



GAVI Alliance **Progress Report** 2008

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



BILL & MELINDA
GATES *foundation*



THE 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.

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Message from the Chair of the GAVI Alliance



Mary Robinson
Chair of the GAVI
Alliance Board

I am pleased and honoured to take the chair of the GAVI Alliance at the dawning of its new Board. As I take up this role, I am aware of a clear voice in my ear. It is the voice of Nelson Mandela, who called me when I was High Commissioner for Human Rights and he was chair of the GAVI Fund Board, and said, "Mary, you're working for human rights, and this is a huge human rights issue. GAVI must be able to reach every child, everywhere."

As a Board member and High Commissioner I was a strong advocate for the right to health and I talked to governments about their responsibility to ensure access to vaccines and a delivery system that provides for effective immunisation. They are taking up the opportunity to introduce new vaccines, and demand for GAVI support is accelerating quickly.

"The GAVI Alliance must continue to be bold and courageous... we must not lose sight of our ambition"

Movement towards Millennium Development Goal 4 to reduce child mortality is evident. UNICEF reports a decline in under-5 mortality to 9.2 million in 2007 with immunisation playing a critical role. But we still face a daunting challenge: more than 25,000 children die each and every day. The two major killers are pneumonia and diarrhoea, for which powerful new vaccines are becoming available. GAVI has played an important part in accelerating the availability of these vaccines for the world's poorest countries. Their introduction into routine immunisation programmes brings the very real prospect of dramatic health improvements. It is an opportunity ripe for the taking and one that I am confident our donors will not let slip. We have the technology of powerful new vaccines appropriate to the developing world and we have the demand for them from countries. All that is needed is the boost from donors to enable GAVI's support.

While saving lives is without question an important goal, we must also remember that the impact of disease on a family, a community and an economy can be devastating. A sick child is unable to attend school, unable to learn; family income is spent on health-care

instead of education; parents forego income to care for a sick child; communities suffer from lost productivity; governments are burdened by health-care costs at the expense of other development. Clearly, preventing disease in children through immunisation is a foundation of economic growth and prosperity for individuals, families, communities and countries. That is why GAVI's mission is to save children's lives *and* protect people's health.

We know, too, that empowering women to care for their own health and that of their families can transform a community and a country. I am particularly pleased to take the chair of the GAVI Alliance in a year when a new gender policy is adopted and takes effect. Ensuring that girls and boys, and women and men, have equal access to appropriate immunisation and health services must become a global standard.

It's heartbreaking to see sick children in hospital who, if they had been immunised, would not be there. But when you see a mother with a smile on her face and her baby immunised saying, "now my child has such better chances at life", that is one of the best things we can do to reaffirm the importance of the values of the Universal Declaration of Human Rights, and particularly the right to health.

The challenge shared by the GAVI Alliance partners is to ensure that immunisation and health are kept high on global and national agendas. The financial crisis is forcing leaders to make difficult choices. The GAVI Alliance must continue to be bold and courageous. There are exciting opportunities to save lives and protect health through the amazing power of vaccination. We must sharpen our focus so that we remain within our means, but we must not lose sight of our ambition.

A handwritten signature in black ink that reads "Mary Robinson". The script is fluid and cursive, with a large, stylized 'M' and 'R'.

Message from the Chief Executive Officer of the GAVI Alliance



Julian Lob-Levyt
Chief Executive Officer
of the GAVI Alliance

GAVI's impact is evidenced most boldly by the more than 3.4 million deaths averted, which WHO attributes directly to our support for countries' immunisation programmes. But there is much more to the GAVI Alliance story. As we enter our tenth year, all partners in the Alliance have reason to feel proud of their contribution to our collective efforts.

This progress report illustrates how much has been achieved together – in immunisation coverage rates, in injection safety standards, in strengthening service delivery, in introducing new vaccines and in proving new models for financing development. Our results reflect the dynamic of GAVI's public private partnership and our resolute focus on sustainable impact through empowering country-led development, shaping markets and leveraging the full breadth of Alliance partners' skills and expertise. Our investments over recent years are paying dividends: the collective effort of Alliance partners has helped to build the confidence and capacity for countries to make evidence-based decisions to adopt new vaccines and has also encouraged vaccine manufacturers to focus on the diseases of the developing world.

"In this economic environment, the global community will need to focus on proven and effective interventions"

The immediate opportunities to build on this success are huge. GAVI's impact on the Millennium Development Goals, particularly MDG 4 to reduce child deaths, will be profound. Country demand for new vaccines will drive GAVI's programme expenditure to over US\$ 1 billion in the coming year. It is a paradox that success is blossoming at a time when the global economy is taking a sudden and deep downturn. Just as the opportunity presents itself to dramatically scale up our successful business model, we are challenged by a significantly more difficult fundraising environment.

Our good fortune is that we are better placed than ever to present the case to donors to increase their investment in GAVI. At its foundation, our business is immunisation – the most successful medical intervention in history and one of the most cost-effective

contributions to development. On this sound product base, we have built a business approach that works: one that was widely applauded by the leaders who gathered in Accra in September to review the progress of the global agenda for aid effectiveness.

To continue to be a pathfinder, we must keep scanning the horizon to identify future opportunities. This year we completed a strategic assessment of the next generation of potential vaccines for GAVI support, and prioritised those that would have the most impact on disease burden in developing countries.

In 2008 the GAVI Alliance forged the most significant governance and administrative changes since inception. In October, the new GAVI Alliance Board met as a unified body, bringing to life the model of a true public-private partnership. And at year's end, the administration of the Secretariat shifted from UNICEF, which had so generously nurtured us through our own childhood and adolescence, to a new international organisation under Swiss law.

Together these transformations have created a more effective, efficient and accountable Board and Secretariat and positioned the GAVI Alliance to tackle the competitive challenges of rallying donor support in these difficult economic times.

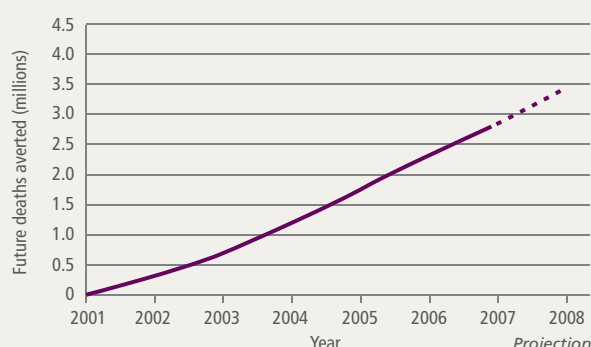
The coming years will be challenging, but it is also the opportunity to sharpen our approaches – to seek further efficiencies and focus in our administration, programmes and in the broader health landscape. In this economic environment, the global community will need to focus on proven and effective interventions such as those that GAVI provides. Above all we must not lose sight of the magnificent potential that is within our immediate reach. For a relatively modest increased investment, we can meet rising country demand and deliver the life-long promise of good health that vaccines can provide.

A handwritten signature in black ink, which appears to read "Julian Lob-Levyt". The signature is written in a cursive, flowing style with a long horizontal line extending from the end.

Key indicators

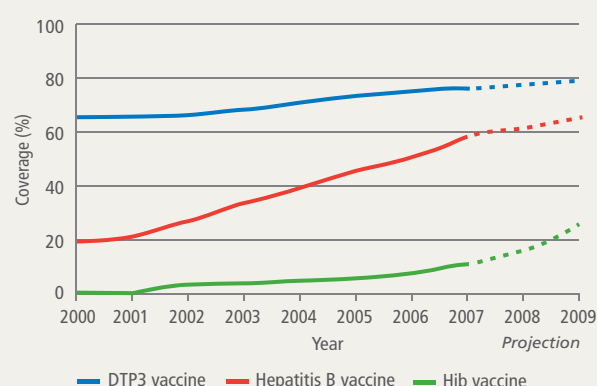
Accelerating vaccines: GAVI support has prevented 3.4 million premature deaths

Steady increase of future deaths averted with hepatitis B, Hib and pertussis vaccines



Source: 1

Immunisation coverage in GAVI countries continues to rise



Source: 2

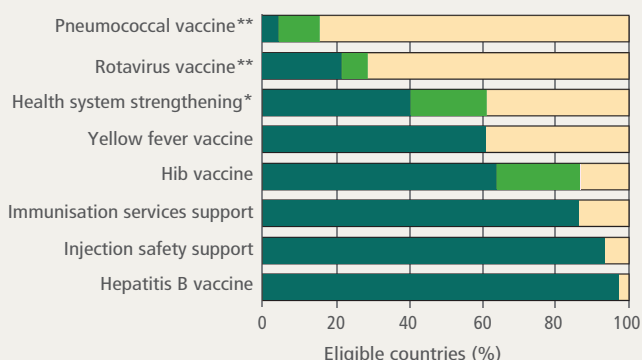
As a result of GAVI Alliance support, WHO projects by the end of 2008 3.4 million future cumulative deaths caused by hepatitis B, *Haemophilus influenzae* type b (Hib) and pertussis have been averted. This is an increase of 600,000 on the estimate of future deaths averted at the end of 2007.

WHO projects that from 2000 to 2008, a cumulative 213 million additional children have been reached with GAVI-supported underused vaccines. Over the same period:

- A cumulative 50.9 million additional children were vaccinated with three doses of the diphtheria-tetanus-pertussis (DTP3) vaccine.
- Hepatitis B vaccine has reached a cumulative 192.2 million additional children, up from an estimated 155.7 million at the end of 2007.
- The cumulative additional number of children supported with three doses of Hib vaccine is 41.8 million, up from an estimated 28.2 million just 12 months earlier.

Uptake of support: GAVI provides long-term funding to countries

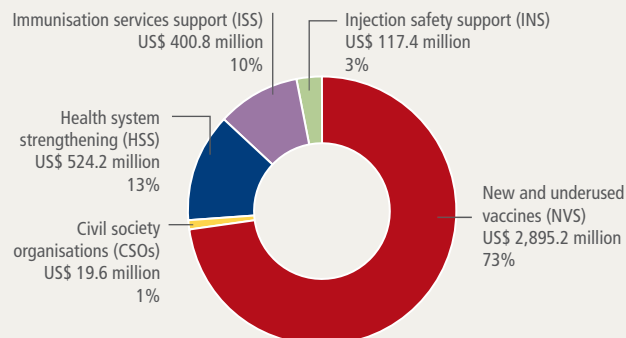
Countries take up GAVI support for vaccines and programmes in 2008



- * Funding commenced in 2006
- ** Funding commenced in 2007
- Countries approved for support 2000-2007
- Countries approved for support 2008
- Remaining countries eligible for support

Source: 3

US\$ 4 billion committed to countries through end-2015, as at 31 Dec. 2008



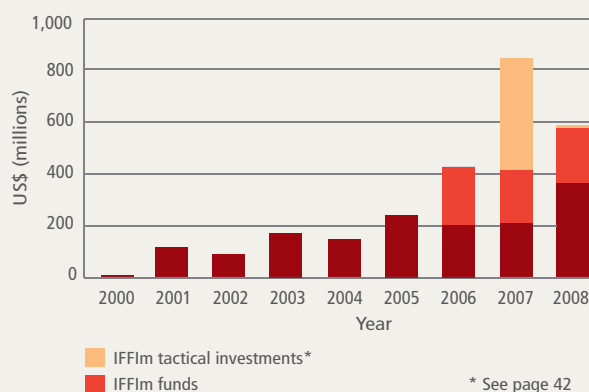
Source: 4

Demand for Hib vaccine and support for health system strengthening rose significantly in 2008. An additional 15 countries received approval for Hib vaccine. This brings the total GAVI-eligible countries approved for the vaccine to 59, or 86% of the 68 countries eligible. The addition of the new vaccines against rotavirus and pneumococcal diseases in 2007 is generating new demand for GAVI support.

GAVI makes long-term commitments to countries aligned to their national plans. The largest amount of GAVI's support is directed towards the provision of new and under-used vaccines. It represents 73% of total country support. Flexible cash support for improving health systems and immunisation support services accounts for 23% of resources to 2015.

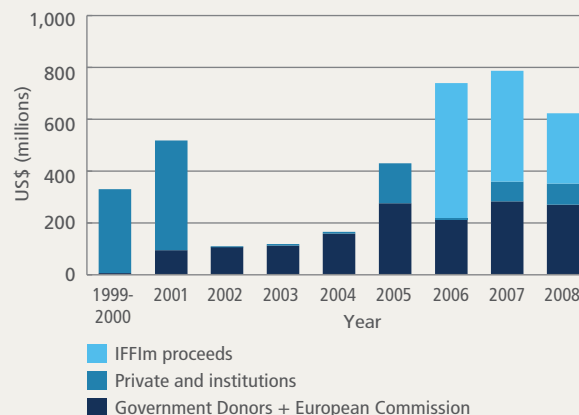
Frontloading IFFIm funds: helps to meet country demand

Country demand drives rising disbursement



Source: 5

IFFIm dramatically boosts public and private contributions



Source: 6

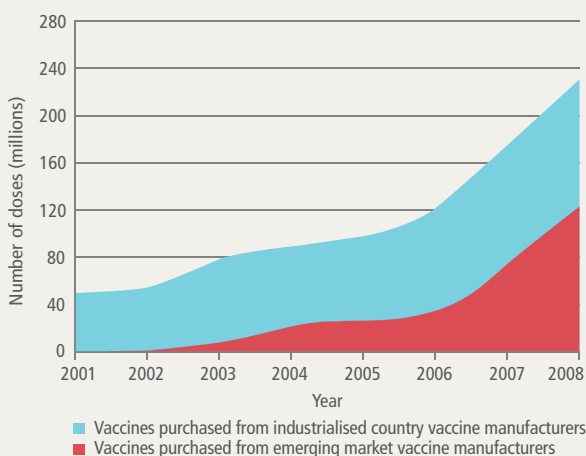
Steadily growing demand from countries for support for new and underused vaccines and GAVI programmes drives rising disbursement of funds. However, meeting this demand and the prospect of new vaccines in GAVI's portfolio require increased multi-year funding.

Initial strong funding to launch GAVI enabled an ambitious start and catalytic boost to global immunisation. Future financial needs are no longer met by donor support and a divergence is growing between country needs and predicted funding.

GAVI funding comes from donor governments and private organisations, as well as from the International Finance Facility for Immunisation (IFFIm). IFFIm's Vaccine Bonds have significantly accelerated funding to countries by frontloading long-term donor commitments on capital markets.

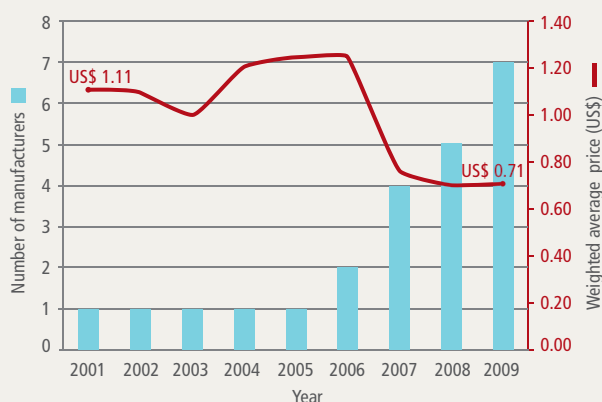
Shaping markets for vaccines: more suppliers secure supply

GAVI's consolidation of demand for vaccines secures supply of vaccines



Source: 7

Increased competition decreases the price of DTP-Hepatitis B vaccine



Source: 8

A growing number of emerging market manufacturers are increasing their production capacity for vaccines. GAVI's ability to consolidate demand for vaccines, making it more predictable and long-term, is encouraging more manufacturers to enter the market. For many vaccines such as yellow fever and pentavalent, this is crucial to securing a more stable supply. For some vaccines, such as the combination DTP-Hepatitis B, the result of more producers has been a significant price decrease.

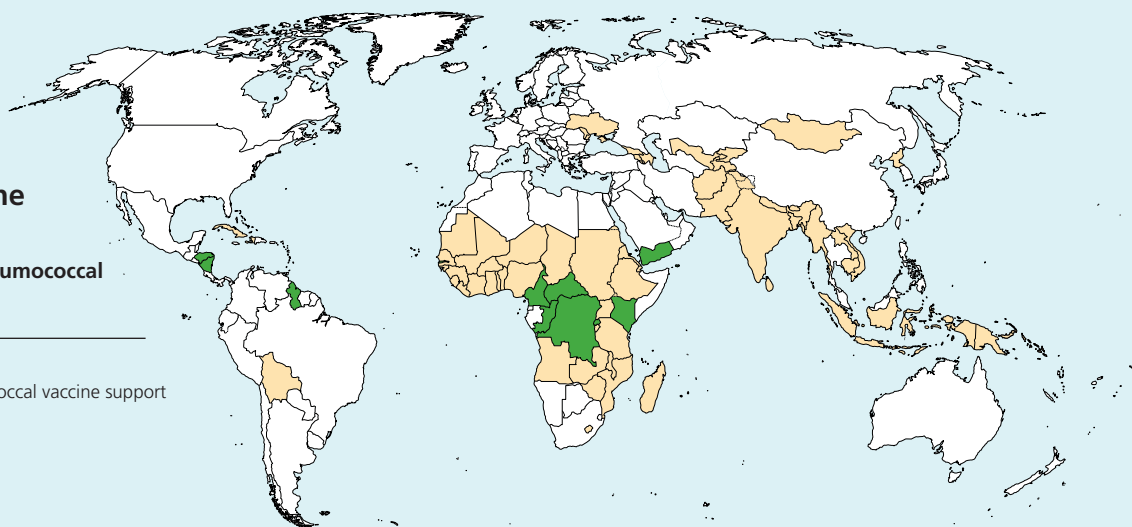
Country demand rises for GAVI support for new and underused vaccines

Country demand for support to introduce underused vaccines – against *Haemophilus influenzae* type b (Hib), hepatitis B and yellow fever – has grown steadily since GAVI's inception. New vaccines against pneumococcal and rotavirus disease present opportunities for GAVI-eligible countries to further protect children and save lives.

