

Report of the Chief Executive Officer

30 November 2016

Dear Board members

I am finalising this report from rural Madagascar where I have witnessed some of the challenges countries face in strengthening their immunisation programmes. Madagascar has among the highest poverty levels in the world with over 75% of the population living on less than US\$ 1.90 per day (based on 2012 data – the latest for which it is available). Following a sustained period of political crisis, it remains fragile with large inequities and weak systems. There are particular challenges in rural areas with limited resources flowing from central level. The government reports coverage of 85%¹ nationwide but it is clear when you visit communities that this is far from reality. Most clinics have only one healthworker (who must close the facility for activities such as outreach, training and collecting vaccines), many lack working cold chain equipment and other infrastructure, and they face regular stockouts due to supply chain challenges. The country has conducted eight polio campaigns in the past two years after cases of vaccine-derived polio virus were detected, and this has also diverted healthworkers from routine immunisation. From the President and First Lady, to the Prime Minister and Minister of Health, and down to community healthworkers, everyone we met showed a strong commitment to immunisation and a willingness to address these challenges. The Alliance has scaled up its support (described below) but this was a timely reminder of the challenges we all face to achieve our 2016-2020 goals.

The last two years have been a period of intense change for the Alliance. We developed the 2016-2020 strategy, secured renewed backing from donors at the Berlin Replenishment, reviewed and modified many of our policies to support the new strategy, developed new approaches in key areas, redesigned how the Alliance operates with the Partners' Engagement Framework (PEF), introduced a new accountability framework, zero-based partner and Secretariat budgets, and introduced a new risk policy and risk management approach with a significant scale-up in resources. We have largely completed this process and are now

¹ Unless otherwise noted, all references to immunisation coverage and under-immunised children in this report refer to the number of children receiving three doses of DTP-containing vaccine

transitioning to focus on scaling up implementation. At the same time, we will continue to learn and adapt and respond to new developments as they occur. At this meeting, the Board will make decisions on human papillomavirus vaccine (HPV), stockpiles, yellow fever, fragility and emergencies, additional investment in the Cold Chain Equipment Optimisation Platform (CCEOP) and flexibilities to further test a new Country Engagement Framework (CEF – on the consent agenda), which will adapt the Alliance’s approach based on lessons learned from our work to date and a changing external context.

The Secretariat continues to refine the Board agenda and papers in response to Board requests and guidance from the Chair. This meeting will have an extended closed session following Board feedback that they would like more private discussion time. Following the positive response to the strategy presentation in June, we have created a more structured *Strategy Progress Update* including a set of dashboards to systematically report progress against the Alliance’s strategy indicators and KPIs (I suggest reading this report in conjunction with that paper). At the request of Board members in June, the *Country Programmes (CP) Update* focuses on explaining how the Alliance’s new tools and approaches come together at country level to accelerate progress on coverage, equity and sustainability. Following discussion at the Board Retreat in April, the Board will also consider a *Risk & Assurance report* which describes the key risks facing the Alliance, our exposure and mitigation strategies, and key sources of assurance. This is designed to align the Alliance on our highest risks to focus our mitigation efforts, and will inform a review of the Alliance’s risk appetite statement in 2017. The *Strategy Progress Update*, *CP update*, *Risk Update* and *PEF update* are cross-referenced to ensure they are mutually coherent. We also continue to work to streamline Board papers, while providing more extensive materials on myGavi. To facilitate distribution and review of papers, and provide easier access to supplemental materials, we are working on a new digital platform to replace myGavi in 2017. We appreciate feedback on these changes, as well as potential other improvements, including during discussions on the Board and Committee self-evaluation, so that we can continue to enhance our support to the Board.

Early progress on implementation of 2016-2020 strategy, but significant challenges and risks remain

We are approaching the end of year one of implementing the 2016-2020 strategy and while limited hard data is yet available on our progress, the early signs are positive. As described in the *Strategy Progress Update*, the Alliance appears to be **on track to achieve our 2020 Mission Aspiration**. The Board’s decisions at this meeting on HPV and yellow fever could further increase our impact.

