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| **SUBJECT:** | **RECALIBRATING GAVI 5.0 IN LIGHT OF COVID-19 AND SUCCESSFUL REPLENISHMENT** |
| **Agenda item:** | 02 |
| **Category:** | For Decision |

## Section A: Executive Summary

### Context

The COVID-19 pandemic has triggered an unprecedented crisis, calling for an equally exceptional response. At the Global Vaccine Summit in June 2020, in a remarkable show of solidarity, global leaders came together to support the Alliance and its mission for 2021-2025. The successful replenishment provides Gavi with an opportunity to bolster support for its ambitious equity agenda, mitigate the impact of the COVID-19 pandemic on immunisation, sustain hard won gains and scale up smart investments in improving the quality, efficiency, effectiveness and sustainability of immunisation delivery systems. **Given the profound, multi-faceted impacts of COVID-19 and in light of the successful replenishment, it is opportune for the Alliance to take stock and re-examine the objectives for Gavi 5.0.**

### Questions this paper addresses

- What **key shifts in Gavi 5.0 priorities** does the Alliance envisage in the context of COVID-19 and the successful replenishment?
- What are the implications for Gavi's **programmatic focus**?
- What are the **resource implications**?

### Conclusions

While **leaving no one behind with immunisation and Gavi's strategic goals and objectives for 2021-2025 are more relevant than ever**, **the following recalibrated priorities will require urgent action:**

1. **Maintaining, restoring and strengthening immunisation services:** Given the COVID-19 pandemic has caused widespread disruption of immunisation services in Gavi supported countries, a key priority of the Alliance will now be to support countries in adapting services to operate safely in the context of the pandemic, restoring previous levels of immunisation coverage and catching up on children missed due to the breakdown of services. In doing so, there is an opportunity to 'build back better' with efficient, integrated and sustainable approaches.

2. **Reaching zero-dose children and missed communities**: Gavi's ambitious equity agenda has become even more urgent as COVID-19

thrusts millions of people into deeper poverty, exacerbating inequities and gender discrimination. An unambiguous and relentless focus with highly local approaches and partners is needed to reach zero-dose children and missed communities. In the absence of urgent attention, decisive action and increased investments, there is an imminent risk of increasing child deaths and disease outbreaks.

3. **Pacing the expansion of new vaccines:** As countries' immediate focus is towards containing the pandemic, keeping immunisation services running and trying to reduce the number of zero dose and under-immunised children, further vaccine introductions may happen at a pace that is slower than expected. New vaccines included in the Vaccine Investment Strategy (VIS) will have to be deferred until the acute phase of the pandemic is over.

4. **Delivering COVID-19 vaccines:** Timely delivery of COVID-19 vaccines in Gavi-supported countries will be critical to halting the pandemic. Given the different vaccine profiles and target populations, delivery will require novel approaches from those used for traditional vaccines. While countries are expected to leverage existing capacities, which have been strengthened with Alliance support, some additional support will be needed. More detail is provided in Doc 03.

5. **Safeguarding domestic financing for immunisation:** While domestic financing for immunisation remains a key priority for the Alliance, the significant economic impact of the pandemic may require a recalibration of expectations on countries' transition trajectories and ability to co-finance vaccine doses. The Alliance has been working to protect the significant gains in increasing country ownership and financial sustainability of immunisation programmes. As of August 2020, countries had already met 57% of their 2020 co-financing obligations. Given the continued low visibility on the pandemic's impact in 2021 and beyond, Gavi's response must remain flexible and agile.

**Besides the above, this paper outlines additional areas for strategic investments that are critical to deliver on the objectives set out in Gavi 5.0.** It also considers the need for **expanding partnerships and additional capacity for Alliance partners and the Secretariat**. With limited resources in comparison to the additional needs, Gavi's investments will be catalytic in nature. The high-level investment needs presented in this paper, which indicate the underlying relative prioritisation, will be refined and substantiated based on the Board's feedback, and brought to the Programme and Policy Committee (PPC), Audit and Finance Committee (AFC) and Board for further consideration.

