

Report of the Chief Executive Officer

7 June 2017

Dear Board members,

We are 18 months into the 2016-2020 strategy and our focus is on implementing, learning and adjusting our approach to support countries to achieve our ambitious coverage, equity and sustainability goals. **The agenda at this meeting reflects that with fewer major decisions and more of a focus on reviewing progress and lessons learned, and adapting where needed.** We will be reflecting on implementation of the Partners' Engagement Framework (PEF), progress and challenges in country programmes including the lessons we can draw from Pakistan's recent experience, aligning on updates to our risk appetite statement and discussing an extension to our support for inactivated polio vaccine (IPV) given programmatic developments.

Following positive feedback at the last Board meeting, the *Update on Gavi's 2016-2020 Strategy, Indicators and KPIs* is now a standing item on the Board agenda. It provides a systematic overview of key areas of progress and challenges as we implement our strategy (the end of year report will be more complete as it will include updated coverage data, which the World Health Organization (WHO) and UNICEF publish in July). **The Board also discussed at our last meeting the desire for more strategic discussion of higher-level and longer-term issues.** I have sought to use this report to frame two issues that I think are particularly timely: our initial thinking on how we might engage differently with countries during and after transition (in follow-up to the April Board Retreat) and how we balance risks and country ownership given our growing understanding of weaknesses in some countries' systems. The report also provides an update on key developments in the global landscape, reports back on previous Board decisions which are not otherwise addressed in the Board agenda, and provides an update on the Alliance's performance and operations. I will expand on some of these issues in my presentation at the meeting.

In response to Board requests, **we have continued to make Board papers more concise and strategic and have rolled out the BoardEffect** platform to facilitate easier access to materials. We are organising technical briefings for Board members on the day before the meeting to allow for more informal presentation and discussion of issues that are relevant to the Board but not on

the agenda at this meeting. These will cover the Vaccine Investment Strategy (which is on the Board agenda in November), immunisation in humanitarian settings, and climate change and the environmental impact of immunisation. As ever, we welcome your feedback on how we can better support the Board.

Key developments in the global landscape

We are in the middle of a period of intense change in the global health and geopolitical landscape creating both risks and opportunities for the Alliance. In January, Antonio Guterres took office as the new Secretary-General of the United Nations and last month Dr. Mark Dybul stepped down as Executive Director of the Global Fund. At the World Health Assembly in May, Dr. Tedros Adhanom Ghebreyesu – former Minister of Health of Ethiopia and Gavi Board member – was appointed as the next Director General of the WHO.

Following recent elections, there are new leaders in the United States and France while discussions are ongoing to form a new government in the Netherlands. In this context, we are grateful to retain strong donor support. As discussed in the *Resource Mobilisation Update*, **we recently received two positive donor evaluations and have now signed every grant agreement from the Berlin Replenishment that can be signed, amounting to 87% of pledges** (the rest can only be signed on an annual basis). The United States recently confirmed an increase in 2017 funding for Gavi and the Administration has recommended a further increase in its 2018 budget proposal despite proposing very large and concerning cuts for many other global programmes. Considerable uncertainty remains. We currently have no commitments for US funding in 2019 and 2020, though we are hopeful based on recent developments. Moreover, the United Kingdom is going to the polls tomorrow while Germany, Norway and possibly Italy will hold general elections before the end of 2017. We will continue to engage intensively with current and new leadership of our partners and donors to ensure sustained support for Gavi and immunisation.

Another emerging risk is the intensification of anti-vaccination sentiment.

There is a particularly concerted campaign in the United States, which is making use of professionally produced films and documentaries, sophisticated social media techniques and well-known spokespeople including Robert F. Kennedy Jr. and Andrew Wakefield, both of whom have met with then President-elect Trump. While there have long been anti-vaccine movements, the latest efforts appear better organised and resourced, and include some groups who seem to be using it for commercial gain (for example, websites using it to sell advertising and related products) as well as some political groups (e.g. 5-Star movement in Italy). Campaigners have stated that they wish to undermine both the regulatory system and vaccine confidence and are also targeting other countries. The film *Vaxxed* has been shown in a number of countries including Belgium, France, Ireland, Italy, Australia and New Zealand, and is available on Amazon.

