

Report of the Chief Executive Officer

3 December 2014

Dear Board members

Eight months ago, we met in Berlin for a pivotal Board Retreat to debate the building blocks of Gavi's 2016-20 strategy. In eight weeks' time, another meeting in Berlin will determine whether the Alliance is fully funded to deliver on that strategy. When Gavi's history is written, these two meetings in the German capital may be seen as the defining moments of this period.

There has of course been a huge amount achieved between those meetings. In 2014, we saw the 73rd – and final – Gavi country launch pentavalent vaccine; we achieved our vaccine introduction targets for this strategy period for pentavalent, pneumococcal and rotavirus vaccines; we saw nearly every Gavi country apply for inactivated polio vaccine (IPV) support; we reached more children than ever before with routine immunisation; we saw record levels of co-financing; we achieved the lowest weighted average price ever for our main three vaccines; we agreed on our 2016-20 strategy framework; and we made great strides to being fully replenished. We also continue to work hard to address the major challenges we face including coverage and equity of immunisation, challenging political situations in some countries, more countries defaulting on co-financing as their payments increase, enhancing risk management, and growing fiscal pressure in a number of donor markets. Looking back on 2014, I am proud of the progress we have made in continuing to accelerate access to the wonder of immunisation.

Immunisation: more critical than ever

Our Board meeting comes at a time when the world is being reminded of the grave threat still posed by infectious disease. Ebola, and its tragic impact on the population of affected countries, has been prominent in the global news agenda. But we are also witnessing a resurgence of measles, with many developed countries experiencing their highest number of cases in decades, while polio continues to stubbornly elude the final push for elimination. These events are a reminder of the **power of immunisation and importance of Gavi.**

Measles and polio are of course easily prevented with effective vaccines – the challenge is to reach every child with those vaccines. For Ebola, however, there is currently no licensed vaccine. As Dr. Kerry Phelps, former President of the Australian Medical Association insightfully observed at an event for Gavi hosted by Australian Foreign Minister Julie Bishop, the Ebola outbreak reminds us what the world was like before vaccines; a time when health systems alone were powerless to stop people dying from infectious diseases. The current situation demonstrates that infectious diseases remain a serious threat to human security, that this threat does not respect borders and that effective vaccines are critical to tackle such diseases.

It is hard to capture in words the full horror of **Ebola**. None of the three worst-affected countries had seen the disease before and their fragile health systems – still recovering from conflict in Sierra Leone and Liberia – were not equipped to control it. As a result, it spread rapidly. The speed of transmission, high case fatality rate, and excruciating experience of the dying has captured the public imagination with Ebola causing almost as much concern in the developed world as it has in countries at the centre of the outbreak. An October edition of the New York Times contained five articles on Ebola, none of which mentioned Africa.

The irony is that Ebola poses limited threat to wealthy countries because it is relatively easy to control where surveillance, health systems and government infrastructure are sufficiently robust. This is demonstrated by the experience of Senegal, which rapidly identified a case of imported Ebola, contained the affected patient, traced all his contacts and successfully prevented further transmission. We will be hearing at our meeting from Gavi Board member and Senegalese Health Minister, Dr. Awa Marie Coll-Seck, about how Ebola has affected her country and the lessons that can be drawn from Senegal's experience.

In the worst affected countries, Ebola continues to spread. To date, there have been over 15,000 reported cases, which have resulted in nearly 6,000 deaths. These figures are almost certainly under-estimates. There are hopeful signs that transmission is slowing in Guinea and Liberia, but it is too early to tell if this is a long-term trend while the outbreak in Sierra Leone continues to accelerate. There are also concerns that the situation could worsen in Mali, with eight cases and six deaths reported to date.

While the death rate is appalling, it is only one aspect of the impact of Ebola. The economic and social fabric of the affected countries have been devastated. A World Bank survey found nearly half of Liberians who were employed when the outbreak began are no longer working, while supply chains for food and other commodities have broken down and there are concerns over the coming harvest. There are also stories of desperate communities persecuting people suspected of carrying Ebola. The scars and long-term impact of this disease will run deep.

The World Bank estimates that the economic impact on the three worst-affected countries will be over \$2 billion in 2014-15, with the economies of Liberia and Guinea contracting in 2015, reversing years of rapid economic progress. The Bank estimates that the cost to the region could be as high as \$32 billion, while the IMF has reduced its growth projections for Africa from 5.5% to 5% largely due to Ebola. Both organisations have warned about the economic risk for the whole continent if the outbreak is not brought under control quickly. And of course, there is still a very real risk that the disease spreads further. A single case in a slum community with poor health services anywhere in the world could quickly turn into a new outbreak. Ebola is therefore truly a threat to human security globally.

As the epidemic has continued to spread, there has been a growing focus on the potential impact of an efficacious vaccine. In conversations with a diverse range of leaders, including Ministers of Health, Heads of Agencies, donors, civil society organisations (CSOs) and others, I have been struck by the consensus that Gavi has a critical role to play in accelerating availability of such a vaccine. Although Gavi is not an emergency response organisation, this situation underlines the relevance and power of our model. Working with partners, we have utilised the capabilities and infrastructure of the Alliance to develop a robust approach to potentially make a vaccine available as soon as it is proved efficacious. It is important to recognise that working at this speed does present some risk. The Board paper reflects our attempt to compress into eight weeks what would usually take over a year of analytic and consultative work. Moreover, Gavi's engagement in Ebola will take us into uncharted territory by potentially supporting vaccines with limited safety and efficacy data, and deploying that vaccine in an emergency situation which is inherently riskier than our existing programmes.

