

Report of the Chief Executive Officer

19 June 2019

Dear Board members,

In December 2018, over 300 participants from donor and implementing country governments, Alliance partners, the private sector, civil society and beyond gathered in Abu Dhabi for our mid-term review (MTR). The MTR is primarily an accountability exercise to report back to donors on our progress against the commitments we made at the 2015 Replenishment. It is also an opportunity to look forward and consider our future direction. This event was significantly larger than the previous MTR in 2013, reflecting the growth in the scale and diversity of the Alliance over the intervening five years. The agenda reflected this, seeking to balance detailed discussions on the performance of the Alliance with higher-level plenary conversations on the broader context and future outlook. Feedback from participants was very positive, although there were a number of constructive suggestions for improvement that we will take on board for the next MTR.

At the MTR, we reported that the Alliance is on track for our 2015 Replenishment commitments including immunising 300 million additional children, averting 5-6 million deaths, generating US\$80-100 billion in economic benefits, having 19 countries transition out of Gavi support by 2020 and making progress towards our target for healthy vaccine markets. We also highlighted the key challenges we face, including the need to accelerate improvements in coverage and equity (particularly in fragile settings), programmatic weaknesses in some transitioning countries, and supply shortages for some vaccines, and how we are addressing these. The Board will discuss these topics as part of the semi-annual update on *2016-2020 Strategy: Progress, Challenges and Risks*. We will have a better idea of progress on many of our indicators when the 2018 WHO-UNICEF estimates of immunisation coverage (WUENIC) are released in July. However, we do see some early progress on equity with most of the nine countries who have conducted new surveys in this period having shown significant improvement. It will be important that we learn from these countries as we prepare to make equity our organising principle in the next strategy period.

In the coming months, the Alliance will need to keep focused on achieving our

current goals, while also preparing for implementation of our 2021-2025 strategy ("Gavi 5.0"). This is reflected in the agenda for this meeting, which combines time to review our progress to date and adjust based on lessons learned and emerging risks, with important decisions around the strategy framework for Gavi 5.0 and discussions of how this will be operationalised and funded.

Key developments in our global landscape

Growing global challenges underscore importance of immunisation

In March, **Cyclone Idai** hit the east coast of southern Africa causing severe flooding in Mozambique, Malawi, and Zimbabwe, killing over 1,000 people, leaving millions in need of assistance and resulting in over US\$2 billion in damage. Mozambique was hit particularly hard with over 600 deaths, and a cholera outbreak subsequently taking hold with 4,000 confirmed cases by mid-April. The International Coordinating (ICG) Group released 900,000 doses from the Gavi-funded cholera vaccine stockpile and the Alliance also provided funding for operational costs for the vaccination campaign. Within a month, cases fell to nearly zero demonstrating the importance and efficacy of the vaccine. Follow-up vaccination will start in the coming weeks. Although cholera may have been contained, Mozambique faces a long journey to recovery. Over 50 health centres were destroyed by the cyclone and other critical infrastructure, such as cold chain, has been damaged. The Secretariat and Alliance partners are discussing with the Ministry of Health how Gavi can best support the recovery effort.

Idai is the third-deadliest tropical cyclone on record. It is an example of the growing threat of **climate-related events** to public health and health systems. The cholera response is evidence of the critical role vaccines play in increasing resilience to such events. The potential public health impact of climate change was further illustrated by a new study, published at the same time as Idai was ravaging Mozambique. This projects that the mosquitoes which carry yellow fever, Zika, dengue and chikungunya could reach much of northern Europe and North America, exposing nearly one billion more people to these diseases by 2080. This underscores the increasingly global risk posed by diseases that have historically been seen as problems of the developing world. Immunisation is already the best strategy for controlling yellow fever, and future vaccines are likely to be critical tools to control many of these other diseases.