To date, the response from the mainstream media and policymakers in developed countries has been robust. However, there is a risk of

misinformation spreading to Gavi-supported countries which may be less well-equipped to respond. Even countries with strong institutions can be affected, as was the case during the recent measles-rubella (MR) campaign in India when rumours circulated about the safety of the vaccine, leading parents to refuse vaccination for their children and significantly reducing coverage (though this was subsequently resolved). The Secretariat and partners are working together to monitor developments and prepare a response plan in case of further escalation, including reaching out to other influential institutions for their help if required.

Despite these risks, **political commitment to immunisation remains high in Gavi-supported countries**. In February, African Heads of State endorsed the African Declaration on Immunization. This committed countries to prioritise universal access to immunisation, increase domestic investment and strengthen delivery - especially in the poorest and most marginalised communities. The Declaration was proposed by the Government of Ethiopia (under the leadership of Dr. Tedros in his role as Minister of Foreign Affairs prior to being elected WHO DG) working with WHO, the African Union and the Gavi Secretariat. This formally makes immunisation a priority for all African governments and is an important milestone in efforts to ensure sustained prioritisation of immunisation.

Since the Board approved Gavi support for WHO's Eliminating Yellow Fever Epidemics (EYE) strategy in December, **there has been a large outbreak of yellow fever in Brazil** with over 3,000 reported cases and approximately 400 deaths. While the outbreak now appears under control, there were cases in Rio de Janeiro and other large cities, causing concerns of sustained urban transmission as was seen in Angola last year. With winter approaching, it is expected that cases in Latin America will further decline but – as demonstrated by Zika which is carried by the *Aedes aegypti* mosquito which can also carry yellow fever – there is a risk it could emerge in northern countries of the Americas during the coming summer. To address the outbreak, the International Coordinating Group (ICG) dispatched three million doses of vaccine to Brazil. This situation illustrates how spikes in vaccine demand to respond to large-scale outbreaks could delay implementation of some of the activities planned under the EYE strategy (given current supply constraints). It also underlines the urgency of creating a strong governance structure to oversee global yellow fever control efforts. On a related note, I am pleased to report that **the Secretariat has signed terms of reference with WHO on the Secretariat's participation as an observer of the ICG** (following consultation with other ICG members). This is a temporary arrangement until a sustainable and comprehensive solution is found to improve governance following the ongoing external evaluation of the ICG.

DR Congo also suffered a major yellow fever outbreak last year and is now dealing with an outbreak of Ebola. As of 6 June, five confirmed and three probable cases of Ebola had been identified in a remote region in the north of the country resulting in four registered deaths. The government mobilised rapidly, drawing on its experience of managing seven previous Ebola outbreaks. When I met the Minister of Health, he told me that he had hoped to use the Ebola vaccine as soon as the outbreak was confirmed. Some doses remained available

from the last Ebola outbreak and from stocks held by the US Government Biomedical Advanced Research and Development Authority, while Merck has made a further 300,000 doses available as part of Gavi's Advanced Purchase Commitment (APC). However, several complications impacted rapid use of the vaccine, particularly the need to create a cold chain to store it at -80°C and the need for the country to approve an expanded access protocol (developed by Médecins Sans Frontières (MSF)) to import and use it pre-licensure. The protocol was approved nearly three weeks after the outbreak was detected.

This example illustrates why we need a faster, global mechanism to facilitate use of investigational, pre-licensure vaccines in emergencies. Had the outbreak spread rapidly, the delay in approval could have been very costly and had the disease spread across the nearby border with Central African Republic, the government there would have needed to separately approve the expanded access protocol. To help address this for Ebola, WHO requested Merck submit an application for Expanded Use Authorisation and Listing (EUAL) as part of the APC. Merck submitted this at the end of 2015 but it has not been fully reviewed and EUAL was not referenced as a mechanism for using the vaccine in the recent recommendation by WHO's Strategic Advisory Group of Experts on Immunisation (SAGE). Given the efforts by the Coalition for Epidemic Preparedness Innovations (CEPI) and others to accelerate development of vaccines to respond to outbreaks, we clearly need to find new ways to deploy such vaccines as quickly as possible when required.

