Report to the GAVI Alliance Board

12-13 June 2012

Report of the Chief Executive Officer

5 June 2012

Dear Board Members,

Our Board meeting next week in Washington DC will occur around the UNICEF/USAID **Child Survival Call to Action**. As you may recall, this special event started out as an immunisation meeting around the one year anniversary of the GAVI pledging conference, but now is much broader. We will of course attempt to use the opportunity to highlight the important role of immunisation in preventing child illness and deaths and have joined with the UN Foundation to hold a side event to celebrate the anniversary of the pledging conference and all of the work that has gone on since then.

Immediately after our productive Board retreat in Oslo, Dagfinn joined the celebrations in **Haiti** of World Immunisation Week, and I visited **Ghana** for the simultaneous launch of pneumococcal and rotavirus vaccines. Dagfinn was struck by the intensification of a vaccination campaign against measles, rubella and polio by Haiti's Ministry of Health as they also prepare for the roll out of pentavalent vaccine later this year. For me, the excitement of people in Ghana was palpable; there's strong national commitment to achieve high and equitable coverage. It was also great to see so many members of the Alliance represented, all playing their part in supporting Ghana in taking a giant step for its children. We will be carefully evaluating the simultaneous introduction to see what we can learn, including whether simultaneous introductions should be more widely encouraged.

This month, we also saw the adoption of the **Global Vaccine Action Plan** of the Decade of Vaccines by the World Health Assembly. Discussion emphasised the centrality of immunisation in public health and health systems, and the importance of using existing mechanisms was highlighted by several member states, as was their support for GAVI. The resolution called for progress to be assessed annually by the WHO regional committees and the WHA, which provides a useful opportunity to keep vaccines as a top priority on the global health agenda.

Achieving our mission

The GAVI Progress Report for 2011 sets out what we achieved together in the first year of the strategy period including a fuller data picture than ever before. It shows that we are generally on track to meet our ambitious goals — although we will have to work hard to overcome some of the vaccine capacity issues discussed below. Regardless, I think the report is a clear message of our shared obligation to deliver on our existing commitments under the 2011-2015 strategy — our first priority. The report has been sent to you and an animated electronic version will soon be available on the website.

At its meeting in Dhaka at the end of 2011 the Board asked the secretariat to prepare a paper analysing the landscape of options facing the Alliance, so that the Board could better understand the context for individual decisions and also their opportunity costs. We had a rich discussion on these during the retreat in Oslo in April, which has helped to set GAVI's agenda at this meeting and in the future.

While our business model has achieved impressive results to date, we need to further strengthen it as we significantly step up the pace of vaccine introductions. The risks that emerge from our tracking of the indicators are set out in more detail in the business plan paper, but the particular areas I would flag are the need to improve the quality of introductions and subsequent performance with real time evaluation of the roll outs — including monitoring coverage, vaccine wastage and data quality — all with a focus on how we are performing where it matters most: at the country level. Our approach now needs to be conditioned by the facts that we are now supplying vaccines which are more powerful and expensive than before, and which are at least in the short term, supply constrained.

In discussions with the Board and Executive Committee, and as I flagged in my CEO report to the Board meeting in Dhaka, a process of reviewing our business model for delivering in and with countries has begun. This process is now being driven by a time-limited **cross cutting country team**, with staff from departments and skill sets across the secretariat, supported by an expert in change management and organisational development. The team's approach is to work with people at the operational level, particularly in countries, to get an overview of the key processes, to scope the issues and identify possible solutions (decisions on which will be taken through the usual governance mechanisms), rather than starting with solutions and then consulting. Deploying staff in this way inevitably puts additional pressure on the secretariat and on partners who are giving their time to the exercise. However, I believe that it is better to have our approach embedded and worked through from the outset, rather than employing a team of external consultants to produce a report. Overall, my aim is to make changes incrementally, in discussion with partners and where appropriate the Board, recognising that this is a system that needs to keep delivering as changes are introduced — although where issues are identified that we can address quickly, we should of course do so. In establishing the cross cutting team, I asked them to think outside the box — however, I also put some parameters around their work, including that we need to maintain the fundamentals of the Alliance. So we need to continue to work with Alliance members and others rather than establishing secretariat offices in countries, and I also emphasised our priorities of sustainability and country ownership.

This process is linked to but separate from the revision of business plan priorities and the next two years' budget. The business plan focuses on deliverables and the consequent allocation of resources, while at this stage the cross cutting team is looking at the overall processes and systems, and each of the interdependent systems within this which make up the business model.

Naturally the emerging picture will be familiar to those who have worked with GAVI for some time. The starting point is that like any business, GAVI needs to take an overview of its **supply chain**, and the flow of goods (vaccines), information (on supply and demand) and money through the chain. The various parts of the chain are in the hands of different partners of the Alliance, and indeed different units within

partners. The strength of this chain depends upon the **quality of information flows** along the chain, and upon timely decision making about money and goods.

Taking the first of these issues, naturally we are operating in a field where no-one has perfect information about the supply of vaccines or the demand situation. However, it is apparent that we are not currently making the best use we could of the information that is already in the system and that could potentially be available to decision makers, including in some cases real time information. For example, the Alliance has a dual role in supporting countries to be ready to introduce vaccines (or to provide health systems support), and also in assessing country readiness. Both of these require much more systematic and rapid feedback of information than is currently provided.

