | 1,911,360 | 3,555,033 | 8,070,044 |
| Chad | | 2,305,000 | 443,812 | 2,862,000 | 8,316,944 | 13,927,756 |
| China | | | 15,926,581 | 800,000 | 21,952,552 | 38,679,133 |
| Comoros | | | 42,322 | 260,000 | 443,053 | 745,375 |
| Congo | | | 224,534 | 1,965,000 | 5,137,080 | 7,326,614 |
| Democratic Republic of the Congo | 5,319,000 | 49,240,000 | 2,713,931 | 27,621,280 | 71,236,221 | 156,130,432 |
| Côte d'Ivoire | | 3,117,997 | 1,609,500 | 4,108,000 | 22,643,482 | 31,478,979 |
| Cuba | | 849,500 | 360,000 | | | 1,209,500 |
| Djibouti | | | 33,900 | 212,800 | 653,066 | 899,766 |
| Eritrea | | 1,348,000 | 148,029 | 636,540 | 4,631,805 | 6,764,373 |
| Ethiopia | 1,983,500 | 76,493,935 | 2,696,697 | 20,609,820 | 107,727,100 | 209,511,052 |
| Gambia | | | 101,184 | 1,251,550 | 7,032,727 | 8,385,461 |
| Georgia | | 311,000 | 61,451 | 335,500 | 420,629 | 1,128,580 |
| Ghana | | 4,650,750 | 855,300 | 4,017,800 | 68,908,105 | 78,431,955 |
| Guinea | | | 347,460 | 3,139,400 | 8,308,166 | 11,795,026 |
| Guinea-Bissau | | 601,500 | 115,787 | 700,360 | 1,196,304 | 2,613,950 |
| Guyana | | | | 434,800 | 1,254,748 | 1,689,548 |
| Haiti | | | 397,500 | 1,256,000 | | 1,653,500 |
| Honduras | | 1,109,250 | 457,000 | 588,285 | 3,972,500 | 6,127,035 |
| India | | | 18,427,489 | 1,200,000 | 33,215,782 | 52,843,271 |
| Indonesia | 3,900,500 | 24,827,500 | 9,856,844 | 14,134,000 | 17,511,000 | 70,229,844 |
| Kenya | | 9,903,000 | 1,129,963 | 6,225,180 | 112,840,422 | 130,098,564 |
| Kiribati | | | | 100,000 | 38,998 | 138,998 |
| Democratic People's Republic of Korea | | 1,758,500 | 743,726 | 2,450,471 | 7,403,442 | 12,356,140 |
| Kyrgyzstan | | 935,000 | 189,168 | 510,000 | 2,450,377 | 4,084,544 |
| Lao People's Democratic Republic | | | 255,505 | 1,631,200 | 5,780,249 | 7,666,955 |
| Lesotho | | | 106,633 | 415,600 | 1,288,719 | 1,810,952 |
| Liberia | | 3,067,500 | 360,500 | 2,388,750 | 4,709,038 | 10,525,788 |
| Madagascar | | 2,515,500 | 670,422 | 3,540,000 | 26,768,197 | 33,494,118 |
| Malawi | | 3,641,000 | 726,834 | 2,086,000 | 58,142,514 | 64,596,347 |
| Mali | | 2,918,000 | 666,222 | 5,654,060 | 26,068,607 | 35,306,889 |
| Mauritania | | | 205,000 | 588,000 | 2,529,309 | 3,322,309 |
| Republic of Moldova | | | 87,000 | 200,000 | 1,291,106 | 1,578,106 |
| Mongolia | | | 113,427 | 161,000 | 2,395,723 | 2,670,150 |
| Mozambique | | | 835,881 | 1,312,500 | 28,074,320 | 30,222,701 |
| Myanmar | | 10,302,500 | 2,083,978 | 5,892,080 | 14,649,190 | 32,927,748 |
| Nepal | | 8,667,000 | 1,151,893 | 3,679,020 | 22,278,365 | 35,776,279 |

| Country | Civil society organisations | Health system strengthening | Injection safety | Immunisation services | New and underused vaccines | Total (US$) |
|---|---|---|---|---|---|---|
| Nicaragua | | 690,000 | 462,500 | 548,410 | 1,420,000 | 3,120,910 |
| Niger | | | 943,757 | 10,015,600 | 12,661,924 | 23,621,281 |
| Nigeria | | 22,098,500 | 9,533,500 | 47,424,000 | 21,123,849 | 100,179,850 |
| Pakistan | 3,038,000 | 23,525,000 | 7,405,082 | 43,945,500 | 161,414,558 | 239,328,140 |
| Papua New Guinea | | | | 634,000 | 5,793,123 | 6,427,123 |
| Rwanda | | 5,605,000 | 369,500 | 3,598,350 | 36,177,765 | 45,750,615 |
| Sâo Tomé and Principe | | | 21,656 | 260,000 | 124,332 | 405,989 |
| Senegal | | 2,480,500 | 619,474 | 2,705,740 | 23,279,180 | 29,084,894 |
| Sierra Leone | | 1,684,750 | 272,660 | 2,164,440 | 8,812,710 | 12,934,561 |
| Solomon Islands | | | | 100,000 | 308,736 | 408,736 |
| Somalia | | | 210,140 | 1,218,000 | | 1,428,140 |
| Sri Lanka | | 1,900,000 | 709,749 | 200,000 | 8,517,000 | 11,326,749 |
| Sudan | | 8,837,000 | 1,492,752 | 13,678,580 | 31,648,571 | 55,656,902 |
| Tajikistan | | 980,500 | 348,745 | 1,434,500 | 4,642,528 | 7,406,273 |
| United Republic of Tanzania | | | 1,016,452 | 9,182,380 | 47,224,966 | 57,423,798 |
| Togo | | | 317,617 | 2,773,400 | 5,471,145 | 8,562,162 |
| Turkmenistan | | | 155,043 | 100,000 | 978,617 | 1,233,659 |
| Uganda | | 4,521,500 | 1,207,299 | 6,681,000 | 103,783,260 | 116,193,059 |
| Ukraine | | | 739,456 | 100,000 | 3,042,858 | 3,882,314 |
| Uzbekistan | | | 727,012 | 259,500 | 11,426,877 | 12,413,389 |
| Vietnam | | 12,098,500 | 3,226,000 | 1,714,000 | 12,646,718 | 29,685,218 |
| Yemen | | 4,762,000 | 1,194,757 | 4,297,500 | 35,481,980 | 45,736,237 |
| Zambia | | 2,917,500 | 689,237 | 3,964,060 | 37,701,487 | 45,272,284 |
| Zimbabwe | | | 948,925 | 1,362,906 | 9,782,283 | 12,094,115 |
| **Total US$** | **16,424,000** | **351,326,682** | **110,497,505** | **348,562,423** | **1,556,119,510** | **2,382,930,120** |

