

Report of the Chief Executive Officer

3 June 2015

Dear Board members

2015 is a year of transition for Gavi. It marks the culmination of our 2011-15 strategy period and our the busiest ever year for Gavi's programmes. At the same time, following our successful Replenishment in January, we are now preparing intensively to operationalise the 2016-20 strategy. This report provides an update on our achievements to date and how we are preparing for the future.

Delivering more than ever in Gavi's 15th anniversary year

Gavi celebrated its birthday in January, fifteen years after it was launched at the World Economic Forum in Davos. The Forum marked the anniversary with a "Davos moment" in front of world leaders during this year's Davos meeting. I was invited to address the plenary session and Professor Klaus Schwab, the Founder and Executive Chairman, commented that "I am very proud because Gavi was born here in Davos 15 years ago. It is one of the initiatives which you make possible through collaboration between the public and the private sector."

On January 27th, the Alliance received the best possible birthday present when donors fully funded our **Replenishment** ask. We received pledges of more than US \$7.5 billion in new contributions, with most donors increasing their funding and pledging for the full five year strategy period despite the difficult economic climate. We also welcomed four new donors to the Gavi family – China (the fifth and final BRICS country to become a Gavi donor), Oman, Qatar and Saudi Arabia. We are deeply grateful for the commitment of all our donors and especially appreciate the role of the German Government who, with Chancellor Merkel's personal leadership, played a critical role in ensuring Replenishment's success. Germany also put Gavi firmly on the international agenda (including the G7 which Germany currently chairs) during a critical year for global development. It also led the way in being the first donor to turn its pledge into a legal agreement along with the European Commission and our new Middle Eastern donors. We expect to finalise agreement with China at the end of this month and hope to sign agreements with France, the Gates Foundation and the Netherlands over the summer. We are

therefore making good progress towards our target of signing 75% of agreements by the end of 2015. We continue to engage with Japan, who were the only major Gavi donor unable to pledge for 2016-20 in Berlin (although they did double their support for 2015), and who will succeed Germany as Chair of the G7. Dagfinn met with the Government and political leaders in Tokyo last month and we hope they will make an announcement in the coming months.

The success of Replenishment provides a strong foundation to further **accelerate the Alliance's work** with Gavi-supported programmes projected to avert nearly as many deaths over the next five years as over Gavi's first 14 years. In 2015, we expect to support around 100 vaccine introductions and campaigns, more than double the number supported in 2014 (itself a record). As usual, country planning cycles mean that most are projected to take place in the second half of the year, a trend exacerbated this year as countries strive to introduce inactivated polio vaccine (IPV) before the end of 2015 to meet globally agreed timelines. So far this year we have supported 19 introductions, meaning the next seven months will be even more intense with more than one introduction every three days.

The latest introductions mean we have reached a number of milestones in our vaccine programmes, demonstrating the Alliance's progress over the past fifteen years. We now provide financing for 15 antigens, a three-fold increase over 2000, and support more than 310 vaccine programmes across Gavi countries. The five-in-one pentavalent vaccine is now the cornerstone of immunisation programmes in all Gavi countries. In addition to the traditional vaccines against diphtheria, tetanus and pertussis, penta also protects against hepatitis B and haemophilus influenza Type B (Hib). Vaccines against these latter diseases were available in only a handful of Gavi countries in 2000. 50 Gavi countries have introduced pneumococcal conjugate vaccine (PCV), just over four years after the first Gavi-supported PCV introduction, and over 35 have introduced rotavirus vaccine.

We are also seeing rapid implementation of our newer programmes. Three years after the Board decided to open a window for human papillomavirus virus (HPV) vaccine, more than half of the countries eligible for HPV support have been approved for a demonstration project or full launch. This is the second cancer vaccine Gavi supports (after Hepatitis B). It is vitally important given the rapidly growing burden of cervical cancer which now kills approximately as many women as childbirth globally, the vast majority in Gavi-eligible countries. Countries are forecast to scale-up IPV even more quickly than HPV. All 71 eligible countries seeking Gavi support for IPV have been approved and most are set to introduce by the end of 2015, less than two years after the Board approved the programme. Also in 2015, Laos became the first country to use Gavi-supported Japanese encephalitis (JE) vaccine and Ghana is expected to be the first country to introduce Meningitis A vaccine into its routine immunisation (RI) schedule later this year. Finally, it is possible that the first doses of Gavi-supported Ebola vaccine could be

procured this year, depending on clinical development timelines, regulatory decisions and the evolution of the epidemic.

Gavi's health systems strengthening (HSS) programme is also operating at unprecedented scale. Following the latest Independent Review Committee (IRC) recommendations, Gavi is managing 78 HSS programmes with commitments to countries totally US \$1.2 billion (covering 2007-19). As new grants have been approved, the portfolio has been increasingly targeted at improving immunisation outcomes, a requirement for all new applications since the Board approved a new approach in November 2011. Average coverage with three doses of a DTP-containing vaccine across the 73 Gavi countries increased in 2013 for the first time during this strategy period. As a result, more children than ever are being reached with routine immunisation in Gavi countries and we hope to see further progress when the 2014 data is released by WHO and UNICEF in July.