We need to make clearer distinctions between the approval process for applications and the planning process for money and vaccine supply. Our assessment of the number of doses a country needs and the timing of a launch should be based upon operational discussions within the Alliance — particularly with countries — rather than on the formal approval of a programme which might be some years in advance of introduction. I am not at present confident that we have in place systems to set the right targets for the number of doses for countries, and I do not see sufficient evidence of the routine robust dialogue we need on this vital subject. Better information flows are also needed after vaccines have been introduced. Our current tools — Annual Performance Reviews and Post Introduction Evaluations — are useful, but not timely enough.

Of course GAVI is not an ordinary business, either in its mission or its structure, and efforts to strengthen our systems need to take account of the character of the Alliance. I do not want to prejudge the outcome of the work going on with partners through the cross-cutting team, but I think there are some relatively quick wins in terms of the information systems we use to share information across the Alliance, for example the practice of communicating through letters, the information from which is then keyed into databases, rather than communicating through shared databases. But much of the information required might not be hard data but the judgement of people at the operational level, and therefore what we need to establish are approaches that encourage conversations between the right people at the right time, rather than necessarily new information technology systems or formal reporting and controls. In all of this, we need to be clear that our primary focus is helping countries manage their systems better, rather than creating parallel reporting mechanisms.

On the issue of **timely decision making**, I believe we can strengthen our processes, and the Board has before it a proposal to do so, in the Amendment to the Programme Funding Policy (document 6). The proposal will allow the secretariat in discussion with partners to manage small changes in demand or price, within a Board approved envelope. At present, for example, a small change in vaccine price or a shift in the allocation of supply requires a new approval process from the IRC and then the Board or EC. For example, Angola's date for the introduction of pneumococcal vaccine shifted to October 2012 from earlier in the year, changing the profile of doses required in 2012 and 2013, and creating a need for an additional approval process.

The other driver for this proposal is the fact that we accept applications for the health systems funding platform on a rolling basis — to better align with the country's planning cycles, requiring frequent Board or EC meetings to consider these proposals

after IRC review, often for relatively small sums. Board members have often told me and it was also a conclusion of the Board's self-evaluation that the Board's time should be used more efficiently, and meetings should be used to consider more strategic issues. The Audit and Finance Committee has recommended for Board approval a proposal which the Board would still make overall decisions about new vaccine introductions, but would provide the secretariat flexibility and allow for more timely decision-making in relation to cash programmes and extensions and adjustments to vaccine programmes within a Board approved envelope.

Progress update

A key risk is the short term availability of some vaccines.

The application round which was launched after the 13 June 2011 pledging conference had an unprecedented number of applications, partly because the Alliance has been successful in making the case for immunisation particularly with two new vaccines targeting two of the largest killers of children and in working with countries to prepare for introductions, and partly because of the deferral of decisions on new applications which occurred in 2010. Just as it is better for countries to have a long term perspective to plan introductions and the management of their immunisation systems, so vaccine suppliers need a reliable long term forecast of demand to meet supply. Because vaccine production is — rightly — a highly regulated business and scale up in even the most controlled situations often encounters delays, production schedules need to be established well ahead of time. As I set out below, we are working in the medium term to provide the manufacturers with a high degree of predictability, and in return are achieving better prices and reliable supply. However, in the short term, we face insufficient available capacity to meet new demand and this means that in some cases we will have to work with countries to delay or phase introductions. More details are in the Accelerated Vaccine Introduction update (document 15).

For **rotavirus** vaccine all countries approved and planning introduction in 2012 should be able to introduce, although some with phased introductions. Ghana and Rwanda also introduced rotavirus vaccines in the first half of this year, for a total of nine countries now implementing rotavirus vaccine programmes with Alliance support. However there will be a temporary capacity availability shortage situation in 2013 that cannot be eliminated completely.

For **pneumococcal** vaccines, current analysis indicates 10 countries approved will be able to introduce in 2012. A delay in approval of the two dose presentation of pneumococcal vaccine has now been resolved with the pre-qualification of that presentation — although there will be a requirement for additional training with its use. Close follow up with suppliers regarding additional supply is on-going and recent information indicates a possible improvement in the situation which will require additional procurement of doses. One of the issues on the demand side is that some of the countries which have introduced pneumococcal vaccine so far have in effect done mini catch up campaigns, by immunising children under one year of age rather than those children eligible for doses at 6, 10 and 14 weeks. Supply for pneumococcal vaccine remains tight in 2013. However we are optimistic that we will be able to introduce in some of these countries including through phased roll outs in some countries.

We are using our market power to **shape the market** and to ensure that in the medium term there is greater supply at a better price. In April we announced the establishment of rotavirus vaccines supply agreements and highlighted that the bulk of the vaccines were procured at 67% lower than the previously available public price; a market impact valued at US$650 million.

GAVI continues its **pentavalent** programme with 65 countries reached by end 2011. In late 2011, two states in India launched pentavalent vaccines, and GAVI has received requests to support introductions in a further six states. Haiti and Nigeria have now integrated pentavalent into their infant immunisation schedules, with four more countries — Timor-Leste, Myanmar, North Korea and Somalia — due to introduce this year or in 2013. Now that almost all GAVI-eligible countries have introduced pentavalent vaccine, the distinction between "traditional" and "new" vaccines is no longer clear.

