Report of the Chief Executive Officer

16 June 2021

Dear Board members,

We are now 16 months into the pandemic, and the world continues to be marked by uncertainty and risk. In most countries, health systems are struggling under the dual burden of maintaining and restoring routine programmes and responding to COVID-19. At the same time, some high-income countries are beginning to celebrate a return to normality, owing to high vaccination rates. As our Board Chair José Manuel said in his remarks at the launch of our Gavi COVAX Advance Market Commitment (AMC) Investment Opportunity, "In a globalised world, all economies are interdependent. We can't just say to each other, 'Your side of the boat is sinking'." The global economy cannot be restored without everyone protected and back to work, and if populations remain unprotected, the threat of new variants remains.

When we look back on history, there are already many things that we, as a global community, will applaud – and many we will say we should have done differently. The pace of vaccine research and development has been remarkable. There are 16 vaccines in use globally; we were able to move vaccines to lower-income countries two and a half times faster, to four times the number of countries and seven times the number of doses than over the same time span during the swine flu pandemic. The level of collaboration across partners is unprecedented: as an Alliance, we mobilised swiftly to provide countries with the flexibility in funding they needed, and we worked successfully with countries to maintain and restore routine immunisation in the face of lockdowns and overburdened health systems. Importantly, the strong supplier base that the Alliance has developed over the past 21 years has meant that we have not experienced shortages in our supply of Gavi-supported routine vaccines, despite heightened competition for raw materials and for manufacturer capacity.

We also stood up the first emergency global vaccine procurement mechanism – the COVAX Facility – built on the knowledge that should a vaccine be developed, vaccine equity would be our only way out of this pandemic. This was made possible due to the incredible work from across the Alliance. Sincere gratitude also goes to our donors who have stepped up with generous financial commitments, including our successful COVAX AMC Summit earlier this month, co-hosted by Prime Minister Suga of Japan, at which we raised US$ 2.4 billion from nearly 40 donor

governments, the private sector and foundations, exceeding the funding target and bringing the total pledged to the COVAX AMC to US$ 9.6 billion to date (with an additional US$ 775 million pledged for delivery). The funds raised will enable Gavi to secure 1.8 billion doses of COVID-19 vaccines for lower-income countries participating in the COVAX Facility. The vaccines, to be delivered in 2021 and early 2022, should enable COVAX to protect almost 30% of the population in 91 AMC economies.

While imperfect, the COVAX Facility presents a model for collaboration with many "firsts" to be proud of: a pandemic vaccine AMC, global vaccine access and allocation mechanisms, a no-fault compensation programme, model-standardised indemnity and liability agreements, a humanitarian buffer and more. Administration of the Facility also brought complexity and risk to the Secretariat, requiring heightened risk mitigation efforts. Together with our partners, we have faced many challenges, and our current supply challenge is formidable. The Facility is working to meet this supply shortfall, by diversifying the portfolio, securing additional deals, bringing forward as many doses as possible and working with higher-income countries to free up doses now for those who need them most. Based on our deals plus recent dose-donation announcements, we expect our supply to begin ramping up in the coming weeks and months, and we are grateful to the donors who have made generous dose donations to help fill this acute supply gap. At the recently completed Carbis Bay G7 Summit, the G7 countries pledged millions of additional doses, supplementing the doses announced at the G20 Global Health Summit in Rome and at the COVAX AMC Summit.

While our successes over this time will no doubt shape the future of pandemic preparedness, so too will our challenges and our failures. Through Gavi, over the past 21 years we have shown the power of vaccines to save lives and transform communities. Now with COVAX, we have put forward a path to vaccine equity in real time. While many have embraced the charge, and many more have benefited from it, many have not lived up to the challenge; as a result, we have not yet achieved it. We are continuing to push forward, knowing that equity is our only way out of this pandemic, while working with countries to ensure that equity is prioritised in routine immunisation too – given that the number of zero-dose children is poised to increase as a result of the pandemic. This is essential to prevent a spike in child deaths, disease outbreaks and medical impoverishment.

