SUBJECT:	**STRATEGY, PROGRAMMES AND PARTNERSHIPS: PROGRESS, RISKS AND CHALLENGES**
Agenda item:	06
Category:	For Guidance

Section A : Executive Summary

This report provides an initial progress update on Gavi 5.0, associated opportunities and risks[1] **and a final update on progress made in Gavi 4.0,** informed by the updated WUENIC[2] data released in July 2021.

Despite pandemic related disruptions to immunisation services, the Alliance achieved or exceeded all of its Gavi 4.0 mission targets. Although there was a decline of 4 percentage points in DTP3 coverage between 2019 and 2020, disruptions appear to have been concentrated in Q2 2020 with the majority of Gavi-supported countries showing restoration of services to pre-pandemic levels by the end of 2020. This is a testament to the dedication of countries, supported by the Alliance, to protect immunisation services during these challenging times.

However, the outlook remains uncertain with monthly administrative data showing potential disruption, mainly in some Asian countries in 2021. Although it is too early to say the extent to which these trends represent real disruption rather than reporting issues, it is clear that the situation remains tenuous**.** A real risk of backsliding remains, not only from potential future waves of COVID-19 infections but also from the diversion of resources to COVID-19 vaccine delivery. A synergistic approach to COVID-19 vaccination and routine immunisation, clear guidance to countries, flexible and tailored support based on country needs, and enhanced advocacy will be critical to mitigate these risks.

In light of ongoing risks and uncertainty, priorities and targets for Gavi 5.0 continue to be reviewed and will be adapted as required. The Board endorsed a recalibrated set of priorities in December 2020, with the Alliance prioritising access to COVID-19 vaccines; maintaining, restoring and strengthening routine immunisation; reaching zero dose children and missed communities; and safeguarding domestic financing for immunisation. Other areas of Gavi 5.0, including new vaccine introductions and the approach for engaging middle-income countries (MICs), will advance at a slower pace than initially planned.

In order to support countries to simultaneously deliver routine immunisation and COVID-19 vaccinations, while also catching-up missed children to prevent outbreaks, the Alliance is seeking to increasingly take a joined-up view of these intertwined priorities. Concretely, this will require **further integration and**

[1] Associated risks refer to the top risks in the Risk & Assurance Report 2021
[2] WHO/UNICEF Estimates of National Immunization Coverage

rationalisation of structures, processes, fora, staffing and funding across Gavi 5.0 and COVID-19 vaccine delivery.

The Board is requested to provide guidance on the above mentioned recalibrated priorities, synergistic approach to routine imunisation and COVID-19 vaccination and efforts to prevent backsliding and reach zero-dose children.

Section B : Final reporting for Gavi 4.0 and progress and risk update on Gavi 5.0

1. Mission Indicators: Gavi 4.0 final reporting and progress update on Gavi 5.0

1.1 **Thanks to the significant progress Gavi-supported countries made in expanding the reach of immunisation services before the pandemic, the Alliance exceeded all of its Gavi 4.0 mission targets despite COVID-19-related disruptions in 2020.** Between 2015 and 2020, Gavi helped countries immunise 324 million unique children, and avert 6.9 million future deaths and 325 million future disability-adjusted life years (DALYs).[3] All countries that transitioned from Gavi support continued to deliver all recommended vaccines in their routine programmes.

1.2 **However, Gavi 5.0 begins amid a reversal of pre-pandemic gains and continued uncertainty about the future evolution and impact of COVID-19 on routine immunisation systems.** The rollout of COVID-19 vaccines is rapidly scaling up (see Doc 07), and as the risk of new pandemic waves persists, resources and capacity for routine immunisation services will likely be stretched further. Hence, the Alliance's ambitious targets for Gavi 5.0, such as increase in coverage of diphtheria-tetanus-pertussis

[3] Updated estimates on Under-5 Mortality will only be available in December 2021.