There is strong **momentum on immunisation coverage** in many priority countries with the number of under-immunised children having halved in PEF

Tier 1 countries since 2001 (and reduced by over 10% between 2014 and 2015). From the progress we see on the ground in many of these countries (such as India and Pakistan), it is likely that WHO-UNICEF (WUENIC) data will show this momentum was sustained in 2016 when data is reported in July 2017. However, progress across the Gavi portfolio is more mixed. Two Tier 1 countries (Nigeria and Chad) and half of Tier 2 countries have coverage below 65% while the number of under-immunised children in Tier 2 countries actually rose between 2014 and 2015. To achieve our 2020 goals, we will need to significantly accelerate the rate of improvement. Looking further ahead, **under 30% of currently under-immunised children live in countries that will be Gavi-eligible** by the middle of the next strategy period as large countries such as India and Nigeria transition. This raises a question about the Alliance's future role in driving global improvements in immunisation coverage and equity - a topic which the Board can perhaps reflect on more at our next retreat.

Countries are also **performing well in terms of sustainability**. To date in 2016, countries have provided US\$ 77 million in co-financing, as opposed to US\$ 52 million at the same point in 2015. This has been matched by growth in overall domestic investment in immunisation which grew from US\$ 3.78 per child in 2011 to US\$ 5.09 per child by 2015. 2016 saw the first four countries become fully self-financing under the new transition policy and all transitioned successfully. Most of the 20 other countries currently in transition are also on track. However, as highlighted in the Risk & Assurance report, there are **growing risks to both co-financing and transition**. DR Congo only recently paid its 2015 co-financing without which, the Board would have had to consider suspending support. And four countries (Angola, Congo, Papua New Guinea, Indonesia) are at particular risk of failing to transition successfully due to co-financing challenges, low coverage or having introduced few vaccines. Anuradha visited Indonesia and East Timor last week to better understand some of these issues and we plan more senior level visits to high-risk countries in 2017. The Programme & Policy Committee (PPC) has requested a dedicated discussion of sustainability in May.

This is an **important period for market shaping** after the Board approved the new Supply and Procurement Strategy in June 2016. By the middle of next year, the Alliance will have issued new tenders for 75% of its projected vaccine demand for 2016-20. In October, the Alliance completed a tender for pentavalent vaccine, which demonstrated that the market is now a lot healthier than it was just a few years ago with seven prequalified suppliers. Following the tender, we anticipate that the weighted average price of penta will be reduced by 50% from 2016 levels and 70% from the price in 2010 when the Alliance began actively market shaping. Combined with reductions in the projected volume required – due primarily to cross-Alliance work to optimise country stock levels – this will save almost US\$ 700 million in pentavalent costs 2016-20 compared to the forecast at the time of Replenishment (a reduction of over 50%). This is an

example of how partners and the Secretariat are working to deliver value for money and these savings enable us to increase investment and impact in other programmes including the decisions coming to this Board. At the same time, Janssen's recent announcement of their intention to end production of penta is a reminder of the challenging trade-offs we will need to manage to maintain healthy markets. Gavi is also making incremental progress on pneumococcal conjugate vaccine pricing (PCV). Earlier this year, GSK announced that they are passing on savings from production efficiencies (in line with their commitment) with a price of US\$ 3.05 per dose for their 2-dose presentation from 2017. I hope to be able to update you on further developments for PCV at the Board meeting.

New tools and approaches being scaled and institutionalised

As highlighted in the *CP Update*, the Alliance is implementing a package of **new tools and approaches to better support coverage, equity, sustainability and risk management** at country level. While it is early days, there are signs these new tools and approaches are enabling the Alliance to better support countries, and that they are starting to work together as part of a more joined up country support model. We are testing further changes to how the Alliance supports countries through a new **Country Engagement Framework**. Building on the new health systems and immunisation strengthening (HSIS) framework approved by the Board in June 2016, the CEF is a dialogue-based process to review and monitor the full portfolio of support requested by each country (while ensuring adequate independent review). It has been tested in five countries and the Board is being asked to approve specific flexibilities to enable further refinement to the model in anticipation of a 2017 Board decision to scale-up more broadly.

The Alliance continues to work on **cross-cutting approaches** in key programme areas. The Board has already endorsed approaches for supply chain, data and sustainability. Since June, we have developed an approach to strengthen in-country **Leadership, Management and Coordination**, with an initial 'menu' of support options to strengthen immunisation teams in Ministries of Health and national coordination fora (e.g. Inter-Agency Coordinating Committees (ICCs)). Potential interventions, which will be tailored to countries' specific needs, include embedded managerial support through experienced 'Management Partners', an interactive management training course for EPI managers, and new guidance, tools and technical support for ICCs (for more detail, see Appendix F to the *CP Update*). These will be tested in a set of countries (discussions are ongoing in countries including Uganda, Malawi and East Timor), funded through existing PEF and HSIS resources. We will report back to the PPC and Board on lessons learned and plans, if successful, to scale this approach more broadly.

