

Report of the Chief Executive Officer

22 November 2017

Dear Board members,

It is indeed an honour to have been reappointed by the Board as CEO of the Alliance. I am excited by what our innovative model has achieved to date and humbled by the challenges we still face to ensure that every child receives all the vaccines they need. I am also delighted that we will continue to benefit from Dr. Ngozi's leadership as we tackle these challenges, following her reappointment as Chair by the Board.

My highest priority is to deliver on reaching every child – both by continuing to roll out new vaccines to deal with intra-country equity and improving coverage and equity (C&E) – and on ensuring the success of our sustainability model. Success is critical both for the Alliance and the broader community. By extending routine immunisation to reach the underserved, we are building a foundation for universal health coverage (UHC) as I discuss further below. And by pioneering a systematic approach to transitioning countries out of development assistance, Gavi's sustainability model is a pathfinder for the broader community.

We continue to see strong progress on sustainability with countries co-financing a record amount in 2017 and 17 countries due to have transitioned by the end of the year. We will meet in Lao PDR which is an example of the success of the model. Since 2000, it has raised coverage with three doses of DTP-containing vaccine (referred to as DTP3 in the rest of the report) from 51% to 82% and has introduced pentavalent, pneumococcal, inactivated polio, rubella and Japanese Encephalitis vaccines, a second dose of measles and conducted a human papillomavirus (HPV) demonstration project. This has averted over 25,000 deaths (from a population of less than seven million) and significantly contributed to Lao PDR nearly halving child mortality since 2000. The country is on course to transition successfully at the end of 2021 and has an ambitious agenda for the future including introducing rotavirus and HPV vaccines nationwide in 2019, increasing domestic investment in health and immunisation and improving health service delivery. Nonetheless, it continues to face coverage and equity challenges exacerbated by its geography, language barriers and transport infrastructure which limit access to health services for non-Lao ethnic groups, as well as programme management capacity and human resources capacity. The country has experienced outbreaks of vaccine-derived poliovirus, diphtheria, pertussis and measles in recent years and the response, including ten polio

vaccination campaigns since 2010, likely impacted DTP3 coverage which fell from 89% to 82% in 2016. Our meeting will be a chance to celebrate the remarkable progress that Lao PDR and other transitioning countries have made, to reflect on how Gavi should engage with countries after they transition and discuss some specific sustainability risks following up on the April Board Retreat.

Our progress on reaching every child is more mixed. We reached a record number of children with three doses of DTP-containing vaccine in 2016, are reaching children with more vaccines than ever and are on track to surpass our goal for the number of children immunised 2016-2020. However, due to rising populations, DTP3 coverage remained flat according to the WHO-UNICEF Estimates of Immunisation Coverage (WUENIC) released in July (although there is evidence of early progress on our C&E agenda in key countries). I discuss this in detail below following feedback from the AFC and PPC that the Board should have a deeper discussion of this issue.

Also at the request of the PPC, we have developed an Investment framework to better quantify the trade-offs of Gavi's investment decisions (which is available to the Board on BoardEffect and appended to the typhoid paper for that decision). Following Board member feedback, we have also worked to make Board papers shorter and more strategic and the main Board pack is 25% shorter than in June. Since it is not formally on the Board agenda, I also wanted to highlight that you received the annual update on implementation of Gavi's gender policy as part of the material on BoardEffect. This highlights the importance of our gender work and how we are enhancing our work in this area.

Developments in the global health landscape

Changing leadership of Gavi's partners

As we discussed in June, we are in the midst of a period of change in global leadership with elections in many large countries and new leadership of several international organisations. Last week, the Global Fund Board appointed Peter Sands as Executive Director and in October the United Nations Secretary-General launched a process to select a new Executive Director of UNICEF. In July, Dr Tedros Adhanom Ghebreyesus began his role as Director General of WHO. These changes in leadership of partner agencies present an opportunity to recommit to the Alliance and to bring fresh thinking to the challenges we face.

Dr. Tedros has issued a draft programme of work laying out the direction of WHO for 2019-2023. While it will be finalised through the World Health Assembly process, the initial draft provides a bold vision with a focus on health coverage, health emergencies, global health priorities and the contribution of health to the Sustainable Development Goals (SDGs). It highlights how WHO plans to work differently with an emphasis on transparency, accountability and performance against measurable outcomes. Dr. Tedros has spoken of the need to strengthen WHO's partnerships. Earlier this month, he made an unprecedented invitation to the leaders of Gavi, the Global Fund and the International Committee of the Red Cross to address the global WHO leadership meeting (including all six Regional

Directors and WHO Representatives from 148 countries) and discuss how WHO could become a better partner, especially at country level. After consultation with the Secretariat, he also decided to increase the seniority of WHO representation on the Gavi Board by nominating Dr. Soumya Swaminathan, Deputy Director-General for Programmes as the Board member. Dr. Princess Nothemba (Nono) Simelela, Assistant Director General for Family, Women, Children and Adolescents, will replace Flavia as the Assistant Director General responsible for immunisation and is expected to be nominated as the Alternate Board member.

