GAVI Alliance Progress Report 2005



GAVI ALLIANCE

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Message from the Chairs of the GAVI Alliance Board and GAVI Fund Board

The GAVI Alliance is a public-private partnership focused on increasing children's access to life-saving vaccines. The foundation of GAVI's work is that all children – no matter where they live – deserve a healthy start.

More than 10 million children under five die each year, mainly from preventable causes. An estimated 25 percent of these deaths could be avoided through immunisation with existing and newly developed vaccines such as pneumococcal and rotavirus. Yet, even existing vaccines – vaccines that save lives and cost little – vaccines that parents in industrialised countries take for granted – do not reach millions of children in developing countries. When new vaccines are created, children in those countries are forced to wait a decade or more to benefit. Through the continued work of the GAVI Alliance, this situation can change.

The year 2005 was one of extraordinary attention to the plight of the poorest countries in the world, particularly those in Africa. The international community raised the hopes of millions by declaring that it intended to make poverty history. A major stride forward was taken when some of the richest countries, along with GAVI partners, announced their intention to tackle one of the most glaring manifestations of poverty in an affluent world: vaccine-preventable child mortality.

In 2005, groundbreaking funding commitments were made by six governments – France, Italy, Norway, Spain, Sweden and the United Kingdom – to the International Finance Facility for Immunisation (IFFIm). Their leadership and commitment helped ensure that an innovative aid mechanism like IFFIm came to fruition. In 2006, Brazil and South Africa joined the countries supporting the IFFIm. GAVI and the more than 70 of the poorest countries eligible for its support will make effective use of these funds, beginning in 2006 with programmes to support polio eradication, and immunise against measles, yellow fever and maternal and neo-natal tetanus.

The additional funds now committed to accelerate the delivery of new and underused vaccines underscore GAVI's initial success. However, the true measure of our work ahead will be meeting the Millennium Development Goals by 2015.

The year reviewed in this report illustrates how GAVI, a unique partnership, has been able to build on a collective vision of a world where children have access to life saving vaccines, and how the partnership began to tackle a major barrier to children's health: lack of access to technology. We are proud of the results reported here, which have been achieved in some of the poorest countries in the world.

It is our honour to serve the GAVI Alliance as Board Chairs, and offer our gratitude to all the partners, to our Boards and to the Secretariat for their unceasing commitment.

Ann M. Veneman
Chair of the GAVI Alliance Board

Graça Machel
Chair of the GAVI Fund Board

Introduction by Julian Lob-Levyt, Executive Secretary of the GAVI Alliance and CEO of the GAVI Fund

2005 was a pivotal year for the GAVI Alliance. Building on the lessons and significant achievements of the first five years of the partnership, Phase 2 was launched in December with the Boards of the GAVI Alliance and GAVI Fund meeting together for the first time following a convergence into one Alliance and one Secretariat. Now a stronger, more cohesive entity, the Alliance is poised to meet future challenges as we scale up our efforts under the framework of the Global Immunisation Vision and Strategy and the ambition of the Millennium Development Goals.

Along with partners in the global health community, GAVI was a part of the collective demand for change which resulted in the historic decision at the 2005 G8 Summit in Gleneagles to increase global development aid by US$50 billion a year by 2010, with a doubling of aid for Africa.

Realisation of this and other promises to the poorest countries over the next ten years will take continued bold leadership and vision of a world without extreme poverty. The success of the Alliance will be determined by this broader context – as a partnership we will hold ourselves and others accountable for delivery.

GAVI's core mission is and will remain getting new and underused vaccines to the poorest countries. In the first five years of GAVI, 15 million more children were reached with basic vaccines, 99 million more children were reached with new vaccines and 1.2 billion auto-disable syringes were delivered. These remarkable results show that GAVI has succeeded as a catalyst for accelerating progress in global health. It has also become a driver for innovation—in financing, technology and in how the public and private sector can work in partnership to drive performance and results.

At both the global and country level, we have been actively engaged on how GAVI and other development partners can coordinate efforts and finance around country plans to rapidly scale up service delivery. Scaling up comprehensive health services is entirely feasible and remains the common underlying platform required to underpin the numerous separate health initiatives currently underway. In opening its new health systems window, GAVI has both the opportunity and responsibility to ensure that our work in this area is properly coordinated within a broader effort to get behind country-led plans. New policies broadening the applicability of GAVI support to country needs will facilitate the accelerated introduction of new vaccines—and will also help countries build up the enabling environment critical to the success and sustainability of GAVI's mission.

GAVI's 2005 Progress Report shows we are on the right track. By the end of 2005, all but two of the GAVI- eligible countries had been approved for support—97% of our programme coverage target. The results that GAVI-supported countries have achieved—together with Alliance partners—provide additional incentive to pick up the pace over the next ten years. Importantly, GAVI-supported countries have been directive in terms of where we can do better to coordinate efforts and increase the flexibility of GAVI support so they can take advantage of the added value which GAVI brings.

Our challenge for the future, as our funding base expands and as we begin to support health system strengthening, will be to sustain our results based approach and to prepare the ground for the introduction of an exciting new range of vaccines to tackle major diseases. GAVI will continue to lead efforts to harmonise our programmes with those of others and the broader development effort and community.

In closing, I would like to first thank our Board members for their support and commitment. I also wish to pay personal tribute to all the Secretariat staff in Geneva and Washington. The dedication and hard work of these women and men has been remarkable. In particular the Secretariat has been resilient as we have adapted our structure, systems and procedures to become increasingly "fit for purpose".

Julian Lob-Levyt,
Executive Secretary, GAVI Alliance and CEO, GAVI Fund

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2005: Taking Stock

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all but two of the GAVI-eligible countries had been approved for support - 97% of our programme coverage target.

GAVI Achievements

The year 2005 proved to be a pivotal year for the GAVI Alliance. It saw renewed commitments from all the partners to continue to support and extend GAVI's mission to reduce inequities in health and to improve access to new and underused vaccines, as well as to speed up the introduction of priority new vaccines in low-income countries.

New and additional pledges by the Bill & Melinda Gates Foundation, Canada and Norway among others increased GAVI's resources. Further commitments by France, Italy, Spain, the UK, Sweden and Norway were secured through new innovative financing particularly through the International Finance Facility for Immunisation (IFFIm) which was announced in September 2005 (Brazil and South Africa have also committed to join the IFFIm in 2006). Based on market mechanisms, the central aim of the IFFIm is to save more children's lives and to do so faster, in order to support the achievement of the Millennium Development Goals. By investing the majority of resources up front - "frontloading" - this innovative funding programme will increase significantly the flow of aid to ensure reliable and predictable funding flows for immunisation programmes and health systems development during the years up to 2015. An anticipated IFFIm investment of US$4 billion is expected to prevent five million child deaths between 2006 and 2015, and more than five million future adult deaths. To complement the IFFIm's impact, initial work was also started in 2005, on other innovative financing mechanisms such as the Advance Market Commitments or International Development Association (IDA) buy downs.

In six years, the Alliance has also raised almost US$3.3 billion in traditional funding from governments and private sources, US$1.7 billion of it actually received. US$1.6 billion has been committed. With a total of US$775.5 million disbursed by December 2005.

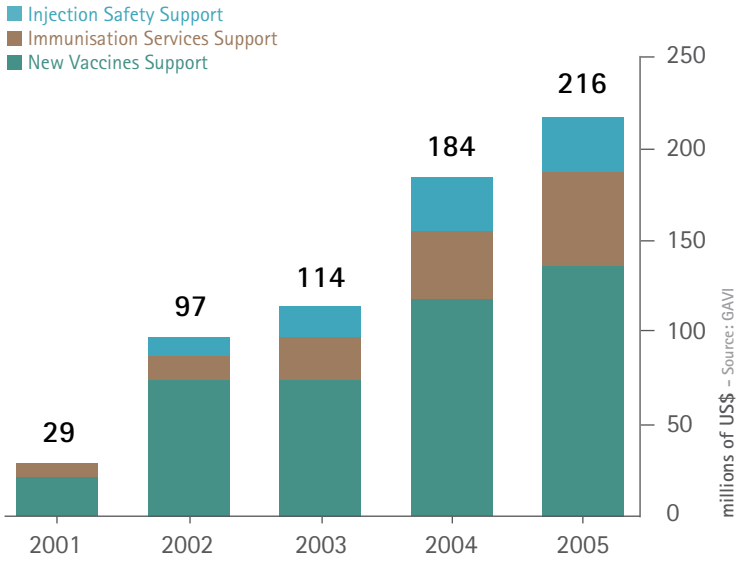
The year 2005 also proved to be a time for strengthened ties with the GAVI partners. The Global Immunisation Vision and Strategy (GIVS) provides a renewed focus for GAVI and its partners as the first ever strategic framework on immunisation to present a vast range of approaches from which countries may select those most suited to their needs. A strategic country consultation process was also put in place to ensure that GAVI increased dialogue with partner countries. This process culminated in the New Delhi Partners' meeting in December.

From the organisational standpoint, the convergence of the Vaccine Fund team with the GAVI secretariat ensured greater alignment between programme funding and the support GAVI and the partners are providing to countries to implement their immunisation programmes.

Of 75 countries eligible for GAVI support, 73 have been approved for disbursement, 70 have actually received support. The funding provided has gone to:

- introduce new and underused vaccines (hepatitis B, *Haemophilus influenza* type b, and yellow fever);
- strengthen immunisation and healthcare delivery systems;
- ensure the safety of immunisation;
- boost coverage with established vaccines against diphtheria, tetanus, pertussis, tuberculosis, measles and polio;
- speed up the development of priority new vaccines for developing countries (for example against rotavirus, pneumococcal disease and meningitis types A and C) and ensure affordable access to them.

GAVI Support Received By Countries



Country Highlights

Niger

In the past couple of years Niger has been facing persistent low immunisation coverage, with a DTP3 coverage of 31% in 2001. In 2005, with support from the World Health Organization (WHO) and UNICEF, the country accelerated plans to Reach Every District (RED). A full reorganisation was therefore initiated, facilitated by additional favourable factors including high level political commitment, integration of Vitamin A distribution in routine immunisation, and strong coordination from EPI partners. Because of the scattered, nomadic population, more mobile and outreach teams were sent out to vaccinate unimmunised children. 67% of children were immunised through mobile and outreach teams. The estimated administrative coverage for 2005 is 89%.

Yemen

In 2000 Yemen DTP3/OPV3 coverage was already up to 86% before dropping down to 66% in 2003. The microplans Reach Every District approach was developed to counter fragile global health services coverage, especially in rural areas. In 2005, DTP3/OPV3 coverage was back up to 86.7%. Yemen has presented a plan for gradually phasing out GAVI support for the pentavalent vaccine starting with a 10% planned payment from 2006.

GAVI SUPPORT RECEIVED BY COUNTRIES

In its first six years GAVI has helped to achieve a significant increase in the number of children worldwide with access to immunisation. By the end of 2005 the Alliance's support had ensured that:

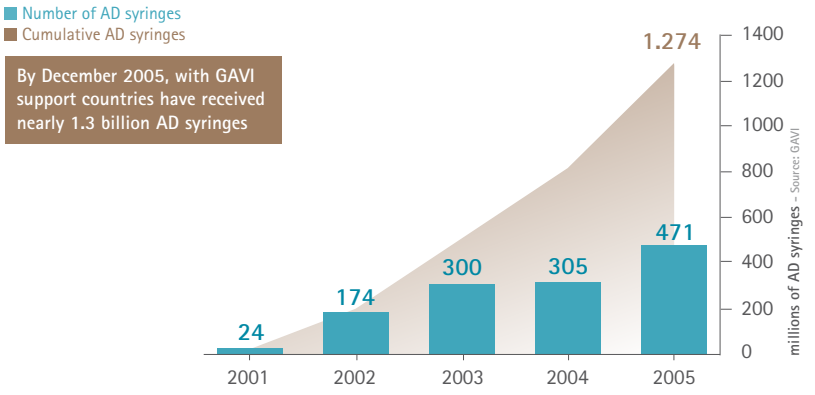
- about 15 million more children were protected with existing vaccines against diphtheria, tetanus and pertussis; *
- about 90 million more were immunised against hepatitis B; *
- about 14 million more were immunised against Hib, and the same number against yellow fever; *
- more than 1.2 billion single-use syringes were distributed to ensure safe vaccinations, eliminating the risk of HIV and other infections (hepatitis B, hepatitis C) from dirty needles.