In its first 15 years, Gavi has also helped catalyse significant growth in domestic investment in immunisation. Country co-financing of Gavi-supported programmes for 2014 should exceed US \$100 million for the first time, once all countries have paid. We expect total co-financing to reach over \$440 million 2011-2015 and to grow two and a half-fold during the next period, reflecting the increasing number of Gavi-supported programmes and higher share of costs being funded by countries as they get wealthier. This represents a fraction of domestic investment in immunisation across the 73 Gavi countries, which GVAP projects will grow from US \$8 billion 2011-2015 to US \$12 billion 2016-20. As a result, countries will be financing nearly two thirds of their immunisation programme costs by 2020, up from under 40% in 2011. Working with countries to scale-up their expenditure on immunisation, and requiring them to take on more of the cost as they get richer until ultimately they transition out of Gavi support, is a core element of Gavi's development model. Four countries (Bhutan, Honduras, Mongolia and Sri Lanka) are set to make the transition to fully financing their programmes in 2015, the first countries to do so since Gavi's graduation policy was introduced in 2010.

While the overall picture is promising, some countries are facing challenges. Overall countries co-financed more vaccine programmes than ever in 2014, but 17 defaulted on co-financing for at least one programme. Seven of them had also defaulted in 2013, evidence of a difficult cycle of default in a subset of countries. Moreover, while most countries which have crossed the eligibility threshold are on course to graduate successfully, a limited number may face challenges. To address these issues, the Board is being asked to approve targeted changes to Gavi's graduation and co-financing policies as discussed below.

Focusing on progress in the largest countries

With the conclusion of Gavi's Replenishment, the Alliance has been able to fully concentrate on our number one priority – accelerating progress in immunisation in

Gavi-eligible countries. For me personally, this has meant a renewed focus on the largest Gavi countries which have some of the greatest challenges. Over half of under-immunised children¹ in the 73 Gavi countries live in five large nations – India, Nigeria, Pakistan, Ethiopia and DR Congo. If you exclude these five, average immunisation coverage across Gavi countries would be 83% as opposed to 76%² with them. Ultimately, our success as an Alliance in expanding access to immunisation and reducing mortality and morbidity will depend heavily on the performance of immunisation programmes in these countries. I will visit each of the above countries during 2015 and wanted to share some reflections from my trips so far as well as some updates on those I have not yet visited.

India alone accounts for nearly one third of the world's under-immunised children and has by far the largest burden of vaccine-preventable disease. It has lagged behind other Gavi countries, both in introducing new vaccines and in progress raising immunisation coverage (which, according to WHO / UNICEF data, has remained 72% since 2008 though that is partly due to lack of data). However, after its success eradicating polio India is now working to rejuvenate its RI programme and will complete national roll-out of pentavalent vaccine this year with Gavi's support. The new Government has committed to further progress and I was impressed by the ambition of the officials I met on my recent visit. India has already announced it will introduce four new vaccines (IPV, rota, measles-rubella (MR) and adult JE) and has launched Mission Indradhanush, which is closely aligned with Gavi's 2014-16 HSS grant, to improve coverage in the lowest-performing areas. This momentum is encouraging and there is an opportunity to further accelerate progress in coverage and new vaccine introductions with targeted support from Gavi. India is projected to cross Gavi's eligibility threshold this year and the Alliance's approved support is due to end next year. Given that other Gavi countries would remain eligible for support for five years after crossing the eligibility threshold and that the Gavi Board has always taken a differentiated approach in approving support to India, we requested guidance from the Policy & Programmes Committee (PPC) on how to proceed. The PPC strongly endorsed the concept of Gavi providing catalytic support over the coming five years and requested that the Secretariat develop a comprehensive strategy, working with the Government and partners, to bring to the Board for decision in December.

In neighbouring **Pakistan**, routine immunisation continues to face challenges. It is one of three remaining polio-endemic countries, and considered the furthest from eradication (with 23 of the 24 polio cases reported globally to date in 2015). There is therefore intense focus on polio with limited leadership on routine immunisation. This was exacerbated by devolution of the Federal Ministry of Health, which

¹ As measured by children receiving three doses of a DTP-containing vaccine

² All coverage references in this report refer to the percentage of children reached with three doses of a DTP-containing vaccine unless otherwise stated

muddled responsibilities between Federal and Provincial levels. Nearly half of children do not receive a full course of the vaccines in Pakistan's immunisation schedule and there is significant inequity across the country. In Baluchistan, for example, only 27% of children receive three doses of penta and some districts report 0% coverage. Addressing these challenges is a priority given the size of Pakistan's birth cohort (the third largest in Gavi) and because Gavi has committed more support to Pakistan than any other country since 2000.

Like India, Pakistan has strong institutions which can drive rapid change with the right political leadership. In Punjab province, for example, the Chief Minister has personally committed to revitalise RI with a target of 80% coverage by the end of 2015 and has introduced bold reforms and innovative approaches to achieve this. To encourage similar leadership and innovation across Pakistan, I co-led an Alliance mission to Pakistan with Dr Ala Alwan, the WHO Regional Director for EMRO, as well as leaders and Board members from WHO in Geneva, UNICEF and the Gates Foundation, and country-based representatives from DFID, the World Bank, the Islamic Development Bank and civil society. As I reported to the Board by email, we had good discussions with Prime Minister Sharif and leaders from all four Provinces who committed to work to improve RI performance. Since our visit, the Federal Government has signed the long-delayed Partnership Framework Agreement with Gavi, launched a forum to coordinate priority actions for the newly established Task Force on maternal, newborn, child health, nutrition and immunisation, started consultations to clarify responsibilities of federal and provincial governments (through an intra-Ministerial forum chaired by the Federal Minister for Health, which will report to Parliament), and secured its co-financing for 2014. However, it will require substantial follow-up and the full engagement of Alliance partners to sustain this focus on RI and support change given complex dynamics at both Federal and Provincial level. The upcoming introduction of IPV provides one important opportunity to further enhance the focus on routine immunisation and leverage polio assets to strengthen RI programmes.