Immunisation, UHC and the Sustainable Development Goals

Dr. Tedros has made universal health coverage the central pillar to his agenda. He and I agree that immunisation must be one of the first and highest priorities in delivering UHC for a multitude of reasons. Firstly, it is one of the best buys in health and, as one of the most important preventive interventions, it is critical to make UHC affordable (alleviating the financial burden of paying for treatment and palliative care). Secondly, it reaches more households routinely than any other health intervention, providing a strong platform to deliver other health services. And we are extending this platform to reach the unreached through our work on C&E. Lastly, immunisation is among the most equitable interventions and disproportionately benefits the most marginalised populations who are least likely to have access to curative services. Dr. Tedros and I agreed to work to increase the prioritisation of immunisation in the SDGs and UHC and I welcome any guidance the Board may have on how to achieve this.

As we have discussed many times, a bold indicator to measure immunisation within the third sustainable development goal (SDG3) is critical to ensure it is prioritised. I was therefore delighted that WHO's Strategic Advisory Group of Experts on Immunisation (SAGE) recommended that we track immunisation coverage with a life course approach including six vaccines:

- Third dose of diphtheria, tetanus & pertussis containing vaccine as the traditional measure of routine immunisation coverage;
- Last dose of pneumococcal vaccine as a proxy for coverage of newer vaccines;
- Second dose of measles vaccine to measure coverage during the second year of a child's life;
- Last dose of HPV vaccine to measure coverage among adolescents.

A number of SAGE members indicated that it would be ideal to measure how many children were fully immunised with all vaccines universally recommended by WHO but acknowledged that this is methodologically challenging and asked that WHO and partners work to address it over time. In the interim, the SAGE recommendation is a good proxy measure for full child immunisation (assuming it is endorsed by the Inter-agency Expert Group on SDG Indicators).

Of course, immunisation is relevant well beyond SDG3. It directly contributes to

14 of the 17 SDGs from alleviating poverty (SDG1) to improving education outcomes (SDG4) to reducing inequalities (SDG10). It is relevant to every country worldwide and is a public good since immunisation performance anywhere impacts health outcomes everywhere (as diseases do not respect borders). The Alliance mission, with its focus on leaving no one behind, and our partnership model are also closely aligned with the SDGs (SDG17 is to create a partnership for the Goals). I look forward to continuing the discussions we had at the April Retreat and June Board on how to increase the contribution of immunisation towards the SDGs. This will likely frame some of our future conversations on Gavi's 2021-2025 strategy (Gavi 5.0)

Developments in the donor landscape

We have been working to ensure Gavi and immunisation remain prominent on the donor agenda following an 18-month cycle of elections in most of Gavi's major donor countries. These elections have largely resulted in governments which are supportive of Gavi but, as we have discussed before, significant risks and uncertainty remain. Following active dialogue between Gavi and the Italian G7 Presidency, with support from civil society partners, the G7 Health Ministers meeting in November recognised the Vaccine Alliance as a "key global initiative" in its final communiqué. We also continue to diversify our donor base. I am delighted that Denmark, which was one of six founding donors but stopped funding Gavi in 2013, plans to renew its support (subject to approval by parliament where Gavi has strong cross-party support). Sweden, another founding donor, recently announced plans to increase its support to SEK 350 million (approximately US\$ 44 million) in 2018. And two of our newest donors have also announced additional support. South Korea pledged US\$ 4 million for 2018 while India, the first Gavi implementing country to become a donor, confirmed that it will double its contribution to US\$ 8 million for 2017-2020.

The UK, which is Gavi's largest donor, has just completed its Annual Review of its investment in Gavi, IFFIm and the AMC. Gavi and IFFIm scored an A while the AMC scored an A+. The review of Gavi found that we are on track for our mission indicators but are behind on some of the other ambitious targets we set ourselves – especially on C&E, health systems strengthening (HSS) and in some operational areas. The Department for International Development (DFID) have emphasised the importance of accelerating progress in these areas.