(DTP3) and the first dose of measles-containint vaccine (MCV1), breadth of protection, and reduction of zero-dose children are put at risk. The Alliance continues to gather data and actively work with countries to **ensure all support through Gavi's levers and COVAX is synergistic, flexible, tailored to each country (see Section 3), and focused on helping to maintain focus on routine immunisation while delivering COVID-19 vaccines**. However, as flagged previously to the Board, there remains a risk that the Alliance's ambitious 5.0 targets may have to be adapted, and the Board will be engaged should this be the case.

2. Strategic Indicators: Gavi 4.0 final reporting and progress update on Gavi 5.0

Strategic Goal 1: Accelerate Vaccines

2.1 **Whilst the Alliance was making strong progress on increasing vaccine coverage before the pandemic, it missed its Gavi 4.0 coverage targets due to COVID-19-related disruption in 2020**. DTP3 and MCV1 coverage in 68 Gavi-eligible countries both increased by 3 percentage points (pp) from 2015 to 2019, before declining by 4pp and 3pp respectively in 2020. Almost all countries faced severe pandemic-related disruption with immunisation coverage dropping by nearly 40% in the second quarter of 2020. The latter half of 2020 however saw a remarkable recovery, driven in part by the nimble and agile support that the Alliance provided to maintain routine immunisation services. Despite this recovery however, more than half of planned vaccine introductions in 2020 did not take place, with most being postponed until 2021. Moreover, there are now a greater number of zero-dose children than at any point in Gavi 4.0 almost entirely driven by India, Pakistan and Indonesia. This makes delivering on the Alliance's zero-dose agenda more critical than ever.

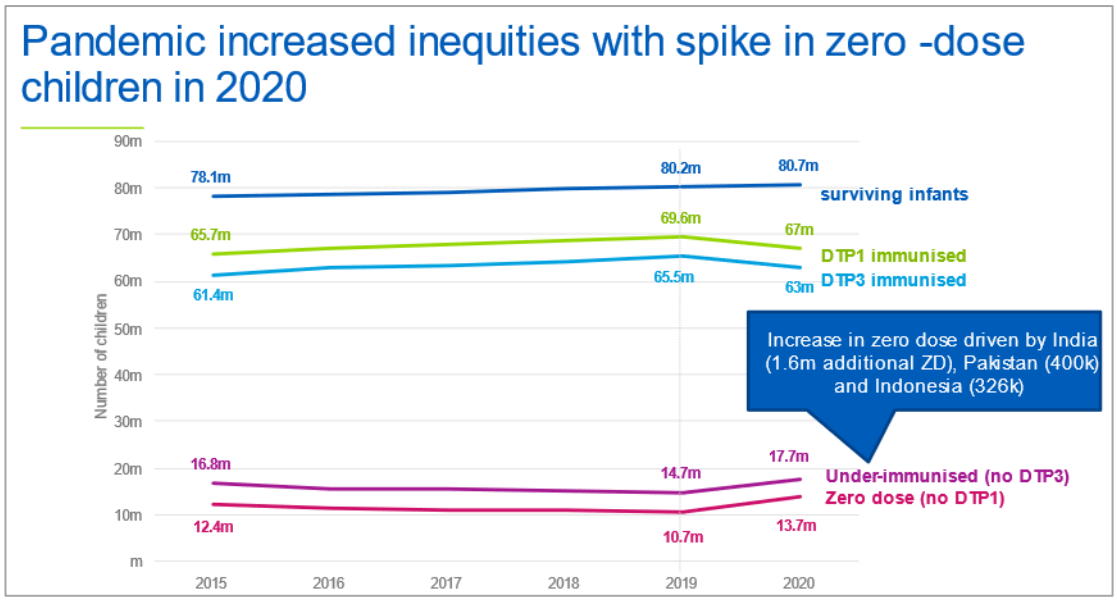

Figure 1: routine immunisation coverage trends over Gavi 4.0

2.2 **The ten Partners' Engagement Framework (PEF) Tier 1 countries[4] that accounted for over 70% of underimmunised children in Gavi 4.0, and benefited from enhanced Alliance engagement and technical assistance under PEF made very encouraging progress between 2016- 2019.** DTP3 coverage increased by 6 pp during these years, double the average improvement across 68 Gavi-eligible countries. However**,** the pandemic reversed some of these gains, with PEF Tier 1 countries seeing a 5 pp drop in coverage in 2020.