More than 1.7 million future deaths are estimated to have been prevented through GAVI's support by the end of 2005, some of them in childhood and others in the productive adult years. Spending on vaccines in the 70 poorest countries supported by GAVI more than doubled from US$2.50 to more than US$5 per child between 2000 and 2005. On average one-third of their immunisation costs are financed by the poorest countries themselves.

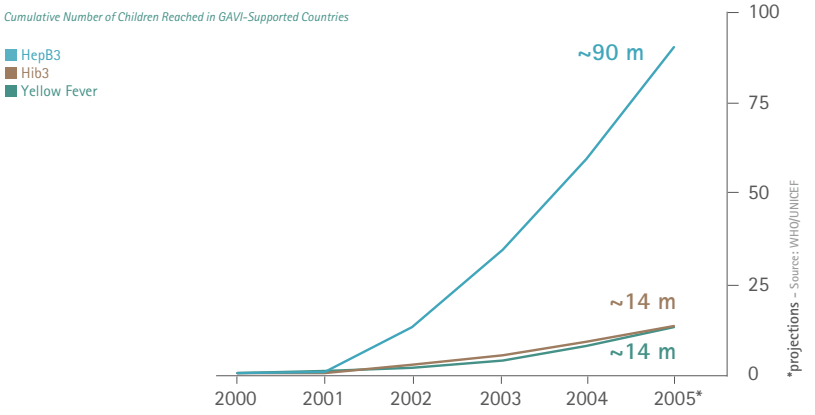
Even in so-called "fragile states," coverage increased substantially as a result of increased political will and partners' engagement.

* Estimates to end 2004, projections for 2005

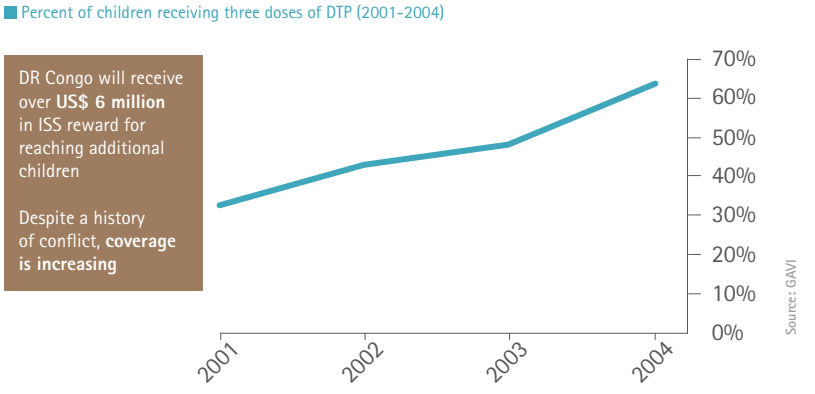
Number of Auto-Disable (AD) syringes (in millions) received by countries



Results: Reaching More Children



Results: Democratic Republic of Congo



Programme Funding

The GAVI Alliance maximises the impact of its resources by targeting the countries in greatest need, directing more help to countries with lower immunisation rates and high numbers of unvaccinated children. All GAVI eligible countries can apply for additional funding to build their health capacity and improve their immunisation services. All countries are given flexibility in deciding how best to use this funding to increase immunisation rates. After an initial investment phase future funding depends on the countries meeting their goals and showing results.

Other GAVI support is decided by the capacity of the countries to absorb it. For example, while all eligible countries can apply for yellow fever vaccines and injection safety equipment, a country's immunisation coverage must be higher than 50% before it can qualify to receive hepatitis B and Hib vaccines.

GAVI makes sure its resources are predictable: it promises support to countries only if there is enough money in the Fund to pay out a full five-year commitment, or a strong probability that the funding will be available. But it is not designed to provide unlimited funding into an indefinite future. After five years of support countries are expected to replace the Fund's contribution with new sources of finance.

What GAVI has shown itself uniquely able to do is to harness the strengths and experience of a range of partners. It focuses on those areas where no partner can work effectively alone, and on adding value to what they are doing already.

Vaccines/supplies	US$490.00 m
Accelerated Development of Priority New Vaccines (ADIPs)	US$32.10 m
Yellow fever vaccine stockpile	US$15.80 m
Immunisation safety	US$91.20 m
Immunisation services support	US$124.50 m
Introduction of new vaccines	US$6.90 m
Africa Measles Campaign	US$12.50 m
Hib Initiative	US$2.40 m

By December 2005 GAVI had committed a total of more than US$1.6 billion over five years. By the end of 2005 it had disbursed a total of US$775,5 million.

Donor Contributions and Pledges to GAVI by End of 2005

Millions of US$ (unaudited)	Total Received	Total Pledged
Canada	US$143.55m	US$158.94m
Denmark	US$7.79m	US$7.79m
European Union	US$4.92m	US$4.92m
France	US$12.06m	US$18.09m
Ireland	US$2.63m	US$2.63m
Luxembourg	US$1.00m	US$1.40m
Netherlands	US$87.06m	US$125.86m
Norway	US$142.93m	US$892.93m
Sweden	US$26.52m	US$26.52m
United Kingdom	US$73.76m	US$117.61m
United States	US$283.21m	US$353.21m
Bill & Melinda Gates Foundation	US$908.50m	US$1,508.50m
Other Private	US$4.23m	US$4.23m
Total Contributions	**US$1,698.16m**	**US$3,222.63m**

In the countries receiving funding to help to strengthen immunisation services, by the end of 2004 an extra 8.6 million children had been immunised with DTP3, a figure expected to have risen to 14.8 million by December 2005.

Of the countries approved for funding for hepatitis B vaccine, 31 (57%) are now using combination vaccines, which avoid increasing the number of immunisation injections needed during the first year of life.

DTP-HepB combination	14
DTP-Hib combination	1
DTP-HepB-Hib combination	17
monovalent hepatitis B	23
yellow fever	15
immunisation services support	53
immunisation safety	69

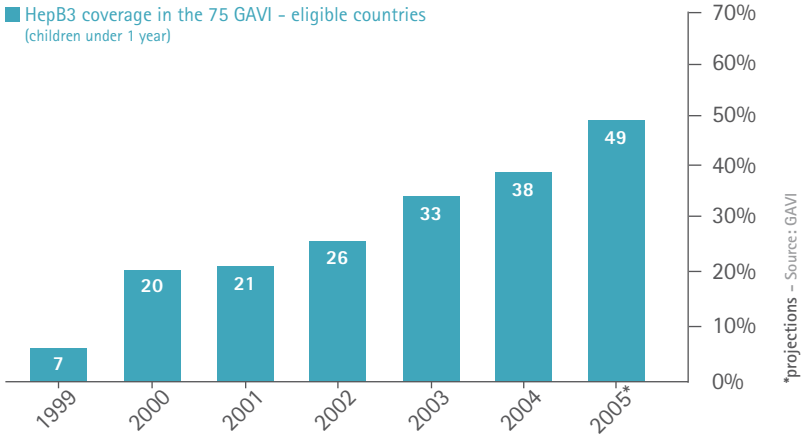
By December 2005, 73 of the 75 countries eligible for GAVI support had applied, and all had at least one type of support approved.

Sustainability is becoming a reality and not just a goal. All 15 countries where GAVI support for injection safety has now ended have already found funding for continued support. Of the 9 countries which indicated previously that they would provide co-financing during phasing out of GAVI support for 2005, 4 have provided funds to UNICEF for purchase of vaccines. Accountability is a high priority, too. So far 31 countries have successfully undergone an external data quality audit (DQA) to verify the accuracy and completeness of their administrative reporting system.

To continue to increase access to life-saving vaccines for all children additional funding is needed. And in order to reach the MDGs, a significant increase in development assistance to the poorest countries is required, as is a shift in the way that assistance is delivered. GAVI and its donors are pioneering innovative financing mechanisms to bridge the gap between the available resources and the real needs.

2005 also saw great innovation in funding with the official launch in London of the International Finance Facility for Immunisation.

Results: Hepatitis B



China's Success Story

Hepatitis B is one of China's urgent infectious disease problems. 120 million Chinese persons are hepatitis B virus (HBV) carriers, at risk of developing liver cancer and of spreading the disease to others. This makes liver cancer the second most common cause of cancer death in China. In 2002, a project aiming at making HepB vaccines available in China was launched, targeting China's poorest child population - approximately 6.5 million children. Financing sources for this program were evenly coming from GAVI and from the China central government. As a result, HepB national vaccine coverage has risen from 60% in 1999, to almost 84% in 2005 (source: WHO). The China-GAVI project has helped catalyze the inclusion of HepB vaccine in China Extended Program on Immunization (EPI). Limited GAVI funding has leveraged strong national support and major policy changes that assure sustainability of success. China is committed to provide HepB vaccines at no cost after GAVI's 5 year funding plan, providing the assurance of future funding of HepB vaccination for all infants in China.

THE INTERNATIONAL FINANCE FACILITY FOR IMMUNISATION (IFFIm)

The IFFIm is a new international development financing institution that is supported by sovereign donors (currently the governments of France, Italy, Norway, Spain, Sweden and the United Kingdom) which will fund the GAVI Alliance programmes. Brazil and South Africa have also decided they will support the IFFIm. IFFIm will have a financial base comprised of legally-binding payment obligations from sovereign donors. It will borrow operating funds in the international capital markets over the next 10 years, up to a prudently limited proportion of the sovereign obligations making up its financial base (gearing ratio). Given the strength of its backing from largely triple-A-rated sovereigns, and its conservative financial policies, IFFIm has been rated triple-A by credit rating agencies.

An expected IFFIm investment of US$4 billion is likely to prevent five million child deaths between 2005 and 2015, and more than five million future adult deaths. This is in addition to the estimated 1.5 million lives that will be saved if investments in the GAVI Alliance continue at their current level.

IFFIm resources will have a substantial and immediate impact in two key areas: supporting new and underused vaccines, and strengthening health systems and immunisation systems. Health systems strengthening and immunisation are inextricably linked. There is a clear justification for frontloading resources to accelerate vaccine development and availability, but substantial funding to support health systems is also needed to expand access to traditional vaccines and manage and deliver new ones, such as vaccines against rotavirus and meningococcus.

Strengthening immunisation services and scaling up coverage of immunisation in the poorest countries, will also require substantial investments in the health systems that deliver vaccines. However constraints that affect immunisation delivery often affect other essential health interventions as well. By keeping IFFIm resources flexible, countries will be able to use them to alleviate these system-wide barriers and possibly lead to a more comprehensive provision of health services across the board. Funding will be based on need and absorptive capacity. Countries with lower DTP3 coverage, high numbers of unvaccinated children and large internal disparities (i.e., between states) will receive more resources. Smaller investments will be made in better-performing countries, recognising that lower income countries still need additional resources to maintain achievements and further improve the quality of immunisation services.

In fact, 84% of the world's unimmunised children are born in the GAVI eligible countries that qualify for IFFIm support.

To drive mortality down quickly from highly infectious vaccine-preventable diseases such as measles and tetanus, supplementary immunisation activities, often referred to as immunisation campaigns, will be funded in the countries where the need is greatest. These mass campaigns will be designed and implemented with the additional goal of strengthening routine health and immunisation services. So the gains made through these campaigns will be maintained and strengthened. As expenditure for campaigns is once-only or uneven in nature, and the need for the campaigns is reduced over time, they are ideally suited to a front-loaded financing mechanism. In addition, the health benefits derived from campaigns occur within a very short time period and can cover a larger population than routine, on-demand services. After year one, normal GAVI application process initiated by countries will kick in.