Next year's Mid-Term Review (MTR) will be an opportunity to demonstrate to all donors how we are delivering on our promises. We are on track to achieve our major commitments spelled out in the Investment Case: immunising 300 million children, averting 5-6 million deaths, nearly tripling country co-financing and having over 20 countries transition by 2020. The success of the MTR will be critical to our next replenishment, which will likely take place in an increasingly crowded landscape with many other organisations planning replenishments over the next few years.

Changing vaccine industry leadership

The vaccine industry played an important role in Gavi's last replenishment – both as advocates and through their own pledges. Sir Andrew Witty of GSK attended the replenishment launch meeting in Brussels and made a long-term price commitment for transitioned countries. Leaders from both multinational and developing country manufacturers attended the Berlin pledging conference and made a range of further commitments. Since then, there has been significant turnover with new CEOs of GSK and Sanofi and new vaccines leadership at Sanofi and Merck. These changes are occurring in an increasingly complex market environment. Gavi now supports 16 vaccines (17 if the Board decides to open a window for typhoid at this meeting), each with unique supply dynamics. In some markets (such as HPV) we continue to face supply shortages whereas others (such as penta) have an abundance of supply and fierce price competition is leading some manufacturers to exit. This complexity will continue to grow as countries transition. We need to continue to work with industry to develop “healthy markets” which provide incentives to ensure the right vaccines are developed and made available in the right quantities at an affordable price, and to develop new champions among this new group of leaders.

Reporting back on previous Board decisions

Board decisions on Syria, India and malaria vaccine

At its meeting in Abidjan last December, the Board approved vaccine and cold chain equipment support for Syria recognising the exceptional humanitarian situation and uncertainty over whether its gross national income (GNI) per capita was below Gavi's eligibility threshold (the World Bank have not reported a GNI per capita figure since 2007 when it was US\$1,870). Since then, coverage has increased due to greater vaccine availability (thanks in part to Gavi support) and a number of health facilities have reopened. Despite this, coverage remains low and the country is suffering outbreaks of vaccine-derived poliovirus and measles. Efforts to address this suffered a setback last month when violence destroyed the only vaccine cold room in Deir ez-Zor in Al-Mayadin district, which is at the centre of the polio outbreak. Approximately 100,000 doses of measles vaccine and 35,000 doses of polio vaccine – including some supported by Gavi – were stored in these facilities. The Alliance will continue to work to try to reach as many children in Syria as possible. However, these efforts may be hindered by a lack of funding for the UN's Humanitarian Response Plan for Syria (HRP), which finances the operational costs of immunisation activities for WHO, UNICEF and other partners. Only 44% of the HRP needs were funded as of November 2017.

In July, Gavi Board member Danny Graymore and I visited India where we saw the remarkable progress since the Board approved the Alliance partnership with India. Prime Minister Modi wants to make immunisation part of the country's 75th independence anniversary celebrations in 2022 and has challenged the Ministry of Health and Family Welfare to reach 90% full immunisation coverage by the end of 2018. To this end, he has launched an “Intensified” Mission Indradhanush

programme targeting the lowest performing districts and urban areas and his office is closely monitoring performance. Following the launch of rotavirus vaccine in four States last year, the country has started a phased introduction of pneumococcal vaccine in three states including Uttar Pradesh and Bihar which are two of the largest and poorest in the country (penta, by contrast, was first introduced in the strongest states). A recent report estimated that full national scale-up of these vaccines could avert over 90,000 child deaths and provide India with over US\$ 1 billion in economic benefits annually. In August, the country launched the second phase of its measles-rubella campaign (the largest ever globally targeting 410 million children). The government requested US\$ 8.5 million in technical support from the Alliance to address vaccine hesitancy and programmatic issues that affected the first phase, which I have approved since it can be funded within the Board-approved US\$ 500 million envelope (this will be offset against projected savings on rotavirus vaccine prices in the current tender).

In June 2016, the Gavi Board approved support for pilot implementation of the RTS,S malaria vaccine conditional on matching funding being made available by other donors. The Global Fund and Unitaïd Boards subsequently agreed to provide such funding. The latter formally authorised its contribution in June 2017, which has enabled Gavi to finalise a grant agreement with WHO (with signature and disbursement of the first tranche expected later this year). In the interim, WHO has moved forward with planning in the three pilot countries (Ghana, Kenya and Malawi) thanks to bridge funding from PATH. The first children are expected to be immunised in mid-2018 with interim results available by mid-2020.

Gavi's role in epidemic response

At our last meeting, I was asked to describe Gavi's role in epidemic response. Gavi contributes in three major ways. By far our biggest contribution is through support for routine immunisation programmes and preventive campaigns to control epidemic-prone diseases. We currently provide such support for eight diseases with outbreak potential (cholera, diphtheria, Japanese encephalitis, measles, meningitis, pertussis, polio and yellow fever). The 2018 Vaccine Investment Strategy (VIS), which the Board will discuss at this meeting, may approve support for additional routine and outbreak vaccines.