The role we propose for Gavi has four components. First is to create a funding structure to enable sufficient production levels and rapid procurement if a viable candidate becomes available. Second, we recommend supporting operational costs of vaccine roll-out to enable effective and timely delivery of these vaccines. The third component is to fund a stockpile to enhance preparedness for future outbreaks, including encouraging development of a second generation (e.g., multivalent, temperature-stable) vaccine. The final element is to help rebuild health systems in affected countries and in particular to re-establish immunisation services, including funding catch-up immunisation for children who missed their routine vaccines due to Ebola. While not directly related to the Ebola vaccine, this last piece is critical. Even now, many more people are dying in affected countries from diseases other than Ebola. President Johnson-Sirleaf of Liberia made this point in a recent Washington Post op-ed, observing that "with the malaria season setting in and routine immunisation programmes stopped, even when this outbreak is over we must prepare for other diseases to take hold". She called on donors, including Gavi, "to help rebuild our health systems, invest in health facilities, staff and equipment and restore immunisation levels." I want to thank

President Johnson-Sirleaf for her unwavering support to Gavi and Replenishment despite Ebola, including insisting on maintaining the event she had agreed to host for Gavi at the UN General Assembly and personally ensuring that President Keita of Mali stood in her stead when she was unable to travel to New York.

Liberia's experience demonstrates how years of economic development can be undermined by a sudden disease outbreak. After decades of instability and conflict, it has been among the world's fastest growing economies. By investing some proceeds of this growth in health – including more than doubling routine immunisation (RI) coverage since 2004 – it became the first sub-Saharan African country to achieve the fourth Millennium Development Goal (MDG) of reducing child mortality by two-thirds from 1990 levels. Ebola threatens to reverse this progress and underlines why it is critical that a renewed commitment to health underpins the **Sustainable Development Goals (SDGs)**. The SDGs will guide global development efforts post-2015 and Gavi is advocating strongly that health must remain central as a key enabler for equitable sustainable development. We are also calling for the goals to be measurable and easily communicated with ambitious and clear indicators to track progress. Gavi's results-driven public-private partnership model and our experience with innovative financing and market-driven solutions has featured in many reports on the post-2015 agenda.

The draft SDGs include the target of achieving universal health coverage (UHC). We believe that immunisation can be an important pathfinder for UHC, as the health service that routinely reaches the greatest number of children and as one of the most efficacious and cost-effective health interventions. In line with the Lancet Commission on Investing in Health's concept of progressive universalism, we believe that reaching every child with routine immunisation can provide a platform for delivery of other healthcare services over time. We are therefore delighted that the importance of immunisation is explicitly recognised in the draft SDGs and are advocating for inclusion of an ambitious indicator – such as the fully immunised child – as one measure of the world's progress towards UHC.

A recent report by the World Health Organisation's (WHO) Strategic Advisory Group of Experts (SAGE) on implementation of the **Global Vaccine Action Plan (GVAP)** provides a timely reminder of the importance of vaccines and how much more we have to do to deliver the full benefit of immunisation to every child. The report finds that implementation is "far off track" with only one of six targets likely to be achieved. The target which is on track is that in which Gavi is most directly engaged – ensuring 90 low or middle-income countries introduce at least one under-utilised vaccine by 2015. The others – interruption of polio transmission, global elimination of maternal and neonatal tetanus, regional elimination of measles and rubella, and reaching 90% DTP3 coverage in every country – are likely to be missed. As the report notes, "there is a pressing need to expand and

strengthen the delivery of vaccines, so that they protect all people” and address the 1.5 million deaths that still occur each year from vaccine preventable disease.

The SAGE report identifies five problems to address including poor data, vaccine affordability and supply, and lack of integration. Gavi is already working to help address these challenges and is engaged in some capacity in five of the GVAP targets (the exception being maternal and neonatal tetanus, which we did fund in the past through an investment case). As we move towards the next strategy – with a focus on coverage and equity of immunisation – it is a timely moment to reflect on how Gavi can better support progress towards the GVAP targets and ensure better integration at global and country level so that routine immunisation becomes the centrepiece of all our efforts to tackle vaccine-preventable disease.

Programme and policy update

2014 has been a truly remarkable year for Gavi’s programmes. The Alliance has already supported a record 44 **vaccine introductions**, more than all of 2013 – itself a record year. We expect to surpass 50 by December 31, meaning Gavi will have supported nearly one introduction every week of 2014 on average. This was also the year in which we celebrated the introduction of pentavalent vaccine in every Gavi country, following its launch in South Sudan in July (with extraordinary support from partners given the volatile situation). This demonstrates how far we have come as an Alliance from our starting point in 2000, when fewer than 10% of low-income countries had introduced Hepatitis B vaccine in their national immunisation schedules and fewer than 5% had introduced Hib. Fifteen years later, pentavalent vaccine is no longer a “new” vaccine but a key building block of routine immunisation programmes in all of the world’s poorest countries.

