Report of the Chief Executive Officer

21 November 2018

Dear Board members,

We look forward to welcoming you to our first meeting at the Secretariat's new home in Geneva – the Global Health Campus (GHC). Gavi turns 18 this year and like many 18 year-olds, we have moved into a new home which reflects our increased maturity and changing needs. The GHC also opens up many new opportunities for collaboration. We look forward to showing you around and to discussing the many important decisions on this Board agenda.

Key developments in our global landscape

Enhancing collaboration in global health to achieve the SDGs

Our move to GHC comes at an opportune time when there is growing impetus to enhance **collaboration in global health**. At the World Health Summit in Berlin, eleven leading health organisations, including Gavi, committed to developing a *Global Action Plan for Healthy Lives and Well-Being for All*. This was a response to a challenge from President Akufo-Addo of Ghana, Chancellor Merkel of Germany and Prime Minister Solberg of Norway of how the global health community could work better together to help countries accelerate progress towards the health-related SDGs. The document released in Berlin provides a roadmap for developing the final plan which will be released at the UN General Assembly in 2019. The Secretariat has been closely engaged along with our Alliance partners WHO (which has led the process), UNICEF and the World Bank as well as the Global Fund. The energy, collaboration and commitment to rethink how we work among partners is very encouraging. At the same time, making collaboration work is not simple, and there is an increasing number of alignment efforts across many intersecting groups with similar members. It will be important to bring these together going forward and focus on identifying concrete and targeted activities that can rapidly deliver change in key areas.

Efforts to enhance collaboration should build on what is already working. The Alliance is a leading example of partnership in action. Since 2015, the Alliance

has grown significantly with a growing range of expanded and private sector partners complimenting the work of core partners. Beyond the Alliance, we have also continued to deepen our collaboration with the **Global Fund**, and to make it more systematic. As the two leading multilateral health funds, we are aligning our contributions to global coordination efforts including the Global Action Plan. We continue to strengthen programmatic collaboration by, for example, exploring how Gavi can use the Global Fund's existing online platform to track health system performance, and jointly developing and co-financing a course on health systems, financing and sustainability with the World Bank. There is also common work in an ever-growing number of countries including alignment of grants, joint planning of investments and use of common fiduciary mechanisms. And now we have moved to the GHC, we are working to expand the areas where we share services with the Global Fund and other tenants of the Campus. This includes plans to use the same printer service provider, computing supplier, cyber-security provider, a common IT service desk, travel agency and travel security provider.

One area of cooperation is in defining how we and the Global Fund work with the **Global Financing Facility** (GFF). We welcome the GFF's aim to help countries develop sustainable financing strategies for reproductive, maternal, neonatal, adolescent and child health by prioritising interventions, aligning resources and mobilising new funds to fill gaps. Its Replenishment, which I attended, will ensure more resources are available for critical areas which have been under-funded historically (such as nutrition and family planning). All three agencies are working together to clarify how we collaborate including at country level. This is a work in progress as the GFF continues to refine its own mission and ways of working.

Scaling up primary healthcare – the critical role of routine immunisation

One area where collaboration can help accelerate progress is in strengthening **primary healthcare** (PHC). PHC is critical to deliver the SDGs and make Universal Health Coverage (UHC) achievable and affordable. It is the principal entry point into the health system and the primary platform to prevent disease. A recent paper from the Lancet Global Commission on Investing in Health (of which I am a part), found that over 90% of the most cost-effective health interventions can be delivered through PHC. However, it is often insufficiently prioritised in government budgets and the health policy discourse. In recognition of this, governments and the broader community came together in Astana in October to celebrate 40 years since the first global meeting on PHC in Alma Ata.