I would like to flag an issue to the Board which might seem obscure but which represents a serious risk to vaccine supply. **Thimerosal** is an organomercury compound used in the production of some vaccines and as a preservative in multi-dose vaccines, including pentavalent vaccine. Although WHO and other regulatory agencies are clear that thimerosal is safe for use in vaccines,[1] it is potentially subject to a treaty on banning all mercury being considered by the UN Environment Programme which could inadvertently ban the use of thimerosal in vaccines and vaccine production. If such a ban were introduced, vaccine production would be disrupted, and it would not be possible to supply multi-dose vials until another preservative could be found and approved for each vaccine — which could take years, and be very expensive, and single dose vials would overload the cold chains of many countries. The next meeting of the key intergovernmental negotiating committee will take place in Uruguay from 26 June to 2 July. We have been working with WHO and other partners to make sure that the case is made. This negotiation represents a significant risk to vaccine supply and I would urge all of those involved or potentially involved to make sure that supply of vaccines to GAVI-eligible countries is not disrupted.

The Board in November 2011 opened a funding window for **HPV** vaccine provided that GAVI secures acceptable price reduction commitments for HPV and that proposals demonstrate the ability of the country to deliver HPV vaccines to the new target population, including through a successful demonstration project and that a communication strategy is in place in that country. Prices are not published until the supply tenders are completed but I have received indications that at least one supplier has offered an acceptable price reduction.

GAVI launched the guidelines for country applications for national introduction of HPV vaccine in April. As HPV is a new vaccine preventing cervical cancer and delivered to a new target group — adolescent girls — and because introduction of HPV vaccines presents a unique opportunity for countries to deliver other health interventions for adolescent girls, we have been working with a wide array of stakeholders from immunisation, reproductive and adolescent health, education, and

[1] All studies have shown thimerosal to be safe. However, the anti-vaccine community has made this a major controversy by claiming that too much mercury is poisonous. However, thimerosal is broken down into Ethyl-mercury, which is easily excreted and has a much better and different safety profile than methyl-mercury implicated in mercury poisoning.

cervical cancer communities to develop the HPV programme. Surprisingly, despite the opportunity and obvious benefits to reaching adolescent girls with important public health interventions, there has been muted interest from many in the public health community in combining interventions.

Countries that have demonstrated capacity to roll out the vaccine to adolescent girls can apply for national introduction of HPV – applications will come to the IRC later in the year. For countries that do not have this capacity, a demonstration programme is being developed to allow countries to learn by doing. There has been enormous interest in this vaccine. As of today, 13 countries are forecast to have demonstration programmes by 2015, and six countries are forecast to introduce nationally by 2015.

US$445m of funding for 54 countries has been approved by the Board for **health systems**, with US$358m so far disbursed. As part of the Board's 2011-2015 strategy, health systems funding is measured through its impact on immunisation outcomes. It has taken some time to adapt the approach required in new applications and to re-programme the existing portfolio, but I now have greater confidence that this adaptation is underway. In general the quality of applications in the 13 received since the end of last year has improved, which is a tribute to the countries concerned and to the work with partners, including peer review in WHO's Africa region which is a welcome innovation I would encourage other regions to emulate. However, at the May IRC review, of the nine countries reviewed, five have been asked to provide clarifications, and four applications have had to go back to countries for re-submission, one for the third time. This is unacceptable and suggests that we are not providing countries the level of technical assistance required. Suggestions from the Health Systems Funding Platform IRC have been discussed at the PPC and will be incorporated into future rounds.

Designing a health system strengthening programme requires an iterative process involving countries and partners, involving an assessment of the health system framework, constraints to immunisation programmes, and judgments about the comparative advantage of partners, while making sure that the government remains in charge of and responsible for the programme. This approach requires on-going engagement, rather than an "apply, approve, fund" approach. It also requires that health systems planners collaborate with immunisation managers at all levels. Implementation support needs to be strengthened, through existing or if necessary, new partners and evaluation tools need to be incorporated. I have created a new Technical Advisory Group on Health System Strengthening to provide advice to me. I was delighted that Anders Nordström, as a well-known and respected health systems expert, accepted my invitation to be chair despite his other commitments. This group, consisting of independent health systems experts as well as those from partners, will help to ensure that we have the best possible expert advice on health systems, and that our approach is based on the plurality of sources of technical assistance that countries now want. This group will also be critical to advise on the tailoring of HSS programmes, including in relation to performance based funding.

Although we have rightfully focused on initiating vaccine roll-outs, it is critical that GAVI also focuses on two other areas highlighted in our business plan: the sustained introduction with high coverage and equity as well as our work on low performing

countries.[2] Although a stated priority, work in these low performing countries has not proceeded fast enough to meet the targets in our business plan. We are recommitting to making this a priority for the Alliance with accelerate engagement starting with a focus on Chad and Uganda (and see below on DRC and Nigeria). I am planning on visiting one or more of the under-70% countries with other Alliance leaders in the coming year, as a way of intensifying focus on this issue.