Gavi's recent engagement with **Nigeria** has unfortunately been dominated by the misuse identified in last year's audit. The outgoing government recently took some key actions to address this including referring the matter to the Economic and Financial Crimes Commission (EFCC) for further investigation, agreeing to initiate an extended audit (although it recently asked to defer the start date while the EFCC conducts its investigation) and to install a fiduciary agent. Successful implementation of these steps is important to normalise Alliance engagement with Nigeria. Resolving this issue and re-focusing on programmatic collaboration is critical given that the country – with the second largest birth cohort in Gavi – had immunisation coverage of less than 60% in 2013. Moreover, after re-basing its gross domestic product (GDP) last year, Nigeria has crossed Gavi's eligibility threshold. This means it is on the path to graduation, has limited time to apply for new Gavi support and strengthen its systems, and will need to fully finance

immunisation from domestic resources within the coming years. Analysis conducted by McKinsey for the Government of Nigeria and the Gates Foundation demonstrates the challenge this will present – estimating that the total cost of Nigeria's RI programme will be over US \$400 million per year by 2020, while the 2014 Federal budget included only US \$13 million for routine immunisation. It is therefore vital that the incoming Government makes routine immunisation an early priority. We are planning a high-level Alliance mission to Nigeria, similar to that conducted in Pakistan, as soon as the new Government is ready to receive us. The objective is to agree on a roadmap to work together to improve coverage and equity, prepare Nigeria's immunisation programme for graduation, introduce additional vaccines (Nigeria has applied for rota and indicated it would like to apply for HPV and Meningitis A) and improve financial management and accountability. I look forward to updating the Board on progress later in the year.

Ethiopia, the second largest recipient of Gavi funds to date, has made major progress in child health. It achieved Millennium Development Goal 4 (reduce child mortality by two thirds compared to 1990) in 2013, two years ahead of target. This was largely driven by improvements in primary health care, including through the health extension project supported by Gavi's first HSS grant. The country has prioritised immunisation, introducing PCV and rota and conducting large-scale campaigns against measles and meningitis A with Gavi support. Immunisation coverage has improved from 65% in 2011 to 72% in 2013, but still underperforms other Gavi countries and nearly one in five districts have coverage below 50%. The programme continues to face challenges, including widespread measles outbreaks and disruptions from the 2013 Horn of Africa polio outbreak. Data quality remains a major issue and the supply chain still has weaknesses, exacerbated by a fire that destroyed 5 newly installed cold rooms earlier this year (as I informed the Board at the time). To address these issues, the country developed a coverage improvement plan in 2013 with a focus on addressing geographical inequities. Implementation, including introducing an electronic health management information system and work to strengthen the supply chain is being supported by Alliance partners and Gavi's current HSS grant. I will visit Ethiopia in July for the Summit on Financing for Development and a joint country visit with Mark Dybul to meet the Government and discuss their needs.

The **Democratic Republic of Congo (DRC)** faces deep-rooted challenges with poor infrastructure (few health facilities can be reached by road), weak supply chains (e.g., regular stockouts at facility level, only an estimated 15% of cold chain equipment is functional), a poorly trained and paid health workforce and limited domestic expenditure on health (5% of the budget, of which only half is disbursed) which has contributed to multiple defaults on its co-financing. Despite these challenges, we are beginning to see progress. DRC introduced PCV in 2011 and was one of the first Gavi countries to introduce IPV. It is using HSS to address key obstacles to delivery of immunisation and other health services such as by building

a robust integrated health supply chain (e.g. building warehouses across the country to distribute drugs, vaccines and commodities, and procuring a boat to deliver commodities to areas which are inaccessible by road) and strengthening data systems and use (e.g. implementing a health management information system). This support is being coordinated with partners including the Global Fund, World Bank and DFID. DRC is also scaling up domestic investment including US \$85 million to construct or rehabilitate 1,000 health sub centres and 200 hospitals. It is now paying for 8% of its vaccine costs (up from none a few years ago), and the Prime Minister has publicly committed to address its co-financing default. These efforts are starting to have an impact with immunisation coverage in 22 health zones targeted by Gavi support rising from 45% to 80%. Anuradha was in DRC in April for the IPV launch and I plan to visit in October.

Update on key programmes

As discussed above, Gavi is managing a record number of programmes. The most recent is **Ebola**. In December, the Board approved Gavi's role in the Ebola response in order to accelerate availability of a potential Ebola vaccine, ensure the world was better prepared for a future epidemic by supporting a vaccine stockpile, and support recovery efforts by strengthening health systems and restoring routine immunisation services (including via catch-up campaigns). We will discuss the evolution of the epidemic and our response as a standalone item at this meeting³ but I wanted to share a few early lessons from our experience to date. The first is that responding to unforeseen emergencies – especially those for which no licensed vaccine yet exists – hugely increases the complexity and uncertainty of our work. Since December, non-vaccine efforts to control Ebola have been more successful than we had dared hope and indeed Liberia has been declared Ebola-free, testament to the strong leadership of the Liberian Government. The focus has moved from Ebola control to recovery with outbreaks of vaccine-preventable diseases underlining the importance of restoring immunisation as quickly as possible. Partly due to the limited number of new cases, clinical development timelines for Ebola vaccine candidates have been delayed. We are receiving new intelligence and changing information on a daily basis, and adjusting our engagement in response. This has required much more hands on management than for most of our vaccine programmes. At the same time, the changing course of the epidemic and our response has meant we have been unable to provide Board members and donors with the level of predictability on our financial needs and impact which they have come to expect from Gavi.

