GAVI Progress Report
The Vaccine Fund Annual Report
2004

Letter from the Chair of the GAVI Board

GAVI's 16 partners created the Alliance in 2000 because the survival of a young child born into the world often depended on whether he or she was born in a country or region with access to basic health, including lifesaving vaccines. This was the case for almost 30 million children born each year, more than two to three millions of which would die from a vaccine preventable disease. While great progress has been achieved by the countries and millions more have access to immunization and are being reached with both traditional and new vaccines, these raw facts remain the principal reason for the existence and role of GAVI.

These statistics also underscore the development by WHO, UNICEF and other GAVI partners, of a new 10 year global vision and strategy for immunization which takes special note of the contributions of public-private partnerships such as GAVI toward the strengthening of health systems and expansion of access to basic immunization. The Global Immunization Vision and Strategy addresses:

- the need to protect more people in a changing world;
- the introduction of new vaccines and technologies;
- positioning immunization, other linked health interventions and surveillance in the health systems context;
- the context of global interdependence in meeting key immunization challenges.

All of us working with GAVI should be proud of the great progress we have achieved in only five years. Though more than 75% of all children are being reached and national immunization systems have been strengthened in many countries, still, today, 27 million children annually continue to lack access to immunization. The progress would not have been possible without the commitment of the 16 GAVI partners each of which has a distinct and important role within the Alliance. My own organization is particularly proud of our key role within GAVI and I have been pleased to serve as chair of the GAVI Board. In addition, I would like to recognize the significant contributions of Tore Godal and Jacques-François Martin, respectively as founding Executive Secretary of GAVI and President of The Vaccine Fund.

On behalf of all partners, I would also like to extend a warm welcome to Julian Lob-Levyt, who has joined the Alliance as GAVI's Executive Secretary and President of The Vaccine Fund, our financing partner.

Our hard work is contributing to better health in the world. We estimate that during the past five years, 670,000 lives will have been saved by immunization as a result of GAVI's support. Indeed, many GAVI supported countries have shown dramatic advances.

Since the beginning of the Alliance, 50 GAVI eligible countries have introduced HepB with GAVI / VF support. Similarly, 15 countries have been approved for Hib vaccine use in countries from Africa, Asia and Latin America. These countries are showing us that positive change is possible from even under the most trying circumstances.

We will however, only continue to make progress and realize this vision through increased solidarity on behalf of the world's children, particularly solidarity between developed and developing countries.

As Alliance partners, we owe it to the world's children to strengthen our collaboration even further and continue to work with national governments to deliver more results.

Lee Jong-wook
Chair of the GAVI Board and Director-General of WHO.

Letter from the Chair of The Vaccine Fund Board

THE IMMUNIZATION IMPERATIVE

Health and development matters are now higher on the international agenda than ever before. Yet the chasm between the haves and have-nots continues to widen. In the western world, populations live longer and healthier lives; in the developing world poor people are experiencing declines in health and life expectancy is decreasing even though some progress has been made. HIV/AIDS and vaccine-preventable diseases take far too many lives that could be saved. Seven to eight thousand children and adults die each day because they have not been fully immunized against life-threatening but preventable diseases.

Though the means exist to save the world's children from the ravages of preventable disease, an estimated 27 million children each year still miss out on vaccination. As a result, two to three million will die annually from preventable diseases, many of whom live in areas beyond the reach of health services. Many more will fall sick, miss school and will contribute to the vicious circle that links poor health to continued poverty into adulthood. We must close this "immunization gap" and begin to break this cycle of poverty to which it is connected. We must also recognize that a clock and an opportunity are ticking away.

Five years ago the world embraced the Millennium Development Goals (MDGs). MDG 4 aims at reducing child mortality by two-thirds by 2015. While we have made some progress, we still have challenges ahead of us. It is only through concerted action over the next ten years that we will make a difference with child immunization. We have the opportunity to ensure that MDG4 will be met.

We will only accomplish this formidable task through increased solidarity on behalf of the world's children, particularly solidarity between developed and developing countries.

As Chair of The Vaccine Fund, I am pleased to present the progress to date. With GAVI / VF's support, an estimated future 670,000 premature deaths have been averted among the children born in 2001- 2003. Thanks to our partners and support from our donors, public and private, many countries have increased routine immunization coverage and more than 9.7 million additional children have been reached with routine vaccination.

Yet our success makes it imperative we have more funds. As many are aware, in 2004, The Vaccine Fund launched a global Campaign for Child Immunization which seeks to raise the visibility of the "Immunization Imperative" in donor countries and to raise the resources needed to support GAVI.

2004 saw successful conferences and symposia taking place to raise the political profile of immunization. The Vaccine Fund's goal over the coming years is to work with all partners to build upon the initial success and expand the availability of child immunization to children not yet reached. Our Campaign goal is to raise US$400 million per year from 2004 to 2006. GAVI / VF will aim to save an additional one million lives by 2006. To achieve this we hope to mobilize the support of the international community and create new and additional resources for immunization in the world's poorest countries.

The International Finance Facility (IFF) concept and the IFF for Immunization supported by the UK and French Governments with other donor partners are some of the innovative resource mobilization opportunities we are jointly exploring with our partners.

Finally, we are also very pleased to acknowledge the critical support of Her Majesty Queen Rania, Chair of the Campaign for Child Immunization, former Norwegian Prime Minister Jens Stoltenberg and former President of Ireland Mary Robinson, among others, for this campaign. We hope you will join us for this noble – and achievable - cause as we aim to reach every child, everywhere.

Graça Machel
Chair of The Vaccine Fund Board

Letter from the Executive Secretary of GAVI and Chief Executive Officer of The Vaccine Fund

I am very honored to have been chosen as the incoming Executive Secretary of GAVI and new President of The Vaccine Fund. These are exciting times of convergence for GAVI / VF. We are bringing together the best of both organizations to create a new entity that will be even more effective in fighting unjust killer diseases that we have the power to defeat.

BY JOINING FORCES, OUR TEAMS WILL BE ABLE SAVE MORE CHILDREN. WE WILL:

1/ deliver better programs and services in the countries we work with,
2/ strengthen our resource mobilization and advocacy efforts and capabilities - bringing our program funding team much closer to our country support activities.
Going forward, we want to continue to reinforce the ties with the members of the Alliance, with our bilateral and multi-lateral Partners to meet the challenges of reaching the Millennium Development Goals.
In this respect, I welcome WHO and UNICEF's Global Immunization Vision and Strategy to save more children and adults, to bring more new vaccines and strengthen health systems in emerging countries to meet key global immunization challenges.

OUR NEW CONVERGED ENTITY IS STARTING ON VERY STRONG FOOTING.

Under leadership of Tore Godal and Jacques-François Martin, we have much to be proud of and I would like to thank them for their dedication and hard work for the cause of the children. At the end of last year - after only five years in operation- 71 countries out of the 75 countries eligible to receive support from GAVI / VF - had effectively received financial support.
This financial support has been used to:

- strengthen immunization systems;
- boost coverage with established vaccines (against diphtheria, tetanus, pertussis, tuberculosis, measles and polio);
- introduce underused vaccines where needed (hepatitis B, Hib and yellow fever);
- accelerate the development of, and affordable access to, priority new vaccines for developing countries;
- ensure immunization safety.

As of December 2004, we had committed US$1.19 billion, disbursed US$532.6 millions for vaccine purchases, immunization safety, and immunization services support as well as accelerated development of priority new vaccines. It is estimated that by end-2003, more than 670 000[1] premature deaths from Hib disease, pertussis and hepatitis B had been averted among children born in 2001-2003. Additionally, the introduction of new and underused vaccines in GAVI / VF-supported countries enabled us to support the immunization of more than 70.5 million children against hepatitis B, more than 8.2 million against Hib and more than 7.6 million against yellow fever. An additional 9.7 million children were also immunized with DTP3 by December 2004[2]. Strengthening injection safety, we supplied 991 million single-use auto-disable syringes to countries as of December 2004.

However, this has been anything but a vertical program. At the end of 2004, approximately one third of GAVI / VF resources have been directed toward strengthening of health systems in the poorest countries we support. Strengthening these systems helps countries respond more effectively to a variety of public health challenges. GAVI's focus on delivering new vaccines, such as hepatitis B, into countries for the first time, is also paving the way for the eventual delivery of HIV/AIDS or malaria vaccines into these same countries when they become available.

GAVI is also continuing to work closely with the vaccine industry to encourage greater interest in vaccine research and development and to increase the number of producers of needed vaccines. Meanwhile, GAVI / VF-supported Accelerated Development and Introduction Plans (ADIPs) are working to ensure that the public health community participates early in the development of vaccines against rotavirus and pneumococcal diseases. The goal is to ensure that if the vaccines developed are appropriate, children in the poorest countries will receive these vaccines sooner rather later.

To achieve our objectives we need to strengthen our funding base.

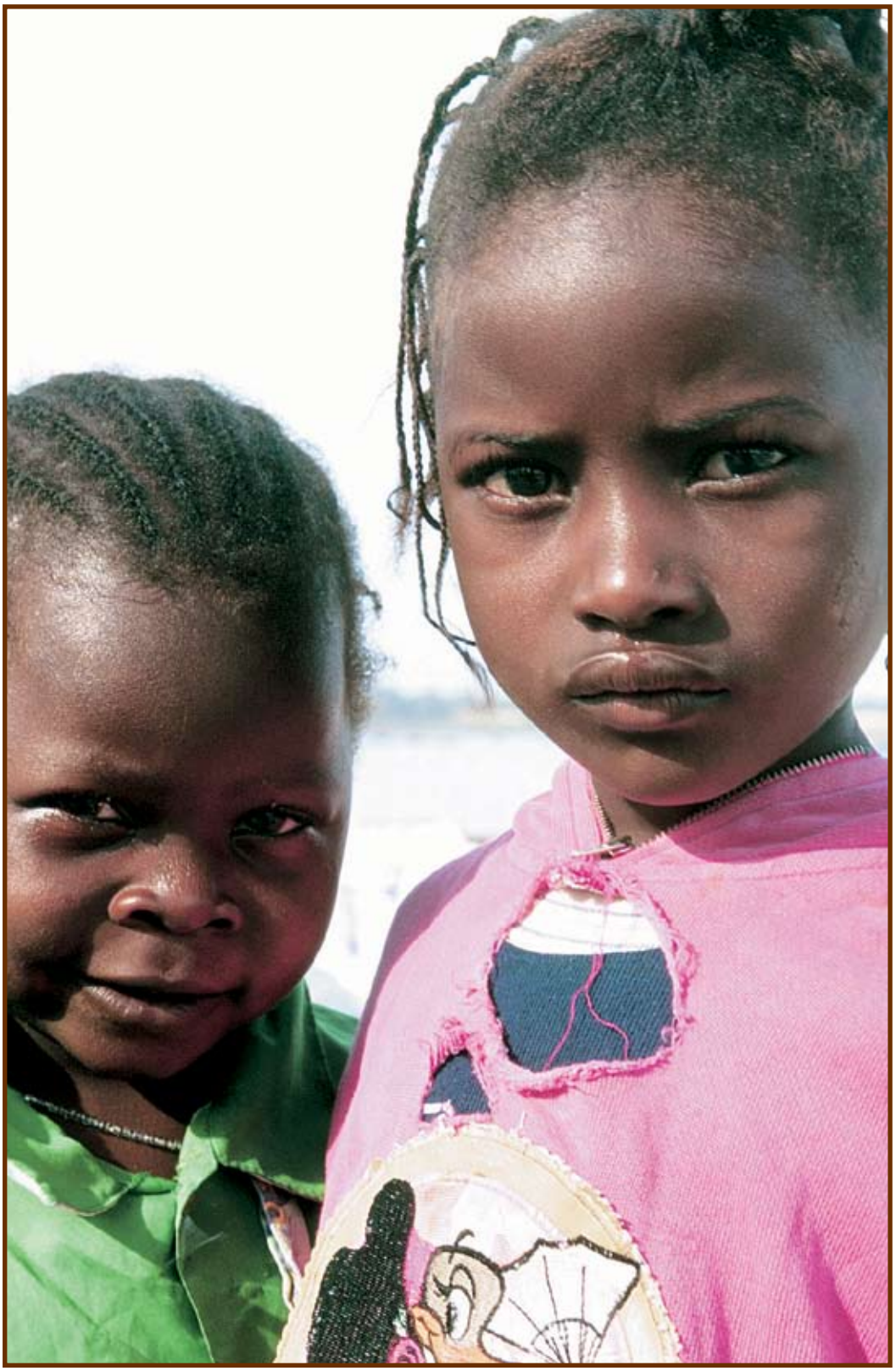
THE GLOBAL CAMPAIGN FOR CHILD IMMUNIZATION

GAVI / VF launched the global Campaign for Child immunization, in February 2004 in London. Our objective over the coming years is to work with all partners to build upon our initial success and expand the availability of immunization to children not yet reached. GAVI / VF will aim to save an additional one million lives by 2006. To achieve this we hope to mobilize the support of the international community and create new and additional resources for immunization in the world's poorest countries. We welcome a new and innovative financing mechanism for development and support The International Finance Facility concept and plan for immunization proposed by the UK, French and Swedish Governments. Such a mechanism would provide frontloaded finance for activities above and beyond our underlying goal to raise US$400 million per year.

Routine immunization is a cornerstone of basic healthcare and an essential first step on the path to human development. Increasing access to immunization is a proven -and one of the most cost effective- ways to safeguard the health of children and families. The benefits of immunization reach far beyond these children and families. They help to create healthier and more prosperous communities and countries and a more just and safer world for all.

Julian Lob-Levyt
GAVI Executive Secretary and Chief Executive Officer of The Vaccine Fund

[1] WHO estimates to end of 2003. Includes both deaths averted among children under five years and deaths from hepatitis B that would have occurred in adulthood.
[2] WHO estimates and projections to end of 2004.



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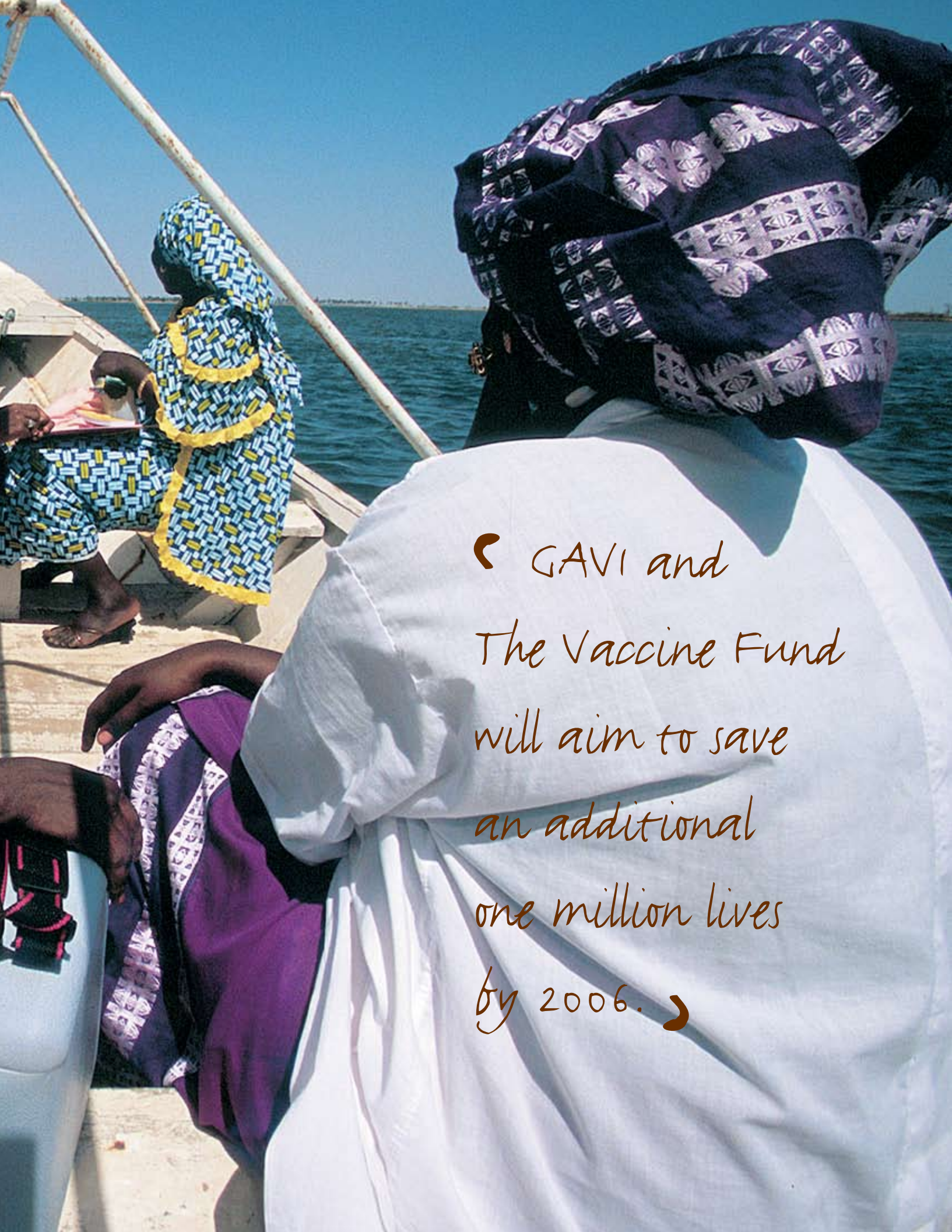


“GAVI and The Vaccine Fund will aim to save an additional one million lives by 2006.”