Routine immunisation is a critical foundation for PHC regularly reaching more communities than any other intervention (40 years ago, less than 10% of the world's children were fully immunised). By starting from identifying the unreached and working backwards to address the barriers to access, the Alliance is taking a particularly equitable approach to strengthening immunisation and PHC. As we build out service delivery, supply chains and data systems to extend delivery of immunisation services to unserved communities, we are building a platform through which other PHC services can be delivered. The opportunity and the

challenge is to work with countries to fully harness this platform. It is opportunities like this that we can better exploit by strengthening collaboration in global health.

As a community, we need to do more to explain to governments (including Ministries such as Local Government, Finance, Budget and Planning, not just Ministries of Health) the return they get on investments in PHC. The World Bank has recently launched the **Human Capital Index**, a new tool which should help. It recognises human capital as a central driver of sustainable growth and poverty reduction and seeks to measures the impact of investments in the social sector on long-term economic development. The Bank plans to use it to support country decisions on investing in human development, which should help increase funding for PHC and particularly the most cost-effective interventions.

Ebola in DRC – a complex emergency

The latest **Ebola** outbreak in DR Congo illustrates the challenges of delivering PHC services in fragile settings. The outbreak earlier this year was challenging but was brought under control relatively quickly. This one is proving far more difficult. With over 370 cases and 200 deaths to date, it is the worst outbreak in DRC's history exceeding the first one ever in 1976 in Yambuku. Nearly 32,000 people having received vaccines made available through Gavi's Advanced Purchase Commitment but the disease continues to spread with more confirmed cases in October than in any month to date. Worryingly, many new cases are in urban areas where the disease can spread quickly and nearly half of them were not known contacts of previous victims. The outbreak is close to several borders creating a real risk of international spread and WHO has deployed experts to nine countries to help prepare. Uganda is preparing to immunise frontline health workers prophylactically, while South Sudan plans to do so and Rwanda is considering it. WHO has requested that Gavi support operational costs and I have provisionally agreed under the Fragility, Emergencies, Refugees policy.

As Dr Oly Ilunga the Minister of Health has noted, a key reason why this outbreak is so hard to control is the "difficult and volatile environment…Since their arrival in the region, the response teams have faced threats, physical assaults, repeated destruction of their equipment, and kidnapping." Two members of the Rapid Response Medical Unit even lost their lives in an attack. North Kivu and Ituri have faced conflict and deteriorating security for several decades resulting in over one million people being internally displaced, continuous movement of refugees to neighbouring countries and mistrust of the authorities in some communities. Despite strong leadership from the Minister and intense support from partners, this has made the response very challenging. The Alliance is working closely with DR Congo, both to address this emergency and to strengthen its routine immunisation (RI) programme. Anuradha was in DR Congo last month, where she helped launch the Minister's "Mashako Plan" to revitalise RI with Alliance support. The Minister was in Geneva last week and we discussed this bold vision, which could help transform primary healthcare in DRC. It could make the country more resilient to future outbreaks but, as is true in a number of fragile countries, the underlying risks will not be resolved by health interventions alone.

Checking in at mid-point of strategy

Delivering on our Berlin commitments

In less than three weeks, Abu Dhabi will host Gavi's **mid-term review** (MTR), where we will report back to donors on our progress against the commitments we made at our 2015 Berlin replenishment. This will be an opportunity to reflect on how far we have come over the first 18 years of the Alliance, discuss progress and challenges in this period and look forward to our future. We are on track to deliver on our major commitments including supporting countries to immunise 300 million children, averting 5-6 million deaths, helping 20 countries to transition from Gavi financial support, ensuring countries continue to co-finance, sustaining progress on market shaping, and generating US$80-100 billion in economic benefits. We will shortly publish a MTR Report, which describes the progress we have made, the challenges we have faced and how the Alliance is adapting. This will be made available to Board members as soon as it is published.