As we have discussed, **increasing population, urbanisation, migration and climate change mean it is an evolutionary certainty that epidemic diseases will continue to emerge and spread.** The Alliance is increasingly contributing to efforts to address this through our support for vaccine stockpiles, engagement in comprehensive control strategies for yellow fever, measles and meningitis, and by building public health capacity through health systems strengthening (HSS) grants and technical support. As discussed below, the next Vaccine Investment Strategy (VIS) will include a lens of vaccines' impact on preventing epidemics.

Reporting back on previous Board decisions

This section provides an update on implementation of previous Board decisions and discussions including the India partnership strategy, support for Syria (and follow-up to Jordan's request for support), the redesigned human papillomavirus (HPV) vaccine programme and investments approved as part of the 2008 and 2013 Vaccine Investment Strategies (typhoid, cholera, rabies and malaria).

The measles-rubella campaign discussed above is one component of **India's partnership strategy with Gavi.** Another is the launch of pneumococcal vaccine which occurred last month. **Introducing the world's most complex vaccine into its most populous country is a major milestone,** and one that until recently looked unlikely before 2020. With pneumonia responsible for nearly one in six child deaths, and 20% of these deaths occurring in India, this single introduction has the potential to significantly reduce global child mortality. India is

also scaling up rotavirus vaccine and Punjab State recently introduced HPV vaccine with its own funding. The Prime Minister is personally tracking the progress of *Mission Indradhanush*, which is designed to increase coverage and equity and is estimated to have increased full immunisation coverage by 5-7 percentage points since 2015. I will lead an Alliance visit to India later this year to discuss progress and how we can further strengthen our partnership.

At the end of last year, the Board agreed to provide support for children in Syria of up to US\$ 25 million per year in 2017 and 2018. The decision recognised uncertainty over Syria's gross national income, which may now be below Gavi's eligibility threshold, and the country's acute needs. Following the Board decision, UNICEF worked with WHO and civil society organisations (CSOs) to draft a proposal, which is aligned with the 2017 Syrian Humanitarian Response Plan agreed between the Government and the UN Office for the Coordination of Humanitarian Affairs and follows the 'Whole of Syria' approach with local and international CSOs playing an important role in service provision, cold chain deployment and social mobilisation. The proposal requests support for Gavi-supported routine vaccines, cold chain equipment and vaccine support for a measles campaign to prevent a wide scale measles outbreak (nearly 1,000 measles cases were reported in Syria in 2017, over twice as many as in 2016). The cost is within the Board-approved envelope and the proposal is being technically reviewed by members of the Independent Review Committee.

In addition to pentavalent vaccine and IPV, the proposal seeks support for the measles-mumps-rubella (MMR) vaccine which is in Syria's existing immunisation schedule. Gavi supports measles-rubella vaccine but not MMR. The incremental cost of the mumps component is around US\$ 2.5 million (~5% of the Board-approved budget). The 2017 Humanitarian Response Plan remains under-funded so it is unclear if funding for this is otherwise available. Given this context, the situation in Syria and the potential disruptive impact of the country switching vaccines, the Secretariat proposes to exceptionally support MMR in this instance. The government also expressed an interest in introducing pneumococcal vaccine in the future. **Syria's gross national income (GNI) may be confirmed as Gavi-eligible when the World Bank releases their latest estimates in July** in which case the Alliance will need to consider a longer term strategy to our engagement.

As you will recall, **the Government of Jordan wrote to the Board before our December meeting requesting support** in light of the large number of refugees they were hosting from Syria and the region. Given that Jordan's GNI is well above our eligibility threshold but recognising the challenges it faces, the Board asked the Secretariat to explore how best to respond. Alliance partners (UNICEF, USAID, MSF and WHO) subsequently discussed the country's needs with the Government, identifying opportunities to improve vaccine planning and modernise vaccine procurement to achieve sustainable, affordable prices. Partners have agreed to provide technical support to the country to address these opportunities which could save the government several million dollars per year. It is considering using these savings to introduce pneumococcal vaccine with catalytic bilateral donor support. **This is a powerful example of Alliance**

partners coming together to support a country's needs based on their individual mandates, even where Gavi is not providing funding.