The second early lesson is that the Alliance as a whole, and the Secretariat in particular, have little surge capacity to respond to such emergencies. While the Board approved new resources to manage Ebola, we are only now starting to

³ Please see Gavi Board Document 14 - Ebola vaccine and mitigation plan

benefit from this capacity due to the time required to recruit high-quality staff. In the interim, this fell to teams who were already fully occupied managing scale-up of our current programmes and preparing to implement the new strategy. This lack of surge capacity is something we hope to address as part of the ongoing organisational work which I discuss further below. Lastly, Ebola highlighted a number of grey areas in how the world supports development of and access to vaccines in response to epidemics, and Gavi's role within this. The PPC had a first discussion on the lessons we can draw from Ebola and what role the Alliance should (and should not) play in preparing for and responding to future epidemics. I believe this would be a helpful debate for the Board to have in due course.

One side-effect of Ebola has been to remind the world of the continued threat of **measles**. As health systems were devastated by Ebola and immunisation coverage dropped, measles outbreaks quickly emerged. Indeed, an article in *Science* warned that if not controlled, measles and other vaccine-preventable diseases could kill more people in Ebola-affected countries than Ebola itself. This is evidence of the highly infectious nature of measles and of its devastating impact. The Global Vaccine Action Plan (GVAP) commits the world to measles elimination but despite progress over recent decades, we remain significantly off-track with a resurgence in cases in both the developing and developed world.

The Alliance is an increasingly important player in measles with total projected expenditure of US \$1.3 billion, of which approximately US \$625 million is projected to occur 2016-20. Our measles programme has grown incrementally over time with four separate components⁴ focused on measles control rather than elimination. With the Board's decision to open a window for measles-rubella vaccine, we are also engaged in rubella control (another disease for which the GVAP targets elimination). Immunisation against measles is a key component of countries' immunisation programmes and outbreaks are often an early signal of low coverage. Given our increasing focus on coverage and equity, our significant projected expenditure and growing questions over the how the world should prioritise elimination versus control of measles and rubella, we believe it is important to develop an overarching strategy for Gavi's engagement in measles. The PPC had an initial discussion in May and agreed that we should develop a strategy for Board decision in December 2015. The PPC also recommended that the Board should make an immediate decision to approve additional measles supplementary immunisation activities (SIAs) in Ethiopia and DRC given ongoing outbreaks and the risk of further escalation.⁵ The need for these SIAs, which will

⁴ Routine measles second dose; Measles-Rubella; Measles supplementary immunisation activities (SIAs) in six large countries; and support to the Measles-Rubella Initiative for outbreak response.

⁵ Please see Gavi Board Document 02D - Measles Supplementary Immunisation Activities

cost US \$30 million, is based on a revised forecast from WHO and therefore was not reflected in the original Board decision to support SIAs in six large countries.

Unlike measles, the world appears closer than ever to eradicating **polio**. No cases of wild polio have been detected in Africa since August 2014 and Nigeria (the last endemic country in Africa) has not reported a case since July 2014. There has also been a marked reduction in the other two endemic countries with one case reported in Afghanistan in 2015 and 22 cases in Pakistan, less than half the number reported in the same period in 2014. To prepare for eradication, the *Polio Eradication and Endgame Strategic Plan* calls for all countries to introduce IPV by the end of 2015. As discussed above, all Gavi countries have been approved for IPV, 10 have already introduced and the rest are on track to introduce this year (including India following the Board decision in December 2014 to provide catalytic support). However, 22 Gavi-supported countries have had introduction delayed due to supply constraints, with nine of these delayed until early 2016. This is partially due to delays in manufacturer scale-up and demand being higher than projected in some countries (e.g. India, Indonesia and Nepal). However, it is also driven by the increasing and unforeseen use of IPV in SIAs as part of a final push for eradication. Uncertainty over introduction dates and other variables (e.g., size of target populations; wastage), as well as ongoing exchange rate volatility, means we are still managing a range of financial scenarios for Gavi's polio programme. Nonetheless, we still expect to be able to manage within the Board-approved envelope (except for the catalytic support to India, which was not part of the original Board decision, and for which Gavi has now received a commitment of additional funding from GPEI).

The second important element of Gavi's engagement in polio is to ensure polio work also strengthens routine immunisation, in collaboration with the Global Polio Eradication Initiative (GPEI) and partners. The Polio Oversight Board (POB) and Independent Monitoring Board (IMB) have both noted progress in this area, including an independent study by Boston Consulting Group which shows that polio staff are heavily engaged in broader immunisation and primary health care activities. However, there are significant differences across countries. Progress is particularly slow in Afghanistan, Pakistan, Somalia and South Sudan, partly because those countries continue to focus intensely on polio eradication. Supporting countries to further leverage the polio infrastructure for RI is a priority for our work on coverage and equity given that polio programme assets are primarily concentrated in countries with low RI coverage.

As I mentioned above, our **HSS** programmes are operating at greater scale than ever before. The IRC has observed that the quality of HSS applications has continued to improve, with technical assistance from Alliance partners, though absorptive capacity and management of those grants remains challenging in a number of countries. As I have previously discussed with the Board, HSS has

historically been a “data-free zone”. We have been working hard to remedy that and ensure that Gavi’s HSS approach is strongly data-driven. This has included understanding how grants are performing based on currently available data, tracking newly available intermediate indicators, developing new performance frameworks to ensure we have the right data in future and working with countries and partners to build an evaluation into each HSS grant.