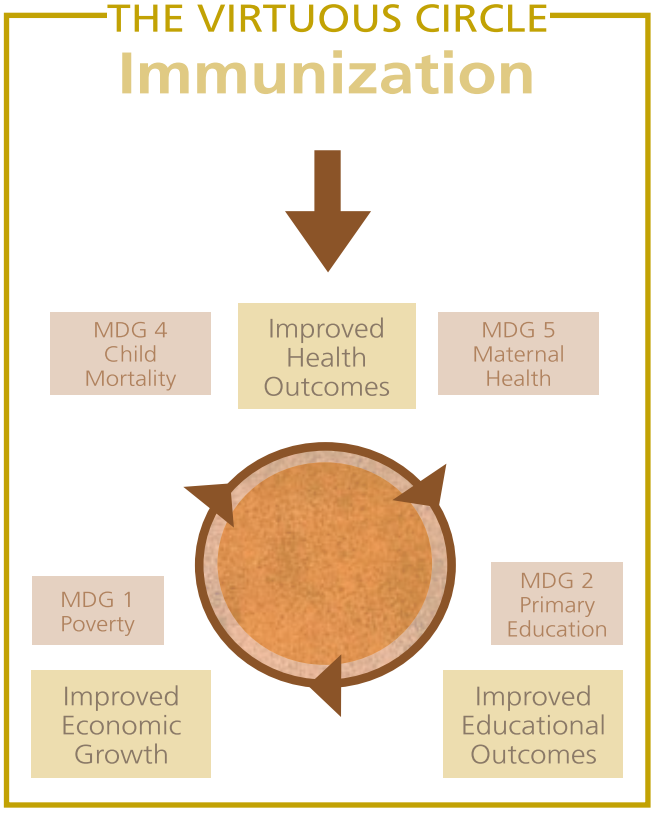
Introduction

Childhood immunization lays the foundation for good health and increased life expectancy and contributes to both economic and social development. By reducing sickness, it helps ensure that the poorest children can attend school regularly, are better able to learn, and more likely to complete their schooling. It helps ensure that adult care givers can remain in productive work, lowers the cost of out-of-pocket spending on health care, and contributes to reducing poverty.

But access to immunization is not yet assured for all children. In 2003, about one-quarter of the children born that year (approximately 27 million) missed out on immunization during their first year of life, mainly in developing countries - leaving them vulnerable to infectious diseases both in childhood and during the productive adult years. Of the estimated 10.5 million children who died before their fifth birthday, about 1.4 million children died from diseases for which vaccines are available today in developing countries. An additional 1.1 million children died from diseases for which vaccines could be available soon.

The global push by UNICEF, WHO and others to immunize children during the 1980s – which boosted global immunization coverage from 20% in 1980 to more than 70% by 1990[3] - is evidence of what can be achieved through a global alliance of immunization partners. However, in many countries, these efforts faltered. Today as governments strive to meet the Millennium Development Goals (MDGs), efforts to sustainably scale up immunization in the poorest countries are pivotal to meet the goal of reducing under-five mortality rates by two-thirds between 1990 and 2015 (MDG4). However, more than half-way toward the deadline, WHO and UNICEF estimate that on current trends (based on vaccine demand, level of funding, health system development and vaccine availability), the immunization coverage rates needed to meet the child mortality goal (90% coverage nationwide and 80% coverage in all districts) will not be reached by 2015.

Many of the vaccines needed to save children's lives already exist. Additional vaccines will soon be available. What is needed now is the global will to ensure that these life-saving tools are also available in the poorest countries – where the needs are greatest.



[3] Fully immunized with DTP, BCG, polio and measles vaccine.

Since 2000, the GAVI partners have set out to challenge the status quo in access to immunization – pioneering a new approach to ensure that children in the poorest countries are no longer denied access to vaccines with the potential to save millions of lives. GAVI / VF has provided support to 71 of the poorest countries to help strengthen immunization services and increase routine immunization coverage. The Alliance has provided almost 1 billion non-reusable syringes to help improve injection safety, supported the introduction of existing but underused vaccines in low-income countries, and developed a new approach to help speed up the development and introduction of priority new vaccines for developing countries.

As a result, by end-2003, it is estimated that through GAVI / VF support, 670,000 premature deaths had been averted among children born in 2001-2003[4]. Among all GAVI / VF eligible countries, an additional 9.7 million children had been reached with routine immunization (DTP3). In addition, more than 70.5 million children had been immunized with hepatitis B vaccine, more than 8.2 million with *Hæmophilus influenzæ* type b (Hib) vaccine, and more than 7.6 million with yellow fever vaccine by end of 2004[5].

From the outset, GAVI / VF has demonstrated how quickly a scale-up can occur. By end-2004, US$1.19 billion of funds had been committed and 71 countries were receiving support. A priority has been placed on the speedy disbursal of funds. In some cases, funding has reached countries within six months of application.

The GAVI partners have also pioneered new ways of providing development aid. These include: the use of performance-related funding to increase the number of children immunized; and allowing countries themselves to decide how to make the best use of funds in efforts to strengthen immunization services. Another innovation is the development of comprehensive plans, involving both the public and private sectors, to help speed up the development and introduction of new life-saving vaccines urgently needed in developing countries.

4 Latest available WHO estimate. It includes both deaths averted among children under five years and deaths from hepatitis B that would otherwise have occurred in adulthood.
5 WHO estimates and projections to end of 2004.

Although there have been many achievements, there have been unexpected challenges as well. The introduction of combination vaccines – which protect children against several diseases in a single shot – has proved to be more difficult than anticipated. The pentavalent vaccine (which includes DTP, hepatitis B and Hib vaccines), in particular, has been in short supply and the price has not fallen as quickly as envisaged. Because of this, some low-income countries will have difficulty finding alternative sources of funding for these vaccines once the GAVI / VF support ends. This funding shortfall has been compounded by lower than anticipated increases in the level of additional funding for immunization from both governments and donors.
An additional challenge is continuing uncertainty about the burden of Hib disease in some countries.

MOVING FROM A 5 YEARS FUNDING FRAMEWORK TO A 10-15 YEARS FRAMEWORK

In December 2004, in response, the GAVI Board agreed to an extension of support to countries already using the still high-priced combination vaccines. This time-limited support is expected to be in the form of a co-financing mechanism in which the cost of the vaccines is shared between governments and GAVI / VF. GAVI / VF is also supporting studies to estimate the burden of Hib disease in GAVI / VF countries so that they can make an evidence-based decision on the introduction of Hib vaccine. Meanwhile, in 2005-2006, as new manufacturers enter the market and demand for the vaccine rises, it can be expected that prices will start decreasing.

An additional constraint is that there is currently only one pre-qualified vaccine that combines vaccines against diphteria, tetanus, pertussis and hepatitis B in a single shot. Combination vaccines are a more efficient way of delivering multiple vaccines, particularly in developping countries.

Ten suppliers have submitted bids to UNICEF in 2003 to supply this vaccine in 2006. A number of these suppliers have already initiated the pre-qualification process.

While generally the impact of the GAVI / VF funding has exceeded expectations, in some cases progress has been disappointingly slow.
For example, despite the safe and effective track record of Hib vaccines, uptake by countries has not yet met all expectations. One of the lessons learned is that five years is a relatively short time for an international development initiative on this scale. It is already clear however, that GAVI / VF has had a great impact in providing access to vaccines in the poorest countries.

« After only five years in operation, 71 countries out of the 75 countries eligible to receive support had effectively received financial support. »

Strengthening the infrastructure for health care

The GAVI partners recognized from the outset that efforts to increase immunization coverage in low-performing countries would require support to help strengthen the health care infrastructure and immunization services. In many low-income countries, immunization efforts are compromised by problems such as lack of finance, a shortage of trained health staff, weak monitoring and reporting systems, inadequate cold chain facilities, and a lack of transportation to enable regular access to hard-to-reach populations.

To help meet these needs, GAVI / VF provide funding and support to help improve immunization services and boost coverage. In many countries, this kind of support extends the reach and capacity of overall health systems – for example, through improvements in infrastructure, training, management and reporting systems, as well as increased access to difficult-to-reach populations.

IMMUNIZATION SERVICES SUPPORT

Immunization Services Support (ISS) is an innovative mechanism for performance-related funding. Established by the GAVI partners to help strengthen health systems in low-income countries - and in an effort to increase immunization coverage - funding is available to all GAVI / VF-eligible countries (defined as those, with Gross National Income below US$1000 per capita) and DTP3[6] coverage below 80%.

GAVI policy recognizes that immunization systems in the poorest countries have differing needs and countries themselves decide how the money should be spent (e.g., for training, outreach or the purchase of new vehicles or cold chain equipment) on the basis of country-identified priorities. After an initial investment period of three years, the continuation of ISS funding for a further three years (the reward phase) is conditional upon on verifiable results showing a year-on-year increase in immunization coverage. In order to receive the rewards, countries are also required to pass an independent data quality audit (DQA) – ensuring that the country-reported data on immunization coverage correspond with the audited data.

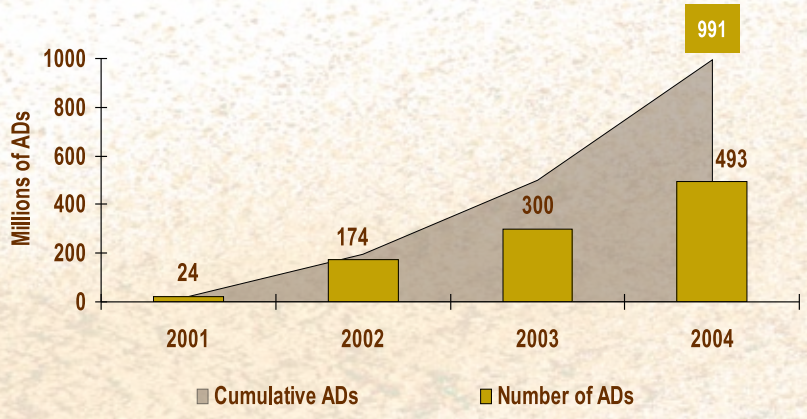
PROGRESS

By December 2004, GAVI had disbursed US$73.8 million in ISS support to 52 countries.

As a result:

- Among all GAVI / VF supported countries, an additional 9.7 million children were immunized with DTP3 by December 2004[7].
- Of the 34 countries eligible for performance-based grants as of December 2004, 21 had received at least one reward for meeting or exceeding their target for the number of additional children immunized with DTP3.

INJECTION SAFETY



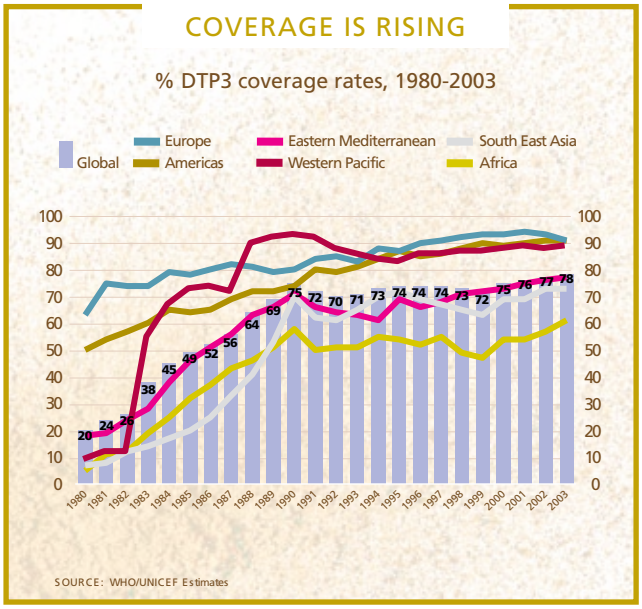
Injection safety is a key focus of GAVI's efforts to strengthen immunization services.

Since the launch of GAVI in 2000, almost 1 billion single-use autodisable syringes have been supplied to countries to improve injection safety (as of end-2004).

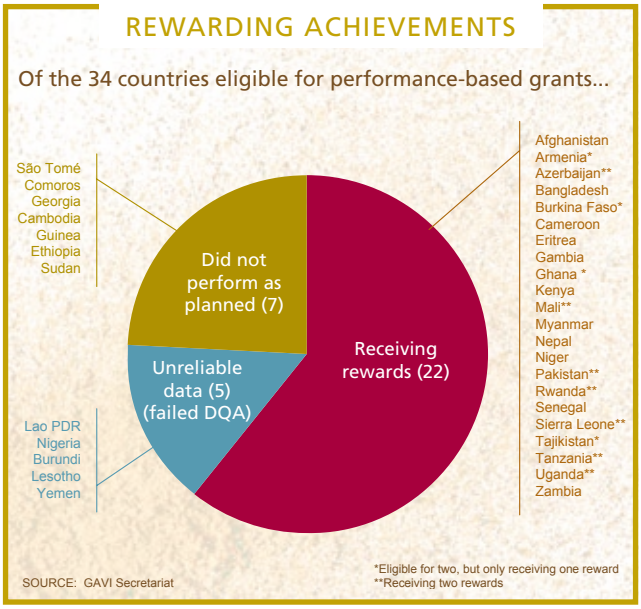
[6] Coverage with three doses of the combined vaccine against diptheria, tetanus and pertussis (DTP3) is used by WHO as a proxy indicator for routine immunization coverage.

[7] WHO estimates and projections to end of 2004.

PROGRAMMATIC IMPACT: COVERAGE IS RISING



INNOVATIONS: REWARDING ACHIEVEMENTS



REWARDING ACHIEVEMENTS
HOW EFFECTIVE IS ISS FUNDING?

To determine how effective the initial ISS funding has been - and what lessons can be learned – the GAVI Board commissioned an evaluation of ISS funding, which was carried out in the first half of 2004. This evaluation[8], by Abt Associates, involved a review of progress reports from 33 countries that had received ISS funds by June 2002 (the cut-off date used) and detailed country case studies based on interviews carried out in 2004 in six countries. Of these countries, three were eligible for rewards (Cambodia, Mali and Tanzania) and three were not (Kenya, Madagascar and Mozambique).

The evaluation found that ISS funds were mainly used for recurrent expenses (81%) and at subnational levels (68%). The main categories for ISS funding were training (21%), monitoring and surveillance (11%) and vehicles (9%). While some countries focused ISS funds on under-performing districts, other countries - for political and equity reasons - shared them among all districts.

The evaluation team considered that while it was too early to reach definitive conclusions about ISS funding, it recommended that, in view of the promising early results, ISS funding should continue.

[8] Evaluation of GAVI Immunization Services Support Funding, Abt Associates Inc, Bethesda, MD, USA, 2004.

The GAVI Independent Review Committee (IRC) Monitoring Team has also recommended continuation of the ISS funding approach. A comprehensive evaluation is now planned for 2006. If confirmed to be successful, the approach could provide valuable lessons for other areas of development funding.

Main findings:

- in most of the countries reviewed, the allocation of ISS funds has been systematic and strategic, i.e., to address obstacles and increase immunization coverage;
- initial results indicate modest improvements in performance at the country level;
- in most countries, the reward incentives of ISS funding have not distorted immunization priorities;
- the flexibility of ISS funding was viewed as its most valuable asset;
- in most countries, ISS funding has been additional to - and has not replaced - existing sources of immunization funding;
- at the same time, total funding for immunization has increased and the total amount of government funding for immunization has also increased.

DR CONGO

In the Democratic Republic of Congo – emerging from recent conflict and still affected by insecurity in some areas - ISS funding has helped strengthen capacity at the district level and boost immunization coverage.

From 1991 to 2003, less than half of DR Congo's children were immunized during the first year of life. In 2002, the country received its first ISS funding and opted to use the funds mainly to cover the cost of vehicles and transportation, for personnel costs and for training and supervision of staff. In addition, DR Congo adopted the Reaching Every District (RED) strategy (see Box) – an approach that involves intensified efforts in low-performing districts.

During 2004, the use of the RED strategy in more than half of the country's 276 health zones helped increase routine immunization coverage nationwide to 60%. After one year, 70% of the children in RED-targeted areas were immunized (DTP3) by their first birthday compared with 54% in non-RED areas. In Tshikapa, for example, one of the RED zones, coverage increased from 29% in 2003 to 68% in 2004.

In 2005, the RED strategy will be extended to other health zones in DR Congo – increasing the percentage of the population targeted from 45% to 65%.

REACHING EVERY DISTRICT (RED)

The Reaching Every District strategy was developed jointly by WHO and UNICEF to increase immunization coverage by building capacity at the district level – with a particular emphasis on detailed planning and regular monitoring. The strategy, which has been supported through the use of ISS funding in GAVI / VF supported countries, has proved to be effective in raising the level of immunization coverage in low-performing countries. The approach has five operational components:

- re-establishment of regular outreach services;
- supportive supervision: on-site training;
- community links with service delivery;
- monitoring and use of data for action;
- better planning and management of human and financial resources.

OTHER ACHIEVEMENTS WITH GAVI / VF SUPPORT FOR SYSTEMS STRENGTHENING

- In Cambodia, DTP3 coverage in 10 districts increased by 16% in 2003 compared with a 4% increase nationwide.
- In Angola, which mapped the population served by individual health facilities in each of the selected districts involved, immunization coverage increased from 46% nationwide in 2003 to 59% in 2004.
- In Ethiopia, the adoption of the Reaching Every District (RED) approach in 13 priority health zones helped increase DTP3 coverage nationwide from 52% in 2003 to 65% in 2004 and measles vaccine coverage from less than 40% to 55%.