Despite the challenges of the past year and a half, we are also continuing to press forward with our collective and growing commitment to embedding gender equality in our policies, strategies and practices. The Global Health 50/50 (GH 5050) Report, which was released on International Women's Day, recognised Gavi as a "very high-scoring organisation". We were ranked among the top 12 health institutions out of a total of 201, our fourth year receiving this recognition. This year, we were also featured in the Center for Global Development Quality of Official Development Assistance (QuODA), which measures 49 bilateral donor countries and multilateral agencies across a series of indicators of aid quality. Gavi performed very strongly, ranking fifth overall (out of 49) and in the top 5 on both the Prioritisation and Transparency & Untying dimensions. The United Kingdom (UK) has also released its 2020 UK annual donor reviews, and Gavi received an

"A" for the overall annual review, with "A+" for IFFIm and "A+" for the Pneumococcal AMC.

Routine Immunisation Demonstrating Some Resilience

As of 15 June 2021, there have been nearly 176 million confirmed cases of COVID-19, including over 3.8 million deaths reported to WHO. Countries such as India are reeling from a devastating second wave of the pandemic, with more than 29.5 million confirmed cases with over 374,000 deaths reported to date. The knock-on effect on routine immunisation and already fragile health systems in countries is worrisome. Fortunately, immunisation is demonstrating better resilience compared to other essential health services, even as we acknowledge that inconsistent data quality and other gaps may be confounding the picture. In the second half of 2020, we saw encouraging evidence of **restoration of vaccination services**. But due to major pandemic-related disruptions in April–May 2020, routine immunisation coverage in Gavi-supported countries is anticipated to drop by 5–10% in 2020, compared to 2019.

Of a target of 39 **vaccine introductions and campaigns** approved by the IRC (Independent Review Committee) for 2021, 12 have been completed, and 2 are underway. It is notable that of the 39, only 8 are newly planned vaccine introductions – 31 of 39 are delayed from 2020. There are a few explanations for this: countries are understandably less ambitious in the midst of the pandemic; their systems are overwhelmed under the weight of rolling out COVID-19 vaccines (an important point we discussed at our last Board meeting); and there are fewer countries remaining that have yet to introduce traditional Gavi-supported vaccines.

As of Q1 2021, five countries are still reporting **vaccine stock-outs** of non-Gavi-supplied vaccines, a major drop from 18 countries reporting stock-outs at the same time last year. Notably, none of these stock-outs are of Gavi-supported antigens. On **co-financing**, over the course of 2020, countries managed to continue to prioritise their commitment to immunisation despite the hardship caused by the pandemic. Countries contributed US$ 128 million in 2020 in co-financing – nearly the same level as in 2019. So far in 2021, 22% of co-financing obligations have been met, which is a similar performance compared to this time last year. We have seen delays in **full portfolio planning**, with only 8 of 22 countries projected for 2021 having started the process. **Health system strengthening (HSS) disbursements**, however, increased in 2020 due to the high uptake of Board-approved flexibilities such as additional HSS for fragile countries under the Fragility, Emergencies, Refugees Policy; increased absorption of reprogrammed funds for COVID-19 response; and improved disbursement timelines. We have projected US$ 240 million in total disbursements this year, and it is too early to know if we are on track, given the dynamic situation.

Drilling Down

COVID-19 has also likely delayed course correction of other important efforts – supplemental measles campaigns are one such example. Persistent challenges associated with **measles**, despite significant investments, suggests the need for an urgent reset in our approach to campaigns. Despite decades of efforts, reported cases have seen a consistent year-on-year increase from 2015, peaking in 2019

to levels not observed since 1996. We invested approximately US$ 600 million from 2016–2020; out of 54 campaigns, only 6 reached the recommended 95% coverage level, and 20 reached a 90% level. There is a clear need for reimagining our approach to campaigns. There are a number of strategies that could help to increase the quality of our measles/measles-rubella campaigns – differentiated vaccine strategies targeting unreached and missed communities; integration with other services, ensuring follow-up of un- and under-vaccinated children; and enrolment in routine immunisation services. I have written to all Measles & Rubella Initiative (MRI) partners to suggest that we need an urgent reset.

In my December 2020 CEO Report, I also expressed concern over the uptick in **polio** cases threatening eradication efforts. As serious as the polio situation is, there has been a significant decrease thus far in 2021 of reported wild and circulating vaccine-derived poliovirus cases compared to this time last year. For Afghanistan and Pakistan, the reasons for this are still unclear; but, hearteningly, ineffective, less sensitive surveillance does not appear to be a significant factor. In the African region, the roll-out of novel oral polio vaccine type 2 (nOPV2) under WHO Emergency Use Listing (EUL) has begun with initial use in Nigeria and Liberia. Global Polio Eradication Initiative (GPEI) partners are working with other countries to help meet the stringent readiness criteria to allow this important new tool to be used in future outbreak responses.