Gavi's second contribution is to build public health capacity in eligible countries through HSS and technical support. This helps equip countries to detect and respond to outbreaks. Many of the key capacities needed for this – such as disease surveillance, laboratories, contact tracing and community mobilisation – are inherent to a robust immunisation programme. However, it is not Gavi's current mandate to ensure countries have strong capacities in all these areas and historically many countries have relied heavily on the polio programme for this. With polio funding set to reduce significantly in the coming years, it is likely that countries will need additional support going forward. Gavi's engagement in this area will be part of our discussions on the Alliance's 2021-2025 strategy.

The Alliance's final area of contribution is through support for outbreak response. We are the sole funder of stockpiles of yellow fever, oral cholera and meningitis (both Meningitis A and the quadrivalent ACWY) vaccines and have committed to fund a stockpile of Ebola vaccine as discussed below. The Alliance finances the vaccines in these stockpiles as well as the operational cost of vaccine use in eligible countries. We also support campaigns to respond to measles outbreaks.

A critical role of the Alliance has been to push for a more integrated, end-to-end approach to epidemic disease control. In yellow fever, for example, the Alliance has advocated for more focus on increasing routine immunisation coverage (which has traditionally received less attention than outbreak response) and for a more joined up approach to market shaping. These principles underlie Gavi's support for the WHO Eliminating Yellow Fever Epidemics (EYE) strategy, which was approved by the Board last year. Unfortunately, there has been limited progress in implementing this strategy. Routine coverage is stagnant and there has been little movement in introducing routine yellow fever vaccine or conducting mass preventive campaigns. The EYE governance structure – including working groups on surveillance, risk assessment and market shaping – is not yet in place. The Secretariat is engaging with partners to push for accelerated implementation to ensure the world is better prepared to prevent and contain yellow fever outbreaks.

Under its Advanced Purchase Commitment with Merck, Gavi committed to fund a stockpile of Merck's Ebola vaccine, once it is licensed, and made a prepayment to Merck for future vaccine procurement. In return, Merck committed to make 300,000 doses of pre-licensure vaccine available for potential use in an outbreak and to submit a full dossier for licensure by the end of this year. Although it has been granted access to the European Medicines Agency's Priority Medicine scheme, which will enable an accelerated review and a rolling submission, Merck has recently indicated that it will not be possible to complete submission of its application this year. In consultation with the Market Sensitive Decisions Committee, we are working with Merck to determine an adjustment to the timing of our agreement. China has also just licensed a domestically produced Ebola vaccine although the Merck vaccine remains the only one for which human efficacy data are available. In the event that the Chinese vaccine is prequalified before the Merck product, the implications for use during an outbreak as well as the creation of a stockpile will need to be considered.

All Gavi-supported stockpiles are administered by an International Coordinating Group (ICG) comprised of WHO, UNICEF, the International Federation of the Red Cross and *Médecins sans Frontières*. When the Gavi Board approved a new approach to stockpile support in December 2016, this was conditional on several principles including more accountability and transparency in ICG decision-making and Gavi Secretariat observership. Since then, the ICG's decision criteria have been made more transparent, it is providing real-time information through a dashboard and the Secretariat is now routinely observing ICG discussions. The recent independent evaluation of the ICG recommended the creation of a more formal and comprehensive governance structure and accountability mechanism including a new oversight body; a clearer definition of roles and responsibilities in

the ICG network; and more standardised reporting requirements for the ICG Secretariat. The Gavi Board also called for stockpile investments to be an integral part of a comprehensive disease control strategy and for procurement to be connected to broader forecasting and market shaping efforts. This has not historically received sufficient attention and the evaluation made recommendations to strengthen work in this area, including calling on WHO to develop a global strategy for meningitis control (as exists for yellow fever and cholera). The Gavi Secretariat will work with partners, especially WHO, to build on this initial progress and implement rapidly and fully the recommendations of the independent evaluation as well as the principles approved by the Gavi Board.