What we are learning presents a mixed picture of the effectiveness of our grants. At the macro level, there is some positive progress. Of 17 countries with coverage below 70% which Gavi selected for special focus in 2011, 12 had seen coverage improve by 2013 with an average improvement of over 15% in the previous 2-3 years. Of the five countries where coverage fell, four were conflict-afflicted during this period (Chad, South Sudan, Somalia and Central African Republic). At the same time, countries are beginning to report on intermediate results indicators, which have been required in new grants since 2013, providing a more detailed micro picture. These enable us to understand where our grants are, or are not, achieving results relatively quickly. For example, in Burundi these indicators showed that 82% of Community Health Workers in 19 target districts were trained on health promotion by 2013, as opposed to only 48% in 2012. While the Burundi example demonstrates clear progress, indicators from other countries identify areas where progress is unsatisfactory, and we continue to work to address problems with missing baselines and data quality. Even where these indicators do not show us what we hope for, however, they do enable us to identify bottlenecks and inform corrective action by Alliance partners. We expect to receive reports on intermediate results from another 19 countries later this year and will continue to seek to improve data availability through intermediate results and outcomes, grant evaluations and through the current Full Country Evaluations. We will update the Board as data becomes available.

One area where we do have increasing evidence is the positive contribution of HSS in strengthening broader health services, especially for maternal and child health (MCH), as well as routine immunisation services. In Laos, for example, HSS funding is being used in five low-performing districts to improve MCH care with a focus on pregnant woman, who no longer incur out-of-pocket expenses. The Government has used HSS to launch a system to register pregnant women using bar codes which helps track service provision, notify births as they take place and then track immunisation. HSS also funded procurement of motorcycles to reach remote locations and deliver an integrated package of MCH services. I hope that the Minister of Health from Laos can share more of his experience with HSS at our upcoming meeting. Similarly, Uganda is using HSS funds to support integrated outreach services with teams of health workers visiting remote communities on a regularly schedule to provide HIV testing and counselling, injectable contraceptives, immunisation and other services. We have similar evidence from a number of other countries such as DRC (described above) and Sri Lanka (which

I will present in my oral report) which demonstrate that HSS can be targeted at achieving routine immunisation outcomes while also strengthening the broader health system. Moving forward, we aspire to increasingly align our HSS investments with other funders where this makes sense, in order to further enhance their impact on both RI and the broader health system. For example, we are working with the Global Fund to align our respective HSS investments in response to the Ebola epidemic and are actively engaged in the Global Financing Facility (GFF) (as discussed in more detail below).

Helping to improve performance of country **supply chains** is a critical aspect of our health systems strengthening work, and a vital foundation for achieving our coverage and equity goals. It is also an important investment in risk mitigation, to ensure that the vaccines purchased by the Alliance – costing approximately US \$1.2 billion each year – are appropriately managed and safely reach the children who need them. Recent vaccine losses (due to fires in Ghana and Ethiopia, and a non-functional cold store in Pakistan) underline the importance of building robust and resilient supply chains to protect Gavi's investments.

The Alliance has made significant progress in implementing the supply chain strategy approved by the Board 12 months ago. 2015 is a foundational year in which we are seeking to ensure countries have in place the basic building blocks to strengthen their supply chains, and are also launching transformational work in a first wave of countries. For example, we are supporting 40 countries to conduct comprehensive effective vaccine management (cEVM) assessments to evaluate the strength of their supply chains and launch improvement plans. In parallel, Alliance partners are working intensively with 14 countries to transform their supply chains including through comprehensive supply chain redesigns. We are also advancing a number of cross-cutting initiatives. For example, WHO recently recommended that vaccine manufacturers include barcodes on the packaging of all their vaccines. This was a priority in the Alliance supply chain strategy, with a Gavi-funded pilot project in Tanzania demonstrating that such barcodes can significantly improve countries' ability to track the flow of vaccines. Similarly, Gavi is helping to establish an East African Community Centre of Excellence for Health Supply Chain Management in Rwanda, which will offer pre- and post-service training to build supply chain human resource capacity in the region. And at this meeting the Board will be asked to approve the creation of a Cold Chain Equipment (CCE) Optimisation Platform, discussed in more detail below, to ensure that countries have the equipment they need to provide immunisation services reliably to the entire population and address failures in the CCE market.

A critical year for global development; Gavi and the post-2015 agenda

World leaders will meet in New York in September to finalise the **Sustainable Development Goals** (SDGs). It is likely that the 17 draft SDGs will be presented

in their current form to UN member states. The focus now is on refining the proposed targets to quantify global ambitions for each goal and defining indicators to measure progress. In parallel, intense work is under way to identify the sources of financing and ways of implementing the SDGs, with member states hoping to reach agreement at a summit in Addis Ababa in July.

The SDGs recognise the importance of immunisation and “vaccines for all” is part of a broader target of achieving universal health coverage. We are working with partners and supportive countries to promote robust indicators for immunisation, moving beyond the traditional indicator of DTP3 coverage to reflect our aspiration that all children should have access to a full range of new and powerful vaccines.

The key priorities emerging from the discussions on the SDGs and Financing for Sustainable Development (FSFD) also align well with Gavi’s development model. There is a growing emphasis on the need for new and innovative partnerships to accelerate development, and on scaling up domestic resource mobilisation and innovative financing (in addition to donor funding) to achieve the SDGs. Our new strategy’s focus – on equity and sustainability – also aligns well with key themes of the SDGs, as does our emphasis on transparency and accountability for results. Gavi’s Replenishment increased the visibility of the Alliance during this critical period and the German Government has helped ensure that immunisation and health remain high on the agenda under their leadership of the G7. Gavi will be actively engaged in the Addis Summit in July and SDG summit in New York in September to maintain the focus on immunisation during this critical period.

The Addis Summit will also be the venue for the launch of the **Global Financing Facility**. We hope that the GFF will help improve reproductive, maternal, newborn, child and adolescent health (RMNCAH) outcomes, especially by mobilising increased domestic investment and leveraging external resources, including from the World Bank. The GFF seeks to prioritise traditionally under-funded areas, such as civil registration and vital statistics, nutrition and family planning, all of which are complementary to immunisation and Gavi’s goals. Gavi is actively engaged in GFF. We participated in shaping the business plan and Anuradha sits on the Investors Group which will oversee implementation.