GPEI partners are at a pivotal moment in the launch of the new strategy, presenting an opportunity for the programme to work differently – in a more coordinated and integrated manner than in the past – leveraging the zero-dose agenda as the point of convergence with Gavi 5.0 and the broader Immunization Agenda 2030 (IA2030) to provide essential health services to the most marginalised and deprived communities. This convergence is currently playing out in the remaining endemic countries – Afghanistan and Pakistan – with Gavi's full portfolio planning process underway.

On 3 May 2021, WHO declared the 12th **Ebola** outbreak in the Democratic Republic of the Congo over (12 cases, 6 deaths), three months after the first case was reported in North Kivu. A second Ebola outbreak was declared in Guinea in February this year. No cases have been detected since 30 April 2021, and the 42-day countdown to declare the end of the outbreak started on 10 May 2021 – so, by the time we meet, we should have news of whether it is officially over. Overall, 23 cases (16 confirmed, 7 probable) and 12 deaths have been notified, and 10,612 people have been vaccinated. The Gavi-supported, WHO-prequalified Ebola vaccine (Ervebo) stockpile continues to grow, with 112,220 doses available for immediate shipment.

Demands on Gavi's **stockpiles** were lower in 2020 than the historical average (13 received in 2020 versus an average of 26 per year between 2016 and 2019), mostly reflecting the lower number of oral **cholera** vaccine (OCV) requests, but higher quantities per request. The 2020 pattern seems to remain in 2021. As of 1 June 2021, there have been a total of four requests in 2021 (two meningococcal and two OCV). The low number of **meningococcal** vaccine requests is consistent with the trend observed in the past years following MenAfriVac introduction, which

has resulted in a substantial decrease of outbreaks in the meningitis belt. The 2021 meningitis season has ended with only 450,000 doses used (primarily linked with meningitis C transmission). The current size of the stockpile is 4 million doses, and we are carefully monitoring doses close to expiry date to avoid wastage and repurposing these doses for preventive use.

Typhoid conjugate vaccine (TCV) roll-out is underway in Pakistan, Liberia and Zimbabwe, with Nepal, Malawi and Kenya upcoming. The roll-out in Pakistan is taking place in three phases. Liberia and Zimbabwe are catch-up campaigns targeting children 9 months to aged 15 years. Liberia is now completing the introduction of TCV in the routine immunisation programme.

You will have seen in a recent Board Update the announcement of Phase IIb trial results of another **candidate malaria vaccine**, **R21/Matrix-M**. On 7 May 2021, the product moved into phase III trials in Mali.[1] This product is not as advanced as **RTS,S**; however, with one approved product (RTS,S) and one candidate moving forward in clinical trials, we welcome the potential of multiple vaccines that may prove to be efficacious, comparable and deployable for longer-term market health and greater public health impact. We are looking forward to working with the malaria community on how best to consider the potential addition of a malaria vaccine, and to further discussions with the Alliance and other stakeholders on the value of such an investment for Gavi. We will be discussing the malaria programme in the end-of-year PPC and Board meetings.

The Alliance continues to make progress on the **yellow fever diagnostics** initiative. A yellow fever molecular test kit by German company Altona Diagnostics GmbH has been validated for use in the WHO yellow fever laboratory network in Africa, and two serology test kits are now being evaluated. Despite logistical challenges from the pandemic, surveys indicate that the time from samples' arrival at national laboratories to completion of testing has dropped from an average of 106 days in 2017 to 39 days in 2020 for samples that initially test positive for yellow fever. Four countries are now able to reliably complete some or all confirmatory testing for yellow fever on their own (up from one in 2017), and more are expected to be able to have this capacity as yellow fever molecular test kits are rolled out. Data from the yellow fever laboratory network has played a key role in prompting Kenya to introduce yellow fever vaccine into routine immunisation and in demonstrating that several suspected yellow fever outbreaks were not in fact yellow fever, forestalling unnecessary outbreak response vaccination campaigns.