Progress and challenges in reaching every child

Since 2000, the Alliance has helped countries immunise more than 700 million children, averting over 10 million deaths. Gavi-supported countries are now immunising 50% more children with DTP-containing vaccines than in 2000 and most are receiving several Gavi-supported vaccines thanks to over 400 **vaccine introductions and campaigns**. Over 100 of these have occurred since 2016, demonstrating the acceleration in our efforts. However, progress has been slowed by supply constraints for inactivated polio vaccine (IPV), rotavirus vaccine and human papillomavirus (HPV) vaccine. These are a reminder of the continued supply risks we face despite progress on market shaping. The rotavirus situation is particularly concerning as one manufacturer reduced its allocation to the Gavi market at short notice, leading to stockouts at central stores in two countries. Fortunately, two new products have been recently prequalified and with, intense support from across the Alliance, two of the four affected countries have already chosen an alternative supplier and should receive first shipments in the coming months (the others are currently deciding on a new supplier).

The context in many Gavi-supported countries has changed significantly since 2000 and this has impacted **where the under-immunised live**. Eighteen years ago, most of the under-immunised lived in rural communities beyond the reach of routine immunisation services. Efforts to extend services mean many of these communities are now being reached (although significant pockets of under-immunised continue to live in remote areas). At the same time, rapid growth of cities means that over 4 billion people now live in urban areas (nearly 50% more than in 2000), whose rapid and unplanned growth means public services are often not reliably available. As a result, a growing number of under-immunised live in urban and peri-urban areas including slums. Fragility is also a growing challenge with more under-immunised now living in fragile areas. For example, the number of state and non-state conflicts has almost doubled over the last ten years. Immunisation coverage in countries classified as fragile by Gavi has risen

by only two percentage points over the past decade, while non-fragile countries have seen coverage rise by 13 percentage points over the same period.

The Alliance continues to **adapt to these challenges**. Since our last meeting, we have launched an urban immunisation toolkit to help countries strengthen service delivery in these communities and updated our gender programming guidance to help countries overcome gender-related barriers to immunisation. We have also developed a new framework to enhance demand generation (Board members will have a chance to learn about this in a technical briefing at this meeting). This is an area where we are working closely with civil society partners. For example, the Secretariat recently organised a meeting to build the capacity of civil society organisations from countries including Angola, Congo Republic, Ghana, Nigeria, Chad and Haiti to help build political will for immunisation. We are also working on a number of innovative partnerships to address demand-side barriers to coverage and equity. These include a new partnership with Last Mile Health and Living Goods to scale-up community health worker availability and training.

We will need to continue to learn and tailor our support as we prepare for Gavi 5.0. ~40% of Gavi-supported countries will be home to nearly 90% of the under-immunised in the Gavi portfolio in the next strategic period, many of which face significant fragility challenges. Reaching these children will require new approaches including working sub nationally in large countries, and may require the Alliance to increase its investment, resourcing and risk appetite.

Delivering on the Alliance's sustainability model

This strategic period is the biggest test yet of the Alliance's **sustainability** model with the first wave of countries transitioning out of Gavi support under current policies. So far, the model is performing well. 16 countries have transitioned to date (though Congo's GNI per capita has fallen back below Gavi's eligibility threshold as discussed below). All of them are fully financing the vaccines they introduced with Gavi support. Eligible countries have continued to scale-up co-financing and increase their broader vaccine financing. The recently released annual report on the Global Vaccine Action Plan found that government expenditure on routine immunisation per live birth increased by 74% in Africa and 62% in South East Asia between 2010-11 and 2016-17. This trend is true even in some of the poorest countries. Following a high-level Alliance mission led by Anuradha last year, for example, Haiti paid its co-financing from domestic resources and budgeted for traditional vaccines for the first time in this period.

Despite progress on financial sustainability, there are **risks to programmatic sustainability** in some countries. Six transitioned countries saw coverage fall in 2017, which is a reminder that even if countries transition with high coverage there is a risk of backsliding. To address this risk, the Board approved continued Alliance engagement with countries post-transition, including providing targeted support where needed to address key gaps. The Board also asked for tailored strategies for five countries which it identified as facing particularly high transition risks. These are discussed further below. This demonstrates how the Alliance at

its best can anticipate risk, learn and adapt. The Alliance's future role in transitioned countries, and potentially some other middle income countries, will be an important question for our next strategy.