Preparing the Alliance to implement Gavi’s 2016-2020 strategy

The Alliance has defined a bold set of aspirations for the next strategy period. We want to achieve a step change in coverage and equity, contributing to a world where every child has access to the full range of lifesaving vaccines. We also want to ensure that immunisation programmes are sustainable during a period when nearly one third of Gavi countries are due to transition out of Alliance support. This is an important proof of concept for the policy of “graduation” which the Board first approved in 2011. At this meeting, the Board will review the **indicators** which are

being proposed to track progress against these ambitious goals⁶. They have all been recommended for approval by the PPC, except those for strategic goal 2 which are still being finalised. The strategic goal 2 indicators and proposed targets for each of these indicators will come to the Board for decision in December. We have, however, included the preliminary draft targets in the paper for this meeting so the Board can provide early feedback on whether these strike an appropriate balance between being sufficiently ambitious and being realistic given our commitment to deliver on the targets we set.

There is intense work ongoing across the Alliance to operationalise the 2016-20 strategy framework and ensure we have all the components in place to deliver. In addition to the Alliance supply chain strategy, which is the most advanced, this includes developing approaches to enhance the availability and use of data to reach under-immunised children, generate increased political commitment to immunisation, strengthen countries' leadership, management and coordination capacity, and ensure parents and communities actively seek immunisation for their children. We believe that achieving transformational changes in **coverage and equity** will require us to address all of these levers collectively. We are also launching a review of HSS and Gavi's other cash programmes to ensure we have the tools to support change at country level. This review will come to the PPC for guidance in October and to the Board for decision next June. Since nearly two thirds of under-immunised children across the Gavi 73 are in 10 countries⁷, we will increase our focus on them and are exploring how we can work differently to best support them. To answer that question, we are launching deep dives in targeted countries to identify bottlenecks to sustained improvements in coverage and equity, prioritise a small number of transformational interventions to address those bottlenecks and ensure that appropriate financial and technical support is provided. This work will also seek to learn from success stories and "positive deviants" to identify innovative interventions that can be scaled up and non-traditional resources which could be engaged more broadly.

In addition to country-focused work, we are exploring where Gavi can leverage its scale to have transformative impact at a global level. One priority is **cold chain equipment**. Lack of CCE is a critical barrier to reaching every child with immunisation. Currently, 20% of clinics that should be equipped with CCE based on country plans have no equipment, 20% of installed equipment doesn't work, 90% of it uses out-dated technology, and there are tens of thousands of additional facilities which countries do not plan to equip due to lack of funding. At the same time new technology is becoming available which is more energy efficient, has lower total cost of ownership and is more reliable. However the upfront cost is often

⁶ Please see Gavi Board Document 11 - Gavi Alliance Strategy 2016-2020 – goal level indicators and disease dashboard

⁷ India, Nigeria, Pakistan, Ethiopia, DR Congo, Indonesia, Vietnam, Kenya, Uganda and Afghanistan.

higher, requiring incentives for their uptake. The proposed CCE Optimisation Platform⁸ is a key component to implement the Board-approved supply chain strategy (which identified CCE as one of five priority areas). It recognises that the current situation is driven by both a funding shortfall and by market failure and aims to address both these issues by providing predictable funding to support countries' purchase of new equipment, accelerating availability and deployment of higher-performing technologies at lower prices, and ensuring CCE is better managed and maintained once installed. The PPC was supportive of the proposed approach which it recommended to the Board for decision.

Ensuring the **sustainability** of immunisation programmes will also require new tools and approaches, especially as countries transition out of Gavi support. A first pre-requisite for countries' programmes to be sustainable is that they can continue to procure vaccines at prices similar to those paid by Gavi for a period while they adjust to fully financing their programmes. Having had to finance a multi-fold scale-up in vaccine costs during graduation, few of these countries would be able to afford the additional burden of a significant increase in prices. In addition, smaller countries may face challenges securing sufficient supplies of vaccines at all given their size, especially in supply-constrained markets. At the Board's request, the Alliance has been working to facilitate **access to appropriate pricing** for countries for a limited period after Gavi financial support ends. The proposed solution⁹ was endorsed by the PPC. It is enabled by the Pan American Health Organization (PAHO) assuring Gavi that this procurement is covered by the existing exceptions it has granted Gavi to the Revolving Fund's Lowest Price Clause¹⁰. We are grateful to PAHO for their collaboration, which has resulted in an agreement that is currently in the process of being signed.

With access to pricing, and more intense support provided by the Alliance earlier during the graduation process, most countries should be able to **transition** out of Gavi support successfully and sustainably. However, a small subset of countries is still likely to face challenges – primarily those which have experienced an unexpectedly rapid increase in gross national income (GNI) per capita. While income growth is a good thing, a number of Gavi-eligible countries have seen GNI per capita increase by 30% or more in a single year, for example due to re-basing of their GDP. These countries have crossed the eligibility threshold much earlier than planned without having had time to build up domestic investment in immunisation and other social programmes, or ensure their programmes are sufficiently robust to graduate sustainably. For this reason, following the review of

⁸ Please see Gavi Board Document 12 - Cold Chain Equipment Optimisation Platform

⁹ Please see Gavi Board Document 07 - Gavi support for access to appropriate pricing for Gavi graduated countries

¹⁰ The lowest price clause (LPC) is included in PAHO Revolving Fund vaccine supply contracts and manufacturers to provide the Revolving Fund with the lowest global price for a given vaccine. PAHO has granted exceptions to the LPC for supply to Gavi for pneumococcal, rotavirus and HPV vaccines.