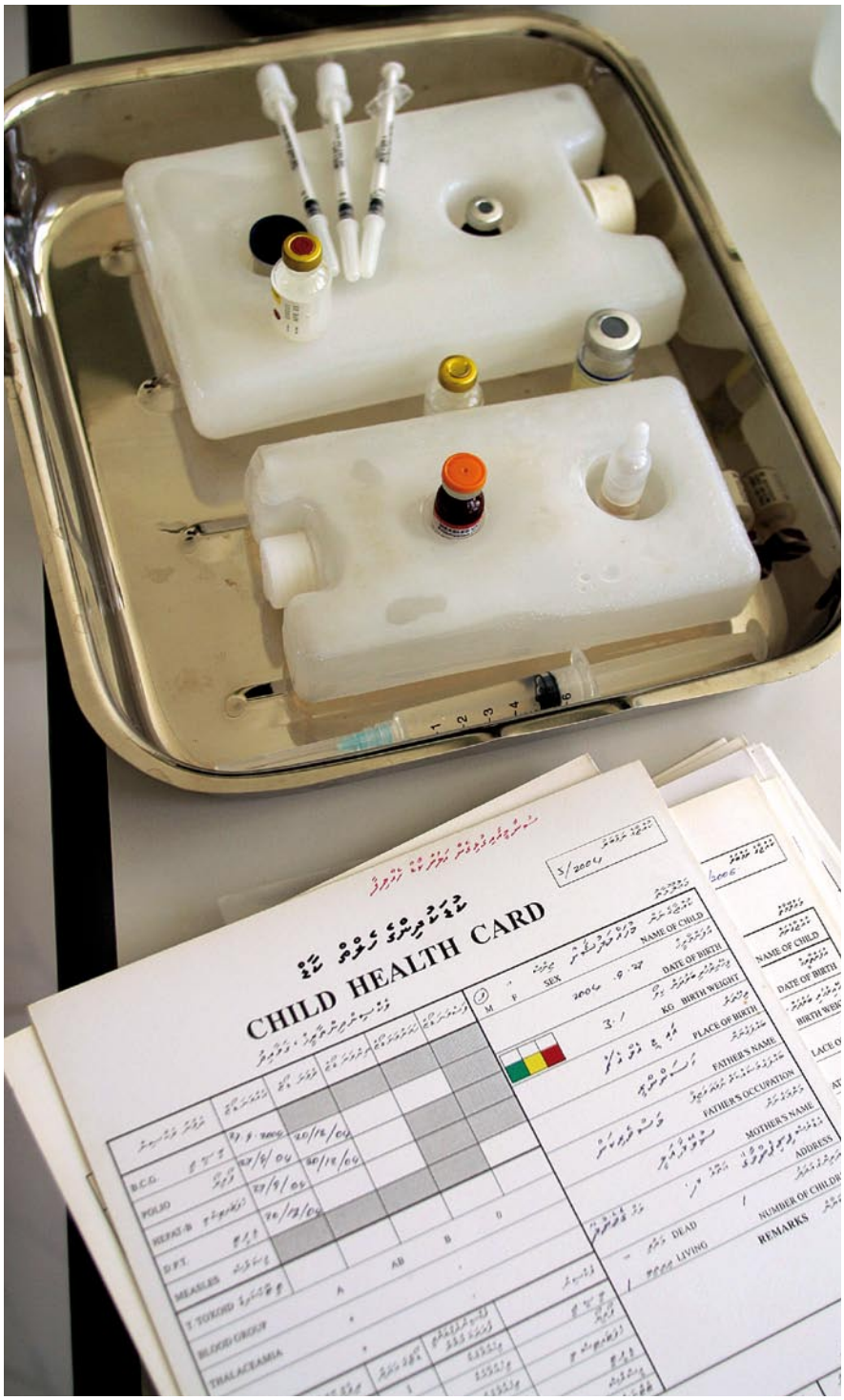
Once the world is declared polio-free, a stockpile of oral polio vaccine (OPV) will be required to protect against any future recurrence. This vaccine must be produced very quickly in the narrow window of opportunity between the interruption of transmission and OPV cessation. The stockpile will serve as an insurance policy against a polio outbreak after the eradication of the wild polio virus.

The IFFIm funds - which will be disbursed through existing mechanisms - will provide partner countries with predictable, stable and coordinated aid flows to finance the investments needed to reduce poverty. The best measure of need is determined at a national level by countries themselves. Once the allocation policies have been defined, each eligible country will have the opportunity to request funding based on its own analysis of needs. This support will build on countries' existing multi-year plans and complement existing resources.

The IFFIm characteristics of predictable, stable and significant resources provide an excellent way to overcome the problems of unpredictable, uncommitted and

short-term flows that have constrained immunisation financing in the past. In addition, immunisation is well suited to use IFFIm funds because it:

- is an essential and highly cost-effective intervention that is integral to the public health system;
- can save millions more children's lives through a substantial ramp-up in coverage rates;
- can use frontloaded funds to accelerate vaccine market forces;
- can be scaled up quickly, even in resource-poor settings;
- is a key first (and sometimes only) point of contact for mothers and children with the health systems, and can be used to deliver other health-related interventions;
- can channel funds through an effective existing system.



Convergence

To support funding and programmes, the GAVI Secretariat optimised its organisational structure in 2005.

The year 2005 saw good progress on the completion of the structural changes to the Secretariat. Starting in December 2005, the Geneva office became fully operational and the Lyon team joined the Geneva staff. With the new team structure in place, vacant posts are being filled to support the scaling up of GAVI. At the end of 2005, the management was strengthened with the appointment of two deputies, one as Chief Operating Officer and the other as Chief Technical and Policy Officer. Convergence, a significantly expanding agenda and increased funding have greatly increased the demands on the joint Secretariat (Washington and Geneva). Staff have responded magnificently, and morale is high, though capacity constraints to serving the Alliance more efficiently remain. Following the recommendations at the September Joint Executive Committee (EC), GAVI has begun the process of improving financial reporting for increased accountability with the establishment of new financial posts.

Given our strengthened focus on partner countries, GAVI has also decided to increase the capacity of the country support team to work more closely with GAVI's country partners. Convergence also has implications for governance structures and board operations. In September 2005, the first joint EC meeting took place. Joint and back-to-back board meetings in Delhi in December 2005 were also a first.

Beyond GAVI's internal structure and organisation, convergence also had implications in terms of branding. GAVI also sought to clarify a longstanding point of confusion for donors and external audiences alike: the relationship between GAVI and the Vaccine Fund. GAVI engaged the firm Saatchi & Saatchi to conduct an extensive interview process, from which some key messages emerged: 1) from an external perspective, convergence was seen as a positive move; 2) the strongest brand equity was in the GAVI name. It was considered so strong that the full name denoted by the acronym (Global Alliance for Vaccines and Immunisation) could be dropped; and 3) as there was no support for a new name for the organisation, 4) the identities of the Alliance and its financing arm should be folded into a single GAVI brand: the GAVI Alliance. As a result of these recommendations, a new brand and logo were agreed and developed.

New Delhi Partners' Meeting

The GAVI Alliance Board met in the Indian capital, New Delhi, on 6-7 December, with the GAVI Alliance third partners' meeting taking place on the two following days. The GAVI Alliance and Fund Boards held separate meetings and also met jointly for the first time, marking the beginning of Phase 2 and agreeing the Alliance's direction during its second phase. This will give way to working with GAVI's global health partners to:

- achieve the massive increase needed in development assistance for health to meet the Millennium Development Goals;
- harmonise partners' work behind country-driven strategies; and
- work to introduce new, better and more affordable technologies.

Discussions at the Alliance Board concentrated on policies for Phase 2, basing decisions on the twin priorities of harmonisation with other global health initiatives and GAVI's historic commitment to a catalytic and results-oriented approach. The Board endorsed the "Best Practice Principles for Engagement of Global Health Partnerships at a Country Level" and noted that GAVI must maintain its strong advocacy of immunisation.

The Board approved the proposed health systems investment case and agreed that support should be available to all GAVI-eligible countries. Due to the variations in systems barriers faced by each country, the health systems window must provide significant opportunities for re-evaluation and refinement. The first tranche of funding will focus on "pathfinder" countries, selected according to their unique circumstances, so each can provide insight for future programmes.

While maintaining its commitment to continued support for HepB and Hib combination vaccines, the Board agreed that vaccination programmes should ultimately be based upon country needs and preferences. It welcomed the possibility of expanding GAVI's support to additional vaccines, including some not yet available.

As the mandate and responsibilities of the Alliance expand in Phase 2, it must exploit the expertise of both the Alliance and the Fund Boards to the maximum. This historic first joint meeting was an opportunity to explore what this may mean. Within this newly defined governance structure, Alliance Directors will provide decisions on programmatic policies and Fund Directors will serve a fiduciary role, meaning that they will ensure maximum transparency and accountability for the use of Alliance resources.

HIGHLIGHTS FROM THE THIRD GAVI PARTNERS' MEETING

The meeting brought together governments of industrialised and developing countries, non-governmental organisations, civil society representatives, WHO, UNICEF, the World Bank Group, the Bill & Melinda Gates Foundation, research and public health institutions, and the vaccine industry, as partners of the GAVI Alliance. It was opened by the Indian Prime Minister, Dr Manmohan Singh, joined by his Norwegian counterpart, Jens Stoltenberg, and Bill and Melinda Gates, co-founders of the Bill & Melinda Gates Foundation.

Mr Stoltenberg announced that the Norwegian Government would increase its support for GAVI from 300 to 500 million Norwegian kroner (US$75 million) annually through 2015 and that Norway would also support the IFFIm.

Technical workshops included presentations and discussion on reaching more children, financial planning for immunisation/health programmes, new vaccines, increasing the demand for immunisation and other basic health services, vaccine supply strategy, integrating public health interventions, introducing new vaccines, new financing mechanisms, health systems support, defining the role of civil society in immunisation, countries in crisis, and health care waste disposal. Key points from each workshop are available on the GAVI website.

Special Focus on GIVS and Partners

The GIVS (the Global Immunisation Vision and Strategy) was developed by WHO, UNICEF and other partners for the period 2006-2015. It is a framework that offers policy-makers a single vision of immunisation and a set of strategies from which countries can choose those that suit them best. The distinctively new feature of GIVS is the unprecedented degree of attention it gives to reaching the hard to reach - the socially marginalised and those living in remote areas, like urban slums and distant rural districts.

The international community has made good progress against childhood disease. Estimates suggest that in 2003 immunisation prevented more than two million child deaths, plus a further 600,000 deaths related to hepatitis B that would otherwise have occurred in adulthood from liver cirrhosis and cancer. Between 1999 and 2004, deaths from measles fell by 48%. There has been outstanding progress towards eradicating polio (down globally by 99% since 1988), and in reducing measles and neonatal tetanus (NNT) deaths (eliminated in all but 49 countries by 2005, compared with 122 countries in 1980). Between 1980 and 2005 global immunisation coverage with three doses of diphtheria-tetanus-pertussis (DTP) vaccine rose from 20% to 78%.

Less encouragingly, though, immunisation coverage had stagnated in the 1990s, when it did not exceed 70-78% globally. In 2002 1.4 million children under five years old died from diseases for which vaccines are readily available. More than a million children died from pneumococcal and meningococcal disease and from rotavirus diarrhoea, all of them diseases for which vaccines are likely to be available soon. That year an estimated 2.1 million deaths occurred across all age groups from diseases preventable by vaccines currently recommended by WHO. By 2005 sub-Saharan Africa had achieved 60% coverage, and an estimated 28 million infants and 40 million pregnant women worldwide remained without immunisation, leaving them vulnerable to infections both in childhood and later on, during their productive adult lives. The result: millions of deaths every year.

The challenges to immunisation today include:

- increasing demand;
- equitable access for all to new vaccines (such as those for pneumococcal disease or rotavirus) and to modern technologies;
- obtaining sustainable financing for introducing more expensive new vaccines and technologies and increasing coverage with existing vaccines;
- increasing vulnerability to global epidemics and other health emergencies; and
- weak immunisation infrastructure and health systems.

The new vision enshrined in GIVS aims for a world by 2015 in which:

- immunisation is high on all health agendas;
- every person, child, adolescent and adult, has equal access to immunisation;
- more people are protected against more diseases.

GAVI Phase 2, also to run from 2006 to 2015, is a key component of GIVS, particularly focusing on the strengthening of health systems and on increasing the availability of new vaccines and technologies.

Country Support - Country Consultation Process

As a learning organisation, GAVI undertook a Country Consultation Process that invited all GAVI-eligible countries to provide comments from their experience of Phase 1 so that planning for Phase 2 could take account of their experience and views. The consultation process began in March 2005, had six components, and continued until June 2005. It considered three areas: GAVI Processes; New Vaccines & Technology (including New Vaccines Support, NVS, and Injection Safety, INS); and Systems Support (including Immunisation Services Support, ISS).