In June 2015, the Board approved the **Cold Chain Equipment Optimisation Platform** to ensure lack of CCE was not a barrier to improving coverage and

equity, accelerate deployment of higher performing and more energy-efficient technologies and shape the CCE market. The Board agreed an initial investment of US\$ 50 million to co-finance equipment with countries and noted more funding may be required to meet country demand. As described in the *CP Update*, twelve countries have been recommended for approval² since the platform launched with total requested support of over US\$ 130 million (over multiple years). There has also been progress on market shaping with 15 products newly prequalified, innovative devices launched, and manufacturers offering much longer warranties and service packages. Given this progress, the Board will decide at this meeting whether to increase its initial investment and create a programme funding envelope for the CCEOP. The *CP Update* describes early lessons learned and changes that have already been made to the platform design. The Secretariat will provide a fuller report on progress and lessons learned in June 2017.

Gavi has also been **scaling up engagement with the private sector** to develop partnerships which can support countries' efforts to modernise and strengthen their immunisation programmes. Our goal is to test a select number of partnerships and scale the most successful across countries based on their needs and priorities. Earlier this year a supply chain leadership course, whose development and implementation was supported by UPS and the International Federation of Pharmaceutical Wholesalers, was launched at the new Regional Centre of Excellence for Health, Immunisation and Vaccine Logistics at the University of Rwanda. A second centre of excellence for Francophone Africa is being expanded in Benin (supported by Agence de Médecine Préventive) and we are exploring the potential to open a centre in Asia. These centres are training a cadre of supply chain managers learning from private sector best practices with nearly 50 participants this year and ~100 more to be trained in 2017. Gavi also recently signed a partnership with Girl Effect to test and scale-up innovative demand generation activities for HPV vaccine and broader health interventions by using Girl Effect's brand and marketing expertise. We continue to explore other potential partnerships – for example, we recently signed a letter of intent with Philips to investigate collaboration to strengthen countries' data systems. Through the Innovation for Uptake, Scale and Equity in immunisation (INFUSE) initiative, which I presented at the last Board, we are also identifying smaller companies and innovations with potential relevance to Gavi countries. To date, we have prioritised seven innovations (out of 70 applications) and are working to match them with private sector financial support or resources and with country demand. The latest financial forecast includes a specific line item to support investment in these private sector partnerships (which will be leveraged by Matching Fund contributions as the partnerships are signed).

² Haiti, DR Congo, Uganda, Cameroon, Kenya, Niger, Madagascar, Pakistan, South Sudan, Uzbekistan, Guinea, and Liberia

Some reflections from recent country visits

After our last Board, I travelled with Mark Dybul from the Global Fund to **Nigeria**, a country facing a complex and daunting set of challenges. Its coverage of 56% (WUENIC) is the seventh lowest of any Gavi country and it has the second highest number of under-immunised children in the world – nearly as many as India despite having one seventh of the population. In some northern states, coverage is under 10%. Gavi's audits have identified systemic weaknesses in the programme as well as misuse. The recent discovery of polio cases from strains which have circulated undetected since 2011 is symptomatic of weaknesses in surveillance and immunisation coverage. While national GNI per capita was US\$ 2,820 in 2015, it is less than half this level in some northern states that, after years of instability and conflict, are in a situation of acute fragility with limited accessibility. Its current annual budget for Gavi-supported programmes is US \$29 million and will need to reach nearly US\$ 200 million by 2023 based on their planned vaccine introductions. The recent reduction in the health budget from 6% to 4% of government expenditure is a sign of how challenging this will be.

The positive news is that the new Government has signalled its commitment to addressing these challenges. Following my meetings with President Buhari and the Ministers of Health and Finance, the leadership of the National Primary Healthcare Development Agency (NPHCDA – the recipient of Gavi support) was replaced, and the Minister of Finance sent a letter to Gavi pledging to repay the misused funds. The new Executive Director of NPHCDA is working to strengthen the performance of his agency in close partnership with Gavi. I will lead a cross-Alliance mission to Nigeria in 2017 to try to build on this momentum and discuss with the Government how we can accelerate progress on their many challenges.