We have also achieved our 2015 introduction targets for each of pentavalent, pneumococcal and rotavirus vaccines (though we are still below our coverage targets). We had already surpassed our target of 69 countries using penta by the end of 2015, with the vaccine in every Gavi country as described above. This year we also reached our targets of 45 countries using pneumo and 33 using rota over a year ahead of schedule. Given these targets were deliberately ambitious, this is a huge achievement. Of course, over the same period we also broadened our portfolio with support for a number of additional vaccines. This year, in line with Board decisions, we opened support windows for Japanese Encephalitis (JE) and routine Meningitis A vaccines and initiated support to the Oral Cholera vaccine stockpile. We expect the first JE vaccine introduction in Laos next year.

At the end of 2013, we also opened a window for inactivated **polio** vaccine (IPV) following the Board’s decision last November. This programme has been implemented at unprecedented speed. In February – within three months of the Board – UNICEF finalised a tender for IPV with prices as low as €0.75 per dose (for a 10-dose vial). Thanks to intense support from partners, 66 countries (over

90% of those eligible) applied within the first year of the programme. This unprecedented rate of applications is remarkable but the harder work will be to ensure that every country successfully introduces the vaccine by the end of 2015, as recommended under the *Polio Eradication and Endgame Strategic Plan*. Nepal became the first country to launch IPV with Gavi support in September. The Alliance is working closely with the Global Polio Eradication Initiative (GPEI) to ensure all remaining countries are able to introduce by the end of next year.

Given rapid progress on IPV, there is a growing focus on the other component of Objective 2 of the Endgame strategy: strengthening RI. This is critical for polio eradication and control – as routine immunisation is the only sustainable way to maintain high immunity long-term – but is also a huge opportunity for RI to benefit from the capacity and know-how of the polio programme. Nigeria's success in controlling Ebola, due in large part to lessons learned and capabilities borrowed from polio, demonstrates the contribution polio can make to strengthening the broader health system. We are engaging extensively with GPEI – including at senior levels and through the Immunisation Systems Management Group (IMG) – to accelerate progress on RI strengthening. Early progress is encouraging with eight of the ten Endgame focus countries having integrated annual EPI plans, which explicitly align RI and polio efforts and resources. There is also growing evidence on how the polio programme can best contribute to RI strengthening. For example, work in Punjab (Pakistan), where RI vaccinators spent 30% of their time on polio campaigns in the first half of 2014, demonstrated it was possible to run successful campaigns without adversely impacting RI. The same project also identified more targeted interventions for polio staff to help address the specific needs of the EPI programme at scale (enhancing data collection, performance management and training of supervisors). This progress is encouraging but more work is needed to ensure polio staff adequately prioritise RI in every country, and that integrated EPI plans include accountability frameworks and harness the polio programme's capabilities as effectively and strategically as possible.

Funding for IPV introduction in **India** was not included in the Board decision since they had signalled to both GPEI and Gavi that they planned to self-finance the vaccine. It was therefore a surprise when India submitted an application for Gavi support in September. We are discussing the reasons for the application with the Ministry of Health and Family Welfare, and it seems to be linked to the decision of the new Government to accelerate introduction of other vaccines including rota, Japanese Encephalitis and rubella. This renewed commitment to immunisation is exciting as India has over 30% of the world's under-immunised children (based on the number of children receiving three doses of a DTP-containing vaccine) and a far higher burden of vaccine-preventable disease than any other country.

We have agreed with GPEI that catalytic support for IPV introduction in India may be appropriate if additional funding is made available. This will ensure that India

can meet the Polio Endgame timeline for introduction (which is important since India is a Tier 1 country) without adversely impacting introduction plans for other new vaccines. It would build on the success of penta, which India is currently rolling out to all States with catalytic Gavi funding and for which the Government will take on full financing from 2016. The Independent Review Committee (IRC) recommended approval of India's application with clarifications and we will therefore present a proposal at this Board meeting for Gavi to provide catalytic support, subject to GPEI providing the necessary funds (they have indicated that they will do so). In parallel, we are developing a new cross-cutting strategy for Gavi's engagement with India given the Government's ambitious immunisation plans, the likelihood that India will pass the eligibility threshold in 2016 and the need to assess potential Gavi support after that date given its unique model¹.

The situation in **Pakistan** – one of the largest Gavi-eligible countries after India – remains challenging. Polio is still the top priority with Pakistan now home to 80% of the world's cases and its polio programme heavily criticised in the latest Independent Monitoring Board (IMB) report. Pakistan has been approved for Gavi IPV support with national introduction planned for June 2015. Routine immunisation continues to perform poorly with coverage of a 3rd dose of DTP-containing vaccines estimated at 66% nationally but far lower in many areas. Pakistan has been implementing a preventive measles SIA (supplementary immunisation activity) with Gavi support. Sindh and Khyber-Pakhtunkhwa provinces conducted the SIA in May 2014 and we are awaiting finalisation of the relevant coverage reports (CSOs are participating in the social mobilisation activities to support a high-coverage SIA). The government is aiming to complete the SIA in most of the rest of the country by the end of this year.