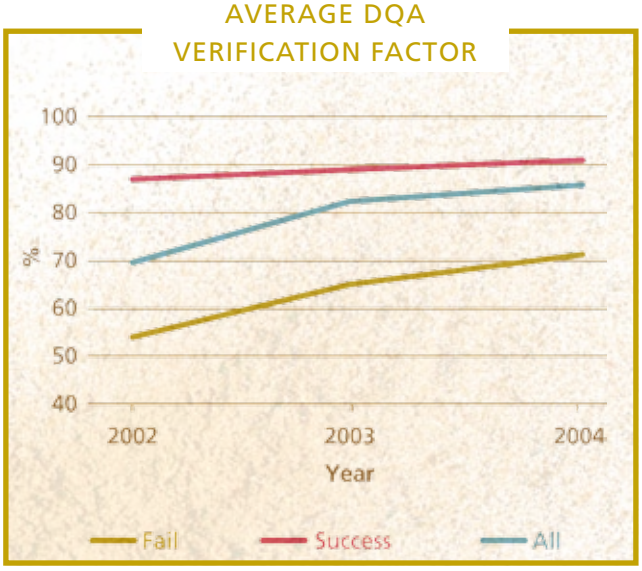
ACCOUNTABILITY

GAVI / VF support involves regular and rigorous performance monitoring. Once a year, supported countries are required to submit an annual progress report, detailing, among other things, progress compared to the previous year, the receipt and use of GAVI / VF funds, and targets for the following year. The annual progress report is reviewed by an Independent Review Committee which then makes recommendations to the GAVI Board. Failure to submit an annual report on time – or failure to produce an adequate report - can result in the delay or suspension of support.

DATA QUALITY AUDITS (DQAS)

Countries receiving ISS funding must also undergo an independent data quality audit (DQA) during the second year of support to verify the quality of the country's administrative reporting system. The aim is to measure the accuracy and completeness of reporting and ensure that the data are sufficiently reliable to enable the payment of rewards for each additional child immunized (with DTP3) through GAVI / VF support. The external audits are carried out over a period of two to three weeks. The auditors aim to establish to what extent country-reported coverage data correspond with the audited data. Unless this so-called verification factor is at least 80%, countries are considered to have failed the audit and are not eligible for reward funding. In 2005, 13 countries are scheduled to undergo DQAs, including nine which failed the first time.

AVERAGE DQA VERIFICATION FACTOR



PROGRESS (as of December 2004)

More than 60% (24 out of 39) of countries had passed their DQA. The percentage of countries passing the DQA at the first attempt rose from 47% to 57% between 2002 and 2004.

The accuracy of country-reported data (verification factor) increased from 70% in 2002 to more than 85% in 2004.

DATA QUALITY SELF-ASSESSMENT (DQS)

In response to needs identified by countries which have undergone a DQA, WHO has developed a data quality self-assessment (DQS) tool to enable countries to check key aspects of their reporting systems and monitor improvements in preparation for an external DQA. The DQS, which has been field-tested in Nepal, Morocco and Togo, is designed to help countries diagnose and solve problems in their health information systems. In addition, software tools to help strengthen the quality of information have been updated and introduced. GAVI / VF has set a target for the DQS to be used systematically in at least 10 countries by end-2005.

KENYA IMPROVES ACCURACY OF REPORTING

Kenya, which did not pass its first DQA in 2002, passed the second attempt in 2004 after increasing the accuracy of its reporting from 49% to 86%. The turnaround followed efforts to address weaknesses identified by the external auditors. This involved:

- development of a plan to improve reporting systems;
- establishment of guidelines for record keeping;
- training for all immunization staff.

SYSTEM-WIDE BARRIERS POSE CONTINUING CHALLENGES

Immunization systems operate within the context of the overall health system and are all too often constrained by the barriers and challenges which affect the health system as a whole. The most common system-wide barriers include lack of political and financial commitment, a shortage of trained health staff, poor management, inadequate physical infrastructure and equipment, and weak monitoring and information systems.

The GAVI Board identified efforts to address system-wide barriers as one of the priorities for GAVI in 2004-2005. As part of the GAVI work plan for 2004-2005, the Norwegian Agency for Development Cooperation (NORAD) coordinated a study to identify ways of addressing system-wide barriers. The main activity was the development of a barrier assessment approach involving health authorities and local research institutions in eight GAVI / VF supported countries: The Gambia, Ghana, Guyana, Rwanda, Sierra Leone, Uganda, Viet Nam and Zambia. The project also reviewed ongoing efforts to address system-wide barriers and recommended better coordination and harmonization of these efforts, including efforts to strengthen low-performing interagency coordinating committees (ICC) and other coordinating mechanisms.

GOOD PRACTICES

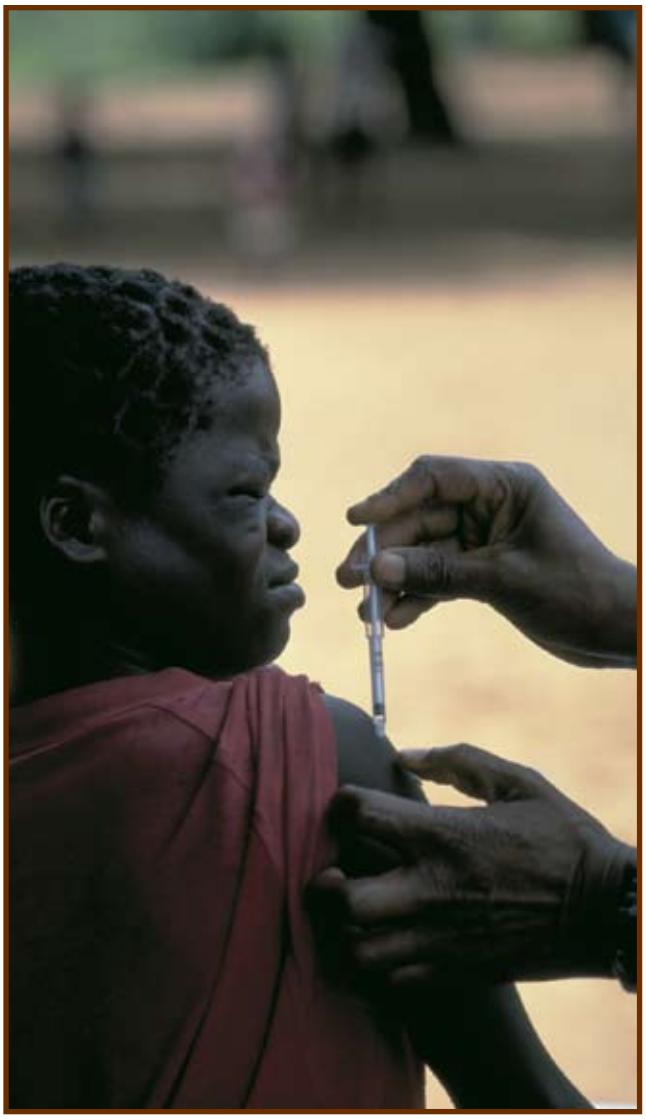
The NORAD-coordinated work plan activity identified a number of innovative approaches countries have adopted to address system-wide barriers in GAVI / VF supported countries, including some which could potentially be scaled up. Examples include:

To address the critical shortage of trained staff:

- In Uganda, lower level staff were trained and upgraded to a new cadre of Assistant Nurses.
- Ghana has increased the intake into training schools, offered incentives such as car and housing loans to help retain staff, and recruited midwives from the private sector.
- In Zambia and Guyana, trained nurses are now being encouraged to stay on after retirement.
- Several countries have improved training programmes and re-scheduled these to reduce the level of staff absences due to training.
- In some countries with high HIV/AIDS prevalence, free antiretroviral treatment is offered to health staff.

To strengthen reporting systems and use data to improve management:

- In Uganda, a district league table with 18 indicators is published in newspapers to highlight performance and make district leaders more accountable.
- Low-performing districts in Ghana are supported to conduct microplanning to improve monitoring and supervision and increase coverage.




« Many of the vaccines needed to save children's lives already exist. Additional vaccines will soon be available. »

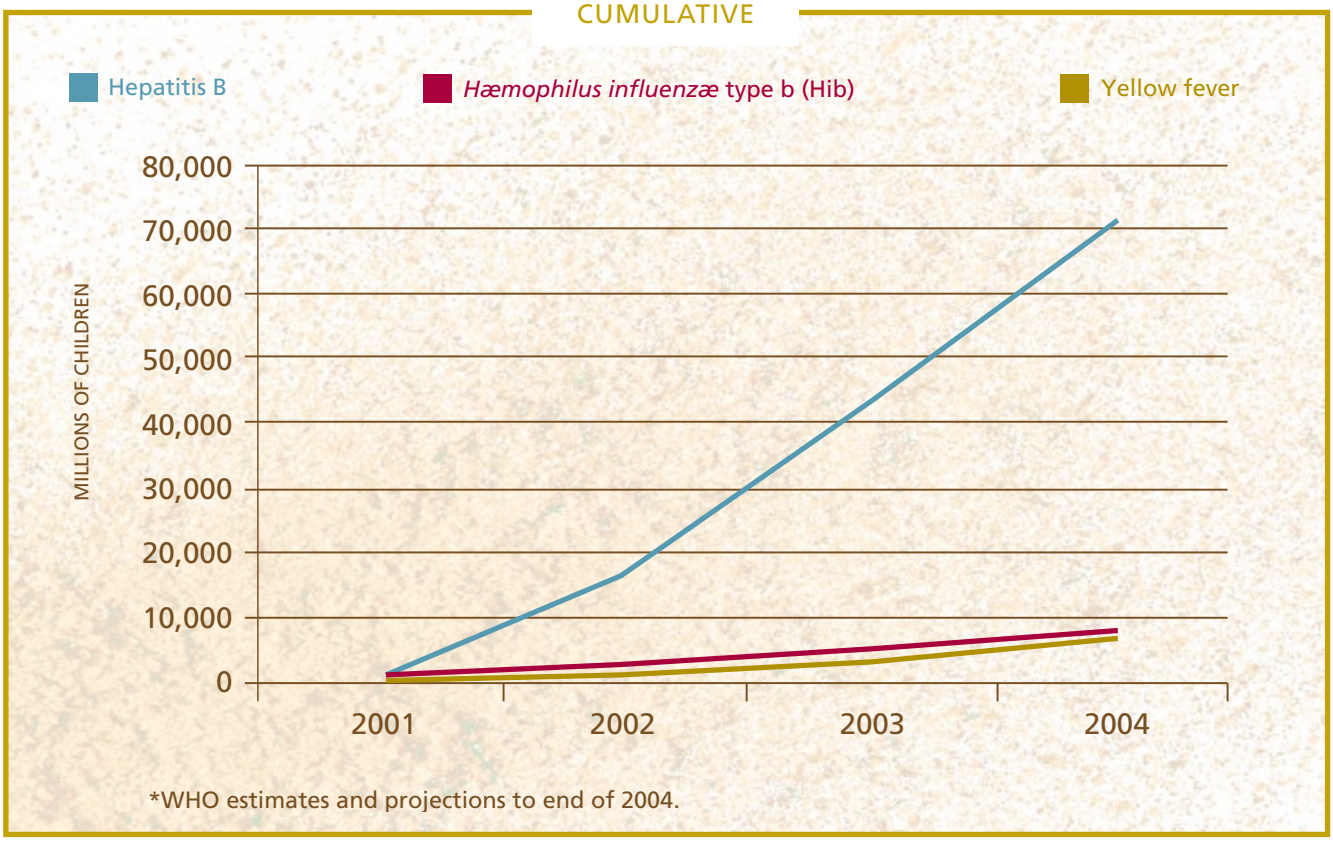
Increasing access to underused vaccines

Established to save children's lives by increasing access to vaccines in the poorest countries, GAVI / VF is committed to bridging the gap between the vaccines available in the industrialized countries and those that are used in developing countries.

Before the launch of GAVI / VF in 2000, children in developing countries rarely had access to more than six vaccines – DTP (diphtheria/tetanus/pertussis), polio, measles and BCG (tuberculosis). In contrast, immunization schedules in many industrialized countries already included additional vaccines - against hepatitis B, Hib, mumps and rubella, for example – which low-income countries could not afford. In addition, vaccines against diseases specific to the poorest countries such as yellow fever where not included in routine immunization schedules in many of the low-income countries at risk. Of the 28 GAVI / VF countries where yellow fever vaccine introduction into routine infant immunization is recommended by WHO, only 10 (36%), were using yellow fever vaccine in their national routine immunization programme when GAVI / VF was launched in 2000.

From the outset, GAVI / VF has provided support for the introduction of priority vaccines in low-income countries. Countries with routine immunization coverage (DTP3) of more than 50% are eligible for time-limited support for the introduction of vaccines against hepatitis B and (where needed) against Hib. In addition, yellow fever vaccine is available for use in all countries at risk in Africa and Latin America - regardless of the level of routine immunization coverage.

In addition to saving lives, GAVI / VF work to shape the market place. The financing and the increasing uptake of underused vaccines (including combination vaccines) in low-income countries will, it is expected, not only lead to a reduction in vaccine prices but, by increasing market confidence, encourage the vaccine industry to invest more; not only in increasing production capacity but also in the research and development of priority new vaccines for developing country markets.



HEPATITIS B VACCINE

Hepatitis B

In 2002, there were an estimated 600,000 deaths worldwide from chronic hepatitis B-related diseases such as cirrhosis and liver cancer. The development of chronic hepatitis B infection occurs mainly in children under five - often with no signs of infection until much later in life. In highly endemic areas, most cases involve mother-to-child (perinatal) or child-to-child transmission (mainly through cuts, bites, scrapes and scratches).

WHO estimates that about 360 million people are chronically infected carriers of the disease – most unaware they are infected but still capable of spreading the disease to others. A long-term treatment exists, but it is very expensive, can have severe side-effects, and has only a 40%-50% success rate. Large-scale vaccination against hepatitis B has been demonstrated to be cost-effective, even in countries with a low prevalence of the disease.

Although a safe and effective vaccine against hepatitis B has been available since 1982 – and WHO recommended that all countries should introduce the vaccine by 1997 - uptake of the vaccine was slow and the target was never met. Even when the initial high price of the vaccine (US$150 for three doses) came down substantially, most low-income countries were unable to secure the funds needed to introduce the vaccine.

GAVI / VF provides vaccines and associated injection equipment for infant vaccination to countries that meet the general conditions, as well as the specifications relating to the type of vaccine requested. Hepatitis B vaccine is accepted for use in all developing countries, and between 2000-2004, GAVI / VF contributed to support HepB vaccine in 50 countries.

This includes:

- in countries where DTP3 coverage is more than 50%, support for the purchase of hepatitis B vaccine (and safe injection equipment) for five years, together with a one-off payment of US$100,000 to facilitate the introduction of the new vaccine.
- UNICEF on behalf of GAVI partners working with vaccine manufacturers to ensure that adequate and affordable supplies of hepatitis B vaccine, including combination vaccines, are available in low-income countries.
- GAVI partners' support to countries in developing a financial sustainability plan to ensure continued financing for hepatitis B vaccine once GAVI / VF support ends.

PROGRESS

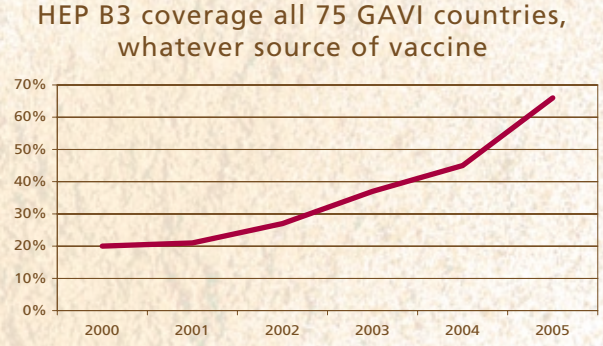
With support from GAVI / VF:

- by December 2004, more than 70,5 million[9] children in low-income countries had been immunized with hepatitis B vaccine;
- as a result, more than 500,000 premature deaths[10] from hepatitis B have been prevented among the children born in 2001-2003;
- 50 of the 75 GAVI / VF eligible countries (more than 60%) have been approved for funding for hepatitis B vaccine so far (as of end-2004) – an increase from only seven before the launch of GAVI in 2000;
- 25 of the countries approved for funding for hepatitis B vaccine have opted to use combination vaccines – thereby avoiding an increase in the number of immunization injections needed during the first year of life.

VIET NAM

In Viet Nam, monovalent hepatitis B vaccine was introduced in 2002 with support from GAVI / VF in 44 of the country's 61 provinces (phased introduction). By end-2003, almost 94% of the children targeted had received the first dose of hepatitis B vaccine – two-thirds of them during the first three days of life. The Government of Viet Nam has co-financed the supply of hepatitis B vaccine from the outset – contributing about 16% a year on average up till end-2006 when GAVI / VF support ends.

GAVI IMPACT



[9] WHO estimates and projections to end of 2004.
[10] WHO estimate based on deaths from hepatitis B that would otherwise have occurred in adulthood.

HÆMOPHILUS INFLUENZÆ TYPE B (HIB) VACCINE

Hæmophilus influenzæ type b

Hæmophilus influenzæ type b (Hib) is a bacterial infection which mainly affects children under five and can lead to life-threatening meningitis and pneumonia. In 2002, there were an estimated 386,000[11] Hib deaths among children under five. In addition, at least 20% of the children who survive Hib meningitis suffer from permanent disabilities such as brain damage and hearing loss, and have an increased risk of dying before the age of five.

In developing countries, Hib accounts for about five times as many cases of pneumonia as meningitis. Although the disease is treatable with antibiotics, the bacterium is showing increasing resistance to some of the most efficient antibiotics. Vaccines are considered the only way to prevent the disease.

In developed countries, widespread use of the Hib conjugate vaccine for more than a decade has virtually eliminated the disease. But Hib remains a major problem in many of the developing countries where the vaccine has not yet been introduced in routine immunization schedules. The disease is known to be a public health problem in many countries in Africa, the Americas and the Middle East, but the full extent of the disease burden in Asia and in the Central Asian Republics has not yet been established.