5.0 Operationalisation & the Groundwork to Reach Zero-Dose Children

Against this backdrop, we are continuing to move forward to operationalise the approach to reaching zero-dose children and missed communities. The Secretariat has held multi-stakeholder dialogues with countries and partners to assess the impact of the pandemic on immunisation and recovery efforts, and to gain insights

[1] It is also expected to run in sites across Kenya, Tanzania and Burkina Faso on the same 3+1 schedule as RTS,S (e.g. 3 doses 1 month apart starting at 5 or 6 months of age, a 4th dose 1 year after 3rd dose).

into country readiness for successful Gavi 5.0 dialogues. And the Equity Accelerator Fund (EAF), one of the levers to advance the zero-dose agenda, is being designed with a view to providing additional and targeted HSS support to countries. During the World Health Assembly last month, we were very pleased to hear more than 30 countries in a cross-regional statement on IA2030 highlight their support for prioritising zero-dose children as being key to expanding immunisation services to help build sustainable and resilient primary health care systems. That GPEI and MRI are also embracing the focus on zero-dose as vital to polio eradication and measles control and elimination is heartening.

Related to this, the revised vaccine funding Application Process Guidelines and Kit have now been finalised, and the immunisation supply chain strategy for 2021-2025 has also been updated. There has also been progress on the Effective Vaccine Management (EVM) agenda and Cold Chain Equipment Optimisation Platform (CCEOP) implementation. In Q1 2021, 7,980 units were delivered and 4,142 installed. We will continue to monitor the impact of COVID-19 and COVAX processes on CCEOP applications and implementation.

With all of the positive momentum, we must also be sensitive to the bandwidth of countries and their priorities. We hear from some countries that they are at capacity with their efforts to maintain and restore routine immunisation and roll out COVID-19 vaccines to protect their populations and put their economies back on track. Through our engagement in the COVID-19 response, we have the opportunity to mitigate risks to routine immunisation systems and our Gavi 5.0 agenda. For example, through high-level political access, increased attention to vaccines, and the potential to deploy leapfrog approaches and technologies, we are working with countries toward the Sustainable Development Goal (SDG) vision of leaving no one behind. Civil society organisations (CSOs), including those in our expanded network of partners for achieving 5.0, are essential for this vision to be realised; and the **new CSO Strategy** will be an important discussion at our upcoming meeting.

Supportive work also continues through the **Global Action Plan for Healthy Lives and Well-being for All (GAP)**. Signatory agencies of the GAP recently published its second joint progress report detailing our support to countries for an equitable and resilient recovery from the pandemic and furthering progress towards the health-related SDGs. Through the sustainable financing for health accelerator, which Gavi co-leads with the Global Fund and the World Bank, as well as the primary health care accelerator, we have been working closely with GAP partners to foster a common approach to equity and to jointly prioritise and align efforts to reach zero-dose children and missed communities.

COVAX Facility & the Road Ahead

COVAX was built on the understanding that to end this global pandemic, everyone, regardless of ability to pay, needs access to vaccines. I was pleased to share earlier in the report the great news of the **Gavi COVAX AMC Summit**.

Money is not the only thing we need to achieve equity, and COVAX continues to face acute vaccine supply challenges. Due to supply constraints, low-income

countries have vaccinated 1–2% of their populations; lower middle-income countries approximately 5%; upper middle-income countries nearly 20%; and high-income countries over 32%. These stark inequities must be remedied, and timing is everything in a pandemic. Advocacy has been helped by a recent IMF Staff Discussion Note emphasising that vaccination is the best investment we can make now for the global economy. The Note proposes a target of vaccinating 40% of the population in each country by the end of the year, and then 60% by early 2022, coupled with other important public health measures. The authors estimate the cost to be around US$ 50 billion (building on ACT-A budgeting), while the benefits of a faster end to the pandemic are estimated at around US$ 9 trillion. As you will have seen through my Board Updates, we **recently signed advance purchase agreements** with three new manufacturers for more than 1 billion doses: Moderna (500 million), Novavax (350 million) and Johnson & Johnson (200 million). These vaccines, to be delivered in 2021 and early 2022, should enable COVAX to protect almost 30% of the population in 91 AMC economies.

Dose donations are already beginning to supplement these volumes; we have also started accepting and distributing doses from France and New Zealand, with many more to come. Belgium, Denmark, Germany, Italy, Spain, Sweden, other member countries of the EU, Canada, Japan and Norway have announced plans to donate doses through COVAX. The United States of America committed 80 million in dose donations (60 million through COVAX), followed by a second announcement of 500 million doses of Pfizer-BioNTech to be distributed through COVAX. Team Europe has also announced its intent to provide COVAX with more than 100 million doses through dose donations, and the UK has committed 100 million doses (80 million through COVAX). We are urging donors to provide donated doses now and through Q3, while the supply is most limited – and not to wait until Q4, when COVAX is forecast to have access to an average of ~400 million doses per month from COVAX deals alone (not including donated doses).

