GAVI ALLIANCE

PROGRESS REPORT 2011

Online report ▼
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www.gavialliance.org

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

unicef

BILL & MELINDA GATES foundation

World Health Organization

THE WORLD BANK

The Alliance brings together developing country and donor governments, the World Health Organization, UNICEF, the World Bank, the vaccine industry in both industrialised and developing countries, research and technical agencies, civil society organisations, the Bill & Melinda Gates Foundation and other private philanthropists.

Life or death for a young child too often depends on whether he [or she] is born in a country where vaccines are available or not.

Nelson Mandela, former President of South Africa and Chair Emeritus of the GAVI Fund Board

Donors to the GAVI Alliance:

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The Bill & Melinda Gates Foundation
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Ireland
Italy
Japan
J.P. Morgan
"la Caixa" Foundation
Luxembourg
The Netherlands
Norway
The Republic of Korea
The Russian Federation
South Africa
Spain
Sweden
The United Kingdom
The United States of America

* Signed grant agreements are currently under negotiation.

CONTENTS

2011 AT A GLANCE

Every 20 seconds, a child still dies of a vaccine-preventable disease. There's more work to be done.

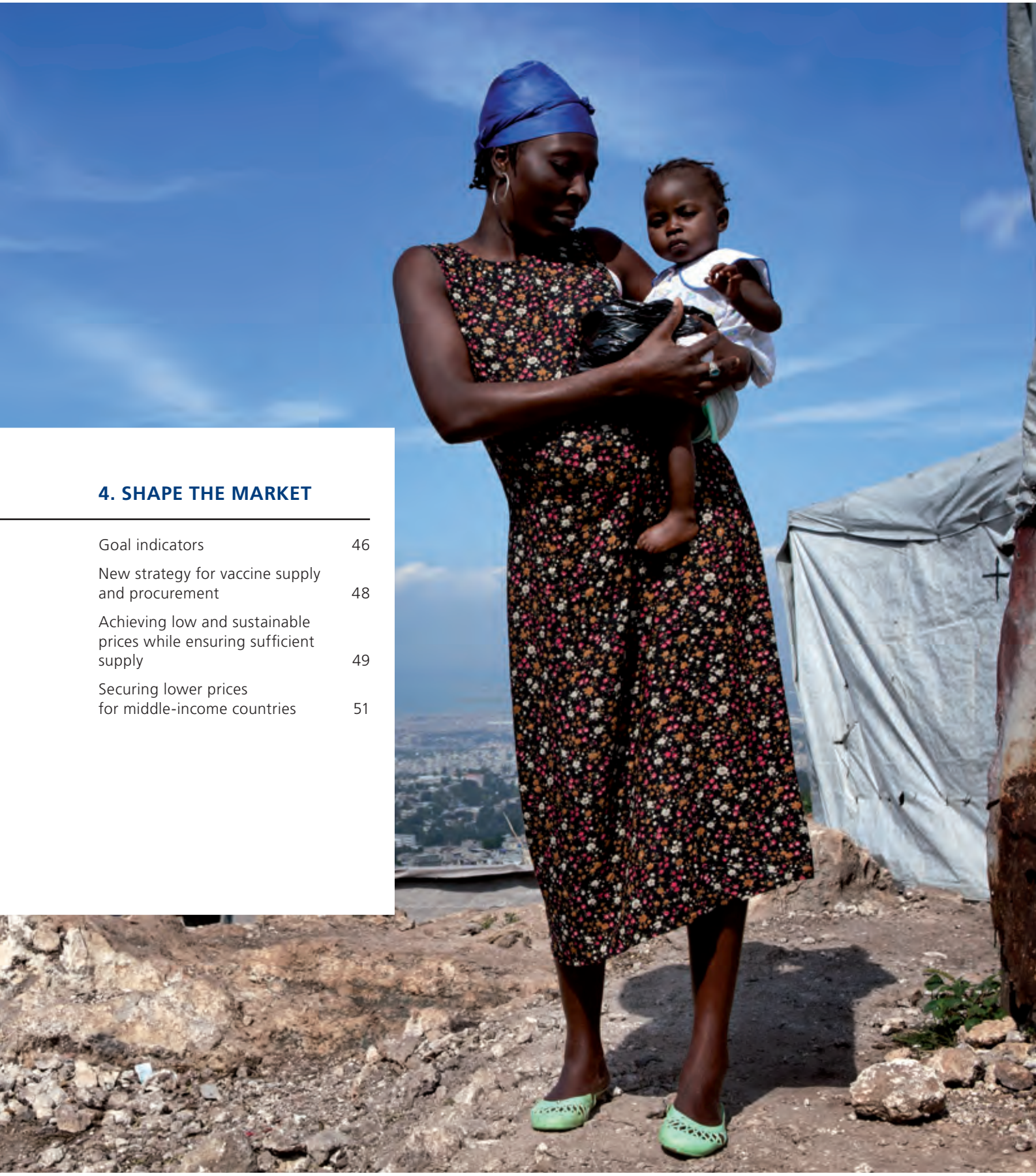
Ellen Johnson Sirleaf,
President of Liberia

1. ACCELERATE VACCINES

2. STRENGTHEN CAPACITY

3. INCREASE PREDICTABILITY & SUSTAINABILITY

ANNEXES



4. SHAPE THE MARKET

Message from the Chair of the GAVI Alliance Board

Dagfinn Høybråten, Chair of the GAVI Alliance Board

Our Alliance is broader and stronger than ever

Immunisation: a matter of justice

Every 20 seconds a child dies from a vaccine-preventable disease. He or she will most likely be in a developing country. For this still to be happening in the 21st century is unjust and morally unacceptable. Being part of the GAVI Alliance allows me, in some small way, to be part of the solution to this injustice.

My first full year as Board Chair was a pivotal one for GAVI. At the start of the year we faced a funding gap of US$ 3.7 billion in the midst of a global financial crisis and the challenging task of recruiting a new CEO.

The additional funds raised at our pledging conference in June 2011 will help us meet the accelerating demand for vaccines in the years to come. I was equally impressed by the ownership and commitment shown by implementing countries in advancing and co-financing their immunisation programmes. The successful recruitment of a new CEO, Seth Berkley, was another highlight.

Our efforts to engage the private sector also bore fruit in 2011, culminating in the establishment of the GAVI Matching Fund. As part of this initiative, the British Government and the Bill & Melinda Gates Foundation have pledged to match contributions to immunisation from the private sector. This mechanism has the potential to help immunise millions more children, translating the public–private match into the most important match of all – that between the vaccine and the child.

The July Board meeting provided an opportunity to recognise the work of our partners and their unwavering support, especially in the lead-up to the pledging conference. I would also like to thank the Government of Bangladesh for hosting our November Board meeting and providing the venue for the GAVI civil society steering committee meeting. It was a timely reminder of the vital role played by civil society in immunisation delivery and advocacy, at both the national and global levels.

I am certain that 2012 will prove to be an equally exciting year. The Child Survival Call to Action, scheduled for 14–15 June in Washington, DC, will be an opportunity to focus on the importance of immunisation for child health. Later in the year, we will hold our fifth Partners' Forum in Dar-es-Salaam, bringing together a wide range of Alliance partners to celebrate our achievements, to learn from the past and to see where we can improve.

Our Alliance is broader and stronger than ever. Together we can help to fulfil every child's right to a healthy, prosperous future.

Message from the Chief Executive Officer of the GAVI Alliance

Seth Berkley, MD, Chief Executive Officer of the GAVI Alliance

2011 was a ground-breaking year in the history of the Alliance

2011: a milestone year for GAVI

2011 was a ground-breaking year in the history of the Alliance and an exciting year to have joined GAVI as its new CEO. Helen Evans did an excellent job as interim CEO in the first half of the year. One of the highlights was undoubtedly the success of the June pledging conference. The heightened global attention to immunisation contributed to an escalation in the demand for new vaccine support.

The rapid increase in the take-up of the new pneumococcal vaccine was another high point. Sixteen countries had started rolling out the new vaccine by the end of 2011 and a further twenty-one have had their applications for support approved. The number of countries wanting to introduce this and other life-saving vaccines is set to accelerate rapidly over the next few years.

I was especially pleased that we took the first steps towards funding rubella vaccines, which will be rolled out together with measles vaccine, and human papillomavirus vaccines which protect against cervical cancer. We also moved towards more customised ways of strengthening health systems to deliver immunisation by developing tailored approaches for fragile countries.

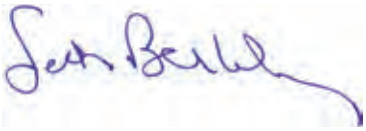
Critical to GAVI's mission is a healthy vaccine market, characterised by security of supply, low prices and competition between a wide range of manufacturers. As a result of a GAVI call to action in 2011, manufacturers made price reduction offers on several key vaccines.

These price offers are a testament to our increasingly proactive approach to shaping the vaccine market, working closely with our pharmaceutical company partners to make vaccines more affordable for developing countries.

In the years ahead, we will continue to strive to improve our model and to accelerate the introduction of new vaccines to provide all children with the best possible start in life. All the GAVI Alliance partners – UNICEF, WHO, the World Bank, developing and donor countries, civil society organisations, private philanthropists and vaccine manufacturers – have an essential part to play. Casting our net wider, I believe that the Alliance can be a platform for engagement by all stakeholders in immunisation.

The power of vaccines is clear. While the world's population more than doubled between 1980 and 2009, the number of diphtheria cases fell by 99%, the number of polio cases reduced by 97% and the number of measles and pertussis cases each dropped by 95%.

By further increasing the support for vaccines, we can continue this progress and turn the miracle of vaccines into effective protection for every child everywhere.



Saving lives and protecting health

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

THE VACCINE GOAL

1 Accelerate vaccines

Accelerate the uptake and use of underused and new vaccines by strengthening country decision-making and introduction.

THE HEALTH SYSTEMS GOAL

2 Strengthen capacity

Contribute to strengthening the capacity of integrated health systems to deliver immunisation.

THE FINANCING GOAL

3 Increase predictability and sustainability

Increase the predictability of global financing and improve the sustainability of national financing for immunisation.

THE MARKET SHAPING GOAL

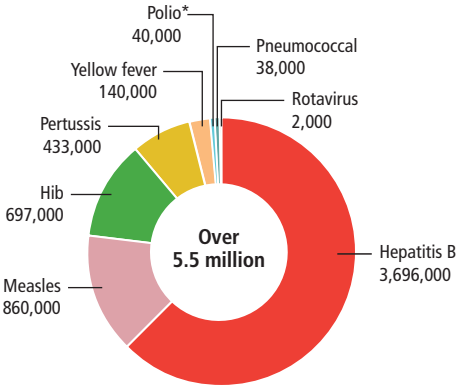
4 Shape the market

Shape vaccine markets to ensure adequate supply of appropriate, quality vaccines at low and sustainable prices for developing countries.

By the end of 2011, GAVI had:

- *contributed to countries preventing over 5.5 million future deaths otherwise caused by* Haemophilus influenzae *type b (Hib), hepatitis B, measles, pertussis, pneumococcal disease, polio, rotavirus diarrhoea and yellow fever;*
- *supported the immunisation of more than 325 million additional children;*
- *committed US$ 7.2 billion to new and underused vaccines and health system strengthening programmes in developing countries.*

Future deaths averted, 2000–2011



* Includes deaths averted by GAVI-supported vitamin A supplementation programmes.

Source: 1

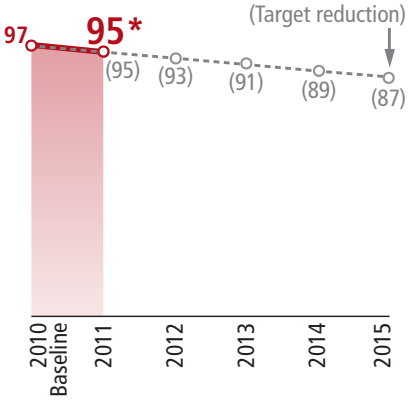
See also ▼
gavialliance.org/goal-level-indicators

Goals ▼
gaviprogressreport.org/2011/goals

Delivering on the GAVI mission

GAVI's 2011–2015 strategy has three indicators, each with specific targets, to measure progress against the overall mission.

Under-five mortality rate in GAVI-eligible countries (per 1,000 live births)



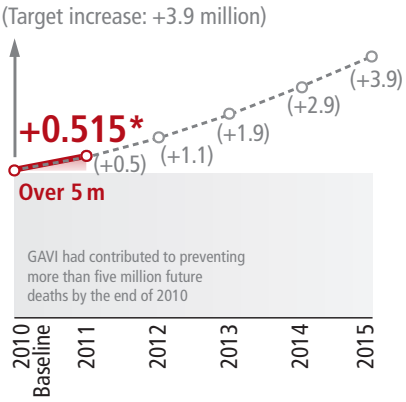
* UNPD projection

The average under-five mortality rate in GAVI-supported countries fell from 97 deaths per 1,000 live births in 2010 to a projected 95 deaths per 1,000 live births in 2011, in line with GAVI's target.

Note: Under-five mortality rates are derived from population-weighted estimates of child mortality rates for the 72 countries eligible for GAVI support in 2010.

Source: 2

Number of additional future deaths averted (millions)



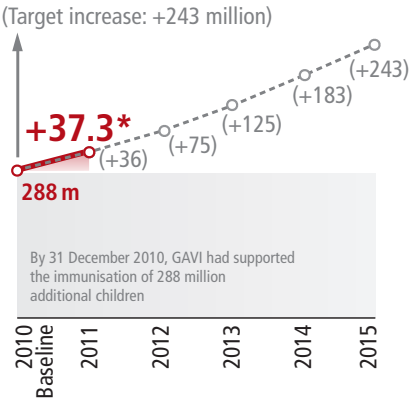
* WHO projection

By the end of 2011, GAVI-funded vaccines had helped developing countries to prevent a projected 5.5 million future deaths. This is an additional 515,000 averted deaths compared with the end of 2010, slightly above the target of 483,000.

Note: The calculation of the number of future deaths averted takes account of nine vaccines funded by GAVI in all 72 countries eligible for GAVI support in 2010.

Source: 3

Number of additional children fully immunised with GAVI support (millions)



* WHO projection

According to WHO estimates, over 325 million children had received one or more GAVI-supported vaccines by the end of 2011. This is an additional 37.3 million children compared with the end of 2010, ahead of the target of 36 million.

Note: The calculation of the number of children immunised includes the total number of children who have received the full course of any of the GAVI-supported vaccines in all 72 countries eligible for GAVI support in 2010. Country data have been corrected so that children who receive multiple vaccines are not counted more than once.

Source: 4

See also ▼
gavialliance.org/mission-indicators

Data ▼
gaviprogressreport.org/2011/data

GAVI supports the countries most in need

To ensure its focus on the poorest countries in the world, GAVI applies an eligibility threshold for support that is based on gross national income (GNI).

In 2011, 57 countries were eligible for GAVI support as their per capita GNI* was equal to or less than US$ 1,500.**

Since GAVI's inception, 77 countries have received support for vaccines or health system strengthening programmes.

Not all GAVI-eligible countries qualify for every type of support. For instance, for a country to qualify for new vaccine support its coverage for three doses of diphtheria-tetanus pertussis vaccine (DTP3) has to be at least 70%.*** Meningitis A and yellow fever vaccines are exempt from this requirement.

As GAVI aims to provide additional catalytic investments, vaccine support is not provided to countries that are already self-funding the vaccine.

FOR THE FIRST TIME IN HISTORY, **CHILDREN IN DEVELOPING COUNTRIES** ARE RECEIVING NEW LIFE-SAVING VACCINES **AT VIRTUALLY THE SAME TIME** AS CHILDREN IN HIGH-INCOME COUNTRIES

* Based on World Bank per capita GNI data for 2009, published in July 2010.