Working with the countries concerned to increase their DTP3 coverage is one element of our approach to **sustainability**: this issue is relevant to all GAVI countries, particularly as they graduate or approach graduation. A large part of our work in this area relates to political will in countries. If immunisation is a sufficiently high priority for the health minister but also the head of government and finance ministers, then many things become possible. We need both a tailored approach to this and also a systematic effort to work with GAVI-eligible countries. The Immunisation Financing and Sustainability task team has agreed on priority countries, which are facing sustainability challenges and we have contracted with the African Development Bank and the Sabin Institute to assist us. The Alliance has had some success in helping to stimulate that political will in India, Nigeria and DRC, but we need to go further, with these countries, and more generally.

Following an offer made by the World Bank at the London pledging conference, the Bank will support an event at its October Annual Meeting in Tokyo to help create a common understanding among Finance Ministers of the value of immunisation and support for sustainable financing of it. The African Development Bank meeting of Ministers of Finance and Health in July 2012 in Tunis will also be important in building the case on these vital issues.

The Board agenda

In addition to the Amendment to the Programme Funding Policy outlined above I will summarise some of the key decisions for the Board at this meeting.

I would like to flag a new practice which we discussed at the Board retreat and we are proposing to initiate for this Board meeting: the "**consent agenda**." It is common at Board meetings that while serious discussion is needed on some items, others have been well discussed by the Board's committees and are ready to be approved with little or no discussion. We are attempting to predict in advance of the Board meeting which items this might be – the agenda for the June meeting contains: the Ethics and revised Conflict of Interest Policies, **Board and Committee Member appointments** and the Evaluation Policy. In Dhaka the Board requested more time to consider the proposed **Ethics and Conflict of Interest Policies**, and following further feedback from Board members, the Governance Committee has now recommended that the Board approve the proposed policies. The Governance committee has reviewed and recommended the slate of appointments. The Evaluation Advisory Committee has

[2] Underperforming countries are defined by GAVI as those with a DTP3 coverage of less than 70%. The WHO/UNICEF 2010 estimates for these countries are: Somalia 45%; Central African Republic 54%; Papua New Guinea 56%; Guinea 57%; Chad 59%; Haiti 59%; Uganda 60%; Democratic Republic of the Congo 63%; Liberia 64%; Mauritania 64%; Afghanistan 66%; Nigeria 69%. DHS surveys also indicate that other countries' actual DTP3 coverage may be below 70%; this is a priority issue in our work on data quality.

recommended some refinements to the original **Evaluation policy** approved in 2008. In particular, the revised policy addresses the role of countries and in-country institutions as well as the evaluation of the partnership dimension of the Alliance. I hope that the Board will find the consent agenda is an efficient way of conducting business, and that the Board will be able to accept the Committee Chairs' advice on these issues. Obviously, any Board member can ask for clarification prior to the meeting or pull items off the consent calendar if there are additional questions or different information requiring discussion at the meeting.

At the end of 2010 the Board approved a five year strategy and **business plan** with a two year budget. At the December Board meeting, the Board will be invited to consider a refined business plan and budget for 2013-14. The Board is asked at its meeting in June to consider the priorities which should be taken into account refining the business plan deliverables and associated activities and budgets for 2013-14. These priorities are based on lessons from the first two years of the strategy, one-to-one discussions with Board members, and workshops held with partners on the strategic goals.

As a follow-up to the Board retreat discussions, the Governance Committee has recommended some changes to the **By-laws and Executive Committee Charter** to formalise the change in composition and function of the EC as well as the representation of constituencies on Board Committees. I would like to thank the manufacturers for their support of the proposed approach of having their representative seat move off the EC so that commercially-sensitive issues can be assigned and discussed in that Committee without any actual or perceived conflicts of interest. From my point of view, it was a sign of the strength of working relationships that we were able to have these conversations and make these changes to improve the functioning of the Board. I would also highlight that it continues to be important for the Alliance that developing country voices are well represented on the Board and its committees.

The Alliance has in the past made a significant contribution to tackling **measles** including supporting the measles initiative, strengthening health systems, providing measles second dose and using measles as a trigger for performance based finance. In Dhaka, the board opened a new window for support for the Measles-Rubella (MR) vaccine, and we are working with the (recently renamed) Measles Rubella Initiative to produce strategies to reach children with the combined vaccine through campaigns in countries that introduce MR into their routine immunization programmes. We forecast that 32 countries will introduce MR by 2015, but we are still evaluating potential supply constraints during the peak introduction years.

The Board retreat gave a clear message that we should go further than these existing plans to help improve measles coverage in advance of the increase in MR campaign introductions. We have responded to that discussion by putting together a proposal to support campaigns in the countries at risk, to provide funding through the Measles Rubella Initiative to deal with outbreaks, and — given the importance of measles as an indicator of country's support for routine immunisation — add an indicator for measles coverage as part of GAVI's strategy. The options presented (document 12) are around the funding mechanisms used to purchase vaccines and to provide operational support to vaccines, and range from simply transferring funds to the Measles Rubella Initiative, to using GAVI systems, to a hybrid model.

My advice to the Board is that we should move to a position where, over time, efforts to tackle measles are better integrated with other immunisation activities, with an increased emphasis on routine immunisation. Using GAVI systems will help to do this, while continuing to use the systems the MR Initiative has developed for responding to measles outbreaks.