2.3 **The repercussions of the pandemic on routine immunisation services are still unfolding.** Latest available administrative data from the first half of 2021 indicate significant regional variations with South-East Asia and the Western Pacific Region in particular continuing to see larger disruptions from COVID-19[5].

2.4 **Despite the relatively low number of outbreaks requiring vaccination responses since the start of the COVID-19 pandemic, the risk of an increase in outbreaks remains high.** Measles outbreaks for example have not shown a spike and in fact the total number of cases has reduced in 2020 and in the first half of 2021. However, this may be related to a deterioration in measles surveillance with 2020 seeing the lowest number of specimens sent for laboratory testing in over a decade, rather than a real decline in cases[6]. Given the continued risk of disruption to routine vaccination services resulting in a greater number of missed children, coupled with easing COVID-19 restrictions, the risk of outbreaks remains significant. The Alliance will continue to monitor the situation closely and is

[4] PEF Tier 1 countries were those with the largest numbers of under-immunised children in Gavi 4.0: India, Nigeria, Ethiopia, Indonesia (only included in the evaluation in 2016), Pakistan, Kenya, Uganda, the Democratic Republic of the Congo, Afghanistan and Chad.
[5] The impact may be more pronounced than currently visible as data for India, accounting for 29% of the birth cohort for Gavi supported countries, for full Q2 2021 has not yet been reported.
[6] WHO report: Global progress against measles threatened amidst COVID-19 pandemic, 10 Nov 2021

standing ready for rapid outbreak response as needed e.g., by providing access to vaccine stockpiles. In addition, the Alliance continues to encourage countries to undertake supplemental approaches to catch up on missed children to reduce the risk of outbreaks.

2.5 **Against 39 planned vaccine introductions and campaigns at the beginning of the year, 26 vaccine launches have already occurred[7].** Of the 26 introductions, 19 were campaigns and 7 were routine immunisation introductions. This better-than-expected result is in part due to 11 (i.e. nearly twice as many as planned) inactivated polio vaccine (IPV) catch-up vaccination activities. This illustrates the ability and desire of countries to continue driving their national immunisation programmes. However, there were several delayed vaccine launches in Chad, Guinea and Zimbabwe – routine as well as campaigns – that highlight the ongoing challenges in countries to manage competing priorities and COVID-19 impacts. The introduction of human papillomavirus (HPV) vaccines in particular has taken a hit during the pandemic and for those Gavi-supported countries where HPV is already introduced, average coverage rates are now standing at only 8% compared to 13% globally[8].

2.6 **Countries are leveraging supplementary immunisation activities to deliver other health care interventions and to identify and reach zero-dose children**. Of the 19 campaigns that were conducted, 9 included co-delivery of other primary health care interventions, additional antigens or specific activities to identify and incorporate zero-dose children in campaign and routine immunisation planning. In addition, the quality of measles campaign planning has improved over recent application rounds, with better use of data, including innovations like use of geospatial tools, to increase targeting of activities to zero-dose communities. Despite these improvements however, the Independent Review Committee (IRC) has identified opportunities to further strengthen measles campaign applications. These recommendations are being followed through to ensure robust planning and implementation of measles campaigns (see Annex C).

Strategic Goal 2: Health System Strengthening

2.7 **In Gavi 4.0, several areas of strategic importance were identified to strengthen health system capacity and ultimately improve vaccine coverage and equity.** These included building efficient and resilient immunisation supply chains; strengthening institutional leadership, management and coordination capacity at country level; improving data availability, quality and tools to strengthen decision making. These areas received closer attention and dedicated support through special investments in Strategic Focus Areas (SFA)[9].