Pneumococcal vaccine

Countries approved for pneumococcal vaccine support, 2007-2008

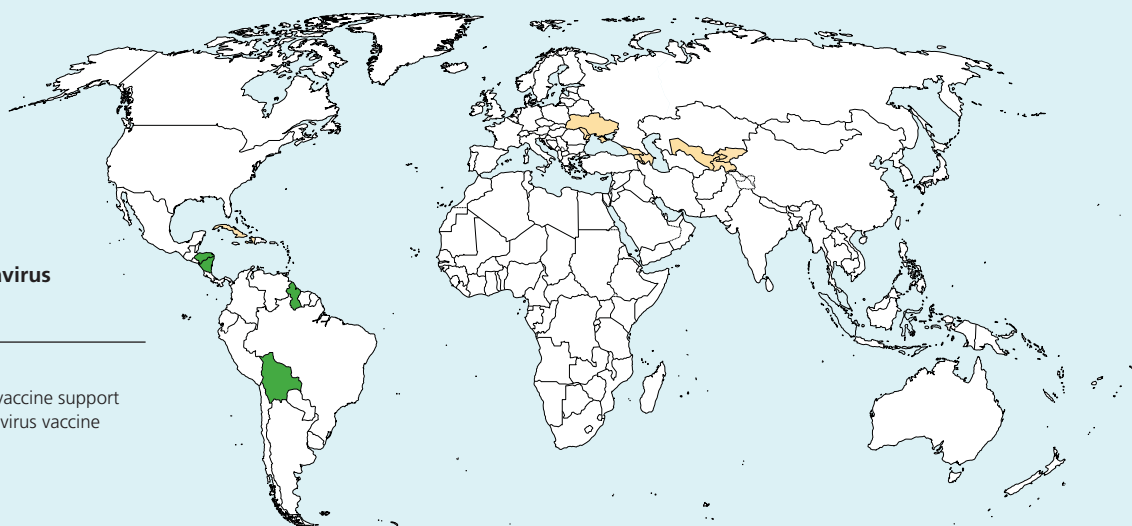
- Approved countries
- Countries eligible for pneumococcal vaccine support



Rotavirus vaccine

Countries approved for rotavirus vaccine support, 2007-2008

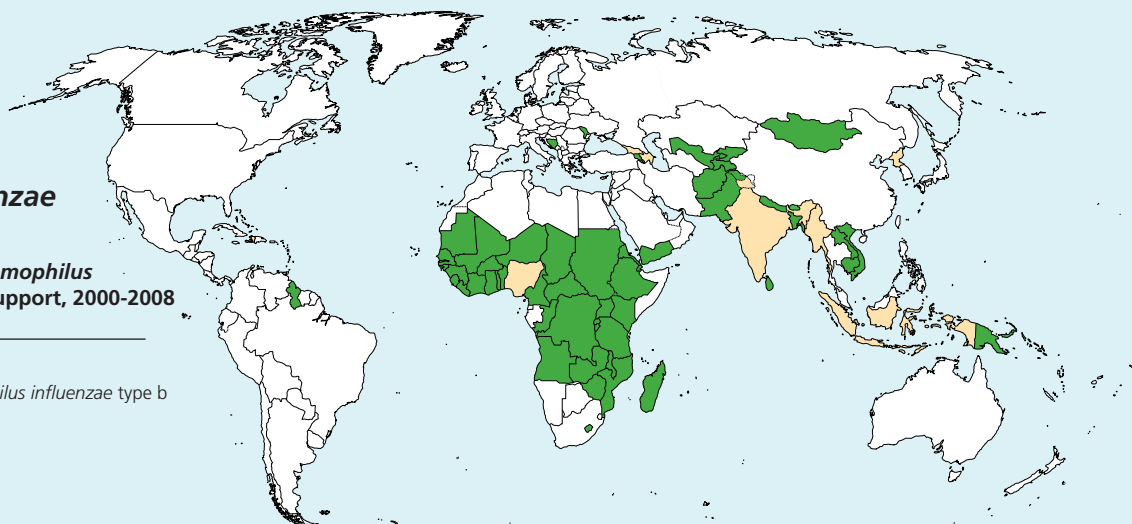
- Approved countries
- Countries eligible for rotavirus vaccine support
WHO recommends routine rotavirus vaccine in 14 GAVI-eligible countries



Haemophilus influenzae type b vaccine

Countries approved for *Haemophilus influenzae* type b vaccine support, 2000-2008

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



Source: 9

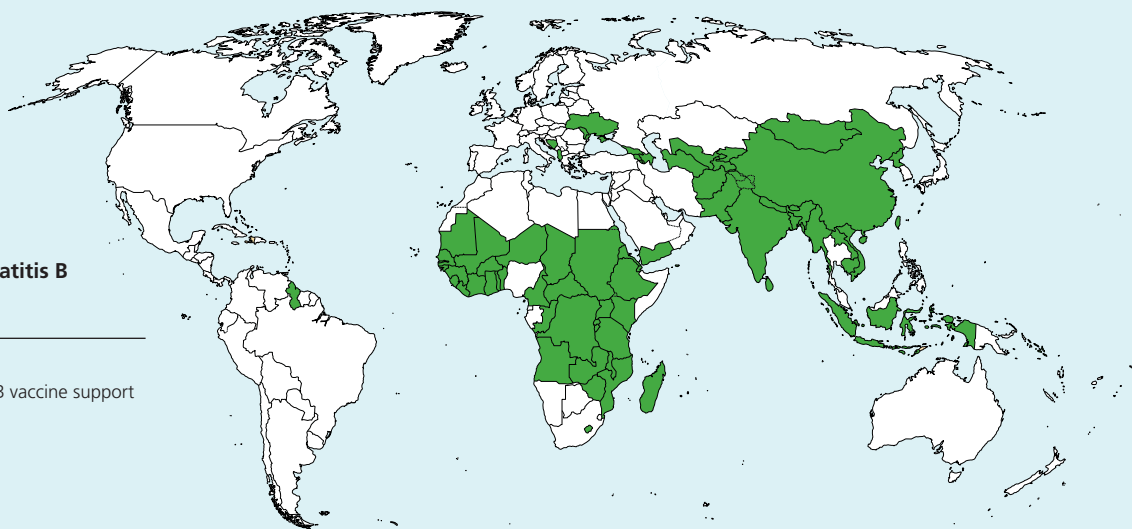
GAVI-eligible countries

GAVI supports countries with the lowest national income based on World Bank data. There are currently 72 countries which are eligible for GAVI funding. Only countries with a Gross National Income (GNI) per capita below US\$ 1,000 in 2003 are eligible. In order for a country to qualify for vaccine support, its immunisation coverage for the third dose of diphtheria, tetanus and pertussis (DTP3) must reach 50% and the government must not already be funding the vaccine (except yellow fever vaccine). GAVI also is guided by WHO recommendations for appropriate vaccine use. All GAVI-eligible countries can apply for immunisation services support, injection safety support and health system strengthening. GAVI eligibility criteria is to be reviewed in 2009.

Hepatitis B vaccine

Countries approved for hepatitis B vaccine support, 2000-2008

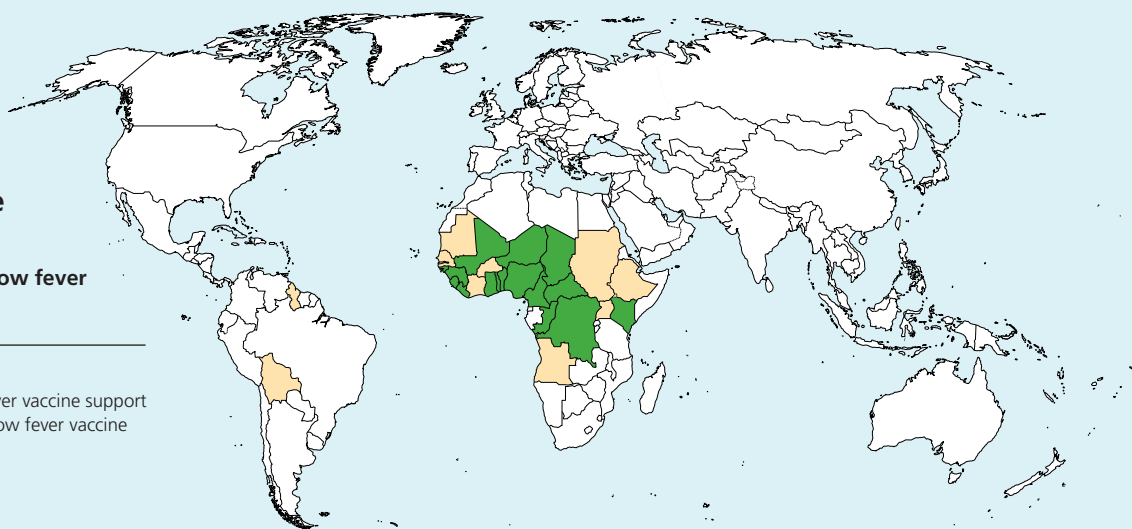
- Approved countries
- Countries eligible for hepatitis B vaccine support



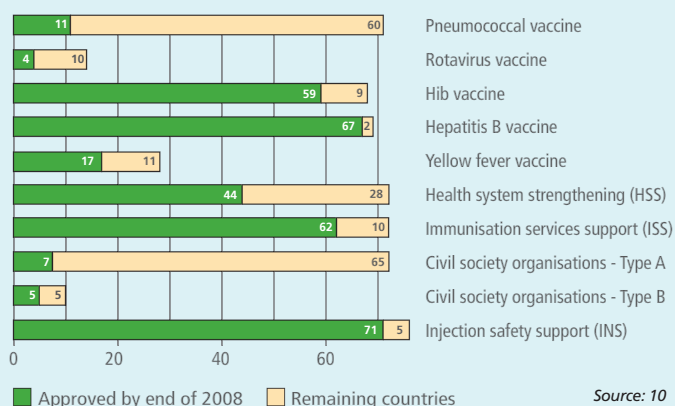
Yellow fever vaccine

Countries approved for yellow fever vaccine support, 2000-2008

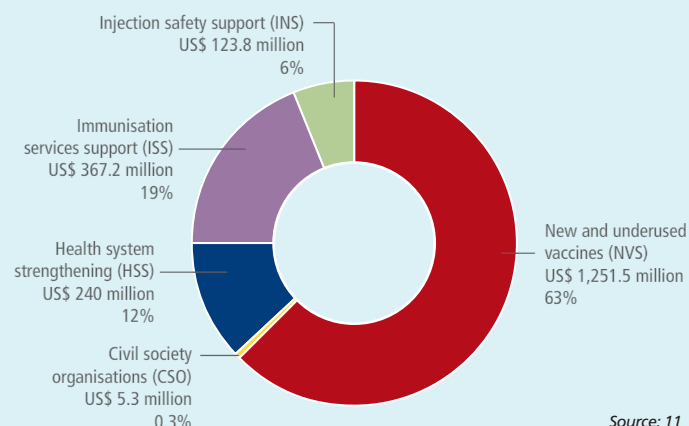
- Approved countries
- Countries eligible for yellow fever vaccine support
- WHO recommends routine yellow fever vaccine in 28 GAVI-eligible countries



Number of countries eligible for GAVI support and approved by end of 2008

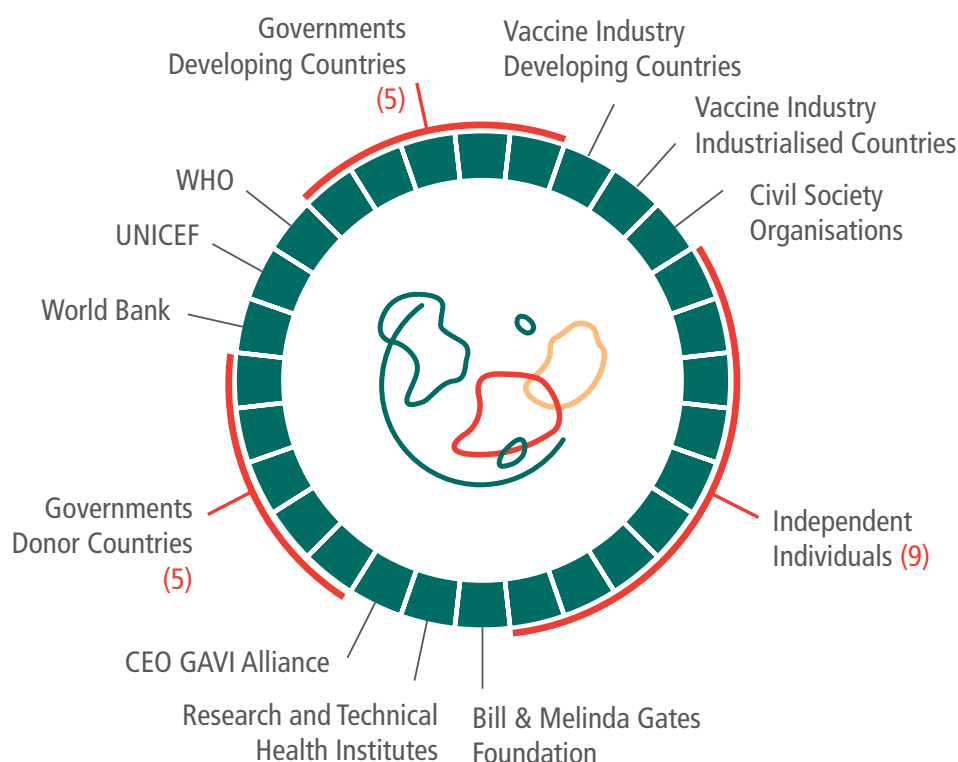


GAVI disbursements to countries 2000-2008 as at 31 Dec. 2008



The GAVI Alliance: working together to increase access to immunisation

The new GAVI Alliance Board



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

The GAVI Alliance Strategy 2007-2010: four strategic goals

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

See also:

Annex 1: GAVI Alliance governance structure, p. 58
www.gavialliance.org/GIVs



Annual donor commitments received in 2008

in US\$	2008	Total
Australia	5,000,000	15,000,000
Canada	0	148,727,565
Denmark		17,051,196
European Commission (EC)	23,129,114	29,238,754
France	0	18,659,114
Germany	0	11,208,400
Ireland	3,841,320	22,670,480
Luxembourg	1,422,900	4,198,665
the Netherlands	38,885,301	159,550,379
Norway	65,449,483	358,056,177
Spain	40,536,200	40,536,200
Sweden	19,151,976	72,247,872
United Kingdom	0	121,562,308
United States	71,913,000	493,725,000
Government Donors + European Commission	269,329,294	1,512,432,110
IFFIm funds	272,638,133	1,225,656,284
Bill & Melinda Gates Foundation	75,000,000	1,062,838,000
la Caixa	6,021,244	6,021,244
Other Private	517,061	10,266,332
Private and institutions	81,538,305	1,079,125,576
Total Contributions	623,505,732	3,817,213,970

Source: 12

Innovative financing mechanisms rely on strong donor support

AMC commitments	US\$ millions
Italy	635
United Kingdom	485
Canada	200
Russian Federation	80
Bill & Melinda Gates Foundation	50
Germany	0
Norway	50
Total	1,500

Source: 13

The Advance Market Commitment received US\$ 1.5 billion in donor commitments to guarantee the price of pneumococcal vaccine once it is developed to the needs of GAVI-eligible countries.

Donors to IFFIm	Length of commitment	Amount in millions	Equivalent in US\$* in millions
United Kingdom	20 years	£1,380.0	2,584.6
France	20 years	€1,239.96	1,738.97
Italy	20 years	€473.5	600.38
Spain	20 years	€189.5	240.3
Sweden	15 years	SEK 276.1	37.67
Norway	5 years	US\$ 27.0	27.0
Republic of South Africa	20 years	US\$ 20.0	20.0

*converted as of date of contribution

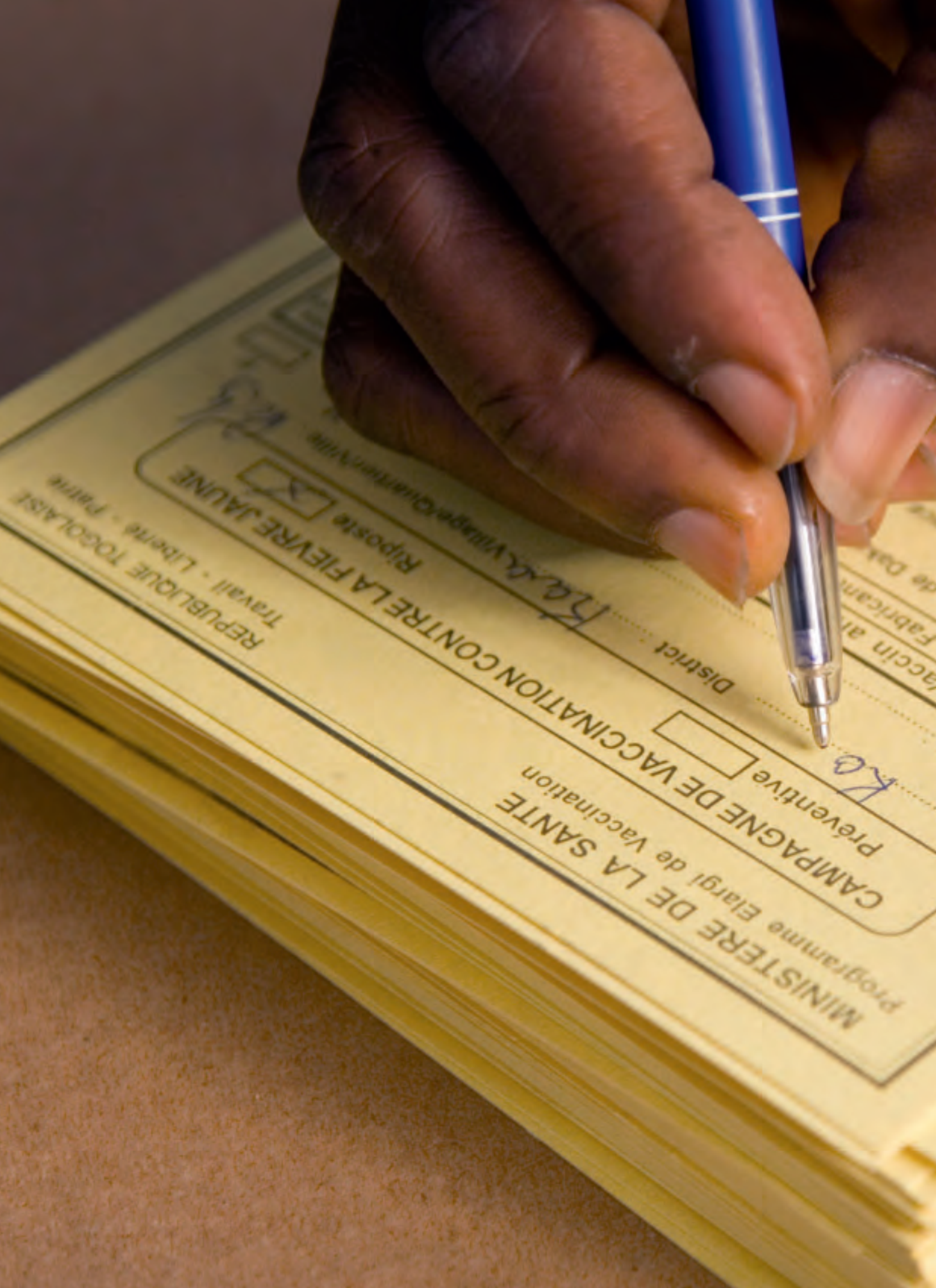
Source: 14

The International Finance Facility for Immunisation (IFFIm) draws on long-term donor commitments to leverage capital markets into immediate funds for immunisation.

