

Report of the Chief Executive Officer

27 November 2019

Dear Board members,

I look forward to seeing you all in Delhi next week. Our meeting has a very full agenda, coming at a busy time for the Alliance and the global health community. On the one hand, we are focused on delivering Gavi 4.0. The latest WHO-UNICEF Estimates of Immunisation Coverage (WUENIC) show that the Alliance is on track to achieve, and in some cases exceed, all of our Mission Indicators as well as our targets for breadth of protection and coverage with a first dose of measles vaccine. However, pentavalent coverage is off track, despite 2.5 million more children being reached in 2018 than in 2015. This is due in part to exceptional events in one large country in 2018 (which will likely be reversed in 2019) as explained further in the paper on *2016-2020 Strategy: Progress, Challenges and Risks*. We are simultaneously preparing to implement Gavi 5.0, including rethinking many of the Alliance's approaches, policies, processes and engagement model, planning for our upcoming Replenishment in London on 4 June 2020, and getting ready to celebrate the 20th anniversary of Gavi's creation at the World Economic Forum in Davos.

It is also a busy time for the broader community. As discussed further below, we are actively engaged in the process to develop the *Immunisation Agenda 2030* and are working with other agencies to begin implementing the *Global Action Plan for Healthy Lives and Wellbeing for All* (GAP). Meanwhile, the health world is facing reversals in efforts to eradicate polio, control measles and bring the ongoing Ebola outbreak in DR Congo to an end. We will therefore have a lot to discuss and reflect on at our meeting.

Key developments in our global landscape

Accelerating progress on primary healthcare and universal health coverage

At this year's United Nations General Assembly, world leaders met for their first ever **High-Level meeting on Universal Health Coverage** (UHC). This was an opportunity to take stock of global progress towards UHC four years after the launch of the Sustainable Development Goals (SDGs), and to recommit to

accelerating progress. The 2019 Global Monitoring Report, released the day before the meeting, showed mixed progress. The good news is that access to essential health services has improved, particularly in lower income countries. At the same time, the rate of change is slowing and the world is off-track to achieve UHC targets by 2030, with the largest gaps in the poorest countries. The report also found that the economic burden of health services on households is growing, with indicators of financial protection going in the wrong direction. For the first time, the report highlighted the impact that gender norms, roles and power relations can have on health-seeking behaviour, access and outcomes. This reinforces the importance of putting gender at the centre of our efforts to reach the unreached in Gavi 5.0.

The report emphasised the importance of prioritising **primary healthcare** (PHC) as the key platform to deliver UHC, something which we have strongly argued as an Alliance, and called for all governments to increase investment in PHC by 1% of gross domestic product. Immunisation is already the most equitable tracer intervention in the UHC coverage index – it has the highest coverage and is least likely to charge user fees. Those not receiving immunisation are unlikely to receive other routine health services. This is why the Board's focus on reaching zero-dose children in Gavi 5.0 is so critical. As I argue below, these children live in the most deprived and marginalised communities and face multiple deprivations. Extending immunisation and other basic PHC services to them is the most direct, equitable and achievable approach to move towards UHC.

Ensuring PHC is appropriately prioritised and funded will require sustained focus and collaboration by all actors in global health. It was therefore timely that the **Global Action Plan for Healthy Lives and Wellbeing for All** was also launched at UNGA. As we have previously discussed, the GAP seeks to systematise and strengthen collaboration between global health agencies to accelerate progress towards the health-related SDGs. Gavi is one of 12 signatories and has been highly engaged, so I was delighted to join other leaders in New York for the launch. Peter Sands, Muhammad Pate and I released a joint op-ed at the time of the launch to highlight the importance of the GAP and in particular the financing accelerator, which our agencies co-lead. I subsequently spoke alongside Peter Sands at the World Health Summit about how we plan to take the GAP forward.