Sustaining donor support in a complex environment

Maintaining **donor** confidence and continuing to demonstrate that we deliver on our commitments will be critical as we prepare to develop our new investment case and launch our next replenishment. It was therefore heartening that DFID's recent annual review awarded Gavi an A on the main grant, an improvement on last year, and an A+ on grants to the International Financing Facility for Immunisation (IFFIm) and Advanced Market Commitment. In another positive sign, Brazil recently committed US$20 million to the Alliance through IFFIm, becoming the second BRICS donor to IFFIm and fifth BRICS donor to Gavi.

Nonetheless, we do face headwinds as we approach our next Replenishment. It will take place at the end of an 18 month period where GFF, Global Fund and the World Bank's IDA will also seek replenishment (Global Partnership for Education is likely to follow soon afterwards). Demand on donor budgets will therefore be greater than ever. There are also risks in some of our key donor countries. The impact of the UK's planned departure from the European Union in March 2019 is unclear but could affect the aid budget and the strength of Sterling. UK support to Gavi is hedged through 2020 but we are exposed to currency fluctuations thereafter. Some key Gavi champions – including Chancellor Merkel and Prime Minister Solberg who were both critical to our last Replenishment – have also faced domestic political challenges and the US political situation has shifted again. Other donors including Denmark, the European Commission, Italy and Sweden have, or may soon have, new leadership with whom we will need to establish relationships. Therefore, while we remain confident in our results and the relevance of Gavi's model, we cannot be complacent.

Reporting back on previous Board decisions

Tailored country strategies

Four of the five countries which the Board identified as being at particularly high transition risk are on the agenda at this meeting (see next section). The fifth was **Papua New Guinea** (PNG), for which the Board approved additional support last year. At the request of the government, this did not extend the transition timeline. At the time, we agreed to revisit this decision in 2019 in advance of the country's scheduled transition in 2020. I led an Alliance mission to the country in July to understand its progress and challenges, and how the Alliance can strengthen its support. Despite strong leadership from the Minister of Health, the country faces severe problems. These include devastating earthquakes earlier this year and an outbreak of vaccine-derived polio virus, which the country has been struggling to control since June. It also has ongoing outbreaks of measles and pertussis. These are symptoms of chronically-low RI coverage, which the country estimates fell by ten percentage points to 51% in 2017. Geographic and linguistic diversity, weak human resources and limited financial management capacity at national

and sub-national levels are particular challenges. The Alliance is scaling up its support. PNG's application to the Cold Chain Equipment Optimisation Platform was approved earlier this year and, with significant Alliance support, the country applied for HSS and a measles rubella (MR) campaign in September. While the applications were weak, an in-country independent review recommended the HSS grant contingent on key changes and proposed a revised MR approach with the vaccine administered as part of a planned polio campaign. Nonetheless, it is highly unlikely that the country will achieve high and sustainable RI coverage by 2020 given the challenges it faces. Last week, I received a letter from the Minister of Health formally requesting an extension of Gavi support. I look forward to discussing how we deal with this request at this Board meeting

At its meeting in December 2015, the Board approved a strategic partnership with **India**. The Programme and Policy Committee (PPC) reviewed progress at the midpoint of the partnership period, as envisaged by the Board decision (the paper is available on BoardEffect). The PPC noted significant progress against all four partnership objectives thanks to the strong leadership of the government, including Prime Minister Modi. Gavi HSS support has helped raise the proportion of children being fully immunised in eight focus states from 64% in 2013 to 83% in 2018 to date; 118 million children have been immunised so far through a Gavi-supported MR campaign; rotavirus vaccine is being rapidly scaled-up nationwide and pneumococcal vaccine (PCV) has been introduced for over 25% of the birth cohort. Domestic financing of Gavi-supported programmes and selected HSS interventions more than tripled to over US$270 million in a single year. India's demand has also impacted the vaccine market, contributing to Gavi saving over US$300 million for pentavalent vaccine, and over US$50 million for PCV.