See also:

Ch. 3: Increase predictability, p. 35

Annex 2: Donor contributions and commitments, p. 60



MINISTÈRE DE LA SANTÉ
Programme Élargi de Vaccination

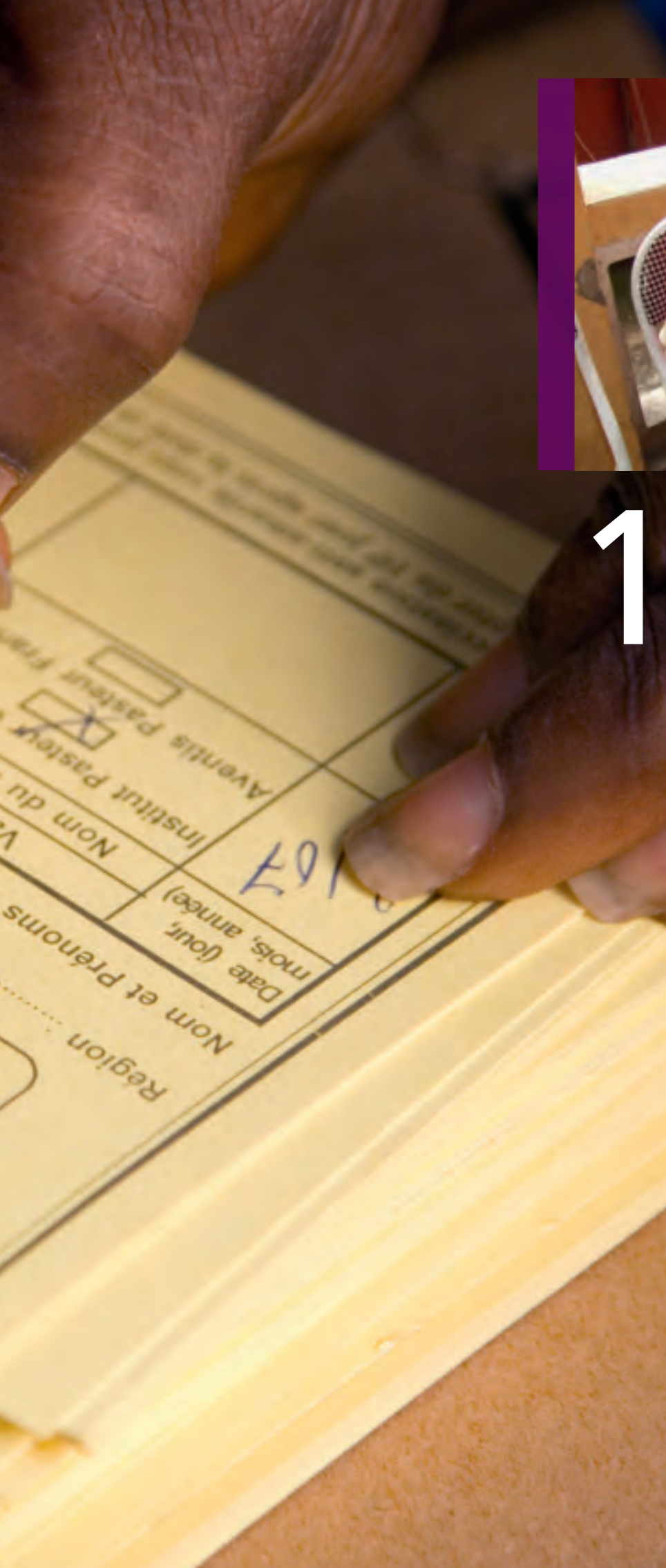
Préventive ☐

District

Riposte ☒

CAMPAGNE DE VACCINATION CONTRE LA FIÈVRE JAUNE

REPUBLIQUE TOGOLAISE
Travail - Liberté - Paix



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 2008:

- Pentavalent 5-in-1 vaccine formula drives sharp uptake of Hib vaccine against meningitis and pneumonia: 59 GAVI-eligible countries now approved for Hib support
- Major push to address pneumonia and diarrhoea: new vaccines and accelerated vaccine initiative
- Four vaccines selected for future GAVI portfolio: human papillomavirus (HPV), Japanese encephalitis, typhoid and rubella
- Support for yellow fever stockpile secures supply of vaccine for outbreaks



Accelerate vaccines

Pneumococcal and rotavirus vaccines represent a major breakthrough in health equity: for the first time, two life-saving vaccines are being introduced in the developed and the developing world at close to the same time.

These two vaccines represent the best hope of achieving the Millennium Development Goal 4 of saving lives of children under five.

More children die of pneumonia and diarrhoea – a leading cause of which is rotavirus – than from any other infectious disease. Now many of these deaths can be prevented with new vaccines. GAVI, WHO, UNICEF and other partners are working on a number of fronts to ensure these vaccines reach the most children, in the right formulation and at the best price as possible.

Progress towards addressing pneumonia has been advanced as well with dramatic uptake of *Haemophilus influenzae* type b (Hib) vaccine against meningitis and some forms of pneumonia. WHO projects an increase of 50% in the number of children reached with Hib vaccine in a year.

The increasingly preferred pentavalent vaccine is helping to boost immunisation coverage against Hib and hepatitis B. The 5-in-1 vaccine combines these two with the standard DTP formula against diphtheria, tetanus and pertussis.

In 2008, GAVI's Board added four vaccines to the Alliance's future portfolio. They were selected because they have the potential to have the greatest impact on the disease burden of the poorest countries. The vaccines immunise against human papillomavirus (HPV) which can cause cervical cancer, Japanese encephalitis, typhoid and rubella.

Three-quarters of all the GAVI Alliance spending is for vaccine procurement. Importantly, many of the poorest countries started to actively co-finance GAVI supported vaccines: a clear demonstration of the priority afforded to immunisation by those most in need.

Introducing new vaccines

New vaccines are now available to address many of the diseases threatening the health of people in the poorest countries. GAVI is working to make them available for introduction into immunisation programmes in developing countries. Key among these are vaccines against pneumococcal and rotavirus diseases, but also vaccines against meningitis, HPV, and other diseases.

Working together to address pneumonia

Of the 9.2 million deaths in children under five years of age, nearly 1 in 5 are caused by pneumonia. Pneumococcal vaccine has the potential to significantly reduce death and

disease due to pneumonia and meningitis. WHO estimates that over 700,000 children under the age of five die each year due to pneumococcal diseases and over 90 per cent of these deaths occur in developing countries. Clearly, lowering child deaths from pneumonia is one of the great health challenges and priorities.

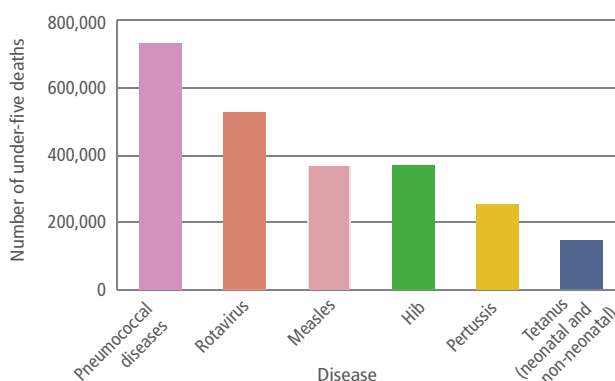
Eight new countries were approved in 2008 for GAVI support to introduce pneumococcal vaccine: Cameroon, the Central African Republic, the Democratic Republic of the Congo, the Congo, the Gambia, Kenya, Rwanda and Yemen. Countries could start

applying for this vaccine in 2007, and all GAVI-eligible countries, with over 50 per cent DTP3 coverage, can apply for the pneumococcal vaccine.

A new generation of pneumococcal vaccines more appropriate for use in developing countries is expected to be available soon. Thanks to the pilot Advance Market Commitment (AMC) for pneumococcal vaccine, these GAVI approved countries will be the first to benefit from the new vaccine.

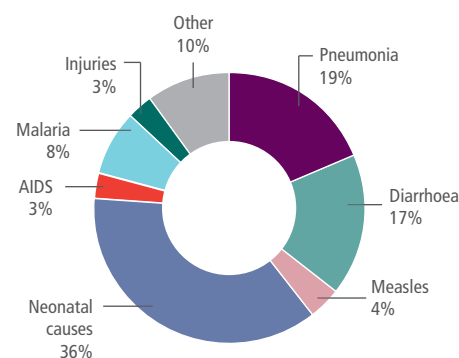
GAVI, WHO and UNICEF and a number of other partners are also working on several fronts to increase uptake of pneumococcal vaccine. The Accelerated Development and Introduction Plan for pneumococcal vaccine (PneumoADIP) has been working towards increased awareness and support to countries in deciding whether to introduce the pneumococcal vaccine. Its work will be carried on by the new Accelerated Vaccine Introduction (AVI) initiative.

Leading causes of vaccine-preventable deaths in children under 5 years old



Source: 15

Major causes of child mortality



Source: 16

“ In Kenya, a child dies every four minutes. This is unacceptable. The main cause of death is vaccine-preventable diseases such as pneumonia. It is imperative that government, the private sector and individuals feel morally obliged to do everything possible to reduce this trend. The war drums on infants’ death must beat louder ”

Professor Fred Were, chairman of the Kenya Paediatric Association and lecturer at the University of Nairobi



The importance of the rotavirus vaccine

Dr Tachi Yamada
President, Global Health Program
Bill & Melinda Gates Foundation

The recent development of the first safe and effective vaccine for rotavirus infection means that we may finally have a solution for one of the most glaring inequities in global health.

The collaboration and hard work that lead to this moment gives us so many reasons to be hopeful. For the first time, a vaccine has become available in the public sector of a GAVI-eligible country – Nicaragua – the same year it was licensed in the U.S. This year, long-awaited results from some of the largest clinical trials ever initiated will yield important safety and efficacy data for rotavirus vaccine formulations in Africa and Asia. Soon there may be a global recommendation for rotavirus vaccine use.

These developments are welcome news for parents around the world. In every time zone and every town, mothers and fathers worry about educating their children and keeping them safe. They also cope with childhood illnesses. Diarrhoea caused by rotavirus affects virtually all children at some point in their development.

Yet whether or not a child survives rotavirus infection depends largely on where they live. Too many children in developing countries succumb, while children in the developed world often suffer only mild illness. I was recently in Uttar Pradesh in northern India. In one area I visited, 30 percent of children have diarrhoea. Treatment is available only erratically.

As a gastroenterologist and a global health advocate, I am very optimistic about the arrival of this new vaccine; I have been painfully aware of the unnecessary deaths caused by diarrhoeal disease. It is hard to overstate what the future widespread use of rotavirus vaccines will mean for all children, their parents and the world.

It will also represent a meaningful milestone for the Bill & Melinda Gates Foundation. Bill Gates often tells the story of reading a newspaper article ten years ago about the leading causes of childhood death, including rotavirus. How is it possible, he wondered, that a disease that now kills 600,000 children per year is the focus of so little attention and investment?

The story inspired his interest in global health and led to the investments and advocacy the foundation pursues today, all of which are guided by the principle that all lives have equal value. In the same way, parents deserve equal opportunity to protect their children from preventable and curable diseases like rotavirus. Like the worries and wonders of raising a child, access to a rotavirus vaccine is one more thing all parents everywhere should have in common.

Reducing the incidence of diarrhoea with the new rotavirus vaccine

Diarrhoeal diseases are the second leading cause of death in children under the age of five. Rotavirus is the most common cause of severe diarrhoea in young children. It can result in acute dehydration, vomiting and fever and is responsible for more than 500,000 child deaths each year, mostly in developing countries. This is nearly one third of the deaths from diarrhoea worldwide.

A vaccine to prevent rotavirus infections was licensed for use in Europe, Latin America, and the United States in 2006. Results from trials in Africa and Asia to assess the safety and efficacy of rotavirus vaccine formulations for these regions are eagerly awaited and will inform WHO recommendations which are necessary for GAVI support. GAVI is poised to also bring this vaccine to these regions.

At present, there are 14 countries in Eastern Europe and Latin America eligible for support from GAVI for rotavirus vaccine and four countries – Bolivia, Guyana, Honduras and Nicaragua – have been approved for introduction.

The RotaADIP, or Accelerated Development and Introduction Plan for rotavirus, has been working to make rotavirus vaccines available to children by helping GAVI-eligible countries to decide on and prepare for introduction. Lead by PATH, the RotaADIP's mandate largely came to an end in 2008 with much of its work rolled into the new Accelerated Vaccine Introduction (AVI) initiative.

Partnering to support introduction of new vaccines

In 2008, GAVI developed a new integrated platform to support accelerated introduction of pneumococcal and rotavirus vaccines in GAVI-eligible countries. The Accelerated Vaccine Introduction (AVI) initiative has changed the landscape of partnership for new vaccines by developing a joint workplan with all partners.

The AVI is a partnership between the GAVI Secretariat, WHO and UNICEF, with a range of activities conducted through a consortium including PATH, the US Centers for Disease Control and Prevention (CDC) and the Bloomberg School of Public Health at Johns Hopkins University.

In October 2008, the GAVI Board approved funding of US\$ 51.3 million for the period 2009-2015 to enable the consortium to undertake special studies, communications and advocacy, and strategic vaccine supply forecasting.

In 2002, GAVI established two Accelerated Development and Introduction Plans (ADIPs) to expedite the development of rotavirus and pneumococcal vaccines and support in developing countries that wish to introduce the vaccines. The PneumoADIP was led by the Johns Hopkins University Bloomberg School of Public Health, and the RotaADIP was led by PATH.

The ADIPs have been successful in their purpose: to shorten the time between vaccine development and introduction in developing countries which decide to include the vaccines. For the most part, their work concluded at the end of 2008. As the two ADIPs were coming to an end, GAVI recognised the ongoing need to support countries to make evidence-based decisions on the introduction of new pneumococcal and rotavirus vaccines and developed the AVI to carry forward this important work.

New funding for meningitis vaccine

In June 2008, the GAVI Board approved US\$ 55 million for a new meningitis investment case. The funding will be used to provide a vaccine stockpile of meningitis A vaccine to counter annual outbreaks.

UNICEF, WHO, the World Bank, the Bill & Melinda Gates Foundation and the Meningitis Vaccine Project (a partnership of WHO and PATH) are working together to develop and implement a strategy to support the 25 most affected GAVI-eligible countries in strengthening routine meningitis immunisation using a new formulation meningococcal vaccine. GAVI has committed US\$ 29.5 million to the strategy for the years 2009 and 2010.

Meningitis causes inflammation of the lining of the brain and spinal cord. The meningococcal bacterium is a significant cause of meningitis. It is largely responsible for major epidemics which break out regularly, particularly in the 25 countries in the "meningitis belt," stretching east to west across Africa from Senegal to Ethiopia. It causes widespread suffering and can impact economic growth, greatly affecting local communities. From 1997 to 2007, more than 650,000 cases and nearly 60,000 deaths due to meningitis were reported in the region.

The meningitis strategy aims to prevent approximately 149,000 deaths by 2015, and prevent permanent disability in approximately 327,000 children and adults.

Steady growth in uptake of underused vaccines

GAVI has had a catalytic effect on increasing uptake of underused vaccines in the poorest countries. From inception to 2008, dramatic and significant inroads have been made, with DTP3 coverage approaching 80%, all but two GAVI-eligible countries providing Hepatitis B vaccine, and a surge in children receiving vaccines against Hib. The advent of the 5-in-1 pentavalent vaccine technology has played a major role.

Significant uptake of *Haemophilus influenzae* type b vaccine

2008 was the year which saw the most dramatic increase in the use of the *Haemophilus influenzae* type b (Hib) vaccine in developing countries. WHO projects the number of children reached with Hib vaccine rose to 41.8 million by the end of 2008, a 50% increase in just 12 months.

Fifteen countries were approved for support to introduce Hib vaccine in 2008, in addition to 20 in 2007, for a total of 59. The pentavalent vaccine has contributed significantly to the uptake of Hib vaccine as it enables delivery of DTP (diphtheria, tetanus, pertussis) plus Hib and hepatitis B vaccines in one shot.

Hib is a bacterial infection which mainly affects children under-five and can lead to life-threatening pneumonia and meningitis. The Hib Initiative has been working to support countries with evidence-based information which has played an important role in country introduction. The Initiative is a consortium of Johns Hopkins University, the US Centers for Disease Control and Prevention and the London School of Hygiene and Tropical Medicine.

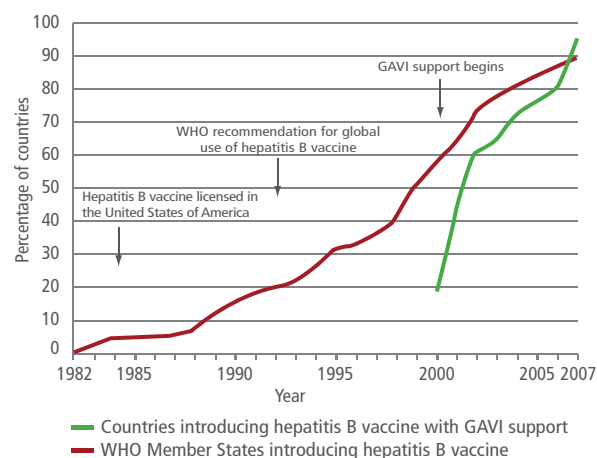
Shaping the market for pentavalent vaccine

By the end of 2008, GAVI had supported pentavalent vaccine in 56 GAVI-eligible countries. This is an increase of 15 countries during 2008.