Recent **measles** outbreaks are a reminder of how quickly vaccine-preventable diseases can spread if populations are not adequately protected. The world has made significant progress in the fight against measles, with deaths falling by over 80% between 2000 and 2016. However, in recent years we have seen a resurgence of the disease including in countries that had previously eliminated it. The number of cases globally more than doubled between 2017 and 2018 and the trend has continued in 2019 with over three times as many cases reported in the first three months of the year than the same period in 2018. Many of these cases are in Gavi-supported countries, with a particularly severe outbreak in Madagascar. However, there has also been a resurgence in both Europe and the

Americas. In Europe, 15 times more people were infected with measles in 2018 than in 2016 and 47 out of 53 countries reported measles cases in the last 18 months. The United States has already recorded more measles cases in 2019 to date than in any of the past thirty years.

In poorer countries, measles outbreaks are typically a symptom of the inadequate reach of routine immunisation programmes. In wealthier countries, they tend to be the result of parents choosing not to get their children immunised, often due to **vaccine hesitancy**. A recent report by the Wellcome Trust, based on surveys with over 140,000 people, found that the vast majority of people believe vaccines are safe and effective but that there is a worrying level of scepticism in some developed countries. In France and Japan, for example, less than half of respondents agreed that vaccines are safe. This is a growing challenge, which appears to be linked to declining trust in governments and in science, and is being exacerbated by technology which means that misinformation and rumours about vaccines can spread faster and further. I recently wrote to the CEOs of leading digital and social media companies to highlight this threat and the potential global ramifications, and pressed them to do more to control the spread of falsehoods and provide accurate information as a public service. Hesitancy was a topic of discussion at the meeting of G7 Ministers of Health in Paris in May, which I attended. While currently concentrated in wealthier countries, misinformation on vaccines is beginning to affect immunisation programmes in poorer countries where penetration of mobile phones and social media is growing rapidly. The French government had invited representatives from Sahel countries to join the meeting and this enabled a very open exchange about the challenges being faced in developing and developed countries and how they could learn from and support each other. The meeting's primary focus was on primary healthcare (PHC), reflecting the growing recognition around the world that strong PHC is critical to creating healthy, wealthy and secure societies.

Vaccine hesitancy is one example of how **demand**-side barriers can impede immunisation outcomes. As we discussed at our last meeting, we will need to do more to generate active demand for immunisation to reach all under-immunised and zero-dose children. This can also increase resilience to the threat of vaccine hesitancy. The new Alliance demand hub is working on a range of new approaches to help build and sustain demand, including engaging with new partners who can bring innovative thinking and new networks. In India, the Alliance has worked with Unilever to scale-up a programme which makes immunisation a core element of "successful parenting". Dr Ngozi and Anuradha recently visited the Self Employed Women's Association (SEWA) in India and discussed the power of immunisation. With over 1.5 million participating women, SEWA is the largest organisation of informal workers in the world and the largest non-profit in India. The Alliance has already worked with SEWA to raise awareness of cervical cancer and human papillomavirus (HPV) vaccine. Going forward, they could become a powerful network to raise communities' understanding of immunisation and its impact on health and wellbeing more broadly. We are now exploring ways to integrate our partnerships with Unilever and SEWA as a model for innovative demand generation at scale.

The ongoing **Ebola outbreak in DR Congo** is an acute example of the challenge of convincing populations to accept vaccines in a situation of general mistrust in the health system and authorities. It is also evidence of why we will need to take a more community-centric approach to designing services in Gavi 5.0 if we want to reach the most marginalised communities. The Ebola response has been impeded by the reluctance of communities to seek care at Ebola treatment centres, along with active conflict (including attacks on health centres and staff), widescale population movement and poor infrastructure. In this context, the number of Ebola cases has continued to grow with nearly half of cases to date occurring in the past three months (approximately twice as many as in the previous three months). With over 2,100 cases and nearly 1,500 deaths to date, this is now the second largest Ebola outbreak in history. With the recent confirmation of three deaths from Ebola in Uganda (in a family who had recently travelled from DR Congo), there is also a growing risk of spread in other countries. Fortunately, the authorities in Uganda have been preparing for such a situation – including by vaccinating nearly 5,000 healthcare workers in 165 health facilities with Gavi support – and have launched a rapid response.