I have also visited **Kenya and Madagascar** – two more PEF priority countries – since the last Board. Both face their own challenges but I was encouraged by how the Alliance is adapting its support to both Governments. There has been a significant **scale-up in Gavi resources targeted at routine immunisation bottlenecks** and this is increasingly focused at sub-national level. Both countries' new health system strengthening (HSS) grants target the areas with the greatest coverage and equity issues – 16 of Kenya's 47 counties and 54 of Madagascar's 112 districts. These grants focus on specific interventions – in Madagascar these include strengthening service delivery to reach every child (adapting the standard "Reach Every District" approach), implementing tailored approaches in hard-to-reach areas and strengthening community dialogue and engagement to promote demand generation (grant implementation will be supported by a fiscal agent to strengthen financial management and improve the flow of funding to rural areas). The grants have specific output indicators which will enable us to track progress in real time and learn and adjust as they are implemented. The Independent Review Committee also recommended applications from both countries for

CCEOP support earlier this month, which will help transform their cold chains – for example, Madagascar will equip 60% of its system with high-performing solar fridges. This is a very different model than Gavi's first generation of HSS grants which were broad support with very little ability to measure results. Through the PEF, partners have also scaled up the number of staff based in both countries who are focused on routine immunisation, including staff based at sub-national level. This is critical to both support and oversee implementation of the grants.

I also was struck by the **healthy engagement across the Alliance** in both countries, in strong partnership with their governments. New mechanisms such as joint appraisals are helping to align all Alliance members around a common baseline, agenda and set of priorities. Increased engagement by senior country managers (SCMs) along with more dedicated resources in partners' country offices has enabled more regular and robust dialogue and support. This is helping to build trust, openness and increasing our ability to respond flexibly to changing country contexts and needs. I saw partner staff and SCMs challenging each other and the governments in both Madagascar and Kenya (both of whom have strong leaders but systemic challenges) in a spirit which was collaborative but strong and maintained a focus on addressing their key challenges.

While these are positive signs, it is clear that the Alliance will **continue to face trade-offs** in how we support each country. In particular, given weaknesses in their systems, we will need to balance ensuring country ownership, accelerating coverage and equity, promoting sustainability and managing risk (the Board will have a chance to discuss some of the risk trade-offs at its Retreat in April 2017).

Emerging health and humanitarian challenges – immunisation is a critical part of the solution

A range of health and humanitarian challenges, where immunisation is an important part of the solution, have been rising up the global agenda. Since Gavi was launched in 2000, most low and middle income countries have seen their economies grow significantly, institutions become stronger and social development indicators improve. However, a significant subset remain highly fragile – often due to weak governance, conflict or social unrest – and many are in a situation of prolonged fragility. **Many of the most acute health and development challenges are increasingly concentrated in fragile countries.** For example, more than 60% of under-immunised children are now in countries considered fragile by leading international classifications as opposed to just over 30% a decade ago³.

There has also been a **growth in the frequency and scale of emergencies**. 20 of the 22 Grade 3 emergencies (the most serious level) declared by WHO in the

³ Based on World Bank lists of Low-Income Countries Under Stress in 2006 and harmonised fragile states list in 2015

last decade have occurred since 2013. Both long-term fragility and emergencies create spillover effects for neighbouring countries, especially through large-scale population displacement. A **record 65 million people were displaced in 2015** – four times more than a decade earlier. Despite the media’s focus on the impact of these population flows in Europe and the United States, the vast majority of displaced people – including nearly 90% of refugees – are hosted in low and middle income countries. The question of how to better support displaced populations was a focus at this year’s UN General Assembly where Member States committed to increase support for countries receiving and hosting large numbers of refugees and migrants and improve delivery of humanitarian and development assistance.

Reaching children in fragile settings, emergencies and situations of displacement – often the most vulnerable to vaccine-preventable diseases – will be critical to achieve our coverage and equity goals. The Board will consider principles for a **policy on fragility, emergencies and displaced populations** at this meeting. This aims to more clearly define Gavi’s role in such situations, building on our comparative advantage, and to ensure the Alliance has the flexibility it needs. The Board will also discuss how to treat countries in acute emergencies that have not historically been Gavi-eligible – **including Syria** whose gross national income may now be below Gavi’s eligibility threshold but for which robust data is not available.