[7] The 26 vaccine launches included 4 introductions not initially planned as part of the 39 target.
[8] In 2020, in six Gavi countries that have introduced the vaccine and reported HPV programme performance in both 2019 and 2020, average HPV coverage dropped by more than 25% in 2020.
[9] Additional SFA groups receiving special investments include demand, immunisation financing and sustainability and gender (starting in 2020)

2.8 **Prior to the pandemic, the Alliance had made good progress in strengthening immunisation supply chains and institutional capacity.** For example, as discussed in the previous SPP (Strategy, Programmes and Partnerships) paper (June 2021), the Alliance's approach to strengthening immunisation supply chains has contributed to consistent improvements in effective vaccine management (EVM) assessment scores. Similarly, the Alliance rapidly scaled up support through the Cold Chain Equipment Optimisation Platform (CCEOP), covering 52 out of 57 eligible countries in Gavi 4.0, and delivering nearly 60,000 CCEOP units. Finally, the Alliance has achieved the strategic target on institutional capacity. **The quality of country-level data however remains a persistent challenge for Gavi.** The indicator on data quality worsened in 2020 at 40% compared to 43% in 2019 and did not meet the Gavi 4.0 target.

2.9 **The Alliance is leveraging its health system investments to accelerate delivery of COVID-19 vaccines.** For example, the CCEOP service bundle structure was leveraged to allow rapid deployment of ultra-cold chain (UCC) for COVID-19 vaccines. In addition, support for strengthening leadership, management and coordination of EPI (Expanded Programme on Immunizaton) programmes through expanded partners has been leveraged, for example to support coordination mechanisms for COVID-19 responses in several countries[10].

2.10 **Focus on zero-dose children and missed communities is being mainstreamed across all Gavi funding levers.** To avoid adding to the three million new zero-dose children from 2020, it is more important than ever that routine immunisation services are strengthened and extended to systematically reach existing and catch up on new zero-dose communities. The Alliance is therefore using all available funding levers to help countries tackle this challenge. Full Portfolio Planning (FPP) processes are ongoing in seven countries, including Kenya, South Sudan and Pakistan, focused on helping countries holistically programme Health Systems Strengthening (HSS), Targeted Country Assistance (TCA) and other funding envelopes to reach zero-dose children, supported by a new, integrated application kit. Progress is being monitored as COVID-19 is limiting some countries' bandwidth to complete FPP processes. In light of this, the Alliance is supporting countries to submit stand-alone applications for specific support where required.

2.11 **To further bolster country efforts to reach zero-dose children, the Alliance is also operationalising the US$ 500 million Board-approved Equity Accelerator Funding (EAF).** Countries can now apply for dedicated, additional funding to reach zero-dose children. Around 14 country applications are expected by mid-2022. US$ 100 million of the EAF will be allocated to new multi-country partnerships to reach zero-dose children and missed communities in fragile, conflict and cross-border settings outside government reach, with the selection of providers expected to conclude before the end of the year. **Additional activities to further**

[10] Mali, DRC (Democratic Republic of the Congo), Madagascar, Comoros, Niger, Côte d'Ivoire

build momentum across the Alliance on the zero-dose agenda include the establishment of a dedicated cross-Alliance Community of Practice (COP), increased focus on advocacy as well as working with the global health community to align support.

2.12 **PEF TCA, a key funding lever, is also shifting its focus towards zero-dose children and missed communities, although faster progress is needed with only 6% of TCA activities specifically mentioning zero-dose children.** The Partnerships Team (PT), during its recent review of TCA, concluded that more needs to be done to ensure that TCA provided by partners is focused on delivering on the ambitious zero-dose agenda. The PT also concluded that greater emphasis needs to be placed on country ownership; empowering countries to engage context appropriate partnerships to best address country specific needs, including developing new partnerships with local institutions. Aligned with Gavi's Civil Society and Community Engagement approach, the intention is for 30% of TCA funds to be earmarked for local institutions in Gavi 5.0.

2.13 **TCA increased significantly during Gavi 4.0 in both funding and staffing (see figure 2). WHO and UNICEF have remained the main providers of technical assistance receiving ~70% of overall TCA funding.** At the end of 2020, additional surge funding was released through COVAX TA[11] to help ameliorate some of the pandemic related challenges.