Six months ago, **the Board approved changes to Gavi's HPV vaccine programme, designed to accelerate country uptake**. There has been a positive response from countries to the new programme design, which supports national introduction without the need for a demonstration project and enables the vaccination of multiple cohorts of girls in the year of introduction. Three countries (Ethiopia, Zimbabwe and Senegal) have already been approved for national introduction. All three plan to vaccinate the maximum five cohorts of girls when they introduce in 2018, reaching approximately ten million girls in that year alone. Another eight countries¹ plan to apply this year and could collectively also reach ten million girls in the year of introduction. **While it is early days and implementation will be complex, we appear on track for our target of reaching 40 million girls by 2020**. There is a risk that some introductions could be delayed due to the timing of supply availability given the rapid acceleration in demand. The Secretariat and UNICEF are working with industry to mitigate this. A further risk was highlighted during the drafting of a recent World Health Assembly resolution on cancer, when some countries questioned the evidence that the vaccine reduces cervical cancer. The Secretariat worked actively to ensure that vaccines continued to be referenced in the resolution.

In the 2008 VIS, the Board prioritised typhoid conjugate vaccine for future support once a vaccine was WHO-recommended and prequalified. At the time, this was expected to happen within five years but it has been significantly delayed. **The first typhoid conjugate vaccine may be prequalified this year and recommended by SAGE in October**. If this occurs, the Secretariat would refresh the original analyses from the VIS (which are now almost a decade old) and if these have not changed significantly, would bring a proposal to the Board in November to open a funding window in 2018. If the analyses are significantly different or there are further delays in the vaccine being prequalified or recommended, we propose to re-assess typhoid as part of the 2018 VIS (if the vaccine were again prioritised, a support window could be opened in 2019).

The 2013 VIS approved new support for yellow fever campaigns² and the global cholera vaccine stockpile, provided funding to strengthen the evidence base for rabies post-exposure prophylaxis, and agreed to consider support for a malaria vaccine when one was licensed. These investments are beginning to demonstrate impact. **Gavi's investment in cholera has supported a significant scale-up in the use of the vaccine and helped to address market failure by breaking the cycle of low demand and low supply**. In 2013, only 300,000 doses were provided to countries from the stockpile. By 2016, this had risen over ten-fold to 3.7M doses. So far in 2017, 11.7M doses have been dispatched to help address recent outbreaks in Mozambique and Somalia and for endemic use in Haiti, Malawi and South Sudan. This increased vaccine use has

¹ Kenya, The Gambia, Tanzania, Zambia, Solomon Islands, Cameroon, Mozambique, and Mauritania

² This was subsequently absorbed into the comprehensive approach to yellow fever approved by the Board in December 2016

been enabled by an existing supplier increasing manufacturing capacity and a new supplier being prequalified in response to Gavi's investment. As envisaged in the original investment case, the increased use of the vaccine is informing a learning agenda on how the vaccine might be used in endemic settings in future.

The Alliance's engagement has also helped transform the learning agenda on rabies. In both the 2008 and 2013 VIS, the Board decided not to open a support window for rabies citing limitations in understanding the feasibility and acceptability of the vaccine for cost-effective use in Gavi countries. Following the 2013 Board decision, the Secretariat commissioned targeted assessments to fill critical evidence gaps on disease burden, vaccine impact and lessons learned about vaccine delivery in low- and middle-income countries. The VIS process and learning agenda helped catalyse public and private partners in the rabies community to develop strategies to address vaccine production, policy and implementation related to both humans and dogs. Following these efforts, SAGE is expected to endorse a revised WHO position on rabies vaccination at its next meeting. Gavi will again consider support for rabies vaccine in the next VIS.

In June 2016, the Board agreed to support pilot implementation of the malaria vaccine (following the 2013 VIS decision). On World Malaria Day this year, WHO announced the pilots would take place in Kenya, Ghana and Malawi with the first vaccinations planned for early 2018 (WHO is providing Gavi with quarterly progress reports, the first of which is available on BoardEffect). A key condition of the Board decision was that Gavi support should be matched by other funders. This was subsequently pledged by Unitaid and the Global Fund, creating an innovative collaboration between three of the leading health financing partnerships. Aligning different structures, cultures, and approval processes has created some delays and we had to wait until the Unitaid Board approved the detailed project documents before signing our grant agreement with WHO (given the need for Gavi funding to be matched). **Unitaid's Board approved their grant this week and we hope to sign our grant agreement with WHO shortly.** In the interim, WHO is using bridge funding from PATH.