Climate change is an increasingly common contributor to emergencies and population displacement, and the spread of vaccine preventable disease. WHO estimates that by 2030, rising temperatures will cause 60,000 additional deaths from malaria and 48,000 from diarrhoea each year. As a result, WHO and the Intergovernmental Panel on Climate Change recognise immunisation as a key tool to adapt to climate change. Gavi supports the global community’s response to the growing risk of climate threats to health and health systems, and recently published a statement on our contribution to environmental risk preparedness. This included initial thoughts on how to reduce the environmental impact of our programmes. We continue to review our approach to resource management at the Secretariat, waste management in countries and sustainable vaccine development. Gavi is joining a coalition of UN and international organisations – including WHO, UNEP, The Global Fund, UNDP, UNFPA, UNOPS and UNITAID – to sign a joint statement that recognises our collective leadership role on sustainability and commits to engage with manufacturers on ways to ‘green’ health sector procurement as called for in the Sustainable Development Goals.

In addition to population displacement, the other major focus at the UN General Assembly was **anti-microbial resistance (AMR)**, one of a range of emerging health threats on the international agenda. A major review, commissioned by the UK Government and chaired by Lord O’Neill (former UK Treasury Minister and Chief Economist at Goldman Sachs), estimated that by 2050 AMR could cause ten million deaths annually and cost US\$ 100 trillion. It identified seven interventions

to halt AMR's spread, including accelerating development and use of vaccines which reduces antibiotic usage. The review also highlighted Gavi's innovative financing mechanisms as the types of tools needed to incentivise development of new drugs and diagnostics. These recommendations were largely reflected in a declaration signed by UN Member States. A number of international organisations have been mandated with taking forward this agenda and we will remain closely engaged to see if there are further opportunities for Gavi to contribute to international efforts.

Global efforts to eradicate **polio** suffered a significant setback in August when four cases of wild polio virus were detected in northern Nigeria nearly three years after the last confirmed case (and just before Nigeria was due to be declared polio-free). The cases were linked to strains last detected in 2011, suggesting they have circulated undetected in these isolated areas for several years. While there has been significant progress globally, this is a reminder of the challenge of achieving and sustaining disease elimination in areas with weak health and immunisation systems. Global Polio Eradication Initiative (GPEI) partners are supporting the Government of Nigeria and surrounding Lake Chad basin countries to respond to the outbreak but it is unclear how it will affect global eradication timelines. The Secretariat is discussing with GPEI how these developments might affect Gavi's role in supporting IPV introduction and routine immunisation strengthening (as per the 2013 Board decision, we will be returning to the Board next year with a recommendation on IPV funding post-2018).

When the Board last met, outbreaks of **yellow fever** in Angola, DRC and Uganda were a major concern. Emergency campaigns with vaccines from the global emergency stockpile (largely funded by Gavi) appear to have been effective with the Uganda outbreak over and the last confirmed cases occurring in Angola in June and DRC in August. However, this experience illustrated the evolving epidemiology of the disease with unprecedented outbreaks in urban areas. The current rainy season will intensify mosquito activity and there remains a risk of further spread including to bordering countries (e.g. Congo Republic, Nigeria). Even if the current situation has been contained, intensified control efforts will be needed to prevent further outbreaks given long-term trends such as urbanisation, population movement and climate change which are extending the range of *Aedes* mosquitos and increasing the frequency of contact with humans. The worst case scenario would be for the disease to become endemic in Asia – which has so far had imported cases but no local transmission – given that billions of people there live in areas with the *Aedes* vector. In the face of these trends, WHO has worked closely with Gavi and other partners to revise its yellow fever control strategy while, thanks to efforts by many Alliance partners and especially industry, additional yellow fever vaccine manufacturing capacity is coming online. This creates an opportunity to intensify global efforts to control yellow fever and the Board will discuss enhancing Gavi's engagement at this meeting.

The yellow fever outbreaks illustrate the importance of ensuring high routine immunisation coverage (supplemented by preventative campaigns as required) in areas of risk, and maintaining emergency **vaccine stockpiles**. The oral cholera vaccine stockpile was similarly critical after Hurricane Matthew in Haiti, enabling the Alliance's to rapidly dispatch one million doses of vaccine which will hopefully make a big difference in efforts to prevent a resurgence of the country's cholera epidemic. Gavi's support for yellow fever and cholera emergency response has been part of a growing role for the Alliance, which also includes support for stockpiles of meningitis A and multivalent meningococcal vaccines (and a commitment to fund a stockpile of Ebola vaccine once one is licensed and WHO-recommended). However, the Alliance has not had a systematic approach to stockpile support and there have been challenges with implementation, long term engagement with suppliers and accountability. Therefore, the Board will consider at this meeting how Gavi should approach support for stockpiles going forward.