Gavi's Graduation and Eligibility policies, the PPC is recommending a limited extension of Gavi eligibility for a targeted set of countries¹¹. This follows an intense and robust debate among PPC members, mindful of the need to preserve the key principles of Gavi's catalytic model and avoid moral hazard while also recognising some countries face real challenges. The PPC also endorsed the other recommendations of the review as presented in the Board paper.

The PPC also recommended targeted changes to Gavi's **co-financing** policy.¹² The policy review found that it is working well but proposed two adjustments. The first is to link countries' co-financing to vaccine prices during Phase 1 of their transition (previously called the "intermediate" phase). This ensures countries are sensitised to prices earlier and consider this when they choose between products – an important consideration for long-term sustainability. The second change is to introduce a new approach to support countries in exiting co-financing default to address the current cycle of repeat default in several countries.

To achieve our 2016-20 strategy goals, the Alliance will need not just new tools and approaches but also new ways of working. Our work will need to become more flexible and responsive to country needs with more rigour and transparency about what is working, what is not working and what we are learning. At this meeting, the Board will be asked to endorse the new **Partners' Engagement Framework** (PEF)¹³ which replaces the business plan as the primary mechanism to plan, coordinate and monitor the work which partners do in support of Gavi's mission. As we discussed at the Board Retreat, the PEF has been designed with three primary objectives: to ensure the Alliance's work is grounded in a coherent multi-year to address countries' specific needs; to strengthen grant oversight and risk management and ensure greater accountability for outcomes and flexibility to address issues as they arise; and to ensure each partner is contributing to the Alliance's work based on their respective comparative advantage. Given the challenges of our new strategy, we will need to engage a broader set of partners including private sector organisations and development agencies working in other sectors. Our aspiration is that the PEF will strengthen engagement among all Alliance partners not just at global level, but also in regions and countries. At country level, we will be working to re-invigorate inter-agency coordinating committees (ICCs) to ensure they are dynamic fora in which all Alliance partners working at scale on immunisation are engaged (whether or not they receive funding through the PEF) and we plan to create standing groups at regional level.

Most funding provided through the PEF will be for "targeted country assistance". In addition, the PEF will include foundational support – long-term predictable

¹¹ Please see Gavi Board Document 05 - Strengthening country transitions out of Gavi support

¹² Please see Gavi Board Document 06 - Review of Gavi's co-financing policy

¹³ Please see Gavi Board Document 10 - A new Gavi Engagement Framework for implementing the 2016-2020 Strategy

funding to enable partners to better plan and resource their core work, while continuing to be subject to robust performance criteria. It will also provide funding for “strategic focus areas” where the Alliance is seeking transformational impact requiring cross-cutting global and regional activities (e.g., supply chain).

The PEF is one mechanism we are developing to enhance accountability within the Alliance. In addition, we propose to create a new **Accountability framework**, to provide more transparency on the performance of all constituents of the Alliance. This will contain an agreed set of corporate performance indicators covering the Alliance’s Secretariat, partners, donors, countries and Governance bodies. We believe that this will greatly enhance the Board’s ability to monitor the Alliance’s performance and hold every member accountable for their contribution.

The new approaches, tools and ways of working necessary to achieve our 2016-20 strategy goals will require some incremental **investment** beyond “business as usual” (this could flow through the PEF, HSS or new initiatives such as the CCE Optimisation Platform). We had foreseen this in our Replenishment ask, which included a US \$500 million provision for strategic initiatives. The Alliance should therefore be able to fully fund these investments while also delivering all of the programmes described in our Replenishment prospectus. The appendix to this report provides more detail on these investments, other new funding requests that are likely to come to the Board, and how we propose each should be funded.

One decision which is likely to come to the Board later this year, unrelated to the 2016-20 strategy but with potential financial implications, is possible support for a **malaria vaccine**. In the 2013 Vaccine Investment Strategy, the Board noted that there was a reasonable case for Gavi support and agreed to consider it if the vaccine was licensed, recommended for use by the WHO Strategic Advisory Group of Experts and the Malaria Programme Advisory Committee, and prequalified by WHO. The leading vaccine candidate – GSK’s RTS,S – is currently being reviewed by the European Medicines Agency and depending on the outcome of that review, a recommendation may be issued by October. If RTS,S is recommended for use, many African governments have indicated they will view the vaccine as a priority given the disease burden. Should WHO make a clear recommendation in October, we would therefore aim to bring a decision to the December Board to minimise delays in vaccine availability and provide clarity to other organisations on Gavi’s role. This will be a tight timeline and would require a special PPC teleconference be convened in November.

The development of a malaria vaccine is an important milestone and could be a new tool in integrated plans for malaria control. In addition to its direct impact, it could be a platform to increase coverage of other malaria interventions (e.g., bednets) given the reach of immunisation services and likely demand for the vaccine. However, implementation will be complex. In addition to understanding

how and where the vaccine should be used, which should be determined in the WHO recommendation, a number of other critical questions need to be resolved. These include how the vaccine should be rolled out and integrated with continued scale-up of other malaria interventions, how to ensure rigorous follow-up given a booster dose is critical to vaccine efficacy, how it should be funded and whether limited supply will affect roll-out. We have already agreed on how to collaborate with the Global Fund, and have formed a joint working team to start coordinating our approach pending the Board decision, and are engaging with other partners.