My understanding is that the Initiative has been an effective mechanism. The Initiative's position is different than the recommendation in the Board paper, taking the view that GAVI funding should use their established systems, which was the approach taken from 2004-2008. The Initiative's reasons for this are set out in their own words in an annex to the Board paper.

This is a sensitive issue as it affects relationships with partners, but we should take a clear decision at this meeting as improving our response to measles is indeed urgent. Whatever decision the Board takes, I hope that it will be possible for all of those involved in helping to tackle measles to work together to meet our shared goals.

From GAVI's earliest days, **vaccine introduction grants** have been provided to make a contribution to the costs of launching new vaccines. Consultations with countries and experts have provided evidence that the timely provision of these funds makes a difference to the success of an introduction, but that the current contribution is insufficient. The PPC recommends that the Board approve an increase in the grants. The principle remains that GAVI is making a contribution to the introduction costs, with the remaining introduction and recurrent costs the countries' responsibility. As noted above, the 2011-2015 Strategy decided that cash programmes should be measured through their impact on vaccine outcomes, and this increase in the vaccine introduction grant will contribute to this. Based on current expenditure levels, this increase can be accommodated within the range 15-25% of total expenditure on cash programmes mandated by the Board.

In 2008 GAVI allocated $11.2m to applied research projects managed by the AVI Technical Assistance Consortium that were necessary to increase the effectiveness of vaccine introductions. By the end of 2012, the majority of these projects will have come to an end and recognising this, at its meeting in Dhaka the Board asked for a **strategy on special studies** to be produced. An expert group was convened to help define questions that are essential to GAVI's mission, and are unlikely to be funded through other mechanisms. The group also helped to map other research underway and funding for research. Using the work of the group, and as part of the business planning process we will identify special studies which should be considered for funding 2013-15, and these will be brought back to the PPC and ultimately the Board.

The Board is invited to support the PPC's recommendation that five studies be funded in advance of the business planning process. The two large studies are a continuation of impact and effectiveness studies of pneumococcal vaccines in South Africa and Kenya. These long term studies are expensive to design and to implement — and will provide the earliest possible results of PCV 10 and PCV13 effectiveness in African countries. If they are allowed to lapse, it will be very difficult to restart them and the earlier investment will not be fully reaped. Two other studies are on the effectiveness of the two formulations of rotavirus vaccines. One new study is also proposed which was requested by the PPC given the recent SAGE recommendation to remove the tight age restriction on the use of rotavirus vaccine. This package of

funding is recommended on the basis that these studies will provide important operational evidence on the roll out of pneumococcal and rotavirus vaccines which will make a difference to the Alliance's work on these vaccines. As a former researcher I am of course interested in this work but I am also clear that GAVI needs to be selective about its involvement in applied research, based on the operational needs of GAVI's programmes, critical gaps in research taking account of the field as a whole, and the Alliance's comparative advantage as a convener in the vaccine world.

Civil society plays an important role in advocating for higher levels of immunization coverage with an equitable distribution as well as helping to achieve better coverage in some areas. The Board has before it a recommendation from the PPC on cash support for **civil society organisations**. The recommendation brings together two priorities — first, making sure that GAVI's cash support is wherever possible part of an integrated approach led by countries' governments as part of plans agreed with relevant stakeholders, and secondly recognising that in exceptional circumstances we may need to fund CSOs directly. The issues around this question have been well debated around the evidence from evaluations.

Further to the discussion in Dhaka about removing the **GAVI Fund Affiliate** (GFA) from the IFFIm structure, the Audit and Finance Committee recommends that the Board approve a decision that GAVI should perform the activities previously undertaken by the GFA. There are no additional risks with this move, and there will be significant efficiency gains

A year on from the 13 June pledging conference

In light of the uncertain economic environment, the need to secure timely receipt of pledged funds, ensure extension of short-term pledges, meet the matching grants challenges, and seek new donors, resource mobilisation remains a strong focus. If demand materialises to the full extent currently projected (and there is naturally some uncertainty in this), and the current level of pledges is maintained into 2015, then $131m of additional resources will be needed for future programmes in 2015. If the measles proposal that is before the Board is adopted, that would require a further $140m through 2015. These needs can be met by pledge extensions from donors who pledged only for a part of the period up to 2015, those who may be able to provide additional funds, and by meeting the matching grants challenges with new public and private donor pledges.

The following five years, 2016-2020, are the focus of planning for a long-term funding model and strategy. I provide an outline below of how we will go about securing our financial position beyond 2015, including the objective of securing sufficiently long-term and flexible funding. Proceeds from IFFIm and the AMC, although lower after 2015, already provide some base, and could be enhanced through re-financing. In addition to rising co-financing contributions, other contributions are currently at a level of $1.1 billion per year — I would stress the word "currently," as direct contributions are in most cases pledged up to 2015, but not beyond. Although projections this far out are necessarily highly tentative, we expect that this would need to grow to about $1.4 billion per year in 2016-2020. Our approach should remain one of collaborative replenishment with the burden being shared between donors, country co-financing

and effective market shaping. The former will require a strong focus on multi-year commitments and funding that can be flexibly deployed.