THE ROLE OF GAVI / VF

The Hib vaccine is generally accepted for use throughout Africa, the Americas and the Middle East. Countries, especially those in Asia and Europe, need to present their cases on the basis of evidence of Hib disease as a public health problem and on cost effectiveness.

GAVI / VF is working to ensure that Hib vaccine is available where needed in the 75 low-income countries which it supports.

This includes:

- country support to establish the burden of Hib disease so that countries can determine whether Hib vaccine should be a priority or not;
- support for the purchase of Hib vaccine (and safe injection equipment) for five years for all eligible countries (i.e., where DTP3 coverage is at least 50% and the disease is a country priority, based on burden of disease data), together with a one-off payment of US$100,000 to facilitate the introduction of the new vaccine;
- working with vaccine manufacturers to ensure that adequate and affordable supplies of Hib vaccine, including combination vaccines, are available in low-income countries where needed;

[11] WHO latest estimates.

- support to countries in developing a financial sustainability plan to ensure continued financing for Hib vaccine once GAVI funding stops.

PROGRESS

- By end-2004, almost 8.2 million children [12] under one year of age had been immunized against Hib disease through support from GAVI / VF.
- By end-2004, 10 countries had introduced the vaccine and an additional 5 countries had been approved to introduce it in the near future.
- 22 countries considered eligible for Hib vaccine support had applied for support but had not yet been approved for funding (as of end-2004).

Twelve GAVI / VF-supported countries are ineligible for funding - either because routine immunization coverage is too low or because they were already using Hib vaccine prior to the launch of GAVI.

CHALLENGES

A situation analysis and intensive country consultation carried out by GAVI in the second half of 2004 found that the burden of Hib disease was poorly understood, even in some of the countries which have recently introduced Hib vaccine with support from GAVI / VF. The study found that in 26 countries – which together account for the majority of the world's children – the burden of Hib disease is still unclear. In response, a four-year programme of support to help GAVI / VF-eligible countries make evidence-based decisions on whether to introduce or sustain Hib vaccination has been launched.

[12] WHO estimates and projections to end of 2004.

YELLOW FEVER VACCINE

Yellow fever

Yellow fever is a mosquito-borne viral hæmorrhagic fever which occurs in tropical regions of Africa and in the Americas – often in explosive epidemics involving heavy loss of life. WHO estimates that there are 200,000 cases of yellow fever every year and about 30,000 deaths. Most cases (90%) occur in Africa, where more than 500 million people are at risk in 33 countries. In the Americas, yellow fever is endemic in nine countries and in several Caribbean islands. Case fatality rates are highest among children and the elderly. No specific antiviral medicines exist to treat the disease.

A safe and highly effective vaccine against yellow fever has been available for more than 60 years. Since 1998, WHO has recommended that the vaccine should be introduced into routine immunization schedules in all at-risk countries. In addition, mass immunization campaigns are recommended among older age groups to prevent outbreaks of the disease. Immunization coverage of at least 80% nationwide is needed to prevent epidemics of yellow fever – a level that would take many years to achieve through routine childhood immunization alone. In the event of outbreaks of the disease, emergency immunization campaigns are also needed to contain the disease among populations that have not been immunized.

During the past few years control of yellow fever (both preventive campaigns and outbreak response) has been hampered by vaccines shortages - demand of yellow fever vaccine has been unpredictable due to the limited funding availability and consequently the low priority of this vaccine in the immunization programs of low income countries. A more recent challenge is a considerable increase in the price of the vaccine - yellow fever is a maturing product geared to a limited market segment with a relatively low production volume. Additionally, a competitive marketplace is difficult to attain. This is due in part to a change of vaccine presentation from 20-dose to 10-dose vials.

THE ROLE OF GAVI / VF

The yellow fever vaccine is accepted for use in Africa and the Americas, according to regional WHO recommendations, regardless of immunization coverage.

GAVI / VF provides yellow fever vaccine for use in: routine immunization; preventive mass campaigns among older age groups; and emergency outbreak response.

Yellow fever vaccine (together with safe injection equipment) is available for routine immunization in all GAVI / VF-eligible countries at risk for the disease.

In November 2002, the GAVI Board approved the establishment of a yellow fever vaccine stockpile of six million doses, to be used for preventive campaigns and loaned for outbreak response over a period of three years. In the event of a yellow fever outbreak, WHO assess the requests for emergency support in consultation with the International Coordination Group.

PROGRESS

Through support from GAVI / VF:

- by end-2004, more than 7.6 million children[13] had been immunized against yellow fever in 15 of the 28 countries eligible for GAVI / VF support for yellow fever vaccine[14];
- vaccine from the 2003 stockpile was used for emergency-campaigns during outbreaks in Sierra Leone (2003) and in Colombia and Liberia (both in 2004);
- phase I of the preventive mass vaccination campaigns using 6 million doses from the yellow fever vaccine stockpile was completed in Senegal and Guinea by the end of 2004. Phase II and preventive mass vaccination campaigns with an additional 6 million doses are planned for 2005.

SUPPORT FOR AFRICA MEASLES CAMPAIGNS COULD SAVE THE LIVES OF 1.8 MILLION CHILDREN

In December 2004, the GAVI Board recommended exceptional funding of US$50 million to reduce measles deaths in Africa and The Vaccine Fund Board approved this use of funds. WHO estimates that the time-limited support from The Vaccine Fund will save the lives of 1.8 million children. The funding will be used by the Africa Measles Partnership over the next five years to support measles immunization campaigns in nine high-burden countries as part of a long-term strategy of accelerated and sustained measles mortality reduction.

[13] WHO estimates and projections to end of 2004.

[14] In addition, eight countries provide yellow fever vaccine in routine childhood immunization without GAVI support, making a total of 82% (23/28) of the GAVI / VF eligible countries in 2004, compared to 36% (10/28) in the year 2000.

COMBINATION VACCINES

From the outset, the GAVI partners have promoted the use of combination vaccines – which include several vaccines in a single shot – because they are considered to be a more efficient way of delivering multiple vaccines, especially in developing countries. Although relatively more expensive, they minimize the number of injections needed during the first year of life, cut down on storage and waste disposal needs, and reduce the time it takes to fully immunize a child – a particular asset in low-income countries where trained health workers are often in short supply.

It was hoped that the initial high price of combination vaccines (tetravalent (DTP/HepB) and pentavalent (DTP/HepB/Hib)) would come down rapidly once a new guaranteed market was established in developing countries, the number of producers increased, and prices became more competitive. However, this process has been slower than anticipated. The problem was compounded by a shortage of the pentavalent vaccine which is currently produced by only one manufacturer.

A future drop in prices is now anticipated as demand increases and more suppliers enter the market. By 2004, at least two developing country manufacturers have licensed a tetravalent vaccine and another developing country manufacturer had licensed a pentavalent vaccine.

GUYANA

Guyana introduced the pentavalent (DTP/HepB/Hib) vaccine in late-2001 with support from GAVI / VF. Funding to support the introduction of the new vaccine (US$100,000) was used to provide training, to refurbish cold chain equipment in all 10 regions, and increase cold storage capacity at the national level.

Although high coverage was achieved in coastal areas, intensive outreach activities were needed to reach children in inaccessible hinterland areas. By end-2003, 90% of children targeted had been fully immunized before their first birthday. The Government of Guyana is co-financing the supply of the pentavalent vaccine – providing 45% of the cost in 2004 and 90% by 2007.

Accelerating the development and introduction of new vaccines

In addition to efforts to increase access to existing vaccines, the GAVI partners are also helping to accelerate the development and introduction of new vaccines with the potential to prevent more than 1 million deaths a year among children under five, mainly in developing countries. The approach – known as Accelerated Development and Introduction Plans (ADIPs) – is designed to spur increased research and development of priority new vaccines for developing country markets and to radically shorten the time it normally takes for these new products to reach children in the poorest countries.

The strategy recognizes that while lack of resources is a major reason why newly licensed vaccines are not available in low-income countries from the outset, it is not the only one. Inability to establish the burden of disease and the cost-effectiveness of a new vaccine, to use advocacy to promote the use of vaccines, to accurately forecast demand and to establish adequate and reliable sources of funding also contribute to the weakness of developing country markets.

In response, the ADIP teams are working with countries to establish the evidence base for the introduction of a new vaccine and at the same time working with vaccine manufacturers to establish market confidence and accelerate the development of the vaccines urgently needed in developing countries.

By end-2004, GAVI / VF had invested US$13.3 million in efforts to accelerate the development and introduction of vaccines against pneumococcal disease and rotavirus diarrhoea, which together account for more than 1 million deaths a year among children under five – mainly in developing countries. The pneumococcal and rotavirus ADIP teams are working with several vaccine manufacturers to accelerate the development of late-stage products. At the same time, they are working with developing countries to establish the burden of disease and the cost-effectiveness of introducing a new vaccine. The Pneumococcal ADIP is based at the Johns Hopkins Bloomberg School of Public Health in Baltimore in the United States and the Rotavirus ADIP (the Rotavirus Program) at the Seattle-based Program for Appropriate Technology in Health (PATH) in the United States.

Elsewhere, WHO and PATH are working in partnership with a developing country manufacturer, the Serum Institute of India Ltd. to accelerate the development of a new conjugate vaccine against meningococcal meningitis for use in sub-Saharan Africa. The Meningitis Vaccine Program, which is a public-private partnership initiative, has negotiated a price and supply agreement with the manufacturer for a conjugate meningococcal A vaccine.

PNEUMOCOCCAL VACCINE

Pneumococcal disease (caused by the bacterium *streptococcus pneumoniæ*) is a leading cause of child deaths worldwide – mainly due to pneumonia, meningitis or septicæmia. In the United States, a conjugate pneumococcal vaccine (Wyeth Lederle's Prevnar) that protects against seven of the more than 90 different sterotypes of the bacterium, has been successfully used since 2000. However, it does not include antigens against the two serotype (1 and 5) that are a major cause of disease in many developing countries. In the Gambia, a trial of a 9-valent Wyeth vaccine that included serotypes 1 and 5 showed promising results, published recently in the Lancet. Radiologically confirmed pneumonia was reduced by 37%, invasive pneumococcal disease by 50% hospital admissions by 15% and deaths from any cause by 16%. However, the manufacturer has no plans to market this 9-valent vaccine and is already working on the development of a 13-valent conjugate vaccine instead.

Another manufacturer, GlaxoSmithKline, is developing an 11-valent vaccine, which is being tested in the Czech Republic. The results of this trial is due in May 2005. Elsewhere, a trial of an 11-valent vaccine is under way in the Philippines, with the results due in mid-2005. However, Sanofi Pasteur which developed this candidate vaccine, has no plans to market the vaccine. It is anticipated that an 11-valent vaccine (including strains 1 and 5) could be licensed by 2008 and that by 2010 there may be at least two manufacturers of 11-13 valent vaccines.

During 2004, the activities of the pneumococcal ADIP included the launch of studies to establish local and regional evidence of pneumococcal disease burden, including the geographic spread of different serotypes of the bacterium and the incidence of antimicrobial resistance, and the development of models to estimate the cost-effectiveness of conjugate pneumococcal vaccines.

ROTAVIRUS VACCINE

Rotavirus is the most common cause of severe dehydrating diarrhoea in children worldwide. It accounts for about one-third of all hospital admissions for diarrhoea and for about 400,000 deaths [15] a year among children under five – mainly in developing countries. Although the disease occurs with similar frequency among young children in all countries, its impact is most severe in developing countries, where children often do not have rapid access to life-saving rehydration therapy.

A rotavirus vaccine developed by Wyeth Lederle (RotaShield) was licensed in the United States in 1998 but withdrawn within a year because it was associated with cases of intussusception (a telescoping bowel condition). Since then several manufacturers have renewed efforts to develop a new vaccine. In 2004, Rotarix, a live oral rotavirus vaccine, was licensed by GlaxoSmithKline in Mexico and the Dominican Republic. Meanwhile, trials of another live oral rotavirus vaccine (RotaTeq) developed by Merck & Co are currently under way, and a number of other candidate rotavirus vaccines are in the pipeline.

The Rotavirus Vaccine Program is generating the evidence base necessary to support the early introduction of rotavirus vaccines in GAVI / VF-eligible countries. Working with global public health institutions, Ministries of Health in developing countries, researchers, and manufacturers of late-stage rotavirus vaccines, the Program is generating critical information regarding disease burden, efficacy of rotavirus vaccines in impoverished settings, and the cost-effectiveness of the vaccines. Initial efforts to introduce rotavirus vaccines are focused on the GAVI / VF-eligible countries in Latin America (Bolivia, Cuba, Guyana, Haiti, Honduras and Nicaragua).

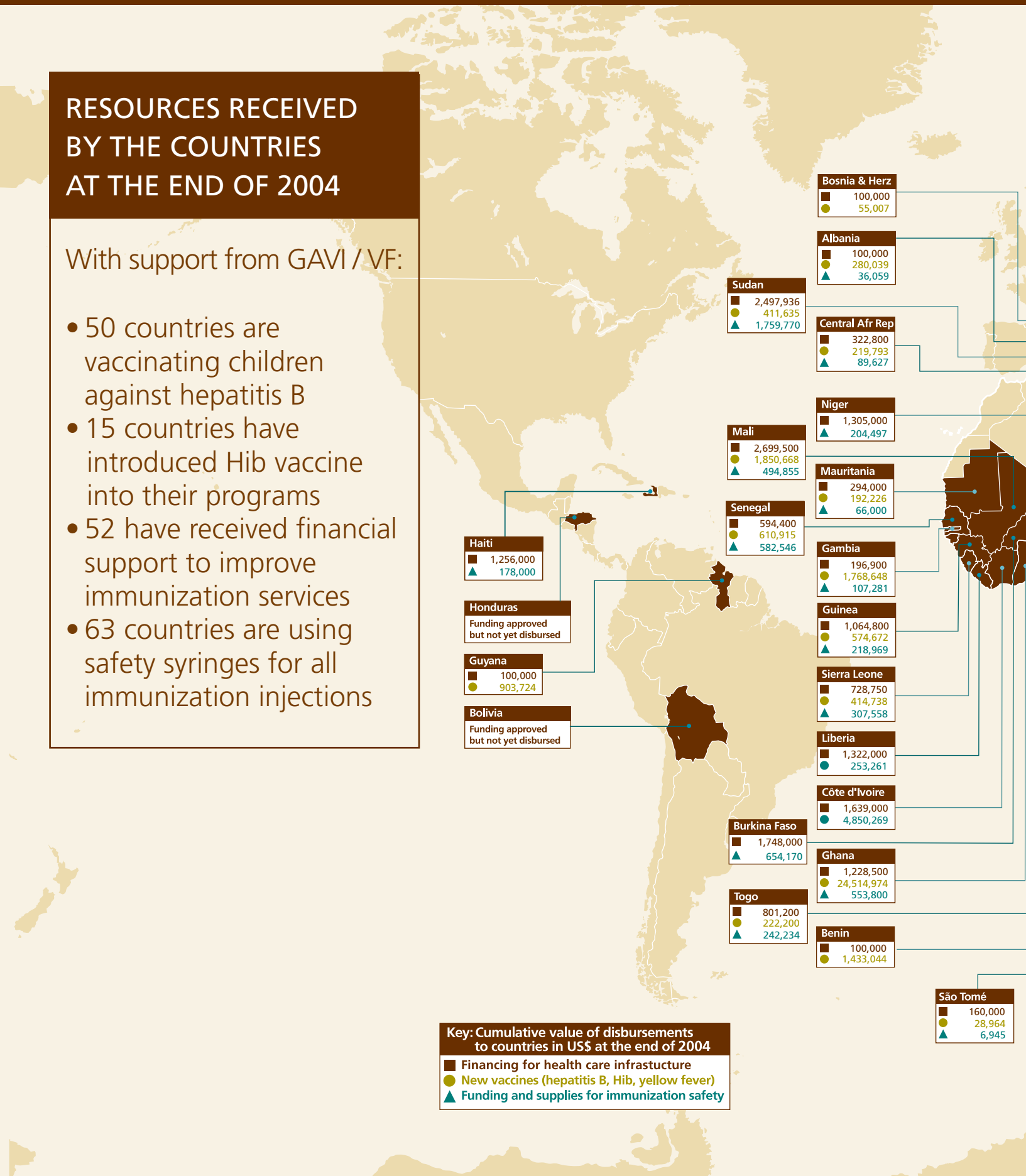
[15] Latest WHO/IVB estimate (2002).