Organisational update

The intense work to prepare for implementation of the next strategy means that we have a particularly heavy agenda for the Alliance's **governance** bodies. The May PPC had to be extended to two and a half days, with a subsequent follow-up call to finalise one item. The agenda for this Board meeting is similarly full, as are the agendas for the next PPC and Board. The intensity of the Board agenda is particularly challenging given the continued high turnover among Board members and the implications for holding a sustained conversation. Nearly half of current Board members have joined since the November 2013 meeting (including the seats turning over at this Board meeting). A number of Board members have asked about the plans for December's Board meeting which the Government of Nepal kindly offered to host. The Government has made strong progress in its recovery efforts and, with partners in the country, has indicated that it will be able to welcome us in December. We will maintain a close dialogue but currently continue to plan for the meeting to take place in Nepal.

As discussed above, the 2016-20 strategy will require us to develop new tools, innovate the way we work and expand the partnership. The next **Partners Forum** will provide an important opportunity to discuss these changes, our shared goals and challenges with Gavi countries, current partners and potential future partners. The Executive Committee endorsed the proposal to organise a Partners Forum at the beginning of the next strategic period and we are in the early stages of planning one for next year, alongside a Gavi Board meeting. We are in discussions with the Government of Senegal, through Gavi Board Member and Minister of Health Awa Coll-Seck, on hosting the Forum.

One key partner with whom we are already working to deepen collaboration is the **Global Fund**. Over recent months, we have had a number of meetings at leadership and operational level to review our existing collaboration and identify opportunities to work more closely together. Key short-term priority areas include risk management (e.g., learning from each other's approach to risk management, sharing intelligence and audit findings, sharing fiduciary agents where this makes sense); aligning our engagement with priority countries (e.g., conducting joint missions with senior leadership, aligning recovery efforts in Ebola-affected

countries); exploring opportunities to align investments in strategic areas (e.g., supply chain, data); coordinating preparations for malaria vaccine; aligning policy positions in international fora (e.g. IHP, GFF) and intensifying our preparations for a joint move to the Health Campus. Mark Dybul and I have agreed to develop a roadmap summarising our work together and where we want to deepen our collaboration, and plan to present this to our respective Boards later this year.

Closer collaboration with the Global Fund is one way in which we are seeking to enhance **risk** management at Gavi. In December 2014, the Board approved a new approach to risk management, with a restructuring of risk functions within the Secretariat, additional resources to manage risk (especially fiduciary risk) and enhanced capabilities and processes. The new Secretariat structure was launched on February 1 and we have expedited recruitment for the new positions (with 20 positions already filled). This includes appointing a new Head of Risk who brings extensive experience working with organisations like Gavi, as well as the private sector, and is due to start on 29th June. The newly formed Secretariat Risk Committee, which I chair, has been meeting monthly and is helping to track implementation of the new risk approach as well as reviewing key and emerging risks. There is also substantial activity ongoing to reinforce risk management systems and capabilities across the Secretariat, especially in the Country Support team which has primary responsibility for stewardship of Gavi's grants. As discussed above, enhancing risk management at country level is a key priority of the PEF and we are working to enhance the focus on risk, including clarifying responsibilities among partners, as we implement the PEF.

Strengthening risk management is one of a number of responsibilities for the **Secretariat** in the next strategic period. Recognising the changing requirements of the new strategy and the evolving expectations of the Board, we are working to ensure the Secretariat is fit for purpose. This effort is focused on three priorities: upgrading the efficiency of the Secretariat's processes and systems; evaluating whether the Secretariat has the resources and capabilities it needs; and ensuring the leadership team is as effective as possible. As I have previously informed the Board, I commissioned McKinsey to conduct a review of our resources and capabilities as well as opportunities to improve the Secretariat's performance. I have also asked Richard Pascale, a globally recognised expert in organisation effectiveness who focuses on innovative organisations, to facilitate a discussion on how we can improve our management as a group and as individuals. This includes supporting me and Anuradha on our personal leadership. In addition, we are working to strengthen our processes and systems through an extensive knowledge management programme. This is seeking to map, optimise and automate processes such as grant management and funds disbursement. It is developing new systems to support collaboration across the Secretariat (and, where relevant, the Alliance). And it is providing staff with the tools they need to maximise the efficiency of their work (e.g. improved document management, better

support for offsite working). I will update the Board on all of these efforts at the closed session, and have asked McKinsey to present their key findings.

I already informed the Board that Robert Newman left his position as Managing Director for Policy & Performance to follow his family to Cambodia where he will be the Country Director for the US Centers for Disease Control and Prevention (CDC). We wish him well and plan to recruit a new senior leader in due course, once we have agreed on any changes which may emerge from the ongoing organisation work. I also informed you that we have appointed Philip Armstrong, whose résumé I shared with you by email, as the new Director of Governance. He will join on 1st August but will attend this meeting so you will have a chance to meet him. You will also be asked if you wish to appoint him as Board Secretary.

The September SDG Summit in New York will chart the future to which countries collectively aspire. The meeting will also provide an opportunity to celebrate the achievements of the Millennium Development Goal era and focus on unfinished business. This includes in the health arena where child mortality has fallen by nearly half since 1990, but at the same time over 6 million children under 5 still die each year, nearly one third from vaccine-preventable diseases. Gavi was born in the same year as the MDGs and has contributed significantly to the progress to date, having expanded our work across the full spectrum of vaccines. We also have a key role to play in ending preventable deaths moving forward by, as Anuradha has synthesised our current strategy goals with an intergenerational lens, “reaching every child with immunisation, today and tomorrow”. Achieving these goals will require that we further strengthen the Alliance, expand our partnership and innovate how we work. It will also require us to regularly assess and be honest about what is working, what is not working and how we can continuously learn and improve as an Alliance. If we do so, and if we all continue to adhere to the principles of transparent, constructive and equitable partnership, the Alliance can look to the future with optimism and confidence.