Over the past year, GAVI has participated in multilateral aid reviews by Sweden (released in October 2011) and Australia (released in March 2012) with very positive results. GAVI is working closely with the Multilateral Organisations Performance Assessment Network (MOPAN) that is currently carrying out an evaluation of institutional effectiveness of GAVI. The **MOPAN** gathers 16 OECD-DAC donors, including 12 GAVI donors, representing 65% of GAVI's funding. This assessment is led by France and the final report is expected by the end of 2012. GAVI is committed to aid effectiveness and welcomes such performance reviews, which provide an opportunity to take stock of progress and identify areas to strengthen its business model. I would also note that these reviews come with sometimes significant workload for the secretariat, as well of course for the donors, and I hope that as far as possible GAVI donors will rely on the MOPAN results rather than conducting separate multiple reviews.

I am looking forward to joining Board members in celebrating the anniversary of the 13 June London pledging conference, against the fitting backdrop of the Call to Action on child survival. As noted above, the conference gave us a firm financial foundation up to 2015. We have also received very welcome additional funding from **Sweden** ($18m for 2012), **Norway** ($3.5m for 2011), the **Children's Investment Fund Foundation** ($6.5m), and "**la Caixa**" business partners and employees ($ 0.4m). I would also highlight the contribution from **Comic Relief** ($4m) which in addition to the funds raised, Comic Relief's tremendous reach highlighted our mission to six million television viewers in the UK through the Sport Relief television show. The contributions of CIFF, "la Caixa" partners and employees, and Comic Relief have all been matched by the GAVI Matching Fund, which is financed by the UK and the Gates Foundation.

While it is of course concerning that a number of donors are cutting their contributions to international development in the light of economic and fiscal challenges, it is encouraging that they have continued to recognise the impact and cost effectiveness of the Alliance's work and have maintained their commitments to GAVI.

Although it is hard to argue with the success of 13 June, naturally we have considered what we can learn from it as we prepare the **long term funding strategy** for our December Board meeting. In this meeting we will start this conversation. Our objectives in producing the strategy are to ensure that it provides an overall approach to resourcing GAVI-supported programmes with an emphasis on long-term predictable and flexible financing including the whole picture of available and potential resources from shorter and longer term pledging and innovative finance, from growing co-financing from our partner countries, from active market shaping and changes in vaccine prices, and from using our resources more efficiently. The strategy will include a proposal about the proportion of GAVI's total resources that should come from more predictable and flexible funding needed to incentivise vaccine development and support sustainable immunisation programmes.

The strategy needs to be part of a process, rather than only a document, and that process needs to build a consensus around how we will approach our fund raising in the future. This approach will aim to provide early clarity for donors about who will be responsible for what; this was one of the key lessons from the review of the process

leading to 13 June. It was gratifying that some of our key donors played a very significant role in the process leading to London; these donors in particular reasonably expect the secretariat to take more of the load — but we will still need very senior advocates to be involved fully and early.

We look forward to welcoming **René Karsenti**, the new IFFIm Board Chair to his first GAVI meeting as well as paying tribute to **Dr. Alan Gillespie** for his long service as founding Chair. René and Alan have been busy. On 17 January 2012, IFFIm was downgraded by Standard & Poor's from AAA to AA+ (IFFIm remains triple-A rated by Moody's and Fitch), as a result of the downgrades of several Eurozone donor countries. IFFIm, through the World Bank, has subsequently successfully accessed the bond markets with its new Standard & Poor's rating. It continues to achieve strong pricing and maturity for the bonds it issues, and remains an important part of our resource mobilisation strategy. The secretariat is working with the World Bank and IFFIm donors so IFFIm can continue to support new GAVI programmes if there are downgrades beyond Standard & Poor's move to AA+.

Country updates

Part of the answer to the challenges I have identified above is to adopt a **more tailored approach** to some countries. At the end of last year, the Board requested that the Secretariat develop a policy that defines GAVI's approach to fragile and under-performing countries. Analysis shows that 80% of the countries currently eligible for new funding are on one of the development agencies' list of fragile countries. There is also no clear link between under-performing immunisation programmes and countries defined as 'fragile.' In April the PPC reviewed and endorsed an approach that involves developing a framework that would allow GAVI to identify particular sets of challenges to accessing GAVI support faced by a subset of countries that require flexibilities in GAVI's policies and to develop country tailored approaches. Following country and stakeholder consultations as well as a public consultation, the proposed policy will be submitted to the PPC in October 2012 for consideration by the Board in December. This sort of adjustment to country circumstances has always been part of how GAVI has done its business, but we need to be clear what can be done at global level — setting strategies for some but not all countries — and where we need to make sure that trusted local partners have the flexibility to work with governments to mitigate risks and address bottlenecks.

At the Dhaka Board meeting, we discussed our approach to the Democratic Republic of Congo (**DRC)**. DRC has potentially an excess of pneumococcal vaccine because it had not paid its 2010 co-financing arrears and consequently was not approved to expand pneumococcal vaccine introduction in 2012 to additional provinces. I am pleased to report that the first co-financing payment of $1.2m for 2010 arrears has now been received; payment for 2011 arrears is now promised. I was also excited with the commitment shown by the new Minister of Health when I met him, and I am hopeful that we are now — following some serious engagement by members of the Alliance — turning the corner. Evaluations of the introductions so far are underway, and in June we will be in a position to make a decision about introduction in a fifth state. Alliance partners convened in April to consider **lessons learned from the oversupply issue**. My view is that the Alliance should conduct this sort of exercise more often. There was agreement that GAVI needs to review country readiness in

the period between approval and vaccine introduction as well as ensure strong monitoring following introduction.