Devolution of the Ministry of Health means that there is confusion in roles and responsibilities between national and provincial levels with high variability in programme performance across the country. This has contributed to the country's inability to spend US\$3.3 million of Health System Strengthening funds which have been deposited with the State Bank of Pakistan since 2010. Pakistan was also in default for its 2013 co-financing until recently due to a court case which ruled the programme could not procure through UNICEF. We organised a high-level meeting – including several Gavi Board members – with the Minister of Health at the World Health Assembly to help resolve these issues and advocate for stronger action to strengthen immunisation. We had planned a follow-up mission to Pakistan in September to meet key leaders at federal and provincial levels but this had to be postponed until February due to the political situation. We will intensify our work with Pakistan, including assigning a dedicated Senior

¹ India has not historically co-financed Gavi-supported vaccines, instead self-financing introduction costs, syringes and other consumables; and taking on full financing after a period of catalytic vaccine support. As things stand now, India will not receive any vaccine support from Gavi during graduation.

Country Manager (SCM), given the size of its birth cohort and our investment, as well as the poor performance of their immunisation programme.

In August, **Niger** conducted a double launch of pneumococcal and rotavirus vaccines. It was the fourth country to simultaneously launch two vaccines with Gavi support, an approach pioneered by Ghana in 2012. While many countries remain cautious about the logistical challenges and additional management capacity required, there is growing evidence of the potential operational benefits of double launches. With the number of vaccine introductions still accelerating – especially with a spike in IPV launches next year – we will continue to support countries to consider and implement this approach where appropriate.

Senegal also launched two vaccines in short succession this month, separately introducing rota and HPV in the same week. This was a remarkable achievement given the country was only recently battling Ebola and the launches occurred at the same time as the *Organisation de La Francophonie* summit. I was delighted to attend the launch with Prime Minister Mohammed Dionne of Senegal, Prime Minister Harper of Canada and of course Gavi Board member Awa Marie Coll-Seck.

As countries continue to introduce new vaccines, most are also making progress in boosting **coverage** to ensure those vaccines reach every child. In July, *WHO and UNICEF Estimates of National Immunization Coverage (WUENIC)* showed coverage with a third dose of DTP-containing vaccines across the 73 Gavi countries reached 76% in 2013, up from 74% in 2012. This means more children are being reached than ever (particularly due to growth in the birth cohort each year) and, we hope, ends several years of stagnation. Separate estimates from the Institute for Health Metrics and Evaluation (IHME) also confirm this upward trend. Several large countries (Nigeria, Ethiopia, Sudan, Indonesia) contributed significantly to this progress, most notably Nigeria where coverage more than doubled after recovering from recent problems with stock-outs and domestic financing. The numbers may also be artificially reduced by the situation in two other large countries: Vietnam, where the penta programme was temporarily halted in 2013 due to concerns over suspected adverse events (but coverage has now recovered); and India, where lack of high-quality data means WUENIC has not been adjusted since 2008 despite anecdotal evidence of progress.

Despite this progress, we are not on track to achieve Strategic Goal 2 coverage targets and more work is needed to ensure sustained improvements in coverage (this will of course be a priority in our 2016-20 strategy as described in the next section). To address this, we continue to enhance health system strengthening support to countries including through the **performance-based funding (PBF)** mechanism. In July, Laos and Burundi became the first countries to receive PBF payments in recognition of coverage improvements and Burundi maintaining

equitable coverage. We are now routinely integrating PBF into our HSS grants and several countries (such as Zimbabwe and Tanzania) are also working to incorporate performance-based incentives in sub-national programmes. While this is encouraging, challenges remain, especially poor data. We will continue to learn and refine the mechanism as we introduce more PBF grants. For example, in response to data quality issues we are integrating better monitoring and evaluation (M&E) frameworks, including intermediate indicators, into each grant and supporting countries to conduct data quality assessments.

We are also operationalising the Alliance **supply chain** strategy, which the Board approved in June. This will support countries to transform their supply chains and ensure they are not a constraint on coverage and equity of immunisation. The Supply Chain Taskforce – led by the Secretariat and UNICEF with the participation of other partners – has developed a detailed implementation plan for 2015, focused on putting key building blocks in place in every country (e.g., moving from just assessing supply chain performance and challenges to implementing improvements through HSS, Business Plan and other support). This will lay the foundations for more transformative changes in the next strategic period.

In parallel, we are also piloting a number of innovative new approaches. Through the business plan, Gavi has funded WHO to support Mauritania in implementing a controlled temperature chain (CTC) for Meningitis A vaccine. CTC enables vaccines to be transported at ambient temperature (up to 40°C) for up to 4 days, ensuring cold chain availability is not a constraint to last-mile vaccine delivery. By the end of the year, we expect to also support CTC implementation in Togo and Côte d'Ivoire. We will continue to help countries roll out this innovative approach and are hopeful that over time other vaccines may also be licensed for CTC. We are also working with the Global Fund and others to support countries (such as Tanzania) to implement electronic Logistics Management Information Systems, which provide an unprecedented ability to manage supplies and inventory levels.

Earlier this year, we launched the Gavi Supply Chain Fund with dedicated funding from the ELMA Foundation. It is designed to provide flexible and rapid support to help countries address specific supply chain bottlenecks for which other funding is not available (e.g., due to their urgency / unforeseen nature). A number of countries have applied for Supply Chain Fund support and we have already disbursed funding to Mali and Cameroon, with a third grant to Niger expected within weeks. While the value of these grants is relatively small (the programme is only \$4 million), impact to date has been significant supporting, for example, targeted cold chain capacity expansion to prevent vaccine introduction delays and innovations in temperature monitoring. Moreover, the grants appear to be having a catalytic impact by introducing new technologies to countries (e.g., solar direct drive and freeze-free refrigerators), which some are then choosing to

fund out of their own resources. For example, the Government of Mali added \$175,000 of its own funds to support from the Supply Chain Fund to procure additional equipment, and the local UNICEF office provided a further \$35,000.