Overall GAVI support has been viewed positively by the countries receiving support. It has helped to raise awareness of and support for immunisation programmes and has helped to increase coverage in a significant number of countries.

But the predominant concern from many countries is that five years is too short a period to introduce - and then transfer responsibility for funding - new vaccines, and to attain global targets including GIVS and the MDGs. Injection safety support (INS) in Phase 1 is overwhelmingly considered a positive experience which has proved a catalyst at country level, but concerns were raised over long-term sustainability. The incentive benefits of a performance-based mechanism for GAVI systems support were appreciated by many countries. Understanding of the precise nature of the ISS investment and reward mechanism had to be strengthened, though.

Respondents recommended that the eligibility criterion for ISS support (DTP3 immunisation above 80%) should not continue for future systems support, so that all countries would be able to apply for support.

A strong message from the country consultation meeting in Geneva, echoed in country visits, was that GAVI should focus on encouraging manufacturers to reduce vaccine prices.

The countries visited welcomed the idea of bridge funding to continue support for combination vaccines, but would need to see the financial consequences before deciding whether to take on a bridge funding commitment (which includes increasing levels of co-financing from the country level).

Possible new vaccines to be considered for Phase 2 support include pneumococus, rotavirus, Japanese encephalitis, rubella, meningococcal meningitis (A & C), HPV and the malaria vaccine when it becomes available. A significant number of countries also requested support for the safe disposal of used auto-disable syringes and other injection safety equipment.

There was consensus that immunisation should remain the focus of GAVI systems support in Phase 2, with support to address system constraints particularly at the service delivery level. There was no full consensus on how far support should be used outside the immunisation system.

GAVI PROCESSES

To improve the efficiency of the application process, some respondents proposed that applications and reports to GAVI should, in the future, require the signatures of only four key stakeholders, including the government, rather than all members of the Inter-Agency Coordination Committee (ICC). The ICC minutes where the report/application was discussed would be provided as supporting evidence. Most respondents indicated an increased understanding of the application requirements and GAVI processes in the years since the initial launch.

However, there was a call for greater recognition of individual country characteristics which might not always fit a standardised model or templates, and for GAVI to increase its flexibility. Reduced duplication in reporting requirements was proposed.

The Data Quality Audit (DQA) was reported as a useful process tool that was having a catalytic effect on information management. Similarly, the Financial Sustainability Plan (FSP) was positively received as a useful process, which should be integrated at an earlier stage in country planning processes.

An ongoing need for coordination among agencies providing support, and for continued support to develop country capacity was also noted.

NEW VACCINES AND TECHNOLOGY

The over-riding concern from many countries is that five years is too short a time to introduce and transfer responsibility for funding new vaccines. Awareness of the cost issue was greater once countries had prepared an FSP (Financial Sustainability Plan) or where they had a SWAP (Sector Wide Approach Plan). Both in the Geneva Country Consultation meeting and from country visits it was recognised that the financing concerns partly reflect the changing behaviour of international donors, challenging the assumption that GAVI can always act as a "lever" for increased donor support for immunisation at country level.

Combination vaccines cause a significant increase in immunisation costs at the national level, raising fears over sustainability after GAVI support ends. Many respondents suggested that GAVI consider a timescale of 10 years in Phase 2, and there was a clear request for additional support to help sustain the use of pentavalent vaccine where it has already been introduced.

The countries visited welcomed the idea of bridge funding to continue support for combination vaccines, but expressed concern over the high cost of the vaccine at the end of the bridge period. The financial consequences would need to be carefully considered before deciding whether to take on increasing levels of co-financing from the country (a condition of the bridge financing).

Some countries wanted to assess whether three years of support was enough to sustain improvements in injection safety. The unfinished agenda for injection safety is to deal with safe disposal of syringes, recognising that this is a much broader issue than simply as it applies to immunisation.

SYSTEMS SUPPORT

Most respondents supported the flexibility of ISS funds, and felt that it was important to continue this principle in Phase 2. A smaller group expressed concerns and felt that guidance on use of funds would be helpful, e.g. to use most at district level and below, as well as clearer accountability.

The incentive benefits of a performance-based mechanism for GAVI systems support were appreciated by countries, but understanding of the precise nature of the ISS investment and reward mechanism were fairly limited. The use of a single indicator (DTP3) was welcomed by many countries as being a simple mechanism for measuring performance. However, some EPI (Expanded Programme on Immunisation) managers would prefer multiple indicators, to give a fairer representation of the overall EPI Programme, and would welcome process indicators.

There was support for increasing the period of systems-strengthening support from 5 to 10 years (or longer), as there is still limited capacity for attaining the Global Immunisation Vision and Strategy (GIVS) targets and meeting the Millennium Development Goals (MDGs) by 2015 in many GAVI countries.

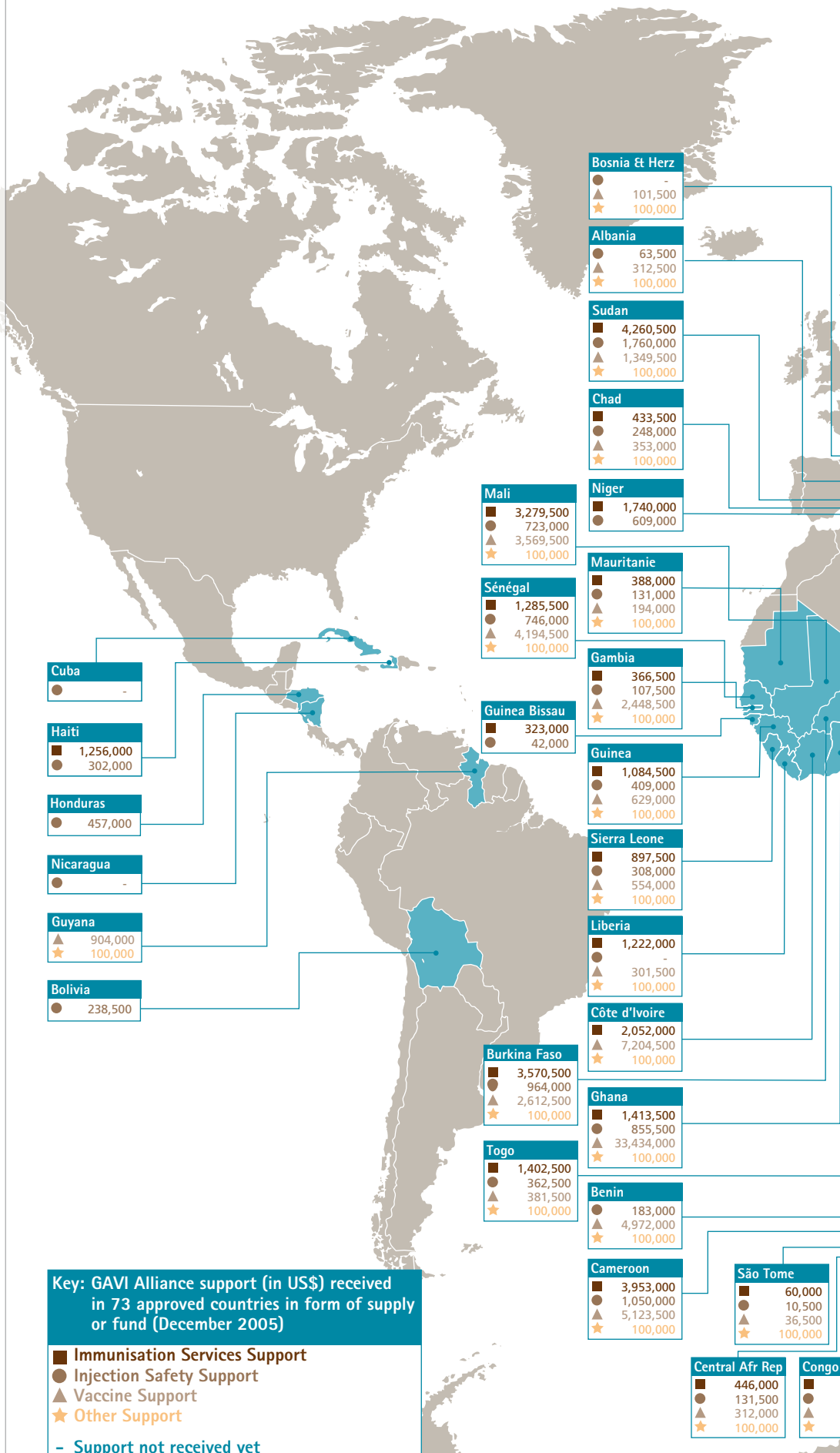
Additional support was proposed for maintaining coverage rates and providing services for "hard to reach" population groups. There was consensus that immunisation services should remain the focus of GAVI systems support in Phase 2, with support to address system constraints particularly at the service delivery level. There was no full consensus on how far support should be used outside the immunisation system. Respondents (mostly but not all those approaching the upper eligibility limit) recommended that the cut-off criterion for ISS support (DTP3 coverage below 80%) should not continue for future systems support, so that all countries would be eligible to apply for support.

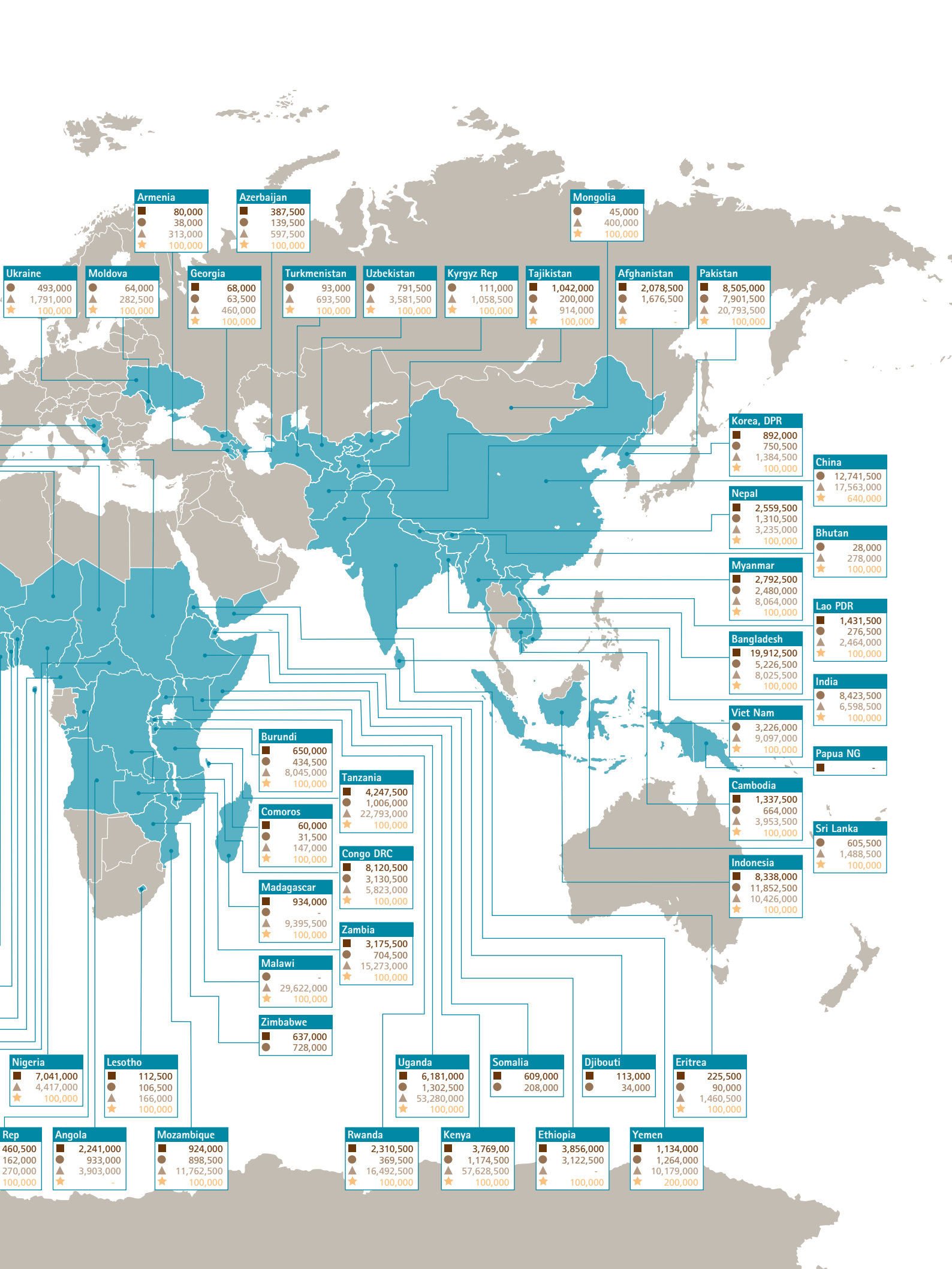
Graduating from GAVI support: Guyana

Succeeding in improving administrative coverage from 53% in 2004 to 83% in 2005 in its worst- performing region, Guyana's high performance is startling. National administrative coverage for 2005 is estimated to be 93%. Guyana was the first GAVI-eligible country in the world that sustained GAVI donations for pentavalent vaccine by subsequently incorporating the pentavalent vaccine purchase into its national budget. The country is now prepared to fully take over funding of pentavalent vaccine from 2006, requesting that the remaining funding be allocated to the completion of cold storage rooms. At this stage, it is the only GAVI country which has fully moved from GAVI to national funding for new vaccines.