Gavi already collaborates closely with over half of the GAP agencies and we are committed to rapidly begin implementation. As a financing organisation, our primary entry point will be the financing accelerator, which we want to align with the PHC accelerator, led by the World Health Organization (WHO) and UNICEF. We see the GAP as an important opportunity to create a common focus on equity and ensure all health agencies work with countries to prioritise reaching missed communities (for which zero-dose children can be a tracer) with an integrated package of PHC services. In order to move quickly and learn, we plan to start in a first wave of priority countries before scaling up. We are grateful to the Bill & Melinda Gates Foundation for providing time-limited support to bolster our capacity to kick-start implementation. We will continue to update the Board on progress and are planning a discussion on GAP at our June 2020 meeting.

A crowded but encouraging Replenishment landscape

Gavi's collaboration extends well beyond the 12 GAP signatory agencies and we are working increasingly closely with a range of other partners including the Global Polio Eradication Initiative (GPEI) and the Coalition for Epidemic Preparedness Innovations (CEPI). As discussed further below, Gavi has recently been accepted as a full partner of GPEI and we have been increasingly coordinating our programmatic and resource mobilisation efforts. GPEI's funding moment took place two weeks ago with donors pledging US\$ 2.6 billion towards the US\$ 3.27 billion ask. The **Global Fund Replenishment** was also successful as donors met the organisation's US\$ 14 billion ask. We were delighted to see the determination of the international community to ensure our sister agency is fully funded with many donors making last minute increases to reach the target.

While the replenishment landscape is crowded (in addition to GPEI and Global Fund, the World Bank is replenishing IDA and the African Development Bank will hold its third Replenishment meeting at the same time as we meet in Delhi), it is encouraging to see donors increasing support for organisations with relevant missions and a strong track record of delivery. Gavi was vocal in calling for the Global Fund to be fully funded and we were in a "silent phase" in **Gavi's replenishment** efforts until their pledging event. We are now moving into a public phase. We launched our Investment Case in August at the Tokyo International Conference on African Development (TICAD), committing to help immunise at least another 300 million children and save 7-8 million lives if we are fully funded. The launch was well-attended by donors and we were joined by six African Heads of State who spoke passionately about the importance of immunisation and Gavi's support in improving their countries' health and economies.

Our replenishment campaign received a timely boost in September when the Alliance was awarded the **Lasker-Bloomberg Public Service Award**. This is widely seen as the highest honour in the medical field after the Nobel prize. It generated significant attention including a long article on the history and achievements of the Alliance in *Cell* by Dr Elias Zerhouni (former Director of the US National Institutes for Health), who called Gavi's impact on public health "extraordinary and profound". I was also asked to write about the award and Gavi in the *Journal of the American Medical Association* and *Scientific American*.

The next major milestone in our Replenishment effort will be the World Economic Forum (WEF) in January where we will celebrate the **twentieth anniversary of Gavi's founding** at Davos in 2000 (at the same time as WEF celebrates its 50th anniversary). This will be an opportunity for all of us to reflect on the immense contribution of the Alliance to the health of the world's children – with over 760 million children already immunised and over 13 million deaths averted – and to call on the global community to step up their support to Gavi so we can deliver on the promise in our investment case. My conversations with donors to date have been encouraging. Despite the political uncertainty in the UK, we have strong support from across the political spectrum and our other major donors have also indicated their commitment to a successful replenishment. A number of emerging

donors have signalled a willingness to substantially increase their contribution, although most would subsequently expect to have a stronger voice in our governance, which is something the Board will need to consider going forward.

Immunisation high on the global agenda

Our replenishment will come at a time when **immunisation is especially prominent on the global agenda**. Its importance was highlighted in the political declaration from the High-Level meeting on UHC, the G7 Health Ministers Declaration, the 2019 Yokohama Declaration and Action Plan, and the Okayama Declaration of the G20 Health Ministers. The G20 also highlighted the importance of Gavi's Replenishment. In September, the President of the European Commission and the Director-General of the WHO hosted a Global Vaccination Summit with leaders from the public, private and non-governmental sectors. This sought to increase awareness of immunisation as "the most successful public health measure" and to increase political commitment and financing for vaccines from all sectors. There was a particular focus on the role of social media companies, who were active participants in the Summit, in preventing the spread of false information which can contribute to vaccine hesitancy.