Vaccines have been a critical part of the response. Over 130,000 people have been immunised so far with rVSV-ZEBOV-GP vaccines made available by Merck through Gavi's Advanced Purchase Commitment (APC). The vaccine is still being used under a clinical trial protocol and the data suggests it has a very high efficacy, validating the results of the original clinical trial in West Africa. WHO's Strategic Advisory Group of Experts on Immunisation (SAGE) recently recommended using a 0.5 ml dose, which is the dose that was used in the ring vaccination efficacy trial in Guinea. This is half the dose used in DR Congo to date, meaning that it will be possible to immunise many more people with the vaccine made available through the APC. We expect that the rVSV-ZEBOV-GP vaccine will be licensed by the end of the year and we will bring an investment case for licensed Ebola vaccines to the Board in December, in line with the original Board decision on the APC. This will also consider how to treat vaccines from other manufacturers including preventive vaccines, depending on an eventual SAGE recommendation.

In addition to Ebola, DR Congo has also been undergoing outbreaks of measles, cholera, monkey-pox, yellow fever and multiple outbreaks of vaccine-derived polio (VDPV). Most of these should be prevented by vaccines in the country's routine immunisation programme. However, less than half of children are being reached with a full course of basic vaccines according to the latest survey. This is well below the 81% WUENIC coverage estimate, highlighting challenges with data quality and the limitations of WUENIC. The positive news is that the Minister of Health has endorsed these figures and developed the Mashako Plan, with support from the Alliance, to strengthen immunisation services and primary healthcare. The goal is to boost routine immunisation coverage by 15% within 18 months in nine priority provinces. Early results show improvements in key indicators such as the number of immunisation sessions, level of supportive supervision and functionality of the cold chain. Discussions are under way to scale up to additional provinces as part of the country's next Health Systems

Strengthening (HSS) grant. I plan to visit DR Congo with Chris Elias from the Gates Foundation in July to meet the new leadership to discuss how we can maintain this momentum.

New vaccines on the horizon

There is growing optimism about a potential **vaccine to prevent tuberculosis** disease. Early data on the M72/AS01E vaccine are encouraging, and manufacturers and the global health community are now discussing whether to commit to significant investments in manufacturing capacity already or wait for further confirmatory efficacy data. This is an important trade-off – waiting presents a lower financial risk but may delay scale-up of supply if the vaccine is successfully licensed – and it is encouraging that this dialogue is being had openly between industry and global health organisations, which has not always been the case in the past. With promising candidates in the pipeline for HIV and malaria, continued efforts to develop a universal flu vaccine, and the Coalition for Epidemic Preparedness Innovations (CEPI) investing in new vaccines for critical outbreak diseases it is an exciting time for vaccine development and underscores the continued importance of being prepared for new vaccine introductions over the coming years. The Gavi Board agreed to help support CEPI's efforts by enabling it to use the International Financing Facility for Immunisation (IFFIm) to frontload support from Norway. Grant agreements with Norway have now been signed and the IFFIm bond for CEPI should be issued by the end of this month.

New vaccines could also be important tools in the fight against **anti-microbial resistance** (AMR). The recent World Health Assembly recognised the growing threat of AMR, which already kills 700,000 people per year and could kill as many as 10 million in 2050 without further action. The risk is highest in developing countries with a recent study finding that 90% of households in Kibera in Kenya use antibiotics in a given year, compared to 17% for the typical US family. The Interagency Coordination Group on Antimicrobial Resistance recently completed its report, commissioned by the UN Secretary-General, which among other recommendations recognised the critical role of vaccines and called for increased coverage and development of vaccines. Gavi's investments in scaling up new vaccines are already making a major contribution. For example, Gavi-supported Haemophilus influenzae type B (Hib), Pneumococcal (PCV) and Meningitis A vaccine programmes are expected to prevent 35m days of antibiotic use between 2016 and 2020.

Enhancing collaboration to address opportunities and challenges

Addressing the above challenges and capturing the opportunities will require **enhanced collaboration** across the global health community. Partnership between the agencies working in immunisation is at the heart of the Alliance model. This strategic period has seen a significant increase in the breadth and depth of collaboration – including intensified work and funding to our core partners, and a significant expansion in the breadth and depth of work with expanded partners.