INVESTMENT US$420 MILLION OUTCOM

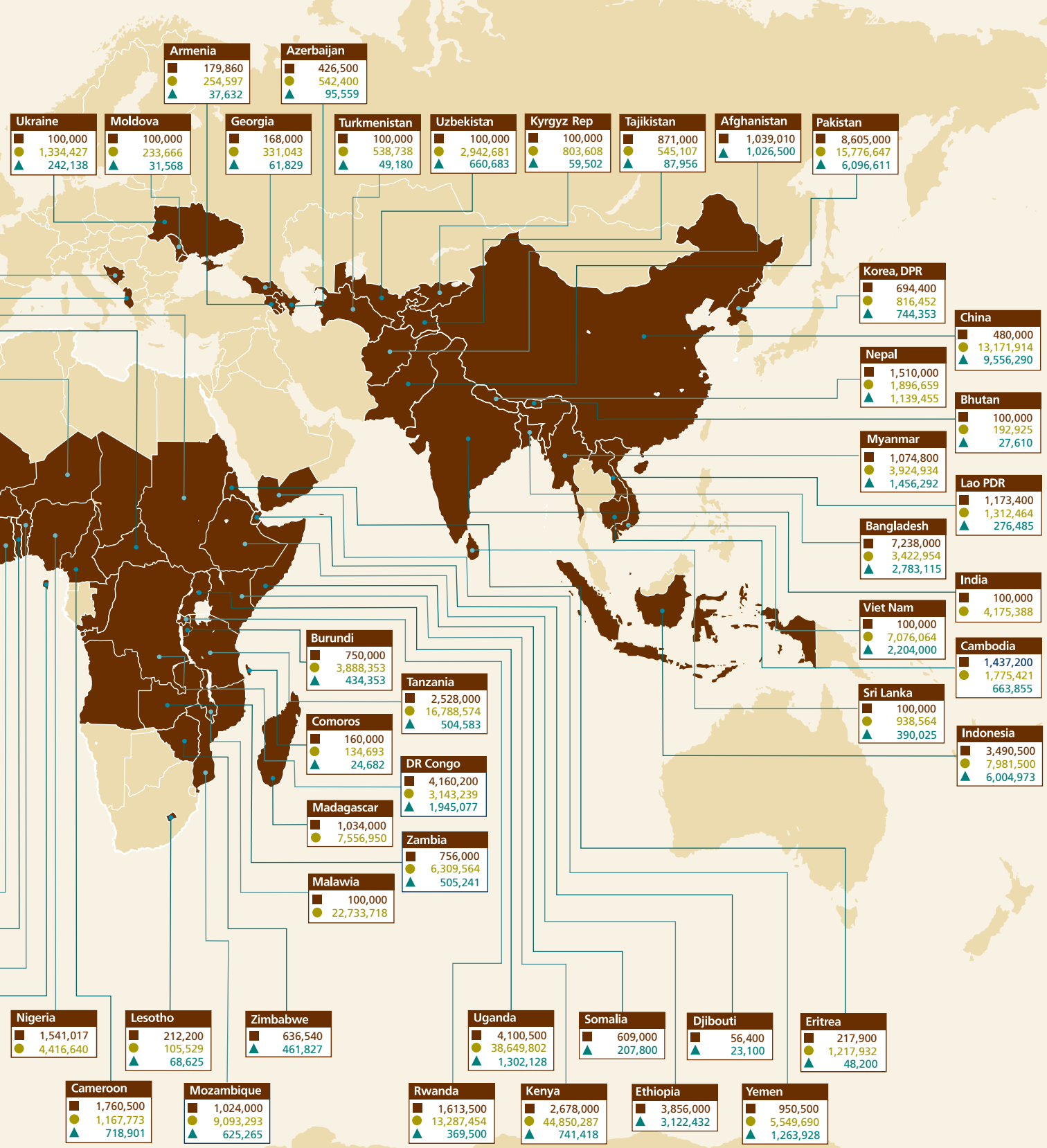
RESOURCES RECEIVED BY THE COUNTRIES AT THE END OF 2004

With support from GAVI / VF:

- 50 countries are vaccinating children against hepatitis B
- 15 countries have introduced Hib vaccine into their programs
- 52 have received financial support to improve immunization services
- 63 countries are using safety syringes for all immunization injections



ME: SAVING MORE THAN 670,000 LIVES



MENINGOCOCCAL A VACCINE

Meningococcal meningitis is occur in countries throughout the world and can arise in explosive epidemics, mainly in developing countries. In Africa, most cases occur in the so-called meningitis belt, a huge swathe of sub-Saharan Africa extending from Senegal in the west to Ethiopia and Somalia in the east.
Polysaccharide vaccines are available which protect against the four main disease-causing strains of the bacterium. Although these have only short-term immunity and are not very effective among children under two years, they are used during epidemics for mass campaigns to protect the populations at risk. There is considerable interest in the development and use of conjugate meningococcal vaccines which can protect young children and offer long-term immunity. A conjugate meningococcal vaccine has been successfully used in the United Kingdom but it protects against serotype C and not against serotype A which accounts for most cases of the disease in sub-Saharan Africa.

The Meningitis Vaccine Project aims to eliminate epidemic meningitis as a public health problem in sub-Saharan Africa through the development, testing, introduction and widespread use of conjugate meningococcal vaccines.

The conjugate meningococcal A vaccine now being developed by the Serum Institute of India Ltd. is the result of a transfer of technology (fermentation, purification and conjugation methods) to a developing country manufacturer. If successful, it could serve as a model for the development of other conjugate vaccines for use in developing countries. If licensed, the vaccine would be made available at about US$0.40 per dose (about the same price as the currently available meningococcal A/C polysaccharide vaccine), a price that has been negotiated by the Meningitis Vaccine Project. Phase 1 trials of this vaccine are due to start in early in India in 2005.


“We must close this “immunization gap” and begin to break this cycle of poverty to which it is connected.”

Sustainability

During the first five years, GAVI / VF support is strictly time-limited – usually over a period of five years. Countries are required to establish a plan for the continued financing of recurrent immunization costs, such as vaccines, once the funding period ends. During the second year of support, countries are expected to prepare a detailed Financial Sustainability Plan (FSP). Although self-sufficiency remains the long-term goal, in the shorter-term, the GAVI Board has defined financial sustainability as a country's ability to mobilize and use efficiently adequate and reliable sources of funding from both domestic and external sources. To support this process, GAVI has developed financial sustainability guidelines and tools to help countries develop their FSP. From 2006, GAVI will move to a longer time frame recognizing that five years is too short.

In Senegal, which introduced hepatitis B vaccine in 2004 with GAVI / VF support, the Government has committed to begin co-financing the supply of hepatitis B vaccine in 2006 - three years before GAVI / VF support ends. Under this five-year co-financing agreement, 1,440,000 children will be immunized with GAVI / VF support and an additional 816,000 children with support from the Government of Senegal and its partners.

PROGRESS

All 15 countries where GAVI / VF support for injection safety has now ended have already secured funding for continued injection safety support. Of the countries receiving GAVI / VF support for new vaccines, five plan to co-finance in 2005 their vaccine supply, including two (Mali and Yemen) which have opted to do so from the outset.

ANALYSIS OF FSPS

In 2004, the GAVI Financing Task Force, carried out a detailed analysis [16] of 22 FSPs submitted in 2003-2004 in order to assess future funding needs. This revealed that while overall spending on immunization has increased since the launch of GAVI / VF in 2000, the level of additional funding for immunization from both governments and donors has been lower than anticipated. As a result, many of the countries that have already introduced the newer and more expensive combination vaccines (especially the pentavalent vaccine) will have difficulty securing the level of resources needed to sustain the cost of these once GAVI / VF support ends after five years. This gap in funding has been exacerbated by the continuing high price of the newer combination vaccines.

In December 2004, the GAVI Board gave approval for the extension of support to countries that have already introduced the more expensive combination vaccines. This time-limited arrangement will be based on a co-financing agreement in which the cost of vaccines is shared between the government and GAVI / VF – a funding mechanism already adopted by some countries during the first phase of GAVI / VF support. The exact mechanisms for this and the financial implications will be decided by mid-2005.
The main findings from the FSP study involving 22 countries include:

Overall spending on immunization has increased.
Total resources available for immunization programmes increased by 47% and for routine immunization services by 61% between the year before and the year after GAVI / VF resources were made available.

Governments and partners are spending more on vaccines.
The share of government funding for routine immunization increased from 51% to 64% in the first few years after GAVI / VF resources were made available. Although international support for immunization rose by 17%, most of this was accounted for by supplementary immunization campaigns. Funding by partners for routine immunization increased by 9%.

The overall budget impact of immunization spending remains modest.
Despite increased spending on immunization, it accounts for a small share of total spending on health by governments and donors. This share has increased from 4% of government spending in the period before GAVI / VF support to 5.7% after support began.

[16] Lydon P. "Financial Sustainability Plan Analysis : A Look Across 22 GAVI Countries". World Health Organization, Mimeograph, 2004.

However, the relatively high cost of combination vaccines has a major impact on programme costs.

The findings suggest that the introduction of monovalent hepatitis B vaccine increases the cost of routine immunization by a factor 1.4, the tetravalent DTP/HepB vaccine by a factor of 2, and the pentavalent (DTP/HepB/Hib) vaccine by a factor of almost 3.

Vaccines account for an increasingly large share of national immunization programme costs.

In countries introducing underused vaccines, the cost of vaccines and injection supplies accounts for an increasing share of total programme costs – ranging from 18% in Armenia (monovalent hepatitis B vaccine) to 74% in Ghana (pentavalent vaccine). In the future, vaccines are likely to account for about 50% of programme needs on average (based on 2004 prices).

Accelerated disease control campaigns account for a large share of programme costs.

On average, vaccination campaigns against diseases such as polio and measles account for about one-third of total programme costs. In some countries, they account for more than half of programme costs.

Future financing is vulnerable.

The gap is growing between the resources needed and the funds secured to ensure continued funding for vaccines once GAVI / VF support ends. Although there have been modest increases in both government and donor spending on immunization, there is little sign in many countries that these will be enough to meet the significant increase in resource needs.

Mobilizing new and additional resources to reach more children

CLOSING THE FUNDING GAP

WHO estimates that US$8-12 billion will be needed to provide yellow fever, Hib and hepatitis B vaccines and to strengthen immunization services in the world's poorest countries from 2005 to 2015.

The goal of GAVI / VF during the coming decade is to continue to close the immunization gap between developed and developing countries—and to ensure that all children, rich or poor, have access to life-saving vaccines. This gap must be closed if the MDGs, particularly the fourth Goal focusing on reduction of child mortality, are to be achieved. Despite strong and growing support from governments and private donors — including 9 governments, the European Union (EU), the Bill & Melinda Gates Foundation and other private donors — additional resources are needed if this goal is to be met.

GAVI / VF and its partners are therefore exploring innovative new sources of financing to reach the resource mobilization objectives. In February 2004, The Vaccine Fund launched a three-year (2004-2006) global advocacy and fund-raising initiative: the Campaign for Child Immunization. Throughout the year, GAVI / VF also worked closely with their partners and the governments of the United Kingdom and France to explore the feasibility of an International Finance Facility for Immunization (IFFIm).

CONTRIBUTIONS RECEIVED AND PLEDGED BY END OF 2004

Millions of US$ (unaudited)	Total Received	Total Pledged
Canada	12.7	19.4
Denmark	4.5	0.0
European Union	1.3	17.3
France	6.0	12.1
Ireland	1.8	0.0
Netherlands	71.3	17.3
Norway	101.9	282.0
Sweden	12.5	14.0
United Kingdom	50.8	13.6
United States	218.7	65.0
Bill & Melinda Gates Foundation *	758.5	0
Other Private	4.0	0.9
Total Contributions	1,244.0	440.7

*Discussions regarding a new pledge of US$750 million from the Bill & Melinda Gates Foundation are underway.

THE CAMPAIGN FOR CHILD IMMUNIZATION

Chaired by Her Majesty Queen Rania Al-Abdullah of Jordan, the global Campaign for Child Immunization aims to raise the resources necessary to save the lives of at least 1 million additional children by 2006 by increasing access to vaccines and strengthening immunization services for the 27 million children in the world's poorest countries who currently lack them. The Campaign comprises a series of advocacy and fund-raising programmes organized by GAVI / VF and its civil society partners. The Campaign's fund-raising goal is to raise a total of US$400 million a year by 2006. The funds will be used to extend GAVI's support for new and underused vaccines and for the strengthening of health systems.

Vaccine Fund Board Member
Her Majesty Queen Rania Al-Abdullah of Jordan

The Campaign was launched in London in February 2004 by Her Majesty Queen Rania Al-Abdullah of Jordan, Jens Stoltenberg (former Norwegian Prime Minister and Leader of the Norwegian Labour Party) and Mary Robinson (former President of Ireland and Executive Director of the Ethical Globalization Initiative). It was attended by Paul Boateng, MP, the then-Chief Secretary to the Treasury.

Several events to advance the Campaign were organized throughout the succeeding months by The Vaccine Fund and its partners.

Vaccine Fund Board Member
Jens Stoltenberg

Vaccine Fund Board Member
Rita Süssmuth

Board members Rita Süssmuth, (former President of the German Bundestag) and Jens Stoltenberg took the Campaign to Berlin, Germany, on 30 June 2004. Thanks to strong support from Ms. Heidemarie Wieczorek-Zeul, German Federal Minister for Economic Cooperation and Development, the Berlin launch was attended by more than 60 Members of the German Parliament (Bundestag) as well as business and civil society leaders.

In September, GAVI / VF, the ADIPs and the Centre for International Health at the University of Bergen in Norway staged a two-day Seminar on Development and Deployment of Vaccines against Poverty-Related Diseases. In the course of the seminar, researchers and policy-makers reaffirmed their support for higher priority for child immunization within global health efforts. They urged national governments to increase their investments in the development of new vaccine technologies and strategies in an effort to speed up the development and delivery of urgently needed vaccines for developing countries. On 12 November 2004, a scientific symposium was held in Frankfurt, Germany, to build support for the Campaign among German industry, public health, academic and other civil society leaders. The one-day event, organized by GAVI / VF and the Stiftung Präventive Pädiatrie, a leading German foundation which advocates for child immunization worldwide, highlighted the need for additional resources to immunize children in the world's poorest countries. Additional Campaign events are planned for 2005 in venues including Barcelona, Spain, and Paris, France, for example.

Other events punctuated the year, such as The Vaccine Fund's participation in the World Vaccine Congress 2004 in Lyon, France, for example and the 4th World Congress on Vaccines and Immunization in Tokyo, Japan. The Vaccine Fund also participated in the 2004 OECD Forum which brought together political, business, international organization and civil society leaders to discuss priority global development issues such as the strengthening of health systems and immunization.

THE INTERNATIONAL FINANCE FACILITY (IFF)

The International Finance Facility (IFF) — proposed by UK Chancellor Gordon Brown and supported by France, Sweden and other governments — is an innovative financing mechanism designed to significantly increase the flow of development assistance in an effort to accelerate progress toward achievement of the MDGs. The aim is to make an additional US$50 billion a year available to the poorest countries between now and 2015 — "frontloading" the resources in order to improve the efficiency and cost-effectiveness of aid flows.

The IFF would use pledges of additional future aid from government donors to leverage capital from the international markets for immediate funding of development programmes in the poorest countries. The funds raised — which would be disbursed through existing bilateral and multilateral agencies and new global partnerships such as GAVI — would provide recipient countries with increased and predictable support to scale up development and poverty reduction efforts.

THE INTERNATIONAL FINANCE FACILITY FOR IMMUNIZATION

The principal goal of the proposed International Finance Facility for Immunization (IFFIm) is to save the lives of an additional five million children over the next decade and an additional five million adult lives as the children reached grow into adulthood by scaling up dramatically efforts by GAVI and its partners to increase access to available vaccines for children in the poorest countries and to strengthen the health systems necessary to deliver these and future vaccines. The resources generated by the proposed IFFIm would accelerate the current progress of GAVI and its partners and contribute to the achievement of the child mortality MDG.

THE MILLENNIUM DEVELOPMENT GOALS

The eight Millennium Development Goals (MGDs) are a commonly accepted framework for measuring development progress

- **MDG 1:** Eradicate extreme poverty & hunger
- **MDG 2:** Achieve universal primary education
- **MDG 3:** Promote gender equality & empower women
- **MDG 4:** Reduce child mortality
- **MDG 5:** Improve maternal health
- **MDG 6:** Combat HIV/AIDS, Malaria, and other diseases
- **MDG 7:** Ensure environmental sustainability
- **MDG 8:** Develop a global partnership for development

Financial comments

(commentary may include unaudited figures)

In 2000, the Global Alliance for Vaccines and Immunization (GAVI) was launched to radically improve access to vaccines in the 75 poorest countries of the world, and to strengthen their immunization services. GAVI's founding partners aimed to pool their collective skills and resources to improve child survival, using one of the most basic and cost-effective public health tools available—immunization. To finance its mission, the GAVI partners created The Vaccine Fund, and charged it with raising new resources for immunization and to provide GAVI recipient countries with multi-year grants.

Governments from Vaccine Fund-eligible countries[17] work with local partners to complete an application for support from The Vaccine Fund for periods which may extend up to 5 years. Applications are then submitted to the GAVI Secretariat and reviewed by the Independent Review Committee. The GAVI Board reviews the recommendations of the Independent Review Committee and submits its award recommendations to the Executive Committee of The Vaccine Fund for final decision and allocation of funds. The Vaccine Fund has the sole discretion to approve award recommendations for funding.

The Vaccine Fund's initial approval of the GAVI award recommendation does not create a commitment of The Vaccine Fund until it has determined whether the GAVI award recommendation will be funded directly from the Trust Account[18] and/or funded from assets of The Vaccine Fund 501(c)(3). The Vaccine Fund records a liability when both the funding source and amount (from The Vaccine Fund) is determined.

To date, the GAVI Board has approved US$1.4 billion in applications; this only includes applications approved during GAVI phase 1 (2000-2005) – and does not yet include applications associated with GAVI phase 2 – which will span from 2006 to 2015.

The GAVI Board approves applications for funding from eligible countries on a continuous basis.

The table below details how the US$1.4 billion is broken down among the different program areas of GAVI:

Programs in Millions of US$ (unaudited)	Approved as of 12/31/04	Disbursed as of 12/31/04
Immunization Services Support	342.8	73.8
New and Underused Vaccines	807.5	369.3
Injection Safety	88.5	63.5
Yellow Fever Stockpile*	12.5	12.6
Accelerated Development and Introduction Plans	660.0	13.4
Africa Measles Campaign	50.0	0.0
Hib Initiative	37.0	0.0
Total Contributions	1,398.3	532.6

*Disbursement figures are sourced from internally audited UNICEF 2004 annual report on The Vaccine Fund Trust Account at UNICEF.