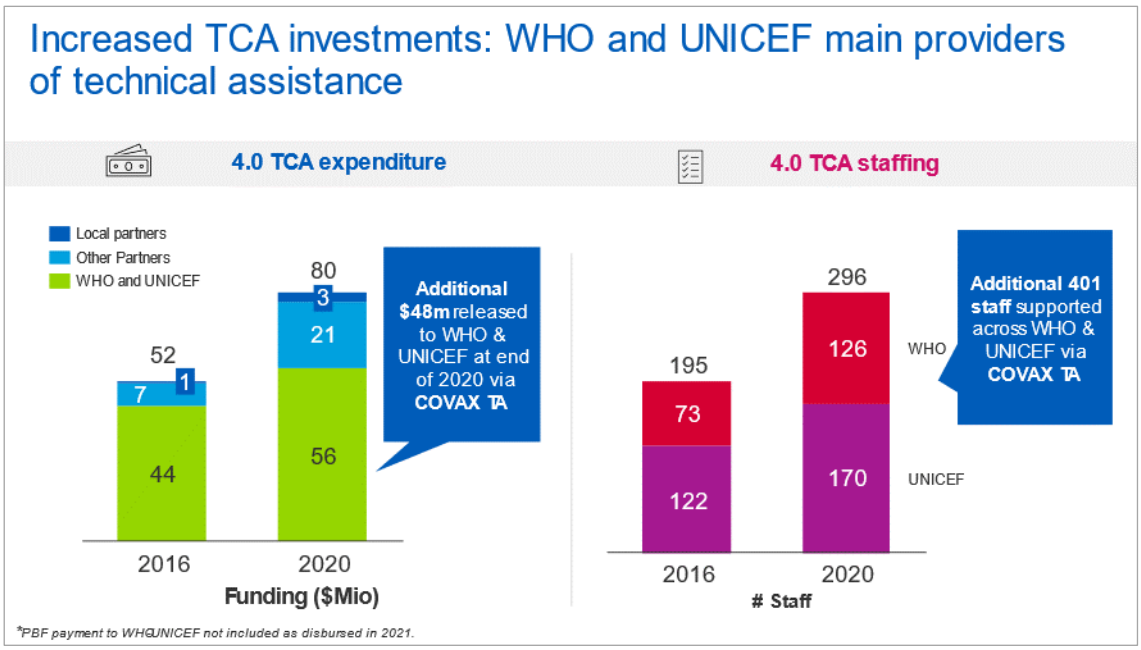

Figure 2: Growth in Technical Assistance provided between 2016-2020, with additional surge capacity provided through COVAX TA

11 COVAX TA is additional funding with a focus on preparing for COVID-19 vaccine delivery and overall COVAX engagement

2.14 **Despite increased funding and staffing levels, challenges persist with only 65% of partner reported TCA milestones being achieved or on-track in 2020[12].** This lower performance than in previous years is likely due to the high number of competing priorities across governments and partners, compounded by the pandemic and not yet fully off-set by the surge capacity.

2.15 **A key enabler of the zero-dose agenda is the Board approved Gender Policy.** Given gender-related barriers are one of the key drivers of lack of immunisation, the policy aims to encourage gender-sensitive programming. To that end, for example, the new application kit for Gavi support aims to ensure gender considerations are mainstreamed into country plans. Recent immunisation campaign applications show how gender considerations are being prioritised and operationalised. **Unfortunately, however, the pandemic has negatively impacted gender related barriers to immunisation.** The Alliance will continue to evaluate gender-responsive and transformative interventions in a range of countries to better inform future programming guidance (See Annex D for a detailed update on implementation of the Gavi gender policy).