The Board will decide on Gavi's next Vaccine Investment Strategy in 2018. As a first step, there will be a technical briefing on the VIS at this meeting and the Board will consider the framework to prioritise investments in November 2017. **This will include new lenses to assess the value of vaccines** including impact on preventing epidemics, global public good use such as disease eradication (e.g., for IPV), strengthening delivery platforms for health interventions (e.g. for pregnant women and neonates) and preventing antimicrobial resistance (AMR). It is widely acknowledged that vaccines have a critical role to play in mitigating AMR but, as was highlighted in a recent meeting I attended at Chatham House, we are at an early stage in aligning the AMR and immunisation policy agendas.

Early thoughts on Gavi's approach to high-risk transitioning countries and engagement with countries post-transition

At its Retreat in April, the Board reviewed the progress of transitioning countries. It concluded that **most countries are on track to have sustainable programmes after they transition out of Gavi support**, while emphasising the importance of more systematic engagement with Ministers of Finance and other critical government stakeholders beyond the Ministry of Health, as well as with other development agencies who are working on transitions (e.g. World Bank, the Global Fund). The Board identified five countries which are at higher risk of failing to transition successfully – Nigeria, Papua New Guinea (PNG), Angola, Congo, East Timor – and asked the Secretariat to consider if more tailored strategies are required. **Based on an initial analysis, the Secretariat believes that Nigeria and PNG are most in need of tailored strategies**, and plans to bring proposed approaches to both countries to the Board in November. We will continue to monitor progress in Angola, Congo and East Timor and explore what additional engagement may be needed to mitigate transition risk.

The Board also asked the Secretariat **how the Alliance might sustain its engagement with countries after transition** to help maintain progress and mitigate the risk of programme performance declining (while emphasising that this should not change the expectation that countries fully fund their existing vaccines at the point of transition). Based on existing Board decisions, the Alliance has already continued engagement in some countries following their transition – in particular, where we have granted a no-cost extension to a HSS grant or are providing catalytic support for certain vaccines as approved under the 2015 eligibility policy (e.g. to support introduction of MR vaccine in Indonesia and HPV in Honduras and Sri Lanka). However, this engagement is time-limited and designed only to support implementation of this specific support.

The Secretariat's early thinking is to take a differentiated approach to post-transition engagement based on countries' specific needs and risks. At a minimum, we would plan to **continue engaging with all transitioned countries** to monitor performance, advocate for immunisation and facilitate sharing of lessons learned and best practice. Potential mechanisms could include periodic visits by Secretariat Senior Country Managers, continued cross-Alliance review of performance and allowing transitioned countries to engage or represent regional constituencies on the Board. We would also work with transitioned countries to discuss how they could contribute back to the Alliance, for example by providing technical assistance to Gavi-eligible countries or even by becoming donors.

We would also explore what role the Alliance might play in market shaping for countries post-transition. The Board recognised at the Retreat that this is a key area of comparative advantage for the Alliance. Countries currently benefit from a number of commitments made by manufacturers to retain access to favourable pricing for between five and ten years after transition. However, there is no provision for what happens after they expire. While countries should be able to self-procure most vaccines successfully given the Alliance's work to create

healthy vaccine markets, they may face challenges in securing sufficient volume or affordable prices in certain markets or through some procurement processes. Therefore, the Alliance could as part of its future strategy consider working with UNICEF to support transitioned countries to achieve successful procurement outcomes for vaccines and cold chain equipment using their own financing.

One of the major risks discussed by the Board was that countries may reach transition with major weaknesses in their immunisation programme or might experience challenges post-transition. In such cases, the Alliance could consider targeted technical assistance and/or HSS grants to address critical bottlenecks to coverage and equity. These would be provided on an exceptional basis, time-limited and contingent on countries continuing to fully finance their vaccine programmes. This might apply, for example, to some of the countries identified by the Board as being at risk of not transitioning successfully, several of whom have low or declining coverage but appear to now have political commitment to strengthen their programmes and ensure financial sustainability.