Funds for approved GAVI programs are disbursed through the Trust Account at UNICEF – either to the Supply Division at UNICEF to fund the purchase of supplies or directly to countries. Since inception, the Trust Account has distributed US$533 million in funding against approved programs. The table above provides a breakdown of how these funds have been distributed.

Phase 1 approvals include a US$216 million firm commitment to purchase vaccines and related supplies that was entered into in December 2003. Remaining obligations associated with this commitment totaled US$155 million on December 31, 2004. This procurement-related obligation will be paid through 2006 and appears as an outstanding obligation on The Vaccine Fund's financial statements.

Funding from public or private donors is received directly into The Vaccine Fund, a 501(c) (3) incorporated in Washington State, USA – and its French affiliate, Le Fonds Pour les Vaccins de L'Enfance or into a separate Trust Account managed by UNICEF. The Trust Account aggregates funds received from both The Vaccine Fund and those received directly. All funds

[17] Any country that has a gross national income below US$1000 per capita is eligible for support from The Vaccine Fund.
[18] The Trust Account is a separate account managed by UNICEF.

received are then subsequently distributed either directly to eligible countries or to the Supply Division at UNICEF for the procurement of supplies.

Together, activity at The Vaccine Fund and the Trust Account paint a complete picture of the resources that have been raised and disbursed for GAVI. The consolidated financial statements found on pages 58 to 72 are for The Vaccine Fund, which includes the 501(c)(3) and its French affiliate. Because The Vaccine Fund does not manage the Trust Account, activity at the Trust Account is not included in The Vaccine Fund's consolidated financial statements.

As of December 31, 2004, the table below estimates how The Vaccine Fund's financial position could evolve should The Vaccine Fund fully approve the remaining applications endorsed by the GAVI Board.

In Millions of US$ as of 12/31/04 (unaudited)	
Estimated value of applications endorsed by GAVI	1,398
Funds disbursed by Trust Account since inception	(533)
Remaining applications endorsed by GAVI not yet funded	866
The Vaccine Fund Investment assets	(726)
Potential Under-funding of GAVI applications	(140)

Since inception, The Vaccine Fund has raised US$1,681 billion in pledged financial support for GAVI from public and private contributors. As of December 31, 2004, US$1.24 billion had been received and US$441 million was pledged and expected to be received. Discussions were underway with the Bill & Melinda Gates Foundation for another pledge of US$750 million. In 2004, US$165 million was received for GAVI programs. Of this total, US$85 million was received into the 501(c)(3) and US$80 million was received into the Trust Account at UNICEF. In addition to revenues that are generated by contributions, The Vaccine Fund maintains an active investment program to enhance the revenues available for GAVI. Since inception, The Vaccine Fund portfolio has generated US$87.2 million in investment income, net of fees. In 2004, the portfolio generated US$19.9 million in net investment income and a composite return of 3.05%. In 2003, the portfolio generated US$24.9 million in net investment income and a composite return of 3.53%. The Vaccine Fund's portfolio is invested in a diversified short-duration, high credit quality fixed income mandate. At December 31, 2004, The Vaccine Fund's investment portfolio totaled US$726 million.

The Board of The Vaccine Fund

GRAÇA MACHEL, CHAIR

Graça Machel, former first lady and minister of education in Mozambique, is widely recognized for her dedication to education and for her leadership in organizations devoted to the children of her war-torn country. She currently serves as chairperson of the Commonwealth Foundation, chancellor of the University of Cape Town, and president of the Foundation for Community Development. Machel is also a member of the Advisory Board of Disarmament Matters at the United Nations, where she has focused on the impact of armed conflict on children, and serves on the boards of the UN Foundation, the UN University and the South Centre.

NELSON MANDELA, BOARD CHAIR EMERITUS

Nelson Mandela was the first black president of South Africa and a legendary figure of the African National Congress (ANC). From 1964 to 1990, Mandela was imprisoned for opposing South Africa's white minority government and its policy of racial separation. In 1993, Mandela and the president who released him, F.W. de Klerk, shared the Nobel Peace Prize. Mandela was elected president of the Republic of South Africa in 1994 and served until 1999. He is the founder of The Nelson Mandela Children's Fund, which addresses the needs of marginalized youth.

HER MAJESTY QUEEN RANIA AL-ABDULLAH OF JORDAN

Her Majesty Queen Rania Al-Abdullah of Jordan serves as Chair of the global Campaign for Child Immunization. Queen Rania's activities encompass issues of international concern, such as the environment, youth, human rights, tourism, and culture among others. In 1995, she established the Jordan River Foundation (JRF), which aims to assist vulnerable segments of Jordan's population. Working closely with various international agencies and the Ministry of Social Development, Queen Rania oversaw the launching of the Child Abuse Prevention Project, the first of its kind in the Arab region. Queen Rania served as President of the Arab Women's Summit, a rotating position she held until November 2004. In addition, Queen Rania sponsors numerous events that promote economic growth as well as the educational, artistic, and cultural diversity of Jordan.

JULIAN LOB-LEVYT, GAVI EXECUTIVE SECRETARY, VACCINE FUND CHIEF EXECUTIVE OFFICER

Julian Lob-Levyt is Chief Executive Officer of The Vaccine Fund and Executive Secretary of the Global Alliance for Vaccines and Immunization (GAVI). Lob-Levyt brings a wealth of experience to the Alliance — both from his work at the international health policy level and from his extensive work in developing countries. Prior to this, Lob-Levyt, a UK national, worked for UNAIDS as Senior Policy Adviser to the Executive Director, Peter Piot. Before that appointment, Lob-Levyt was the Chief Health and Population Adviser (latterly Chief Human Development and Health Adviser) at the UK Department for International Development (DFID), with overall policy responsibility for health, population and HIV. Lob-Levyt represented the UK Government and donor constituencies as a member of the GAVI Board. He also represented the UK as a founding board member of the Global Fund to Fight TB, AIDS, and Malaria and has been involved in the provision of bi-lateral support to a range of public-private health initiatives such as the International AIDS Vaccine Initiative (IAVI) and the International Microbicides Partnership, as well as WHO programmes including Roll Back Malaria, STOP TB, and the lymphatic filariasis and guinea worm programmes. He was also closely involved in the work of the WHO Commission on Macroeconomics and Health, which reported in December 2001.

DWIGHT L. BUSH

Dwight Bush has been a Principal of Stuart Mill Capital, LLC, an Arlington, VA, based investment firm, since 1997. From 1999 through 2002 Bush also served as Chief Financial Officer of SatoTravel Holdings. From 1994 through 1997, Bush served as Vice President-Corporate Development of Sallie Mae Corporation, a US$60 billion financial service corporation, and the US leading provider of education credit. At Sallie Mae, Bush was responsible for mergers and acquisitions and business development, credit and investment policy, and investor relations. In addition, Bush was part of the senior management team responsible for the successful re-chartering of Sallie Mae as a fully privatized corporation. Previously, Bush worked for Chase Manhattan Bank as Managing Director, Project Finance and head of the Public Utilities Group.

MICHEL CAMDESSUS

Michel Camdessus is currently Honorary Governor of the Bank of France. He is also President Chirac's Personal Representative on Africa and has recently been appointed as the French representative for NEPAD (New Partnership for Africa Development). From January 1987 to February 2000 Camdessus served as Managing Director and Chairman of the Executive Board of the International Monetary Fund (IMF). Prior to his position with the Fund, Camdessus was appointed Deputy Governor of the Bank of France, (August 1984) and then Governor (November 1984). Camdessus held several positions in the French government; he started his political career as "Administrateur Civil" in the French civil service, and then joined the Treasury in the Ministry of Finance and Economic Affairs in 1960. From 1966 to 1968, he served as financial attaché to the French delegation at the European Economic Community in Brussels. Camdessus holds a postgraduate degree in economics from the University of Paris and is also a graduate of the Institut d'Etudes Politiques in Paris and the Ecole Nationale d'Administration (ENA).

JOCELYN S. DAVIS

Jocelyn Davis is currently head of the Nelson Hart LLC, a financial services consulting firm with specialized expertise in not-for-profit organizations, strategy development and implementation, governance, project management and staff development especially for senior managers and executives. She is also an Independent Trustee of the Allmerica Investment Trust and an Independent Member of the Investment Committee for the American Psychological Association. In 2001, she joined the Washington CPA firm of Beers & Cutler as Chief Operating Officer and from 1996 to 2001 she was Chief Financial Officer for AARP ("American Association of Retired Persons"), one of the largest not-for-profit organizations in the United States. Davis holds a BBA in Accounting and is a certified Public Accountant.

UFFE ELLEMANN-JENSEN

The Honourable Uffe Ellemann-Jensen is a former Minister for Foreign Affairs and a longstanding leader of the Liberal Party in Denmark and abroad. He was first elected to the Danish Parliament in 1977 and was the political spokesman of the Liberal Party from 1978 to 1982 before serving as the Minister for Foreign Affairs from 1982-1993. Over the course of his political career, he has served as National Chairman of the Liberal Party ("Venstre"), President of the European Liberal Party - European Liberal, Democratic and Reform Party, and Vice-president of Liberal International. He remains very active in foreign affairs and human rights and is currently the Chairman of the Foreign Policy Society in Denmark, the Baltic Development Forum, INTERFORCE Committee, and the Danish Centre for International Studies and Human Right as well as a trustee of the International Crisis Group. Ellemann-Jensen has authored a number of books on economics and politics and received several international awards, including the Robert Schuman Prize (1987), the Hansa Prize (1992), and the Ebbe Munk Prize (2002).

RICHARD D. KLAUSNER

Richard D. Klausner directs the Bill & Melinda Gates Foundation's Global Health program, whose overarching goal is to improve global health equity. Klausner previously served as Director of the National Cancer Institute (NCI) where he led one of the world's largest research and health agencies creating successful national and international programs aimed at applying science and technology to improving the public health. In addition, Klausner has served as a Senior Fellow at the National Academies of Science, Advisor to the Presidents of the Academies for counter-terrorism, and liaison to the White House Office of Science and Technology Policy. Klausner is well known for his work in cell and molecular biology and has served as chief of the cell biology and metabolism branch of the National Institute of Child Health and Human Development. He has also served on numerous advisory committees and is the past president of the American Society for Clinical Investigation. He is the author of several scientific publications, and has received numerous awards and honours. He is a member of the National Academy of Sciences and the Institute of Medicine. Klausner received his undergraduate degree from Yale University and his medical degree from Duke University. After post-graduate medical training at Harvard, he began his research career at the National Institutes of Health.

CHARLES J. LYONS

Charles J. "Chip" Lyons was appointed president of the U.S. Fund for UNICEF in 1997. In that capacity, Lyons is responsible for raising American public awareness of children's needs around the world and the work of UNICEF. Before assuming this position, Lyons served in a variety of roles with UNICEF, including chief

of staff to the executive director. Lyons serves on the boards of Baby-Friendly USA, an organization working to promote breast-feeding as the optimal care for babies, and Rugmark USA, an organization working to reduce exploitative child labour in the carpet industry.

MARY ROBINSON

Mary Robinson is the Executive Director of the Ethical Globalization Initiative. She served as United Nations High Commissioner for Human Rights from 1997 to 2002 and as President of Ireland from 1990-1997. She is a founder member and incoming Chair of the Council of Women World Leaders. Before her election as President, Robinson served as Senator, holding that office for 20 years. In 1969 she became Reid Professor of Constitutional Law at Trinity College, Dublin and now serves as Chancellor of Dublin University. She was called to the bar in 1967, becoming a Senior Counsel in 1980 and a member of the English Bar (Middle Temple) in 1973. Educated at Trinity College, Robinson also holds law degrees from the King's Inns in Dublin and from Harvard University.

MSTISLAV ROSTROPOVICH

Mstislav Rostropovich is the most esteemed cellist of his generation and a relentless defender of human rights. Born in Azerbaijan, he studied and later taught at the Moscow Conservatory. In 1974 Rostropovich and his wife left the USSR, and in 1978 their citizenship was revoked. Having immigrated to the United States, he became music director of the National Symphony Orchestra in Washington, D.C., a position he held from 1977 to 1994. Rostropovich has given benefit concerts to aid earthquake victims, and undertaken fundraising efforts for the first modern, fully equipped children's hospital in Moscow. In 1974 he received the Annual Award of the International League of Human Rights and in 1985 the Albert Schweitzer Award.

AMARTYA SEN

Amartya Sen is a Nobel Prize-winning economist whose contributions to the field of welfare economics have helped explain the causes of famine, inequality and poverty. Sen taught at Harvard University, the London School of Economics, Oxford and New Delhi University before becoming head of Trinity College in Cambridge, England. He is the author of numerous books, including Poverty and Famine: An Essay on Entitlement and Deprivation and Collective Choice and Social Welfare. Sen is the recipient of the Alan Shaw Feinstein World Hunger Award, the Jean Mayer Global Citizenship Award, the Indira Gandhi Gold Medal Award of the Asiatic Society and the Edinburgh Medal.

JENS STOLTENBERG

Jens Stoltenberg started his political career in 1979 with the Norwegian Labour Youth League. He became chairman of the Labour Youth League in 1985, a position he held until 1989. He was elected to the Norwegian Parliament in 1991 and became Deputy-Chairman of the Norwegian Labour Party a year later. Throughout the 1990's, he held key portfolios in the Norwegian government, ranging from State Secretary for the Environment to Minister of Finance, before becoming Norway's Prime Minister in 2000. Stoltenberg is currently Chairman of the Labour Party parliamentary group.

RITA SÜSSMUTH

Rita Süssmuth is a member of the Global Commission on International Migration. She served for 10 years (1988-98) as President of the German Bundestag. Prior to this, she was a Minister in the German Government (1986-88) with the portfolio for health, youth, family and women. Since 1971 she has been a member of various federal commissions and advisory committees on social issues. She received a number of honorary doctorate awards from universities worldwide, including Hildesheim University, Ruhr University and Johns Hopkins University. Süssmuth is currently serving as the Commissioner of the Global Commission on International Migration.

GEORGE W. WELLDE

George W. Wellde, Jr. is the Head of North American Sales for Fixed Income, Currency and Commodities at Goldman, Sachs and Co. He has worked in fixed income sales since joining the Goldman Sachs Group in 1979. Prior to his current responsibilities, Wellde was the branch manager of Goldman Sachs' Tokyo office. Previously, he worked at the Federal Reserve Board and Union First National Bank in Washington, D.C.

• **Governments in developing countries** deliver immunization services to children through their national health systems. Government health ministries manage national coordination – usually through Inter-Agency Coordinating Committees – which have become essential to the work of GAVI.

• **Vaccine manufacturers in developing countries** produce vaccines at affordable prices for sale in the developing world. A new GAVI-inspired network was formed to strengthen collaboration among vaccine manufacturers in developing countries.

• **Governments in industrialized countries** help to build political commitment and establish health as a priority for development assistance. Donor governments support countries in their efforts to improve health and immunization programs by participating in national coordinating groups and providing financial and/or technical support to health sectors and immunization programs.

• **Vaccine manufacturers in industrialized countries**, represented by IFPMA – the International Federation of Pharmaceutical Manufacturer's Associations – have been GAVI partners since its inception, and currently the membership includes Aventis-Pasteur, Berna Biotech, Chiron,GlaxoSmithKline, Merck and Wyeth. The development, manufacturing and marketing of vaccines to all countries of the world are core responsibilities of these member companies.

• **The Bill & Melinda Gates Foundation** invests in global health efforts, especially in support of immunization, and helps raise awareness of the value of immunization. The Foundation has committed more than US$1 billion to projects focused on the prevention and control of infectious diseases. These grants help to build coalitions among scientists, universities, nongovernmental organizations and private industry to ensure that all children have access to vaccines and that new drugs, vaccines and diagnostics are developed and delivered.

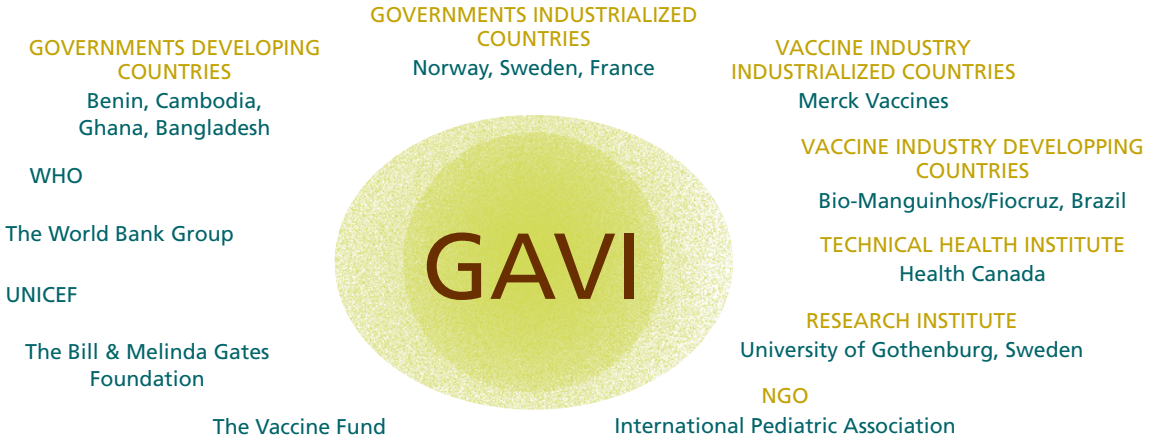
• **Nongovernmental organizations – NGOs** – have a long history of involvement in the field of child health and immunization. Some NGOs provide technical advice and staff to government programs while others provide additional financial support.

• **Public health and research institutions** provide policy recommendations on global immunization practices, act as reference laboratories for surveillance and quality control and provide technical staff for operations to help build capacity for research and development.