More broadly, countries continue to increase their investment in immunisation. Government expenditure on vaccines in the 73 Gavi-eligible countries grew from \$3.78 per child in 2010 to \$4.28 in 2013. **Co-financing** for Gavi programmes has been a key driver of this increase. In total, countries contributed over \$75 million in co-financing for 2013, 20% more than for 2012. It is clear, however, that this growth is increasingly challenging for some countries. 14 of the 68 countries who are required to co-finance failed to meet their full 2013 obligations by the end of the year. Gavi worked closely with these countries and only 3 remain in default – Zimbabwe which has paid all but \$100,000, and Pakistan and Angola which have just made payments which UNICEF should receive shortly. We expect that all countries will be out of default by the end of the year. However, it is likely many of the same countries will again be in default next year since they are now behind on 2014 co-financing. We also know 22 Gavi countries depend on donor funds to pay for “traditional” vaccines while most are co-financing their Gavi vaccines. This is clearly not consistent with long-term sustainability of immunisation.

Given these challenges – and the increased focus on sustainability in the 2016-20 strategy – it is timely for us to be reviewing Gavi’s co-financing policy. One element of the review, which will come to the Board in June, will be to examine if the design of the co-financing mechanism can be adjusted to help reduce the risk of default. Our capacity to engage with Ministries of Finance to increase the fiscal allocation for vaccines will be substantially enhanced by closer collaboration with the World Bank. We are therefore delighted that the Bank is deepening its engagement with the Alliance, including through new work on domestic financing funded under the Business Plan. We also welcome the focus of the Bank-hosted Global Financing Facility on securing increased domestic investment in health.

Increasing domestic investment is particularly pressing for graduating countries, who are taking on the full cost of their immunisation programmes. In parallel to the co-financing policy review, we are reviewing our **eligibility and graduation policies** to ensure they optimally contribute to the Gavi mission while ensuring programmatic and financial sustainability. The PPC discussed the findings of the first phase of the review in October. While the current wave of graduating countries – who entered graduation when the five-year transition was introduced in 2011 – are largely on track to graduate successfully, some countries in the next wave may face challenges. This is due to the combined impact of having introduced more vaccines with Gavi support (so taking on a higher cost per child); having higher fertility rates (so more children to immunise per capita); and having lower average GNI per capita when they enter graduation (since most of

the first wave were already significantly above the eligibility threshold when the graduation policy was introduced). The second wave of graduating countries is also likely to have lower immunisation coverage at graduation. Given these findings, PPC members agreed that further analysis and consultation are merited and asked the Secretariat to explore options for a more tailored approach to graduation to increase the probability that countries transition out of Gavi support successfully. At the same time, the PPC made clear that if any changes are made, they should preserve the catalytic nature of Gavi's model and not create perverse incentives nor expand eligibility beyond the current 73 countries. We will submit analyses and options for decision to the PPC in May and Board in June.

In order to strengthen Gavi's support to countries during the graduation process, last year the Board approved an enhanced approach to engaging graduating countries. This includes helping countries develop graduation plans and providing targeted graduation grants, if needed, to address bottlenecks to sustainability. To date, the Secretariat and Alliance partners have conducted eight graduation missions to help countries develop graduation plans, and we have approved two graduation grants. We plan to visit a further 11 countries next year.

Access to affordable **pricing for graduated countries** will be critical to ensure financial sustainability. Following discussion at the PPC in May, the Secretariat has continued its work on access to appropriate prices (ATAP) in collaboration with Alliance partners, countries and other stakeholders. In line with the PPC's feedback on the need for greater consultation, we have constituted two groups to support this work (in addition to a number of country consultations): a Senior Advisory Group (SAG) to provide overall guidance and a Task Force to conduct analyses and consultations. Both bodies include participants from WHO, UNICEF, the Gates Foundation, the World Bank, countries, donors, civil society, the Pan-American Health Organisation (PAHO) and academia. The SAG met for the first time in October and the Task Force is holding bi-weekly calls to drive the work forward. We aim to bring recommendations to the PPC in May 2015.

As we have previously discussed, the **Least Price Clause** imposed by PAHO's Revolving Fund could potentially deter manufacturers from offering lower prices for Gavi graduates. I was therefore encouraged that the future of the Revolving Fund was an item for discussion at the September meeting of PAHO's Directing Council. We hope that through PAHO's engagement in ATAP and ongoing dialogue, we will be able to find a mutually beneficial solution for Gavi and PAHO countries (including PAHO countries which are graduating from Gavi support).

Gavi continues to work on **market shaping** more broadly. In 2014, we finalised a roadmap for pneumo and updated the roadmap for penta. Roadmaps for Men A, cholera and HPV are currently in development. These roadmaps have proved effective in aligning Alliance partners around common market shaping objectives

and strategies for each vaccine, and they continue to bear fruit. In addition to the newly secured IPV price, we have also seen the weighted average price of fully immunising a child with penta, pneumo and rota fall to \$21 in 2014, 5% lower than in 2013 and a 40% reduction since 2011. We expect further manufacturer commitments as part of Replenishment including price reductions, development of innovative and cost-saving presentations and price sustainability commitments for graduated countries. We are particularly focused on cost savings for pneumo, which is forecast to account for nearly half of Gavi's 2016-20 vaccine spending.