The Board also discussed that some countries will transition without having introduced the full range of Gavi-supported vaccines. To address this, the Secretariat will evaluate the implications of enabling countries to apply for new vaccine support at any point in the five years of accelerated transition (as opposed to only in the first year under the existing policy). As we discussed at the Retreat, some transitioned countries have indicated that catalytic support may enable them to accelerate vaccine introduction (e.g. Indonesia signalled that limited support for a rotavirus vaccine demonstration project would help accelerate nationwide introduction to a birth cohort of nearly 5 million children). The Secretariat proposes to evaluate options to provide such support on an exceptional basis in countries which are fully self-financing their current vaccines.

The Secretariat estimates that this differentiated approach would cost no more than 1-2% of total Alliance expenditure. This will provide “insurance” to protect the investment Gavi has made in transitioning countries. Going forward, **the Board also indicated that it would be important for the Alliance to maintain its vaccine introduction platform** to enable rapid roll-out of priority vaccines that may be developed in the future (such as HIV or tuberculosis). We will begin to consider this as part of the VIS and develop a more comprehensive approach as part of Gavi’s 2021-25 strategy. I look forward to discussing this early thinking with the Board and to receiving your guidance on the proposed approach so that we can develop further in time for the November Board meeting.

Balancing risk and country ownership

During our risk discussion in Abidjan, several **Board members emphasised the importance of improving data quality and our understanding of country realities, and asked if we were ready to have an honest conversation about what these might show without creating perverse incentives.** This conversation has continued to resonate with me as the Alliance works to strengthen data, deepen our insights into country systems and enhance our risk

processes. As we do this, there is a significant likelihood that we will find that systems and country performance are not as strong as we had expected.

The *Alliance Update* discusses one example of this. As we gain more insight into countries' processes and systems (e.g. through programme capacity assessments and audits), we have greater transparency into weaknesses in the capacity of many of them to manage their programmes and Gavi support. For example, 15 of 19 programme audits completed since 2015 have identified some misuse. Most of this is due to weak management systems with symptoms such as inadequate documentation of how Gavi support was used or vaccine wastage due to poor stock management – rather than prima facie fraud (weak systems may of course make such fraud hard to detect). **Efforts to mitigate fiduciary risks arising from these weaknesses are delaying HSS grant disbursements, hindering our ability to deliver on our goals and meaningfully reducing overall Gavi disbursements** (at least in the short term). We are also increasingly having to channel funds through alternative systems. We will discuss this in detail as part of the *Alliance Update*. However, this is an example of a broader issue which I think deserves Board discussion.

Another example is coverage data. In many countries, official coverage estimates are unreliable. Therefore, Gavi has relied on WHO and UNICEF estimates of immunisation coverage (WUENIC) to set targets and measure performance despite the fact that these are often disconnected from the data which countries use to plan, budget and manage their programmes. As part of our efforts to improve data quality through the PEF, WHO and UNICEF are triangulating coverage data and may find that WUENIC has over-estimated coverage in some countries. At the same time, as we work with countries to develop more robust immunisation plans, we're discovering that many have set unrealistic targets linked to aspirational global goals (e.g. Global Vaccine Action Plan target of 90% coverage) rather than basing these on their own specific situation, priorities and plans. Therefore, **the reality may be that coverage today is lower than we thought, and that some of the targets that have been set are not realistic.**

The long-term solution to these problems is to strengthen countries' systems and address performance gaps. We will be discussing many of the ways we are doing this at this meeting. However, building institutions and systems is a long-term endeavour and, with no countries currently meeting all the criteria in the Alliance's key performance indicator for strong institutional capacity, we have a long way to go. **Better understanding countries' challenges is the first step towards helping to fix them but this increasing transparency raises a number of questions on which I would welcome the Board's guidance:**

1. **How do we manage the risk to Gavi's reputation** as we uncover examples where performance may be lower or systems weaker than we had previously understood? **How do we ensure that we maintain an incentive for stakeholders to report information honestly**, even where this reveals performance issues or risks?