• **The World Bank Group** works to reduce poverty through increased financing to combat communicable diseases and increase immunization through more flexible use of International Development Assistance funds. Immunization is now a key health service indicator in the assessment of a country's eligibility for debt-relief under the Highly Indebted Poor Countries (HIPC) initiative.

• **UNICEF** has been a significant actor in the global effort to protect the health of the world's children through routine immunization. Immunization 'Plus' is one of its organizational priorities. UNICEF hosts the GAVI Secretariat in Geneva, Switzerland; provides administrative support to The Vaccine Fund – disbursing The Vaccine Fund grants to countries – and procures vaccines and safe injection supplies on behalf of GAVI partners.

• **World Health Organization**, the world's leader in global public health, provides technical expertise and strategic support to the alliance. Furthermore, WHO staff in the field play a critical role in support of GAVI objectives.



GAVI: AN INNOVATIVE PUBLIC-PRIVATE PARTNERSHIP

Glossary

YELLOW FEVER

Yellow fever is an acute mosquito-born infectious disease that can kill more than half its victims during an epidemic. The disease is characterized by the sudden onset of fever, chills, head, back and muscle pain, nausea and vomiting. These may progress to jaundice, bleeding, kidney and liver failure and symptoms may lead to death in seven to 10 days.

Yellow fever hits hardest in the countries of sub-Saharan Africa. According to the World Health Organization (WHO), the disease is endemic in 33 African countries, which house a total population of 468 million people. WHO estimates that yellow fever strikes 200,000 people each year, resulting in 30,000 fatalities. The disease is a major public health issue in tropical and sub-tropical areas of Asia and South America.

There is no specific drug treatment effective against yellow fever and the most cost-effective approach to controlling the disease is to incorporate vaccination into routine national immunization programs.

The live, attenuated virus vaccine against yellow fever is safe and highly effective. More than 90 percent of children vaccinated develop immunity to the disease for up to 10 years. Children older than nine months can be vaccinated.

Even though WHO has recommended the incorporation of yellow fever vaccine into routine immunization programs, it appears that there are still wide gaps in coverage. Another issue is the lack of yellow fever vaccine product, which has hampered immunization efforts. Although the vaccine is relatively inexpensive, there has been little coordination with the pharmaceutical industry to ensure its continual availability. The Vaccine Fund, through its partnership with the Global Alliance for Vaccines and Immunization (GAVI) and the pharmaceutical companies, aims to create a strategy for the long-term availability of products such as yellow fever vaccine.

HÆMOPHILUS INFLUENZÆ TYPE B (HIB)

Hæmophilus influenzæ type b (Hib) is a major cause of childhood bacterial meningitis (inflammation of the membranes covering the brain) and a variety of serious and potentially life-threatening infections, including pneumonia, epiglottitis, osteomyelitis, septic arthritis and sepsis in infants and older children.

Children between four and 18 months of age are usually the hardest hit by this deadly disease. Pneumonia and meningitis, the most important manifestations of Hib disease, are mainly seen in children less than five years of age. Acute respiratory infections caused by Hib particularly affect the developing world, resulting in two to three million cases of Hib pneumonia every year. Hib is estimated to cause at least three million cases of serious disease and anywhere from 400,000 to 700,000 deaths annually worldwide.

Children can easily spread Hib bacteria. The disease is spread through sneezing, coughing or close contact with an infected person. A person can be carry the Hib bacteria without showing any symptoms, but can still infect others.

There are several Hib conjugate vaccines available. All have shown to be safe and effective in preventing Hib in early infancy and childhood. Hib vaccines are now used as part of routine childhood vaccination programs in more than 20 countries including Canada, the United States, Australia and New Zealand, and many countries of Western Europe. As a result, Hib has largely disappeared from Western Europe, the United States, Canada and Australia. Before an effective vaccine became available, there were an estimated 20,000 invasive Hib infections per year in the United States, with up to 1000 deaths. The number of reported cases has dropped precipitously, particular since 1990. In 1995, about 259 invasive Haemophilus cases were reported among children less than five years old.

To date, Hib vaccines have not been widely used in the developing world. However, use of the vaccine in studies or immunization programs in Chile, Uruguay and Gambia have shown it to be safe and effective. The Vaccine Fund provides funding for Hib vaccines in regions of the world where the disease is documented as being widespread and deadly, such as Africa.

Information supplied by the World Health Organization and the Meningitis Foundation of America.

HEPATITIS B

The hepatitis B virus (HBV) is a leading cause of hepatitis, an inflammation of the liver that can lead to chronic illness and, eventually, death. HBV is the most serious type of viral hepatitis and the only type that causes chronic hepatitis for which a vaccine is available.

Hepatitis B is a worldwide public health problem. According to the World Health Organization (WHO), of the two billion people who have been infected with hepatitis B, an estimated 350 million have developed a chronic infection. At least 900,000 people chronically infected with the hepatitis B, and C virus die each year from cancer of the liver and cirrhosis.

Although anyone is susceptible to HBV, infants and children are considered to be more at risk of infection. About 90 percent of infants infected during the first year of life, and 30 to 50 percent of children infected from ages one to four, develop lifelong infections. One in four children who become chronic carriers of the disease will die of HBV-related liver cancer or cirrhosis years later.

In most of the developing world, including sub-Saharan Africa, most of Asia and the Pacific, most people become infected with HBV during childhood and 8 to 10 percent of the population become chronically infected. In these regions, liver cancer caused by HBV is among the three leading causes of cancer death in men.

Hepatitis B virus is transmitted by contact with blood or body fluids of an infected person in the same way as human immunodeficiency virus (HIV), the virus that causes AIDS. However, HBV is 50 to 100 times more infectious than HIV. Worldwide, most infections occur from infected mother to child, from child to child contact in household settings, and from reuse of unsterilized needles and syringes. In many developing countries, almost all children become infected with the virus.

The hepatitis B vaccine has been available since 1982 and more than 1 billion doses have been safely administered. The vaccine, given in a series of three doses, is 95 percent effective when administered properly. Since 1991, WHO has called for all countries to add hepatitis B vaccine into their national immunization programs. As of March 2000, 116 countries had included hepatitis B vaccine in their national programs. Given that it helps prevent liver cancer, the hepatitis B vaccine is often considered to be the world's first anti-cancer vaccine.


“Our campaign goal is to raise US$400 million per year from 2004 to 2006.”

The Vaccine Fund

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors of
The Vaccine Fund

In our opinion, the accompanying consolidated statement of financial position and the related consolidated statement of activities and consolidated statement of cash flows present fairly, in all material respects, the consolidated financial position of the Vaccine Fund (the Fund) and le Fonds pour les Vaccins de l'Enfance (the Association) (consolidated, The Vaccine Fund) as of December 31, 2004, and the changes in its net assets and its cash flows for the year then ended, in conformity with accounting principles generally accepted in the United States of America. These consolidated financial statements are the responsibility of The Vaccine Fund's management; our responsibility is to express an opinion on these consolidated financial statements based on our audit. The prior year summarized comparative information has been derived from The Vaccine Fund's 2003 consolidated financial statements, and in our report dated, March 17, 2004, we expressed an unqualified opinion on those consolidated financial statements. We conducted our audit of these statements in accordance with auditing standards generally accepted in the United States of America which require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

PricewaterhouseCoopers LLP

May 5, 2005

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

December 31, 2004 and 2003

	2004	2003
ASSETS		
Cash:	$ 1,087,974	$ 2,700,484
Accounts receivable	23,592	283,403
Interest receivable	4,199,649	4,533,274
Prepaid expenses	3,926,867	2,651,503
Promises to give	869,332	1,465,266
Fixed assets	1,811,341	2,282,988
Investments	726,068,690	677,660,036
Total Assets	**$ 737,987,445**	**$ 691,576,954**
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable and accruals	$ 7,562,436	$ 2,808,047
Refundable advances	-	148,750
Grants payable	35,532,548	-
Commitment to fund future procurement	155,013,300	215,283,176
Total Liabilities	**198,108,284**	**218,239,973**
Net Assets :		
Unrestricted	538,866,886	471,871,715
Temporarily restricted	1,012,275	1,465,266
Total Net Assets	**539,879,161**	**473,336,981**
Total Liabilities and Net Assets	**$ 737,987,445**	**$ 691,576,954**

The accompanying notes are an integral part of these consolidated financial statements.

The Vaccine Fund

CONSOLIDATED STATEMENTS OF ACTIVITIES

for the Years Ended December 31, 2004 and 2003

	2004	2003
UNRESTRICTED NET ASSETS		
Revenues:		
Contributions	$ 84,966,494	$ 61,789,802
Investment income, net of related investment management fees	19,890,480	24,903,544
Foreign currency translation adjustment	(399,422)	(10,321)
Other	165,170	519,638
Release of net assets	**791,000**	**625,000**
Total Revenues	**105,413,722**	**87,827,663**
Expenses:		
Program	58,395,433	387,482,912
Management & general (including Convergence-related expenses)	10,663,323	3,864,735
Fundraising	**5,882,359**	**5,115,075**
Total Expenses	**74,941,115**	**396,462,722**
Change In Unrestricted Net Assets	**30,472,607**	**(308,635,059)**
TEMPORARILY RESTRICTED NET ASSETS		
Contributions	338,009	1,017,987
Release of net assets	(791,000)	(625,000)
Change in Temporarily Restricted Net Assets	**(452,991)**	**392,987**
Total Change in Net Assets Before Release of Commitment to Future Procurement	**30,019,616**	**(308,242,072)**
Release of commitment to future procurement	36,522,564	-
Total Change in Net Assets	**66,542,180**	**(308,242,072)**
Net Assets, Beginning of Year:		
Unrestricted	471,871,715	780,506,774
Temporarily restricted	**1,465,266**	**1,072,279**
Total Net Assets, Beginning of Year	**473,336,981**	**781,579,053**
Net Assets, End of Year:		
Unrestricted	538,866,886	471,871,715
Temporarily restricted	**1,012,275**	**1,465,266**
TOTAL NET ASSETS, END OF YEAR	**$ 539,879,161**	**$ 473,336,981**

The accompanying notes are an integral part of these consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS

for the Years Ended December 31, 2004 and 2003

	2004	2003
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets:	$ 66,542,180	$ (308,242,072)
Adjustments to reconcile change in net assets to net cash provided by operating activities :		
Depreciation	1,131,390	221,031
Gains on sale of fixed assets	-	(49,557)
Realized and unrealized losses on investments	116,790	2,085,037
Change in Assets and Liabilities:		
Decrease (increase) in accounts receivable	259,811	(276,550)
Decrease (increase) in interest receivable	333,625	(296,925)
Increase in prepaid expenses	(1,275,364)	(555,115)
Decrease (increase) in promises to give	595,934	(392,987)
Increase in accounts payable	4,754,389	1,724,609
(Decrease) increase in refundable advances	(148,750)	148,750
Increase in grants payable	35,532,548	-
(Decrease) increase in procurement commitment	(60,269,876)	215,283,176
Net Cash Provided by/(Used in) Operating Activities	**47,572,677**	**(90,350,603)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of fixed assets	(659,743)	(2,291,550)
Proceeds from sale of fixed assets	-	101,374
Purchase of investments	(2,707,464,146)	(6,236,720,346)
Sale of investments	2,658,938,702	6,322,233,543
Net Cash (Used in)/Provided by Investing Activities	**(49,185,187)**	**83,323,021**
Net Change in Cash	**(1,612,510)**	**(7,027,582)**
Cash, Beginning of Year	2,700,484	9,728,066
Cash, End of Year	**$ 1,087,974**	**$ 2,700,484**
Non-cash		
Release of commitment to future procurement	$ 36,522,564	$ -

The accompanying notes are an integral part of these consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 - NATURE OF OPERATIONS

The Vaccine Fund is a charitable nonprofit organization established to provide newer vaccines and the means to deliver such vaccines to the children of the world, beginning in those countries where the need for immunization is great and the likelihood of success is high. The Vaccine Fund (the Fund) was incorporated on October 26, 1999, under the laws of Washington State and the United States of America. During 2001, the Fund changed its name from Global Fund for Children's Vaccines to The Vaccine Fund.

In 2001, le Fonds pour les Vaccins de l'Enfance (The Fund for Children's Vaccines), a French association (the Association), was registered in Lyon, France. The purpose of the Association is to contribute to the achievement of the Fund's mission. The Fund is a member ex officio of the Board of Directors of the Association and elects its other members.

The consolidated entities' (referred to as The Vaccine Fund) efforts in furtherance of their charitable purposes are to raise funds from a variety of sources, including the public sector, US Government, and International Governments, to champion the cause of the Global Alliance for Vaccines and Immunization (GAVI). GAVI is a public private partnership created in 1999 with a mission to save children's lives and protect people's health in developing countries through the widespread use of safe vaccines. Members of GAVI include the World Health Organization (WHO), the United Nations Children's' Fund (UNICEF), the World Bank, the Bill & Melinda Gates Foundation, governmental development agencies of the world, technical agencies, and the pharmaceutical industry.

The GAVI Board provides broad strategic direction, including decisions on shared objectives, strategies, and plans, for the partnership. The GAVI Board is supported by a small Secretariat based in Geneva, Switzerland, which coordinates activities among GAVI partners. Among the GAVI Board's duties that directly impact The Vaccine Fund are its review and approval of multi-year program budgets for supplies or cash grants that it recommends to The Vaccine Fund for financial approval. In 2002, The Vaccine Fund became a Board member of GAVI.

UNICEF is a GAVI member with which The Vaccine Fund has a strategic relationship. UNICEF is a key player in the vaccine market and is estimated to purchase 40 percent of the global volume of vaccine doses. Because UNICEF has an established internal mechanism for vaccine supply procurement and distribution, it fulfills these functions on behalf of The Vaccine Fund. In addition, in October 2000, UNICEF established a Trust Account (known as the Vaccine Fund Trust Account) at UNICEF into which international government donations and contributions from the Vaccine Fund would be received. Under the relationship agreement between The Vaccine Fund and UNICEF, funds held at the Trust Account are held in trust on behalf of the donors in order to support GAVI initiatives. UNICEF then facilitates the financial and supply transactions on behalf of GAVI and The Vaccine Fund. Note 3 provides additional information regarding The Vaccine Fund's relationships with UNICEF and GAVI.

NOTE 2 - SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The Vaccine Fund accounts for revenues and expenses on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

Basis of Consolidation

The accompanying consolidated financial statements include the accounts of the Fund and the Association for the years ended December 31, 2004 and 2003. All inter-entity balances and transactions have been eliminated in consolidation.

The Vaccine Fund

Basis of Presentation

Net assets, revenues, gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of The Vaccine Fund and changes therein are classified and reported as follows:

Unrestricted net assets

Net assets that are not subject to donor-imposed stipulations.

Temporarily restricted net assets

Net assets subject to donor-imposed stipulations that are expected to be met either by actions of The Vaccine Fund and/or the passage of time.

Permanently restricted net assets

Net assets subject to donor-imposed stipulations that must be maintained permanently by The Vaccine Fund. As of December 31, 2004 and 2003, The Vaccine Fund did not have any permanently restricted net assets.

Revenues are reported as increases in unrestricted net assets unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets unless their uses are restricted by explicit donor stipulation. Expirations of temporary restrictions on net assets (i.e., the donor-stipulated purpose has been fulfilled and/or the stipulated time period has elapsed) are reported as reclassifications between the applicable classes of net assets. Contributions with donor-imposed restrictions that are met in the same year as received are reported as revenues of the unrestricted net asset class.

Cash

For purpose of reporting cash flows, The Vaccine Fund considers all cash accounts with a maturity of three months or less which are not subject to withdrawal restrictions or penalties to be cash. Cash held in The Vaccine Fund's investment portfolio, which is managed by external advisors, is reported in the Consolidated Statements of Financial Position as investments.

Investments

Investments are valued at fair market value based on published quotations. All gains and losses on investments are reported in the Consolidated Statements of Activities as increases or decreases to unrestricted net assets since the earnings from these investments are not restricted to any specific use other than to fulfill The Vaccine Fund's general mission.

Fair Value of Financial Instruments

The fair values of financial instruments are estimated using available market information and other valuation methodologies in accordance with generally accepted accounting principles. The estimates presented are not necessarily indicative of the amounts that The Vaccine Fund may ultimately realize in a current market exchange. The fair value of financial instruments for which estimated fair value amounts have not been specifically presented is estimated to approximate the book value.

Promises to Give

Unconditional promises to give to be collected within one year are recorded at net realizable value. Unconditional promises to give to be collected in future years are recorded at the present value of their estimated future cash flows using discount rates approximating the risk free rate of return on U.S. government securities with similar maturities. Conditional promises to give are recorded when the conditions are met.

Furniture, Equipment and Leasehold Improvements

Furniture, equipment and leasehold improvements are stated at cost for purchased assets or estimated value at date of receipt for donated assets. Depreciation for furniture and equipment is provided using the straight-line method over the estimated useful lives of three to five years. Depreciation for leasehold improvements is provided using the straight-line method over the shorter of the asset's useful life or the term of the lease. The Vaccine Fund's threshold for capitalization of furniture, equipment, and leasehold improvements is $5,000.

Grants Payable

Grants payable are recognized when the commitment is made and approved by The Vaccine Fund. Grants payable within one year are recorded at net realizable value. Grants payable in future years are recorded at the present value of their estimated future cash flows using discount rates that approximate the risk free rate of return on U.S. government securities with similar maturities.

Costs Associated with Exit or Disposal Activities

The Vaccine Fund records expenses associated with the convergence, as discussed in Note 14, in accordance with Statement of Financial Accounting Standards (SFAS) 146; *Accounting for Costs Associated with Exit or Disposal Activities*. Termination benefits provided to employees are recorded when management commits to a termination plan with specific details and communicated to employees. Costs under remaining terms of outstanding contracts and leases are recorded at fair value when they are terminated. Other operating costs, including those to consolidate facilities or relocate employees, are recorded when the liability is incurred.