The importance of data to accelerate progress on coverage and equity

Coverage and equity in 2016

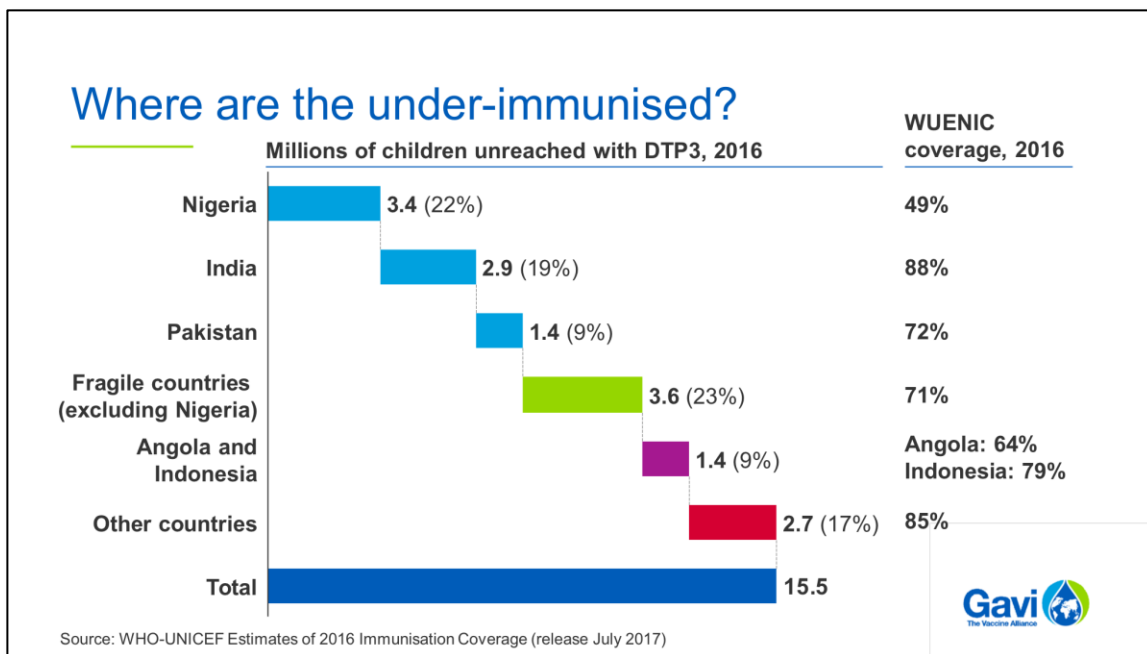
Gavi's coverage and equity agenda has two dimensions – reaching every child with routine immunisation and increasing the number of vaccines each child receives. The latest WUENIC data shows that we have made strong progress on the latter and are on track to immunise 300 million children and avert 5-6 million deaths but that DTP3 coverage was flat between 2015 and 2016.

Breadth of protection with all Gavi-supported vaccines reached 37% in 2016 across the 68 Gavi-supported countries and we are on track to hit our strategy target. This is up from 30% in 2015 and has nearly doubled since 2013. By 2020 nearly two children out of every five in Gavi countries should be receiving all 11 child vaccines universally recommended by WHO up from just one in 20 in 2015. In 2016, nearly two thirds of children in low income countries received three doses of pneumococcal vaccine meaning coverage is now close to that in high income countries. And over 40% of children in low income countries received a full course of rotavirus vaccine, meaning coverage is now higher in the poorest countries than in high-income countries. This is remarkable progress (although coverage is lagging in middle income countries – both those who were Gavi-eligible and those who were not – as many have not introduced these vaccines).

In 2016, the Alliance reached over 700,000 more children with DTP3 (the primary tracer of routine immunisation coverage) than in 2015 and over 4.3 million more than in 2010. However, due to population growth, WUENIC shows that the percentage of children reached was flat at 80% from 2015 to 2016 (up from 78% in 2010). The overall figures mask a more complex country-by-country picture.

Over 80% of unreached children are in 20 countries as the below chart shows. Half of them are in three countries: Nigeria, India and Pakistan. As discussed above, India is making rapid progress with coverage increasing from 79% in 2010 to 88% in 2016. In Pakistan, there has also been significant change. Sub-national surveys suggest coverage in Punjab province increased from 62.5% in 2012 to 85.2% in 2016. Given that Punjab is home to half the country's population, this would suggest national coverage has increased by over 10% (although this is not reflected in WUENIC which shows flat coverage since 2012). Nigeria has not made similar progress. The latest survey suggests only one in three Nigerian

children is being reached. The Government is increasingly signalling the political will to rebuild the immunisation programme and primary healthcare, having accepted the survey results (it previously relied on administrative data showing coverage of over 90%). We will discuss at this meeting how to intensify our engagement in Nigeria.