*Source: 22*

* Actual disbursements may occur at a later stage.
Note 1: GAVI Phase I (2000 - 2006) Approval values have been adjusted to the final actual disbursement values.
Note 2: A US$ 1.2 million envelope for CSO Type A support was approved in 2008. This is not included in the table.

# Annex 4: Sources and references

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1. Source: These estimates and projections are produced by the WHO Department of Immunization, Vaccines and Biologicals, based on the most up to date data and models available as of January 2010;
   For yellow fever figure: Global Alert and Response and Department of Immunization, Vaccines and Biologicals, WHO;
   For polio figure: Polio Eradication Initiative, WHO.
2. Source: WHO-UNICEF coverage estimates for 1980–2008, as of July 2009; WHO ICE- T coverage projections for 2009–2010, as of September 2009; World Population Prospects, the 2008 revision. New York, United Nations, 2009; (surviving infants).
3. GAVI Alliance, 2010
4. GAVI Alliance, 2010

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5. GAVI Alliance, 2010
6. World Bank, November 2009
7. UNICEF Supply Division, 2009
8. UNICEF Supply Division, 2010

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9. GAVI Alliance, 2010

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10. GAVI Alliance, 2010
11. GAVI Alliance, 2010
12. GAVI Alliance, 2010
13. GAVI Alliance, 2010
14. GAVI Alliance, 2010

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15. Source: GAVI Secretariat calculations based on World Health Statistics 2009

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16. Source: WHO, Estimated Hib and pneumococcal deaths for children under 5 years of age
17. Source: WHO, Estimated rotavirus deaths for children under 5 years of age

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18. Source: WHO, Vaccine introduction database

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19. GAVI Alliance, 2010

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20. UNICEF Supply Division, CDC Vaccine Price List
    www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm

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21. GAVI Alliance, 2010

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22. GAVI Alliance, 2010


**a.** Madchi SA, Petersen K, Madhi A, Wasas A, Klugman KP. Impact of human immunodeficiency virus type 1 on the disease spectrum of Streptococcus pneumonia in South African children. Pediatr Infect Dis J. 2000 Dec, 19(12): 1141-1147.

**b.** French N, Gordon S, Mwalukomo T, White S, Mwfulirwa G, Longwe H, Mwaiponya M, Zijlstra E, Molyneux M, Gilks C. A Trial of a 7-Valent Pneumococcal Conjugate Vaccine in HIVinfected Adults. N Engl J Med. 2010; 362:812-22.

**c.** Hinman, A. Immunization, Equity, and Human Rights. American Journal of Preventive Medicine. 2004; 26 (1), 87.

**d.** Mwakyusa, D (2010, Jan). Replicating the GAVI Success Story. Public session at the World Economic Forum, Davos, Switzerland.

**e.** The Taskforce on Innovative International Financing for Health Systems (2009: Sept 23). Leaders commit new finance to tackle women's and children's health in the developing world. Press release, available on www.internationalhealthpartnership.net/en/news/display/leaders_commit_new_finance_to_ta

**f.** Morgan, L. The Financial Crisis and Global Health. Global Health Magazine. 2009; Jan 30. Available on www.cgdev.org/content/article/detail/1423473

**g.** Amin Fatimie, SM. Report from GAVI Alliance Civil Society Meeting in Hanoi, Vietnam. 2009, Nov 21. Vietnam. Available on www.gavialliance.org/resources/Report_on_GAVI_CSO_Day_21_Hanoi.pdf

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# Abbreviations

| | |
|---|---|
| AMC | Advance Market Commitment |
| AVI | Accelerated Vaccine Introduction initiative |
| CSO | civil society organisation |
| DTP3 | three doses of the diphtheria-tetanus-pertussis vaccine |
| Hib | *Haemophilus influenzae* type b |
| HPV | human papillomavirus |
| HSS | health system strengthening |
| IFFIm | International Finance Facility for Immunisation |
| IHP | International Health Partnership |
| IRC | Independent Review Committee |
| ISS | immunisation services support |
| MDGs | Millennium Development Goals |
| NT | neonatal tetanus |
| NVS | new and underused vaccine support |
| OECD | Organisation for Economic Co-operation and Development |
| TAP | Transparency and Accountability Policy |
| UNICEF | United Nations Children's Fund |
| WHO | World Health Organization |



**Note**
The 2009 GAVI audited, consolidated accounts will be available on the GAVI website in or before October, 2010:

**www.gavialliance.org**

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