***Questions to the Board***

- *Does the Board agree with the recalibrated programmatic priorities?*
- *Is the proposed indicative level of investment appropriate?*
- *Are any priorities missing and should be added?*
- *Does the Board agree with the proposal to provide additional HSS to countries dedicated to zero dose and missed communities?*

## Section B: Recalibration of Programmatic Priorities in Gavi 5.0

### 1. Context

1.1 Gavi's successful replenishment in June 2020 reaffirms its mandate and strategic direction and provides an opportunity to strengthen support for the Alliance's ambitious equity agenda in the context of COVID-19. **An additional US$ 1,662 million of non-programmed financing [1] is estimated to be available to compliment planned expenditures to deliver on the Alliance's mission**.

1.2 At the same time, **the COVID-19 pandemic continues to evolve rapidly.** As of mid-September, almost 7.5 million cases of COVID-19 and over 130,000 COVID-19-related deaths have been reported in Gavi-eligible countries, accounting for 24% of total global cases. Recent International Monetary Fund (IMF) reports suggest the pandemic can undo a decade worth of gains in poverty reduction by pushing millions more into extreme poverty and hunger, exacerbating inequalities and deepening gender disparities and barriers in lower income countries. The economic squeeze caused by the pandemic is reducing the fiscal space of countries to invest in health and immunisation.

1.3 Disruptions in immunisation services due to lockdown measures, supply chain disruptions, fears and rumours **risk millions of children missing on-time immunisation services, with marginalised populations disproportionately affected.** The risk of diseases and child deaths among the poor who lack resources to access health care are spiralling, threatening hard won gains. Therefore, the direct and indirect impacts of the pandemic make Gavi's ambition to leave no-one behind with immunisation more challenging but more important than ever.

### 2. Maintaining, restoring and strengthening immunisation services

2.1 While the impact of COVID-19 has varied across Gavi-eligible countries, it is clear that **significant efforts will be required to adapt immunisation services to operate safely in the context of the pandemic, restore previous levels of immunisation coverage and catch-up children** who have missed their vaccinations. The pandemic has also exposed weaknesses in current immunisation programmes, highlighting **opportunities to build back better.** These include, for example, improving real-time data systems, addressing mistrust and hesitancy by strengthening community engagement, promoting delivery approaches that encourage greater integration of primary health care services and introducing digital training tools in place of traditional in-person training.

2.2 In this context, supporting countries to **maintain, restore and strengthen immunisation services** will likely be the **immediate to medium term**

[1] As per the financial forecast presented to AFC in September 2020, subject to legal signature of funding pledges. This figure includes US$ 413 million of provision for strategic investments as well as anticipated savings of 72 million from pacing the introduction of new vaccines described below.

**priority for many countries**. As a result, **much of Gavi's Health Systems Strengthening (HSS) and Targeted Country Assistance (TCA) under the Partners' Engagement Framework (PEF) will be needed to support countries in this objective.** However, HSS for the 2021-2025 strategic period is currently forecast at US$ 1.2 billion, lower than Gavi 4.0, despite the Alliance's higher ambition. The same applies to the TCA forecast. As a result, little will be left for reaching zero-dose children at a time when the pandemic is pushing millions of people into extreme poverty, exacerbating further existing inequities, including gender inequity.

## 3. Reaching zero-dose children and missed communities

3.1 **The Alliance has made equity the defining feature of Gavi 5.0.** This builds on the coverage and equity agenda from Gavi 4.0, adding a more **acute and deliberate focus on reaching zero-dose children**[2] **and missed communities,** towards a vision of reaching every child with a full course of vaccines by 2030. Two thirds of zero-dose children live below the poverty line, in communities which face high child mortality rates and multiple deprivations including malnutrition, lack of education, open defecation, lack of drinking water and social stigma (see Figure 1 below). They are also often home to acute gender challenges such as lack of reproductive and sexual health, child marriages, teenage pregnancies, female illiteracy and gender-based violence. These communities are prone to recurrent outbreaks of vaccine preventable diseases, such as measles, which can spread rapidly necessitating reactive and repeated investments in immunisation campaigns and outbreak response.