WHO projects the number of children receiving the vaccine increased from 28 million to 42 million between 2007 and 2008.

US\$ 196 million have been dedicated for a tactical investment to support the supply of pentavalent vaccine, with 90% of the investment supplied from the International Finance Facility for Immunisation (IFFIm) bond proceeds. This GAVI guarantee helped to stimulate supply by encouraging new investments and increased production capacity by more manufacturers. The increase in demand, production capacity and supply of pentavalent formulation are examples of GAVI's market-shaping influence.

Dramatic uptake of Hepatitis B vaccine in GAVI-eligible countries compared to global introduction



Source: 17

Hepatitis B is a serious disease caused by a virus that attacks the liver, potentially causing liver cancer, liver failure, and death in adults. It has a major health impact in almost all GAVI-eligible countries.

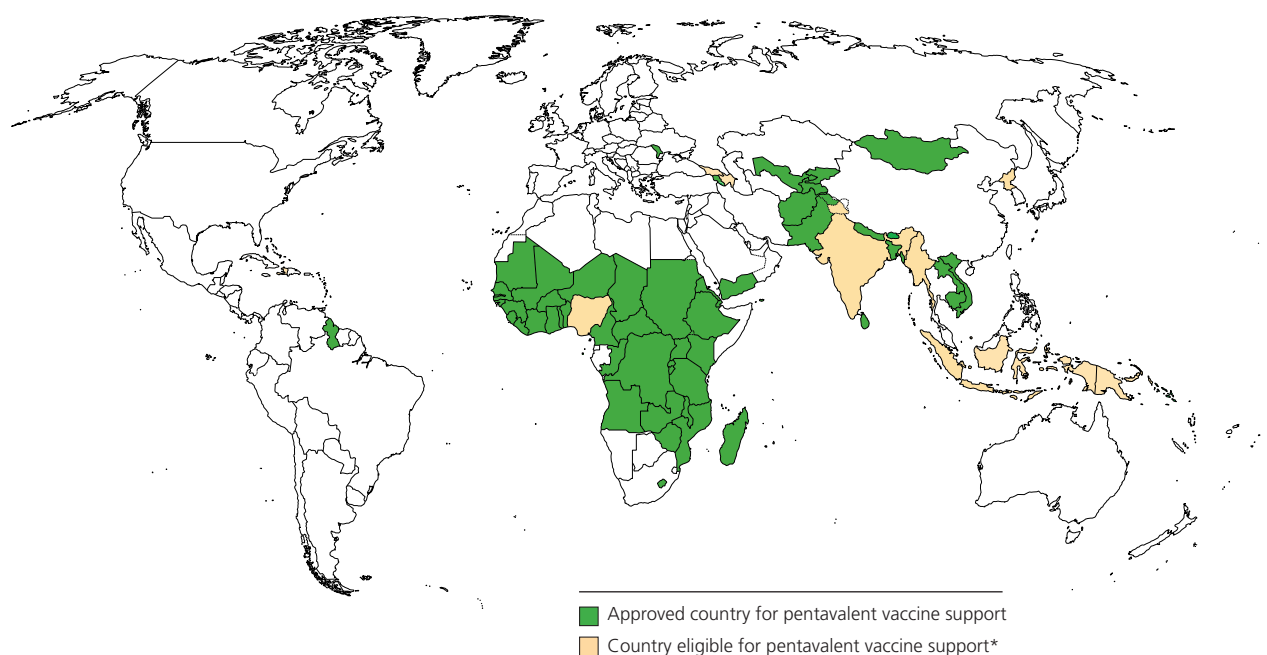
WHO estimates that by the end of 2008 a cumulative 192.2 million children will have been immunised against hepatitis B with GAVI's direct support.

Hepatitis B vaccine coverage in GAVI-eligible countries has increased from around 20% in 2001 to over 60% at the end of 2008. To date, 67 of 69 GAVI-eligible countries have been approved for support.

See also:

Ch. 3: Increase predictability: IFFIm, p. 42

Countries approved for pentavalent vaccine support, 2000-2008



Source: 18

* Some countries provide the same five antigens in pentavalent in separate or different formulas.



Pentavalent introduced in Madagascar

Madagascar launched the pentavalent vaccine during the annual Mother and Child Health Week in October 2008. The Prime Minister and Minister of Health and Family Planning attended, demonstrating the government's commitment to maternal and child health. The Ministry of Health works closely with partners to provide immunisation and health services to the 20-million strong population on the African island nation. Partners such as UNICEF, WHO, and USAID also attended.

During the launch, advocate groups used clowns and puppets to reinforce messages about health interventions provided by the government. They helped to raise awareness about how parents can take very simple steps to keep their children healthy – including immunisation.

Stockpiling yellow fever to save lives

There were a number of major yellow fever outbreaks in 2008 which were contained thanks to the immediate availability of vaccine stockpiles funded by GAVI, as part of the 2007 decision to tactically deploy new funds from IFFIm bond proceeds to global vaccine initiatives.

Additionally, the GAVI Board in 2008 approved a further tactical investment of US\$ 45 million to support mass immunisation campaigns and to ensure the ongoing security of yellow fever vaccine stockpiles.

To date, the stockpile has been used to respond to yellow fever epidemics in Togo, Cameroon, Brazil, Paraguay, Guinea, Liberia, the Central African Republic and Cote D'Ivoire. Also as a result of IFFIm funds to the Yellow

Fever Initiative, five countries have completed preventive mass campaigns: Togo, Senegal, Mali, Burkina Faso, and Cameroon.

GAVI also supports routine yellow fever immunisation in countries where WHO recommends its use. Up to the end of 2008 a cumulative 35.6 million children have been routinely immunised against yellow fever with GAVI support.

GAVI support for the yellow fever stockpile and routine immunisation has ensured a more secure supply of the vaccine in the marketplace. Previously supply was intermittent and unstable, and often the vaccine was unavailable or difficult to procure when outbreaks occurred.



Outbreak

in Burkina Faso

Heading off yellow fever outbreak

In late 2008, the Government of Burkina Faso undertook an immediate mass immunisation campaign to prevent a deadly outbreak of yellow fever. It focused on people in the country's high risk regions.

The Burkina Faso Ministry of Health, the Yellow Fever Initiative, WHO, UNICEF, and local and international civil society organisations worked together to implement the campaign.

More than 10,000 health workers and volunteers were involved, fanning out across targeted regions of the country to administer vaccines and educate populations about the disease.

"Vaccinating 7.9 million people requires significant technical, financial and in-kind contributions from all partners on the ground. Success relies on a coordinated team effort," said Dr Yada Adamou, WHO's African Regional Focal Point for Epidemic and Pandemic Alert and Response.

The campaign was funded through a contribution of US\$ 11 million from proceeds from IFFIm through the GAVI Alliance to the Yellow Fever Initiative, which facilitates widespread vaccination campaigns in yellow fever-endemic countries in West Africa. Burkina Faso's campaign is the largest so far undertaken. GAVI also supports Burkina Faso to include yellow fever vaccine in its routine immunisation programme for infants.

Yellow fever mass immunisation campaigns were begun in the 1940s and were very effective in nearly eradicating the disease in the Americas and Africa. As a result of these successes and the belief that the results were permanent, mass campaigns gradually died out.

In fact, the disease remained dormant in rural regions, waiting for yellow fever immunity to wear off in the population. In Africa, this happened at first gradually, then more rapidly. Today, WHO estimates that yellow fever causes 200,000 cases and 30,000 deaths each year, concentrated mainly in 12 African countries. During epidemics in unvaccinated populations, the risk of death in severe cases may exceed 50% for adults and 70% for children. No treatment beyond supportive care is available.

GAVI supports yellow fever stockpiles, mass immunisation campaigns through the Yellow Fever Initiative, as well as routine immunisation in eligible countries which apply for support.



Looking to the future: four new vaccines

In late 2007, WHO provided a shortlist for GAVI's consideration of 18 diseases for which vaccines exist, or new vaccines are in development.

Through 2008, a major consultative and analytical process was undertaken to determine which vaccines to invest in going forward. The new GAVI Vaccine Investment Strategy sought input from developing countries, GAVI partners, donors, academic institutions, the pharmaceutical industry, civil society organisations and global health leaders.

The Vaccine Investment Strategy identified four vaccines for approval by the Board to be included as part of a future GAVI vaccine portfolio. These are strategic choices, not financial investments at this time.

GAVI's selection was based on the overall burden that these diseases place on the world's poorest countries. The vaccines target human papillomavirus (HPV) which is the leading cause of cervical cancer, Japanese encephalitis, typhoid and rubella (*see box for details*).

This reflects the reality that the landscape for vaccine development has changed dramatically since GAVI's creation in 2000. At that time, there were relatively few new vaccines of relevance to the developing world, and GAVI's work focused on ensuring existing vaccines reached the poorest countries. Now there is a wide range of new vaccines in development against diseases that seriously impact developing countries. There are many possibilities on the horizon, but choices must be made, and the Vaccine Investment Strategy provides an evidence-based framework for working through those considerations.

Vaccines against the greatest burden for the poorest countries

The GAVI Board has prioritised four vaccines for the future vaccine portfolio. They were selected because they address diseases which have the greatest burden in the world's poorest countries:

- **Human papillomavirus (HPV):** about half a million women are diagnosed with cervical cancer every year: about 80% live in developing countries. HPV is the major cause of cervical cancer. A vaccine against HPV was first licensed in 2006 and is being introduced in many developed countries.
- **Japanese encephalitis:** is a serious viral infection which affects the brain and is transmitted by mosquitoes. It hits particularly in Asia where WHO estimates 10 to 15,000 people die from the virus each year. A vaccine exists, but a new generation vaccine which is more appropriate to needs is expected shortly.
- **Rubella:** when a woman is infected with the rubella virus early in pregnancy, she has a 90% risk of passing the virus on to her foetus. This can cause death of the foetus or congenital rubella syndrome (CRS), an important cause of severe birth defects in the ears, eyes, heart and brain. It is estimated that there are 110,000 cases of CRS each year. A vaccine exists, but it is not widely enough used in developing countries.
- **Typhoid:** the disease remains a serious public health problem around the world, with an estimated 16 to 33 million cases and 216,000 to 600,000 deaths annually. New generation vaccines are expected soon.



All girls deserve to be protected from cervical cancer

Half of all women diagnosed with cervical cancer die from the disease, and the vast majority of those deaths occur in the developing world. While richer nations are taking steps to protect women from cervical cancer, including screening and vaccination, women in developing countries are dying.

Cervical cancer is the leading cause of cancer death of adult women in the developing world and the second most common cancer among women worldwide. The highest incidence of disease and death are in sub-Saharan Africa, Latin America and South Asia.

Vaccines against the two most dangerous types of human papillomavirus (HPV) that cause most cases of cervical cancer have been available in developed countries since 2006. The vaccines have been found to be safe and effective in preventing HPV that leads to cervical cancer.

The GAVI Alliance aims to make the HPV vaccine available to girls in the world's poorest countries in the coming years. This is an opportunity to work towards improving women's health by making this life-saving vaccine available to young women and girls no matter where they happen to be born.

“The burden of cervical cancer falls upon the developing world where there is neither screening nor other ways of preventing and treating cancer... GAVI's aim to provide the HPV vaccine to as many developing countries as possible is worthy of donor support”

Professor Harald zur Hausen, the 2008 Nobel Prize winner for medicine for discovering the link between HPV and cervical cancer



unicef



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2

Strengthen capacity

STRATEGIC GOAL:

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

KEY RESULTS 2008:

- 17 new countries approved for health system strengthening (HSS) support
- A further US\$ 300 million committed for HSS
- Evaluation demonstrates GAVI's catalytic impact on setting new standards for injection safety
- Pioneering approach to supporting health systems attracts global interest

Strengthen capacity

Sustained improvements in health for the people of the poorest countries require reliable and equitable services and capacity. Like all public health services, delivery of vaccines and increased immunisation coverage depend on strong health systems.

GAVI supports health and immunisation services in three ways: through immunisation services support, health system strengthening support and funding to better involve civil society organisations in decision-making and service delivery. As well, GAVI funding has had a major impact on improving injection safety standards in developing countries.

GAVI's innovative ways of working – such as performance-based systems and flexible funding – have been recognised for leading new thinking on how to empower countries to improve delivery of public health and services.

Supporting countries to strengthen health systems

In February 2008, the GAVI Board approved an additional US\$ 300 million in funding for health system strengthening (HSS). This is an increase on GAVI's existing window of US\$ 500 million.

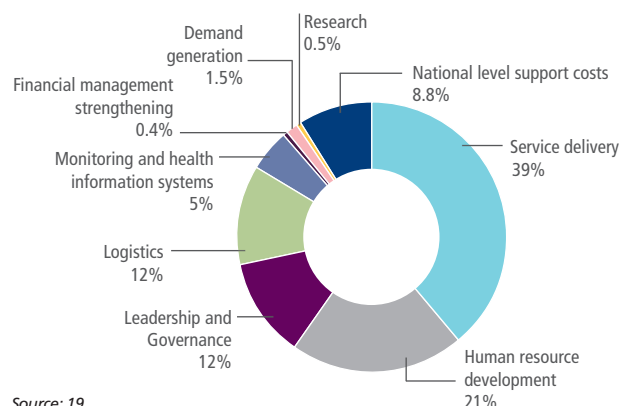
Seventeen countries were approved for HSS support in 2008. They were: Armenia, Azerbaijan, Bangladesh, Bolivia, Burkina Faso, Cambodia, Chad, Côte d'Ivoire, Cuba, Eritrea, Guinea-Bissau, Indonesia, Mali, Myanmar, Senegal, Sudan, and Tajikistan.

US\$ 138 million in funding was distributed to approved countries in 2008. GAVI commits to supporting countries for the duration of their planning cycle, aligning funding with their national health programmes. Some HSS support to countries extends to 2015.

A total of 44 countries have had applications approved since the programme began in 2007. The 2010 target of 50% of GAVI-eligible countries receiving approval for HSS support has already been surpassed.

Breakdown of HSS proposed activities in countries

75% of funding is proposed for use at the district level or below



Source: 19



Innovative and sustainable approaches

A review of applications submitted for HSS funding shows that countries are developing innovative and tailored solutions to their health-care challenges. GAVI's HSS funding might be used to pursue a new approach or to adopt strategies that have been found to work in other countries.

For example, Indonesia's HSS proposal targeted some of the country's more systemic challenges. With a population of about 230 million scattered over more than 6,000 islands, Indonesia faces many challenges to health and immunisation service delivery. The proposal sets out how access to health services can be increased, including contracting-out services, such as community mobilisation and service delivery, to CSOs.

An important goal is to enable long-lasting changes beyond the time frame of GAVI funding. HSS guidelines require countries to consider the financial and technical sustainability of HSS support and describe how they expect to maintain the recurrent cost once support ends. The Gambia aims to

ensure this sustained support: its proposal included a plan to mobilise additional resources to sustain the gains after GAVI HSS funding ends. This involves securing high level political buy-in, organising regional fund-raising activities and seeking resources from local donors.

Monitoring and evaluating progress

In 2008 funding was approved for a major tracking study to begin in 2009 covering six countries.

The study will evaluate the degree to which HSS proposal development and implementation are integrated into countries' existing national and health sector planning and budgeting, financial management and reporting procedures.

It will provide better information on which to base future decisions about HSS, and aims to improve partner support at both the global and national levels.

Sharing good examples of health system strengthening

The goal of GAVI's HSS funding is to support countries in moving towards broader, more integrated health plans and systems to support delivery of immunisation. It also aims to sustainably increase coverage, especially for those hard-to-reach or marginalised populations.

GAVI support has had a catalytic effect at the country level. Some countries report that the HSS application process has encouraged them to look at their entire health system and how best to make the whole delivery platform more effective. Some say the process strengthened their overall integration and planning processes. In other countries, the process has provided unique opportunities for staff focused on immunisation to work with other health colleagues to improve health delivery overall.

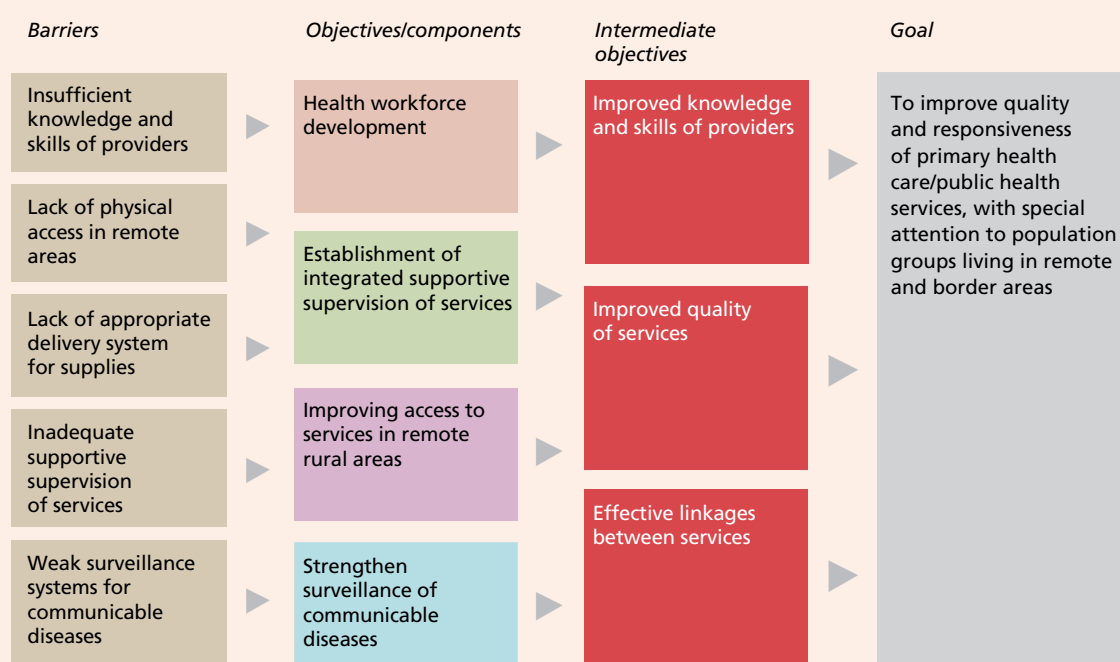
GAVI's HSS proposal guidelines encourage countries to focus on three areas of work in particular:

- Health workforce mobilisation, distribution and motivation
- Organisation and management of health services
- Supply, distribution and maintenance systems for drugs, equipment and infrastructure

Country proposals for HSS funding are reviewed by the Independent Review Committee (IRC), which makes recommendations for approval to the GAVI Board. The IRC has identified examples of good HSS proposals and proposal development from a range of countries which have been shared as an exchange of lessons learnt.