We are also working ever more closely with the Global Fund, with systematic collaboration in 25 countries, plans to coordinate planning of new support to countries as part of their next funding round and growing collaboration in many technical and functional areas. At the leadership level, Peter and I work closely together. We jointly participated in the African Union's high-level meeting on health financing in February and in WHO's partnership meeting in Stockholm in April, and are increasingly speaking on behalf of each others' agencies in major meetings and country visits. Donald Kaberuka, the new Chair of the Global Fund Board and I jointly hosted a high-level panel at the European Development Days last week. Gavi and the Global Fund are also working together with Unitaid to fund implementation pilots for the RTS,S malaria vaccine, which could provide important lessons for the roll-out of future HIV or TB vaccines. And we and the Global Fund are exploring with the Global Financing Facility (GFF) the possibility of jointly supporting countries to develop primary healthcare (PHC) investment cases, to help align our respective support behind each country's own PHC priorities and investments (Anuradha is also a member of a task team set up by GFF to help advance their model).

As we have previously discussed, the ***Global Action Plan for Healthy Lives and Wellbeing for All*** (GAP) is an effort to make such collaboration more systematic across 12 agencies involved in global health. Gavi is one of the 12 signatories and we already work closely with a number of the others including our core partners (WHO, UNICEF, World Bank), the Global Fund, GFF and Unitaid. The full plan is due to be published at the UN General Assembly in September. We are actively engaged and continue to advocate for concrete, practical actions that can be implemented rapidly, building on existing collaboration across agencies. Gavi is co-leading the accelerator on sustainable financing with the Global Fund and World Bank, and we have jointly identified a number of important opportunities to better collaborate and align our support to counties.

Reporting back on previous Board decisions

At our last meeting, the Board agreed to extend the transition timeline for **Nigeria** given the acute challenges facing the country. This was subject to agreement of an accountability framework with the government, and the Minister of Health committed to this when he joined our discussion by videoconference. It took longer than we had hoped to sign the framework due to internal government discussions on some of the targets and the recent elections. However, I am delighted that it has now been signed by the Minister of Health, Minister of Budget & Planning, and Minister of Finance (and is available to Board members on BoardEffect). We can now begin to move forward with the Board-endorsed strategy. The country has already had applications approved for measles second dose introduction, campaigns for yellow fever, Meningitis A and measles, the first tranche of HSS support (focused on national-level investments; the second tranche will focus on State-level investments for which planning is underway) and the Cold Chain Equipment Optimisation Platform (CCEOP). We have also pioneered a tripartite agreement between the Secretariat, technical partners and Government of Nigeria for the provision of technical support, which could be a

model to consider for Gavi 5.0. The Alliance is already working with the country to strengthen vaccines management including by supporting a physical stock count of vaccine doses, conducting a wastage study and reviewing the electronic logistics management information system.

There is early evidence that the increased political commitment and attention to immunisation and primary healthcare is having an impact. The recent nationwide survey showed that over half of children received three doses of pentavalent vaccine, up from just over a third when the last survey was published in 2017. We hope that the new Ministerial team, to be appointed following the recent re-election of President Buhari, will maintain this momentum. I will be visiting Nigeria in November to meet with the new leadership, review progress and discuss the commitments that Nigeria has made under the accountability framework.

Nigeria is one of three remaining **polio**-endemic countries (along with Pakistan and Afghanistan) but may be certified as polio-free later this year. This would be an important milestone in efforts to achieve polio eradication, as was the moment in April when Mongolia and Zimbabwe became the last of the 73 Gavi-supported countries to introduce inactivated polio vaccine (IPV). Despite these positive developments, there have been concerning setbacks to polio eradication with more than twice as many wild polio cases reported to date in 2019 than at the same point in 2018. This has been driven by a spike in cases in Pakistan, which has already recorded 21 cases this year as opposed to 12 in all of 2018. There have also been VDPVs in a number of other countries, highlighting chronic gaps in population immunity. Each outbreak response campaign using oral monovalent vaccine increases population immunity but also later creates a risk of increased circulation of vaccine-derived strains of the virus. In addition to the cost and disruption of such campaigns, these outbreaks risk feeding vaccine hesitancy if they create a perception that vaccines themselves are having harmful effects.