In future, decisions on new support for vaccines against diseases with outbreak potential will be included in the **Vaccine Investment Strategy (VIS)**, through which Gavi evaluates all potential vaccine investments. The Board will have an initial discussion on the next VIS in December 2017 to agree on the scope and prioritisation criteria (with the final investment decisions in 2018). The pipeline of potential vaccines for future VIS reviews is likely to grow over time given growing global focus on developing vaccines for epidemics. Among the key initiatives is the **Coalition for Epidemic Preparedness Innovations (CEPI)**, a new public-private partnership to accelerate R&D for vaccines against diseases which can cause epidemics in low income countries and for which there is no viable market. Founded by the Government of Norway, Indian Department of Biotechnology, Gates Foundation, Wellcome Trust and the World Economic Forum, it is due to launch at Davos in January 2017. Gavi is a member of CEPI's Joint Coordination Group along with other partners, and CEPI reached out to the Secretariat to discuss lessons from Gavi's experience and future coordination (they expect that the vaccines they develop may be relevant to Gavi countries). The Government of Norway also approached the Secretariat and the Board of the International Financing Facility for Immunisation (IFFIm) to explore the possibility of donors channelling support to CEPI through IFFIm. We will have an opportunity at this meeting to get the Board's guidance on future engagement with CEPI.

In June, the Board approved support for pilot implementation of a **malaria vaccine**, one of the most recent diseases for which a vaccine is available (albeit imperfect). The pilots will assess whether the four dose schedule (with three doses outside of the normal immunisation schedule) is feasible and whether the effects of the vaccine on morbidity and mortality are as high as predicted by the models in a real life situation. They will also help to further characterise the safety profile of the vaccine in the context of routine immunisation. The Gavi Board requested further review of the budget to ensure that this is being done as cost

effectively as possible. Since then, WHO has reduced its estimates of the cost of the first phase by nearly 10% to just over US\$ 50 million and the Boards of UNITAID and the Global Fund have approved support of US\$ 9.6 million and US\$ 15 million respectively. This means that the pilots can likely now proceed.

Alliance engaging new global and country leaders

We are in the middle of an 18-month period of **major changes in leadership** at global level and among donor and implementing governments. These changes will present risks and opportunities for the Alliance and it will be important to engage early with new leadership to maintain strong relations and support.

At **global level**, António Guterres was recently elected as the next UN Secretary-General. As a former UN High Commissioner for Refugees, he knows the humanitarian and development world well but has had limited engagement with Gavi. Both Ban Ki-Moon and Kofi Annan were champions for Gavi and I hope to meet the new Secretary General soon to secure his support. The World Health Organization is also due to elect a new Director-General in May 2017 to replace Margaret Chan who will step down after more than a decade. Margaret has also been a very strong advocate for the Alliance globally and within WHO. Three of the six candidates are former Gavi Board members and we hope that whoever is appointed will maintain this strong support. Mark Dybul will also step down as Executive Director of the Global Fund next year with his successor due to be announced by March 2017. As Mark and I discussed with the Gavi Board in June 2016, we are working to intensify collaboration between our organisations especially in the run-up to our joint move to the Health Campus. I therefore look forward to working closely with Mark's successor once they are appointed.

As we have discussed at previous meetings, one important way to ensure global leaders remain focused on immunisation is for it to be appropriately measured in the **Sustainable Development Goals**. I am therefore delighted that after over a year of engagement by the Alliance, immunisation is now included in two health indicators, pending definition of the methodologies and endorsement by the UN Statistical Commission in March 2017. Critically, these indicators will track coverage with every vaccine countries have introduced – and not just coverage with three doses of DTP-containing vaccines as initially proposed. This is a far better reflection of the opportunity to improve children's health over the next 15 years by ensuring they have access to a full range of modern, powerful vaccines.

There are also likely to lead to significant changes in leadership in both donor and implementing countries. Over **one third of PEF priority countries are due to hold elections** between mid-2016 and mid-2017. Government reshuffles have also led to recent changes in leadership of Ministries of Health in other countries including Ethiopia and Tanzania. We will work with the incoming leadership in all of these countries to seek to ensure a strong commitment to immunisation.