In 2008, GAVI gathered and published a booklet of good examples from country reports. The Armenian government's proposal was selected as an example of clear linkages between identified problems, the barriers to be tackled with HSS support, and how they will be addressed.

Armenia's HSS proposal framework



See also:
www.gavialliance.org/HSS/principles

Source: 20

Involving civil society organisations

GAVI recognises the important role of civil society organisations (CSOs) in improving health outcomes and immunisation. Their involvement is central to hopes of achieving the Millennium Development Goals.

CSOs deliver anywhere from 10 to 65% of routine immunisation in many countries. CSOs also mobilise populations for immunisation and other child health services. Importantly, they often act as advocates to influence decision-makers and improve equity of health services by working to ensure all communities and people benefit, particularly those in remote or marginalised populations.

Support to CSOs through countries

2008 was the first full year of GAVI's support to countries to increase the involvement of CSOs. There are two types of GAVI support: the first, called type "A", is available to all GAVI-eligible countries, and is intended to strengthen the role and representation of civil society in country-level coordination.

Over US\$ 567,000 of type "A" funding was disbursed in 2008 to Afghanistan, the Democratic Republic of the Congo, Ethiopia, Ghana, Indonesia and Pakistan to strengthen the role and representation of civil society in country-level health and immunisation plans.

The second, or type "B" support, is available for CSO direct involvement in implementing the country's HSS proposal and/or comprehensive multi-year plan for immunisation. A total of US\$ 22 million will be disbursed to 10 pilot countries by 2010. The GAVI Board approved four additional countries for type "B" funding in 2008: Afghanistan, Ethiopia, Indonesia, and Pakistan. A total of five countries in total have been approved for this type of CSO support.

In each of the countries, a consortium of CSOs will spend the funds on activities that complement those of the Ministry of Health. This may be, for example: outreach to remote groups in the mountains in Afghanistan; involving religious leaders to increase demand for immunisation in Ethiopia; engaging the private sector in Indonesia; or improving the quality and range of maternal and child health services in urban and rural communities in Pakistan.

The GAVI CSO pilot phase ends in 2010, when the support will be evaluated and the results will inform future decisions about direct GAVI funding for CSOs.

Piloting a new way to improve health system capacity

The Democratic Republic of the Congo is the first pilot country to receive broader type "B" funding. In 2008 the country received US\$ 2.9 million of a total funding award of US\$ 5.3 million.

A consortium of five CSOs aims to boost immunisation coverage in 65 low-performing districts by working with communities to create demand and outreach to marginalised populations. The CSOs will train health service providers, and support logistics and vaccine delivery.

Strengthening collaboration

GAVI also seeks to strengthen the voice of CSOs in informing decisions. CSOs are increasingly consulted in developing policy and deciding on new investments. CSOs have a seat on the Alliance Board and are also represented on a number of GAVI task teams and advisory bodies.

“To successfully implement the HSS plan, the Ministry of Health recognises the need for public-private partnership to achieve the desired health outcomes. Opportunities will have to be sought to deepen the engagement of and collaboration with private and civil society organisations”

Ministry of Health of Pakistan, CSO proposal to GAVI, 2008

Immunisation services support: reviewing GAVI's results-based programme

GAVI's immunisation services support (ISS) is a pioneering programme that assists governments with the challenges of scaling up immunisation programmes. It does so in two ways: via flexible funding support for an initial investment phase of two to three years, and in subsequent years as rewards for performance for additional children vaccinated with three doses of DTP vaccine. Reward payments feed back into the immunisation programme to strengthen it to access hard-to-reach and high risk populations.

A total of 62 countries have been approved for ISS funding. Of those, nine countries are still in the investment phase and 41 countries have subsequently received result-based rewards.

In 2008, 17 countries qualified for rewards: Afghanistan, Burkina Faso, Cameroon, the Congo, the Democratic Republic of the Congo, Ethiopia, the Gambia, Guinea-Bissau, Kenya, the Democratic People's Republic of Korea, Liberia, Niger, Pakistan, Sudan,

Tajikistan, Togo and Yemen. Following the first five years of ISS support, countries have to apply to continue receiving rewards.

All ISS grants were temporarily suspended in December following concerns over the quality of data on national immunisation coverage (see *next page*). A detailed review was initiated, and the programme reinstated.

Flexible funding works

Independent evaluations of ISS released in late 2007 found that the programme has helped countries reach an additional 2.4 million children with three doses of DTP – children who would not have been immunised otherwise.

One evaluation reported that countries use ISS funds in line with their National Immunisation Plans, often to plug gaps and support underfunded areas. The majority of funds were spent at the district level where they are most needed. This demonstrates that flexible, integrated funding works.



Improving data quality: lessons learnt

Lessons from GAVI's experience with immunisation services support (ISS) point the way for new approaches to flexible, performance-based development finance. The success of performance-based programmes depends intimately on data quality. Alongside the success of GAVI's ISS in terms of boosting immunisation programmes, much was learned about the types of checks and balances that are needed to mitigate the risk of introducing distortions in country reporting systems.

The independent evaluation of ISS conducted in 2007, as well as other external studies, identified discrepancies in immunisation rates between country-reported health service data and data from other sources such as household surveys.

When the ISS programme was conceived in 2000, the GAVI Board took the decision to use countries' administrative data to calculate reward funding. The inherent risks in using data from weak reporting systems were known. GAVI's decision was based upon a strong desire to strengthen government data collection rather than create parallel collection and reporting systems.

As a check on country data, ISS rewards depend on a Data Quality Audit (DQA). They have helped to identify weaknesses in national data collection and management systems and

failure to pass the DQA has encouraged countries to invest in improvements.

GAVI established a Data Task Team in 2008 to examine immunisation and public health data collection methodologies, including ISS and the DQA. Team members included academics and technical experts from a range of institutions including the University of Aberdeen and the Harvard School of Public Health, the World Bank and UNAIDS, among others.

The experts agreed that there exists no single "gold standard" for measuring the effectiveness of aid programme results and performance. The team recommended that GAVI continue to use the annual estimates compiled by WHO and UNICEF that rely on multiple data sources to monitor progress of immunisation programmes and calculate reward payments. The experts also advised GAVI to support the strengthening of the WHO/UNICEF estimation process and made a number of other recommendations including that GAVI continue to support the strengthening of country administrative data systems.

In 2009 GAVI will take up the lessons learnt and the expert recommendations and, working with others, apply them in the design of new incentive-based programmes to sustain and grow coverage of health services.



Zambia

Saving the lives of children and mothers in Zambia through strong leadership and partnership



Once a month, the outreach workers gather near the Dar Farms in Chibombo District of central Zambia to care for the babies and children, pregnant and breastfeeding mothers of the region. Health workers arrive on scooters provided to reach these remote locations – Dar Farms is 23 km, or an hour's drive, from the nearest major clinic. Among their materials are vaccines in a cool box, autodisable syringes and a safety disposal box. Local volunteers help prepare for the day's work.

Slowly through the morning farm workers – released from work by the commercial farm owners to attend the monthly health outreach session – bring their children to be weighed, to be checked for health problems, and to receive vaccines and health and nutritional advice. Some have walked for two or three hours to attend. More than a hundred children are seen during the session, a tremendous increase in just a few years.

Integrated maternal and child health-care and the synergy of partnership in Zambia come together on the ground here at Dar Farms' outreach session. It is evidence of the transformative impact of the approach of the Ministry of Health on the lives of women and children.

The ministry has established a strong framework for partnership and service provision. It has strengthened the interagency

coordinating committee from its original focus on immunisation to the broader agenda of newborn, child and maternal health. The committee is chaired by the Minister of Health and attended by senior representatives of key partners such as WHO, UNICEF, donor governments and civil society organisations (CSOs). Other mechanisms for partner coordination and involvement are in place, ensuring agendas are jointly formed, issues are discussed and shared plans are put in place. The ministry has also integrated and coordinated its neonatal, child and reproductive health services.

This approach from the ministry extends down through provincial and district levels, where the ministry works with partners to ensure adequate services reach mothers and children. Partners such as UNICEF, WHO, and CSOs play important roles alongside the ministry in strengthening Zambia's capacity to improve maternal and child health through district and community levels. For example, UNICEF provides training to health workers, and WHO provides communicable disease surveillance. CSOs supply crucial support by training health professionals and workers, delivering services, and building health centres. For example, the Churches Health Association of Zambia provides 30% of Zambia's health services.

Silwaba Weby is a mother-and-child health coordinator at the Chibombo district, who says stakeholder meetings are crucial. "At these meetings, the different organisations present the support they provide, so we know about it, and we discuss and allocate tasks so there is no overlap and the resources are used efficiently," he says. "We are the custodians of health services in our district, and we have to make sure that the people here get good services and the right information."

"We were able to do this because we have had very strong political leadership", says Dr Victor Mukonka, Director of Public Health and Research for the Ministry of Health, "Our Minister of Health has worked extremely hard to convince colleagues in the cabinet of the

importance of investing in children and of prevention rather than waiting until the children are sick." As a result, he says, there is major commitment for funding for such health interventions as immunisation. For example, Zambia currently co-finances a quarter of the cost of procurement of vaccines with GAVI and, as Dr Mukonka adds, "We are hoping at the end of the day that we will fully fund for the immunisation of our children."

Zambia has been supported in its efforts with funding from GAVI initially for DTP-Hib and more recently for the 5-in-1 pentavalent vaccine. In order to strengthen and better support immunisation delivery, Zambia applied for and received more than US\$ 6.5 million in GAVI funding over four years to strengthen its health system in 2007.

The health of Zambia's children has steadily improved in recent years. Population surveys show that the infant mortality rate has dropped to 70 per 1000 live births in 2007 from 95 per 1000 live births in 2001. The under-five mortality rate has also fallen to 119 per 1000 in 2007 from 168 per 1000 in 2001. Zambia's strong initiative on "preventing mother to child transmission" (PMTCT) of HIV, coupled with treatment to those born with HIV, has contributed to the drop. As well, deaths from measles have been reduced to near zero, and neonatal tetanus and polio have been eliminated through vaccination.

Eleazor Chiyanka works the fields of Dar Farms. But he is also trained by a local CSO as a community volunteer. He does house visits, teaches people to build and use latrines, and today he helps the nurses by weighing children. He says he likes to help the people in his community. "I see great improvements in the health of children," says Eleazor, "They are not suffering from disease like tetanus and measles that they suffered from before, and their nutrition has improved so if they get sick they will get well again faster."

Farmworker Esther Chisenga has brought her 4 month-old son, Derrick. She says, "I made this journey here because I wanted to make

sure Derrick got his check-up and I also knew it was time for his vaccine because they told me at last month's session. This is important because I want to make sure he is healthy and can grow up to have a good life."

Zambia has created a model of partnership and integration of health services to prioritise and deliver maternal and child health-care. But as Dr Mukonka warns, its success is not guaranteed. "The global financial crisis is beginning to affect Zambia. I would therefore like to appeal to our partners to not relax or reduce the support because we are still scaling up interventions, and after that we need to sustain them."





Working in partnership to improve health-care and immunisation

Faruque Ahmed
Director of Health, BRAC (a development organisation based in Bangladesh)
GAVI Board Member representing Civil Society Organisations

The over-arching goal of BRAC is poverty elimination and empowerment of the poor, particularly women. For us, it's a question of giving people their dignity and ability to live a decent life. BRAC is the largest non-profit organisation in the developing world. We began in 1972, not long after the war which saw the birth of Bangladesh as an independent nation.

Bangladesh was born with high fertility and high mortality rates, but low per capita spending on health services. BRAC became a partner for immunisation with our government and UNICEF in the 1980s. In just 10 years, the partnership was successful in bringing up immunisation coverage in one region from 2% to 75%. So we demonstrated that it is possible to improve immunisation, even with limited resources.

GAVI's support to Bangladesh for vaccines has been really important to improving immunisation for the whole country. But key to success is GAVI's funding to create capacity within the health system to deliver vaccine services, and to fill the critical gaps – like the cold chain, or training, supervision and mobility of the workforce. These are gaps that weren't fully funded from existing resources.

GAVI recognises the important role of civil society in solving those challenges: they can contribute to developing policy and delivering vaccines. It must be done in broad partnership within the country.

And GAVI isn't giving the prescription to the country. GAVI is saying we are here to help you, and asking the countries to come up with their own analysis: what do you need in terms of keeping your immunisation programme up so that you achieve the MDG goals, and how can we help you? So it's a country-led process.

GAVI is committed to work in partnership with other health actors. It listens to its constituents – particularly donor and recipient countries. That's what I see is happening in my country.

Injection Safety Support: catalysing sustainable change

GAVI has played a critical role in setting new global standards for safe injection practices. It has been determined by an independent review that use of autodisable (AD) syringes is higher in GAVI-supported countries than in other lower middle-income countries.

GAVI provides time-limited funding to national immunisation programmes under its injection safety support (INS) programme. This support was designed to enable countries to introduce or increase the use of AD syringes. INS assistance is provided in two forms: in-kind in the form of AD syringes and safety boxes, or cash for countries which already had a source of AD syringes and safety boxes. It is estimated that GAVI has funded the procurement of more than 2.5 billion AD syringes from 2000 to 2008.

Fostering safe practices

By the end of 2008, 71 eligible countries had been approved for INS support since GAVI's inception. Support is limited to three years, and is intended to be catalytic – countries are expected to find sustainable financing to carry on injection safety programmes.

GAVI contracted an external study of the INS programme in March 2008. The evaluation focused on the 58 countries that had completed support by the end of 2006.

Sustaining safe injection systems

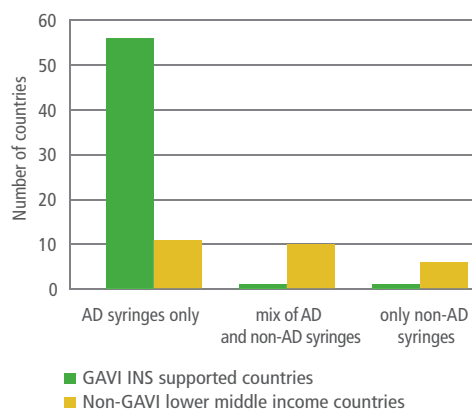
The independent study found after completion of GAVI support that the vast majority of recipient countries in the study were covering the cost of AD syringes and safety boxes with funding by government and/or donor sources.

Out of 58 countries receiving GAVI injection safety support, 30 are now self sufficient – their immunisation injection safety programmes are fully government-funded – 11 rely on a mix of donor funding and government support, 15 rely on donor funding, and only 2 have not been able to sustain support.

The review also found that the use of AD syringes has broadened from immunisation to other health services in some countries. In all countries, the use of disposable technology has heightened the awareness of the need for better healthcare waste management. The study confirmed that the price of AD syringes has fallen significantly from the time GAVI funding began.

Participants in the study, both at global level and in countries, cited the importance of GAVI's role in advancement of injection safety, and noted this as one of GAVI's important achievements. GAVI's time-limited support provided the impetus to address the injection safety problem, but there is ongoing commitment by countries to sustaining safe injections through the use of AD syringes.

Use of AD syringes higher in GAVI INS-supported countries



Source: 21





3

STRATEGIC GOAL:

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

KEY RESULTS 2008:

- Second IFFIm Vaccine Bond issue raises more than US\$ 200 million from private investors in Japan
- Ground-breaking public-private partnership established with la Caixa Bank and its Foundation
- Advance Market Commitment pilot for pneumococcal vaccine nears implementation
- New co-financing approach embraced by countries – a step towards sustainability

Increase predictability



Increase predictability

Predictable and sustainable funding underpins the GAVI model. Committed donors and innovative financing enable countries to scale up immunisation and plan for the future.

It also influences the marketplace for vaccine development, production, supply and stability.

The International Finance Facility for Immunisation (IFFIm) issued a Vaccine Bond in Japan in 2008, demonstrating the appeal of ethical investments. The pilot Advance Market Commitment (AMC) for pneumococcal vaccine moved closer to commencement with preparatory work completed during 2008.

GAVI does not underestimate the challenge of raising funding to meet rapidly growing country demand, especially in an economic downturn. But the Alliance remains confident that, on the basis of its performance to date, it is recognised as a good investment for delivering real health gains. The economic climate is difficult, but health must remain a development priority, and immunisation is one of the most cost-effective interventions.

Funding vaccine support: meeting rising demand

GAVI receives donor contributions from public and private sources which are pooled to become a source of finance that can be used flexibly by countries to meet their needs.

Steady and consistent donor funding enables GAVI to provide long-term commitments to countries. This catalyses confidence in countries to scale up their immunisation programmes, introduce vaccines and strengthen their health systems to support immunisation efforts.

By aggregating demand for vaccines, GAVI is able to create economies of scale and address critical market failures by motivating the vaccine industry to scale up production capacity, attracting new suppliers to the marketplace.

The International Finance Facility for Immunisation (IFFIm) supplied a significant injection of funds in 2007 and into 2008. The rapid disbursement to countries and immunisation initiatives has provided proof of concept that donors' long-term contributions can be transformed into immediate impact and results.

Donor commitment is the engine of country support

Overall funding to GAVI totalled US\$ 624 million for 2008, with a cumulative total of US\$ 3.8 billion for the period 2000-2008.

Direct contributions:

- Donor governments and the European Commission - contributed US\$ 269.3 million in 2008, with a cumulative total of US\$ 1.51 billion for the period 2000-2008.
- Foundations, private individuals and organisations - contributed US\$ 81.5 million in 2008 - including US\$ 75 million from the Gates Foundation - with a cumulative overall total of US\$ 1.08 billion for the period 2000-2008.