** Exceptionally, 16 graduating countries were given a final opportunity to apply for GAVI support in 2011.

*** The filter was temporarily reduced to 50% for the 2011 application round.

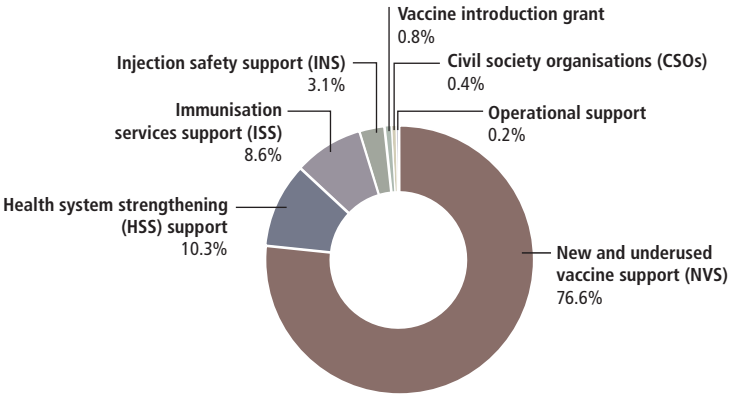
See also ▼
gavialliance.org/eligible-countries

Facts ▼
gaviprogressreport.org/2011/facts

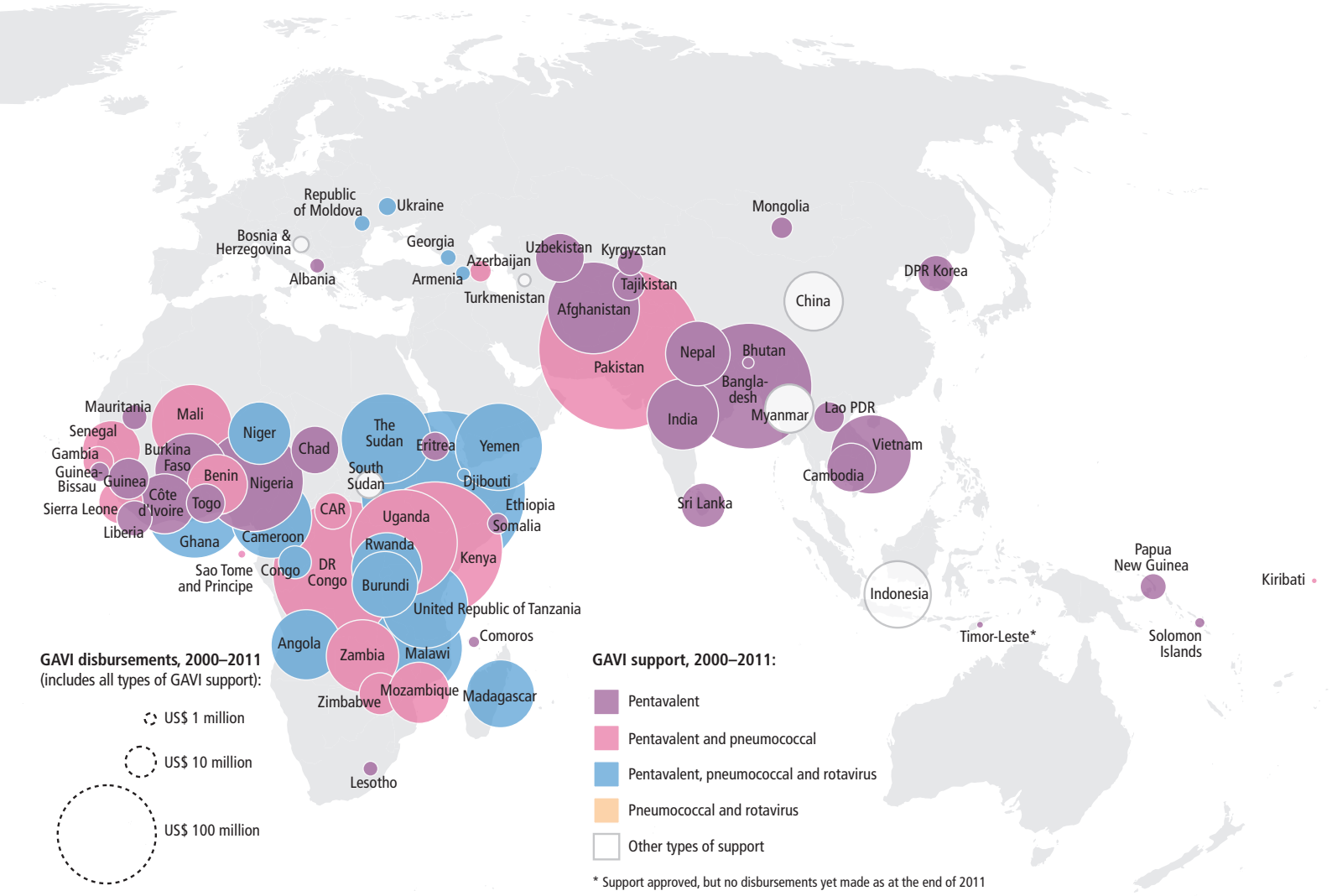
Every child deserves to be protected against disease with vaccines, no matter whether [he or she] is born in Europe, Africa or elsewhere in the world.

Andris Piebalgs,
European Commissioner
for Development

Disbursements to countries by type of support, 2000–2011



Source: 6



Source: 5

Note: Pentavalent, pneumococcal and rotavirus vaccines represent GAVI's main areas of support. In 2011, GAVI also provided support for measles (second dose), meningitis A and yellow fever vaccines, as well as for health system strengthening and civil society involvement in immunisation.

See also ▼
gavialliance.org/approved-countries

Data ▼
gaviprogressreport.org/2011/data

2011 Timeline




JANUARY

Guyana, Kenya, Sierra Leone and Yemen introduce pneumococcal vaccine

Countries step up their share of vaccine costs under the new co-financing policy

MARCH

Mali introduces pneumococcal vaccine

IFFIm issues new vaccine bonds in Japan

Seth Berkley appointed as GAVI CEO

MAY

GAVI commits US$ 100 million to help tackle meningitis A in Cameroon, Chad and Nigeria

Bill Roedy, former CEO of MTV Networks, becomes the first GAVI Envoy

APRIL

The Democratic Republic of the Congo and Honduras introduce pneumococcal vaccine

I always bring my children in on time for their vaccines. I know how important that is for keeping them healthy.

Misael Amador, father, Honduras

JUNE

GAVI pledging conference raises US$ 4.3 billion in donor pledges

Vaccine manufacturers offer price reductions on pentavalent, rotavirus and human papillomavirus (HPV) vaccines

A record 50 countries apply for GAVI vaccine funding

GAVI launches new Matching Fund

See also ▼
gavialliance.org/pneumococcal-timeline

Stories ▼
gaviprogressreport.org/2011/stories

DEVELOPING COUNTRIES HAVE PREVENTED OVER 5.5 MILLION FUTURE DEATHS WITH GAVI-FUNDED VACCINES

JULY

Benin, Cameroon and the Central African Republic introduce pneumococcal vaccine

The Sudan introduces rotavirus vaccine

Azerbaijan introduces pentavalent vaccine

OCTOBER

Ethiopia introduces pneumococcal vaccine

NOVEMBER

Malawi introduces pneumococcal vaccine

GAVI takes first steps to fund HPV and rubella vaccines

The GAVI Board adopts new strategy for vaccine supply and procurement

Geeta Rao Gupta is appointed Vice Chair of the GAVI Alliance Board

SEPTEMBER

Burundi introduces pneumococcal vaccine

IFFIm issues new vaccine bonds in Japan

GAVI approves funding for 37 countries to introduce new vaccines, bringing the total for the year to 38

AUGUST

Seth Berkley takes up the post of GAVI CEO

DECEMBER

Pentavalent vaccine is introduced in two states in India

See also ▼
gavialliance.org/rotavirus-timeline

Goals ▼
gaviprogressreport.org/2011/goals

Donor contributions to the GAVI Alliance

Cash received by GAVI (in US$ millions) as of 31 December 2011

Donors to the GAVI Alliance	2011	Total 2000–2011
Australia	48.8	77.4
Canada	20.7	172.5
Denmark	8.8	36.8
European Commission (EC)	0.0	57.9
France	34.5	53.2
Germany	8.5	30.6
Ireland	4.9	34.8
Japan	9.3	9.3
Luxembourg	1.2	7.7
Netherlands	26.3	242.2
Norway	79.2	598.9
Republic of Korea	0.3	0.7
Spain	2.7	43.2
Sweden	92.7	215.2
United Kingdom	85.1	222.5
United States of America	89.8	736.5
Government donors and EC	**512.9**	**2,539.4**
Anglo American plc	1.0	1.0
Bill & Melinda Gates Foundation	264.1	1,476.9
His Highness Sheikh Mohamed bin Zayed Al Nahyan	14.1	14.1
«la Caixa» Foundation	3.1	18.8
J.P. Morgan	2.4	2.4
Other private	0.8	13.1
Private contributions	**285.5**	**1,526.3**
Sub-total	**798.4**	**4,065.7**
IFFIm to GFA transfers	**300.0**	**2,175.7**
AMC funds	**128.2**	**171.0**
Total contributions	**1,226.5**	**6,412.4**

Donations are recorded on a cash basis.

Note: As GAVI's financing mechanisms enable the innovative use of donor contributions over time, the amount of donor contributions (as detailed in Annex 2) may differ from the amount of cash received by GAVI (as detailed above) in a given year.

Source: *7*

See also ▼
gavialliance.org/donor-profiles

By daring to be imaginative, innovative and bold, we have raised significant capital and ensured the delivery of vaccines to those who need them most.

Ban Ki-moon,
United Nations Secretary-General

Innovative finance mechanisms: AMC and IFFIm

AMC commitments	2009–2020 (US$ millions)
Italy	635
United Kingdom	485
Canada	200
Russian Federation	80
Bill & Melinda Gates Foundation	50
Norway	50
Total	**1,500**

Source: 8

IFFIm commitments*	Length of commitment	Amount (in millions)	Total (equivalent in US$ millions**)
United Kingdom	20 years 20 years	£1,380.0 £250.0	2,979.9
France	15 years 19 years	€ 372.8 € 867.2	1,719.6
Italy	20 years 15 years	€ 473.5 € 25.5	635.0
Norway	5 years 10 years	US$ 27.0 NOK 1,500.0	264.5
Australia	20 years	A$ 250.0	256.1
Spain	20 years	€ 189.5	240.4
Netherlands	7 years	€ 80.0	114.4
Sweden	15 years	SEK 276.2	37.7
South Africa	20 years	US$ 20.0	20.0
Total			**6,267.6**

* The UK and Brazil made new pledges to IFFIm in 2011. Negotiations are currently under way to formally sign these grant agreements.

** IFFIm pledges by donors in US$ and US$ equivalent amounts of national currency pledges calculated using prevailing exchange rate around the time of signing of the grant agreement.

Source: 9

See also ▼
iffim.org/donors

ACCELERATE VACCINES

2011 witnessed an unprecedented acceleration in the roll-out of life-saving vaccines in developing countries.

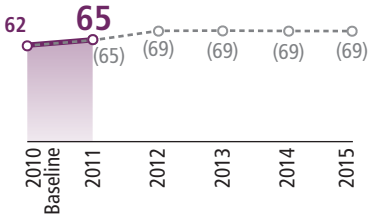
MORE THAN HALF OF ALL GAVI-ELIGIBLE COUNTRIES HAVE BEEN APPROVED FOR SUPPORT FOR PNEUMOCOCCAL VACCINE

Country introductions of new and underused vaccines

By the end of 2011, the cumulative number of introductions reached the target of 65 countries with pentavalent and 5 countries with rotavirus vaccine. Sixteen countries had introduced pneumococcal vaccine, slightly short of the target of 19 introductions.

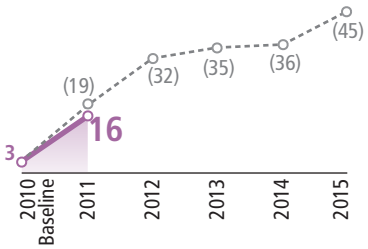
Pentavalent vaccine

Number of countries



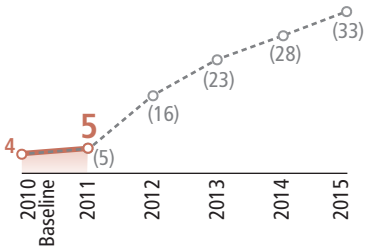
Pneumococcal vaccine

Number of countries



Rotavirus vaccine

Number of countries



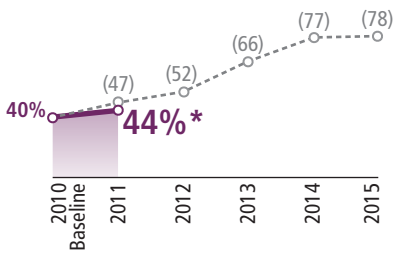
Source: 10

Coverage of new and underused vaccines

Immunisation coverage for pentavalent vaccine in GAVI-eligible countries in 2011 was projected at 44% – three percentage points below target. Projected coverage for pneumococcal and rotavirus vaccine was on target with 5% and 1%, respectively.

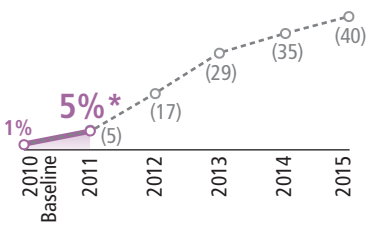
Pentavalent vaccine, 3rd dose

Coverage (%)



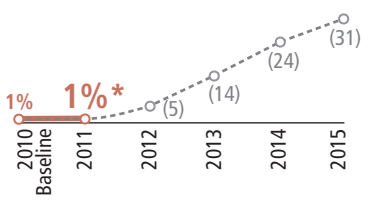
Pneumococcal vaccine, 3rd dose

Coverage (%)



Rotavirus vaccine, last dose

Coverage (%)



* Strategic Demand Forecast v4 projections

Source: 11

See also ▼
gavialliance.org/vaccine-goal-indicators

Data ▼
gaviprogressreport.org/2011/data

I am grateful for this additional protection of my daughter. There is already so much we have to worry about until she will be a grown-up. It's wonderful that pneumonia can now be taken from the list!

Nsadisa Mbala, mother,
the Democratic Republic
of the Congo

Quotes ▼
gaviprogressreport.org/2011/quotes

By the year end, nearly all GAVI-supported countries had been approved for pentavalent vaccine, more than half for pneumococcal vaccine and over 20 for rotavirus vaccine support.

During the year, developing countries, with support from GAVI, continued to accelerate access to immunisation against the three vaccine-preventable diseases that cause the largest number of under-five child deaths: pneumococcal disease, rotavirus infection and infection with *Haemophilus influenzae* type b (Hib).[1]

Five African countries conducted preventive vaccine campaigns against meningococcal disease while yellow fever immunisation campaigns were rolled out in Côte d'Ivoire, Ghana and the Sudan – protecting millions against these deadly and debilitating diseases.

In November, the GAVI Board took steps to open new funding windows for vaccines against human papillomavirus (HPV) and rubella, which will have a direct benefit on the health of women and children.

Increasing demand

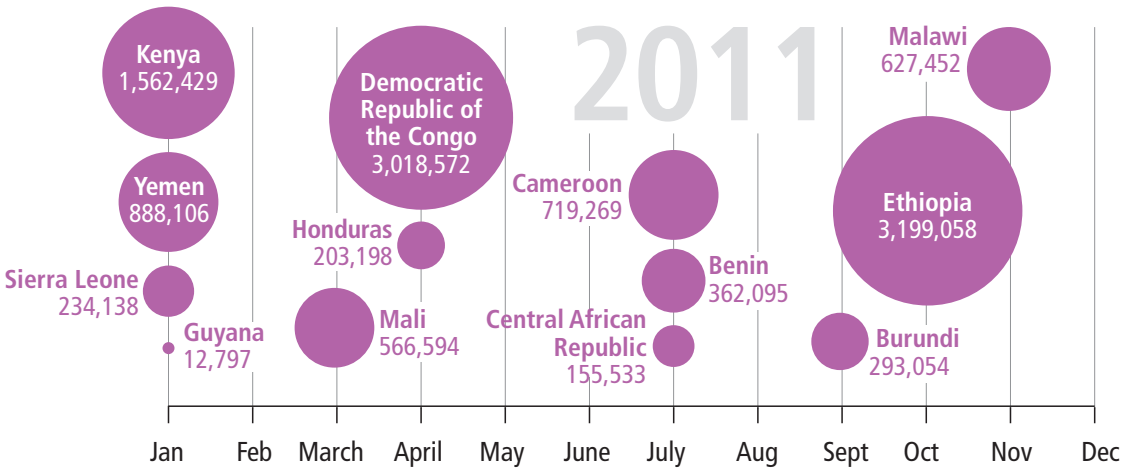
Applications to GAVI for new and underused vaccine support hit a record high in 2011. Countries made a total of 74 applications in the June application round, more than in any previous round.

In 2011, the GAVI Board approved 55 vaccine applications from 38 countries. Eighteen applications were approved for pneumococcal vaccine, 16 for rotavirus vaccine, 5 for pentavalent vaccine and 16 for other types of vaccines.

1 for 430

FOR EVERY CHILD THAT DIES FROM PNEUMONIA IN THE EUROPEAN UNION, 430 DIE IN AFRICA

Pneumococcal vaccine introduction timeline: countries and respective number of newborns, 2011



Source: 12

See also ▼
gavialliance.org/vaccine-support

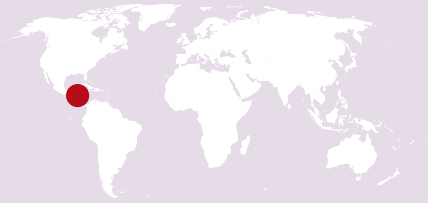
Facts ▼
gaviprogressreport.org/2011/facts

HONDURAS

Partnerships key to immunisation success

Honduras has achieved what many other countries only aspire to: a near-perfect DTP3 vaccination coverage rate of 98%. In 2010, it reported zero cases of diphtheria, Hib meningitis, measles, polio and rubella.[2]

Honduras introduced rotavirus vaccines in 2009 to reduce the incidence of diarrhoeal disease. Two years later, GAVI helped fund the country's roll-out of pneumococcal vaccine, in a bid to tackle the high mortality among the under-fives due to pneumonia.