Resistance to polio eradication efforts continues in some high-risk communities in the remaining endemic countries of Pakistan and Afghanistan, and there is a growing recognition that new approaches are needed to re-establish trust with communities. This will require a more integrated strategy offering a broader package of vaccines and PHC services to these communities, which are often underserved by other health services and home to large numbers of zero-dose children. The Alliance has a key role to play and is working increasingly closely with the Global Polio Eradication Initiative (GPEI) and national immunisation programmes on this. The recent decision to offer the Gavi CEO a seat on the Polio Oversight Board, with the Secretariat also participating in other strategic and programmatic committees of GPEI, is already helping to strengthen collaboration. In Papua New Guinea, for example, the surge in polio resources in response to the VDPV outbreak has been leveraged to strengthen oversight and planning of routine immunisation services as well as the recent measles-rubella campaign. Gavi and GPEI are also coordinating closely as we move to our respective replenishments including identifying opportunities for advocacy and communications on our shared priorities.

In April, Malawi became the first country to introduce the RTS,S **malaria vaccine** as part of the pilot implementation studies being supported by Gavi, the Global Fund and Unitaid in partnership with WHO, PATH and GSK. In previous clinical trials, the vaccine was found to prevent approximately four in ten malaria cases. The pilot studies, which have also commenced in Ghana, are critical to better understand the vaccine's impact on the disease course and cost-effectiveness in a real-world setting as well as the feasibility of the 4-dose schedule (the majority outside the current immunisation schedule) and some safety signals picked up in the original clinical trial. Currently, Gavi has committed funding for the first phase of the pilots. The Board will consider in December whether to approve support for the second phase, which will be required to inform a WHO recommendation on wide-scale use. Both Unitaid and the Global Fund (contingent on the outcome of their replenishment) have already committed to support the second phase.

Malawi also introduced **HPV** vaccine nationwide in January, having been one of the first countries to launch a Gavi-supported HPV demonstration project in 2013. Unfortunately, supply shortages mean HPV introductions in a number of other Gavi-supported countries continue to face delays, and few countries have been able to introduce in multiple age cohorts (which the Board approved in 2016). The manufacturer of countries' preferred product has not supplied Gavi with the expected volume of vaccine. With 90% of the disease burden falling in the world's poorest countries, this will unfortunately lead to a delay in efforts to prevent cervical cancer deaths in these countries. In the medium term, we expect to see improvements in supply – including through prequalification of new vaccines – which should ensure that all countries who wish to introduce HPV into their routine immunisation schedules can do so

When the Board approved the Vaccine Investment Strategy (VIS) last year, it prioritised immunisation products for **Respiratory Syncytial Virus (RSV)**, a disease that causes over 100,000 deaths per year. At the time, we had high hopes for the most advanced candidate which was undergoing clinical trials. Unfortunately, the results of the trials were less positive than hoped with the vaccine failing to achieve its primary endpoint. The vaccine developer is discussing a pathway to licensure with regulators, but it appears less likely that a vaccine will be available to Gavi-supported countries in the next strategic period (given the previous assumptions on timing, this will not have a significant impact on our projected expenditure in the next strategic period).

One year ago, the Board decided to allow countries to apply for up to 25% additional **HSS** support for investments in coverage and equity (in addition to the existing provision in the Fragility, Emergencies, Refugees policy for fragile countries to apply for up to 50% additional HSS). Thirteen countries have already applied for additional HSS, of which eight have been approved to date, and up to another ten countries are expected to apply this year. Approved proposals to date have come from both fragile countries with acute problems (e.g. South Sudan, which will use the support to strengthen service delivery in 54 counties with over 90% of the under immunised) and higher performing countries which are striving to reach the last pockets of under-immunised (e.g. Nepal, which is

targeting specific sub-populations including the urban poor, ethnic minorities, migrant workers, mobile populations, and remote mountain communities). In total, these flexibilities are expected to result in approximately US\$140 million of additional HSS disbursements by 2020, which is likely to result in countries fully utilising the US\$1.3 billion HSS envelope approved by the Board for 2016-2020.