Innovative funding mechanisms:

- IFFIm - contributed US\$ 272.6 million in 2008 to GAVI core programmes and to targeted immunisation initiatives, with a cumulative total of US\$ 1.2 billion for the period 2000-2008.
- Advance Market Commitments - US\$ 1.5 billion has been pledged to the Advance Market Commitments pilot AMC for pneumococcal vaccine.

See also:

The GAVI Alliance: working together, p.8

Annex 2: Donor contributions and commitments, pp. 60-61

“ GAVI should be careful to avoid allowing funding projections to drive strategy development. Instead, GAVI should agree upon a strategy that is a “best fit” with GAVI’s mission and objectives, and fundraise against it. Although GAVI should take a prudent stance on individual investments, it must remain ambitious in its aspirations ”

GAVI Alliance Board, October 2008

**Funding in uncertain times:
bold but prudent**

The global financial crisis is having an impact on all areas of government funding in both donor and implementing countries. The World Bank estimates 53 million more people will be propelled into poverty as a result.

While prudence is essential, the crisis must not dampen ambition or slow momentum. It is, in fact, the very time to hold steady to GAVI’s mission. Health is acknowledged as a central building-block of development, economic stability and growth in the poorest countries, now hit hard by the economic downturn. Vaccines are an excellent investment, among the most cost-effective health interventions. Funding for immunisation must not diminish but increase if the MDGs are to be achieved, lives saved and future economic development ensured.

The demand from GAVI-eligible countries for new and under-used vaccines is growing dramatically with the addition of the first new vaccines against pneumococcal and rotavirus diseases. These two new vaccines could represent dramatic savings of children’s lives.

The prospect of four new vaccines prioritised by GAVI for future support – to prevent cervical cancer caused by human papillomavirus (HPV), Japanese encephalitis, rubella and typhoid – will further raise demand for vaccine support.

Very few organisations are able to provide financial projections that extend beyond two or three years into the future. GAVI’s projections, which carry through to 2015, allow decision-making on medium to long-term investments with a degree of certainty and helps to identify future financing gaps.

On current forecasts, significant additional funding is needed between 2009 and 2015 if GAVI is to fulfil its commitments to developing countries to deliver new and underused vaccines.

At its October 2008 meeting, the GAVI Board requested the GAVI Secretariat to develop a comprehensive fundraising strategy to meet the challenge of the emerging funding gap. The Board has warned against too much caution as GAVI must assure that, now more than ever, considered innovation remains at its core.

GAVI contributors* over the period 2000-2008 include:

Direct Contributions - Australia, Canada, Denmark, the European Commission, France, Germany, Ireland, Luxembourg, the Netherlands, Norway, Spain, Sweden, United Kingdom, the United States, the Bill & Melinda Gates Foundation, la Caixa Foundation and individual donors.

The International Finance Facility for Immunisation - The founder donors were France, Italy, Norway, Spain, Sweden, and the UK. South Africa joined IFFIm in 2007.

Advance Market Commitment - Canada, Italy, Norway, the United Kingdom and the Russian Federation, as well as the Bill & Melinda Gates Foundation.

** detailed at Annex 2*

The Immunize Every Child Campaign celebrates its first year

On 25 September 2008, GAVI celebrated the first full year of the *Immunize Every Child Campaign* with a high-level member briefing and Every Child Council reception to coincide with the UN session on the Millennium Development Goals in New York. More than 50 current and potential donors took part in the day's activities.

The reception featured a conversation on GAVI's work and effectiveness between Jordan's Queen Rania and GAVI Alliance Chair Mary Robinson and closing remarks by HRH Princess Cristina of Spain. New members were welcomed to the Every Child Council: Dr Isidro Fainé, President of la Caixa, and Paul and Elaine O'Connell, Boston-based philanthropists.

GAVI's *Immunize Every Child Campaign* seeks to engage private philanthropy in furthering the mission of improving health through immunisation.

By the end of 2008, the *Immunize Every Child Campaign* had more than 1700 donors and prospective donors, compared with 999 donors and prospects at the end of 2007. Fundraising campaigns were launched through the US Combined Federal Campaign, the world's largest workplace giving programme, and the Business Alliance for Childhood Vaccination through la Caixa Bank of Spain (see story).

Co-financing: countries committing to sustainable vaccination programmes

2008 was the first year that a number of GAVI countries were required to co-finance GAVI-supported vaccines. As a result, 27 countries are now co-financing their vaccine costs: six countries co-finance on a voluntary basis and for 21 countries co-financing is compulsory. In 2008, countries co-financed US\$ 17.3 million of GAVI-supported vaccines.

A number of countries have chosen to co-finance beyond the required minimum, such as Benin, Liberia, Madagascar, Niger and Zambia, among others. This demonstrates the value of the vaccines to these countries, and that countries are truly taking charge of their new vaccine costs.

GAVI's co-financing policy is a unique model to ensure sustainable financing and vaccine support. Countries start co-financing when they introduce new vaccines, or receive continued support for existing vaccines beyond the first five years of GAVI support. Co-financing promotes country ownership. It also supports GAVI's efforts to have a positive influence on pricing and market dynamics. It is an important element in ensuring long-term financial sustainability of these vaccines.

Going forward, all countries will co-finance GAVI-supported vaccines according to their ability to pay and the number of different vaccines deployed.

Commitment to immunisation

Spain's public and private leadership

In 2008, the Government of Spain and a major Spanish bank and foundation made bold and substantial commitments to immunisation with donations and fundraising campaigns. It shows determination to address childhood disease and death, and points the way for future philanthropy.

The Spanish Government made a new donation of €29 million to the GAVI Alliance. This contribution will be used directly to fund GAVI programmes and comes in addition to Spain's existing commitment of €189.5 million over 20 years to IFFIm. Spain was one of the founding donors of IFFIm.



Emerging as a significant donor in development assistance, Spain has achieved remarkable progress over recent years in its drive to reach 0.7% of GDP spending on overseas development aid. Despite turmoil in the global economy, the government has shown resolve to maintain its promises to the world's poorest countries, reaching 0.5% of its GDP at the end of 2008.

The new donation to the GAVI Alliance reinforces Spain's commitment to the Millennium Development Goals, as prioritised in its III Plan of Development Cooperation 2009-2012, in particular MDG 4 to reduce infant mortality. The Government of Spain, through the Spanish Agency for International Development Cooperation (AECID), also promotes the private sector to join forces and resources to address the challenges of global health.

Also in 2008, GAVI collaborated with la Caixa, Spain's leading savings bank, in an innovative public-private fundraising partnership programme. The initial effort was an outreach campaign to la Caixa's 26,000 employees to contribute to GAVI through a payroll deduction plan. The employee programme was followed by a campaign to engage la Caixa's 400,000 corporate depositors, called the Business Alliance for Childhood Vaccination. Both initiatives are among the first of their kind in Europe and garnered widespread support among la Caixa's employees and corporate clients.

La Caixa Bank's associated foundation – *Fundación "la Caixa"* – made its first contribution in support of GAVI and joined GAVI's Every Child Council. The €4 million grant is the largest made by the foundation to a single organisation.

The importance of multiple funding sources – public and private – to finance development becomes increasingly crucial for ensuring a stable and predictable funding base. Through the new Government contribution as well as the private campaign and donation received through the la Caixa bank and foundation, Spain sets an example for other donors. It brings to GAVI a true mix of public and private money, demonstrating strong support for the cause of immunisation across different layers in society.

“By working together, we can efficiently move towards eradicating infant mortality and significantly improve living conditions for children”

Isidro Fainé, Chief Executive Officer, la Caixa Foundation



IFFIm: significant aid, quickly delivered

Dr Alan Gillespie
Chairman, IFFIm

Financing is one of the most important tools to empower those in poverty to achieve their basic needs. Healthy children are the feedstock of any strong society and health-care for the poor has been a particular beneficiary of innovative financing.

The compelling premise behind the International Finance Facility for Immunisation, or IFFIm, is that there is zero value vaccinating a child in 2012 or 2015 – when gradually rising ODA might be available – when he or she will probably die from disease this year. That idea prompted six European governments to pledge over \$5 billion to fuel this new arrangement. In effect the 20-year government pledges are, via placing bonds in the capital markets, converted into cash today.

Proceeds from IFFIm's bond issues have transformed the capacity of GAVI, with nearly all of the US\$ 1.2 billion raised in the last two years already dispensed. IFFIm will result in 500 million children across seventy-two of the poorest countries having immunity from disease.

IFFIm illustrates three important things. First, political will. Will to innovate, to bring a new flexibility to public finances, to accelerate capital availability. Will to fund on a scale – \$5 billion – and for a duration – 20 years – never before evident in the aid system. And will to work multilaterally, pooling resources into a global collective effort.

Second, IFFIm is as targeted as the sharp point of an injection needle, a tightly focused health-care intervention, delivering vaccines and strengthening health delivery systems. This, as development economist Jeffrey Sachs appeals, provides measurable inputs and outputs and true traceability.

Third, it is effective both in financial and health terms. IFFIm bonds have a high appeal to investors providing solid AAA credit backing to their capital, a market-based interest rate and the "socially responsible return" of knowing their investment or savings is put to such good use. This double sweet spot is IFFIm's win-win, bringing together capital market investors and children. Both benefit.

Looking ahead, the call to governments at the UN Conference on Financing for Development in Doha, Qatar in November 2008 is to continue to innovate in development finance. The current crisis in the capital markets must not diminish the appetite to access the US\$ 125 trillion global pool of savings to fund development. Governments need to continue to seek out inventive ways to harness the private capital markets. A bailout for the bottom billion too!

The International Finance Facility for Immunisation: from strength to strength

In Japan in March 2008, the second International Finance Facility for Immunisation (IFFIm) bond was issued – the first time in Japan.

While the first IFFIm Vaccine Bond was sold to large institutional investors in the global market in December 2006, this issuance was offered to individual investors as uridashi bonds, which are sold in foreign currency to Japanese retail investors, in this case, in South African rand. The two-year bonds raised South African rand (ZAR) 1.7 billion, or US\$ 223 million. The enthusiastic response to the Japanese IFFIm bond demonstrates strong demand among retail investors for high-quality ethical investments.

By the end of 2008, IFFIm had raised a total of US\$ 1.2 billion dollars. Further bond issues may occur in 2009 in Japan and the United Kingdom. Other markets are under consideration.



VIEWPOINT

“ The International Finance Facility for Immunisation has been raising funds for programmes through the Global Alliance for Vaccines and Immunisation. GAVI is delivering on its promise of providing reliable, long-term and stable funding for children’s vaccination ”

UN Secretary-General Ban Ki-moon at the UN Conference on Financing for Development in Doha, Qatar, November 2008

Proof of concept: capital markets can be harnessed for development

IFFIm has powerfully demonstrated that public funds and international capital markets can come together in innovative ways to accelerate development financing. IFFIm bonds leverage multi-year donor commitments into immediately available cash resources. In essence, significant aid, quickly delivered.

The UK, France, Italy, Spain, Sweden, Norway and South Africa provided grant funding to IFFIm through the GAVI Fund Affiliate. Together they have pledged to contribute funding over up to 20 years, which represents a ground-breaking commitment to long-term financing. GAVI expects additional donors will be attracted to contribute further to IFFIm’s success.

The financial mechanism of IFFIm is “fit for purpose”: frontloading of bond proceeds has brought a radical alteration to both the timeframe and scale of immunisation programmes that GAVI supports in the world’s poorest countries. An anticipated US\$ 4 billion raised through IFFIm and distributed by GAVI over the next 10 years is expected to protect more than 500 million people through vaccines. This will significantly progress the Millennium Development Goals, in particular MDG 4, reducing deaths in children.

IFFIm’s model of international development financing is drawing interest at a global level. UK Prime Minister Gordon Brown, who was

instrumental in the founding of the IFFIm concept, launched The High Level Task Force on Innovative International Financing for Health Systems in September 2008 with the World Bank and others. Among other innovative financing ideas, the task force will explore the potential to expand IFFIm and apply it to other health development financing. Similarly, IFFIm was acknowledged as an important new finance mechanism for development at the UN Conference on Financing for Development in Doha, Qatar, in November, where the Secretary-General noted its impact on child vaccination.

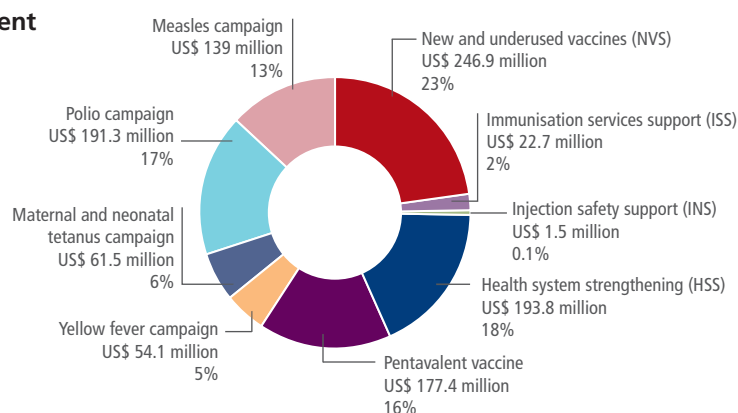
IFFIm’s funds bring fast results

Over 90% of IFFIm bond proceeds were rapidly disbursed to support countries through GAVI programmes. Funds have also been invested tactically to support global immunisation initiatives.

With IFFIm funds, GAVI has supported countries wanting to introduce the liquid pentavalent vaccine. US\$ 177.4 million has been earmarked for securing supplies of this 5-in-one vaccine, which delivers the traditional DTP (diphtheria-tetanus-pertussis) vaccines now combined with hepatitis B and Hib vaccines.

This funding for the long-term purchase commitment of pentavalent vaccines has had a catalytic effect on both the demand from countries and on the supply side from the vaccine industry.

GAVI disbursement of IFFIm funds, 2006 - 2008



Source: 22

Strategic funding of global vaccine initiatives

Approximately half of IFFIm funds raised in 2006 were allocated in 2007 to one-time tactical investments with partners in immunisation. The aim has been to enable rapid progress towards the Millennium Development Goals.

These tactical investments supported The Global Polio Eradication Initiative, The Measles Initiative, the Maternal and Neonatal Tetanus Elimination initiative, and The Yellow Fever Initiative. The impact continues to roll out through 2008:

- Funds for polio eradication helped support the immunisation of more than 100 million children in 11 polio-affected countries
- The goal of 90% reduction in measles deaths by 2010 appears within reach
- Preventive campaigns against maternal and neonatal tetanus in 2008 will protect 44.5 million women in 30 countries
- Support for stockpiling yellow fever vaccine enabled ministries of health, UNICEF, WHO, and other partners to stop yellow fever outbreaks in a number of countries including Togo, Cameroon, and Senegal. The focus is now on preventive activities, reducing the risk of outbreak.

IFFIm bond issues 2006-2008

First bond issue to international investors, November 2006:

US\$ 1 billion 5-year benchmark bond, 5% coupon due on November 14, 2011

Joint Lead managers:

Deutsche Bank and Goldman Sachs

AAA/Aaa/AAA rating

(Fitch, Moody's and Standard & Poor's)
Diverse geographic and institutional interest: North America 36%, UK 12%, Switzerland 8%, rest of Europe 21%, Middle East & Asia 23%

Second bond issue to retail investors in Japan, March 2008:

South African rand (ZAR) 1.7 billion 2-year uridashi bond (public Japanese retail market), 9.9% coupon due on 18 March, 2010

Lead Manager:

Daiwa Securities SMBC Europe Ltd.

AAA/Aaa/AAA rating

(Fitch, Moody's and Standard & Poor's)
Strong response from retail investors: fully sold during 5-day subscription period and upsized from ZAR 1.0 to 1.7 billion

See also:

Ch. 1: Accelerate vaccines: pentavalent vaccine, p. 16

Ch. 1: Accelerate vaccines: yellow fever, p. 18

IFFIm

funds at work

Door to door in rural Bangladesh

They travelled in 4x4 vehicles, by boats and on foot. In the spring of 2008, teams of interviewers fanned out across two districts of Bangladesh to verify that no children had died of neonatal tetanus (NT) in the previous year.

If their findings bore out the assertion, it could be assumed that all of Bangladesh is NT-free. No small achievement for a country that, at one time, had one of the highest NT mortality rates in the world. In the 1980s, NT was responsible for as much as 56% of all newborn deaths in some parts of the country.

Conducted by the Bangladesh Ministry of Health with the country's extended programme on immunisation (EPI), WHO and UNICEF, the elimination survey was carried out on 20 and 21 May 2008. The survey was funded by GAVI with proceeds from IFFIm to the Maternal and Neonatal Tetanus (MNT) initiative.



Two districts were selected because newborns there were judged to be at highest risk of NT. Rangamati district would have more than six thousand households surveyed, with more than four thousand households to be surveyed in Sunamganj district.

It was a logistical challenge. The 60 teams of two interviewers needed training, transportation and communication. Every single house had to be visited, every live birth recorded but many of the villages and homes were difficult to reach. Some teams had to visit as many as 120 households a day. Teams gathered at the end of the day with supervisors and doctors to review data and provide feedback, but often they were without electricity. Numbers were poured over by candlelight where necessary.

The survey found that there had been no deaths of newborns due to NT between 15 April 2007 and 14 April 2008. This strongly suggests that NT has been eliminated in those districts. As a result, Bangladesh has been certified as NT-free, a considerable immunisation and public health achievement.



AMCs: needs-driven vaccines for the developing world

Market failures inhibit rapid development of affordable vaccines for developing countries. Advance Market Commitments (AMCs) aim to address this challenge by stimulating the development and manufacture of affordable vaccines tailored to the needs of developing countries.

Through an AMC, donors commit money to guarantee the price of vaccines once they have been developed, thus creating the potential for a viable future market. These commitments may provide vaccine makers with the incentive to invest the considerable sums required to conduct research and build manufacturing capacity.