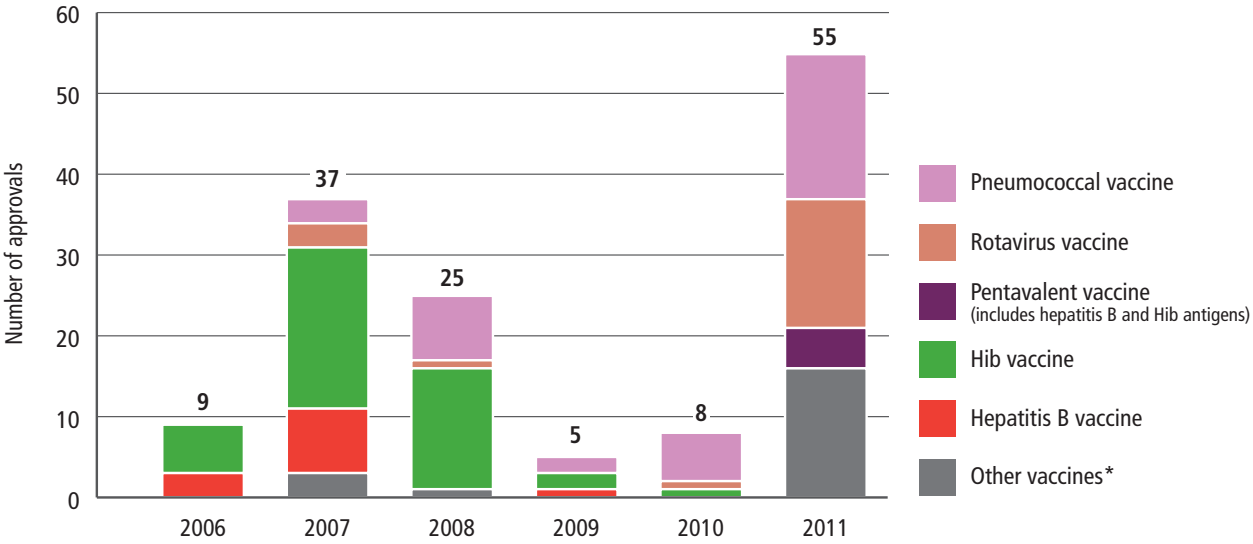


Delivering vaccines, which must be refrigerated from the moment they are manufactured up until the point they are administered, is not a straightforward task. This is especially true in Honduras, where nearly half of the rural population lacks a reliable electricity supply. It takes all stakeholders working in concert to achieve this level of success.

I am enjoying a healthy life thanks to vaccines.

Saleha Akhter, 11-year-old student, Bangladesh

Number of approvals for GAVI vaccine support, 2006–2011



* Includes measles second dose, meningitis A and yellow fever vaccines

Note: in 2011 the majority of countries were approved for pentavalent vaccine, rather than for Hib and hepatitis B vaccine separately. Therefore, from 2011 onwards GAVI changed its reporting method to include the combination pentavalent vaccine only.

Source: 13

See also ▼
gavialliance.org/2011/saleha-akhter

Stories ▼
gaviprogressreport.org/2011/stories

Accelerating access to pneumococcal and rotavirus vaccines

Pneumonia and diarrhoea are the two leading causes of death among children under the age of five.

Pneumococcal vaccines help to prevent pneumonia, and also provide protection against meningitis and sepsis. The rapid introduction by countries of pneumococcal vaccine offers the potential for a significant reduction in the number of child deaths, especially from pneumonia. In 2011 alone, GAVI-supported programmes helped to immunise an estimated 3.3 million children against pneumococcal disease.

By the end of 2011, 16 developing countries had already started to introduce the vaccine with GAVI support, while another 21 had had their applications for support approved. As a result, the vaccine will soon be part of routine immunisation programmes in more than half of all GAVI-eligible countries.

Over 20 GAVI-eligible countries have thus far been approved for support for vaccines against rotavirus, the main cause of deadly diarrhoea in children. July 2011 marked a milestone for rotavirus control in Africa, as the Sudan became the first African nation to introduce rotavirus vaccine with GAVI support.

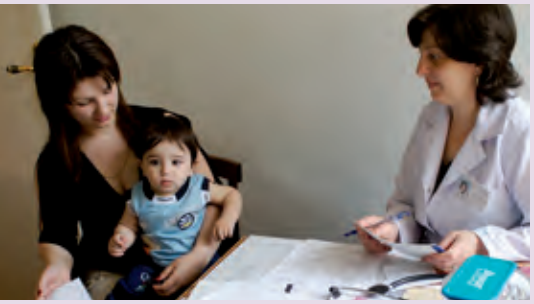
While these new vaccines can save millions of lives in their own right, their introduction provides additional opportunities to promote complementary ways of preventing and treating pneumonia and diarrhoea. This includes encouraging behaviours such as exclusive breastfeeding, hand-washing and care-seeking, and use of antibiotic (for pneumonia) and oral rehydration therapies (for diarrhoea).

Pneumonia is still killing too many of our children, but with this new vaccine we aim to reverse this tragedy and set our children on course for a healthy future.

Dr Sabine Ntakarutimana, Minister of Health, Burundi

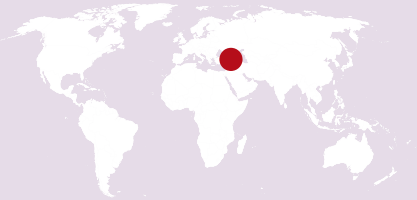
ARMENIA

Supporting vaccine decision-making



A few years ago, Armenia was divided over whether to introduce rotavirus vaccine into its national immunisation programme. PATH, an international non-governmental organisation (NGO) and a member of GAVI's Accelerated Vaccine Introduction initiative, worked with a local NGO, the Armenian Center for Protection of Public Health and Social Rights, to provide decision-makers with the tools and evidence needed to assess the value and potential benefits of rotavirus vaccines for Armenian children.

Armed with regional and country-specific data about the burden of rotavirus disease, as well as detailed information about the safety, efficacy and cost-effectiveness of rotavirus vaccines, Armenian health officials were able to make an informed decision about the appropriateness of rotavirus vaccine for their country. Armenia has since applied for rotavirus vaccine support from GAVI and plans to introduce the vaccine in late 2012.



How vaccines work

Each child is born with a natural immune system which protects against disease-causing agents, such as bacteria and viruses. When such an agent – or antigen – enters the body, the immune system produces antibodies to destroy it. Once our immune system has been exposed to a particular antigen, it "remembers" it and can defend against it in the future.

Vaccines contain inactivated or greatly weakened versions of the antigens (or parts of the antigens) that are responsible for disease. The antigens in vaccines are not strong enough to cause illness, but they prime the immune system to recognise a particular antigen and to mount an appropriate immune response.

Over 20 countries
WILL SOON HAVE ROLLED OUT ROTAVIRUS VACCINE WITH GAVI SUPPORT

See also ▼
gavialliance.org/pneumococcal

Quotes ▼
gaviprogressreport.org/2011/quotes

INDIA

Embarks on historic introduction of Hib vaccine

Two Indian states, Kerala and Tamil Nadu, both with high DTP3 immunisation coverage and reliable vaccine delivery systems, started rolling out the pentavalent vaccine in December 2011. The vaccine, which protects against five infections, brings the vaccine against *Haemophilus influenzae* type b (Hib) into India's national immunisation programme for the first time.

"The pentavalent vaccine is already available in the private market at a very high cost. When it comes in the public health system it is free of cost and hence available to those who otherwise cannot afford it," said Anuradha Gupta, then Joint Secretary in the Federal Ministry of Health.

Almost 20% of all child deaths caused by Hib infection occur in India.[3]

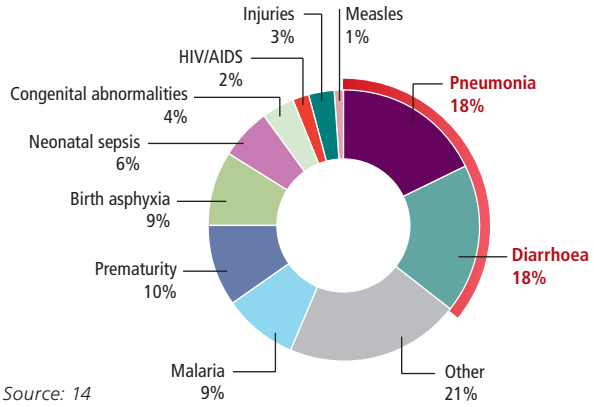
Pentavalent vaccine boosts protection against Hib and hepatitis B

By the end of 2011, GAVI-supported countries had immunised 296 million children against hepatitis B, one of the main causes of liver cancer and cirrhosis later in life. This has helped to prevent 3.7 million future deaths caused by both the chronic and acute effects of hepatitis B infection.

Infection with Hib causes some 3 million cases of serious illness and more than 380,000 deaths per year, mainly through meningitis and pneumonia. The vast majority of Hib-related deaths occur in children, in particular among those aged between 4 and 18 months. By providing countries with vaccines to immunise close to 124 million children against Hib, GAVI has contributed to the prevention of 697,000 future deaths.

Most GAVI-eligible countries have introduced hepatitis B and Hib vaccines as part of the easy-to-administer pentavalent vaccine, which protects against five diseases: hepatitis B, Hib, diphtheria, pertussis (whooping cough) and tetanus.

Causes of child deaths in low-income countries



Source: 14

Note: WHO and UNICEF are currently revising the methodology for estimating child mortality. New data is expected in mid-2012.

Vaccines key to cancer prevention

Almost 20% of all cancer cases are caused by chronic infections. Hepatitis B is a leading cause of liver cancer, while human papillomavirus (HPV) infection is responsible for virtually all cases of cervical cancer. GAVI is directly supporting the introduction of safe and effective vaccines that can protect millions from these two leading cancers.

296 million

WITH SUPPORT FROM GAVI 296 MILLION CHILDREN HAVE BEEN IMMUNISED AGAINST HEPATITIS B

See also ▼ gavialliance.org/hib

Facts ▼ gaviprogressreport.org/2011/facts

Protecting women and girls against cervical cancer and rubella

Cervical cancer claims the lives of some 275,000 women every year – the vast majority of whom live in developing countries. If left unchecked, this number could rise to more than 400,000 women per year by 2030.

New HPV vaccines, which can prevent approximately 70% of all cervical cancer cases, have recently been introduced in many wealthy countries. Making these vaccines available to girls in developing countries is vital, as they often lack access to cancer screening and treatment services.

Following a 2008 assessment of the potential impact of 18 vaccines, in 2011 GAVI took its first steps towards supporting the introduction of the HPV vaccine in developing countries. Countries will be invited to apply for support provided that GAVI can secure acceptable price commitments from manufacturers and countries can demonstrate their ability to deliver the vaccines. The aim is to immunise over 28 million women and girls by 2020.

The introduction of HPV vaccines will be challenging for many developing countries. WHO recommends that girls aged 9–13 years, many of whom do not have routine contact with health services, are immunised. At the same time, HPV vaccines offer an exciting opportunity to help countries integrate vaccine delivery with other important interventions for girls such as adolescent reproductive health, HIV prevention, nutrition, family planning and maternal health.

On the basis of the 2008 impact assessment, the GAVI Board also decided to invite countries to apply for measles-rubella vaccine support in 2012. Rubella infection early in pregnancy can cause severe congenital defects in children and may result in stillbirth and miscarriage in pregnant women. It is estimated that of the 112,000 children born with rubella-related birth defects every year, 90,000 are in GAVI-eligible countries. GAVI's support will help to fight this disease and protect both mothers and babies from its effects.

GAVI will build on the success of measles control activities by supporting the combined measles-rubella vaccine. Beginning in 2012, GAVI will fund catch-up campaigns of measles-rubella vaccine for countries, on the condition that they introduce the vaccines into their routine immunisation programmes at their own cost.

GAVI's decision to include the HPV vaccine is a visionary investment that will promote equity, the health of women and development.

Julio Frenk, Dean, Harvard School of Public Health and Chair, Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries

7 out of 10

CERVICAL CANCER CASES CAN BE PREVENTED WITH HPV VACCINES

See also ▼
gavialliance.org/hpv

Photos ▼
gaviprogressreport.org/2011/photos

Meningococcal A vaccine dramatically reduces meningitis cases

Meningitis epidemics periodically sweep through central Africa, leaving thousands of people dead or disabled in its wake. MenAfriVac, a new meningococcal A vaccine licensed in 2010, has the potential to eliminate a leading cause of meningitis epidemics. Between 2011 and 2015, GAVI intends to support the roll-out of the vaccine in all 25 countries in the "meningitis belt", a string of countries stretching from Senegal to Ethiopia.

So far, six countries have successfully rolled out the new meningococcal vaccine. In early 2011, GAVI approved new applications for meningococcal vaccine support from Cameroon, Chad and Nigeria, accelerating the process so that the vaccine could be introduced before the start of the epidemic season. Later in the year, applications from four other countries were approved. During 2011, an estimated 32.6 million people were vaccinated against meningitis A.

The new meningococcal A vaccine has proved to be highly effective. Burkina Faso, which introduced the vaccine in 2010, reported just four cases of meningitis A in the 2010–2011 epidemic season – the lowest number ever recorded. All the reported cases were in unimmunised people.

People are always apprehensive, scared ahead of the meningitis season. They never know what will happen… The new vaccine is a golden opportunity to protect our people.

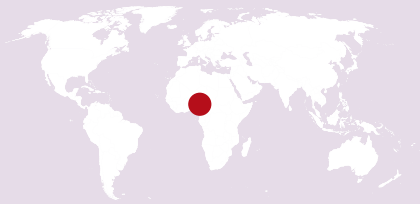
Muhammad Sani Adamu, Head of Accelerated Disease Control, National Primary Health Care Development Agency, Nigeria

CAMEROON, CHAD AND NIGERIA

Protecting millions against debilitating meningitis

In December 2011, a young boy is immunised at a hospital in N'Djamena, Chad, with a new vaccine against meningitis A. He is one of an estimated 19 million people who received the vaccine as part of a mass immunisation campaign that took place in Chad and two of its neighbours, Cameroon and northern Nigeria.

Chad is among one of the worst affected countries in Africa's notorious meningitis belt. It is regularly subjected to epidemics of meningitis that arrive with the hot seasonal winds, spreading death, disability, and fear. The region's biggest epidemic of recent years, in 1996–1997, affected 250,000 people, killing 25,000 and leaving another 50,000 with disabilities ranging from deafness to mental retardation.



Only 4 cases

OF MENINGITIS A WERE REPORTED IN BURKINA FASO IN THE 2010–2011 EPIDEMIC SEASON – ALL IN UNIMMUNISED PEOPLE

See also ▼
gavialliance.org/meningitis-a

Stories ▼
gaviprogressreport.org/2011/stories

Millions more protected against yellow fever

GAVI support for routine yellow fever immunisation continued through 2011. Currently 17 countries receive yellow fever vaccine support. WHO estimates that GAVI has contributed to the routine immunisation of close to 54 million children against yellow fever – 9 million of those during 2011 alone. An estimated 140,000 future deaths have been prevented.

GAVI also funds immunisation campaigns to prevent yellow fever outbreaks in high-risk countries. Since 2007, 12 countries have been supported in this way. In 2011, yellow fever vaccination campaigns took place in Côte d'Ivoire and Ghana, protecting approximately 14 million people against yellow fever.

The Decade of Vaccines – scaling up demand, development and delivery

Following its launch in May 2011, the Decade of Vaccines collaboration embarked on a consultative process to develop an ambitious Global Vaccine Action Plan (GVAP) aimed at stimulating the demand, development and delivery of life-saving vaccines.

GAVI has contributed to the collaboration, and the work of the Alliance will be one of the key elements of the GVAP. By increasing coverage of nine existing GAVI vaccines by 2020, 9.5 million future deaths can be prevented in GAVI-eligible countries, and billions could be saved in treatment and lost productivity costs. These preliminary estimates are based on current assumptions about factors such as vaccine prices, country demand and funding sources.

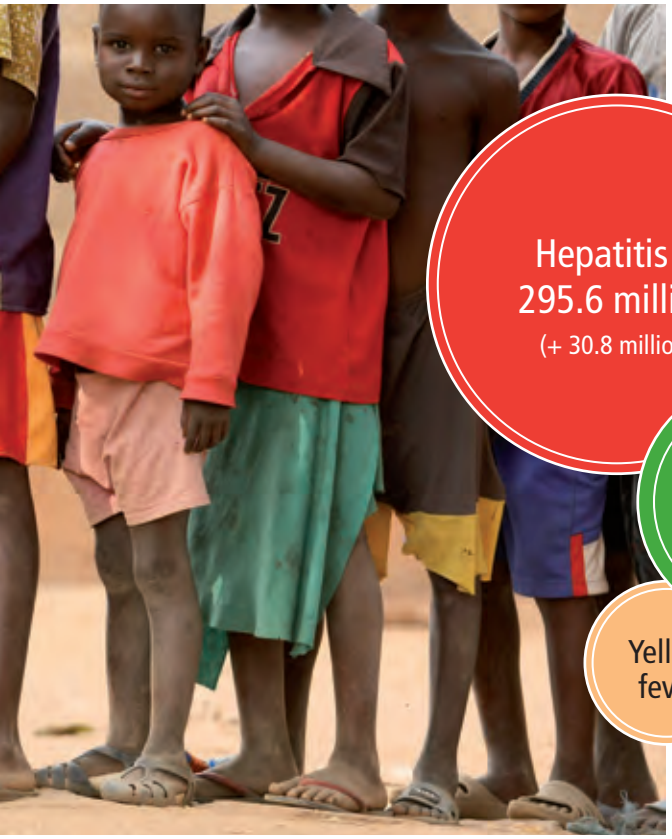
Over half of the 30% drop in child mortality since 1990 is attributable to immunization.