2018 was the first year of implementation of **CCEOP** at scale in countries. By the end of 2018, 20,000 fridges had been procured and 17,000 delivered following the first deployments in Haiti in mid-2017. A further 25,000 units are expected to be procured in 2019 and the Alliance expects to procure 65,000 by 2020. 30% of equipment approved to date is for previously unequipped facilities, which is critical for them to offer reliable immunisation and outreach services. Ongoing evaluations of CCEOP by JSI and CHAI have provided early evidence of impact with an increase in facilities offering immunisation after being equipped through CCEOP. The evaluations found that the country-level implementation of CCEOP has been effective and that deployment has been faster than with traditional procurement, but also highlighted a number of potential areas for improvement including the cost of the service bundle, the need for improved training of Ministry of Health technicians and some concerns among manufacturers about how the market is being managed. UNICEF and the Secretariat are already working to address these findings. The Secretariat anticipates a small underspend in the overall Board-approved funding for CCEOP since a few countries have chosen not to apply for their full allocation and the Programme and Policy Committee has recommended that the Board approve the use of the remaining funds for a learning agenda on potential cold chain innovations that the Alliance may scale-up in the next period. This is on the consent agenda for this Board meeting.

The Board will consider potential revisions to Gavi's **gender** policy in December. Gavi's approach to gender was recently recognised by Global Health 50/50, which rated the Alliance as one of the ten "highest scorers" out of 140 organisations in global health. We are committed to strengthening our approach further and to making this a central part of our approach to reaching the unreached in Gavi 5.0. To inform the policy review, the Secretariat commissioned an independent evaluation of the current policy. It found that the policy was well-designed for addressing gender concerns at global level, that Gavi has become more engaged in discussions on gender in health and that leadership is highly committed to implement the policy. However, it also found that the policy has not translated sufficiently into robust programming on gender at country level with insufficient engagement of core partners and under-developed monitoring and evaluation. The evaluation recommended developing a clear theory of change and monitoring and evaluation framework, strengthen gender-responsive programming, enhance the Secretariat's processes to coordinate its work on gender and to increase the engagement of partners. The Secretariat is working with partners to address these recommendations as part of the policy review.

Agenda for this Board meeting

Following positive feedback from Board members, we have maintained the

approach to the **Board agenda** which we introduced at our last meeting. This is designed to enable sufficient time for reflection on implementation of the current strategy on the first morning of the meeting, and to review routine business at the end, while dedicating the majority of time to decisions and strategic discussions. Our focus at this meeting will inevitably be on approving the 2021-2025 strategic framework, how we will work together over the next 18 months to prepare for operationalisation, and our approach to mobilising the resources to fund it leading up to our Replenishment in mid-2020. The Board will make two other decisions which will have significant implications for Gavi's post-2020 strategy – our approach to co-financing IPV and the criteria for a potential extension of Papua New Guinea's transition timeline given the major programmatic risks it faces.

This meeting is the culmination of an intensive 15-month process to develop our **2021-2025 strategy framework**. The Board began discussing some of the key trends which will shape Gavi 5.0 at the April 2018 Retreat, with further discussion in June 2018. At our last Board meeting in December 2018, we aligned on some of the key themes and questions and then deep dived into the details at our three-day Retreat in March this year followed by the call two weeks ago to discuss the revised strategic framework and potential engagement in middle income countries. Our discussions to develop the strategic framework have been informed by consultations with dozens of countries, over a hundred staff at partner agencies, civil society and vaccine industry representatives. We have tried to reflect all of the key points of feedback received from the Board into the revised strategic framework and are hopefully now well-placed to approve it at this meeting and begin the process of planning to operationalise it.

One of the areas with the most diverse perspectives is Gavi's engagement in never Gavi-eligible **middle income countries (MICs)**. I have heard a range of views among Board members from those who feel Gavi's comparative advantage and purpose is supporting the poorest countries to those who believe that in the era of the Sustainable Development Goals, Gavi needs to adapt to ensure no child is left behind and ensure that population immunity to infectious disease is as broad as possible. There is no question that Gavi's eligibility and transition policies are fundamental to our identity as an organisation and our financial support should continue to be focused on the poorest countries. And we do not know for certain that we can replicate the success we've had supporting Gavi-eligible countries, especially given that progress in middle income countries will need to largely leverage domestic financing. At the same time, Gavi's success has created a new inequity with children in middle income countries now least likely to have access to the full range of vaccines universally recommended by WHO. As Dr Ngozi summarised on our last call, Board members recognise that this is a problem that the world cannot ignore and that we should explore potential options for the Alliance to engage with MICs subject to a range of considerations as detailed in the Board paper on Gavi 5.0. If this is agreed, the Secretariat will work with partners to further understand the problem and potential solutions, including through engaging more directly with middle income countries which we have not done extensively to date. We will then come back to the Board with detailed plans if we are able to develop a model that makes sense for