Strategic Goal 3: Improve Sustainability

2.16 **Despite the impact of the pandemic on economies and health budgets, Gavi's co-financing approach delivered success in Gavi 4.0.** All countries paid their 2020 co-financing obligations on time, excluding the nine countries that received a COVID-19 co-financing waiver. This amounted to a total of US$ 129.4 million in country contributions for 2020, nearly the same level as in 2019, bringing their total contribution over Gavi 4.0 to US$ 655 million. Considering an estimated extra US$ 911 million paid by countries on self-financed programmes formerly supported by Gavi[13] this amounts to a total of US$ 1.6 billion of domestic financing in Gavi 4.0 compared to USD$ 5.4 billion Gavi investments in vaccine programmes over the same period.

2.17 **The value of co-financing waivers for 2020 amounted to US$ 4.4 million and represents ~3% of total co-financing obligations for the year[14].** Moreover, no additional waivers have been approved in 2021 to date. This reflects Gavi's focus on protecting past gains in domestic financing for vaccine procurement and, where possible, identifying external financing options before turning to waivers. Gavi has intensified proactive monitoring for countries at risk of co-financing non-payment, with prompt actions being taken to mitigate risks where possible. **In many instances, the Alliance's early discussions with countries enabled finding solutions to potential co-financing challenges without a formal waiver being requested**.

2.18 **So far this year, 71% of co-financing obligations have been paid. This is below the average percent paid at the same time in 2019 and 2020**

[12] Note, the 65% of milestones include 28% completed (as per Alliance KPI) as well as 37% currently on track
[13] This amount includes self-financing by India, which has a tailored approach not actual co-financing.
[14] Pakistan also received a partial waiver of US$ 16 million for its fiscal year 2020-2021. Though it was approved end of 2020, it is attributed to the 2021 calendar year and budget.

(79% and 81% respectively). The Alliance is monitoring co-financing payments closely. Waiver requests submitted by several fragile and conflict countries[15] are currently reviewed in coordination with the World Bank and other partners.

2.19 **Whilst government health spending increased in 2020 to help mitigate the impact of COVID-19, it contributed to a 13% increase in debt in Gavi-supported countries.** As countries struggle to recover from the crisis and reduce deficits, government per capita health spending is expected to decrease in 2021 and 2022 in low-income countries, with a return to 2020 levels only by 2024. This could compromise gains achieved in domestic financing for vaccines, while official development assistance could simultaneously decline, increasing the competition for scarce resources.

2.20 **There has been good progress in countries approaching the transition to self-financing status with 7 of 8[16] (88%) eligible countries in the accelerated transition phase on track to transition successfully.** This assessment is based on countries achieving their transition plan's milestones, sustaining or increasing DTP3 coverage and meeting co-financing requirements. This is an increase from 67% in 2019, exceeding the target of 75% by 2020. India is the only eligible country not on track for successful transition due to a drop in DTP3 coverage due to COVID-19[17] (see Doc 10).

2.21 **Those countries that have already transitioned to self-financing continued to deliver all recommended routine vaccination programmes throughout 2020.** Whilst on average, former Gavi countries saw a 3-percentage point (pp) increase in DTP3 coverage between 2015- 2019, 7 out of 17 countries saw decreases of greater than 1%, and three saw more significant decreases[18]. This highlights the importance of continuing targeted support for former Gavi-eligible countries, where needed, to ensure sustainable and resilient immunisation programmes. This will be addressed through the roll out of the MICs approach which, following the Board's decision in December 2020, will have an initial focus on preventing and mitigating backsliding in former Gavi-countries.

2.22 Gavi is a co-lead of the Sustainable Financing for Health Accelerator (SFHA), which aims to strengthen collaboration among multilateral organisations on Health Financing to accelerate progress on health-related SDGs. **In 2021, the SFHA collaboration has led to successful development of country-level platforms for health financing and donor alignment** in seven countries[19]. For example, the country platform contributed to the first joint mission with the Primary Healthcare (PHC)-accelerator on PHC for Universal Health Coverage (UHC) in Pakistan, while in Tajikistan, a joint statement on health financing reforms was presented to