Political leaders are becoming ever more vocal champions for immunisation. At UNGA, Dr Ngozi and I gave an award to Prime Minister Sheikh Hasina of Bangladesh to recognise her personal leadership on immunisation. This has helped her country to achieve coverage of 98%¹, introduce nearly all Gavi-supported vaccines and reduce child mortality by over 65% since 2000. African leaders are also increasingly focusing on immunisation as a critical priority in efforts to achieve UHC, as demonstrated by the six Heads of State who attended Gavi's Replenishment launch. In DR Congo, President Tshisekedi hosted a National Forum on Immunisation and Polio Eradication within months of taking office, which I attended along with leaders from across the Alliance. He and all 26 Regional Governors in attendance committed to increase oversight, accountability and financing for immunisation, building on and enhancing the Mashako Plan which I highlighted at our last meeting. Almost immediately afterwards, the government released US\$ 3 million in delayed vaccine co-financing commitments. Dr Ngozi and Anuradha have just returned from a trip to Kenya where leaders including the President, Cabinet Secretary, parliamentarians and County Governors emphasised their commitment to immunisation as a critical platform to achieve UHC. This was also an example of how Gavi is engaging countries earlier in the transition pathway (with Kenya due to enter accelerated transition in 2022, requiring a very substantial increase in domestic resources), and deepening engagement with sub-national leadership in federated countries.

Immunisation and the role of Gavi are also increasingly recognised **beyond the health sector**. I was invited to join a meeting at UNGA to pledge support for the Rohingya crisis in Bangladesh. This was largely attended by humanitarian

¹ Based on coverage with three doses of pentavalent vaccine

organisations but Gavi's engagement was strongly welcomed as a way to help bridge the humanitarian-development nexus, which will be critical to achieve sustainable improvements in health in protracted humanitarian crises. The Alliance was also asked to make a commitment for the Climate Action Summit, and committed to scale up investments in climate resilient health systems and support vaccine stockpiles to protect populations from climate-sensitive diseases

This growing global focus on immunisation underscores the importance of the ***Immunization Agenda 2030 (IA2030)***, which is being developed under WHO's leadership to guide global immunisation after the *Global Vaccine Action Plan* ends in 2020. The process has been very participatory and its emerging priorities align well with Gavi 5.0, with a focus on strengthening routine immunisation, improving equity and using immunisation as a platform for integrated PHC. We are working with WHO to increase the emphasis on gender and programmatic sustainability, align indicators to simplify the work of countries, and to ensure that *IA2030* provides a platform to move away from disease-specific vertical initiatives, before it is submitted to the World Health Assembly in May 2020.

Working differently to reach zero-dose and deliver equity in PHC

The Board has defined **equity as the organising principle of Gavi 5.0**, echoing the SDG vision of leaving no one behind. And it is realistic that we could leave no one behind with immunisation. With nine in ten children being reached globally with at least a first dose of pentavalent vaccine, universal immunisation is within reach and can be a first step towards UHC. The children who are not reached by immunisation today are among the most invisible and marginalised in the world. Since routine immunisation coverage is higher than any other routine health intervention, clusters of zero-dose children are likely to belong to communities that do not receive other health services. They are also likely the communities most in need, facing the highest incidence of disease and with the least financial resources to cope when they do get sick. Nearly 80% of zero-dose children live in Gavi-supported countries and two thirds of these live below the poverty line. While reaching these communities may be more difficult and expensive, the impact will be disproportionately high in terms of improving health outcomes and reducing poverty. It is also an investment in global health security as these communities are likely to be most at risk of disease outbreaks and have the least capacity to detect and respond to those outbreaks when they occur.

Beyond high coverage, there are other reasons why **immunisation is an important pathfinder for equitable PHC services**. It is the most cost-effective health intervention, with a return of US\$ 54 for every US\$ 1 invested in Gavi countries. And strong immunisation services are critical for effective disease prevention, without which UHC will be unaffordable. It therefore makes sense for all countries to make reaching every child with immunisation a top public health priority. Immunisation also has the advantage of being relatively simple to deliver. A health worker, child and vaccine can come together in any setting – under a tree, at the market or even on trains (a strategy India has used for polio) – without requiring complex infrastructure. Immunisation is also relatively

measurable. While we are working to develop more precise data, we broadly know how many children are being immunised and where populations are being missed. Immunisation therefore provides a good means to target the unreached, measure progress in achieving the most basic level of universal health coverage and to evaluate the impact of our investments in strengthening health systems.