the Alliance, countries and manufacturers alike. To ensure sufficient time to discuss this topic at this meeting, we have organised an extended pre-Board technical briefing where the Secretariat will present in-depth analysis of the middle income country situation and considerations.

Within Gavi-eligible countries, the Board has been clear that we should adopt a bold vision of **leaving no one behind with immunisation by 2030** and make equity our organising principle for the next strategic period. This will entail a much more deliberate focus on reaching the under-immunised, especially zero-dose children, underserved and marginalised communities. Those are the communities most in need of immunisation – as they are least likely to have access to other health services if they get sick – and also those who are most likely to be the source of disease outbreaks which can spread to the rest of the population.

To reach these communities, we can build on the work we have done to focus our support in this period – with over 70% of HSS grants now targeting specific regions or communities with the most under-immunised, nearly 350 staff in partners' countries offices now supported through the Partners' Engagement Framework including many at sub-national level, and CCEOP extending cold chains to thousands of previously unequipped facilities. However, if we are truly to reach communities who are still being missed despite our overall progress – with Gavi-supported countries immunising 50% more children than they were in 2000 – we will need new tools and approaches. This includes better data so we can understand *where* the under-immunised are, not just at district level but at the level of the individual community; and a better understanding of *who* they are and *why* they are being missed. That could be a question of limited or low-quality services, demand-side challenges, gender-related barriers, political decision-making or a mix of all of these. Going forward, services will need to be far more tailored to address all of these considerations. This will require a more ruthless focus in our investments on reaching the unreached, a more outcome-driven approach and stronger, more agile and data-driven management of immunisation programmes. The Alliance itself will have to become more flexible and responsive to the needs of countries and communities, and streamline our processes so they do not become a bottleneck. We have heard the Board's call to be ambitious in looking at not just what we do in Gavi 5.0 but also how we do it. At this meeting, we will discuss the roadmap to address all of these changes over the next 18 months, with a particular focus on reviewing our funding policies.

Of course, we can only implement Gavi 5.0 if we mobilise the resources required. We have been fortunate that in our two previous funding cycles, donors have fully met our ask and we are hopeful that they will maintain this support at our next **replenishment**. The first step will be for us to translate our major goals for the next period into an Investment Case that will be launched in August. The Government of Japan has kindly agreed to host a launch event at the Tokyo International Conference of Africa's Development, which is attended by most African Heads of State. This will kick-off over six months of intensive engagement with donors in the lead-up to the pledging conference in mid-2020. We are grateful to the British government, our largest donor, for agreeing to host the

pledging conference for a second time. We will have a full discussion of the road to replenishment at this meeting, including a discussion with Richard Clarke, Director General for Policy, Research and Humanitarian at the Department for International Development, who is leading the UK government's preparations.

Key developments at Secretariat and partners

This year is one of **change in Gavi's core Alliance partners**. In March, Dr Tedros announced a major reorganisation of the World Health Organization with the aim of increasing efficiency, coordination and responsiveness to emerging global health challenges. The Immunization, Vaccines and Biologics (IVB) department will report to Dr Peter Salama who will become the WHO representative on the Gavi Board. Princess Nono will remain WHO's Alternate Board member. Shanelle Hall, a longstanding Gavi friend, recently stepped down from UNICEF and will be replaced on the Board by Dr Omar Abdi, Deputy Executive Director for programmes, while Ted Chaiban will be moving later this year to lead UNICEF's Middle East and North Africa office. Tim Evans is also leaving the World Bank and will be replaced on the Board, after six years of service, by Dr Mohammad Pate who will take over as Global Director for Health, Nutrition, and Population and Director of the Global Financing Facility (and who we know well from his work as Minister of State for Health in Nigeria). Lastly, Orin Levine, another longstanding friend of Gavi, has assumed a new role within the Bill & Melinda Gates Foundation as Director of Global Delivery Programmes. Happily, he will also remain a Gavi Board member.