[15] Those include Afghanistan, Somalia, South Sudan, Sudan and Syria.
[16] India, Lao PDR, Nicaragua, Nigeria, Papua New Guinea, Sâo Tomé, Solomon Islands and Uzbekistan.
[17] India improved DTP3 coverage from 87% in 2015 to 91% in 2019, but dropped back to 85% in 2020 due to COVID-19; Doc. 9 lays out Gavi's proposed Strategic Partnership with India for the 2022-26 period.
[18] Bolivia -14pp, Honduras -10pp, and Viet Nam -8pp (although this has largely recovered in 2020)
[19] Ghana, Cote d'Ivoire, Niger, Lao PDR, Myanmar, Pakistan, and Tajikistan

the President to support strategic health financing transitions. **At the global level, the SFHA has been working to advance domestic resource mobilisation efforts and enhance the role of Civil Society Organisations (CSOs).** To support this, Gavi, along with the Global Financing Facility (GFF), Global Fund and other partners are co-financing the joint learning agenda to build CSO capacity in health financing and budget advocacy in 20 countries.

Strategic Goal 4: Market Shaping

2.23 **Market shaping indicators mostly achieved their Gavi 4.0 targets in 2020** as indicated in the final reporting on these indicators provided at the June 2021 Board meeting.

2.24 **Market shaping milestones of note so far during 2021 include**: (i) the launch with partners of five-year end-to-end strategies including action plans for all three Vaccine Innovation Prioritisation Strategy (VIPS) priorities[20]; (ii) a risk-share with MedAccess to fund continued production of RTS,S malaria antigen in anticipation of upcoming funding decisions[21]; (iii) new UNICEF long-term supply agreements for Measles/Measles Rubella (M/MR), Rota and Typhoid Conjugate Vaccine (iv) WHO prequalification of a second Ebola vaccine, single-dose vial IPV vaccine, and an improved meningococcal ACYW-135 conjugate vaccine.

2.25 Since the Board approved an initial investment of US$ 5 million in June 2021, **the VIPS Alliance (i.e. Gavi, WHO, UNICEF, BMGF and PATH) has secured an additional US$ 2.1 million in external funding from a private foundation donor** to conduct additional work on micro-array patches (MAPs). This has no net impact on the Secretariat financial forecast as this is a fully funded grant.

2.26 **There remains a continued risk to supply of Gavi-supported vaccines posed by COVID-19, although to date this risk has not materialised.** The impact of a pneumococcal vaccine disruption was successfully managed with partners through supporting product switches and providing bridge shipments, therefore preventing any material supply interruptions. **Alliance partners are closely monitoring the situation, with regular engagement of manufacturers**. In addition, the COVAX Manufacturing Task Force is making progress in the CEPI-led effort to de-risk the environment for raw materials and consumables such as syringes, adjuvants, tubing, glass vials or filters. Some repurposing of primary and secondary production lines for COVID-19 vaccines is inevitable, but this has so far not resulted in any trade-offs with non-COVID-19 vaccines. One manufacturer nevertheless warned that **campaigns such as M/MR will need to be well coordinated and phased to avoid unexpected demand spikes.**

[20] Three VIPS priorities: microarray patches (MAPs), heat stable and Controlled Temperature Chain qualified vaccines and barcodes on primary packaging
[21] See Doc 08 Malaria Vaccine Programme Investment Case

2.27 Gavi is also monitoring COVID-19's impact on development timelines of pipeline vaccines in Gavi-supported categories; some delays have been reported by manufacturers, which in two cases resulted in revisions to Roadmap assumptions. At present there are **no pipeline delays we consider to be critical to long-term market health outcomes**.

3. Integration of COVID-19 vaccination and routine immunisation

3.1 In order to support countries to simultaneously deliver both routine immunisation and COVID-19 vaccinations while also catching-up missed children to prevent outbreaks, **the Alliance is seeking to increasingly take a joined-up view of these intertwined priorities**. With the COVAX focus now increasingly moving from upstream guidance and tools to delivering COVID-19 vaccines on the ground, there is an opportunity to examine rationalising COVAX structures, processes, fora, staffing and funding in order to drive both routine immunisation and COVID-19 vaccination.