We will need to show humility as we set out to reduce the number of zero-dose children. There is a reason these communities are being missed and we do not yet have all the answers for how to reach them. At the same time, **we are not starting from scratch**. The latest WUENIC data shows that we have managed to reduce the number of zero-dose children in the 68 Gavi countries by 8% between 2015 and 2018 (despite the birth cohort growing by 1.5 million children during these years). With a more intensive focus on zero-dose in Gavi 5.0, we will aim to accelerate this progress. This will require that we are consistent as an Alliance in advocating for governments to prioritise these communities, and in ensuring that Gavi support is focused on achieving reaching zero-dose children. Reducing the number of zero-dose children – as well as the number of under-immunised – needs to become a primary measure of collective performance.

We can **build on and learn from the success of countries** that have reduced the number of zero-dose children in this period. Six countries have made particularly significant progress: Nigeria, India, Mali, Liberia, Uganda and Pakistan. Between them, they have reached an additional 1.5 million zero-dose children. Their experience highlights three areas where we will need to increase our focus as an Alliance: (1) Enhancing service delivery, (2) addressing demand and gender-related barriers including through greater community engagement, and (3) improving management and accountability of immunisation programmes.

India is a model for how enhanced **service delivery** can help reach missed communities. In 2014, it launched Mission Indradhanush (MI) in an effort to reach 90% full immunisation coverage by 2020. It focused on 201 (out of 731) districts which account for nearly half of all missed children. Building on lessons learned from polio eradication (and supported by Gavi's health system strengthening (HSS) grant), MI uses a combination of intensified service delivery strategies to reach children being missed by the routine system, along with robust monitoring to track progress. In Mali, the government refocused its Gavi HSS grant to target a subset of districts with a disproportionate number of missed children, using a high-quality coverage and equity assessment conducted by UNICEF. It focused on improving service delivery in these districts based on rigorous local microplans and accountability, as well as direct funding to civil society organisations to deliver integrated mobile services for nomadic and conflict-affected populations. New service delivery approaches, including closer engagement with civil society to plan and deliver services, will be particularly critical in fragile settings where a growing proportion of zero-dose children live.

Over recent years, we have seen growing recognition of the impact of **demand-side barriers** on immunisation, with available data suggesting between one and two thirds of missed children are due to demand-related challenges. These can

range from inadequate understanding of immunisation, to concerns about side-effects to the quality and convenience of services. They can also be driven by gender inequities in society, which can impede the ability or willingness of parents to immunise children. This is an area where the Alliance needs to increase its focus and to scale-up new ways of working and innovation.

Board members will have a chance to hear about Gavi's partnership with the Government of India and Unilever to address such barriers through *Safal Shuruaat* ("Successful beginning"). This programme explains to parents why immunisation and handwashing are critical and seeks to engage fathers and empower mothers in ensuring the health and success of their children. Early results are promising with double-digit improvements in immunisation coverage in targeted communities without any change in service delivery. The proportion of zero-dose children (no pentavalent vaccine) fell from 25% at baseline to under 1%. The programme was submitted by the Ministry of Health as a Best Practice at the 6th National Summit on Good & Replicable Practices and Innovations in Public Healthcare Systems and is due to be scaled up to 14 districts (from two initially), reaching an 2-3 million households. Gavi has also supported Pakistan to address gender-related bottlenecks through its lady health worker programme and is exploring scaling up the *Kiran Sitara* ("Agents of Change") programme with our *INFUSE* partner IRD. This trains adolescent school-going girls to engage their communities – especially women and their families – to promote behaviour change for healthier lifestyles with early pilots supported by the Gates Foundation proving effective in identifying zero-dose and under-immunised children.

There is growing recognition of the role of rigorous, data-driven **management and accountability** in improving programme performance. In 2014, for example, the Chief Minister of Punjab Province – home to half of the population of Pakistan – launched a programme to hold district managers more accountable and to strengthen the supervision of vaccinators using digital technology. This was initially supported by the UK Department for International Development and subsequently scaled up by Gavi. By allying the leadership of the Chief Minister to rigorous regular performance review and course correction, the province was able to increase full immunisation coverage from 49% to 84% in only three years with greatest improvement in the poorest communities. We are supporting similar approaches in a number of other countries, including DR Congo where this approach underpins the *Mashako Plan*, and is showing promising initial results.