Dr Margaret Chan,
Director-General, WHO

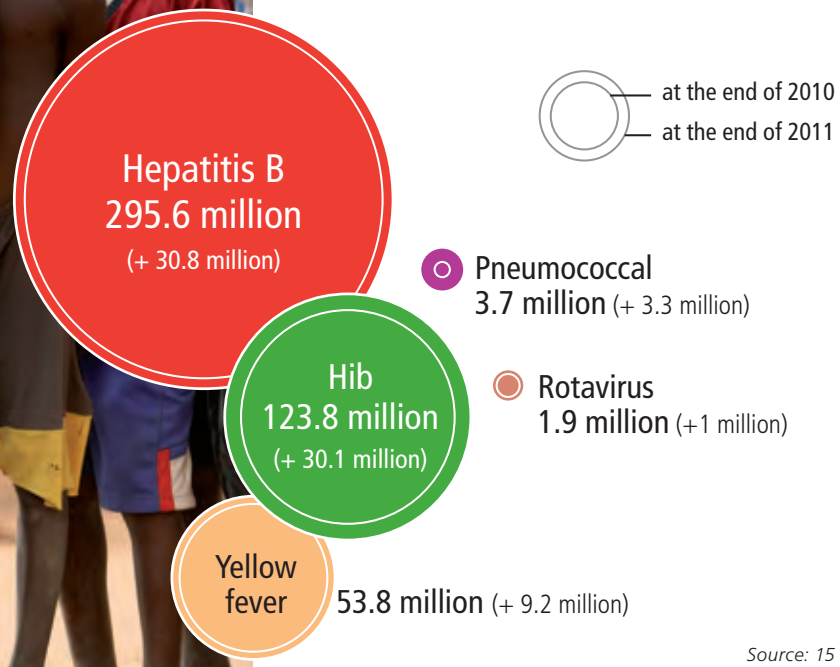
14 million people
WERE IMMUNISED THROUGH GAVI-SUPPORTED VACCINE CAMPAIGNS AGAINST YELLOW FEVER IN 2011

See also ▼
gavialliance.org/yellowfever

Facts ▼
gaviprogressreport.org/2011/facts



Total number of children immunised at the end of 2011 (increase relative to the end of 2010)



Source: 15

GAVI to support nine more countries with routine measles vaccine

By taking steps to introduce measles second dose vaccine into their routine immunisation programmes from 2012 onwards, nine more countries in Africa and Asia are building their defences against a major vaccine-preventable killer of children.

Failure to reach uniform high coverage with two doses of measles-containing vaccine is one of the key obstacles to further reductions in the number of children dying from measles. Still one of the biggest vaccine-preventable killers of children, according to the Measles Initiative measles killed an estimated 2.6 million children in 1980 before the impact of immunisation reduced the number by over 90% to 164,000 in 2008.

"Measles is extremely difficult to control precisely because it is so contagious," said Andrea Gay, Executive Director of Children's Health at the UN Foundation, a partner in the Measles Initiative. "GAVI's support for routine immunisation with two doses of measles-containing vaccines is a massive help to controlling this deadly disease," she said.

From 2012 onwards, GAVI will also be funding the supply of measles-rubella combination vaccines as part of campaigns to reduce the impact of rubella in developing countries.

9 out of 10
PREGNANT WOMEN WITH RUBELLA WILL TRANSMIT THE DISEASE TO THEIR UNBORN CHILD

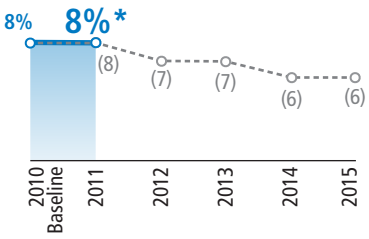
See also ▼
gavialliance.org/measles

Data ▼
gaviprogressreport.org/2011/data

STRENGTHEN CAPACITY

The success of national immunisation programmes depends upon strong health systems. Over 50 countries have received health system strengthening support from GAVI to ensure that vaccines are delivered to those who need them the most.

Drop-out rate between DTP1 and DTP3 (%)



* WHO/UNICEF projection - calculated based on trends

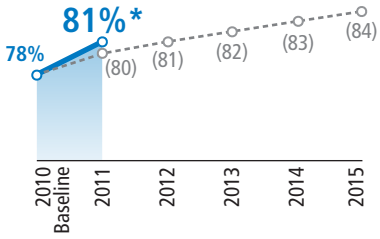
The drop-out rate measures the difference between coverage of one dose of diphtheria-tetanus-pertussis vaccine (DTP1) and coverage of three doses of the same vaccine (DTP3). The drop-out rate in 73 GAVI-eligible countries was projected at 8% in 2011 – in line with GAVI's target.

Source: 16

DTP1 = one dose of diphtheria-tetanus-pertussis (DTP) vaccine

DTP3 = three doses of DTP vaccine

DTP3 coverage (%)



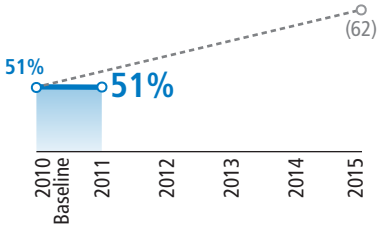
* Strategic Demand Forecast v4 projection

DTP3 coverage climbed to a projected historic high of 81% in 72 GAVI-eligible countries in 2011. This is one percentage point above the 2011 target.

Source: 17

Equity in immunisation coverage (%)

Proportion of countries meeting the minimum equity benchmark



Just over half of GAVI-eligible countries with available survey data (51%) have a differentiation of less than 20 percentage points between DTP3 coverage in the poorest quintile of the population and the wealthiest quintile. GAVI aims to increase this percentage to 62% by 2015.

Source: 18

See also ▼
gavialliance.org/health-systems-goal-indicators

Goals ▼
gaviprogressreport.org/2011/goals

Why DTP3?

DPT3 coverage is considered the best indicator of the reach of national immunisation programmes. A fully-functioning immunisation system – comprising a well-trained work force, robust vaccine supply and distribution systems, and strong management and monitoring functions – is essential to immunising children with three doses of DTP at the recommended 6-, 10- and 14-week intervals. The vast majority of children in GAVI-supported countries receive DTP as part of the pentavalent vaccine, which also includes antigens against hepatitis B and Hib.

81%

DTP3 VACCINE COVERAGE IN 72 GAVI-ELIGIBLE COUNTRIES REACHED A RECORD HIGH OF 81% IN 2011

See also ▼
gavialliance.org/2011/bangladesh-gallery

Photos ▼
gaviprogressreport.org/2011/photos

Strong health systems – availability of financing, quality services, human resources, governance, information and technology – have an immediate and direct impact on immunisation.

Immunisation is often the backbone of child health interventions. In settings where the health system is weak and treatment is a challenge, preventative approaches such as immunisation become even more important.

The goal of GAVI's health system strengthening (HSS) support is to strengthen the capacity of health systems to deliver immunisation. The support aims to resolve barriers to delivering immunisation, to increase equity in access to services and to support civil society involvement in immunisation planning and delivery.

GAVI has approved support for health system strengthening programmes in 54 countries. By developing tailored approaches for fragile and underperforming countries, GAVI is taking steps to further customise its HSS support.

I know about vaccinations from community health workers and health extension workers. They remind me when to go, and I can ask them if I have any questions.

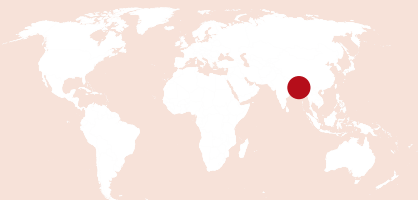
Margaret Teshome, mother, Ethiopia

BANGLADESH

Advocacy key to immunisation success

Immunisation charts on the wall of the Upazila Health Complex in Kapasia, Bangladesh, tell a clear story: a steady rise in the delivery of pentavalent vaccine. As in much of Bangladesh, immunisation coverage in this district of 400,000 people is close to 90%.

Advocacy plays a key role in mobilising Bangladeshis to attend immunisation sessions. Each year, Premier Sheikh Hasina makes a televised national address to urge Bangladeshis to vaccinate their children. On Immunisation Day, the health ministry provides 20,000 mobile vaccination stations, in addition to 140,000 fixed immunisation clinics.



"Illiterate people have a 74% immunisation rate," says Health Minister A.F.M. Ruhal Haque. "We have been able to convince them to come to the vaccination stations. That is the success of Bangladesh."

See also ▼ gavialliance.org/hss

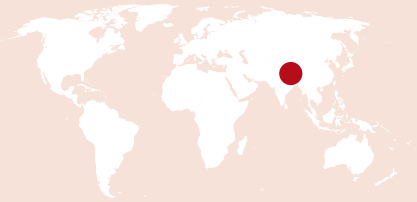
Stories ▼ gaviprogressreport.org/2011/stories

NEPAL

Harmonised health system delivers results

Nepal exemplifies how a harmonised health systems approach can deliver results. With a 65% drop in the number of deaths in children under five since 1990, Nepal is on track to meet Millennium Development Goal 4 on child mortality.

Nepal's successes are rooted in a harmonised health sector, built on the principles of aid effectiveness. Nepal is the first country to receive GAVI funding through the Health Systems Funding Platform. Together with Platform partners and other leading donors, GAVI aligns its support for health systems with Nepal's health planning, budgetary and reporting frameworks and cycles.



Healthy children need healthy mothers. To give a child a bright start into life, a package of good nutrition, hygiene, vaccination and health care must be available to the mother and her baby.

Pierrette Vu Thi, UNICEF Representative, the Democratic Republic of the Congo

Harmonised platform for strengthening health systems to deliver immunisation

The Health Systems Funding Platform (the Platform) was initiated in 2009 as a mechanism for aligning donor support for national health system strengthening programmes. In line with the principles of aid effectiveness, the Platform aligns planning, budget financial management, monitoring and reporting to a country's national health plan and budget cycles. It thereby aims to lower administrative costs, increase efficiency and reduce fiduciary risk.

Throughout 2011, GAVI continued to work to refine the new application procedures and helped a number of additional countries secure funding for their national health plans and strategies through the Platform. Application guidelines and forms became available in August, and eight countries applied for the first round of funding before the end of the year. These applications will be reviewed during 2012.

The Platform partners – GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank and WHO – also worked to harmonise and align monitoring & evaluation and fiduciary frameworks in countries that are already receiving HSS support, including Guinea, Niger and Senegal.

From 2012 onwards, GAVI will review applications on a rolling basis, enabling countries to submit proposals at a time appropriate to their own planning cycles.

See also ▼
gavialliance.org/2011/nepal-health-system

Quotes ▼
gaviprogressreport.org/2011/quotes

Managing risk in cash support programmes

The GAVI Secretariat makes every effort to mitigate against the misuse of GAVI's cash-based support, and has established a series of financial control mechanisms and safeguards as part of its Transparency and Accountability Policy (TAP).

GAVI vigorously condemns any misuse of its funding. Children's lives are jeopardised when GAVI funds are not used as they are intended.

Helen Evans, Deputy CEO of the GAVI Alliance

How the Transparency and Accountability Policy (TAP) works:

1 The TAP team assesses country programme financial controls prior to the start of the programme and addresses any identified weaknesses.

2 The country submits annual independent audit reports for each programme and one overall annual progress report.

3 The TAP team regularly assesses the financial controls to ensure that they operate effectively in practice.

4 If GAVI finds anything out of the ordinary, cash disbursements are halted, any unspent funds in-country are frozen and a review is undertaken.

5 If misuse is confirmed, the government is required to repay any missing funds.

6 Even if cash programmes are suspended, vaccine support generally remains uninterrupted to ensure that children do not miss out on routine vaccinations.

By the end of December 2011, the TAP team had completed financial management reviews in a total of 37 GAVI-supported countries, 9 of which were conducted in 2011. GAVI has identified six cases of potential or confirmed misuse of funds since its inception. Four of these investigations have been concluded, while investigations in Côte d'Ivoire and Zambia are ongoing.

Following the GAVI Alliance Board meeting in July 2011, GAVI started to implement a series of new measures designed to further prevent misuse of funds. These include the recruitment of additional country responsible officers, more frequent scrutiny of programme reporting, involvement in the selection of independent auditors, and training in fiduciary risk mitigation for relevant staff members.

See also ▼
gavialliance.org/transparency-accountability-policy

Data ▼
gaviprogressreport.org/2011/data

Performance-based funding: linking HSS support to results

GAVI's cash support is intended to help countries strengthen their immunisation services, health systems and civil society engagement in immunisation.

In 2011, the Board decided to channel all GAVI's cash support via a single funding window, to be delivered through the Health Systems Funding Platform. Support will be performance-based, feed directly into national strategies, and be linked to improvements in immunisation coverage and equity of access.

The funding will be split into fixed and performance-related payments.

In the first year, countries will receive a fixed amount of funding from GAVI to invest in their national health systems. In subsequent years, they will receive both fixed and performance-related annual payments, provided they meet set targets for immunisation coverage and equity.

This approach will be gradually rolled out to countries as their existing GAVI cash support lapses. GAVI will tailor the support to country circumstances, and develop alternative funding mechanisms to support countries that are fragile, underperforming or very large.

Working with countries to improve data quality

GAVI receives data on country progress in immunisation from three different sources. Each country reports its own administrative coverage data, based on information compiled at the local, district and regional levels, directly to GAVI through joint reporting forms and annual progress reports. In addition, some countries conduct household surveys based on random samples, which are used to estimate immunisation coverage rates. As data gathering is often challenging for countries, WHO and UNICEF make annual estimates of their own based on a range of historical and current data, keeping in mind previous trends in immunisation coverage.

Efforts by countries and partners have led to improvements in the quality of routine immunisation data in the last few years. However, improving data quality is a long-term process and large discrepancies between different sources of data are still common. Given the critical importance of the accuracy and reliability of country administrative data, GAVI is increasing its investment in efforts to verify and strengthen the quality of reported data.

Routine immunization is reaching more Ghanaian children than ever before... No surprise that child mortality in our country has almost halved since 1990.

Joseph Yieleh Chireh,
Minister of Health, Ghana

Every 60 seconds

THREE CHILDREN DIE OF A VACCINE-PREVENTABLE DISEASE

See also ▼
gavialliance.org/hsfp

Facts ▼
gaviprogressreport.org/2011/facts

Addressing gender-related barriers to immunisation

According to a recent GAVI-funded review of gender issues in immunisation, conducted by WHO, boys and girls have the same likelihood of being immunised at the global level.[4] However, there is evidence that gender-related barriers are creating inequities in access to health services in some countries, especially those where women have a low status. Typically in these societies women lack access to health services, and their children – both girls and boys – are less likely to be immunised.

The GAVI Alliance strategy for 2011–2015 positions gender equity as an overarching principle for all of its work, and the gender policy recognises equal access to immunisation as a key factor for expanding immunisation coverage and for making immunisation more equitable. GAVI encourages countries to use their HSS funds to overcome gender-related barriers to immunisation and to develop gender-sensitive health services. When applying for HSS support, countries are requested to identify any gender-related obstacles to accessing immunisation services and to outline a plan to tackle them.

Countries are advised to implement immunisation programmes and campaigns that reach out to both male and female caregivers of children. Also, GAVI recommends that they provide immunisation services in places that are accessible to both men and women. In settings where mothers are unable to interact with male vaccinators due to cultural taboos, countries are encouraged to have female service providers for women.

It's encouraging that GAVI supports countries to overcome gender barriers as well as closing equity gaps – ensuring results and access to vaccines for all.

Gunilla Carlsson, Minister for International Development Cooperation, Sweden

GAVI moves forward on gender balance

With nine women and nine men, the Independent Review Committee (IRC) that is responsible for monitoring country progress in implementing GAVI support is GAVI's first committee to have achieved a gender balance. This is in line with GAVI's gender policy, which requires that a gender balance is obtained in all areas of GAVI's work, including its governance structures.

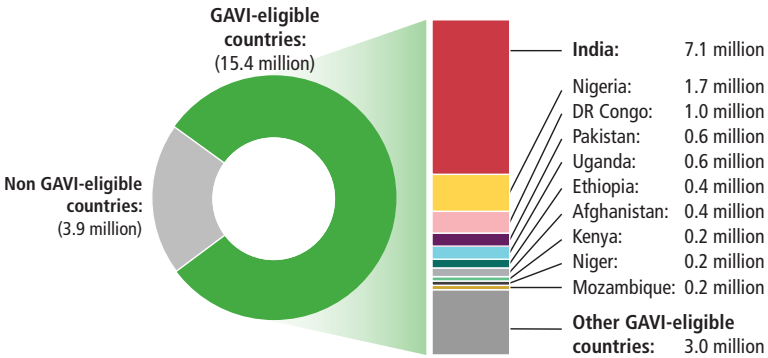
For the first time in 2011, the IRC also included a gender and social development expert, who prepared a gender analysis and recommendations as part of the overall IRC report. "We are living what we preach," says Dr Bola Oyeledun, the IRC Chairwoman.