India recently requested that Gavi share the cost of the recent significant and unexpected increase in IPV price, noting that otherwise this may force it to make trade-offs within its immunisation budget, it remains Gavi eligible and they are the only Gavi eligible country self-financing IPV. The country is also worried about anti-vaccine activists using the large price increase as an excuse to criticise the government's focus on expanding immunisation. The PPC recommended the Board support this request although there were some dissenting views. The Board will discuss this as part of the polio agenda item.

Gavi vaccine programmes

The situation in DR Congo is testament to the importance of having vaccine doses available to respond to **Ebola** outbreaks. Following notification from Merck of delays in submitting the vaccine for licensure, the Market-Sensitive Decisions Committee agreed to extend the timeline of Gavi's Advanced Purchase commitment. This will ensure that investigational doses remain available until the vaccine is licensed and prequalified, and a stockpile can be created. Since then, the US Food and Drug Administration has approved a rolling Biologics License Application (BLA) to support an accelerated review process for licensure.

Despite continued supply constraints, three Gavi countries (Senegal, Tanzania and Zimbabwe) have introduced **HPV** vaccine in 2018 and Ethiopia is scheduled to do so this year. However, a number of other countries have been delayed due to supply constraints. The leading supplier has committed to increase supply for Gavi markets from five million doses in 2018 to 20 million in 2019. However, there will be continued competition for doses. The US recently extended the age group for which it recommends the vaccine while the leading suppliers' product was also licensed in China earlier this year. With WHO having recently endorsed a goal to eliminate cervical cancer, demand may increase further and there is a risk that the poorest countries with the greatest burden may not be able to access the vaccine. The latest modelling suggests it will take at least 65 years to achieve elimination globally with current tools. In the meantime, the Alliance will continue to work with manufacturers to maximise the supply available to Gavi countries.

In December 2016, the Board approved an additional US$150 million for **yellow fever** to support the WHO's Eliminating Yellow Fever Epidemics (EYE) strategy. A key component of EYE is strengthening routine immunisation. It is therefore disappointing that the latest WHO and UNICEF immunisation coverage estimates show that average routine yellow fever coverage in the African countries at risk for yellow fever remains 36%, with no change for five years. There has been some progress in implementing EYE with a governance structure established and eight high-risk countries having submitted implementation plans. But continued outbreaks are a reminder of the need for greater urgency. The Alliance is supporting a campaign to vaccinate 1.1m people in Congo Republic in response to an outbreak in Point Noire, and another campaign in Ethiopia where a recent outbreak has killed 10 people. The latter is of particular concern since Ethiopia is at the edge of the area considered high-risk by WHO, has not introduced the vaccine in its RI programme and the outbreak is in a region affected by conflict which may complicate the response. Nigeria's outbreak, which we discussed at our last meeting, has been ongoing for over a year. The Alliance has supported five emergency campaigns and is supporting a mass preventive campaign at a total cost of over US$61 million. While only one confirmed case was detected between April and July 2018 multiple new cases have been detected since and the country continues to identify an average of 50 suspected cases each month.

Due to similarities in symptoms with other diseases, only a fraction of the cases being identified in Nigeria are actually yellow fever which is why robust diagnostic laboratory capacity is needed. Like many African countries, Nigeria has limited capacity for this, partly due to the lack of a commercially available test kit. The PPC therefore recommended that the Board approve the proposed investment in **yellow fever diagnostic** capacity, which could save lives, enable a quicker response to outbreaks and save limited vaccine supply.