These examples demonstrate that with the right approaches and innovations, it is possible to make rapid progress in reaching under-immunised and zero-dose children. If we are successful in Replenishment, we hope to increase investment in HSS to accelerate scale-up of such approaches. Of course, once we reach these children, we want to deliver not just a first dose of vaccines but to reach them with a full course of immunisation and to work with others to provide an **integrated package of basic PHC services**. This both maximises the impact of our investment in reaching those communities, and will likely increase demand by ensuring parents can access a full range of services when they bring their children to be immunised. To this end, we are increasingly working with partners

who can co-invest in strengthening service delivery and funding other PHC services. For example, under the Partners' Engagement Framework, we have agreed to fund the World Bank global service delivery team to make the case and provide support to countries and World Bank offices to prioritise reaching zero-dose communities in their operations. Similarly, we are discussing with WHO using zero-dose children as a tracer for the work they are doing to strengthen integrated PHC through the UHC partnership. We are also working with the Global Fund and GFF to coordinate our discussions with countries on health financing with a focus on bringing basic PHC services to missed communities.

Reporting back on previous Board decisions

Vaccine programmes

Polio programmes have been uniquely successful in reaching zero-dose children. This has helped reduce the number of wild polio cases from ~350,000, when GPEI was founded in 1988, to 33 in 2018. Two of the three types of wild polio (types 2 and 3) have been eradicated with eradication of type 3 confirmed in October this year. Despite this success, polio efforts suffered further setbacks in 2019. There have been many more cases of wild and vaccine-derived poliovirus (VDPV) this year than in 2018, including major VDPV outbreaks in Angola, Central African Republic, DR Congo and Nigeria, and confirmed circulation in Benin, Chad, Ethiopia, Ghana, Myanmar, the Philippines, Somalia, Togo and Zambia. Polio is considered a Public Health Emergency of International Concern and confirmation of circulating wild or vaccine-derived polio results in multiple rounds of response campaigns. This can have a significant impact on routine immunisation, as highlighted in this year's *Risk & Assurance Report*. Angola, for example, has responded to seven VDPV2 outbreaks with 21 polio campaigns since June with GPEI spending over US\$ 20 million. This is more than the support approved by the Gavi Board for Angola's three-year post-transition plan, and there is a risk that the intensive polio effort could distract from work to strengthen routine immunisation (which had made progress with penta3 coverage increasing by seven percentage points between 2017 and 2018). There is also a risk that the monovalent type 2 oral polio vaccine used in the response to VDPV2 outbreaks might seed the further spread of VDPVs, which could contribute to community resistance in the face of multiple rounds of polio campaigns.

Better collaboration, improved synergies with routine programmes and tailored delivery strategies will be needed to achieve polio eradication. There is hope that a novel oral polio vaccine – which is less likely to cause vaccine-derived polio – will be available soon. But that remains uncertain and it alone will not reverse the skepticism of communities who regularly see polio workers but receive no other routine services to address their health needs. There is, however, an opportunity. If routine immunisation can harness the reach, data and capacity of polio programmes, we can bring a full package of vaccines and other basic PHC services to these communities. This would be a win-win – increasing equity of immunisation and PHC while also helping to ensure continued acceptance of

polio immunisation. It will require changes in how polio and routine immunisation programmes operate but it is feasible, and should be helped by Gavi recently becoming a member of GPEI and being asked to join the Polio Oversight Board.