Nigeria is classified as fragile under Gavi’s fragility policy. Collectively, fragile countries are home to 45% of the under-immunised children in Gavi – half in Nigeria and the rest in 17 other countries. Average coverage across these 17 has been flat at 71% over the past four years with progress in some countries (e.g. Central African Republic, Chad, DR Congo) offset by falling coverage in others (e.g. Haiti, Papua New Guinea (PNG), South Sudan, Yemen). Given the acute challenges these countries face, maintaining average coverage could be seen as an achievement. The new Fragility & Emergencies policy approved by the Board in June provides the Alliance with new flexibilities to support progress in these countries. A further 10% of the under-immunised are in countries that will have transitioned by the end of this year, mainly Angola and Indonesia. The Board will have the opportunity to decide how the Alliance engages with countries after transition at this meeting.

New ways of working beginning to deliver results

To accelerate progress on coverage and equity, the Alliance recognised it would need to work differently. In 2016 – the last year for which WUENIC data is available – the Alliance focused on putting in place new policies, tools and approaches (e.g. shifting from the Business Plan to the Partners’ Engagement Framework (PEF); a new health systems and immunisation strengthening framework to focus our grants on key drivers of coverage and equity; a more

flexible approach to grant application and review¹; the introduction of joint appraisals to ensure regular country-level dialogue; launching special strategies in strategic focus areas (SFAs) which are critical to C&E). The Secretariat and many Alliance partners – including UNICEF, the Gates Foundation and CDC – have also reorganised their teams to better focus and target resources on C&E.

These approaches are starting to mature and deliver results, and should translate over time into further improvement in C&E. The Alliance is working with countries such as Kenya, Pakistan, Uganda, Senegal and Mali to re-focus their HSS grants on low coverage areas and key C&E bottlenecks. In 2016, there was a 20% increase in the proportion of requested HSS grants which targeted at data and a 10% increase focused on health workforce strengthening. Grant Performance Frameworks (GPFs) are increasingly measuring how our grants contribute to key C&E drivers and, where this is not happening, allowing us to learn and adjust rapidly. In DR Congo, for example, Gavi's HSS grant supports outreach in 112 particularly low coverage areas and the GPF shows that 80% of the planned outreach sessions are occurring in line with the target. On the other hand, the GPF also showed that the number of facilities with stockouts has not fallen as fast as intended. The Alliance is now supporting the country to monitor stock data monthly and to address the key bottlenecks. Moreover, PEF means over half of tailored country assistance (TCA) is now provided at country-level as opposed to under 10% two years ago. And supply chains are getting stronger with two thirds of countries who have had two effective vaccine management assessments (the tool WHO and UNICEF use to assess supply chains) showing improvement, by over 10% on average. Countries have also applied for 62,000 pieces of equipment through the Cold Chain Equipment Optimisation Platform, with 26% for previously unequipped facilities

The critical importance of better data availability and use

All of this is evidence of progress. It is not yet clear if this is translating into systematic changes in coverage and equity, however, as the available data is not sufficiently accurate, sensitive or timely. Data is one of the highest risks in our Risk & Assurance report and, for me personally, one of the greatest challenges we face. To reach the unreached, who are by definition, among the most remote and marginalised communities, we need to know where they are and measure the success of our efforts to reach them in real time (or as close to real time as possible). This data needs to be available at sub-national level – down to the district and ideally community level.

The Alliance has been making progress in this direction. When I joined Gavi in 2011, our HSS and technical support were largely a data-free zone. We had very limited understanding of what we were funding or the impact it was having. Today, we have GPFs for every grant, data on precisely what TCA we provide in each country and its progress, and mechanisms to systematically review this

¹ The Board is being asked to formalise these flexibilities which it previously recommended on a temporary basis at this meeting

data (such as JAs, the High-Level Review Panel and PEF Management Team). We also have more data sources: we are supporting countries to conduct regular surveys, we have funded the inclusion of immunisation in DHIS2 (a health management information system now being used in 60 countries) and, for the first time this year, WUENIC reported sub-national data for most countries (although the quality is variable). Last year, we launched a data SFA to bring a more transformative approach to data strengthening.

However, this progress is not as fast as I would like and the question is how we accelerate this work. Data systems in many countries remain weak with administrative data being at least ten percentage points different from WUENIC estimates in half of the 68 Gavi-supported countries. Therefore, we rely on WUENIC for our longer term indicators, but this does not provide us with the real-time information we need. It is released seven months after the year for which it is reporting. Even then, it often does not include all available information (as illustrated by the Punjab example discussed above) and is not sufficiently sensitive to detect incremental changes in coverage.