We continue to see multiple outbreaks of **cholera**. In Yemen, which has reported over one million cases since April 2017, WHO is warning there could be a third wave of the epidemic. A number of other countries have recently applied for vaccines from the Gavi-funded stockpile including DR Congo, Laos, Niger, Nigeria, Uganda and Zimbabwe. In May, the World Health Assembly adopted a

resolution on cholera prevention and control, which aims to reduce deaths from the disease by 90% by 2030 and recognises the role of immunisation as part of an integrated control strategy. We will discuss as part of the Vaccine Investment Strategy (VIS) whether to extend Alliance support to endemic use of the vaccine.

One year ago, the Board approved the opening of a window for **typhoid** vaccine, which was recommended in the 2008 VIS. Zimbabwe has become the first country to use the vaccine with Gavi support in response to a drug-resistant typhoid outbreak in Harare. Pakistan is expected to become the first country to introduce the vaccine routinely in 2019. Many other countries have indicated interest and we expect that demand will scale up rapidly over the next few years.

Agenda for this Board meeting

Following positive feedback from Board members at our last meeting, we have maintained the new meeting structure with a more integrated strategic update on our first morning, prioritising decision items on the agenda and clustering them thematically, and with routine updates towards the end of the meeting. We have a very full agenda so have sought to make as much time as possible available for decision items, while several decisions recommended by the PPC are on the consent agenda (see below). My report is also a bit longer than usual to provide an update on items that previously would have been in the Alliance Update.

Finance and Risk-related decisions

As usual at the end of year meeting, the Board will approve a new **financial forecast**. To help newer Board members understand the Alliance's finances, the Secretariat will hold a technical briefing on the day before the Board. The Board will also consider a request from the Government of Norway to use **IFFIm** to frontload its contributions to the Coalition for Epidemic Preparedness Innovations (CEPI), another organisation working on vaccines for developing countries. The end of year meeting is also when the Board approves the **Risk & Assurance report**. While we will discuss risk throughout our two days, this is an opportunity to review the Alliance's overall risk profile which remains largely stable. At the Board's request, we will also discuss how the Alliance manages **fiduciary risk**, and options to reverse the recent trend whereby a declining portion of our cash grants is being disbursed directly to governments due to risk considerations.

Shaping our future strategy and programmes

At this meeting, we will discuss the changing context, key considerations and emerging questions for our **2021-2025 strategy**. Based on the Board's guidance, the Secretariat will prepare a more in-depth discussion with specific proposals for options at the Board Retreat in March next year. Gavi's original mission – to accelerate introduction of new vaccines – will likely remain a core component of our next strategy and the **VIS** proposes that Gavi extend support to a number of new vaccines. The PPC endorsed the VIS recommendations, while noting that it will be important to consider the implications as we decide on the parameters of our 2021-2025 strategy in June 2019. The PPC also recommended the Board

approve funding for a learning agenda for **pandemic influenza**.

Gavi's future role in **polio** has also been assessed as part of the VIS. It is highly likely that the timeline for eradication will be further extended given that a recent Independent Monitoring Board (IMB) report found polio eradication efforts have stalled with twice as many wild cases to date in 2018 as in 2017. Most PPC members felt that Gavi should continue to fully fund IPV for all currently-supported countries after 2020 given the importance of the vaccine as a global public good to achieve and sustain polio eradication. However, some felt that wealthier Gavi countries should contribute to the cost. As polio was not part of the Berlin Investment case we will need to discuss the implications of taking on this mandate to ensure it does not compete with other parts of the Gavi agenda.

In June, the Board approved an extension of **Nigeria's** transition timeline and an investment of up to US$1 billion. Its progress will be a critical success factor for our next strategy. The encouraging news is that after many years of investments by many partners – and particularly intense focus from the Gates Foundation – there are early signs that coverage may be beginning to improve in northern Nigeria. It will be important that we build on this momentum, working with all partners in Nigeria. We will discuss a draft of the accountability framework for our investment at this meeting although this is less advanced than we had hoped since the Board was clear that there should be no work on it until the government fully reimbursed the misuse of past Gavi grants, and this only occurred in August.