As an Alliance, our next great challenge will be to support Gavi COVAX AMC countries in maximising their **absorptive capacity** to deploy at pace the doses we will soon be providing, while also safeguarding routine immunisation systems. Delivery of COVID-19 vaccines is challenging due to the scale, urgency, logistics and also worrying levels of vaccine hesitancy, even among health professionals. Country preferences for specific products are also starting to create additional complexities. At the same time, delivery funding from external sources is highly limited or has been delayed, while domestic budgets are under unprecedented strain. The Alliance has been working with countries on delivery preparedness from the start through the development of national vaccine deployment plans, readiness checklists and assessments, cold chain support, and collaborative efforts to address vaccine hesitancy and misinformation. COVAX is also partnering with the African Union and Africa CDC and will soon be formalising this relationship with a Memorandum of Understanding to address these key challenges. And yet already, with our limited volumes to date, we have had to reallocate a small amount of COVID-19 dose shipments due to lack of uptake and rapidly approaching expiry dates. The new Covid Delivery and Systems Strengthening envelope (CDSS) that the PPC recommended to the Board for decision will provide countries with the opportunity to boost their systems capacity and address vaccine hesitancy issues.

We are also continuing to work with the World Bank, including emphasising the need for delivery support and partnering on cost-sharing for countries to procure additional doses of vaccine through the Facility. Countries, donors, Alliance members and other partners are committed to getting doses out as quickly as possible for an end to the acute phase of this pandemic, while minimising opportunities for wastage.

Since our last Board meeting, we have been **ramping up our communications efforts**, particularly with AMC92 economies. Within the Office of the COVAX Facility, a dedicated team has been established to support the wide-ranging communications needs for all participants, providing regular briefing sessions, FAQs, biweekly newsletters and situation reports, in addition to official notification letters on dose allocations and frequent bilateral exchanges. Our **COVAX AMC Engagement Group** and **COVAX Shareholders Council** have met three times since the Board meeting in December 2020, serving as a forum for open dialogue between COVAX partners, donors, and the representatives of both AMC-eligible and self-financing participants. The last meeting of the Shareholders Council was chaired by the recently appointed co-chairs, Dr Chrysoula Zacharopoulou, European Parliamentarian, and Dr Fernando Ruiz Gómez, Minister of Health of Colombia.

Earlier this month, we launched the application process for the **COVAX Humanitarian Buffer**. Although the priority is for all populations to be included in national immunisation plans, the Buffer provides a last resort and supports efforts to ensure all populations, including those in fragile and conflict settings, have access.

We are also continuing to work closely with manufacturers, including through the new **COVAX Manufacturing Task Force**, to, in the immediate term, support manufacturers in increasing capacity to support our participants through addressing supply bottlenecks, pushing forward tech transfer agreements, as well as support for longer-term development of regional manufacturing capacity.

It continues to be a busy time for COVAX. One year into Gavi's engagement in standing up the Office of the COVAX Facility, the Board will be deciding whether to continue to host the Facility, the scope of participation and the considerations that should inform our objectives going forward. These are important questions which we will discuss at the meeting, building on the discussions that have already started with the PPC and AFC, with implications for many countries, our partners and the Secretariat.

The Engine Room

It has been a long time since we first went into lockdown in March 2020. Gavi Secretariat staff are continuing to work primarily from home at both sites until September, although the DC office has been open for several months now as a resource for staff. Recently the Canton of Geneva **eased the requirement to work from home**, and we are in the process now of opening the Global Health Campus to allow for 20% occupancy over the course of the summer. **Duty travel** continues to be embargoed until the end of June unless exceptionally approved. As of July,

we will start facilitating missions deemed critical, to be evaluated on a case-by-case basis and subject to a strict assessment by the Travel and Security teams. Understanding that we will be entering a new normal in the coming months, we have launched a project on **ways of working**, examining what a full return to the office may look like. The closure of the office has shown us what can be accomplished remotely or with the additional flexibility that many staff will require or desire. In addition, due to the growth of our team, we no longer have space for one desk per person, acknowledging in the past that we often had low usage due to extensive travel. We have completed the initial phases of the project following extensive internal consultation, insight and best practice from Alliance partners and external thought leaders, and a comprehensive staff survey with a response rate of over 80%. Based on fairly broad-based agreement across the organisation, we are moving forward to rearrange our office into "neighbourhoods" to retain the sense of place and permanence for teams, but allowing more space for in-person collaboration permissive of remote participation and more flexible seating plans.