We need to help countries transform their data systems using twenty first century innovations and technologies. Already many consumers in Gavi countries are using digital technology for their banking, shopping and communications but immunisation data largely still relies on traditional paper-based registers. One example of the impact that new technologies can have is India's electronic vaccine intelligence network (eVIN), which is supported by Gavi's HSS grant and implemented by UNDP based on technology provided by two Indian-led private sector partners. This digital platform provides visibility and analytics on supply chain performance down to the health facility level. It is now installed in over 10,000 locations and has helped reduce stockouts by more than 70% in selected states. It will be rolled out nation-wide as part of Gavi's new HSS grant and we are exploring how it can be scaled up in other countries. These types of approaches are going to be critical to deliver transformative change, which is why we are proposing to increase our investment in private-sector partnerships in innovation as part of the 2018-19 budget.

Such transformational change is our long-term vision. In the interim, we can do more by systematically triangulating existing data. Our investments in knowledge management are enabling us to compare data sources more readily. The Secretariat has developed a tool which can quickly analyse and visualise multiple data sources in easy to read, impactful charts, graphs and metrics. This has also improved efficiency, reducing the time to incorporate new WUENIC data from 15 person days to under eight hours. We can also make better use of polio data. In many priority countries, the polio programme has mapped each household in detailed microplans that could be repurposed for routine immunisation. Integrating this into routine immunisation programmes – who are often not using it today – must be a priority before the polio programme sunsets. We are also evaluating how Gavi can incentivise countries to report more accurate data.

Improving data systems alone will not make a difference if that data is not

routinely tracked, assessed and acted upon. Where that occurs, it is possible to see rapid results even in the most challenging countries. In Nigeria, for example, the Alliance supported an overhaul of the supply chain using simple dashboards to measure performance. These were reviewed by a dedicated team in real time to identify stores and facilities with either excess or inadequate stock levels and take corrective actions. The result was that the number of stores with adequate stock more than doubled at state, district and facility level. This has also enabled the Alliance to adjust and better plan vaccine shipments to Nigeria. This year, the Alliance has launched dedicated efforts to generate the required political will and build the management capacity to ensure available data is routinely used.

As discussed above, I believe that the new ways of working are beginning to have an impact. However, transformational change will require a relentless focus by all Alliance partners and measuring it will require major improvements in the quality and use of data. Strengthening data systems and programmes' capacity to use that data will therefore be among the Alliance's highest priorities in 2018.

Balancing sustainability and new vaccine introductions

In discussing its recommendations on the Alliance's approach to Nigeria, PNG and post-transition, the PPC debated a tension that is at the heart of Gavi's mission. Gavi's purpose is to accelerate access to new and under-used vaccines in the poorest countries and it has supported hundreds of vaccine introductions since 2000. Sustainability is also core to the Gavi model. This requires that every country contributes to the cost of their vaccines and takes on the full cost when they transition out of support. These two objectives can be in tension.

At its Retreat, some Board members suggested amending Gavi's policies so that countries can apply for vaccine support at any point up until they transition (currently, they have only a single year after entering accelerated transition). The current policy has led some countries to rush to apply for new vaccines, often before they were ready to introduce them. However, one PPC constituency was concerned that such a change might stress country's preparation for transition (by burdening countries with the cost of an additional vaccine at the same time as Gavi support is ramping down). The PPC therefore did not recommend the proposed change and suggested that this be taken to the Board for discussion.

The trade-off between sustainability and vaccine introduction varies significantly across countries. The concerns were most acute in Nigeria and PNG. Nigeria will need to increase its budget for vaccine procurement 16-fold between now and transition. PNG is struggling to fund even the operational costs of its programme. Moreover, introducing new vaccines might potentially distract from efforts to raise coverage of existing vaccines. At the same time, both countries have among the highest burden of vaccine preventable diseases in their regions. Nigeria could prevent over 450,000 future deaths between 2018-2025 by introducing Rotavirus, Meningitis A, Measles second dose and HPV vaccine. Moreover, if it does not introduce meningitis A vaccine, it will likely see outbreaks of the disease which could also spread to neighboring countries. Such outbreaks could cause

significant loss of life and would require emergency response campaigns which will likely be far more costly and disruptive than a planned vaccine introduction.

In most transitioning countries, this trade-off is less acute. In Vietnam for example, which like PNG is due to transition in 2020, vaccines are estimated to account for less than 0.1% of the health budget and it has a strong programme (with 96% DTP3 coverage) which could readily introduce new vaccines. The country has indicated they plan to introduce pneumococcal and rotavirus vaccine in 2021-25 and catalytic Gavi support could assure this occurs and perhaps accelerate this further. I look forward to hearing the Board's guidance on how we balance this tension between sustainability and vaccine introduction in all transitioning countries.