I was pleased to learn following an Alliance mission to **Pakistan** in April that clarity is beginning to emerge regarding the impact of devolution of the Federal Health Ministry on the management of immunisation programme, particularly as the Government has been preparing to introduce pneumococcal vaccine from July 2012. Government and partners however recognise that the presence of endemic polio reflects the underlying weakness in the EPI programme in two provinces. GAVI is discussing with Government a proposal to support a two-phase rollout of pneumococcal vaccine (PCV10) from July 2012, with a national scale-up from 2013. Once we are clear how the introduction has proceeded in the first phase, we will take a view on further roll-outs.

We have also been discussing options for the introduction of rotavirus vaccine with the Government of **Ethiopia**, in part because of a lack of supply capacity, and also because as I reported at our Board meeting in Dhaka, there is uncertainty about DTP3 coverage in Ethiopia. Regrettably because of supply capacity, **Senegal**'s introduction of pneumococcal vaccine has been postponed to 2013.

As I reported at the last Board, the general backdrop in **India** is of movement towards a national roll-out of pentavalent vaccine, and greater interest in new vaccine introductions. Following successful introduction in two states, India has formally decided to introduce the vaccine in six additional states, followed by a gradual national scale up. There is also growing enthusiasm for measles rubella vaccines. India has approached GAVI for catalytic assistance to strengthen their health systems in the states in northern India with weaker health systems in order to improve immunisation coverage, sustain the gains of polio eradication and eventually scale up pentavalent vaccine nationally. Manufacturers are hard at work on local production of pneumococcal and rotavirus vaccines. Recognising that India is critical to the success of GAVI's mission — there are more unimmunised children in India than there are children in the birth cohort of GAVI's next largest country — the Board has a paper on our proposed strategy with India and we hope to have a senior leader from India discuss their experiences at the Board meeting.

Following a military coup in **Mali** in March, UNICEF suspended shipments of pentavalent, pneumococcal and yellow fever vaccines. Three months' stock of vaccines remains and we will keep the situation under review so that shipments can restart as soon as we have confidence that they will be properly managed. There was also a coup in **Guinea Bissau** in April and discussions are underway about how shipments of pentavalent and yellow fever vaccines should be handled; again, stocks of vaccines remain in the country to provide for short term needs. Both remind us of the need for flexibility and quick decision making in our work.

We are continuing with our work to develop a customised approach for GAVI support to **Nigeria**, working with the Large Country Task team and the Nigerian government. The country is engaged in a phased introduction over three years of pentavalent vaccine starting with 14 states and the capital in June. A similar introduction of pneumococcal vaccine is planned in 2013. We are also working with Nigeria to reprogramme their HSS support to focus on where it is most needed. High level

political attention was focused on these introductions at the successful National Vaccine Summit in April.

We have been approached by a leading vaccinologist as well as the President of the Rostropovich Foundation (Mstislav Rostropovich was a former member of the Vaccine Fund Board), requesting that GAVI help with the price of pneumococcal and rotavirus vaccines, as opposed to funding, for the **occupied Palestinian territory** (oPt). The Rostropovich Foundation has purchased pneumococcal vaccine for the last three years and the oPt is now ready to begin to take over financing. They also want to introduce rotavirus vaccines. The oPt meets GAVI's criteria on GNI per capita and DTP3 coverage, but is not a member state of the UN. UNICEF supply division have contacted manufacturers to see if they would consider providing GAVI pricing for the oPt. After reviewing the risks that we are setting a precedent, I am comfortable that they are manageable. I am happy if the Alliance can help these children get access to a sustainable supply of new vaccines, and will be pleased to discuss this proposal with the Board, collectively or individually.

Since my last report to the Board, the **Transparency and Accountability Policy** (TAP) team has been proactively involved in cross-cutting initiatives within the Secretariat, including contributing to the development of new policy initiatives, accelerating funding to recipient countries by taking measures to resolve bottlenecks in the disbursement process, designing the model to support fiduciary control over the HPV demonstration project, and shaping fiduciary requirements over the vaccine introduction grants. TAP has been able to recruit several high-calibre professional staff bringing the total headcount to seven, allowing a much quicker response to countries. Since the last Board meeting, TAP has conducted 20 country visits to conduct financial management assessments, follow-up visits and investigations. I think we can see the result as countries now have much better clarity on the approaches which will minimise the risk to GAVI resources, and in cases where there has been misuse, our policy of zero tolerance has been applied including reimbursement of misused funds. We of course are sorry to see Cees Klumper soon to depart, but appreciate his service and willingness to continue to serve until his replacement is in place. We are well into the search for his successor and will be able to update you on the search at the meeting. Important to his and his successor's work will be an evaluation of our vaccine program risk management. As I signalled to you at the last board meeting, this is an important risk and we need to do a better job managing it.