Consent agenda

The PPC reviewed costed post-transition plans for **Angola, Congo Republic and Timor-Leste**, as requested by the Board. These proposed to extend the investments approved at the last Board meeting and to add some additional support in Angola and Timor Leste (e.g. polio transition and civil society advocacy for immunisation at national, provincial and local levels in Angola, and pneumococcal vaccine and HPV vaccine introductions in Timor-Leste). These changes would require a further US$10 million, in addition to the US$ 20 million already approved by the Board for these countries. The PPC was supportive of this request. The PPC also discussed a post-transition plan for Congo Republic but this may no longer be relevant since the latest World Bank data shows Congo Republic's gross national income (GNI) per capita has fallen significantly below Gavi's eligibility threshold. While Congo's three-year GNI per capita average remains just above the threshold, growth projections from the International Monetary Fund suggest that Congo will regain eligibility in 2020. Therefore, the PPC has recommended that the Board make Congo Republic eligible again in 2019 and increase its HSS ceiling to US$10 million in line with the proposed plan.

Syria is another country which will become Gavi-eligible, having been classified as a low-income country by the World Bank in July. It is the first new country to enter Gavi eligibility since the eligibility policy was introduced, underscoring the devastating impact that years of conflict have had. The exceptional support approved by the Board for 2017 and 2018 has helped increase immunisation

coverage, address outbreaks of vaccine-preventable disease and begin to rehabilitate the cold chain. The PPC recommended that the Board provide a no-cost extension to this support in 2019, while the Alliance works with the country and other partners to develop a fuller application for Gavi support.

The PPC also recommended changes to the Health Systems & Immunisation Strengthening framework to help countries in efforts to control **measles**. While measles deaths are at record lows, there is a resurgence of cases globally with every region except South-East Asia reporting more cases in 2018 to date than in 2017. Europe has reported the highest number of measles cases in a decade and the Americas, the only region to have eliminated indigenous transmission, has lost its elimination status. A key problem is inadequate routine immunisation coverage. While 95% coverage is needed to control measles, this has stagnated at 77-78% since 2010 in Gavi countries and declined in the 20 Gavi priority countries. To control outbreaks, respond to global guidance and pursue measles elimination goals, countries are applying for and conducting frequent nationwide measles immunisation campaigns. These are expensive, can disrupt routine health services and often do not achieve the necessary coverage. This negative spiral of low routine coverage, inadequate campaigns and ongoing transmission requiring further campaigns is very destructive. As recommended by the Independent Review Committee, the proposed changes are designed to help countries conduct more targeted, sub-national campaigns and use the funding saved for enhanced routine immunisation activities.

Key developments at Secretariat and partners

We are delighted to welcome a new **leadership team on immunisation at WHO** including serving Gavi Board member Kate O'Brien, who will be the new Director of Immunization, Vaccines and Biologics. Ann Lindstrand has also joined WHO as the new EPI Coordinator, a post which had been vacant for several years. They will attend this Board meeting and we look forward to further strengthening our partnership under their leadership.

We continue to work to improve the **health of the Alliance** more broadly. After our last Board meeting, we held a retreat with staff from the Secretariat and core partners' offices from across the world. This identified a set of priority initiatives to address some of the challenges identified in the Alliance Health Survey. These include new collaboration tools, more opportunities for staff to work from each others' offices and team building activities at regional levels and are now being rolled out. The World Bank did not participate in the last survey but does plan to participate next time and we are working to strengthen our relationships. Since our last meeting I have had two meetings with Kristalina Georgieva, the CEO of the World Bank who is also keen to enhance our joint work.