Investment: US$639 million as of end 2005

Outcome: saving more than 1.7 million lives

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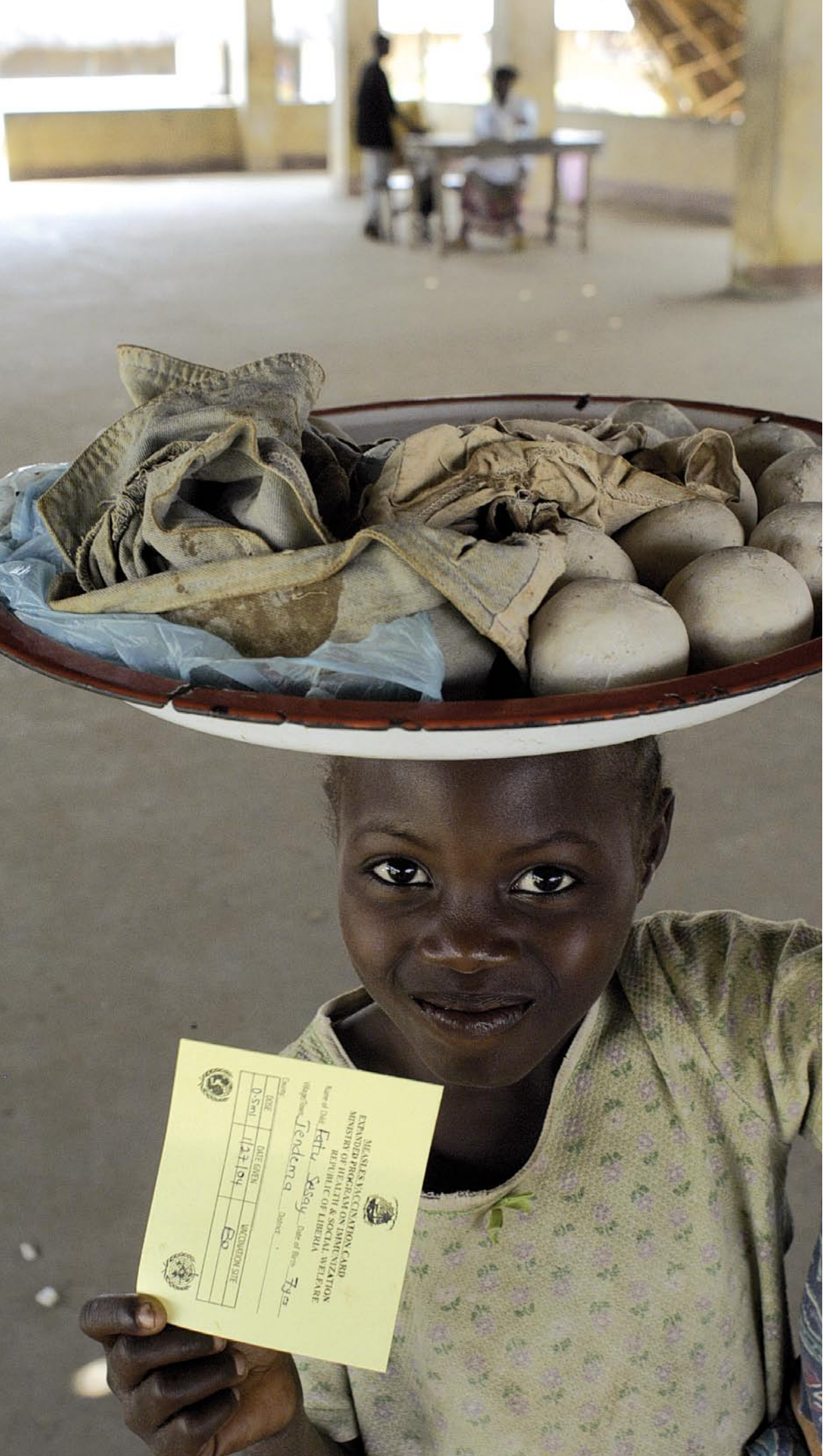
Going Forward: 2006, Launching GAVI Phase 2


MEASLES VACCINATION CARD
EXPANDED PROGRAM ON IMMUNIZATION
MINISTRY OF HEALTH & SOCIAL WELFARE
REPUBLIC OF LIBERIA
Name of Child: Fatu Sesay
Village/Town: Tendema
District:
Date of Birth: 7yrs
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"**GAVI Phase 2 (2006-2015)** is particularly focusing on the strengthening of health systems and on increasing the availability of new vaccines and technologies."

GIVS Costing/Funding the Gap

GIVS (the Global Immunisation Vision and Strategy) was developed by GAVI Partners, WHO and UNICEF for the period 2006-2015 as a framework that offers policy-makers a single vision of immunisation and a set of strategies from which countries can choose those that suit them best. Its ambitious aim mirrors MDG4's objective of reducing vaccine-preventable illness and deaths by two-thirds by 2015.

The distinctively new feature of GIVS is its unprecedented degree of attention to reaching the hard to reach - the socially marginalised and those living in remote areas, like urban slums and distant rural districts. For people like these, GIVS will offer several different ways of improving child health and survival at the point of immunisation - insecticide-treated nets against malaria, for example, and nutritional improvements. Choosing and planning the introduction of new vaccines and technologies will be a matter for individual countries.

For the period from 2006 to 2015 the countries eligible for support from GAVI will need around US$35 billion for immunisation. US$19-23 billion has already been promised by national governments, bilateral and multilateral donors, with GAVI itself providing US$5.5-7 bn. But that still leaves a gap of US$11-15 billion to be filled. If GIVS were fully funded, that would save 10 million lives and reduce vaccine-preventable mortality by two-thirds.

The Challenge: Funding the Gap

- **US$35 billlion needed** for immunisation 2006 - 2015*
  US$19 – US$23 billlion already funded: national governments, bilateral & multilateral donors.
  US$11 – US$15 billion= gap
- Closing the gap means **accelerating progress** to meet MDG4

Source: GAVI – * Source: WHO-IVB

GAVI Phase 2

How much will GIVS cost and who will pay for activities carried out under it? Preliminary estimates of current spending on immunisation and the cost of scaling up immunisation efforts between the years 2006 and 2015 in the 72 Phase 2 GAVI-eligible countries have been calculated.

By 2005, costs have doubled compared with more than US$1 billion that was spent on routine immunisation for the delivery of basic vaccines in 2000. This will be mainly because of the introduction of new vaccines and acceleration towards further mortality reduction with existing vaccines. That extra US$1 billion will need to increase still further, to US$4 billion a year in the poorest countries by 2015.

But the gains in prospect are immense. Ten million lives could be saved within a decade, and more than 70 million children in the world's poorest countries could be protected every year against 14 of the principal diseases affecting children and adults (tuberculosis, diphtheria, tetanus, pertussis, measles, rubella, yellow fever, Haemophilus influenzae type b, hepatitis B, HPV, polio, rotavirus, pneumococcus, meningococcus, and Japanese encephalitis). It is mainly because the cost of new life-saving vaccines will initially be higher that the annual costs

of reaching all the goals outlined in the study are estimated to rise so much.

By 2015, immunisation could be preventing four to five million child deaths per year. At an average cost per death averted of under US$1,000, immunisation continues to be one of the most cost-effective health investments available. GIVS spells out the highly significant contribution of immunisation to Millennium Development Goal 4 - a two-thirds or greater reduction in global childhood deaths and illness attributable to vaccine-preventable diseases by 2015, compared with the 1990 level.

GIVS also provides specific goals for immunisation, such as achieving at least 90% national vaccination coverage, and at least 80% vaccination coverage in all districts by 2010 or earlier, or reducing measles mortality by 90% by 2010, as compared with the 1990 level.

Spending on vaccines in the 73 poorest countries approved for GAVI support doubled from US$2.50 per child in 2000 to more than US$5.00 in 2005. The poorest countries currently finance, on average, one-third of their immunisation expenses. In addition to protecting children against vaccine-preventable diseases, immunisation programmes also help to strengthen health systems and to deliver other life-savers, such as measures against malnutrition, malaria and intestinal worms.

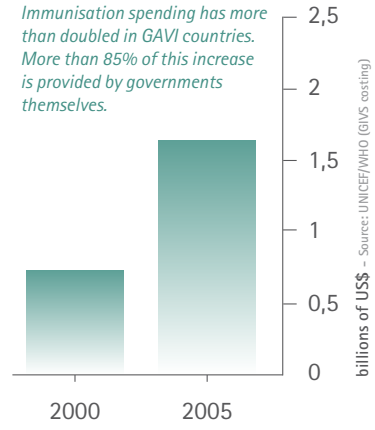
Member states have endorsed GIVS. WHO, UNICEF and other partners will encourage and support them in incorporating GIVS strategies while planning, financing and implementing their immunisation activities. GIVS has been presented and discussed at WHO and UNICEF meetings at global, regional and country levels, as well as during meetings of member states, immunisation partners (including Australian Aid, Canadian International Development Agency, Centers for Disease Control and Prevention of the US Health and Human Services Department, UK Department for International Development, Ministry of Foreign Affairs of France, the Bill & Melinda Gates Foundation, GAVI Alliance/GAVI Fund, Government of the Netherlands, Norwegian Agency for International Development, PATH, International Federation of Red Cross and Red Crescent Societies, United Nations Foundation, US Agency for International Development, the World Bank, and WHO's Strategic Advisory Group of Experts on Immunisation).

GAVI Phase 2 Funding Needs

- If current donors continue rates of commitments and IFFIm launches as planned, GAVI will **raise about US$6 billion from now until 2015**
- With current policies supported by GAVI including new support to systems and new applications for current vaccines, GAVI is projected to **spend about US$4 billion** until 2015
- **US$2 billion** is set aside for the introduction of further new vaccines
- WHO estimates **US$3.7 to US$4 billion is needed** for new vaccine introduction (vaccines only – does not include systems costs)*
- GAVI faces **a gap of at least US$1.7 to US$2 billion** even with current IFFIm and regular donor commitments

Source: GAVI, UNICEF/WHO (GIVS costing)

Results: Increased Financing Costs



Source: UNICEF/WHO (GIVS costing)

Financing for Development

The year 2005 delivered remarkable commitment to development. The donors and the G8 group of countries pledged to double aid to Africa. Globally, aid is projected to rise from US$80 billion to US$130 billion a year by 2010. Increased funding for health and substantial funds now flowing to tackle the HIV pandemic show serious attention is focused on health. Many African governments have progressed on their 2001 commitment to raise health spending to 15% of their national budgets. On the macroeconomic front, a growing consensus has emerged internationally that the challenges of increasing social sector budgets at the country level are real but manageable. Greater predictability in donor finance is widely agreed to be key to the solution.

However, it would be wrong to be complacent. Development assistance in 2004 was still at lower levels than in the 1990s, and a third of overall increases in aid went to Iraq and Afghanistan alone. Despite welcome new commitments, present spending on human development - health, education, and social protection - still falls far short of the large amounts needed to come anywhere near meeting the Millennium Development Goals.