Update on the Secretariat and partners

Secretariat and Alliance morale

At our last meeting, I presented the key findings of the first ever Alliance Health Survey. This showed that staff across the Alliance share a pride in Gavi's mission and a strong sense of fit among partners but highlighted concerns about the level of trust and quality of communication among Alliance members. To address this, leadership from across the Alliance have agreed on a set of actions including a cross Alliance communication plan, a roster of individuals engaged in Alliance work to allow better communication, more joint missions to countries, regular Alliance-wide virtual meetings and harmonised onboarding packages. We are also improving the efficiency of our processes. For example, with improvements in the Country Portal and support from the Alliance, 82% of countries completed their submissions on time in 2017 compared to 40% in 2016. We plan to conduct a follow-up survey early in 2018 to measure the impact of these changes.

In the closed session of the June Board, we also presented a summary of the 2017 Secretariat staff survey. This showed a high level of staff engagement (with a 98% participation rate) and a strong sense of pride, personal accomplishment and support for our values. It identified core strengths around collaboration and teamwork, line management, diversity in the workplace and employees being treated with respect. It showed we have made significant progress in the priority areas of professional development and reward and recognition identified in the last survey, although staff feel more work is needed in both these areas. The survey also identified a need to strengthen the Secretariat's feedback culture, decision-making processes, accountability and IT systems and to ensure that all staff feel safe to speak up. Since the results were released, we have held a cascading series of meetings across the organisation to better understand the underlying drivers of the issues identified and how we best address them. This included facilitated team-level discussions on the results and follow-up actions, an all-staff discussion, and dedicated retreats of the Senior Management Team and the Director group to reflect on their role in leading change. We are working on action plans at the organisational and team level and will track our progress through regular staff discussions and potentially pulse surveys.

Enhanced collaboration with Global Fund and others

The move to the Global Health Campus (GHC) will provide new opportunities to address some of the issues identified in the staff survey by reuniting all Geneva-based staff in a single, modern space specifically designed for collaborative working. Gavi is on track to move to the GHC in July 2018, three months after the Global Fund. As Mark Dybul and I presented to the Gavi Board last year, we work closely together in many areas where this can increase our respective impact. Teams across the organisations routinely share knowledge and insights (e.g. Gavi Senior Country Managers regularly exchange information and updates with their Global Fund counterparts; our governance teams frequently discuss best practices) and align and contribute to each other's policies wherever this makes sense (e.g. policies on fragile settings and incentives for health-workers). We are increasingly coordinating planning and implementation of programmatic investments, especially in priority countries and strategic focus areas (e.g. shared fiduciary oversight or programme management mechanisms and coordinated investments in areas such as data, supply chain and health-worker capacity in countries including DR Congo, Ethiopia, and Nigeria). We are also increasingly conducting joint advocacy at global and country level (e.g. through joint country missions at leadership and technical level; sharing a seat on the UHC2030 Steering Committee and the Global Financing Facility (GFF) Investors Group). The move to GHC will enable more seamless engagement and even greater collaboration across teams. It will also create opportunities for greater operational efficiency through sharing services such as facilities and event management, the IT network and helpdesk, travel and security, occupational health and procurement. We expect to collaborate closely in many of these areas and are exploring if there are opportunities for more integration or alignment of other systems such as financial management or grant management.

We also continue to increase collaboration with other partners. Along with the Global Fund, we recently agreed with the World Bank and GFF to scale-up our joint work on health financing and transition. This will allow us to better align our policies and engagement with countries and to provide coordinated support to strengthen financial sustainability. We are similarly working to strengthen our collaboration in adolescent health. The Secretariat recently hosted a workshop with a range of partners (including WHO, UNICEF, UNAIDS, Global Fund, GFF, the Global Partnership for Education and other partners as well as bilateral donors and some implementing countries) to explore how Gavi's HPV platform could be better used to accelerate adolescent health integration. This identified concrete opportunities to align and map current global initiatives for adolescent health and highlighted the importance of coordination at the country level.

This Board meeting will be an opportunity to reflect on the progress of our strategy and adjust our approach, based on lessons learned to date, to increase our impact and mitigate emerging risks. We will also consider the 2018-2019 budget, where we have sought to maintain a strong focus on value for money

with flat budgets for partner and Secretariat headquarters functions. And we will make decisions on the VIS and support for typhoid vaccine (the latter could avert a significant number of the estimated 145,000-220,000 typhoid deaths that occur each year and contribute meaningfully to efforts to combat antimicrobial resistance). These decisions will be the first in a series of conversations over the next 18 months to shape Gavi's 2021-25 strategy, which we will continue at the March Board Retreat. I look forward to discussing all of this with you in Vientiane next week.