Preparing the Alliance for continued success

In June, the Board approved the high-level strategic framework which will guide the Alliance's work during the **2016-20 strategy** period. A critical next step is to define targets for what we seek to achieve during this period and indicators to measure our progress against those targets. Two parallel streams of work are under way. The first focuses on Gavi's direct impact with targets and indicators linked to each strategic goal. For example, we are working on a composite indicator to measure uptake and coverage of multiple vaccines and identifying indicators to track various dimensions of equity (e.g., by income level, by geography, gender-related barriers). This work is being led by the Secretariat with a core group composed of WHO, UNICEF, the Gates Foundation and the United States Centers for Disease Control and Prevention (CDC). The second stream focuses on the proposed "disease dashboard", which will include empirical measures of the health impact to which the Alliance contributes. To support this work, we have convened a technical consultation group with experts from partners and other research and technical institutions. A prioritisation exercise is under way to identify indicators which measure the largest drivers of health impact (such as pneumonia, diarrhoea, hepatitis B, and measles) while leveraging existing data sources, drawing from partner investments and aligning with indicators for other global and regional initiatives. We will be consulting with Board constituencies in March on a draft set of targets and indicators, and plan to present a final proposal to the PPC in May and the Board in June.

In parallel, we have also launched a number of workstreams to develop the strategies, policies and mechanisms required to fully operationalise the strategy. The previous section described a number of key components – including our supply chain strategy, ATAP and the ongoing reviews of the co-financing and eligibility and graduation policies. We are working with partners to develop our strategies in other critical areas highlighted in the strategic framework including coverage and equity; data quality, availability and use; a refresh of the vaccine supply & procurement strategy; initial work to explore possible market shaping of non-vaccine commodities such as cold chain equipment; private sector engagement; and will launch further work on leadership, management & coordination and demand generation next year. We will keep the Board informed

of these as they are developed. We also continue to follow development of the leading malaria vaccine candidate very closely. In last year's Vaccine Investment Strategy, the Board asked that we bring back the decision on opening a window once the vaccine is licensed and recommended for use by the joint meeting of the WHO Strategic Advisory Group of Experts and the Malaria Policy Advisory Committee. We anticipate this recommendation will be issued in October next year, and we will then bring a recommendation on Gavi support to the earliest possible Board meeting. If the Board was to approve support for a malaria vaccine we could open a window as early as 2016 if there was adequate funding.

Achieving our goals for the next period – especially a step change in coverage and equity – will require more than just new strategies. It will also require that we further enhance the **way the Alliance works** at global, regional and country levels. In October, we organised a workshop with current and potential future partners, donors and other Alliance members to discuss how we could work differently at country level – especially in the countries with the most under-immunised children – to accelerate progress on coverage and equity. We agreed to conduct in-depth analyses in up to five countries over the coming months to understand key barriers, align on strategies to address these and agree on how the Alliance should work differently to support those strategies. This work will build upon joint appraisals, EPI assessments, and other information sources. We will use the findings to inform decision-making on how we strengthen the Alliance model – including processes, policies and systems – across all Gavi countries.

We are also reviewing how we coordinate the Alliance's work at global and regional level including re-designing how activities are planned, coordinated and funded. We are looking to replace the current business plan process to enable Gavi to be more country-focused, strategic, flexible and accountable. This will also draw on the deep insights on countries' programmes and needs generated through the detailed reviews presented to the High Level Review panel, which just completed its first full cycle. The 2015 business plan – which the Board will review at this meeting – includes early changes in this direction but is primarily a bridging plan with more significant changes to be implemented from 2016. We are also evaluating if the bodies which coordinate the work of the Alliance – such as the strategic goal management teams – should be redesigned, strengthened or supplemented to enhance cross-Alliance communication and coordination, avoid silos, and provide the right fora to engage on country-specific issues.

To deliver on our ambitions for the next strategic period, the Alliance needs to be fully funded at our upcoming **Replenishment**. We are now coming to the end of an intensive 60-day campaign to influence budget processes and decision-making in key donor markets. We have received strong and positive signals from most donors, thanks in large part to the support provided by a wide coalition of partners, advocates and champions. In particular, I wanted to thank the many

civil society organisations who have campaigned tirelessly for Gavi and the Heads of State and Ministers from a number of Gavi countries who have acted as Champions on our behalf. Bill and Melinda Gates have both also been deeply engaged and the German Government has played a critical leadership role. This has included extensive outreach and advocacy by Chancellor Merkel herself, which has significantly influenced the decision-making of a number of donors.

As you are aware, several donors have already made official announcements. In September, Prime Minister Solberg of Norway announced a pledge of at least \$215 million per year for 2016-20 (matching their 2015 contribution) and we hope that this may increase further. Last week the UK, Gavi's largest donor, pledged an additional £1 billion for the next period in addition to existing IFFIm and AMC commitments. This is an increase from the £814 million of new funding which the UK committed in 2011. At last week's Francophonie Summit, Prime Minister Harper of Canada also announced a large increase with CAD \$500 million in new funding. And the Dutch Parliament approved a motion calling on the Government to increase its contribution from €40 million to at least €50 million per year, despite pressure on their aid budget. In addition, Chancellor Merkel has publicly committed that Germany will pledge at least €500 million through to 2020.