Companies that participate in an AMC make legally binding commitments to supply the vaccines at lower and sustainable prices after the donor funds made available for the initial fixed price are spent. Most importantly, the donor funds are not provided until after the proposed vaccines have met stringent, pre-agreed technical criteria and developing countries request them. Decisions about which

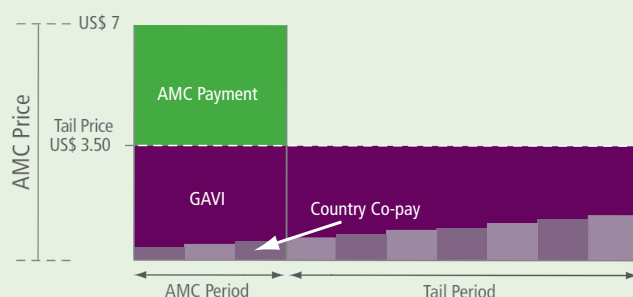
diseases to target, criteria for effectiveness, price and long-term availability are made in advance by independent advisory groups.

Ultimately, developing country governments are able to budget and plan for their immunisation programmes knowing that vaccines will be available in sufficient quantity, at a price they can afford, for the long term.

In October 2008, The UK-based All-Party Parliamentary Group on Pneumococcal Disease Prevention in the Developing World endorsed the potential impact of the pilot AMC and congratulated the donors, partners and stakeholders for translating political will into specific strategies and tactics.

The AMC is an important step towards reducing the health inequities between rich and poor, and a way to protect the lives of the world's poorest children by making life-saving vaccines available more quickly and at affordable prices.

AMC Pilot Financing



Source: 23

The Implementation Working group has recommended that the AMC makes a binding commitment to supply vaccines for ten years at US\$ 3.50 per dose or less. In return, the US\$ 1.5 billion of AMC donor money will contribute to increase the price to US\$ 7 for the first doses of vaccines provided by each company. Legal agreements that outline these recommended terms are under draft.

“The Pneumococcal AMC will save 7 million childhood deaths through the introduction of the right vaccines in adequate quantities at more predictable and sustainable prices”

Report from the All-Party Parliamentary Group on Pneumococcal Disease Prevention in the Developing World

Advance Market Commitments: a market-shaping and life-saving approach

During 2008, the Advance Market Commitment (AMC) pilot for pneumococcal disease progressed towards implementation and achieved a number of major milestones.

Partnering to overcome a leading killer of children

Serious pneumococcal diseases caused by *Streptococcus pneumoniae* – primarily pneumonia and meningitis – are the number one vaccine-preventable causes of death in children under five. Over 700,000 young children die each year: 90 per cent of these deaths occur in developing countries.

In February 2007, the governments of Italy, Canada, Norway, Russia and the United Kingdom, and the Bill & Melinda Gates Foundation launched the pilot AMC against pneumococcal disease with a collective US\$ 1.5 billion commitment.

The pilot is designed to demonstrate both the feasibility of the mechanism and its impact on accelerating vaccine development, production scale-up and introduction. It will produce three overarching benefits: it is expected to prevent more than seven million childhood deaths by 2030, a significant contribution to achieving MDG 4; the AMC will stimulate more predictable and sustainable prices and supply of vaccines over the long term; and it will foster competition, encourage innovation, and engage emerging as well as multinational manufacturers.

GAVI Alliance partners are working together to launch the pilot. The GAVI Secretariat provides programmatic and administrative support, the World Bank gives financial support, WHO has established the minimum technical criteria for a suitable pneumococcal vaccine, and UNICEF will be responsible for vaccine procurement and distribution.

In July, recommendations for the terms and pricing for the pilot were issued by the Implementation Working Group of leading economists and vaccine experts, together with the World Bank, the GAVI Secretariat and UNICEF.

In November, a Monitoring and Evaluation Framework was developed by the AMC stakeholders to strictly scrutinise and assess the pilot and its impact.

In December, a target product profile (TPP), developed by WHO, was endorsed by the Independent Assessment Committee (IAC), a group of independent experts in public health, public and private finance, and vaccine development. The TPP is a set of technical specifications that relate to the public health impact and suitability of vaccines to be developed. To be eligible for AMC funding, proposed vaccines need to meet the TPP. The IAC will determine whether a candidate vaccine meets TPP specifications.

As soon as the legal agreements are signed in 2009 and improved pneumococcal vaccines become available, UNICEF will begin procurement for GAVI-eligible countries. A new generation of pneumococcal vaccine is expected to be available for introduction as early as 2010.





4

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 2008:

- Streamlined governance and administrative structures increase efficiency
- Heightened recognition of GAVI's programme innovations
- Implementation of new gender policy
- Strengthened approaches to data quality assurance and managing fiduciary risk

Add Value



Add Value

2008 was a year of significant transition for the GAVI Alliance. The reorganisation of the GAVI Alliance Board and members of the GAVI Fund Board into one new Board promised strengthened and more rational oversight of the growing organisation.

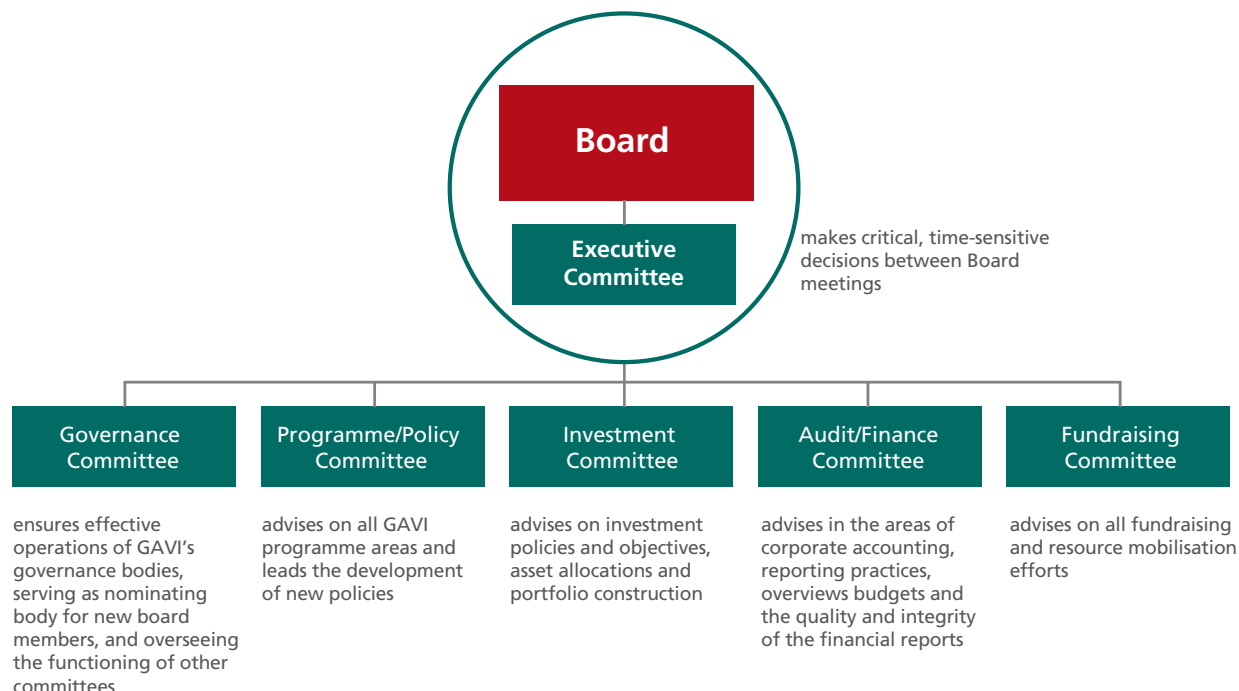
Preparation was also underway for the recognition in Switzerland of the GAVI Alliance as an "international organisation" under Swiss law in 2009.

GAVI succeeded in ensuring recognition of immunisation's key contribution in achieving the Millennium Development Goals as well as

the value of innovative ways of financing and supporting developing countries' health plans.

New policies developed and adopted in 2008 strengthened GAVI's approach to gender equality, fiduciary risk management and evaluation. These support the new structure and scope of the Alliance.

The GAVI Alliance Board's new committee structure



Effective, efficient, accountable: the new GAVI Alliance Board and structure

In October 2008, the new GAVI Alliance Board met for the first time as a unified governing body of the GAVI Alliance with responsibility for all the organisation's activities. Two-thirds of the new Board's members sit as representatives of their institutions or constituencies, and one-third are independent individuals.

The new Board is the product of the reorganisation of members of the old GAVI Alliance Board and members of the GAVI Fund Board. The merger delivered efficiency gains as well as strengthening the GAVI Alliance as a public-private partnership.

Mary Robinson, former President of Ireland and High Commissioner for Human Rights, was elected Chair of the Board and WHO Assistant Director-General, Denis Aitken, the Deputy Chair. A robust new Board committee structure was established to share the effort of scrutiny and analysis.

GAVI's new governance arrangements provide better accountability, including by bringing

together programme and financial oversight functions. It increases GAVI's ability to act flexibly and confidently in responding to the changing operating environment.

The GAVI Alliance began in 1999 as an informal unincorporated alliance between major stakeholders in immunisation. Its Board was representational: individuals representing multilateral development agencies, donors, developing country governments, civil society organisations, and the academic community developed shared goals, strategies and programmes.

In parallel, the GAVI Fund was set up under United States' law as a not-for-profit organisation to serve as GAVI's financing arm. Its Board was corporate: individual volunteers with financial expertise or influential individuals committed to the GAVI mission but who, for the most part, worked outside the realm of global public health.





Reorganising Boards and strengthening the public-private partnership

GAVI's success saw it quickly evolve into a multi-billion dollar global health organisation with significant programme activities and innovative financing initiatives.

In November 2007, the two Boards agreed to reorganise and bring their public and private expertise into one efficient, centralised decision-making authority. The path from this decision to the final agreement about the structure took most of 2008, with negotiations focused on preserving the characteristics of the Alliance – organisations, institutions, companies and governments acting to accomplish a common purpose – while leveraging the strengths of private sector individuals with expertise and objectivity.

At the same time, extensive planning and development of the new administration for the GAVI Secretariat was under way in 2008. It involved preparing for the transition on 1 January 2009 to a unified GAVI Alliance Secretariat, formally established as an "international organisation" under Swiss law, with offices in Geneva and Washington DC. A new human resource management platform and associated administrative procedures were established to replace the old GAVI Fund administration in Washington DC and the UNICEF-administered systems in Geneva.

Recognising added value and innovation

The critical role of health in the global fight against poverty was highlighted throughout 2008 in a number of high-level public events and important discussions. The GAVI Alliance played a prominent public role, highlighting both the contribution of immunisation to the Millennium Development Goals and the success of GAVI's innovative approaches to development. It is a reflection of GAVI's growing reputation that it was referenced as an example of success by prominent global figures including the United Nations Secretary-General, Prime Ministers and Presidents.

As the Japanese Government prepared to host the G8 summit, GAVI was invited to join consultations on health outcomes. When WHO Director-General Margaret Chan addressed the world's Health Ministers at the World Health Assembly in May she highlighted immunisation as "one of the best success stories in public health" and expressed her "very special appreciation to UNICEF and the GAVI Alliance".

In September, the OECD, the World Bank and the IMF gathered ministers from over 100 countries, heads of bilateral and multilateral aid agencies and leading civil society organisations in Ghana to review progress on shared commitments to improving the effectiveness of aid. GAVI featured at the opening plenary and the concluding Accra Action Agenda noted that, "global funds and programmes make an important contribution to development". This was a significant turnaround from three years earlier at the last aid effectiveness summit, when global programmes were criticised for being insufficiently integrated into partner countries development approaches.

At the Financing for Development meeting in Doha in December, GAVI's innovative financing mechanisms were showcased and success applauded. And when former US President Jimmy Carter gathered a select group of health experts and organisations to a retreat to advise Secretary-General Ban Ki-moon on how best he might support the promotion of the health MDGs, GAVI was there.

Following a submission from the Dutch Government to the OECD's Development Assistance Committee, the GAVI Alliance was formally recognised in 2008 as a multilateral organisation. Donor contributions to GAVI and GAVI's commitments and disbursements will from now onwards be distinctly recorded in global development fund statistics. It is a small measure of recognition of GAVI's place in international development and a further enabling step to transparency and accountability – core values of the Alliance.

Throughout 2008, GAVI played a key role in the International Health Partnership, a growing movement of developing and developed country governments, civil society and international health organisations seeking to realign and intensify global efforts behind country plans and approaches. GAVI's financing and programme support for countries' health systems strengthening attracted close attention as models for potential broader application. When UK Prime Minister Gordon Brown and World Bank President Robert Zoellick joined other world leaders in September to announce they would be chairing a Task Force on Innovative Financing for Health Systems, GAVI's IFFIm was again recognised as a success to be replicated.

Addressing gender, managing risk, measuring effectiveness: GAVI's new policies

In 2008 GAVI developed and adopted a range of new policies to ensure equal access to immunisation for girls and boys, address fiduciary risk and institute a rigorous evaluation programme. They are in line with and support GAVI's new governance structure which is rational, transparent and accountable.

GAVI's gender policy: ensuring equal access to immunisation

The GAVI Alliance is committed to helping women, men, girls and boys in the developing world gain equal access to vaccines. GAVI adopted a new gender policy in June 2008 which recognises that addressing gender inequalities is a key factor in expanding immunisation coverage and strengthening health services.

Drawing closely on the experiences and capacity of its partners including UNICEF, WHO and the World Bank, the gender policy promotes raising awareness, providing leadership and developing a more coordinated effort at country and global level to fulfilling international commitments to gender equality in health.

According to GAVI-commissioned research, gender can be a factor in whether a person receives immunisation. When national health services fail to focus on gender, more boys tend to be immunised than girls. For example, there are indications that gender gaps exist in some countries in Asia and Africa between the percentage of boys versus girls who have been immunised, for example, in India, Gabon and Ethiopia. In some countries, there is an opposite trend: in Nigeria there are signs that the proportion of boys immunised may be lower than the proportion of girls.

Women in the world's poorest countries are more susceptible to disease than men because too often they do not share equal access to basic health-care, with far-reaching consequences for future generations. As the primary caregiver, a mother's health is inseparable from her child's. Not only do healthy mothers give birth to healthy children, but women are also the first to recognise and seek treatment for their sons' and daughters' illnesses.

See also:

Ch. 1: Accelerate vaccines: HPV, pp. 20-21



Facing health challenges together

Her Excellency Ellen Johnson Sirleaf President, Republic of Liberia

With assistance from the GAVI Alliance and other partners, our immunisation programme and efforts to improve our health system have gone well. Our Ministry of Health has established its goals and has set up the organisation to respond. We still have a long way to go, but we have a plan to deliver basic health packages and that is the major thrust right now.

During the preparation of our Poverty Reduction Strategy (otherwise known as "Lift Liberia") in 2008, we consulted with people from all across the country and all walks of life. Liberians spoke of building a country where a child can live in safety, go to a school with qualified teachers, get clean water and medicine, and study by electric light. Of particular importance have been improved education and health systems.

Poor health contributes significantly to poverty in Liberia, and health systems are in a state of disrepair in the aftermath of 14 years of conflict. We will continue to revitalise health services to increase access, fight major diseases, and reduce malnutrition and maternal and child mortality.

In fact, we are starting to see declines in infant mortality rates, which can be attributed to increased immunisation. Our surveys indicate mortality rates for children under the age of 5 years have dropped to 111 per 1000 in 2007 from 194 per 1000 in 1999/2000.

Prevention of disease through immunisation and other measures is crucial as we don't have the capacity – human, equipment or financial – for all the health demands. If we can do a lot in those basic areas and restore services in our hospitals and clinics, we'll go a long way to meeting our health goals.

One of our challenges is that most of the health services in rural areas have been done by civil society organisations simply because we don't have the capacity to roll out the services in those regions. If we lost that capacity, that would be a big gap. That's where GAVI can be helpful to us, in supporting the ongoing work of CSOs.

The agenda is enormous and as much as we've done, there's more to do. We are trying to rebuild institutions destroyed during the conflict. But with support from GAVI and other partners, we can lift Liberia and its people into better health and a more prosperous future.

Gender-based social roles increase the risk of ill-health and diminish access to health services, with a consequential impact on quality of life and economic opportunity.

More evidence is needed to gain a fuller understanding of the gender implications of immunisation. The absence of disaggregated sex data is a problem in this regard, particularly at country level. As part of refining and implementing the new gender policy, a review of epidemiological evidence related to gender differences in vaccination coverage and burden of disease will be conducted, along with examining the feasibility of collecting and using sex disaggregated data.

New transparency and accountability policy to help manage risk

As programme support to countries deepens and cash-based support increases, GAVI adopted a new transparency and accountability policy (TAP) in June 2008. The policy establishes a risk-based approach to fiduciary management while striking a balance with strong country ownership.

The new policy framework is designed to apply to all countries approved for cash-based programmes such as health system strengthening (HSS) and immunisation services support (ISS). GAVI recognises that countries must be able to use funds flexibly and in accordance with their own health sector strategies. However, GAVI must also be able to ensure this will not lead to misuse or mismanagement of funds.

The policy is based on the principle of relying on and aligning with existing country systems as much as possible. It aims to promote accountability to ensure that funds are used for their intended purpose, and are managed in a transparent manner that adheres to international standards.

VIEWPOINT



A financial management assessment will serve as the baseline risk analysis of a country's system. It will allow GAVI to gather information on eligible countries' public financial management systems, with particular emphasis on the public health sector. GAVI will work with the country to complete these assessments in all countries receiving GAVI cash-based support.

Countries are expected to channel GAVI's cash support through joint or pooled financing mechanisms and reporting systems where feasible. For the majority of GAVI countries (approximately 54) without joint financing mechanisms, the financial management assessment will support countries to identify and develop the most secure financing mechanism for GAVI funding.

In exceptional cases of suspected or proven misuse of GAVI funds, GAVI and its partners will work with government authorities to institute procedures to recover any lost funds and mitigate the possibility of further misuse.

The policy will be implemented in 2009 on a phased basis, with countries considered to have the highest fiduciary risk undergoing financial management assessment earlier than others.

Evaluating GAVI's effectiveness and added value

GAVI is a learning organisation and also recognises that it must be accountable to partners, donors and other stakeholders for the effectiveness of its funding and programmes. The new evaluation policy adopted in June 2008 will be the foundation of a multi-year plan to assess GAVI's work for effectiveness, efficiency, impact and sustainability, with the goal of improving performance.

The evaluation policy builds on the principles of independence, impartiality, validity, transparency and commitment to international standards, following the OECD Development Assistance Committee's criteria for evaluating development assistance.