The GAVI Alliance Board has also become increasingly gender balanced, following the adoption in 2010 of a set of guidelines requiring a 60/40 gender ratio on the Board. At the end of 2009, the Board consisted of 41 members and alternate members, 83% of whom were men and 17% women. By the end of 2011, the proportion had changed to 66% men and 34% women.

See also ▼ gavialliance.org/gender

Photos ▼ gaviprogressreport.org/2011/photos

Over 19 million children remain unimmunised



Source: 19

1 in 5

CHILDREN MISSES OUT ON LIFE-SAVING VACCINES EVERY YEAR

Ensuring every child's right to health

Although immunisation rates are at their highest level ever, averaging over 80% across GAVI-supported countries, nearly one in five children is still not receiving routine vaccinations.

While equity between high- and low-income countries is at the core of GAVI's mission, equity within countries is equally critical. GAVI's aim is for all children, regardless of where they live, to enjoy the full benefits of immunisation.

In all countries, children in the poorest households are more likely to die before their fifth birthday than children in wealthier families.[5] Other children miss out on routine vaccination programmes because they are living in remote locations, urban slums or border areas.

Only 48 WHO member states have achieved the goal of 80% DTP3 coverage in all districts.[6] To help address this imbalance and to ensure that life-saving vaccines reach the poorest and most remote populations, GAVI continues to support the delivery of vaccines through health system strengthening, civil society support and immunisation services support.

GAVI also works with WHO to identify inequalities in immunisation coverage and to better understand why they exist. Armed with a stronger knowledge base, selected countries are being assisted to address gaps in their coverage.

See also ▼
gavialliance.org/history

Data ▼
gaviprogressreport.org/2011/data

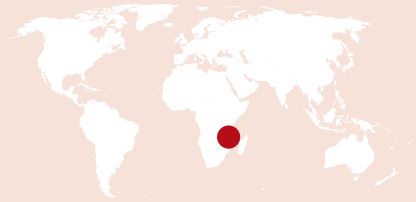
MALAWI

Spreading the word on immunisation

In remote villages such as Chifuchambewa in eastern Malawi, vaccination experts from the Ministry of Health rely heavily on village leaders to spread the word about the importance of bringing babies for routine vaccination.

Medson Kolole, Chief of Chifuchambewa village, plays an active role in the health of his villagers. "One of the main roles of the village chief is to sensitise families about a healthy way of life," he says. "We work closely with the community health workers – and they work with us. We respect them and follow their advice, especially about vaccinating our children."

Pneumococcal vaccines, introduced in Malawi in November 2011, will help protect the country's children against the world's number one killer of children under five, pneumonia.



My district is very lucky to have a CSO coming to work with our mothers to ensure children are fully protected from preventable diseases. We have to sustain this initiative and scale it up to more communities.

Honourable Foster Adoh,
District Chief Executive,
Twifo Hemang Lower Denkyera
District, Ghana

Lessons learned to inform future support to civil society

In many countries, it is civil society organisations (CSOs), often working in close cooperation with government, that are ensuring that life-saving vaccines are delivered to the children that need them the most.

Recognising this critical role, GAVI introduced a pilot funding window in 2007 to support civil society coordination and involvement in immunisation and health system strengthening.

Although no new programme funding was approved in 2011, some existing CSO pilot programmes were extended. In March, Afghanistan and Togo received additional funding to further strengthen CSO involvement in health planning processes. Later in the year, GAVI extended its civil society support to Afghanistan and Pakistan to ensure that health system strengthening activities, and thereby service delivery, could continue uninterrupted.

During the year, GAVI embarked on aligning support to CSOs with the Health Systems Funding Platform, working in close collaboration with its CSO constituency.

An evaluation of GAVI's support to CSOs was initiated in 2011. GAVI will draw on the conclusions of the evaluation to develop a framework that presents why and how GAVI works with and supports CSOs.

See also ▼
gavialliance.org/2011/malawi-mothers

Stories ▼
gaviprogressreport.org/2011/stories

AFGHANISTAN

Civil society drives health improvements

As is the case in many fragile states, Afghanistan's civil society organisations do much of the work of providing basic health services to the population.

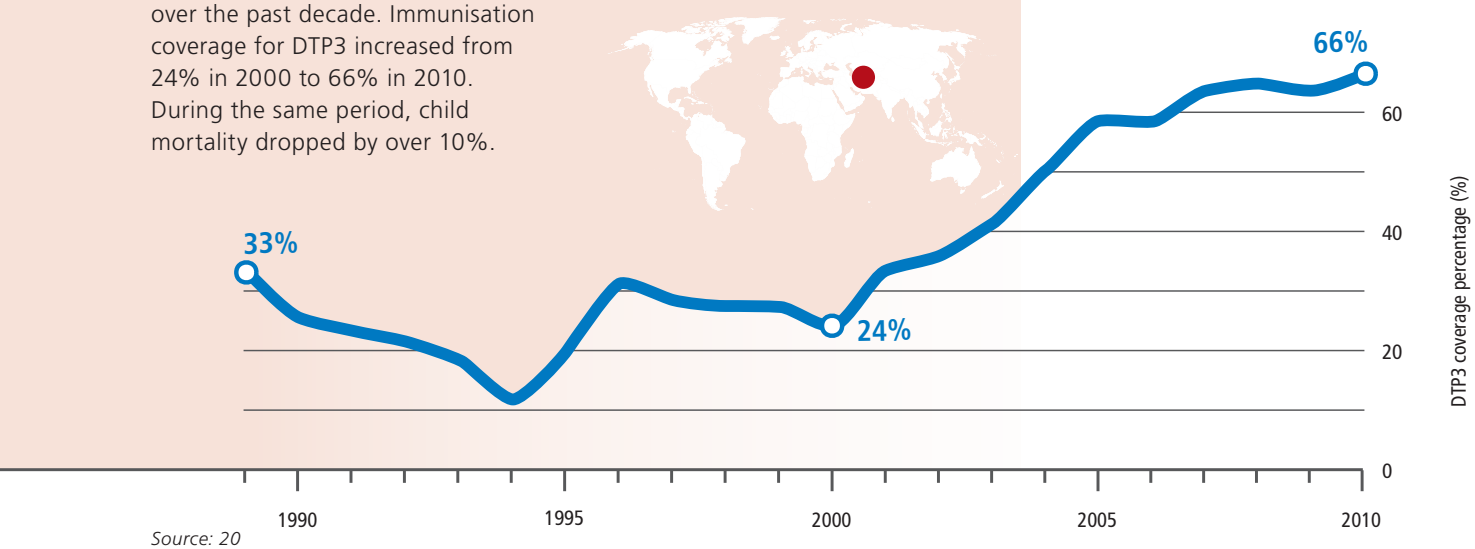
Despite the fact that Afghanistan is still one of the world's poorest countries, some of its basic health indicators have improved rapidly over the past decade. Immunisation coverage for DTP3 increased from 24% in 2000 to 66% in 2010. During the same period, child mortality dropped by over 10%.

"We would never have succeeded in making this progress unless we had close collaboration between the Afghan Government, the civil societies and communities. By working with CSOs at grass-root level, our work is owned by the people and sustained by the people," says Afghanistan's Minister of Public Health, Dr Suraya Dalil.

One goal we all share is to prevent disease and death to improve the lives and health of children. Vaccines are a means to this end, and should be offered to all who need them.

Dr Sabrina Bakeera-Kitaka, paediatrician and GAVI CSO Steering Committee member

DTP3 coverage in Afghanistan



Source: 20

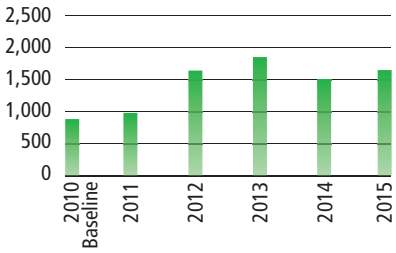
See also ▼ gavialliance.org/cso

Quotes ▼ gaviprogressreport.org/2011/quotes

INCREASE PREDICTABILITY & SUSTAINABILITY

Securing sustainable and predictable funding for immunisation programmes is critical to GAVI's mission.

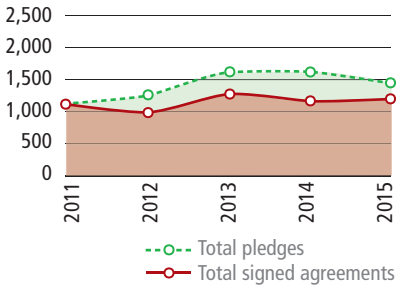
Total resources mobilised to meet country demand (US$ millions)



In 2011, GAVI mobilised 100% of the resources required to finance forecasted country demand for GAVI support.

Source: 21

Signed grant agreements vs total pledges, 2011–2015 (US$ millions)

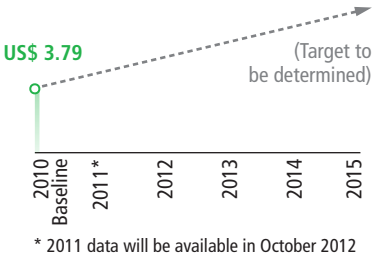


By the end of 2011, more than 80% of the donor pledges made for the 2011–2015 period had been signed as formal grant agreements.

Source: 22

Country investments in vaccines

Average expenditure per child (US$)



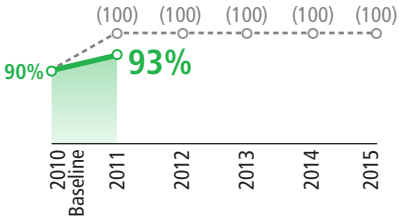
* 2011 data will be available in October 2012

This indicator measures the level of national financing made available for immunisation and reflects the priority that governments place on vaccines as a core public function.

Source: 23

Fulfilment of co-financing commitments

Proportion of countries (%)



In 2011, 93% of countries required to co-finance met their commitments in a timely manner. The fulfilment of co-payments is a measure of country commitment to financing vaccines.

Source: 24

Vaccination is an essential cornerstone for child health and development. So by investing in vaccination, we invest in development.

Dr Guelaye Sall, paediatrician, Senegal

See also ▼ gavialliance.org/financing-goal-indicators

Data ▼ gaviprogressreport.org/2011/data

Best buy

VACCINES ARE ONE OF THE "BEST BUYS" IN PUBLIC HEALTH, OFTEN COST-SAVING IN THE LONG RUN THROUGH REDUCTIONS IN HEALTHCARE EXPENSES

See also ▼
gavialliance.org/predictable-financing

Facts ▼
gaviprogressreport.org/2011/facts

Through long-term funding from donors, innovative finance mechanisms and a ground-breaking co-financing policy, GAVI aims to ensure that immunisation programmes are sustainable and predictable.

The successful resource mobilisation meeting, held in London in June 2011, marked an important milestone for GAVI. Donors pledged an additional US$ 4.3 billion, bringing the total resources available to GAVI for the period 2011–2015 to US$ 7.6 billion. GAVI is now well positioned to accelerate the roll-out of new vaccines, increase equity in access to immunisation and lay the foundations for additional life-saving vaccines.

The International Finance Facility for Immunisation (IFFIm) issued two bonds in 2011, raising approximately US$ 395 million. The Advance Market Commitment (AMC) continued to speed up access to pneumococcal vaccines, with 13 GAVI-eligible countries introducing them in 2011 alone. Through the GAVI Matching Fund, a new private sector initiative, GAVI is further harnessing the potential of innovative approaches to financing.

To ensure country ownership and long-term sustainability of immunisation programmes, GAVI is maintaining its focus on vaccine co-financing. More countries than ever are meeting their co-financing requirements, a testament to their commitment to investing in immunisation.

See also ▼
gavialliance.org/funding

Photos ▼
gaviprogressreport.org/2011/photos

Co-financing: laying the foundation for long-term sustainability

GAVI's innovative co-financing policy is a fundamental part of the Alliance's efforts to guarantee national ownership and long-term sustainability of immunisation programmes. It requires all countries to contribute a portion of the cost of their new vaccines.

The size of the contribution is based on each country's ability to pay. Countries are divided into three groups: low-income, intermediate and graduating. Low-income countries contribute the least (US$ 0.20 per dose) while graduating countries are expected to take over the full cost of their vaccines after five years of gradually increasing their contributions.

More countries than ever are contributing to their vaccine costs. Of the 59 countries required to co-finance in 2011, 55 had fulfilled the requirements by the end of the year. Four countries defaulted, down from seven in the previous year. Four highly committed countries chose to co-finance their vaccines ahead of the mandatory starting date, while six countries fulfilled their commitments to pay more than required. Co-payments amounted to approximately US$ 37 million in 2011, representing 8% of the total value of vaccine support to the co-financing countries.

The GAVI Alliance partners are working to provide tailored support to countries that will graduate from GAVI support in 2016, to ensure a smooth transition to independent funding of their immunisation programmes. Allliance partners are also looking at ways to support countries that are facing difficulties in meeting their co-financing requirements.

Vaccinating our children is essential if we want to offer them a better future, and a chance to lead a productive life. We are proud to be co-financing.

Adama Traoré,
Minister of Health, Burkina Faso

Small island states punch above their weight

In spite of the challenges of political instability and a lack of resources and infrastructure, three small countries in the Western Pacific region are leading the way in demonstrating ownership of vaccine financing. Papua New Guinea is co-financing its pentavalent vaccine entirely on a voluntary basis, while Kiribati and the Solomon Islands are contributing more per dose than is required.

"This is an investment in our future," says Steven Toikilik, national manager for the Expanded Programme for Immunization in Papua New Guinea. "By spending money on immunisation, we're saving on the costs of health care and medicines, and the tragedy of preventable death and disability."

Kiribati and the Solomon Islands are co-financing their vaccines with the help of UNICEF's Vaccine Independence Initiative. By pooling vaccine procurement for Pacific Island countries, the Initiative helps to ensure a steady supply of quality vaccines to the region while acting as a line of credit, making vaccine financing more manageable for the countries.

93% of countries

IN 2011, 93% OF COUNTRIES REQUIRED TO CO-FINANCE MET THEIR COMMITMENTS

See also ▼ gavialliance.org/co-financing

Stories ▼ gaviprogressreport.org/2011/stories

GAVI's 2011 funding base

Total donor funding to GAVI amounted to US$ 1.23 billion in 2011. Cumulative funds received by GAVI for the period 2000–2011 totalled US$ 6.41 billion.

Direct and Matching Fund contributions

Contributions from 15 donor governments (Australia, Canada, Denmark, France, Germany, Ireland, Japan, Luxembourg, the Netherlands, Norway, the Republic of Korea, Spain, Sweden, the UK and the USA) amounted to US$ 512.9 million in 2011. The cumulative total of direct contributions from national governments and the European Commission for the period 2000–2011 amounted to US$ 2.54 billion.

Foundations, private individuals and organisations contributed US$ 285.5 million to GAVI in 2011. In addition to contributions from the Bill & Melinda Gates Foundation and His Highness Sheikh Mohamed bin Zayed Al Nahyan, GAVI received Matching Fund contributions from Anglo American, "la Caixa" Foundation and J.P. Morgan. The cumulative total of private sector contributions for 2000–2011 was US$ 1.53 billion.

IFFIm funding

GAVI drew down US$ 300 million in IFFIm funds in 2011, bringing the cumulative total for 2006–2011 to US$ 2.2 billion. Australia, France, Italy, the Netherlands, Norway, Spain, Sweden, South Africa and the UK have contributed to IFFIm.

AMC funding

The Bill & Melinda Gates Foundation, Canada, Italy, Norway, the Russian Federation and the UK have collectively pledged US$ 1.5 billion towards the AMC for pneumococcal vaccines. By the end of 2011, GAVI had received US$ 171 million in AMC funds via the World Bank, US$ 128.2 million of which was received in 2011.

Vaccines are one of the most cost-effective investments we can make in global health.

Bill Gates, Co-Chair,
Bill & Melinda Gates Foundation

Donor reviews give top scores to GAVI

Two donors released reviews of GAVI's performance in 2011. The UK undertook a detailed review of multilateral aid, assessing the effectiveness of over 40 multilateral organisations in tackling poverty. Its conclusions endorsed both the value of immunisation and GAVI's organisational strengths. Sweden also conducted a review of GAVI in 2011, giving top marks to the organisation for relevance and effectiveness.

See also ▼
gavialliance.org/donor-contributions-pledges

Facts ▼
gaviprogressreport.org/2011/facts

Resource mobilisation: paving the way for more equitable vaccine access

Recognising the need to attract new sources of funding to meet accelerating country demand, GAVI held its first ever pledging conference in June 2011. At this historic event, 19 new and existing public- and private-sector donors collectively pledged US$ 4.3 billion to support GAVI's programmes. Although a portion of the pledges are contingent upon GAVI attracting new funding from other donors, the additional funding will allow GAVI to roll out life-saving vaccines faster than ever before.

Several new donors pledged to GAVI for the first time in 2011. Japan delivered its first contribution to GAVI in 2011, and Brazil pledged to join IFFIm. GAVI's largest corporate donor, the "la Caixa" Foundation, extended its financial commitment while Anglo American, Absolute Return for Kids (ARK) and J.P. Morgan signed up to support GAVI programmes via the new GAVI Matching Fund.

The powerful mobilisation effort leading up to the conference involved all Alliance partners and advocates, from civil society to political leaders. The Group of Eight (G8) heads of state and governments called for a successful completion of the pledging conference, paving the way for success.