Each of these donors increased their pledge compared to 2011-15 and we are very grateful for their leadership and support. These commitments provide strong momentum as we approach the Pledging Conference and mean we are over halfway to our Replenishment ask. Nonetheless, there is no room for complacency. Many donors are yet to decide on their 2016-20 commitments, and face the dual pressures of fiscal constraints and unforeseen needs including Ebola, Syria, Ukraine and other crises. While we remain optimistic that we can achieve our target – and expect commitments from a number of new donors – we are unlikely to know the final outcome until the Pledging Conference itself. We still need all of our donors, and our champions, to step up if we are to be fully funded.

The Replenishment ask did not include a provision for Ebola. Given the urgency of the outbreak and need to act, I am exceptionally recommending that Gavi proceed with the recommendations of the Ebola paper before all of the necessary new resources are secured. To jumpstart implementation, Gavi can make US\$100 million available from existing resources (based on reduced demand estimates for other programmes due to high in-country stock levels and vaccine introduction delays including in Ebola-affected countries). To be sustainable and not impact achievement of our 2016-20 strategy, we will immediately engage with key partners to help secure funding for Ebola vaccines (and specifically for Gavi's Ebola response) from financing already committed by donors for the Ebola effort. We have already had positive discussions with the African Development Bank (AfDB), which is helping to lead and finance a regional response and is willing to

commit at least US\$ 50 million (subject to approval from their Board of Directors). This leaves a gap of up to US\$250 million given the projected Ebola cost envelope. Other donors have also expressed interest and we hope Board members, both governmental and otherwise, will work with their constituencies to help us that ensure this special financing support is understood and forthcoming.

Our ability to proceed as proposed is in part due to the financial flexibility provided by the international Finance Facility for immunisation (IFFIm). IFFIm gives Gavi early access to liquidity from pledges that will be contributed later. The Ebola situation demonstrates the powerful role that IFFIm plays for Gavi enabling some of today's immunisation needs to be met from future contributions. That is why as part of our Replenishment ask we have asked that donors contribute at least \$1 billion through IFFIm. As part of Replenishment, we also hope to secure new support for the Gavi Matching Fund which, with support from DFID and the Gates Foundation, has helped attract over \$100 million in private sector support to Gavi to date. We anticipate that a number of private sector partners may make new commitments in Berlin. Further details on the Replenishment effort are included in document 08 and we will provide a further update when we meet.

As we approach Replenishment and the next strategy period, we are enhancing our focus on **risk management**. Risk management at Gavi has evolved significantly over the past 14 years. However, we believe this is an appropriate moment to systematically review our approach, and strengthen as required. Effective risk management is critical to maintain donor confidence as we ask for another \$7.5 billion in funding, especially in a context of declining risk appetite among some donors. As Gavi continues to grow in scale and expenditure (e.g., threefold increase in active programmes between 2011 and 2015; tripling in cash grants since 2010), it is important to ensure our risk management capabilities adjust accordingly. Moreover, Gavi's new strategy – with its enhanced focus on coverage and equity, especially in the weakest countries, and on financial sustainability with the first wave of countries graduating – will bring significant new challenges and risks.

We are developing a comprehensive risk framework for Gavi and will discuss the first two components in operationalising the framework at this Board. Firstly, the proposed Risk Policy provides an overarching frame for how we manage risk. It seeks to calibrate and align the Alliance's understanding of risk, risk appetite in key areas of our business and principles of our approach to risk management. Fiduciary risk is a particular priority given Gavi's primary function as a financing organisation. We are therefore also proposing a number of changes to enhance Gavi's structures, processes and resourcing to efficiently manage fiduciary risk, with an initial focus on the Secretariat. These changes will enhance our ability to manage risk more broadly and serve as a foundation for further strengthening going forward. We have requested additional funding to support some of these

changes in our 2015 budget request. However, given the importance of this issue, we have already re-allocated some of the Secretariat's 2014 budget, as discussed with the Executive Committee and AFC, to accelerate implementation.

One outcome of the proposed changes will be to enhance our capacity to assess and strengthen countries' financial management systems, and to regularly audit their use of Gavi support. We have a strong record of managing any identified **misuse** of Gavi funds and securing reimbursement. However, we believe it is appropriate to further strengthen our capabilities in this area given that Board members have emphasised they have no tolerance for misuse. Since the last Board, two countries have fully reimbursed Gavi for misused funds (Madagascar and Sierra Leone, which paid despite Ebola). This means 60% of the funds Gavi has identified as misused to date have been repaid (countries have committed to reimburse 100% of funds identified as misused). Four cases remain open (Nigeria, Niger, DRC and Cameroon). The largest is Nigeria with \$2.2 million of misuse identified by the recent audit. The Government has agreed in principle to reimburse funds identified as misused; to appoint a fiduciary agent to oversee financial management of Gavi grants at federal and state levels; and to a full-scale audit. I will update you on this at the Board meeting.

Organisational update

In October, Publish What You Found released its latest **Aid Transparency Index** which rated Gavi in the top "very good" category for the second year running. The report ranked Gavi fourth of the 68 international development organisations evaluated and particularly commended our transparent publication of programme documents, organisational plans and financial information. This transparency is critical for all parties involved in the Alliance's work – donors, countries, partners, CSOs and Secretariat staff – to hold each other accountable, especially given our Alliance model which relies on all partners working successfully together.