We just finished conducting a staff pulse survey. The results were mixed. We are doing well on communicating with the staff; people are engaged and have a high sense of personal accomplishment; and we have improved in our provision of feedback. On the other hand, **Secretariat workload** remains high; some staff continue to fear speaking up; and the impact of the past many months of isolation on Secretariat staff, including morale, anxiety levels and mental health, remains an issue. Over the course of the pandemic, Gavi has taken many measures to support staff and prepare for our return to the office, including flexible remote working guidelines; flexing of our annual leave and home leave policies; ongoing discussions around prioritisation of work; trainings on mental health with external doctors offered to staff and managers; increased communication across the organisation through frequent all-staff meetings; and a new Wellness Committee charged with making wellness recommendations based on staff sentiment. We will continue to monitor this closely as we return to the office with some sense of normality and will calibrate further responses based upon this assessment. Related to this, diversity and inclusion remains a priority across the organisation and in our programmes. Building on the survey conducted in September of last year, the staff-led **Diversity & Inclusion Committee** will be bringing on an independent, external expert to help us work through our policies, practices and processes and to produce an action plan and strategy to hold us true to our Commitment.

Implementation of our **organisational review** changes, including implementation of the structural changes, is on track but not complete, so we have yet to reap the full benefits (a more thorough brief on the status of the organisational review is being shared separately). As part of this process, we have prioritised recruitments and onboarding of new staff, recognising that even before the pandemic, there was a need for additional staff. The environment in which we are operating has also continued to shift since we took the decision to implement the organisational review, and it is possible that additional adaptations will be needed going forward to accommodate shifting demands on the Secretariat. Related to this is the **staffing up of the Office of the COVAX Facility**. We are currently at 74%

completion[2] with some incredible talent, including secondees, having joined this vital global effort.

In Closing

This is a complex and pivotal moment in the history of the Alliance. With 5.0, Gavi has embarked on its most ambitious strategy yet, to reach those we have missed. Since agreeing to this strategy, the global landscape has been shaken by the COVID-19 pandemic, throwing more communities into poverty and threatening already fragile systems. Gavi has taken on the added challenge of addressing inequity in the vaccine response to the pandemic through its work on COVAX. We have discussed previously that this requires the organisation to become more nimble and to take on more risk. Clarity on risk appetite – the amount of risk an organisation is willing to take, accept or tolerate to achieve its goals – is needed to limit excessive and unrewarded risk-taking, as well as undue risk aversion which can impede progress and success. Following from the December 2020 Board meeting when the Board agreed with the need to recalibrate its appetite for risk, we will be asking you to approve a revised Risk Appetite Statement recognising the current operating realities and the increased ambition of the organisation. It serves to align stakeholders across the Alliance and guide decision-makers in taking the right amount of the right type of risks to deliver on Gavi's mission, enabled by robust risk management to ensure these risks stay within the Board-approved risk appetite.

Gavi 5.0 and COVAX share the same foundational principles of equity. They are symbiotic initiatives, offering an expanded operational platform for the Alliance, including further positioning us as strategic actors in global health security. It is most important to view this from the country lens of maintaining health services and combatting the pandemic as two integral and intwined priorities, neither of which can afford to fail. If the Board agrees with the recommendations of the Programme and Policy Committee (PPC) and Audit and Finance Committee (AFC), this will lead us to a place where we will be working to fully integrate the two efforts, taking into account the needs of the reduced numbers of self-financing COVAX participants that fall outside of the AMC92.

There are immense changes underway in the organisation to achieve the ambitions of Gavi 5.0 and COVAX, which impact the countries we support, our partners and our staff. There is no question that while we remain firmly focused on our mission to save lives through immunisation, these uncertain times serve as a reminder to be cautious, retain flexibility and evaluate financial as well as human costs. As always, I thank all of you for guidance and partnership as we continue to navigate these uncharted waters.

[2] Out of approximately 109 budgeted roles, 81 have been filled; and the remaining are being actively recruited. Additionally, 10 secondees are assigned to COVAX.