The investigations into misuse of funds in **Cameroon** and **Niger** will be communicated shortly, in line with our transparency policy. Both governments have reconfirmed their commitments to reimburse the funds to GAVI under the 2013 budget, and have initiated legal proceedings against individuals under suspicion for the misuse of funds. The investigation in **Côte d'Ivoire** is on-going and I will update the Board as soon as it is completed. After almost four years of suspension due to misuse of ISS funds that have been fully reimbursed to date, GAVI is in the process of signing a new MoU with the Government of **Uganda** which establishes the resumption of cash-based support.

Secretariat staff and accommodation

Following the Board approval of the business plan enhancements for 2012 and associated budget we have been recruiting to strengthen the skills in those priority areas. I am delighted that we have strengthened our senior management team with appointment of Catherine Pawlow to take the leadership role in human resources in late June. Catherine, a Belgian national, has extensive HR experience at a senior level in both public and private sectors as well as in developing countries. As I see human resources as a key strategic role in a knowledge based organisation such as GAVI rather than a purely technical one, Catherine will serve on our Executive Team.

I have noted above that the TAP team has been strengthened and the search for a new Director of Internal Audit, made necessary by Cees Klumper's departure, is well underway. I hope also to be able to update you on the appointment of a new managing director for country programmes following the restructure in Country Programmes.

We recently launched a search for a new Director of Media and Communications, as Jeffrey Rowland will be joining the Innovative Finance team in October to play a leading role in the GAVI Matching Fund activities, building on his prior experience with cause-related marketing and his five years at the helm of GAVI communications.

The lease on the secretariat's building in Geneva expires in 2015, and we are reviewing our options with a strong focus on cost. One option will be to take some space along with the Global Fund to fight AIDS, TB and Malaria in the soon to be created Health Campus designed to provide a hub for international not for profit health organisations, and which the Canton of Geneva is supporting by providing land. Options on this will be brought to the Board in December.

Looking ahead

The next Board meeting (3-4 December) will be co-located with the 5th GAVI **Partners' Forum** in Dar es Salaam, Tanzania (5-7 December). The Partners' Forum will also be used to provide a forum for discussion on the implementation of the Global Vaccine Action Plan of the Decade of Vaccines. We anticipate that 400-600 partners and stakeholders will participate which will serve as an opportunity for partners and countries to provide feedback to the Alliance, share best practices, discuss challenges, explore new collaborative models to enhance future programmatic performance, and encourage innovation to address key bottlenecks — all the while celebrating the progress that has been made. We expect senior leadership to attend and are also in discussion with Tanzania about a simultaneous launch of pneumococcal and rotavirus vaccines, which would provide a tangible focus for discussions about the progress we are making and the challenges we face.
Our work programme will continue to be shaped by the **Board retreat discussion**. We discussed the possibility of GAVI funding a stockpile to provide **cholera** vaccines for routine and campaign use in endemic areas, thereby supporting the creation of a viable cholera vaccine production base, and we will bring a further analysis of the options back to the Board. We will of course also keep the Board updated on progress on **malaria** and **dengue** vaccines. We will bring a proposal to the Board next year on how we should engage with **lower middle income countries** through

continuing engagement with our graduating countries as well as where through market shaping, we might be able to identify synergies.

Since the Board retreat, at its meeting in May the World Health Assembly declared **polio eradication** to be a programmatic emergency for global public health, and eradication continues to represent a large proportion of the human and financial resources committed to immunisation. The countries where polio remains endemic are also countries where the routine immunisation system faces particular challenges. So GAVI needs to work more closely with the Global Polio Eradication Initiative (GPEI) in these countries. Furthermore, as we discussed at the retreat, there are discussions about significant changes in the eradication strategy, with new vaccines being introduced to reduce the risk of vaccine induced polio. The WHO's SAGE meeting in November will provide further advice on the polio strategy. The sense of the retreat discussion was that the Board would want further advice, including from SAGE, but that there was potentially a role for GAVI in facilitating the introduction of inactivated polio vaccines in the routine immunisation system. As the prospect of extending the existing pentavalent vaccine to a hexavalent including inactivated polio comes closer we need to make sure that we have in place a robust market shaping strategy.

The Call to Action is a timely reminder of how far we have come in giving children everywhere the start in life that they need, and how much more we still need to do. The **Millennium Development Goals** have made a real difference to how effectively the world has focused on some key goals, including on child mortality. At present there is limited focus on health in discussions about what goals should be pursued after 2015. I would argue that we need to ensure that health goals, and in particular child mortality — which has the power to engage people — remains high on the agenda. I know that many of the Board members will be personally or through their institutions involved in the post-2015 debate — I believe this is an area where we all have a responsibility to make our voices heard.

Dagfinn will no doubt give his further reflections on the retreat discussion on **roles and responsibilities** at the Board meeting; for my part I was pleased with the openness of the discussion, and from the feedback I have received, many of you were too. It is the strength of the Alliance that many different perspectives are reflected around the table but that we are all searching for how to increase the efficiency and reach of our work. I believe that the retreat discussion helped us all understand the different perspectives better, and how we can manage the inevitable tensions that arise constructively so that we can use the power we have round the table as organisations and individuals to meet our shared goals. I look forward to our further discussions in this spirit during our meeting in Washington DC next week.