2. **What are the implications of better understanding these weaknesses for Gavi's risk appetite?** While the actual level of risk has not changed, will we become more risk averse now we better understand our exposure?
3. **What are the implications for Gavi's model with its focus on country ownership?** How do we ensure that our support is grounded in and strengthens countries' own data, plans, targets and systems while managing the risk posed by the weakness of those same systems?

Working with partners

At the end of last year, we conducted the first ever Alliance Health Survey, of over 800 staff in WHO, UNICEF and the Secretariat (the Secretariat conducts a survey of its staff every few years and we will discuss the results of the latest one in the closed session at this meeting). It showed pride in the mission of Gavi, a sense of strong fit among partners and improvements in accountability and transparency. However, it also identified concerns on the level of trust between Alliance members, the quality of cross-Alliance communication and robustness of some processes. On most dimensions, the Alliance appeared healthier at country level than at global or regional levels. The findings have been discussed in global Alliance coordination fora, at Regional Working Groups and in a dedicated all-day retreat with leadership from WHO, UNICEF and the Secretariat. We have collectively prioritised a set of actions to streamline communication between partners (e.g. through a roster of Alliance colleagues, an online document-sharing platform), improve trust (e.g. through joint communication from Alliance leadership, harmonised on-boarding packages) and strengthen collaboration among Alliance leadership (e.g. more joint missions).

The survey findings partly reflect our ongoing efforts to transform how we work across the Alliance. The PEF has made technical assistance more responsive to country needs, more transparent and harmonised across partners. Similarly, the Country Engagement Framework (CEF) is designed to create a single, harmonised approach to planning, prioritising and approving all Gavi grants to each country (its early progress and lessons learned were recently reviewed by the Programme & Policy Committee). **These mechanisms are transforming our model for engaging with countries. And increasingly, they are being enabled by knowledge management tools.** Over the past year, the Secretariat has launched online Country and Partner Portals to support the CEF and the PEF. These are allowing a wide set of partners and country stakeholders to share critical information on a single platform and increase the transparency of Gavi support across the Alliance. These systems will begin to generate a rich set of data on Gavi grants and immunisation programmes which will enable us to strengthen our analysis and insight into performance over time. We are exploring how best to make all non-confidential data available to the broader community.

We are increasingly engaging with a broader ecosystem of other partner organisations to improve our effectiveness and efficiency. Our collaboration with the Global Fund continues to grow, especially in the priority areas which Mark

Dybul and I discussed with the Board last year. We are working together to share knowledge, information and lessons learned; coordinate political advocacy in priority areas; and coordinate planning of programmatic investments, especially in strategic focus areas and on transition. **We now have some collaboration with the Global Fund in the vast majority of Gavi countries** ranging from coordination of activities and sharing of information to joint investments and common fiduciary mechanisms. As we will discuss at this meeting, we are working closely together to plan the move to Health Campus and explore opportunities to further strengthen cooperation once we are co-located.

With the move to Health Campus, we will also share a building with Unitaid, with whom we recently started collaborating closely on malaria vaccine, as well as Roll Back Malaria and the Stop TB Partnership. As discussed in the *Strategy Progress Update*, we now have regular joint leadership meetings with the Measles & Rubella Initiative to oversee implementation of our measles strategy and – as we will discuss at this meeting – work closely with the Global Polio Eradication Initiative on IPV. We are increasingly engaged with CEPI to ensure synergies between their investments and our programmes. We are also working closely with the Global Financing Facility (where we sit on the Investors Group) and Partnership for Maternal, Neonatal and Child Health (where we occupy the Board seat representing Gavi, GFF and the Global Fund) to ensure that our investments are well aligned with broader health investments. And as we seek to accelerate scale-up of HPV, we are exploring how we can work more closely with the Global Partnership for Education. **These examples illustrate how the Alliance is collaborating with an increasingly diverse set of partners.** This requires increased engagement, especially from Secretariat staff, but is critical to ensure we deliver integrated support to countries as efficiently as possible.

It is too early for us to be able to show that we are definitively delivering on the targets of the 2016-20 strategy. However, I believe there are many reasons to be optimistic based on our progress to date. We will need to maintain progress in the context of a rapidly changing global environment, and with an eye to the future issues that will face the Alliance. In this context, I look forward to your guidance at this meeting on some of the key questions I have outlined and on a rich agenda reviewing our progress and challenges ahead.