Gavi's **governance** bodies are one critical transparency mechanism. We have been working hard with the Board and Committees to increase the efficiency and effectiveness of Gavi's governance. One element of this has been to reduce the number of governance meetings. In 2014, there will be 38 meetings of the three Gavi-related Boards (Gavi Alliance, IFFIm and Gavi Campaign) and Committees, down from 51 in 2011. We will continue to work to streamline these meetings to ensure we use Board and Committee members' time as efficiently as possible.

This meeting will see the highest turnover of Board members in Gavi's history. We have ten Board seats and seven Alternate seats becoming vacant and 11 more Board seats will become vacant in 2015 (with three new Board members taking their seats for one meeting only). Over the next year, we will also see a new Board Vice Chair, AFC Chair, Investment Committee Chair, and Evaluations Advisory Committee Chair. This level of turnover – which was a challenge the

Board itself highlighted in the self-assessment – makes it more difficult to have a sustained strategic dialogue among Board members and to maintain strong institutional memory. At the Board's request, we have introduced more structured and intensive onboarding for new Board members to help mitigate this challenge and this has received positive feedback to date. The turnover has highlighted one important development – a significant increase in competition for Board seats within developing country constituencies. Until recently, a number of developing country Board seats remained unfilled for extended periods of time. By contrast, today there are multiple candidates for many of these seats with constituencies actively debating whom to nominate. This is a welcome trend given the critical importance of developing country voices in Board discussions and decisions.

At this meeting we are losing two of our longest-serving Board members. George Welde has served on the Board – and as Investment Committee Chair – since our earliest days. He has helped oversee a portfolio that has contributed almost \$400 million to Gavi's mission and played a critical leadership role during the governance transition in 2007-08. George's voice has been so vital in our discussions, tirelessly pressure-testing our assumptions and asking how Gavi can do, and be, better. Despite stepping down, he will remain engaged in Gavi's governance as he is leading the search for the next Board Chair (for the second time!) and as an advisor to the Investment Committee. We also say farewell to Ashutosh Garg who has served on the Board since before the governance transition. Ashutosh has been an important member of the Executive Committee, providing much-needed continuity, an independent perspective and always challenging us to do more. Ashutosh knows first-hand how much more there is to do, having effectively served as Gavi's point person in his home country, India, which has the most under-immunised children of any country in the world. I look forward to celebrating both of them when we meet, as well as thanking Geeta – who will step down as Vice Chair but will thankfully remain UNICEF Board member – and all our other departing Board members.

This will also be Debbie Adams' last Board meeting as she will be leaving Gavi at the end of the year to return to her family in the UK. As Gavi's Managing Director of Legal and Governance – and Secretary to the Gavi Board – Debbie has played an important role in building highly professional legal and governance functions in the **Secretariat**. I know from conversations with many Board members that she will be greatly missed. We are in advanced stages of the search for a new Director of Governance to join soon after Debbie's departure. Early in the new year, we will also welcome Edmund Grove as the new Director of Country Programme Audit. This is a new position created as part of our efforts to strengthen fiduciary risk management. Edmund brings many years of experience working in audit and risk-related positions across the private and public sector. He joins Gavi from UNOPS where he worked for three years as a Deputy Comptroller, and most recently as Coordinator for Enterprise Risk Management.

This report highlights some of the growing demands on the organisation. Board members have asked at previous meetings whether I feel Gavi is adequately resourced to deliver on everything that the Board has requested. I am concerned that we are now facing a real risk of overstretch as we continue to add new – and often unanticipated – mandates (including polio and Ebola in the last year alone) for which we do not have surge capacity, and face the challenges of the next strategy period. Given this concern, we are commissioning a leading consulting group to benchmark the resources of the Secretariat, assess whether teams are right-sized to deliver on expectations, and identify potential areas to improve the efficiency and performance of the organisation. This will be an important topic for conversation in June. In the meantime, we are working to accelerate planned recruitments to address the most acute capacity constraints. We have also accelerated discussions with the Global Fund to identify areas where closer collaboration could help improve both organisations' efficiency and effectiveness.

At the last Board, we unveiled Gavi's new **brand**. This is being rolled out across our materials and publications. You will notice that the papers for this meeting are on the new template and our website has been re-launched. We will continue to introduce the brand across Gavi's business in a phased fashion as we use up existing materials. We have received many positive comments on the new brand and I look forward to further feedback from Board members when we meet.

Lastly, I wanted to update the Board on the progress of the **Health Campus**. This had been held up by a series of legal challenges and, until recently, appeared to have reached an impasse. However, we understand these issues have now been resolved and we hope that the building may be ready by late 2017 or early 2018. Given the delays in the Health Campus and capacity constraints in our current location, we have leased some temporary additional space in a building across the road. The operations team secured very attractive rents which mean the new space is cheaper per FTE at full capacity than our current building.

January marks not only Gavi's second Replenishment but also 15 years since Gavi was launched at the World Economic Forum in Davos. It will also coincide with the 500 millionth child being reached with Gavi support. This is a huge milestone. And we continue to accelerate – next year will see another new record for the number of vaccine introductions, with more than twice the number supported in 2014 (as most countries introduce IPV). With an enhanced focus on coverage and equity during our next strategy period, we will be reaching 60 million children annually, resulting in more than another million lives saved each year. I look forward to celebrating these achievements and discussing how we continue to build Gavi's future together when we meet next week.