Between the June 2016 Board and end of 2017, **donor countries representing nearly two thirds of Gavi support 2016-20 have elections and referenda**, which could lead to a change in government. The UK vote to leave the European Union resulted in Prime Minister Cameron – a Gavi Champion who hosted the 2011 Replenishment – stepping down and being replaced by Theresa May. Priti Patel, the new Secretary of State for International Development, has reaffirmed the Government's commitment to spend 0.7% of gross national income on aid. In November, Dr. Ngozi met Priti Patel and I met James Wharton, Parliamentary Under Secretary of State who oversees DFID's relationship with Gavi. It is early days in their tenure but both seemed supportive of Gavi. UK support was also reflected in DFID's recent annual review which gave a score of A+ for their main Gavi grant, the 2011-2015 results and IFFIm, and an 'A' for the AMC investment.

In November, the US elected Donald Trump as its next President. While it is too early to know how this will impact US development aid, we hope Gavi's model – focused on cost effectiveness, accountability, private sector and sustainability – will fit well with the new administration's priorities and we retain strong bipartisan support in Congress. We are working to engage the President-elect's transition team and I will visit Washington, DC early next year. France, Germany, Norway and the Netherlands also have elections in 2017 and Italy will hold a referendum which may affect the government. In many of these countries, support for populist parties – who do not typically see development aid as a priority – is growing. Thus, these elections present a risk but they could also create new opportunities, as illustrated by the election of Prime Minister Trudeau in Canada who hosted the Global Fund Replenishment and is a strong supporter of global health and Gavi.

Political and economic changes and uncertainties have created volatility in exchange rates. The **currencies of most Gavi donors have depreciated against the US dollar**, in which most Gavi expenditure is denominated. Since Replenishment, Sterling has fallen by over 15% against the dollar (particularly since the UK referendum on the EU) while the Norwegian Krone and Canadian dollar have fallen by nearly 10% and the Euro by almost 5%. Further fluctuations are likely. Gavi's hedging policy means much of Gavi's exposure is hedged until 2017. This was possible thanks to intense efforts by the Secretariat and donors to sign grant agreements and pay 2016 contributions as quickly as possible. By the end of 2016, grants representing 83% of Berlin pledges will be secured. Almost all others are from countries that can only sign annual grant agreements.

We are mitigating these risks by **intensifying engagement with current and potential future leaders in core donor markets** while continuing to broaden our outreach to governments in the Middle East, Asia, Europe and elsewhere to **diversify Gavi's donor base**. Last week, we signed a grant agreement with the Principality of Monaco who become a Gavi donor for the first time, and we are working to welcome Switzerland as a new donor by the end of this year. In

September, Dr Ngozi travelled to the Middle East to encourage further support from the region, building on pledges from Saudi Arabia, Qatar and Oman at the 2015 Replenishment. This included signing Saudi Arabia's US\$ 25 million pledge to fund pentavalent, PCV and rotavirus vaccines for Yemen. Gavi's decision to accept this support (which was agreed before the conflict in Yemen began) attracted some strong criticism but our priority has been to maintain relatively high childhood immunisation coverage in Yemen despite the conflict. Gavi's growing engagement with the private sector (described above) provides further mitigation by attracting additional resources and expanding the number of Gavi champions in key markets. **Gavi's Mid-Term Review (MTR)** in 2018 will provide an opportunity for a deeper engagement with Gavi's donor community to help sustain their long-term support. We will share an update on MTR plans in June.

Organisational update

Both **WHO and UNICEF held retreats** with their EPI teams and partners in 2016 which were designed to enhance dialogue, engagement and alignment across the Alliance. In January, the Secretariat will host a retreat with WHO and UNICEF leadership to discuss the results of the recent Alliance Health Survey. This is designed to understand how staff in core partner organisations (including the Secretariat) feel about Alliance health and to identify improvement opportunities.

Following our discussion in June with Mark Dybul on collaboration between Gavi and the **Global Fund**, we continue to strengthen our work together at global and country level. Construction of the Health Campus is on track for early 2018 and the building is taking shape. We have formed a joint Steering Committee and are working together to create a campus which enhances the work of both organisations while reducing costs, maximises the opportunity for synergies and can host other global health organisations. We are also moving our Washington, DC office to a nearby location which will reduce costs there by over 50%.