Additionally, current aid flows have two key limitations:

- Under-investment: Estimates suggest that an additional US$50 billion are needed each year in order to reach the MDGs; health needs alone require at least an additional US$20 billion per year by 2010. Current progress, both in terms of financing trends and progress on key indicators, is well below what is needed to achieve the goals by 2015.
- Aid volatility: The volatility of donor aid flows is high, with the result that African countries currently shoulder the bulk of the financial risk. Accelerated efforts to meet the MDGs require significant additional national and Official Development Assistance (ODA) resources, but current aid instruments place a disproportionate balance of risk on developing countries, rather than the donors.

If we are to pick up the pace, innovative financing mechanisms will be key to providing the sufficient, predictable, and long-term financing needed to build systems that reach the vulnerable and excluded. Measurable effects have made health a robust environment to test and roll out innovative financing.

As a platform for implementing these new ideas, GAVI is showing the way forward:

- Scaled-up financing is needed: a serious commitment to meet the MDGs will require a joint approach that involves increased investment by partner country governments along with better, more stable aid flows from donors.
- Increased aid flows: increased investment - particularly in the social sector - will be critical to finance

costs such as system-building which require large investments but improve economic growth in the long run. In particular, in-kind investments in commodities can be scaled up rapidly without major concerns around absorptive capacity or macroeconomic stability that large inflows of money present.

- More stable financing: more money alone is not enough. Long-term predictable aid flows are needed to reduce volatility and provide increased certainty over future budget flows to enable better planning in countries.

INNOVATIVE FINANCING MECHANISMS

Innovative financing mechanisms provide a way to overcome some of the current limitations of aid flows while mitigating the risks of scaling-up. Developing these innovative mechanisms requires the ability to translate private sector innovation into a development context. New aid instruments, such as the Global Health Partnerships, are often ideally placed to do this.

GAVI and other global health partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, with their focus on a country-driven approach, accountability, and results, have shown that substantial additional new finance can be absorbed and deliver better health, even in so-called fragile states or where systems are weak and the old arguments of poor absorptive capacity prevail.
In more stable environments, additional finance designed to lend support to the rehabilitation of systems has also delivered strong outcomes. The results from the first five years of the GAVI Alliance present a clear case for increased investment in health and for health systems in particular.

How and when the increased levels of funds are disbursed and then spent are critical factors in improving aid quality.

The International Finance Facility for Immunisation (IFFIm) offers a way to provide long-term more predictable aid flows in a front-loaded manner. This delivers increased financing in the near-term to accelerate progress towards the MDGs, while promoting more stable financing to reduce aid volatility.

Advance Market Commitments (AMCs) propose a mechanism to "pull" the development of new technologies. By combating market failure through the guarantee of a resource envelope for future vaccines, this mechanism moves forward their availability.

Both of these mechanisms can be expanded to other sectors of development and offer real solutions to combating some of the challenges it faces. As both efforts go forward, lessons could be learned to expand - and scale-up - both of these mechanisms.

> "By matching the capacity of medical advance with the power of long-term finance we are launching an initiative capable of saving ten million lives - sparing millions of families across the world from the avoidable pain of a son or a daughter needlessly dying."
>
> Gordon Brown,
> UK Chancellor of the Exchequer

International Finance Facility for Immunisation

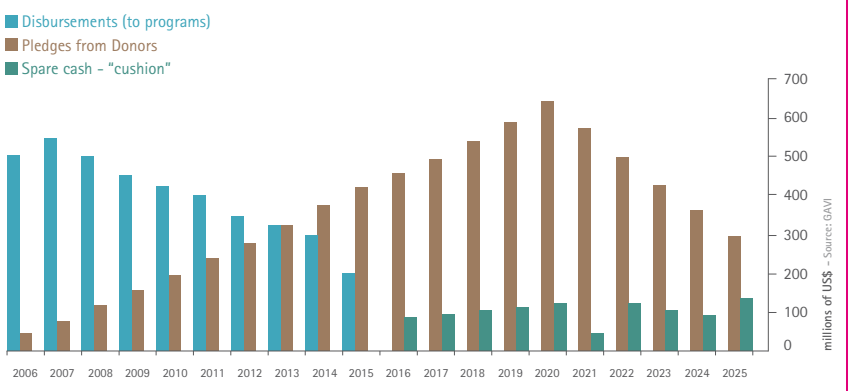
The International Finance Facility for Immunisation (IFFIm) is a pilot of the larger International Finance Facility (IFF) that was originally proposed by the Government of the United Kingdom. The IFF was designed to double global aid for development. The IFFIm, developed within the GAVI Alliance, raises resources on a smaller scale, aiming to provide US$4 bn in disbursements over 2006-15. Currently the Governments of Brazil, France, Italy, Norway, South Africa, Spain, Sweden, and the UK have committed to fund the IFFIm.

The IFFIm will finance the provision of vaccines and support the immunisation and health systems that deliver them; successful demonstration of the financing mechanism, however, will make the case for its expansion to other sectors.

The mechanism takes long-term (twenty-year), legally binding commitments from donors and borrows against them in the capital markets to disburse these funds over ten years. While there is a moderate borrowing cost involved, the estimated 3.5% cost will be far outweighed by the anticipated rate of return from investments in immunisation at 18%. This will be true for other specific sectors as well, justifying the additional cost to donors. Importantly, the borrowing and additional risk is borne by donors, not by countries, with the results being more stable, longer-term aid flows for African countries.

The IFFIm: Donor Pledges

Long term commitments generate near term ressources.



BENEFITS OF THE IFFIm

New Donors: the IFFIm has enabled GAVI to draw upon new donors to support immunisation. Donors that may be severely fiscally constrained in the near term and unable to increase direct aid flows can provide development funds in this way, providing guarantees of future aid flows to generate disbursements to countries now.

Predictability: the predictability of IFFIm funding will yield a number of specific benefits. It will:

- Allow long term commitments: IFFIm funds are based on long-term, legally binding commitments from donor countries. This provides a rare certainty of aid flows; it is most comparable to the commitments made by donor countries to the International Development Association of the World Bank.
- Improve planning and budgeting in country: Predictability enables national governments to make longer-term budgeting and planning decisions (in the case of the IFFIm, up to ten years). While the IFFIm generates funds disbursed through GAVI, the mechanism could easily be applied to generate funds to provide budget support or basket funding.
- Leverage the market: In the case of the IFFIm, predictable funding has the potential to generate significant market benefits by allowing bulk purchasing of vaccines. This provides strengthened negotiating power and the ability to negotiate longer-term arrangements with suppliers, generating lower prices and correspondingly more vaccines for the same envelope of funds.

Frontloading: Scale-up is particularly relevant for systems for health and education, where economies of scale exist. With regards to the IFFIm specifically, three specific benefits result from frontloaded aid:

- Impact on disease burden: Providing large funds up-front for preventive activities such as immunisation can reduce disease incidence rapidly, saving lives and reducing disability.
- Continued economic and fiscal benefits: These benefits include higher productivity and lower costs to health services resulting from lower disease burdens. A front-loaded programme will realise these benefits more quickly.
- Providing predictability to partner countries and industry: With programmes such as the IFFIm, donors are able to bear more of the financial risk. They can reduce the volatility, improve the predictability, and improve the longevity of aid, thereby giving countries greater confidence to invest in health. Another benefit of predictability is that it creates an increase in the likelihood of investment by firms in larger-scale production capacity and enables them to reduce vaccine prices as they have more certainty about future demand.

More specifically, GAVI will use IFFIm resources to generate the following benefits:

SUPPORTING NEW VACCINES

IFFIm resources will be available for eligible countries to procure under-used and newly licensed vaccines to combat the diseases that cause a significant proportion of child mortality. In the near term, IFFIm funds will be used to stimulate increased manufacturing capacity and reduced costs for the combination DTP-HepB and DTP HepB-Hib vaccines. Vaccines against rotavirus, meningococcus A, pneumococcus and Japanese encephalitis should become available in the coming years and could have a significant impact on reducing the disease burden in developing countries.

STRENGTHENING IMMUNISATION SERVICES

Scaling up coverage of immunisation in the poorest countries will require substantial investments in the health systems that deliver vaccines. Constraints that affect immunisation delivery often affect other essential health interventions as well. By keeping IFFIm resources flexible, countries will be able to use them to alleviate these system-wide barriers and potentially lead to a more comprehensive provision of health services.

> "We understand that our future depends on victory in the struggle against social inequality, and on the elimination of hunger and poverty. To this effect, Brazil has decided to join the International Finance Facility for Immunisation."
>
> President Luiz Inácio Lula da Silva,
> President of Brazil

Advance Market Commitments

It has become clear that new technologies such as vaccines or antiretrovirals (ARV) for HIV have the potential to deliver a generational leap in achieving the MDGs. The health gains made in Europe over 150 years could be achieved in developing countries over a 10-20 year period. In particular, vaccines could prevent between two and three million of the nearly 11 million annual child deaths. Therefore, mechanisms that can accelerate the development of new technologies are a crucial component of scaled-up efforts.

Advance Market Commitments (AMCs) are a mechanism designed to accelerate the development and availability of priority new vaccines to developing countries. Ministers of Finance from the Group of Seven (G7) countries have affirmed their interest in AMCs as a market-based mechanism that would accelerate access to priority technologies, such as vaccines for diseases prevalent in African countries such as pneumoccocal and rotavirus diseases.

The process of developing a new vaccine entails huge scientific challenges, can take up to twenty years and requires a series of large investments to research candidates, develop a product and ultimately produce the vaccine. The risks and costs of each of these investments are normally recouped through sales once the vaccine is on the market. However, industry has no assurance of recouping investments needed to serve developing country markets because the markets are perceived by private industry to be small and risky. The result is that children and adults in poor countries often do not have access to new vaccines for 10-15 years after initial licensing in rich countries. Further, the development of vaccines targeted for diseases prevalent in Africa may be either untouched or on a much slower track than vaccines for more profitable markets.

An AMC for vaccines is a financial commitment to subsidise the future purchase, up to a pre-agreed price, of a currently unavailable vaccine - if an appropriate vaccine is developed and if it is demanded by country governments. By guaranteeing that the funds will be available to purchase vaccines once they are developed and produced, the AMC mimics a secure vaccine market and takes away the risk that countries will not be able to afford a high priority vaccine that they would like to introduce into their national programme.

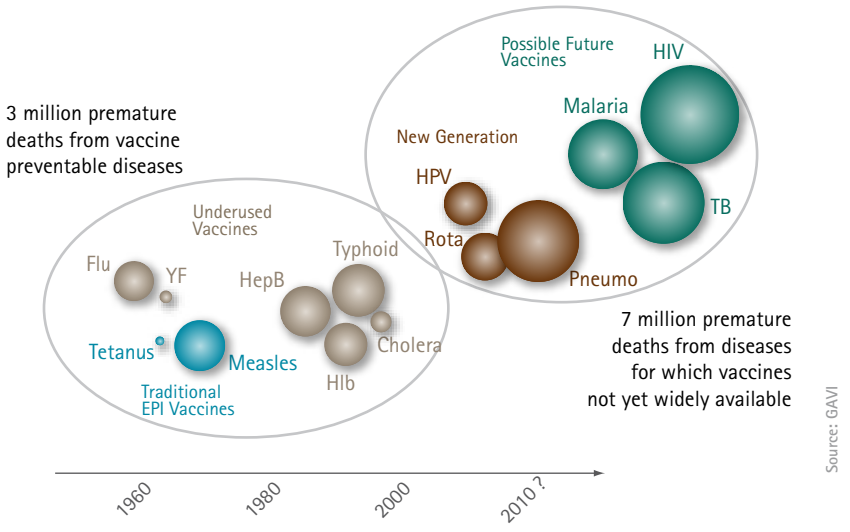
While the AMCs are currently focused on vaccines, this mechanism could be applied to accelerate the development of other new technologies. Using this for other health and bio-technologies, including pharmaceuticals, would be straightforward. However, this could be applied to the agriculture sector, driving forward the development of new fertilisers or other technologies that can improve crop yields for example.

BENEFITS OF AN AMC

An AMC:

- addresses a current market failure. By establishing a secure market, AMCs create incentives for investment in specific vaccines for poor countries that are similar to those prevailing for medicines developed for affluent markets. In this way, AMCs will mobilise additional private resources to fight poverty and global diseases even before donors disburse any money.

The Vaccine Challenge



- stimulates competition. AMCs are open to all firms; therefore, they can be designed not only to accelerate the development of new and effective vaccines, but also to develop second and possibly even third generation products that improve on the first and ensure a competitive market.