Pakistan is one of the two remaining polio-endemic countries and in 2016, it also became the first country to report a major outbreak of extremely drug resistant (XDR) **typhoid**. It has now reported over 10,000 cases and other countries including Australia, Canada, Denmark, Ireland, Taiwan, the United Kingdom and the United States have also reported cases in travelers returning from Pakistan. Until the invention of antibiotics, typhoid killed approximately 20% of all those infected, and was responsible for millions of deaths. The rise of XDR typhoid illustrates the huge health risk posed by antimicrobial resistance, with only one routine antibiotic still effective as treatment. This is why the Gavi Board's decision to approve support for typhoid conjugate vaccine (TCV) in November 2017 was so critical. Pakistan has become the first country to introduce TCV with Gavi support having recently launched an immunisation campaign in Sindh province, where XDR typhoid was first reported. Similar campaigns will be conducted in the rest of the country over the next two years and the vaccine will simultaneously be introduced into routine immunisation. Liberia and Zimbabwe (which also has a drug resistance problem) have also been approved for support and are expected to introduce in the first half of 2020, subject to sufficient supply being available.

This meeting is an opportunity to reflect on the impact of the Board's decision in 2014 to commit US\$ 390 million to respond to **Ebola** in West Africa. In many ways, this was an example of the Alliance at its best. The Board identified a pressing need to guarantee a market and was willing to invest (at significant risk) to respond. The Alliance very quickly developed an innovative solution that harnessed the capacity of many different partners through an advanced purchase commitment (APC) for Ebola vaccine. The doses made available through the APC have been critical to efforts to combat subsequent outbreaks in DR Congo (the latest outbreak remains uncontrolled even if diminished) and have likely saved thousands of lives. The original Board-approved envelope runs until the end of 2020. With one candidate vaccine licensed and prequalified just a few weeks ago, and more candidates expected in the coming years, the Board is being asked to make a long-term funding commitment for vaccines to respond to future outbreaks as well as potential preventive use in high-risk groups.

At this meeting, the Board will also discuss future support for **malaria vaccine**. The Board first agreed to co-fund the vaccine pilots being led by WHO in June 2016 (the Global Fund and Unitaaid subsequently agreed to co-invest). The Board decision committed support for the initiation of the pilots and we now need to decide whether to fund the completion of the pilots through 2023, as well as how to work with the manufacturer to plan for future production. New data shows that the significant protection and benefit provided by the vaccine is sustained during seven years and provides reassurance on safety. This suggests that the vaccine could become an important additional tool in the fight against malaria, at a time when progress in controlling the disease has stalled. The PPC recommended extending support to complete the pilots but was more cautious about already

making a financial commitment to secure production capacity in the absence of a WHO policy recommendation given the uncertainties and suggested that the Secretariat explore partnering with a third-party to minimise Gavi's risk exposure.

Key country updates

Last year, the Board approved a new strategy with support of up to US\$ 1 billion to help **Nigeria** improve the performance of its immunisation programme and successfully transition out of Gavi support. This support was contingent on the country meeting conditions to be agreed in an Accountability Framework, which the Ministers of Health, Finance and Budget & Planning have now signed. The country has met its initial obligations by releasing over US\$ 40 million in vaccine financing for 2019 from budgetary resources (including 98% of their co-financing) and including over US\$ 60 million in its 2020 budget. There is also increasing leadership at State level. Convened by Bill Gates and Aliko Dangote, all State Governors committed to actions including scaling up investment in immunisation and PHC, providing counterpart funds for Gavi campaign support (and HSS in our focus states) and greater accountability of State primary healthcare agencies.

Nigeria is also making programmatic progress with recent surveys showing continued improvement in coverage (not yet reflected in WUENIC) and having gone three years with no new wild polio cases. However, it continues to struggle with multiple vaccine-preventable disease outbreaks (including vaccine-derived polio, measles, meningitis and yellow fever). Gavi has now approved support to address many of these including Meningitis A routine introduction and catch-up campaign, a measles campaign and second dose introduction and a yellow fever campaign. Gavi has also approved support for cold chain equipment and an initial HSS grant focused on national-level activities and the country recently submitted HSS plans for eight focus states. The first of nearly 10,000 units of Gavi-supported cold chain equipment arrived in October and installation has begun, prioritising hard to reach facilities. This is one of a number of efforts ongoing to strengthen the supply chain and improve vaccine management in Nigeria – including a Gavi-funded stock count across the country, support to strengthen the logistics management information system and better triangulation of data to ensure appropriate allocation of vaccines to the country. I will lead a high-level Alliance mission to Nigeria – along with several Board members – in mid-December to emphasise the importance of maintaining this momentum, continuing to prioritise routine immunisation and strengthen accountability.