Despite these achievements, GAVI's donor base remains narrow, comprising 26 public- and private-sector donors. Within this group funding is highly concentrated, with six donors providing more than 80% of GAVI's resources for 2011–2015.

GAVI continues to work to expand and diversify its sources of funding. New donors, particularly from emerging market economies and the private sector, are vital if GAVI is to secure the long-term success of its mission.

GAVI has a clear and critical role, delivering some of the most cost-effective health interventions. It demonstrates tangible results and is innovative. It takes a country-led approach and is very transparent.

UK Multilateral Aid Review, 2011

See also ▼
gavialliance.org/resource-mobilisation

Quotes ▼
gaviprogressreport.org/2011/quotes

Innovative finance

GAVI's innovative finance approaches are a key part of securing predictable and long-term financing for immunisation and health system strengthening programmes. To date, GAVI has developed three innovative finance mechanisms: the International Finance Facility for Immunisation (IFFIm), the Advance Market Commitment (AMC) and the latest addition, the GAVI Matching Fund.

In order to further strengthen private sector outreach, in particular through the Matching Fund, the GAVI Alliance Board and the GAVI Campaign Board decided in 2011 to integrate the GAVI Campaign into the Innovative Finance team. The restructuring, which was completed by the end of the year, will increase operational efficiency while retaining the Campaign's tax-exempt, not-for-profit status in the USA.

The case for further investment through IFFIm is strong.

IFFIm evaluation, 2011

UGANDA

Maternal and neonatal tetanus eliminated

In July 2011, Uganda announced that it had eliminated maternal and neonatal tetanus thanks to the efforts of its Maternal and Neonatal Tetanus Elimination campaign team. Close to two million women in high-risk districts in Uganda were immunised against tetanus during the period 2002–2009. A validation survey carried out in 2011 confirmed the success of the campaign.

Tetanus is one of the most common deadly consequences of unclean births. It is almost always fatal, especially when appropriate medical care is not available. The disease can be prevented by immunising mothers, and by emphasising hygienic delivery and umbilical cord care practices. Although total eradication is not possible, tetanus is considered eliminated when it causes less than 1 death per 1,000 births in one year.

The Maternal and Neonatal Tetanus Elimination Initiative, which helped to implement the immunisation campaign in Uganda, is supported by public- and private-sector actors, including the Bill & Melinda Gates Foundation, the GAVI Alliance, PATH, UNICEF, USAID/Immunization Basics and WHO. GAVI has contributed over US$ 61 million to the Initiative through funds received from IFFIm.

A 2011 INDEPENDENT EVALUATION OF IFFIM FOUND THAT IT HAD YIELDED EXTREMELY GOOD DEVELOPMENT RETURNS

See also ▼
gavialliance.org/innovative-finance

Stories ▼
gaviprogressreport.org/2011/stories

IFFIm: increasing flexibility and predictability of funding

Launched in 2006, IFFIm uses long-term donor pledges to issue and sell vaccine bonds in the capital markets. The money raised helps fund GAVI programmes to meet immediate country demand for vaccines. Nine donors – the UK, France, Italy, Norway, Australia, Spain, the Netherlands, Sweden and South Africa – are currently contributing to IFFIm.

As the first aid-financing entity in history to attract legally-binding long-term commitments of up to 23 years, IFFIm has significantly increased the predictability of funding for countries. A 2011 independent evaluation of IFFIm concluded that it had yielded extremely good development returns, helping to prevent 2.1 million future deaths and delivering more than three times the value of each dollar spent.

The year 2011 was an important one for IFFIm. It raised US$ 395 million for GAVI programmes through two bond issuances, received an additional pledge from Italy and secured a commitment from Brazil to become IFFIm's 10th donor. The UK, IFFIm's largest donor, confirmed that it would match the pledges from Brazil and Italy of US$ 20 million and €25.5 million, respectively.

IFFIm has achieved its success under the very able chairmanship of Alan Gillespie, who in November 2011 announced his retirement from the IFFIm Board. A new Chair, René Karsenti, President of the International Capital Market Association, was appointed to the Board in late 2011, and was scheduled to take up the position in early 2012.

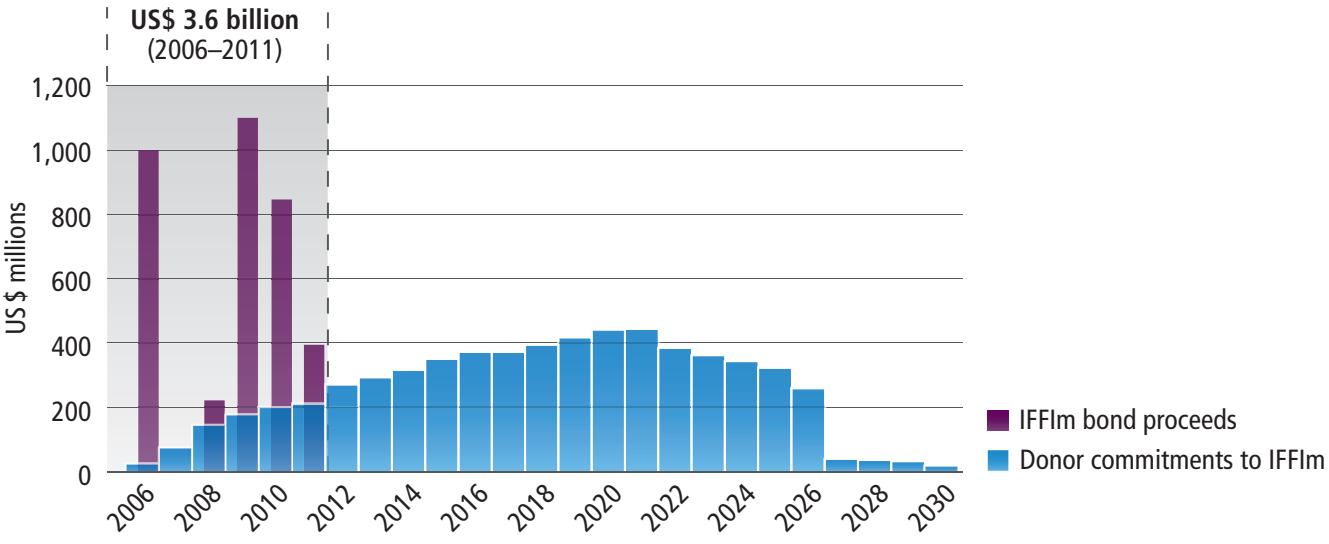
I know that immunisation is one of the most cost-effective investments for the health and development of a child. The benefits go much beyond the medical – they are also economic and societal.

Dr Dorothy O. Esangbedo, President, Paediatric Association of Nigeria

Bill Roedy becomes first GAVI Envoy

Bill Roedy, the architect behind the internationally known MTV Networks, joined the GAVI family on 25 May 2011 to advocate for immunisation. As the first GAVI Envoy, Roedy participated in GAVI's pledging conference, authored several opinion pieces, visited GAVI-funded projects in Bangladesh and Rwanda, and reached out to his strong corporate network to support the Matching Fund initiative. "I have never seen a leaner, neater, hungrier, more efficient operation in all of global health, in fact in all of business," he said.

By issuing bonds in the capital markets, IFFIm has enabled GAVI to nearly double its support to countries since IFFIm's inception



Source: 25

The GAVI Matching Fund: the power of private sector support

The GAVI Matching Fund, launched in 2011, offers businesses, charities and foundations a way to assist GAVI in fulfilling its mission. The British Government and the Bill & Melinda Gates Foundation have collectively pledged approximately US$ 130 million to match contributions from corporations, foundations and other organisations, as well as from their customers, employees and business partners.

Through 2011, the new funding mechanism had attracted four private investors: Absolute Return for Kids (ARK), Anglo American, the "la Caixa" Foundation and J.P. Morgan. Together they have pledged approximately US$ 14.7 million, which translates into an additional US$ 29 million worth of support for GAVI's immunisation programmes.

GAVI aims to raise US$ 260 million for immunisation through the Matching Fund by the end of 2015.

The GAVI Matching Fund is an example of what can be achieved when governments, corporations, foundations and the general public work together to address issues such as inequity in the availability of vaccines for children. It not only provides an important source of funds, but also brings new champions and expertise to help advance GAVI's work.

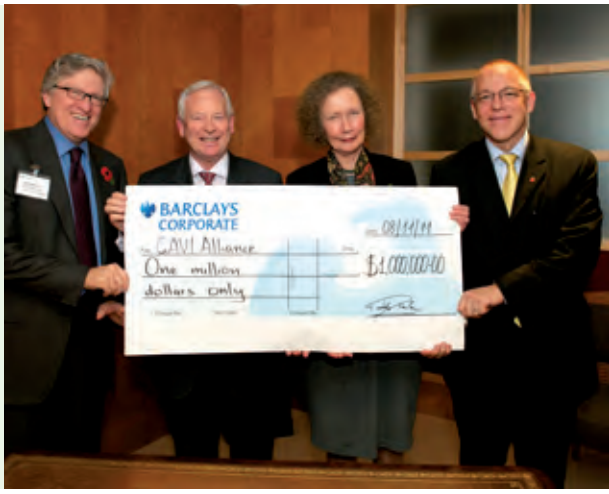
Collaborating with Coca-Cola in Ghana

The Coca-Cola Company, the world's largest beverage company, is working with the Bill & Melinda Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and GAVI to find ways to strengthen Ghana's vaccine supply chain by sharing Coca-Cola's unparalleled distribution and logistical expertise to ensure that vaccines are delivered to "the last mile." In addition, the Ministry of Health will be able to tap into Coca-Cola's marketing expertise to boost awareness of and participation in vaccine campaigns.

Anglo American becomes private sector champion for GAVI Matching Fund

In June 2011, Anglo American became the first UK company to make a pledge to the GAVI Matching Fund. From left: Jeff Raikes, CEO of the Bill & Melinda Gates Foundation; Sir John Parker, Chairman of Anglo American; Helen Evans, Deputy CEO of the GAVI Alliance; and Michael Anderson, Director-General in the UK Department for International Development, holding the first of three US$ 1 million cheques from Anglo American.

"Private businesses play an important role in addressing public health threats," said Sir John Parker. "Successful partnerships – like ours with GAVI – are critical to the success of efforts to strengthen health systems and thereby improve the health of families, communities and societies."



How the GAVI Matching Fund works

Step 1: The private sector partner makes a financial pledge to GAVI.

Step 2: GAVI works with the partner to find ways to engage its customers, employees, business partners and others to contribute through the GAVI Matching Fund.

Step 3: Every donation made to GAVI through the GAVI Matching Fund by the private sector partner, its customers, employees and business partners is matched either by the British Government or by the Bill & Melinda Gates Foundation. 100% of funds go to GAVI for immunisation programmes in developing countries.

See also ▼
gavialliance.org/matching-fund

Facts ▼
gaviprogressreport.org/2011/facts

From left: Her Royal Highness the Infanta Cristina of Spain; Jaime Lanaspa, Executive Director, "la Caixa" Foundation; Dagfinn Høybråten, Chair of the GAVI Alliance Board; and Joe Cerrell, Director, Bill & Melinda Gates Foundation Europe.

We hope 'la Caixa' will serve as a model for many other private institutions to step up and join GAVI.

Her Royal Highness the Infanta Cristina of Spain, Director of the International Cooperation Programme for "la Caixa" Foundation

"LA CAIXA" FOUNDATION

Innovation in public-private philanthropy

The "la Caixa" Foundation, a long-time GAVI supporter and inaugural partner of the GAVI Matching Fund, provides a compelling example of how the public and private sectors can work together to mobilise funds for immunisation. A key part of the mission of "la Caixa" – the foundation of the major Spanish bank – is to help vulnerable groups, often in partnership with innovative organisations. One of the foundation's focus areas is preventative healthcare, such as immunisation.

The "la Caixa" Foundation joined forces with GAVI in 2005, and in 2008 created the innovative Business Alliance for Child Vaccination. The Business Alliance, which so far has raised a total of €864,208 for immunisation programmes, includes 158 Spanish businesses. "La Caixa" employees have donated an additional €146,348. These donations augment gifts made by "la Caixa" of €13 million.

Now "la Caixa" has taken the next step, joining the GAVI Matching Fund with a €4 million pledge to procure pneumococcal vaccines for GAVI-supported countries in Latin America. The pledge, together with 2011 donations of €230,220 from the Business Alliance and €47,847 from "la Caixa" employees, is being matched by the Bill & Melinda Gates Foundation.

Working with Vodafone

GAVI is working with Vodafone, one of the world's leading communications companies, to explore the use of mobile ("mHealth") technologies to improve vaccine stock management in implementing countries. This collaboration was initiated following a meeting among Vodafone CEO Vittorio Colao, the UK Secretary of State for International Development Andrew Mitchell and GAVI CEO Seth Berkley.

See also ▼
gavialliance.org/2011/la-caixa

Quotes ▼
gaviprogressreport.org/2011/quotes

AMC accelerates protection against the main child killer disease

The pneumococcal AMC stimulates the supply of appropriate and affordable pneumococcal vaccines for developing countries. Donors commit funds to guarantee a fixed low price of vaccines once they have been developed, giving manufacturers an incentive to invest in vaccine development and manufacturing capacity.

In light of the rapidly growing demand for pneumococcal vaccines, UNICEF and GAVI called upon vaccine manufacturers to make new supply offers in 2011. In addition to the 600 million doses over 10 years secured the year before, two manufacturers committed to supply 180 million doses each over 10 years, ensuring faster access to the pneumococcal vaccine for more countries than ever before.

While the current AMC vaccine suppliers are based in the UK and the USA, two emerging market manufacturers have registered to participate in the pneumococcal AMC once their products have been developed and achieved the necessary WHO prequalification.

By the end of 2011, a total of 16 countries had embarked on GAVI-supported programmes to introduce pneumococcal vaccines as part of their routine childhood immunisation programmes. For the first time in history, children in developing countries are receiving new life-saving vaccines at virtually the same time as children in high-income countries.

It's how you spend the money that saves lives.

Mary Robinson, former President of Ireland and former Chair of the GAVI Alliance Board

KENYA

First African country to introduce new pneumococcal vaccine

Hundreds of infants in Kenya received their first shots against pneumococcal disease in early 2011 at an event to celebrate the global roll-out of vaccines targeting the world's biggest child killer – pneumonia.

Kenya's President Mwai Kibaki joined parents, health workers, ambassadors and donors in Nairobi to witness children being immunised as part of the Government of Kenya's formal introduction of pneumococcal vaccine in its routine immunisation programme for all children.

Kenya is the first African country to roll out the new AMC-supported pneumococcal conjugate vaccine, which has been developed specifically with the needs of children in developing countries in mind. The conjugate vaccine is highly complex and sophisticated, and would in the past likely have taken up to 15 years to develop and become available to children in the world's poorest countries.

6 out of 10

IN NICARAGUA, THE FIRST GAVI-ELIGIBLE COUNTRY TO INTRODUCE ROTAVIRUS VACCINES, 6 OUT OF 10 SEVERE CASES OF LIFE-THREATENING DIARRHOEA WERE PREVENTED.

See also ▼ gavialliance.org/pneumococcal-amc

Stories ▼ gaviprogressreport.org/2011/stories

GEORGIA

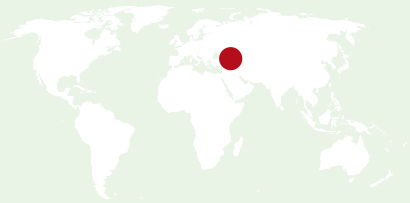
Graduating Georgia sees immunisation growing

Georgia, one of the 16 countries graduating from GAVI support, plans to use information campaigns to further boost its immunisation coverage. Based on revised eligibility criteria, the former Soviet republic will start to phase out GAVI support from 2012.

Georgia's routine immunisation coverage is 91%, up from 80% in 2000, but public attitudes and lack of information remain the biggest obstacles to increasing immunisation, says Givi Azaurashvili, Georgia's manager for the Expanded Programme on Immunization.

"Based on the information campaigns that we are planning to run, we expect that demand for vaccines will increase. Georgia stands firm on its commitment to increase coverage, to increase the budget for immunisation," he says.

Georgia has already introduced the pentavalent vaccine, plans to roll out the rotavirus vaccine in 2012 and aims to introduce the pneumococcal vaccine in the near future.



According to a G8 study, which calculated the proportion of donor support that directly benefits maternal and child health, 100% of contributions to GAVI reach mothers and children in the developing world. Governments donating to GAVI are thus assured that their commitments will help meet the goals set out in the G8 Muskoka Initiative.

See also ▼
gavialliance.org/graduation-policy

Facts ▼
gaviprogressreport.org/2011/facts

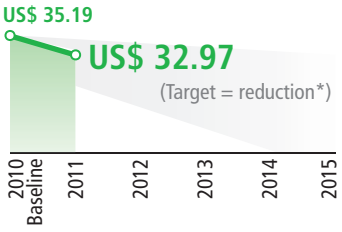
SHAPE THE MARKET

MANUFACTURERS HAVE OFFERED TWO-THIRDS PRICE REDUCTIONS ON HPV AND ROTAVIRUS VACCINES

Creating a healthy vaccine market, characterised by low and sustainable prices and a steady, reliable supply of quality vaccines, is at the core of GAVI's business model.