- encourages lower vaccine prices. The AMC can also provide incentives for firms to invest in more efficient, large-volume production facilities, thus allowing firms to have lower costs per dose that can be passed on through the provision of vaccines at lower prices in the long term.

- complements a range of interventions. AMCs are particularly effective when combined with push interventions - such as the public and philanthropic funding of research through academia, public-private partnerships and other bodies - because of the network effects of the increased number of scientific researchers working on the target diseases as well as the enhanced probability that scientific research swiftly translates into the production of effective and safe vaccines.

INTERNATIONAL SOLIDARITY CONTRIBUTION

Innovative financing mechanisms include methods tailored to generate additional resources for development in constrained donor environments, where funds are scarce. The international solidarity contribution (airline ticket levy), championed by France and other governments, is one such tool designed to be simple, equitable, and economically neutral.

There are several benefits of an International Solidarity Contribution. It can:

- provide additional resources. The introduction of an air ticket contribution would generate additional revenue to supplement traditional ODA.

- ensure predictable flows. Funds generated from the international solidarity contribution will be both stable and predictable over time. International solidarity levies are ideally placed to finance policies where traditional ODA is too irregular to provide meaningful investment. Such an investment is a fund to ensure a guaranteed, solvent market for drugs such as ARV. Thus these funds will in part be used to develop

The challenge of reorganisation: Liberia & Nigeria

Liberia – post conflict situation

Emerging from recent conflict, and facing resettlements and an influx of refugees, Liberia's challenge is therefore also to recover from the collapse of its health services.

Immunisation is demonstrating how it can lead the way to rejuvenated health services and become the "pathfinder" for wider health systems development. Operational support was provided to national EPI programmes, including extensive training of EPI staff. Six nationwide multi-antigen immunisation outreach activities were conducted, aimed at reaching the underserved communities. In addition, high level political commitment for child survival and development allowed administrative DTP3 coverage to increase from 31% in 2004, to 87% in 2005; more than 100% increase just over the space of 12 months.

Nigeria – facing challenges

Nigeria is in the midst of reorganisation. Facing one of the lowest immunisation coverage rates in the world, (2005 administrative DTP3 coverage - 38%), the country has developed a routine immunisation and multi-year strategic plan for 2006-2010. With a high level of political commitment at the federal level, the country's renewed leadership of the immunisation programme is committed to improving data management and performance at state and local government levels. The country is intensifying outreach activities in hard-to-reach and underserved areas and implementing multi-antigen campaigns. Nigeria is setting high goals for the years to come, with a target of achieving at least a 10-15% increase in yearly coverage of DTP3 and of reaching at least 65% of DTP3 coverage in 2006.

the International Drug Purchase Facility (IDPF), designed both to expand resources for drug purchase and to engage players in the market to match increasing demand with adequate supply at affordable prices.

- implement nationally and coordinate internationally. Nationally employed levies will be associated with a cooperative agreement to ensure coordinated support for unmet needs.

Adequate financing for development to reach the MDGs requires both increased and more stable aid flows - both of which are challenges with current aid flows that innovative financing mechanisms propose to resolve. Scaling up rapidly however presents a number of challenges, which the proposed mechanisms aim to reduce.

Predictability of aid flows, such as that provided through the IFFIm, help strengthen fiscal sustainability and allow long-term planning.

Contrary to popular argument, the social sectors have fewer constraints on absorptive capacity and represent productive investments that generate long-term returns on economic growth. For example, scaling up "quick wins" such as immunisation, even in fragile states, has shown that significant additional new finance can be absorbed by many African countries to deliver better health.

Both of the above mechanisms can be expanded to other sectors of development and offer real solutions to combating some of the challenges for development. As both efforts go forward, lessons can be learned and shared to expand and scale-up other development initiatives.

HARMONISATION AND ALIGNMENT

Additional finance is clearly one part of the story. In addition to improving financing, however, harmonisation and alignment are essential. Country-led strategies will be hampered if aid is fragmented through parallel or competing tracks. On this front, current follow-up efforts to the High Level Forum on the Health MDGs, are focusing on creating a coordination mechanism that would facilitate the development process by providing a brokering service to coordinate and harmonise efforts across the range of stakeholders. In line with the Fast Track Initiative for Education, efforts will initially be focused on a learning set of countries, with an aim to expand this more broadly across Africa.

> "The idea of innovative finacing for development is now an issue on the agenda of all major international forums and its principle has gained broad support within the international community.
>
> Jacques Chirac
> President of the French Republic

The Future and Phase 2

There are three key themes to GAVI's Phase 2 - stepping up activity in order to meet the Millennium Development Goals (MDGs); adding value through harmonising all the work included under the aegis of GAVI; and promoting improved and more affordable technologies.

Over the past year, the international community has mobilised around the political and symbolic opportunities presented by 2005, and has renewed its commitment to meet the MDGs. The level of demand for results has increased with the knowledge that the MDGs are within reach - and this means that all the GAVI partners must work towards their goals in a different way to ensure that their commitments will actually be fulfilled.

But if the MDGs are still within reach, it is far from certain that the world will reach all of them without far greater effort than it has yet shown. Widely recognised as one of the most challenging of the eight goals, MDG4 commits governments to reduce mortality rates among children under five by two-thirds between 1990 and 2015. Progress on this will be measured against three indicators: under-five mortality rates, infant mortality rates, and the proportion of one-year-olds immunised against measles. But in many of the poorest countries today - more than half-way towards the deadline - the child mortality goal is far from being met. The World Bank estimates that only 16% of developing countries are on track to reach this goal - including none in sub-Saharan Africa. WHO and UNICEF estimate that on current trends (based on vaccine demand, level of funding, health system development and vaccine availability), the immunisation coverage rates that are needed to meet the child mortality goal (90% coverage nationwide and 80% coverage in all districts) will not be reached before 2037 - more than two decades beyond the target date. In some countries, efforts to increase immunisation coverage are hampered by weak health systems, conflict, and the unaffordable cost of some vaccines in low-income countries. Yet 25% of MDG4 could be delivered by immunisation alone. As a result, in 2003:

- In 2005, over 28 million children missed out on immunisation during their first year of life, leaving them vulnerable to infectious diseases both in childhood and during the productive adult years;
- In 2002, 1.4 million children under five died from vaccine-preventable diseases for which vaccination is already included in most immunisation schedules. For example, over half a million children died from measles and more than a million from pneumococcal and meningococcal disease and rotavirus diarrhoea - all of them diseases for which vaccines are likely to become available in the near future.

The global push to immunise children during the 1980s is evidence of what can be achieved through a global alliance of immunisation partners. Today, the commitment by governments to reduce under-five mortality by 2015 calls for a similar global push to raise immunisation coverage to 90% in all countries. Partners in the GAVI Alliance have demonstrated how quickly a scale-up can occur. Many of the vaccines needed to save children's lives already exist. And additional vaccines will soon be available. What is needed now is the global political will to ensure that these life-saving tools are also available in the poorest countries, where the needs are greatest.

Efforts to strengthen immunisation systems also have a wider impact on the provision of basic health services - through addressing system-wide barriers (such as lack of human resources) and creating opportunities for the delivery of other health interventions such as bednets to prevent malaria. Immunisation also has an impact on efforts to meet other MDGs. For example, when children are healthy they are more likely to attend school regularly and are better able to learn, helping to achieve the target of universal primary school education (MDG2). For adult carers, immunisation also helps prevent the loss of productive work caused by childhood illness, and lowers the cost of out-of-pocket spending on heath care, contributing to the goal of halving extreme poverty and hunger (MDG1).

1) SCALING UP TO MEET THE MDGs

The world will not meet the MDGs, or even sustain the progress it has so far made towards them, without massively scaling up activity and investment in health. That means that significant new funding will be needed to repair and strengthen health systems. GAVI embraces in that overall context an ambition to scale up to create basic

integrated health services for all. GAVI alone cannot (and should not) aim to fix these cross-cutting issues. But it will play its full part. GIVS needs to be fully financed as part of the ambition to scale up. GAVI needs additional and significant support to achieve that ambition. It is a question of keeping the hugely ambitious promises made in 2005, when the G8 members committed themselves to double aid to Africa and to finance fully health and education services. And it will mean remembering just what a key driver HIV remains.

2) ADDING VALUE THROUGH HARMONISATION AND INTEGRATION

Finding extra funding is just the start. It will make sense only if it is harmonised and set within the Organisation for Economic Co-operation and Development (OECD) / Development Assistance Committee (DAC) framework for aid effectiveness. That will mean that it must be seen as part of a longer-term ambition for proper financing of basic health services in the poorest countries. The extra finance must also be long-term, secure and predictable, and it must be in line with national planning and budgetary processes.

Integration is another key challenge. The Alliance will also integrate its efforts to rehabilitate health services with maternal and childhood health work at both country and district levels. This will mean working as partners, abandoning a traditional "top-down" approach, and forging global links to address common challenges. Importantly, it will mean being able to show results. GAVI will need to improve ways of measuring the added value it offers compared with traditional aid instruments. It will need to demonstrate what this extra dimension means in practice, and constantly to challenge existing ways of working and to show how to innovate. It will mean being part of a radical change in how development assistance is delivered and received.

The Alliance will need to work closely with other global health partnerships to ensure that what they do collectively complements the work done by the developing countries themselves, and is under their strategic direction, always with the support of their development partners. To this end GAVI welcomes the initiative of the High Level Forum to scale up jointly efforts in a first wave of countries. With the support of UNICEF (and WHO-led efforts to integrate interventions at the district level) this could make a real and substantial difference by 2015.

3) PROMOTING NEW, BETTER AND MORE AFFORDABLE TECHNOLOGIES

New and under-used technologies, such as vaccines and tools for immunisation safety, will increasingly provide opportunities to leap forward in terms of development possibilities, and they are urgently needed. Among the lessons GAVI has learnt in its first few years is that it takes longer to achieve this than anyone thought in Phase 1. The good news is that progress is being made. The supply study recently conducted by the Boston Consulting Group (BCG) shows that the world is moving from a monopoly situation to a more diverse market. Using the potential of new technology to the greatest extent possible will be the key to achieving both immunisation targets and the health-related Millennium Development Goals.

Governance

DESCRIPTION OF BOARDS

As a public-private partnership, the core of GAVI's strategic guidance and direction is vested in two independent boards with unique but complementary roles.

The GAVI Alliance Board

This sets the programmatic policies for the Alliance, as well as monitoring and overseeing all programme areas. With membership drawn from a diverse range of partners, the Board provides a forum for balanced strategic decision-making and partner collaboration.

The GAVI Fund Board

This sets policies and strategies, and monitors and oversees areas relating to fundraising and fiduciary control. In doing so it ensures that all programmatic decisions are backed by sound financial analysis, bringing transparency, accountability and value-for-money to all of GAVI's activities.

GAVI ALLIANCE BOARD FUNCTIONS AND OPERATIONS

Functions

The GAVI Alliance Board sets overall policies and strategies, and monitors and oversees areas relating to programmes. The board also provides a common forum for partner collaboration.

The Board:

- shapes the strategic vision and direction for the Alliance;
- provides the highest-level policy decisions, ensuring alignment in Alliance partner activities;
- reviews, approves and provides guidance on the 2006-2010 Alliance Strategic Plan, as well as corresponding work plans;
- considers the recommendations of the Independent Review Committee and approves support for country immunisation programs;
- notes and monitors the commitments of Partners to undertake certain strategies and activities;
- approves budgets of the Secretariat and any task force that might be established by the Board;
- contributes, through its members, to fundraising and advocacy activities;
- nominates the Executive Secretary and submits their name to the host organisation for appointment;
- resolves issues among partners.

Responsibilities

Core responsibilities of Board members are as follows:

- as a member of the GAVI Alliance Board, to make an active and effective contribution to the Board's collective performance of its functions as the governing body of the Alliance (see above), including regular attendance at meetings.
- as a partner/constituency representative on the Board, to provide the highest level of representation, including:
  - maintaining close liaison between GAVI and the partner/constituency, including mutual exchange of ideas, issues and concerns;
  - fostering, and as appropriate strengthening, partner/constituency participation in activities designed to secure the strategic objectives of the Alliance.