In 2018, the World Bank confirmed **Syria** is a low-income country making it Gavi-eligible for the first time. The Board had previously approved exceptional support for Syria, recognising uncertainty over the country's income level and its acute needs as a result of the ongoing conflict. The Alliance has engaged with the Government to explain Gavi's support model and, following a successful mission in October, the country has submitted an application for pentavalent, inactivated polio and measles-mumps-rubella vaccine (the mumps component will be funded by UNICEF in 2020 as this is not Gavi-supported). It has also begun working on a HSS application. Since our exceptional support is coming to an end, it may be

necessary to launch some vaccine procurement steps before the country's recent application is approved and all the legal documents underpinning our support are finalised in order to avoid stockouts, and I will keep the Board informed.

There is a decision on **Sudan's** future eligibility for Gavi support on the Board consent agenda. Sudan is due to enter accelerated transition in 2020 based on its three-year average GNI per capita. However, this average hides significant volatility. After nearly doubling between 2013 and 2017, Sudan's GNI per capita fell by over a third between 2017 and 2018 and is now back under Gavi's eligibility threshold. Current projections suggest it is unlikely to recover in the near term due to continued political instability and the loss of oil revenues following the independence of South Sudan, and that the country will remain Gavi eligible for the foreseeable future. If the current *Eligibility and Transition Policy* is strictly applied, Sudan would likely enter accelerated transition in 2020, only to return to Gavi eligibility in 2021 or 2022. This would be highly disruptive in a country that is already struggling with political and economic crises. The Secretariat is therefore proposing that the determination of Sudan's eligibility for 2020 be based on 2018 GNI per capita instead of the average of the last three years (this is similar to the approach that the Board exceptionally approved for Congo Republic). As the current policy does not account for such dramatic, unexpected falls in GNI, the Board will consider whether to institutionalise this approach for all countries as part of the *Funding Policy Review* at this meeting.

Gavi 5.0 and other Gavi programmes

Following the Board's approval of the Gavi 5.0 strategic framework in June, the Secretariat has been engaging with partners to begin work on operationalisation. The **Funding Policy review** is the first time we have reviewed all of our funding-related policies together, in order to develop a more comprehensive and coherent framework for how we support countries. The Steering Committee (which includes several Board members) has met twice since June and the first set of recommendations were endorsed by the PPC in October. The Board is being asked to make a number of decisions at this meeting so we can prepare to implement them in 2020, with the final policy coming to the Board next June. Board members will also find an update on *BoardEffect* on the approach to develop the Gavi 5.0 **targets and measurement framework**. This will be critical to ensure we are aligned on a common ambition rooted in a well-defined theory of change for each area of the strategy, and can hold ourselves accountable. The approach is being developed with a Technical Working Group of Alliance stakeholders, building on lessons from what worked and what did not in Gavi 4.0. One of its first recommendations was to define "zero-dose" children as those who have not received a dose of pentavalent vaccine for the purposes of Gavi's strategy. The paper on *2016-2020 Strategy: Progress, Challenges and Risks* provides an update on the other workstreams to operationalise Gavi 5.0, all of which are now underway and we will continue to update the Board regularly.

The Board will also discuss exploratory work on engaging **middle income countries**. We hope to come back with a proposal for this in 2020 so the Board's

early guidance would be helpful. Linked to this work, we are also looking to institutionalise **post-transition support**, which the Board first approved in 2017 to address institutional or programmatic capacity risks in transitioned countries. To date, nearly 14 countries have been approved for support and some global and regional support is also being implemented, collectively using approximately 80% of the US\$ 30 million Board-approved envelope. The Secretariat developed a tailored application process for this support which sought to balance ensuring proposals were well-targeted at key risks to sustainability while being as light as possible given the limited funding involved. Countries have proposed a number of interventions to address their particular capacity gaps such as upgrading supply chains and addressing vaccine hesitancy. While the quality of applications has improved over time, the support required from partners and the Secretariat to help countries develop them has been higher than expected. These early lessons will be considered as we institutionalise this support in Gavi 5.0.