Change in the total cost to fully immunise a child with pentavalent, pneumococcal and rotavirus vaccines

Selected vaccine package price (US$)



* Future targets are not publicised to avoid setting a minimum price

The total vaccine cost of fully immunising a child with pentavalent, pneumococcal and rotavirus vaccines dropped from US$ 35.19 in 2010 to US$ 32.97 in 2011. Price targets have been set but are not published to avoid setting a minimum price.

Source: 26

Achieving our goal depends not only on increased donations, but also upon a healthy vaccine market.

Dagfinn Høybråten,
Chair of the GAVI Alliance Board

See also ▼
gavialliance.org/market-shaping-goal-indicators

Goals ▼
gaviprogressreport.org/2011/goals

Photos ▼
gaviprogressreport.org/2011/photos

In 2011, GAVI elevated market shaping to one of its four strategic goals, giving increased focus to this vital area of its work.

Market shaping illustrates the dynamics of GAVI's public-private partnership, combining recognition of the power of market forces with the development objectives of sustainability and equity.

Since its inception, GAVI has helped to shape the vaccine market by accumulating donor funds, aggregating developing country demand and buying large volumes of vaccines. This has led to increased market certainty, significant price decreases and a more stable supply of vaccines for developing countries over the past decade.

In 2011, GAVI and its partners adopted an even more proactive approach to market shaping. The new strategy for vaccine supply and procurement has two main objectives: to ensure a secure supply of appropriate, high-quality vaccines through a diverse supplier base, and to minimise the cost of vaccines.

Together, we are creating a market that provides the poorest nations with the lowest prices… a market that better matches supply and demand and assures greater supply security.

Anthony Lake,
Executive Director, UNICEF

New strategy for vaccine supply and procurement

GAVI's new strategy for vaccine supply and procurement was adopted by the Board in November 2011. The strategy aims to sustain a sufficient and uninterrupted supply of high-quality vaccines, to promote low and sustainable vaccine costs for developing countries, and to foster an environment for innovation.

Other priorities include shortening the time it takes for new vaccines to become available for use in developing countries, supporting the development of optimal product formulations to meet countries' needs and distribution systems, and facilitating the entry of new vaccine manufacturers into the market.

While the new strategy applies to all vaccines in GAVI's portfolio, it recognises that each vaccine has its own specific market, characterised by the level of competition, the size of the demand and the complexity of production. The nature of the interventions and tools used by GAVI to influence the market will therefore be specific to each vaccine.

In order to increase the reliability of demand, GAVI makes every effort to provide both purchasers and providers of vaccines with timely, transparent and accurate market information. This helps countries by contributing to price transparency, and it helps manufacturers by contributing to accurate demand forecasts.

The adoption of the new strategy was preceded by extensive consultations with all partners and a range of stakeholders, including the general public.

See also ▼
gavialliance.org/supply-and-procurement

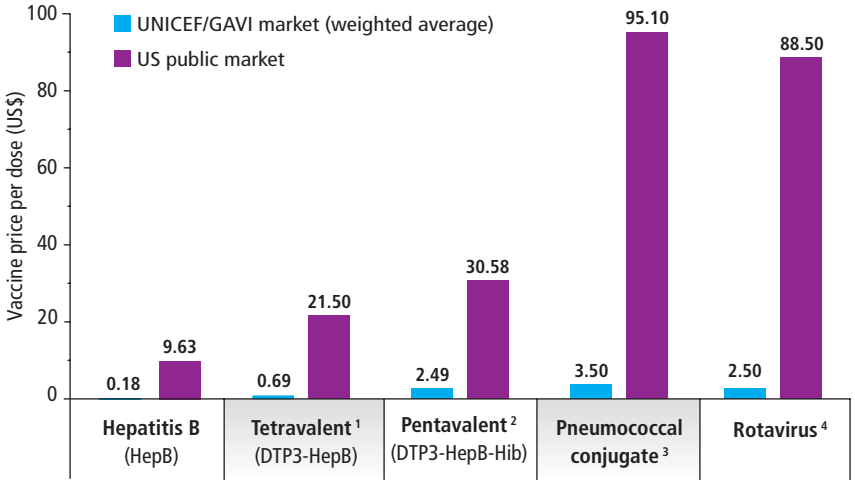
Facts ▼
gaviprogressreport.org/2011/facts

Achieving low and sustainable prices while ensuring sufficient supply

Over the past decade, GAVI support has encouraged new manufacturers from both developing and industrialised countries to enter the market, which in turn has helped to reduce vaccine prices and ensure an uninterrupted supply of vaccines to GAVI-supported countries.

Between 2000 and 2011, the price of hepatitis B vaccine dropped by 69%. The pentavalent vaccine price fell by more than 30% from US$ 3.61 per dose in 2007, when most GAVI-eligible countries switched over to this five-in-one vaccine, to US$ 2.49 per dose in 2011.

Tiered pricing



[1] The combination procured by UNICEF is not provided in the US markets; US prices refer to the sum of a DTaP (diphtheria-tetanus-acellular pertussis) vaccine and a HepB monovalent vaccine.

[2] The combination procured by UNICEF is not provided in the US markets; US prices refer to the sum of a DTaP vaccine, a HepB monovalent vaccine and a Hib vaccine.

[3] 13-valent vaccine (US markets) and tail price cap under the AMC agreement (UNICEF/GAVI market).

[4] Refers to GlaxoSmithKline product procured by GAVI as of 2012.

Source: 27

MADAGASCAR

Pentavalent vaccine makes a difference in Madagascar

Doctor Hanintsoa Rakotoarimanga checks a mother's immunisation record before giving the pentavalent vaccine at a health point in Isotry, a district of Madagascar's capital, Antananarivo. Madagascar is one of just seven countries that managed to reduce its under-five mortality rate by more than 60% over the 20-year period, 1990–2009. This shows that even in the most difficult of circumstances, immunisation and other basic interventions can play key roles in preventing disease and saving lives.

According to Dr Rakotoarimanga, the pentavalent vaccine is having an impressive impact in Madagascar. "Since we started to use the pentavalent vaccine, we have seen much fewer cases of pneumonia and meningitis," she says.

The price of the pentavalent vaccine has consistently become more affordable since 2007, when most GAVI-supported countries switched over to this five-in-one vaccine.

BETWEEN 2000 AND 2011, THE PRICE OF HEPATITIS B VACCINE DROPPED BY 69%

See also ▼
gavialliance.org/making-vaccines-affordable

Quotes ▼
gaviprogressreport.org/2011/quotes

As a result of a GAVI call to action in 2011, one manufacturer offered its rotavirus vaccine at US$ 2.50 per dose, a 67% reduction on the previous lowest price paid by GAVI. Another manufacturer offered its human papillomavirus (HPV) vaccine at US$ 5 per dose, a 64% reduction on the lowest public price at the time. As countries prepare to apply for HPV vaccine support for the first time, GAVI is actively pursuing further price reductions from manufacturers.

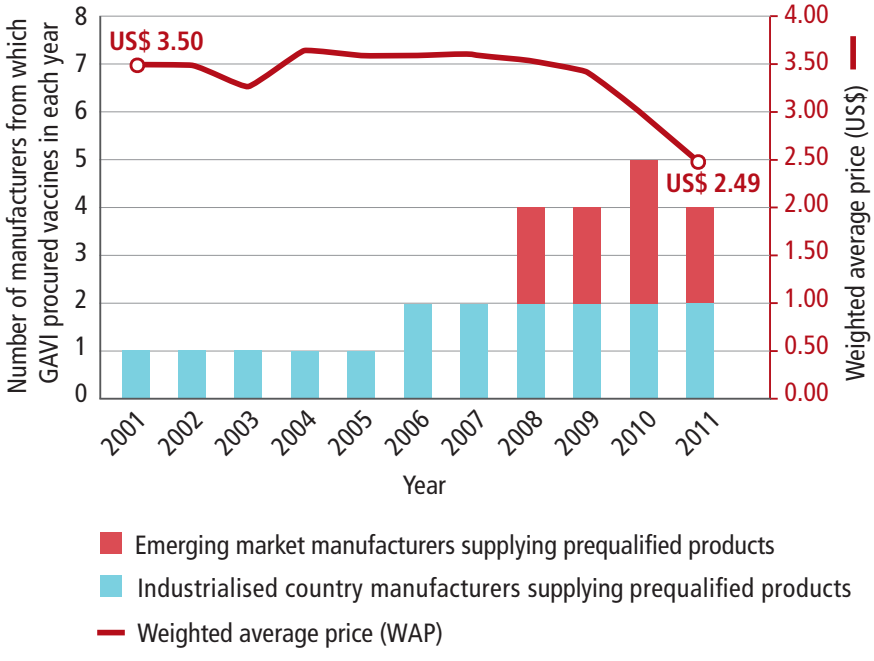
GAVI currently buys the majority of its vaccines in the pentavalent vaccine market. Predictable country demand for this vaccine and assured funding from GAVI has attracted new manufacturers to this market. In 2001, GAVI procured vaccines from just one manufacturer. By 2011 this had increased to four manufacturers, two of which were based in emerging market economies.

In 2010 and 2011, pentavalent vaccines produced by two Indian manufacturers were removed from the WHO list of prequalified vaccines due to concerns over quality control procedures. This highlighted the difficulty of producing large quantities of high-quality vaccines, given the complexity of the technologies involved. However, thanks to careful planning and efforts by the remaining manufacturers and procurement partners, supply disruptions were avoided or kept to a minimum. By procuring vaccines that have been prequalified by WHO, GAVI aims to ensure that the vaccines it supports are safe and effective and meet the specific needs of each country.

GAVI's efforts to shape the vaccine market… have led to the arrival on the market of new products adapted to the needs of developing countries, at prices that are more in line with these countries' ability to pay.

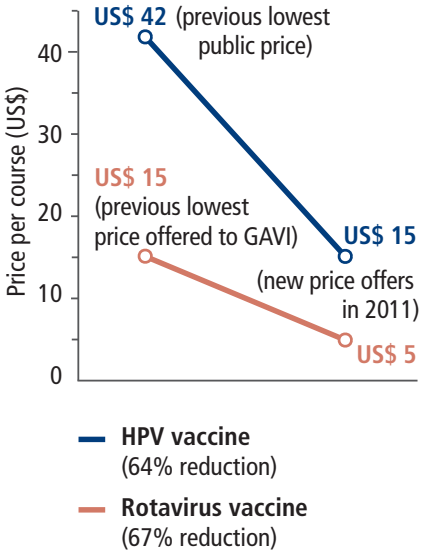
Swedish assessment of the GAVI Alliance, 2011

Number of manufacturers and price decline of pentavalent vaccine



Source: 28

Reduction in rotavirus and HPV vaccine prices



Source: 29

Securing lower prices for middle-income countries

An important part of GAVI's mission is to ensure the long-term sustainability of vaccine programmes. This includes facilitating continued access to affordably-priced vaccines for countries after their GAVI support has ended.

During the year, the GAVI Alliance partners continued their efforts to secure low and sustainable vaccine prices for graduating countries which will no longer have access to GAVI funding after 2015.

Crucell and Sanofi Pasteur will extend GAVI prices for their pentavalent vaccines to the 16 countries currently expected to graduate from GAVI support. Sanofi Pasteur confirmed that this would also apply to its yellow fever vaccine and the rotavirus vaccine being developed by its subsidiary Shantha. These offers will help to sustain vaccination programmes once GAVI support ends.

These announcements build on similar commitments by Pfizer and GlaxoSmithKline to provide access to pneumococcal vaccines to all graduating countries through the Advance Market Commitment at the same low, long-term price available to GAVI-eligible countries.

The partners are also exploring ways to facilitate access to more affordable vaccines among other lower middle-income countries.

IN DEVELOPING COUNTRIES WILL BE IMMUNISED WITH PNEUMOCOCCAL VACCINES IN 2012

THE SUDAN

The Sudan introduces rotavirus vaccine

In July 2011, the Sudan became the first GAVI-eligible country in Africa to introduce a new vaccine to protect children from rotavirus, the leading cause of severe infant diarrhoea.

"The introduction of the vaccine will reduce the suffering and deaths of our children," said Dr Walyeldin Elfakey, Senior Paediatrician at the Omdurman Paediatric Hospital in Khartoum.

Looking around the ward, Dr Elfakey said, "All of these children were admitted within the last 24 hours. Some children died before they made it here. Some have developed malnutrition. Some are receiving IV fluids and oral rehydration.

The introduction of rotavirus vaccine will reduce all this suffering."

In 2011, one manufacturer announced a price offer for rotavirus vaccine of US$ 2.50 per dose, or US$ 5.00 per course. This is a fraction of the price charged for the same vaccine in the United States of America (a price reduction of 97%) and represents a two thirds reduction in price when compared with rotavirus vaccines bought for low- and middle-income countries in Latin America and the Caribbean region.

8 out of 10

BY THE TIME THEY ARE 18 MONTHS, 8 OUT OF 10 AFRICAN CHILDREN WILL HAVE CONTRACTED ROTAVIRUS

See also ▼
gavialliance.org/2011/rotavirus-vaccine-in-africa

Stories ▼
gaviprogressreport.org/2011/stories

ANNEXES

GAVI is focused on results – this is at the heart of our approach to development.

Andrew Mitchell, MP,
Secretary of State
for International Development,
United Kingdom

Photos ▼
gaviprogressreport.org/2011/photos

Annex 1

The GAVI Alliance governance structure (as of 31 December 2011)

GAVI Alliance Board

There are 28 seats on the Board:

- 4 representing UNICEF, WHO, the World Bank, and the Bill & Melinda Gates Foundation
- 5 representing developing country governments
- 5 representing donor country governments
- 1 member each representing civil society organisations, the vaccine industry in developing countries, the vaccine industry in industrialised countries, and research and technical health institutes (4 in total)
- 9 independent individuals with a range of expertise
- The CEO of the GAVI Alliance (non-voting)

Institutions

UNICEF
Geeta Rao Gupta, Vice Chair of the Board

WHO
Flavia Bustreo

The World Bank
Cristian C. Baeza

The Bill & Melinda Gates Foundation
Christopher J. Elias

Independent members

Dagfinn Høybråten, Chair of the Board

Wayne Berson

Dwight L. Bush

Ashutosh Garg

George W. Wellde Jr.

Constituencies

Developing country governments

Constituency 1
Toupta Boguena (Chad)

Constituency 2
Guillermo González González (Nicaragua)

Constituency 3
Agnes Binagwaho (alternate; Rwanda)

Constituency 4
Trinh Quan Huan (Vietnam)

Constituency 5
Abdulkarim Yehia Rasae (Yemen)

Donor governments

Australia/Canada/Japan/ Republic of Korea/USA
Amie Batson (USA)

Ireland/Norway/United Kingdom
Paul Fife (Norway)

Italy/Spain
José Luis Solano (Spain)

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

Netherlands/Sweden/Denmark
Anders Nordström (Sweden)

Civil society organisations
Alan Hinman (Task Force on Child Survival)

Developing country vaccine industry
Mahima Datla (Biological E Limited)

Industrialised country vaccine industry
Ronald Brus (Crucell)

Research and technical health institutes
Anne Schuchat (National Center for Immunization and Respiratory Diseases, US Centers for Disease Control and Prevention)

CEO

Seth Berkley

See also ▼
gavialliance.org/board-composition

Other GAVI Alliance-related governance structures

International Finance Facility for Immunisation (IFFIm) Company

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

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

Didier Cherpitel
Former Chairman and Managing Director, J.P. Morgan

John Cummins
Group Treasurer, The Royal Bank of Scotland

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

René Karsenti
President, International Capital Market Association

Arunma Oteh
Director-General, Securities and Exchange, Commission of Nigeria

GAVI Fund Affiliate (GFA)

Wayne Berson (Chair)
Partner and National Director of Not-for-Profit Services, BDO USA, LLP

André Prost
Former Director of Government and Private Sector Relations, World Health Organization

Bo Stenson
Former Deputy Executive Secretary, The GAVI Alliance

Stephen M. Zinser
CEO and Co-Chief Investment Officer, European Credit Management Ltd

GAVI Campaign

Paul O'Connell (Chair)
President and Founding Member FDO Partners, LLC

Steven Altschuler
President and CEO, The Children's Hospital of Philadelphia

Daniel Schwartz
CEO, Dynamica, Inc

Seth Berkley (Honorary)
CEO, The GAVI Alliance

See also ▼
gavialliance.org/other-governance-structures

Annex 2
Donor contributions and commitments, 2000–2031
As of 31 December 2011 (US$ millions)