Transparency is a core principle of the Alliance and we have worked hard over recent years to meet the recommendations of the Aid **Transparency** Index. In 2018, we have again been rated as "good" alongside UNICEF, the Global Fund and many of our donors (Canada, the European Commission, Germany,

Netherlands and Sweden). While this is welcome news, we were disappointed not to be rated “very good” given the substantial investment that the Secretariat has put into meeting the requirements (such as publishing 78 different data sets on a monthly basis). We have sought to better understand from the authors what we can do to achieve a very good rating especially on some qualitative indicators where the assessment methodology is unclear, but have been unable to obtain specific feedback. From discussions with peer organisations, it seems we are not alone in facing this challenge which raises the question of whether we should continue to invest in responding to the requirements of the index given the lack of clarity on the methodology, weighting and some of the key indicators being used.

One change that will impact future how we report our data in future is the implementation of a new **Enterprise Resource Planning system** for the Secretariat. This is needed due to our existing software approaching the end of support. This is a major investment that should provide an integrated finance system, consolidating many legacy tools and with the ability to align and integrate with other internal and external systems. It will impact almost every area of our business and we are taking the opportunity to review and improve our processes. The programme, which is currently in the design phase, is requiring significant engagement across the organisation to ensure that it delivers value within the approved investment. Given the magnitude, importance and risks associated with this programme, the Audit & Finance Committee is receiving regular updates.

In my June report, I highlighted the growing number of **governance** meetings. This has continued and it is likely that this year we will hold around 50% more meetings than planned. The trend has been exacerbated by some Committees meeting more frequently while others have created specific sub-committees. It is our role as a Secretariat to serve the needs of our governance bodies but it is proving challenging, both for us and some Committee members, to manage the increased frequency of meetings, many of which were not on the workplan. I would welcome a discussion with the Board about this trend and what more we in the Secretariat can do to help address it.

In recent meetings, Board members have expressed an interest in the welfare of **Secretariat staff**. I am concerned about the growing workload that many teams face. FIND and the growing number of governance meetings are two examples of activities that are impacting staff workload. There are also external drivers such as the many efforts to enhance coordination in global health. This issue was reflected in our 2017 Gavi people survey, where over half of staff believed that there were insufficient staff in their team to handle the workload. It was also highlighted in the 2016 Ombudsman report which identified a “culture of overwork at Gavi. Whilst we have managed to keep our budget flat over this cycle, there is a growing strain within the Secretariat. We will have an opportunity to discuss this as part of HR Annual Report in the closed session.

In the same discussion, we will provide an update on our efforts to strengthen **safeguarding** in the Secretariat. As I mentioned in my last report, this is an issue we take very seriously. Since then, we have had an in-depth discussion on how

we strengthen our controls at the Secretariat leadership team retreat in September and are now rolling out a mandatory training on dignity at work (which we developed jointly with the Global Fund) to all staff. I am also delighted that the Gavi Secretariat has become the first international not-for-profit organisation to obtain certification from the EQUAL-SALARY Foundation demonstrating our commitment to offer equal salary to women and men.

***

As Gavi enters its 18th year, and the first children immunised with Gavi support prepare to enter adulthood, the Alliance itself is coming of age. We have demonstrated the power of the Alliance model, uniting all key stakeholders in immunisation to deliver what no single organisation alone could achieve. Our development model is also now proven including our ability to mobilise domestic resources through co-financing and transition, and our ability to shape markets for vaccines and other health commodities. But what makes the Alliance truly special is immunisation itself. There is no more cost-effective way to save lives and protect people's health. It is one of the first health interventions that we each receive after birth and one of the very few that every single person on the planet should receive. And we are getting closer to the goal of true universality. Nearly 27 million more children received a full course of DTP-containing vaccines in 2017 than in 2000 (80% of those additional children live in Gavi-supported countries), and 90% of children now receive at least one dose of the vaccine (even more are reached if you include campaigns). If we continue to invest, learn and adapt, it is possible that immunisation could become the first health intervention to reach every single child by 2030, truly delivering on the aspiration of the Sustainable Development Goals to leave no one behind. This is the first step towards universal primary healthcare. And as we extend routine immunisation services to reach the unreached, we are building a foundation to deliver nearly all other primary healthcare services as well as strong and resilient health systems, which are the first line of defence against disease outbreaks.