One year ago, the Board approved the opening of a window for **yellow fever diagnostics**. This was designed to shape the market for yellow fever diagnostic test kits and address gaps in countries' capacity to identify and respond to outbreaks. At a recent industry meeting, six test kit manufacturers confirmed that the Board decision has helped to incentivise the development and production of new yellow fever diagnostic kits going forward. One manufacturer has already developed a new, low-cost rapid test, now in prototype form, which could significantly improve testing of the disease. To ensure that new test kits are used once developed and validated, the Secretariat and partners have developed a procurement and distribution mechanism for yellow fever laboratory supplies and six countries (Benin, Chad, Ethiopia, Ghana, Guinea and Sudan) have had applications recommended for approval by the Independent Review Committee.

Key developments at Secretariat and partners

2019 was the third year in which we have run an **Alliance health survey**. For the first time this year, World Bank colleagues took part along with WHO, UNICEF, CDC and the Secretariat. 539 staff responded across these agencies (a 45% participation rate, 9% lower than in 2018). Overall results were largely stable with high levels of pride across agencies and reasonable (but not ideal) ratings on all other dimensions. There was a meaningful improvement in overall satisfaction with the partnership, and improved trust at WHO and CDC in their Secretariat colleagues. Most respondents also felt that efforts over the past two years to improve Alliance health have been useful. While these are positive signs, we need to further unpack why Alliance health has not improved more despite these efforts and will be discussing across the Alliance in the coming months. As we embark on our new strategy, we have an opportunity to re-energise our partnership and further strengthen the bonds that make the Alliance unique.

We also remain focused on strengthening the **Secretariat's organisational health**. In September, our leadership team met for a two-day retreat. Facilitated by an expert from IMD Business School, we had very frank conversations about where our culture is working and where we need to improve. We are already

changing the way we work as a result – including through a leadership-team wide process to agree corporate priorities in 2020 and scheduling more regular, semi-structured check-ins between leadership team members. We are also developing a short programme for our senior leaders with a top business school to help strengthen our leadership competencies individually and as a group. The Senior Management Team continues to reflect on how we can best drive organisational change, prepare the Secretariat for Gavi 5.0 and reinforce Gavi's culture.

As the Board knows, we have undertaken a major **transformation of the Secretariat's finance systems** with the introduction of SAP. After many months of preparation, the new system went live in October. This has been a major effort involving teams from across the organisation, most of whom were contributing on top of their day jobs. All the efforts paid off with a successful launch and the system being used to manage Gavi financial transactions and programme and portfolio accounting from day one. As is normal for such a major new system we have experienced some teething problems (e.g. challenges attaching documents within the approval process), but these are being systematically addressed and we have seen system usage steadily increasing as users get more familiar with new workflows. In the first seven weeks after go-live, we processed over 450 transactions and disbursed US\$ 130 million in funding to countries and UNICEF.

SAP has already enabled us to review and rationalise our financial processes. As we prepare for Gavi 5.0, we are also reviewing our portfolio management processes (and considering if new systems are needed to optimise these). We will also conduct a review of the overall Secretariat structure and capacity to ensure that we are fit for purpose and will continue to report to the Board on the changes we are making to ensure we are ready to deliver on our new strategy.

When we next meet, we will have just completed our Pledging Conference in London. It is fitting that our last meeting before Replenishment should take place in India, which is a poster child for the catalytic power of our Alliance. When Gavi was created in 2000, fewer than 60% of India's children received a full course of basic vaccines. Today, nearly 90% of India's children are being reached – nearly six million more every year. These children now receive not only basic vaccines but nearly a full package of infant vaccines. In this strategic period alone, India has introduced pneumococcal, rotavirus, inactivated polio and rubella vaccines under our partnership. Although India has received less support per child than almost any other Gavi country, the current government has harnessed our support to jumpstart introduction of new vaccines and to test and scale up innovative approaches to reach every child. Increasingly, the country is becoming a crucible for innovation from which the entire Alliance can learn. We will get to see some of these approaches at this meeting during the field visits and in our discussions. The country is already on the journey to transition out of Gavi financing in 2021, including by becoming a donor to the Alliance and a strategic partner in our market shaping work, and we look forward to continuing our long and fruitful relationship for the benefit of children in India and across the world.