Operations

The Board meets in principle twice a year, with teleconferences held as needed. The meeting agendas are prepared by the Executive Secretary in consultation with the Working Group and the Chairperson. The Executive Secretary is the Secretary of the Board. Attendance at meetings by Board members is limited to their designated representatives, without the possibility of their replacement by alternates in the case of absence. Observers may be invited to contribute to Board meeting discussions in an ex officio capacity, upon invitation from the Chairperson. While they may be invited to participate, observers will not be allowed to vote in Board deliberations.

The Board normally takes its decisions by consensus. Nevertheless, should a vote be required, each member will have one vote only. The decisions taken by the Board will not be considered as binding upon the organisations and will not override their respective governing bodies.

GAVI Alliance Board Membership 2005

Dr LEE Jong-wook
Director General,
World Health Organization

Mr Alan Court
Director, UNICEF Programme Division

Dr David W. Fleming
Director of Global Health Strategies,
Bill & Melinda Gates Foundation

Dr Hetherwick Ntaba
Minister of Health, Malawi
(Executive Committee member only)

Mr Jean-Louis Sarbib
Senior Vice-President,
Human Development, the World Bank

Ms Joy Phumaphi
Assistant Director-General for Family and Community Health (FCH), WHO

Dr Sigrun Mogedal
Ambassador for HIV/AIDS,
Ministry of Foreign Affairs, Norway

Dr Adel A. F. Mahmoud
President, Merck Vaccine Division

Dr Khandaker Mossarraf Hossain
Minister of Health, Bangladesh

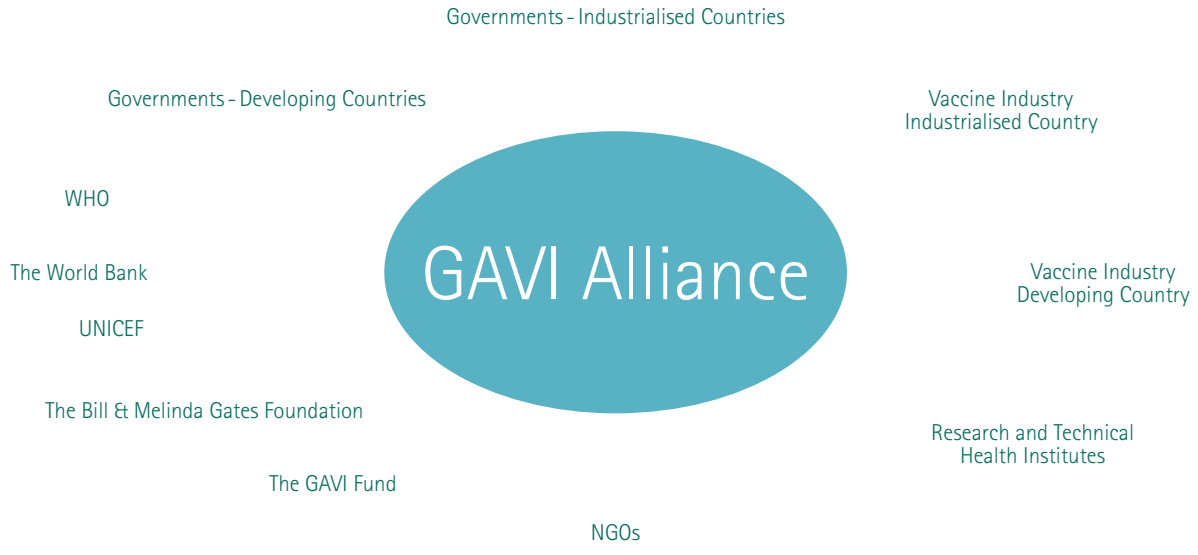
Professor Eng Huot
Secretary of State for Health, Cambodia

Major Courage Emmanuel Kobla Quashigah (Maj., Rtd.)
Minister of Health, Ghana

Ms. Annika Bjurner Söder
State Secretary to the Minister for International Development Cooperation, Sweden

Dr Arlene King
Director of Immunisation and Respiratory Infections Division,
Health Canada

The public-private partnership model as a driver for innovation



GAVI: An Innovative Public-Private Partnership

Prof. Jan Roland Holmgren
Professor of Medical Microbiology, Chair of the Department of Medical Microbiology and Immunology, Göteborg University, Sweden

Dr Adenike Grange
President of the International Pediatric Association, Nigeria

Ms. Brigitte Girardin
Minister-delegate for Cooperation, Development and Francophony, Ministry of Foreign Affairs, France

GAVI FUND BOARD FUNCTIONS AND OPERATIONS

Functions

As a fiduciary agent, the GAVI Fund Board sets policies and strategies for investment, fundraising and financial management.

The Board:

- shapes financial strategy and direction to support the objectives of the GAVI Alliance long-term strategic plan;
- monitors GAVI income received via the following funding sources:
  - direct contributions from individuals, foundations and donor governments to the U.S. nonprofit 501(c)(3);
  - direct contributions from donor governments to GAVI trust accounts;
  - proceeds of bond sales from the IFFIm;
- validates budgets, certifies availability of funding, and decides funding sources for the following:
  - direct financing to support country programmes;
  - purchase of vaccines to support country programmes and other programmes including the ADIPs, the Hib Initiative and the yellow fever stockpile;
  - operational costs of the Secretariat; and added value activities included in the GAVI Alliance work plan;
  - monitors investments and asset liabilities to ensure financing is available as needed;
- establishes a framework for monitoring and periodic independent evaluation of performance and financial accountability of activities supported by GAVI;
- appoints the Chief Executive and Secretary of the Fund;
- appoints Board members;
- establishes sub-committees as appropriate; sets criteria for membership of, and appoints, sub-committee chairs and members;
- establishes and monitors all policies that relate to legal or compliance issues and risks;
- carries out all other activities as required to support the purposes of the GAVI Alliance.

Operations

The Board meets in principle twice a year, with teleconferences held as needed. The meeting agendas are prepared by the President and CEO in consultation with the Chairperson. The President and CEO is the Secretary of the Board.

Deliberation in meetings is limited to elected Board members only, without the possibility of their replacement by alternates in the case of absence. Observers may be invited to contribute to Board meeting discussions in an ex officio capacity, upon invitation from the Chairperson and without ability to vote in meeting decisions.

Decisions are taken by majority vote, with one vote for each director in attendance. A quorum of directors must be present during voting in order for decisions to be officially adopted. The GAVI Fund Board's bylaws define a quorum as a simple majority of Board membership.

Current Membership of the GAVI Fund Board

Graça Machel,
Chair, Mozambique

Nelson Mandela,
Board Chair Emeritus, South Africa

Her Majesty Queen Rania Al-Abdullah of Jordan,
Jordan

Julian Lob-Levyt,
GAVI Alliance Executive Secretary, GAVI Fund President & Chief Executive Officer, UK

Wayne Berson,
USA

Dwight L. Bush,
USA

Michel Camdessus,
France

Jocelyn S. Davis,
USA

Uffe Ellemann-Jensen,
Denmark

Charles J. Lyons,
USA

Mary Robinson,
Ireland

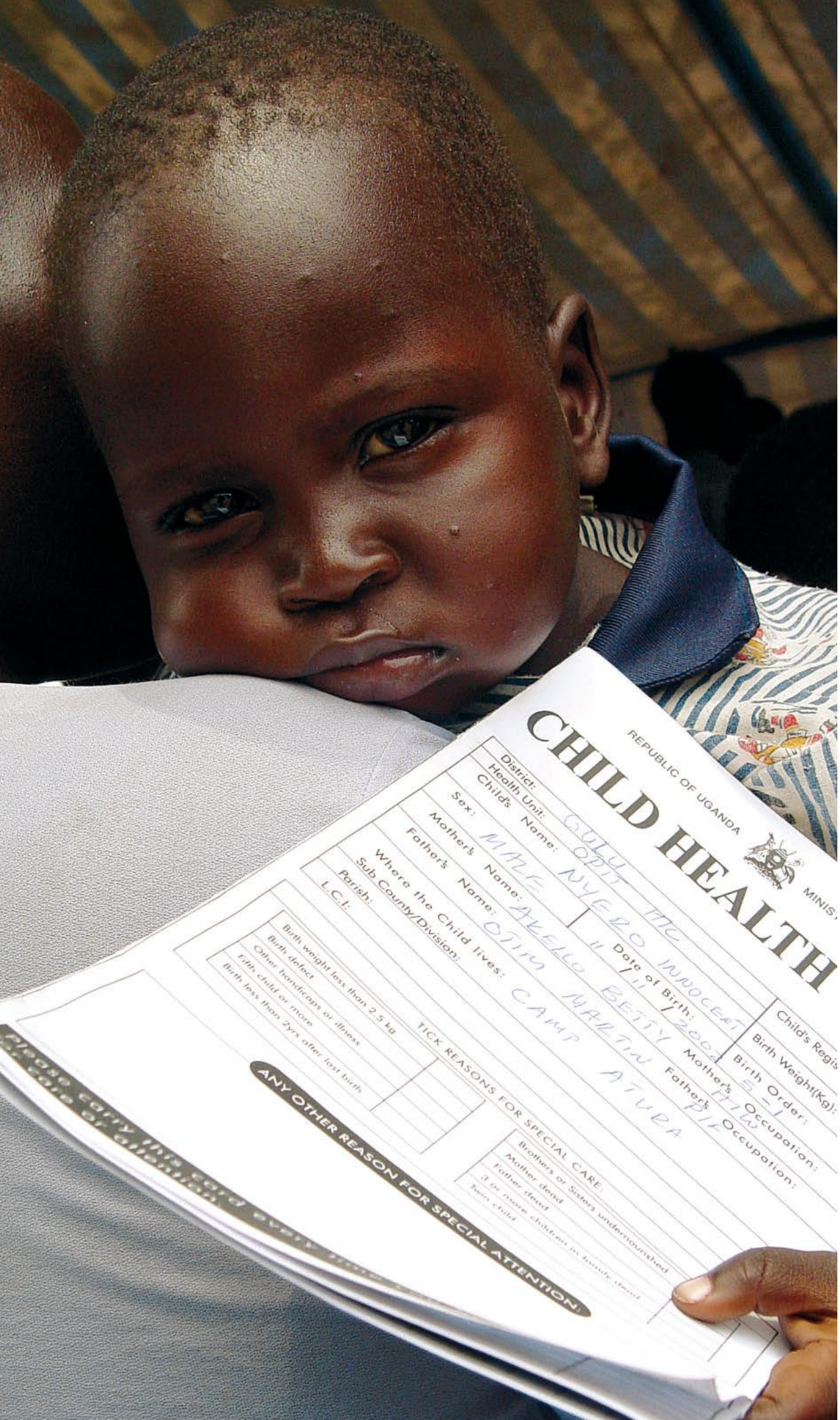
Mstislav Rostropovich,
Azerbaijan

Amartya Sen, PhD,
India

Rita Süssmuth,
Germany

George W. Wellde,
USA

Allan C. Golston,
USA


REPUBLIC OF UGANDA
CHILD HEALTH
District:
Health Unit:
Child's Name:
Sex:
Mother's Name:
Father's Name:
Where the Child lives:
Sub County/Division:
Parish:
L.C.I:
Date of Birth:
Mother's Occupation:
Father's Occupation:
Child's Regis
Birth Weight(Kg):
Birth Order:
TICK REASONS FOR SPECIAL CARE:
Birth weight less than 2.5 kg
Birth defect
Other handicaps or illness
Fifth child or more
Birth less than 2yrs after last birth
Brothers or Sisters undernourished
Mother dead
Father dead
3 or more children in family dead
Twin child
ANY OTHER REASON FOR SPECIAL ATTENTION

Through GAVI and partners' support, more than 1.7 million deaths are estimated to have been prevented by the end of 2005.

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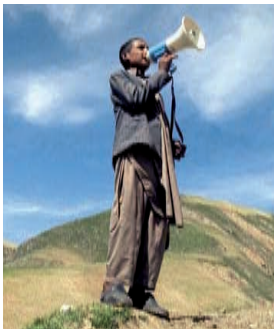

GAVI Alliance
c/o UNICEF
Palais des Nations
CH-1211 Geneva 10 – Switzerland
Tel: +41 (0)22 909 6500
Fax: +41 (0)22 909 6550
E-mail: info@gavialliance.org

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www.gavialliance.org