	Contributions												Pledges						
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016–2031	2011–2015 unallocated Matching Fund	Total
Absolute Return for Kids (ARK)													1.6	1.6					**3.3**
Matching Fund													1.6	1.6					**3.3**
Anglo American plc												1.0	1.0	1.0					**3.0**
Matching Fund												1.0	1.0	1.0					**3.0**
Australia							5.0	5.0	5.0	5.0	8.6	51.9	84.7	90.0	5.1	14.9	222.8		**497.9**
Direct contribution							5.0	5.0	5.0	5.0	8.6	48.8	79.6	84.9					**241.9**
IFFIm												3.1	5.1	5.1	5.1	14.9	222.8		**256.1**
Bill & Melinda Gates Foundation	325.0	425.0		3.5	5.0	154.3		75.0	75.0	85.0	85.0	227.2	271.7	270.1	250.0	267.0		44.0	**2,562.8**
Matching Fund												3.1	2.9					44.0	**50.0**
Direct contribution	325.0	425.0		3.5	5.0	154.3		75.0	75.0	75.0	75.0	214.1	258.8	260.1	250.0	267.0			**2,462.8**
AMC										10.0	10.0	10.0	10.0	10.0					**50.0**
Brazil													1.0	1.0	1.0	1.0	16.0		**20.0**
IFFIm													1.0	1.0	1.0	1.0	16.0		**20.0**
Canada			1.9	4.8	9.1	130.9	5.2			105.3	19.8	44.6	40.9	31.7	20.6	3.8			**418.5**
Direct contribution			1.9	4.8	9.1	130.9	5.2					20.7	14.1	14.1	14.1	3.8			**218.5**
AMC										105.3	19.8	23.9	26.9	17.6	6.6				**200.0**
Denmark		1.1			3.3	3.4	4.4	4.7		9.1	1.8	8.8	4.9	4.9	4.9	4.9			**56.2**
Direct contribution		1.1			3.3	3.4	4.4	4.7		9.1	1.8	8.8	4.9	4.9	4.9	4.9			**56.2**
European Commission (EC)				1.3				4.8	23.1	28.6			28.4	29.0					**115.3**
Direct contribution				1.3				4.8	23.1	28.6			28.4	29.0					**115.3**
France					6.0		12.6	24.7	52.4	56.2	57.3	99.9	91.8	81.4	115.2	123.0	1,150.7		**1,871.2**
Direct contribution					6.0		12.6					34.5	22.6	8.0	37.2	40.1			**161.1**
IFFIm								24.7	52.4	56.2	57.3	65.3	69.2	73.4	78.1	82.9	1,150.7		**1,710.1**
Germany							5.3	5.9		5.7	5.1	8.5	64.2						**94.8**
Direct contribution							5.3	5.9		5.7	5.1	8.5	64.2						**94.8**
His Highness Sheikh Mohamed bin Zayed Al Nahyan												14.1	8.8	10.1					**33.0**
Direct contribution												14.1	8.8	10.1					**33.0**
Ireland			0.5	0.6	0.7	0.8	7.9	8.3	3.8	3.5	3.6	4.9	1.5	3.4	3.4				**43.0**
Direct contribution			0.5	0.6	0.7	0.8	7.9	8.3	3.8	3.5	3.6	4.9	1.5	3.4	3.4				**43.0**
Italy							3.7	7.3	83.3	87.7	83.1	87.4	87.7	88.2	88.6	89.3	561.0		**1,267.5**
AMC									50.2	55.7	52.3	52.4	52.7	53.2	53.6	54.3	210.6		**635.0**
IFFIm							3.7	7.3	33.1	32.0	30.8	35.0	35.0	35.0	35.0	35.0	350.4		**632.5**
Japan												9.3							**9.3**
Direct contribution												9.3							**9.3**

Source: 30

See also ▼
gavialliance.org/disbursements

	Contributions												Pledges						
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016–2031	2011–2015 unallocated Matching Fund	Total
JP Morgan												2.4							**2.4**
Matching Fund												2.4							**2.4**
«la Caixa» Foundation									5.8	5.9	4.0	3.1	2.9						**21.7**
Matching Fund												3.1	2.9						**6.0**
Direct contribution									5.8	5.9	4.0								**15.7**
Luxembourg						0.6	1.3	0.8	1.4	1.2	1.1	1.2	1.2	1.2	1.2	1.2			**12.5**
Direct contribution						0.6	1.3	0.8	1.4	1.2	1.1	1.2	1.2	1.2	1.2	1.2			**12.5**
Netherlands		24.1	13.4	16.5	17.3	15.9		33.5	38.9	45.2	25.1	26.3	20.0	56.5	63.8	85.6	20.0		**502.1**
Direct contribution		24.1	13.4	16.5	17.3	15.9		33.5	38.9	31.2	25.1	26.3		36.4	43.7	65.6			**388.0**
IFFIm										14.0			20.0	20.0	20.0	20.0	20.0		**114.1**
Norway		17.9	21.3	21.8	40.9	39.5	72.6	91.3	70.6	88.0	99.1	112.1	151.4	170.5	189.6	208.8	118.7		**1,514.2**
Direct contribution		17.9	21.3	21.8	40.9	39.5	67.4	86.2	65.4	82.8	76.5	79.2	112.7	138.8	165.8	185.1			**1,201.2**
AMC											2.1	25.0	15.0	7.9					**50.0**
IFFIm							5.2	5.2	5.2	5.2	20.5	7.9	23.7	23.7	23.7	23.7	118.7		**262.9**
Republic of Korea											0.4	0.3	0.3						**1.0**
Direct contribution											0.4	0.3	0.3						**1.0**
Russian Federation											8.0	8.0	8.0	8.0	8.0	8.0	32.0		**80.0**
AMC											8.0	8.0	8.0	8.0	8.0	8.0	32.0		**80.0**
South Africa								1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	11.0		**19.9**
IFFIm								1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	11.0		**19.9**
Spain							11.6	11.7	52.3	11.5	11.1	14.7	12.0	12.0	12.0	12.0	120.2		**281.1**
Direct contribution									40.5			2.7							**43.2**
IFFIm							11.6	11.7	11.7	11.5	11.1	12.0	12.0	12.0	12.0	12.0	120.2		**237.9**
Sweden		1.9	1.1	2.4	4.9	12.7	14.6	18.0	21.6	16.3	38.9	95.2	2.5	42.6	42.6	42.6	15.1		**373.0**
Direct contribution		1.9	1.1	2.4	4.9	12.7	14.6	15.5	19.2	13.8	36.5	92.7		40.1	40.1	40.1			**335.6**
IFFIm								2.4	2.5	2.5	2.4	2.5	2.5	2.5	2.5	2.5	15.1		**37.4**
United Kingdom	4.5		15.0	5.6	18.5	6.6	23.2	65.1	31.2	44.9	97.0	222.1	334.8	596.7	640.4	528.5	2,426.1	73.0	**5,133.1**
Matching Fund												3.4	2.6	2.6				73.0	**81.7**
Direct contribution	4.5		15.0	5.6	18.5	6.6	23.2	48.1			15.9	81.9	203.6	400.2	383.8	340.8	26.5		**1,574.1**
AMC											22.2	52.9	18.2	65.5	109.7	29.9	186.6		**485.0**
IFFIm								16.9	31.2	44.9	58.9	83.9	110.3	128.3	147.0	157.9	2,213.0		**2,992.3**
United States of America		48.1	53.0	58.0	59.6	64.5	69.3	69.3	71.9	75.0	78.0	89.8	100.0	145.0	205.0				**1,186.5**
Direct contribution		48.1	53.0	58.0	59.6	64.5	69.3	69.3	71.9	75.0	78.0	89.8	100.0	145.0	205.0				**1,186.5**
Other private donors	0.02		1.6	2.6	1.8	0.5	1.9	1.1	0.8	1.0	1.0	0.8							**13.1**
Direct contribution	0.02		1.6	2.6	1.8	0.5	1.9	1.1	0.8	1.0	1.0	0.8							**13.1**
Grand total	**329.5**	**518.1**	**107.9**	**117.0**	**167.2**	**429.7**	**238.5**	**427.6**	**538.1**	**676.1**	**628.9**	**1,134.5**	**1,322.6**	**1,645.9**	**1,652.4**	**1,391.7**	**4,693.6**	**117.1**	**16,136.2**

Note: All 2000–2011 direct, Matching Fund, and AMC contributions are recorded in US$ at the actual exchange rates for the day of cash received. All 2000–2010 IFFIm contributions are recorded in US$ at the actual exchange rates for the day cash received.
All 2012–2031 direct, Matching Fund, and AMC pledges are expressed in US$ at 10 June 2011 exchange rates. All 2011–2031 IFFIm pledges by donors in US$ or US$ equivalent amounts of national currency pledges are calculated using the prevailing exchange rate around the time of the signing of the grant agreement.

Annex 3

Board approvals for programme expenditure, 2000–2011*

as of 31 December 2011 (US$)

Country	CSO	HSS	INS	ISS	NVS	Operational support	Vaccine introduction grant	Total
Afghanistan	2,425,500	34,100,000	1,676,500	14,025,300	48,216,491		504,000	100,947,791
Albania			110,377		1,647,015		300,000	2,057,393
Angola			1,252,610	2,988,000	48,717,452		100,000	53,058,062
Armenia		184,500	64,942	79,860	1,565,002		200,000	2,094,305
Azerbaijan		582,000	151,040	749,380	2,581,332		200,000	4,263,752
Bangladesh		7,243,500	6,144,414	23,340,200	139,068,164		1,387,000	177,183,278
Benin		886,500	358,664	182,500	37,722,891		207,500	39,358,055
Bhutan		116,000	31,741		803,318		200,000	1,151,059
Bolivia		2,093,000	873,500	287,500	10,848,183		100,000	14,202,183
Bosnia and Herzegovina			53,130		2,131,864		100,000	2,284,994
Burkina Faso		4,313,000	931,560	9,768,940	45,019,738		100,000	60,133,238
Burundi	461,520	7,492,000	390,294	3,435,000	34,973,863		210,000	46,962,676
Cambodia		6,389,000	587,653	1,828,700	15,898,953		231,000	24,935,306
Cameroon		7,762,000	992,844	7,983,620	52,687,641	1,803,735	632,000	71,861,840
Central African Republic		2,484,000	119,651	1,611,360	8,413,778		300,000	12,928,789
Chad		2,305,000	443,812	2,637,000	18,595,905	1,270,548	225,000	25,477,266
China			15,926,581		21,952,552		800,000	38,679,133
Comoros			42,322	60,000	768,062		200,000	1,070,384
Congo			224,534	1,665,000	9,366,829		300,000	11,556,364
Côte d'Ivoire		3,117,997	1,612,989	5,473,000	32,369,124		288,500	42,861,610
Cuba		849,500	359,889					1,209,389
Democratic People's Republic of Korea		2,785,500	743,726	2,222,971	9,030,153		227,500	15,009,850
Democratic Republic of the Congo	5,319,000	49,239,500	2,713,931	25,807,280	151,915,588		1,814,000	236,809,299
Djibouti			33,900	169,300	1,018,010		100,000	1,321,210
Eritrea		1,358,250	148,029	436,540	6,619,632		200,000	8,762,451
Ethiopia	3,320,000	76,493,935	2,696,697	23,445,320	179,501,277		981,500	286,438,730
Gambia		364,000	101,184	583,800	8,601,140		706,250	10,356,374
Georgia		435,500	61,451	135,500	1,435,129		200,000	2,267,580
Ghana	382,500	7,160,375	855,300	4,968,300	82,260,146		100,000	95,726,621
Guinea		1,632,500	347,460	2,918,900	14,617,074		220,500	19,736,434
Guinea-Bissau		601,500	115,787	500,360	2,178,370		200,000	3,596,017
Guyana				65,500	2,154,248		374,800	2,594,548
Haiti			397,500	1,256,000				1,653,500
Honduras		2,185,500	457,000	93,000	16,206,373		495,285	19,437,158
India			18,427,489		175,203,533		415,523	194,046,545
Indonesia	3,900,500	7,961,000	9,856,844	12,636,000	17,511,000		100,000	51,965,344
Kenya		9,903,000	1,129,963	5,870,180	185,196,476		543,500	202,643,119
Kiribati					89,138		100,000	189,138
Kyrgyzstan		1,155,000	189,168	720,000	4,799,882		200,000	7,064,050

Source: 31

* Values reflect Board approvals for programme expenditure made between 2000 to 31 December 2011. These do not include Board approved programme budgets for 2012 that were approved in 2011.

CSO civil society organisation
HSS health system strengthening
INS injection safety support
ISS immunisation services support
NVS new and underused vaccine support

Country	CSO	HSS	INS	ISS	NVS	Operational support	Vaccine introduction grant	Total
Lao People's Democratic Republic		438,500	255,505	1,431,200	7,860,986		200,000	10,186,191
Lesotho			106,633	149,600	1,869,551		200,000	2,325,784
Liberia		4,090,000	360,500	2,188,750	7,724,649		200,000	14,563,899
Madagascar		7,667,000	615,555	3,243,000	39,090,890		533,500	51,149,944
Malawi		11,343,000	722,509	1,986,000	75,387,687		323,000	89,762,197
Mali		4,575,800	666,222	5,004,607	56,468,467		277,500	66,992,596
Mauritania		377,000	205,000	416,000	4,609,447		200,000	5,807,447
Mongolia		333,000	113,427	397,000	3,838,702		100,000	4,782,129
Mozambique			835,881	1,665,500	41,443,820		388,500	44,333,701
Myanmar		3,649,000	2,083,978	7,707,080	13,833,610		100,000	27,373,668
Nepal		13,267,000	1,151,893	3,312,520	31,792,365		366,500	49,890,279
Nicaragua		1,038,000	462,500	113,500	11,789,500		437,410	13,840,910
Niger		3,986,000	943,757	9,509,600	28,126,405		506,000	43,071,762
Nigeria		22,098,500	12,630,270	47,324,000	41,730,813	4,496,950	100,000	128,380,534
Pakistan	4,586,988	23,525,000	7,405,082	48,763,740	237,533,911		3,694,000	325,508,720
Papua New Guinea				434,000	6,788,576		200,000	7,422,576
Republic of Moldova			87,000		2,133,303		200,000	2,420,303
Rwanda		5,605,000	369,500	2,958,700	44,544,465		639,650	54,117,315
Sao Tome and Principe			21,656	60,000	253,843		200,000	535,499
Senegal		1,806,750	619,474	2,605,740	31,411,680		100,000	36,543,644
Sierra Leone		2,215,500	272,660	2,655,440	18,104,494		200,000	23,448,094
Solomon Islands					654,376		100,000	754,376
Somalia		2,787,000	210,140	1,218,000				4,215,140
South Sudan		5,321,744	171,495	4,532,780				10,026,018
Sri Lanka		3,630,000	709,749		15,286,669		200,000	19,826,418
Sudan		12,751,500	1,321,257	10,598,300	78,320,165		571,000	103,562,222
Tajikistan		282,000	348,745	2,056,000	8,255,754		200,000	11,142,499
Togo		1,200,500	317,617	2,952,900	10,131,053		200,000	14,802,070
Turkmenistan			155,043		978,617		100,000	1,233,659
Uganda		4,521,500	1,207,299	6,581,000	121,248,469		100,000	133,658,268
Ukraine			739,456		2,705,007		100,000	3,544,463
United Republic of Tanzania			1,016,452	11,413,380	76,817,552		647,000	89,894,384
Uzbekistan			727,012	0	23,995,377		259,500	24,981,889
Vietnam		16,285,000	3,226,000	1,930,500	46,545,218		692,500	68,679,218
Yemen		6,335,000	1,194,757	5,049,500	70,316,813		457,000	83,353,069
Zambia		2,917,500	689,237	3,864,060	49,139,127		100,000	56,709,924
Zimbabwe			948,925	1,262,906	16,929,283		100,000	19,241,115
Grand total	**20,396,008**	**403,240,351**	**113,536,664**	**351,329,615**	**2,619,345,970**	**7,571,233**	**26,556,918**	**3,541,976,758**

Note 1: This table does not include tranches pending IRC review.
Note 2: GAVI Phase I (2000–2006) approval values have been adjusted to the final actual disbursement values.
Note 3: CSO Type A is not included as these approvals are not country specific.

Annex 4
Sources and references

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Page 6

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Page 7

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3. WHO impact estimates
4. WHO/UNICEF immunisation coverage estimates and United Nations Population Division population estimates

Page 9

5. GAVI Alliance, 2012
6. GAVI Alliance data as at 31 December 2011. These disbursements are from inception until 31 December 2011.

Page 12

7. GAVI Alliance, 2012

Page 13

8. GAVI Alliance, 2012
9. GAVI Alliance, 2012

Page 14

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Page 16

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Page 17

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Page 19

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Page 23

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Page 24

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Page 31

19. WHO/UNICEF coverage estimates 2010 revision. July 2011

Page 33

20. WHO/UNICEF, 2011

Page 34

21. GAVI Alliance, 2012
22. GAVI Alliance, 2012
23. Country annual progress reports and joint reporting forms
24. UNICEF Supply Division and the PAHO Revolving Fund

Page 41

25. World Bank, November 2011

Page 46

26. UNICEF Supply Division

Page 49

27. UNICEF Supply Division; CDC

Page 50

28. UNICEF Supply Division, 2012
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Page 56

30. GAVI Alliance, 2012

Page 58

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Abbreviations

AMC	Advance Market Commitment
CEO	Chief Executive Officer
CSO	civil society organisation
DTP3	three doses of the diphtheria-tetanus-pertussis vaccine
EC	European Commission
G8	The Group of Eight
GNI	gross national income
Hib	*Haemophilus influenzae* type b
HPV	human papillomavirus
HSS	health system strengthening
IFFIm	International Finance Facility for Immunisation
INS	injection safety support
ISS	immunisation services support
NGO	non-governmental organisation
NVS	new and underused vaccine support
TAP	Transparency and Accountability Policy
UN	United Nations
UNICEF	United Nations Children's Fund
UNPD	United Nations Population Division
WHO	World Health Organization

See also ▼
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Notes

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