Gavi has invested heavily in **knowledge management** since 2014 and these efforts are beginning to deliver. In 2016, a key priority has been to move core grant management processes to an online country portal. This allows countries, partners and the Secretariat to report on and access common data on grant management and performance in real time. Most countries are using the portal with 718 users across 73 countries to date and we are refining it based on user feedback. The investment in this platform enabled us to rapidly roll-out similar portals for partners to report on their work under the PEF and for Secretariat teams to report on progress against their team performance metrics. The knowledge management team is working to link all the data in these portals with other systems and databases to enable more strategic analysis at grant, country and portfolio level. We are considering how to make some of these data and analysis tools available to the broader community including through our website.

2016 is the first full year in which the **Audit & Investigation** department has operated with an expanded team (the last vacancy approved by the Board in 2014 – a Francophone Head of Programme Audit – has just been filled). This has enabled a significant scale-up in audits. As Simon has discussed with the Audit & Finance Committee (AFC), the team has made good progress against its plan to conduct nine internal audits and ten programme audits in 2016. As we scale-up this work, we will identify more issues, especially in programme audits. Simon will continue to brief the AFC routinely and the Board on significant developments. In June, he briefed the Board on Nigeria. As discussed above, we have received written commitment to reimburse and the Government recently accepted the final report which will be posted online in mid-December (with the same findings on which the Board was briefed). Gavi works hard to ensure all misuse is repaid. To date, countries have committed to reimburse all agreed misuse and Gavi has recovered 99% of amounts due. Since June, Niger and Togo made final payment on their reimbursements (US\$ 656,000 and US\$ 10,000 respectively) and Kenya paid all US\$ 1.6 million in misuse identified by this year's audit ahead of schedule. Misuse is often the symptom of weak controls, systems and processes and Gavi works with countries to address weaknesses identified in each audit. For example, the Alliance has worked with the Governments of Nigeria and Kenya to develop action plans which address weaknesses in financial management (and in Kenya vaccine inventory management) from their respective audits.

Within the Secretariat, we continue to strengthen **performance management**. This now links individual performance to team and corporate performance metrics, which in turn link to the Alliance KPIs and strategy indicators. We are holding Secretariat leadership increasingly accountable for strong performance management of their staff, and providing training and coaching to assist them. At corporate level, we have created a rigorous process to define team performance metrics and review progress through semi-annual discussions with the full leadership team as well as one-on-one meetings with each team leader.

We are also working to better **develop our people** and make the Secretariat a best-in-class work environment. We have scaled up our training programmes with over 500 participants participating in close to 50 trainings in 2016 with a satisfaction rate over 84%. These trainings target both core technical skills and leadership and management skills and have received very positive feedback. We have worked with Zurich Financial, who manage our Long Term Savings Plan, to improve the service offering as well as with our health insurance providers to keep a strong and cost effective programme. Lastly, the Secretariat leadership team will discuss how to further strengthen organisational values and culture at our Retreat in February, including through the design and use of Health Campus.

This is the first away Board since 2013, providing us with an opportunity to see first-hand some of the progress and challenges countries face, especially during Tuesday's field visits. Côte d'Ivoire is an appropriate setting for the decisions the Board will take at this meeting. Two periods of political tension and conflict (2002-2004 and 2010-2011) plunged a previously stable and prosperous state into a situation of real fragility, with immunisation coverage dropping by nearly 25 percentage points between 2010 and 2011. The fragility policy enabled Gavi to apply country-specific flexibilities to support the country's recovery including by waiving the coverage filter to approve support of new vaccines (as the country was able to show its coverage was recovering rapidly). Since 2013 Côte d'Ivoire has introduced PCV, rotavirus and inactivated polio vaccines as well as conducting a Meningitis A campaign and HPV demonstration project. Coverage has returned to pre-conflict levels and it is the fastest growing economy in Africa.

Despite its achievements, Côte d'Ivoire has not yet progressed to full national introduction of HPV and, while it has successfully controlled yellow fever over recent years, routine yellow fever vaccine coverage is under 50%. Ebola demonstrated the risk posed to Côte d'Ivoire by disease outbreaks (the country shares its border with Guinea and Liberia) although its health system was strong enough to prevent local transmission. Moreover, rapid economic growth and urbanisation are also creating new challenges for the healthcare system. I met with Prime Minister Daniel Kablan Duncan, along with President Hollande, at the Francophonie Summit last week in Madagascar and he emphasised his desire for technology and innovation to help them leapfrog over these challenges. Through our support and initiatives such as INFUSE, which the Prime Minister of Côte d'Ivoire helped to launch, we hope to support this ambition. I look forward to discussing these issues with you and Government leaders in Abidjan next week.