This is a critical moment for the Alliance as we shape our new strategy, begin to prepare for implementation and embark on the road to replenishment. With so many changes in Gavi's relationships, Anuradha and I have also been working hard to ensure that we deepen our engagement with the Principals of Alliance partners – all of whom we have had the chance to see in recent months. I was particularly pleased to have the chance to visit Myanmar with Henrietta Fore in January, where we could jointly speak on behalf of the Alliance about the importance of ensuring equitable access to vaccines among every community in the country and see the impact of Gavi's investments on immunisation outcomes.

Under Kate O'Brien's leadership, WHO's IVB department is working with the global immunisation community to develop the ***Immunization Agenda 2030***, to replace the Global Vaccine Action Plan when it ends in 2020. WHO has taken a highly participatory approach to developing this and many representatives from Alliance partners and the Secretariat are closely engaged. Kate presented the emerging thinking at our March retreat and, as she said then, this is an important opportunity for us to align Gavi 5.0 with the global agenda on immunisation. So far, they are highly aligned and we will continue to work closely together as WHO works towards approval at the World Health Assembly in May 2020.

This is also a time of change in the **Secretariat** with two of our longest-serving and most important leaders retiring. Barry Greene has been the Managing Director of Finance and Operations since 2010. He has been a steady hand who

has stewarded our finances confidently through two Replenishments (a period when Gavi's annual expenditure has nearly doubled), overseen Gavi's very successful investment portfolio, and guided the process to develop and move to the Global Health Campus among many other critical contributions. We are delighted to have Assietou Sylla Diouf to replace Barry. Assietou was previously Director of Programming, Budgeting, Finance and Accounting at the African Union where she was instrumental in shaping new budgetary processes and strengthening financial management. Previously, Assietou held senior finance positions in public and private sector in her native Senegal, London and the Middle East. Hind Khatib-Othman will also be retiring as Managing Director of Country Programmes after seven years at Gavi. She has led the transformation of the department from a small team, with light-touch oversight of our programmes, into a professional department with in-depth country knowledge, specialised expertise and extensive relationships. Under her leadership, Gavi's programmes have increased significantly in scale and complexity with over 400 million children immunised and over 300 vaccine introductions completed, and our approach to grant and risk management has matured hugely. Recruitment for Hind's replacement is under way and we hope to announce a replacement soon.

The Secretariat is in the midst of a particularly busy period, finishing the job on our current strategy, developing the 2021-2025 strategy framework, preparing to operationalise Gavi 5.0, kicking off replenishment after our recent MTR, engaging actively in the Global Action plan and working to enhance collaboration with partners within and outside the Alliance, preparing for our next DFID annual review which will be particularly critical in the context of replenishment, and with a major change programme under way to implement SAP as our new financial system. SAP will go live in October and provide a foundation for a more fundamental relook at our systems and processes in preparation for Gavi 5.0. These are all important priorities but the Secretariat team is increasingly stretched and we will need to take a fundamental look at how we optimise our structure and resources as we prepare to implement Gavi 5.0

As we meet to approve Gavi's next strategy, immunisation is stronger than ever. More children are being immunised today with more vaccines than ever before. New vaccines continue to become available which are making ever more diseases preventable through immunisation. And new technologies and innovation are making it more feasible to reach the last mile and unserved communities. However, we cannot be complacent. Over 110 million children are born annually around the world and each year immunisation programmes need to start from scratch to try to reach every single one of them. The resurgence of measles cases shows that there is a real risk of backsliding in performance – even in the highest performing countries – if we do not continue to prioritise immunisation. And the complex challenges confronting global efforts to eradicate polio show how difficult it is to entirely control infectious diseases. Immunisation is more important than ever and Gavi's mission of ensuring everyone receives the vaccines they need has never been more relevant.