3.2 Hence, although the COVID-19 pandemic is far from over and it is not yet clear if and when the Alliance would establish a standard vaccine programe for COVID-19[22], **the Secretariat has initiated a process to review the current organisation of the COVAX Facility and other teams involved in COVAX.** The objective of this exercise is to ensure a fit-for-purpose organisational structure leveraging core capabilities, aligned with the 2021 organisational review, and with clear roles and responsibilities in support of Gavi's recalibrated priorities. The aim would be to progressively integrate teams and structures over the course of 2022, while being adaptive to evolving circumstances. The Secretariat has also been working with WHO and UNICEF to pursue effective integration and rationalisation across the Alliance, including in relation to the TA provided to countries. Updates will be provided to the Gavi governance bodies in due course.

4. Updates to Gavi's core funding policies and the Fragility, Emergencies and Refugees (FER) policy

4.1 **As part of the process to operationalise Gavi 5.0 and to strengthen the core principles of equity, sustainability and simplicity, Gavi is updating its core funding policies:** the Eligibility & Transition Policy; the Co-financing Policy; and the Health System and Immunisation Strengthening (HSIS) Support Framework (additional information on HSIS in Appendix 2). The review was paused due to COVID-19 but is now being restarted, allowing lessons learnt from Gavi's response to COVID-19 to be integrated into the revised policies.

4.2 **In October 2021, the Programme and Policy Committee (PPC) provided guidance on key issues to steer the development of the proposed changes.** The PPC was supportive of the direction the proposed changes were taking, in particular:

[22] Which will depend on a number of elements including on more certainty on epidemiology and vaccine effectiveness

a) exploring potential co-financing exceptions for new vaccines, e.g. Malaria and Hexavalent [23], whilst emphasising the importance of financial sustainability;

b) moving to comprehensive multi-year co-financing agreements, including campaigns and refugees (Co-financing Policy Review, Appendix 1); and

c) complementing coverage and equity criteria with other programmatic issues when considering extended transition support (Eligibility and Transition Policy Review, Appendix 1).

4.3 **Following an external evaluation, the FER policy is also being revised** with an aim to better reflect the goals of Gavi 5.0, and lessons learnt from Gavi's response to COVID-19. Three key issues were presented to the PPC for their guidance. The PPC agreed with the need to change how Gavi defines fragility to ensure health system indicators are included, and recommended speed in Gavi's processes and a higher risk appetite in emergencies. Despite a Secretariat recommendation, the PPC requested the Secretariat consider time-limited support to certain populations in never-eligible middle-income countries such as refugees, internally displaced populations, and vulnerable migrants (Fragility, Emergencies, Refugees Policy, Appendix 3). The Secretariat will further investigate the need in such settings.

4.4 Final policies will be brought to the PPC for recommendation in May 2022, and **Board approval in June 2022**.

Section C: Actions requested of the Board

The Gavi Alliance Board is requested to provide **guidance** on the following questions:

a) Do the Alliance's recalibrated priorities require further adaptation at this point, acknowledging risks and challenges are constantly evolving?

b) Is the proposal to adopt a synergistic approach to COVID-19 vaccination and routine immunisation the right direction to take? Are there any concrete suggestions that the board might want to offer in this regard?

c) Should the Alliance do anything else or different to support countries to deliver on the core Gavi 5.0 priorities including preventing backsliding of routine immunisation, and reaching zero-dose children?

Annexes

Annex A: Updated Alliance KPIs dashboard

Annex B: Strategy Indicators reported as originally defined

Annex C: IRC/HRLP recommendations

Annex D: Implementation of Gavi gender policy

[23] Diphtheria, tetanus, pertussis, poliomyelitis, haemophilus B, and hepatitis B,

Additional information available on BoardEffect

Appendix 1: Funding Policy Review: Review of the Co-financing and Eligibility and Transition Policies

Appendix 2: Funding Policy Review: Update on Health Systems and Immunisation Strengthening (HSIS) Support Framework

Appendix 3: Review of the Fragility, Emergencies and Refugees Policy