Allocation of Functional Expenses

The costs of providing various programs and other activities have been summarized on a functional basis in the Consolidated Statements of Activities. Accordingly, certain costs have been allocated among program activities and supporting services as shown on the supplemental Consolidated Statements of Functional Expenses.

Use of Estimates

The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Federal Income Taxes

The Fund is exempt from federal income taxes under Internal Revenue Code Section 501(c)(3). As of December 31, 2004 and 2003, the Fund was not a private foundation under Section 509(a) of the Code because of the advanced ruling period granted by the IRS. In 2004, the Fund received its final determination of non-private foundation status from the IRS.

Vulnerability to Certain Concentrations

Financial instruments that potentially subject the Fund to concentrations of credit risk consist of deposits in banks and investments in excess of the Federal Deposit Insurance Corporation and other privately insured limits. The Fund invests its excess cash in money market and debt instruments and has established guidelines relative to diversifications and maturities aimed at maintaining safety and liquidity. The portions of cash that were uninsured as of December 31, 2004 and 2003 approximated $641,000 and $2,741,000, respectively. The Vaccine Fund has not experienced any credit losses on these financial instruments in past years.

For the years ended December 31, 2004 and 2003, 70 and 92 percent, respectively, of The Vaccine Fund's contribution revenue is from one U.S. government agency. Management is aware of the related vulnerability. Concentrations of credit risk with respect to "promises to give", i.e. contributions receivable, consists of 3 individual donor pledges of which 70 percent is due to be received in fiscal year 2005. The Vaccine Fund has not experienced any loss related to these receivables.

Reclassifications

Certain items presented in the Consolidated Financial Statements for the prior year have been reclassified to conform to the current year presentation. Such reclassifications had no effect on the change in net assets or net asset balances as previously reported.

NOTE 3 – Relationships with UNICEF and GAVI

The administration of the Trust Account involves staff across four UNICEF divisions. Under the Trust Account agreement, UNICEF provides a biennial budget that reflects the cost of administration for review by The Vaccine Fund. During 2004 and 2003, The Vaccine Fund prepaid UNICEF for administration of the Trust Account for the next calendar year. Prepaid administrative fees are as follows as of December 31:

		2004		2003
Prepaid administrative fee for next calendar year	$	3,592,347	$	2,503,200
Administrative fee expense	$	3,409,035	$	2,052,868

The prepaid administrative fees for UNICEF are included in prepaid expenses in the Consolidated Statements of Financial Position. The administrative fee expenses are reflected in program expenses in the Consolidated Statements of Activities.

The Trust Account receives monies from donor countries and from The Vaccine Fund which are used to finance the purchase and distribution of vaccines and related products, and strengthen immunization service programs. The Trust Account is a separate account administered by UNICEF in accordance with their internal financial regulations, rules and administrative instructions.

(Unaudited)		2004		2003
Cumulative contributions by The Vaccine Fund	$	308,434,378	$	271,028,124
Cumulative contributions by other donors		228,618,703		148,770,465
Total Cumulative Contribution to Trust Account	**$**	**537,053,081**	**$**	**419,798,589**

Cumulative disbursements from the Trust Account were as follows as of December 31:

(Unaudited)		2004		2003
Cumulative disbursements	$	532,649,468	$	383,367,919

The GAVI Board approves vaccination and immunization program budgets which may extend up to 5 years in duration. The GAVI Secretariat then presents award recommendations to The Vaccine Fund for consideration. A GAVI Board approval alone is not binding on The Vaccine Fund. The Vaccine Fund has the sole discretion to approve award recommendations for funding. The Vaccine Fund's initial approval of the GAVI program recommendation does not create a commitment of The Vaccine Fund until it has determined whether the GAVI program recommendation will be funded directly from the Trust Account and/or funded from assets of The Vaccine Fund. The Vaccine Fund records a liability at the time the funding source and amount (from The Vaccine Fund) is determined. As a result, a liability is not recorded by The Vaccine Fund until a funding decision is made.

The table below summarizes this position as of December 31:

(Unaudited)		2004		2003
Estimated program budgets endorsed by GAVI	$	1,398,318,610	$	1,172,497,610
Funds disbursed by Trust Account since inception		(532,649,468)		(383,367,919)
Remaining program budgets endorsed by GAVI not yet funded		865,669,142		789,129,691
The Vaccine Fund Investment assets		(726,068,690)		(677,660,036)
Potential Under-funding of GAVI Program Budgets	$	(139,600,452)	$	(111,469,655)

Starting in 2006, GAVI will begin consideration of its programs for the next ten years. These amounts are not included above. Future funding requirement for GAVI Programs is anticipated to come from several sources: future funding by government and private donors, and from The Vaccine Fund. See also Note 15 – Subsequent Events.

NOTE 4 - Promises to Give

The Vaccine Fund's unconditional promises to give consisted of the following as of December 31:

		2004		2003
Contributions due in less than one year	$	625,000	$	625,000
Contributions due in one to two years		250,000		875,000
Unconditional promises to give before unamortized discount		875,000		1,500,000
Less unamortized discount		(5,668)		(34,734)
Net Unconditional Promises to Give	**$**	**869,332**	**$**	**1,465,266**

No promises to give were received in the year ended December 31, 2004. For those promises to give received during the year ended December 31, 2003, a 2.32 percent discount rate was applied commensurate with the pledge period.

NOTE 5 - Conditional Promise to Give

During 2002, The Vaccine Fund has received a conditional promise to give totaling 24,500,000 Pounds Sterling over the period April 2002 to December 2005. The payment of the promise to give is subject to the donor's receipt of a satisfactory financial report by The Vaccine Fund detailing how the previous contributions have been committed and a projection of needs.

Amounts received are as follows as of December 31:

Amount received in 2003	$	5,605,950
Amount received in 2004	$	19,169,153
Total Amount Received	**$**	**24,775,103**

The Vaccine Fund expects to receive remaining contributions totaling 10,500,000 Pounds Sterling in 2005. The total US dollar amount received will depend on the Pound Sterling exchange rate at the time of receipt of the remaining contributions.

NOTE 6 - Fixed Assets

Fixed assets consisted of the following as of December 31:

		2004		2003
Furniture and fixtures	$	662,322	$	577,189
Equipment		1,165,280		764,435
Leasehold improvement		1,378,513		1,204,748
Total fixed assets		3,206,115		2,546,372
Accumulated depreciation		(1,394,774)		(263,384)
Total Fixed Assets	**$**	**1,811,341**	**$**	**2,282,988**

7 - Investments

Investments consist of the following as of December 31:

		2004		2003
Cash equivalents	$	157,640,414	$	38,470,463
Fixed income		568,428,276		639,189,573
Total Investments	**$**	**726,068,690**	**$**	**677,660,036**

The Vaccine Fund has provided a portion of these investment assets as security to UNICEF for the forward contract purchase for vaccine purchase. See Note 9 below.

Investment returns for the years 2004 and 2003 were as follows at December 31:

		2004		2003
Dividends and interest	$	21,962,547	$	28,925,550
Realized and unrealized gains (losses)		(116,790)		(2,085,037)
Investment fees		(1,955,277)		(1,936,969)
Total Return on Investments	**$**	**19,890,480**	**$**	**24,903,544**

8 – Grant Payable

In November 2004, The Vaccine Fund entered into a 5 year grant agreement with the UN Foundation to fund a measles partnership in Africa. As of December 31, 2004, the remaining grant payable under this agreement consisted of the following:

Grant payable due in less than one year	$	12,520,000
Grant payable due in one to three years		24,480,000
Grant payable before unamortized discount		37,000,000
Less unamortized discount		(1,467,452)
Net Grant Payable	**$**	**35,532,548**

A discount rate of 3.46 percent was applied to record the present value of the grant payable in future years.

9 – Commitment to Fund Future Procurement

During 2003, The Vaccine Fund entered into an agreement with UNICEF to pledge up to $215,283,176 of its investment assets to UNICEF through March 2006. The pledge is in connection with the 2004-2006 vaccine purchases for which UNICEF has firmly contracted with a pharmaceutical company. Under the agreement, UNICEF will issue purchase orders periodically through March 2006 to initiate agreed vaccine shipments. As The Vaccine Fund disburses funds to the Trust Account, its commitment under this agreement will decrease.

Ten days prior to the issuance of a purchase order, UNICEF will request funds equivalent to the value of the purchase order from The Vaccine Fund. The Vaccine Fund granted a security interest in a separately held investment account to UNICEF. In the event The Vaccine Fund fails to disburse the requested funds at the end of the ten day window, UNICEF may liquidate securities in the investment account for the value of the purchase order.

During 2004, contributions to the Trust Account from donors other than The Vaccine Fund fulfilled a portion of the 2004 commitment, which was recorded as "release of commitment to fund future procurement" in the Consolidated Statements of Activities. Details of the commitment still outstanding are as follows:

Commitment balance as of December 31, 2003	$	215,283,176
Commitment fulfilled by The Vaccine Fund		(23,747,312)
Release of commitment (commitment fulfilled by other donors)		(36,522,564)
Commitment Balance as of December 31, 2004	**$**	**15,013,300**

NOTE 10 – Temporarily Restricted Net Assets

Temporarily restricted net assets consisted of the following as of December 31:

		2004		2003
Due to time restriction	$	869,332	$	1,465,266
Due to program restriction for specific recipient country		142,943		
Total Temporarily Restricted Net Assets	**$**	**1,012,275**	**$**	**1,465,266**

NOTE 11 - Retirement Plan

On January 1, 2002, The Fund began sponsoring a 401(k) defined contribution plan for all eligible employees. Employees become eligible upon hiring, and may participate starting on the first day of any month. Employees may contribute voluntary salary deferrals to the plan subject to IRS limitations. The Fund's annual contribution equals 3 percent of each participant's compensation, as well as 100 percent matching contribution up to 2 percent of the participant's compensation. In addition, the Fund may contribute to the plan discretionary amounts above the initial 3 percent. The discretionary amount is fully vested after 12 months. The discretionary amount for 2004 and 2003 equals 10 percent of the participant's compensation. As of December 31, 2004 and 2003, the amount accrued for The Fund's contributions totaled $117,547 and $140,765, respectively.

NOTE 12 - Lease

In 2003, the Fund entered into a ten-year lease agreement, which commenced on November 15. The Fund has the option to extend the term for five years. As part of the lease agreement, the Fund received rent abatement that is equal to four months rent payments, which totaled $90,218. Generally accepted accounting principles require the Fund recognize rent expense for this lease on a straight-line basis over the term of the lease. Accordingly, $87,249 and $24,229 of additional rent expenses have been accrued for the fiscal years ended December 31, 2004 and 2003, respectively. Rental expense totaled $281,059 and $155,944 for years ended December 31, 2004 and 2003, respectively.

Minimum lease payments under this agreement are as follows:

Year Ending December 31,

2005	$	277,263
2006		283,501
2007		289,880
2008		296,402
2009		303,071
Thereafter		1,253,852
Total	**$**	**2,703,969**

NOTE 13 - Related Party Transaction

In June 2000, the Fund entered into an independent contract agreement with Parteurop S.A., a French company. Under this agreement, Parteurop S.A provided two consultants one of whom filled the role of the President of the Fund, with responsibility for strategic, programmatic, financial, and management operations, as directed by the Fund's Board of Directors. The fees paid to Parteurop also covered the services of an assistant to the President. For the years ended December 31, 2004 and 2003, total fees paid to Parteurop under this agreement were $551,421 and $413,622, respectively. The contract with Parteurop S.A. ended on January 31, 2005.

NOTE 14 – Convergence

The Boards of Directors of both The Vaccine Fund and GAVI have approved the convergence of The Vaccine Fund and the GAVI Secretariat. The convergence process is designed to create the structure and platforms necessary to continue to support the public-private partnership in its objectives over the next 10 years. After the convergence, The Vaccine Fund and GAVI Secretariat will have one single Chief Executive Officer. The convergence process will result in the relocation of Lyon-based staff of le Fonds pour les Vaccins de l'Enfance (the Association) to Geneva, Switzerland. The Vaccine Fund 501(c)(3) located in Washington, DC remains unchanged. This arrangement will generate certain restructuring and relocation costs, which will be incurred in 2005 and possibly in 2006.

As of December 31, 2004, The Vaccine Fund recognized $3,634,138 in estimated costs associated with the convergence. The Fund will reimburse the Association for all approved cash payments related to the convergence. Estimated additional costs approved by The Vaccine Fund's Board of Directors subsequent to December 31, 2004, totaling $3,011,540, will be incurred in fiscal year 2005.

Amount recognized as of December 31, 2004	$	3,634,138
Estimated amount approved to be incurred in 2005		3,011,540
Total Estimated Convergence Costs	**$**	**6,645,678**

NOTE 15 – Subsequent Events

The Bill & Melinda Gates Foundation announced a $750,000,000 10-year grant to The Vaccine Fund in January 2005. Grant agreements were signed on February 9, 2005, and the first payment of $150,000,000 was received on February 18, 2005.

REPORT OF INDEPENDENT AUDITORS ON SUPPLEMENTARY INFORMATION

To the Board of Directors of
The Vaccine Fund

The report on our audit of the consolidated financial statements of The Vaccine Fund as of and for the year ended December 31, 2004 appears on page one of this document. That audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The accompanying consolidated statements of functional expenses for the years ended December 31, 2004 and December 31, 2003 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated financial statements taken as a whole.

PricewaterhouseCoopers LLP

May 5, 2005

CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES
for the Year Ended December 31, 2004

	Direct And Indirect Program	Commitment to Fund Future Procurement	Total Program	Management And General	Fundraising	2004 Total
Vaccine procurement commitment	$ -	$ -	$ -	$ -	$ -	$ -
Purchases of supplies and direct program expenditures	14,153,850	-	14,153,850	-	-	14,153,850
Program implementation	8,709,035	-	8,709,035	-	-	8,709,035
Subtotal Program Expenses	22,862,885	-	22,862,885	-	-	22,862,885
Grants	35,532,548	-	35,532,548	-	-	35,532,548
Payroll and benefits	-	-	-	1,846,976	2,720,185	4,567,161
Training and recruitment	-	-	-	189,881	4,798	194,679
Professional fees	-	-	-	2,654,965	1,886,482	4,541,447
Media production and distribution	-	-	-	17,383	163,315	180,698
Events and meetings	-	-	-	84,853	188,088	272,941
Travel and representation	-	-	-	305,932	889,835	1,195,767
Facility and office costs	-	-	-	1,590,768	29,550	1,620,318
Supplies and equipment	-	-	-	338,427	106	338,533
Subtotal Other Operating Expenses	35,532,548	-	35,532,548	7,029,185	5,882,359	48,444,092
Total Operating Expenses before convergence expenses	58,395,433		58,395,433	7,029,185	5,882,359	71,306,977
Convergence expenses	-	-	-	3,634,138	-	3,634,138
TOTAL EXPENSES	**$ 58,395,433**	**$ -**	**$ 58,395,433**	**$ 10,663,323**	**$ 5,882,359**	**$ 74,941,115**

for the Year Ended December 31, 2003

	Direct And Indirect Program	Commitment to Fund Future Procurement	Total Program	Management And General	Fundraising	2003 Total
Vaccine procurement commitment	$ -	$ 215,283,176	$ 215,283,176	$ -	$ -	$ 215,283,176
Purchases of supplies and direct program expenditures	163,671,867	-	163,671,867	-	-	163,671,867
Program implementation	8,527,869	-	8,527,869	-	-	8,527,869
Subtotal Program Expenses	172,199,736	215,283,176	387,482,912	-	-	387,482,912
Grants	-	-	-	-	-	-
Payroll and benefits	-	-	-	1,170,065	2,064,834	3,234,899
Training and recruitment	-	-	-	142,128	107,360	249,488
Professional fees	-	-	-	850,816	1,516,230	2,367,046
Media production and distribution	-	-	-	18,623	492,476	511,099
Events and meetings	-	-	-	9,068	68,968	78,036
Travel and representation	-	-	-	391,647	667,630	1,059,277
Facility and office costs	-	-	-	953,678	197,486	1,151,164
Supplies and equipment	-	-	-	328,710	91	328,801
Subtotal Other Operating Expenses	-	-	-	3,864,735	5 115,075	8,979,810
TOTAL EXPENSES	**$ 172,199,736**	**$ 215,283,176**	**$ 387,482,912**	**$ 3,864,735**	**$ 5 115,075**	**$ 396,462,722**

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P. 25 UNICEF / 030 / Alf Berg

P. 26 UNICEF / 061 / Thomas L. Kelly

P. 28 UNICEF / HQ 02-570 / Giacomo Pirozzi

P. 29 UNICEF / 0122 / Thomas L. Kelly

P. 31 TVF / 116 / Lori Waselchuk

P. 32 UNICEF / HQ 92-1418 / Roger Lemoyne

P. 33 Alf Berg

P. 35 UNICEF / 0591 / Thomas L. Kelly

P. 38 TVF / 096 / Lori Waselchuk

P. 39 TVF / 142 / Lori Waselchuk

P. 40-41 UNICEF / 039 / Thomas L. Kelly

P. 43 UNICEF / HQ 99-0440 / Radhika Chalasani

P. 44 UNICEF / HQ 00-0252 / Giacomo Pirozzi

P. 45 TVF

P. 46 UNICEF / 066 / Thomas L. Kelly

P. 49 TVF / 131 / Lori Waselchuk

P. 54 TVF / 110 / Lori Waselchuk

P. 56-57 UNICEF / HQ 00-0248 / Giacomo Pirozzi