As a public-private partnership, the GAVI Alliance includes a wide range of stakeholders such as implementing countries, technical partners, the private sector, civil society and donors, each with different expectations and perspectives. Evaluations must, as much as possible, reflect the interests of these varied stakeholders.

Evaluations must also take into account GAVI's shared responsibility for implementation with many of its partners, and support received by countries from other partners and donors. Results are therefore the product of joint global, regional and country-level activities – it is not possible in many cases to attribute outcomes and impact to GAVI interventions alone. Evaluation should build on a shared model of accountability.

The evaluation policy took effect in July 2008.

Evaluating GAVI's first years of operation

GAVI commissioned an extensive evaluation of the first phase of its operation from 2000 to 2005, known as Phase 1. The report was received by the Board in October 2008, which took note that an independent evaluation such as this is most valuable if the organisation can take lessons learnt – both

positive and negative – at face value and address them through open dialogue with partners.

The objectives of the evaluation were to identify successes and weaknesses of GAVI in Phase 1. The evaluation also documented the impact, efficiency and effectiveness of the GAVI Alliance in its first years.

Among its many findings, the evaluation determined that GAVI significantly increased access to immunisation in recipient countries and expanded the use of vaccines between 2000 and 2005. Coverage rates increased in GAVI countries: the benchmark DTP3 (three doses of diphtheria-tetanus-pertussis vaccine) coverage rate increased from 64 to 71%.

Nearly all eligible countries applied for immunisation services support (ISS) and injection safety (INS) funding. Nonetheless, the evaluation reports room for improvement of ISS funding in the design of the reward incentive and in providing support to underperforming countries.

The evaluation concluded that GAVI and its partners were successful in positioning immunisation on the international development agenda, ensuring immunisation is more prominent within the health literature and is recognised as a core health service. Significant achievements include aligning immunisation with achievement of Millennium Development Goal 4, launching IFFIm, and securing funding commitments for the AMC pilot for pneumococcal vaccine.

The evaluation includes recommendations to build on strengths and address weaknesses identified in Phase 1. Since the evaluation was commissioned, GAVI has already implemented a number of measures which address many of the recommendations. Further work is underway to explore findings and recommendations in order to contribute to the refinement and adjustment of GAVI policies and operation in the current phase of work.

Effective support for Immunisation

How GAVI funds were put to work in Tanzania



Mpwapwa is a rural district in Tanzania with a population of 280,000 and 32 health facilities, some as far as 160 km from the district capital. Before Tanzania received immunisation services support funding in 2002, there was a major problem with low support in the district for immunisation.

Mpwapwa district received US\$ 13,000 of the country's ISS award. They put it to work creating awareness and community sensitisation to immunisation. This tapped into Tanzania's strong community structures and leadership. Meetings were held where community leaders and officials took responsibility for supporting immunisation.

Once solid support was in place, the funds were put to work in tangible ways: health workers were trained, refrigerators for vaccines were fixed, bicycles were purchased for outreach, calculators were obtained to help improve data collection and a stock of vaccination cards was purchased. The district authorities worked with partners such as St. Luke's dispensary, Care International and Simavi to reach out to all communities in the large district.

Within one year, DTP3 coverage rose in the district and has not fallen since. The modest ISS funding that reached Mpwapwa district in Tanzania was carefully managed over several years and put to good use in practical ways. This injection of funds was clearly an important factor in increasing and sustaining the district's immunisation coverage.

annexes



Annex 1:

The GAVI Alliance governance structure

The GAVI Alliance Board

In October 2008, the new GAVI Alliance Board was officially launched. It is the product of a reorganisation of the GAVI Alliance Board and the GAVI Fund Board.

There are 28 members on the new Board:

- 4 permanent members representing international and public institutions
- 5 representing developing country governments
- 5 representing donor country governments
- 4 members each representing: the developed-country vaccine industry, the developing-country vaccine industry, research and technical health institutes and civil society organisations
- 9 independent individuals with a range of academic, finance and public health expertise
- The CEO of the GAVI Alliance

Representative Board members

The Board's representative members ensure that institutions and constituencies provide input into the development of all of GAVI's policies, and to the management of its operations. Partners such as UNICEF, WHO, the World Bank and the Bill & Melinda Gates Foundation hold permanent seats on the board. Constituency representatives serve on a time-limited basis.

Institutions

UNICEF

Saad Houry

WHO

Denis Aitken, Vice-Chair

The World Bank

Julian Schweitzer

The Bill & Melinda Gates Foundation

Jaime Sepulveda

Constituencies

Developing country governments

Armenia

Tatul Hakobyan

Ethiopia

Tedros Ghebreyesus

Yemen

Abdulkarim Yehia Rasae

Vietnam

Trinh Quan Huan

Rwanda

Richard Sezibera

Donor governments

USA/Canada/Australia

Gloria Steele (USA) (interim)

United Kingdom/Norway/Ireland

Gavin McGillivray (UK)

Italy/Spain

Alberto Mantovani (Italy)

France/Luxembourg/European Commission

Gustavo Gonzalez-Canali (France)

Netherlands/Sweden/Denmark

Yoka Brandt (Netherlands)

Research and technical health institutes

International Vaccine Institute: John Clemens

Industrialised country vaccine industry

GlaxoSmithKline Biologicals: Jean Stéphenne

Developing country vaccine industry

Serum Institute India: Suresh Jadhav

Civil society organisations

BRAC: Faruque Ahmed

Unaffiliated Board members

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 and fundraising.

Mary Robinson, Board Chair

Graça Machel

Wayne Berson

George Bickerstaff

Dwight Bush

Wayne Berson

Ashutosh Garg

Dagfinn Høybråten

Jean-Louis Sarbib

George Wellde

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

The GAVI Alliance Board establishes policy, oversees operations and monitors programme implementation. It is supported by six committees:

- **Executive Committee:** makes critical, time-sensitive decisions between Board meetings
- **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
- **Programme/Policy Committee:** advises the Board on all GAVI programme areas and leads the development of new policies
- **Investment Committee:** advises the Board on investment policies and objectives, asset allocations and portfolio construction
- **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.

Other GAVI Alliance governance structures

The International Finance Facility for Immunisation (IFFIm)

In addition to the GAVI Alliance Board, GAVI relies upon two other entities – The IFFIm Company and the GAVI Fund Affiliate – which administer IFFIm.

The IFFIm Company

Securitises long-term donor pledges from the GFA, and provides front-loaded resources to the GFA for GAVI programmes. It is a multilateral development institution established as a charity in England and Wales. The IFFIm Board, working with 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

Arunma Oteh

Vice President, Corporate Services
The African Development Bank

John Cummins

Group Treasurer
The Royal Bank of Scotland

Dayanath Chandrajith Jayasuriya

Senior Partner
Asian Pathfinder Legal Consultancy and Drafting Services

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

Stephen Zinser

Chief Investment Officer
European Credit Management Ltd.

Bo Stensen

Former Deputy Executive Secretary
The GAVI Alliance

See also:

The GAVI Alliance: working together, p. 8

Ch 4: Add value: New GAVI Alliance Board and structure, p. 49

www.gavialliance.org/boardmembers

Annex 2: Donor contributions and commitments

as of 31 December 2008

Government contributions 2000 - 2026 (US\$, in thousands)

Country	1999-2000	2001	2002	2003	2004	2005	2006
Australia							5,000
Canada			1,880	4,755	6,033	130,869	5,190
Denmark		1,147			3,339	3,416	4,411
European Commission (EC)				1,260			
France					6,029	⁽²⁾	12,630
Germany							5,260
Ireland			511	624	650	831	7,902
Italy							
Luxembourg						645	1,319
the Netherlands		24,060	13,375	16,493	17,330	15,859	
Norway		17,895	21,326	21,791	40,925	39,535	64,979
Russian Federation							
South Africa							
Spain							
Sweden		1,892	1,115	2,385	4,931	12,663	14,594
United Kingdom	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 of 31 December 2008

Notes:

⁽¹⁾ The contribution from Denmark for 2008 was received in 2009.

⁽²⁾ The contribution from France for 2005 was received in 2006.

⁽³⁾ The remaining second half of the contribution from Ireland for 2008 is expected in 2009.

Private contributions 2000 - 2014 (US\$, in thousands)

Donor	1999-2000	2001	2002	2003	2004	2005	2006
Bill & Melinda Gates Foundation	325,000	425,000		3,500	5,000	154,338	
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

Note:

The Bill & Melinda Gates Foundation made an initial 5-year pledge of US\$ 750 million and a pledge of US\$ 75 million per annum from 2005 up to 2014.

	1 year agreement
	2 to 3 year agreement
	4-year or longer

Predictable donor support

Reliable and predictable support gives countries the confidence to plan for the introduction of new vaccines and invest in their health systems. GAVI's capacity to make long-term commitments depends on having secure long-term sources of finance. IFFIm and the AMC provide GAVI with secure funds that are legally guaranteed by long-term donor pledges. As the tables demonstrate, direct donor pledges are less certain – there are few with a duration beyond 3 years. Donors are encouraged to make multi-year pledges and support GAVI's reputation as a reliable financial partner, enabling countries to securely plan new investments in health.

Converted as of date
of contribution

2007	2008	2009*	2010*	2011*	Total direct committed 2000-11	IFFIm commitments 2006-26	AMC commitments	Total donor commitments to GAVI
5,000	5,000	5,000			20,000			20,000
					148,728		200,000	348,728
4,738	(1)	9,087	4,685	4,685	35,508			35,508
4,850	23,129				29,239			29,239
					18,659	1,738,975		1,757,634
5,948					11,208			11,208
8,311	3,841	3,800 (3)			26,470			26,470
					0	660,382	635,000	1,235,382
812	1,423				4,199			4,199
33,547	38,885	31,206	34,726		225,482			225,482
86,157	65,449				358,056	27,000	50,000	435,056
					0		80,000	80,000
					0	20,000		20,000
	40,536				40,536	240,305		280,841
15,515	19,152				72,248	37,667		109,915
48,114					121,562	2,584,602	485,000	3,191,164
69,300	71,913				493,725			493,725
282,291	269,329	49,093	39,411	4,685	1,605,621	5,248,930	1,450,000	8,304,551

2007	2008	2009	2010	2011	2012	2013	2014	AMC commitments	Total private donor commitments to GAVI
75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	50,000	1,562,838
1,335	6,538								16,288
76,335	81,538	75,000	75,000	75,000	75,000	75,000	75,000	50,000	1,579,126

Source: 24

Annex 3: Approved funding by country and area of support 2000-2008

as of 31 December 2008

Country	Civil society organisations	Health system strengthening	Injection safety	Immunisation services	New and underused vaccines	Total (US\$)
Afghanistan	1,018,000	11,295,000	2,161,500	15,800,420	12,357,478	42,632,398
Albania			61,740	300,000	885,515	1,247,255
Angola			1,188,031	5,781,500	23,468,575	30,438,105
Armenia		94,500	55,190	179,860	429,085	758,635
Azerbaijan			144,718	967,380	798,322	1,910,420
Bangladesh			9,322,160	23,285,700	23,113,738	55,721,598
Benin			305,311	282,500	20,020,828	20,608,639
Bhutan		37,500	22,360	100,000	400,147	560,006
Bolivia		697,000	993,500	243,750	1,766,000	3,700,250
Bosnia and Herzegovina		-	57,791	100,000	1,083,553	1,241,344
Burkina Faso		3,074,000	804,414	11,068,186	44,013,919	58,960,518
Burundi		4,978,000	434,705	2,758,500	23,516,392	31,687,598
Cambodia		2,187,500	792,242	1,437,200	7,254,303	11,671,246
Cameroon		3,770,000	1,117,541	5,676,620	19,165,535	29,729,696
Central African Republic		1,893,000	113,024	1,911,360	1,525,313	5,442,697
Chad		707,000	302,725	3,170,500	3,429,050	7,609,275
China			15,925,727	800,000	21,953,190	38,678,917
Comoros			44,275	260,000	296,950	601,225
Congo			289,531	1,461,500	2,753,518	4,504,549
Democratic Republic of the Congo	2,989,000	41,665,500	3,730,750	30,878,160	55,189,628	134,453,038
Côte d'Ivoire		1,790,000	850,500	4,108,000	16,492,264	23,240,764
Cuba			360,000			360,000
Djibouti			33,900	212,800	381,827	628,527
Eritrea		664,000	135,205	636,540	3,766,718	5,202,463
Ethiopia		68,840,803	3,831,034	20,330,963	107,285,943	200,288,743
Gambia			149,699	845,300	4,464,915	5,459,915
Georgia		188,500	66,459	235,500	780,985	1,271,444
Ghana		1,035,500	855,300	3,776,300	59,921,523	65,588,623
Guinea		-	668,326	3,139,400	3,624,599	7,432,326
Guinea-Bissau		338,500	48,562	700,360	709,116	1,796,538
Guyana				330,000	1,453,757	1,783,757
Haiti			397,500	1,256,000		1,653,500
Honduras		607,000	457,000	293,000	3,186,000	4,543,000
India			23,654,899	1,200,000	36,168,761	61,023,660
Indonesia	1,270,500	7,961,000	11,219,104	15,736,000	17,511,000	53,697,604
Kenya		5,831,000	998,737	5,293,180	100,910,682	113,033,599
Kiribati				100,000	13,500	113,500
Democratic People's Republic of Korea		1,758,500	793,893	2,325,300	5,628,371	10,506,064
Kyrgyzstan		679,500	103,786	472,000	1,928,056	3,183,342
Lao People's Democratic Republic		-	276,911	1,531,200	6,739,120	8,547,231
Lesotho			78,864	399,100	617,404	1,095,368
Liberia		2,045,000	266,500	2,582,500	2,792,853	7,686,853
Madagascar		811,000	843,968	4,378,500	22,134,082	28,167,550
Malawi		3,641,000	779,452	2,086,000	50,857,897	57,364,349
Mali		1,373,000	788,618	5,476,560	21,315,559	28,953,737
Mauritania			275,100	1,247,000	649,106	2,171,206
Republic of Moldova			87,000	200,000	624,718	911,718
Mongolia			18,195	130,500	1,363,190	1,511,885
Mozambique			1,037,915	5,717,000	20,193,701	26,948,616
Myanmar		3,649,000	2,461,656	4,698,080	17,488,747	28,297,483
Nepal		6,166,500	1,426,017	3,679,020	16,611,852	27,883,389

Country	Civil society organisations	Health system strengthening	Injection safety	Immunisation services	New and underused vaccines	Total (US\$)
Nicaragua		343,500	462,500	155,500	2,791,500	3,753,000
Niger			712,687	11,280,380	5,439,000	17,432,067
Nigeria		22,098,500	5,086,000	47,424,000	20,680,234	95,288,734
Pakistan		16,898,500	10,744,548	49,935,980	104,217,642	181,796,670
Papua New Guinea		-	-	634,000	3,503,550	4,137,550
Rwanda		3,889,500	369,500	3,080,700	27,135,417	34,475,117
Sao Tome and Principe		-	8,727	160,000	55,174	223,901
Senegal		1,133,000	1,007,150	2,788,540	22,343,432	27,272,122
Sierra Leone		1,154,000	397,031	2,064,440	8,377,195	11,992,666
Solomon Islands				100,000	101,865	201,865
Somalia			311,100	4,584,487		4,895,587
Sri Lanka		887,500	646,225	200,000	6,711,516	8,445,241
Sudan		3,064,000	2,248,770	9,845,714	20,836,229	35,994,713
Tajikistan		282,000	147,462	1,276,500	1,709,415	3,415,377
United Republic of Tanzania			1,485,881	9,742,260	29,177,013	40,405,154
Togo			387,926	2,505,900	2,246,183	5,140,009
Turkmenistan			57,710	100,000	883,877	1,041,587
Uganda			1,508,143	9,330,520	90,776,420	101,615,083
Ukraine			806,096	100,000	3,037,867	3,943,963
Uzbekistan			940,884	660,000	4,570,845	6,171,729
Vietnam		6,959,500	3,226,000	1,714,000	12,460,571	24,360,071
Yemen		2,574,000	927,532	3,940,500	50,708,214	58,150,246
Zambia		2,917,500	635,920	3,964,060	38,839,578	46,357,059
Zimbabwe			858,004	2,010,080	5,830,758	8,698,842
Total US\$	5,277,500	239,980,303	123,807,128	367,176,800	1,251,470,779	1,987,712,510

Source: 25

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 30 September 2008.
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Dr Elizabeth Guinness

Dr Elizabeth Guinness

Dr Rachel Tarling

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Abbreviations

ADIP	accelerated development and introduction plans	INS	injection safety support
AD	autodisable syringes	IMF	International Monetary Fund
AMC	Advance Market Commitment	IRC	Independent Review Committee
AVI	Accelerated Vaccine Introduction initiative	ISS	immunisation services support
CDC	the US Centers for Disease Control and Prevention	MDGs	Millennium Development Goals
CSO	civil society organisation	NT	neonatal tetanus
Hib	<i>Haemophilus influenzae</i> type b	NVS	new and underused vaccine support
Hep B	hepatitis B	OECD	Organisation for Economic Co-operation and Development
HPV	human papillomavirus	TAP	transparency and accountability policy
HSS	health system strengthening	VIS	Vaccine Investment Strategy
IFFIm	International Finance Facility for Immunisation	UNICEF	United Nations Children's Fund
IHP	International Health Partnership	WHO	World Health Organization

Note

The 2008 GAVI audited, consolidated accounts will be available on the GAVI website on or before October, 2009:

www.gavialliance.org

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Afghanistan	Georgia	Nicaragua
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Armenia	Guinea	Nigeria
Azerbaijan	Guinea-Bissau	Pakistan
Bangladesh	Guyana	Papua New Guinea
Benin	Haiti	Rwanda
Bhutan	Honduras	Sao Tome and Principe
Bolivia	India	Senegal
Burkina Faso	Indonesia	Sierra Leone
Burundi	Kenya	Solomon Islands
Cambodia	Kiribati	Somalia
Cameroon	Kyrgyzstan	Sri Lanka
Central African Republic	Lao People's Democratic Republic	Sudan
Chad	Lesotho	Tajikistan
Comoros	Liberia	Tanzania
Congo	Madagascar	Timor-Leste
Côte d'Ivoire	Malawi	Togo
Cuba	Mali	Uganda
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