3.2 **Reaching zero-dose children with immunisation services is getting ever more complex and expensive.** Half of all zero-dose children are in fragile countries, where conflict, weak infrastructure and poor governance can impede efforts to extend immunisation services and build strong community engagement. In other countries, these children are clustered in marginalised communities who are underserved because they live beyond the reach of existing health services or systematically excluded from government service provision (e.g. in urban slums or remote rural areas or active conflict zones). **Zero-dose children and missed communities can no longer be neglected and call for decisive action** and prioritised investments in line with the central goal of Gavi 5.0, the Immunisation Agenda 2030 and the SDG aspiration to leave no-one behind.

[2] **'Zero-dose children'** are those that have not received any routine vaccine. For operational purposes, Gavi defines zero-dose children based on lack of the first dose of diphtheria-tetanus-pertussis containing vaccine which in Gavi countries is Penta1.

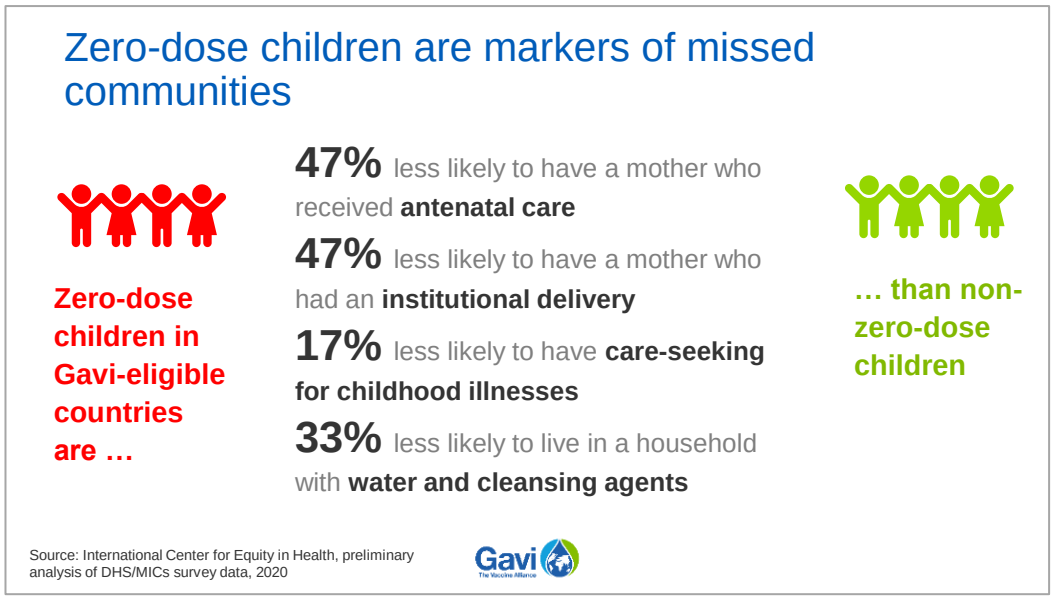


*Figure 1*

3.3 Gavi has made **positive strides and learnt important lessons in pursuing the goal of equity in Gavi 4.0**, reducing the number of zero-dose children by 14% between 2015 and 2019, after a period of near stagnation in Gavi 3.0. This is despite growing birth cohorts in Gavi countries and the fact that the number of zero-dose children in the rest of the world increased by nearly 30% over the same period. Progress has been faster in PEF Tier 1 countries[3], where the Alliance has had the greatest focus in terms of its political engagement, innovations, technical assistance and monitoring. These countries have reduced the number of zero-dose children by 22% between 2015 and 2019 (vs. 6% between 2010-2015), demonstrating the **progress that is possible with sufficient focus, support and engagement**.

[3] PEF Tier countries: Afghanistan, Chad, DRC, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan, Uganda

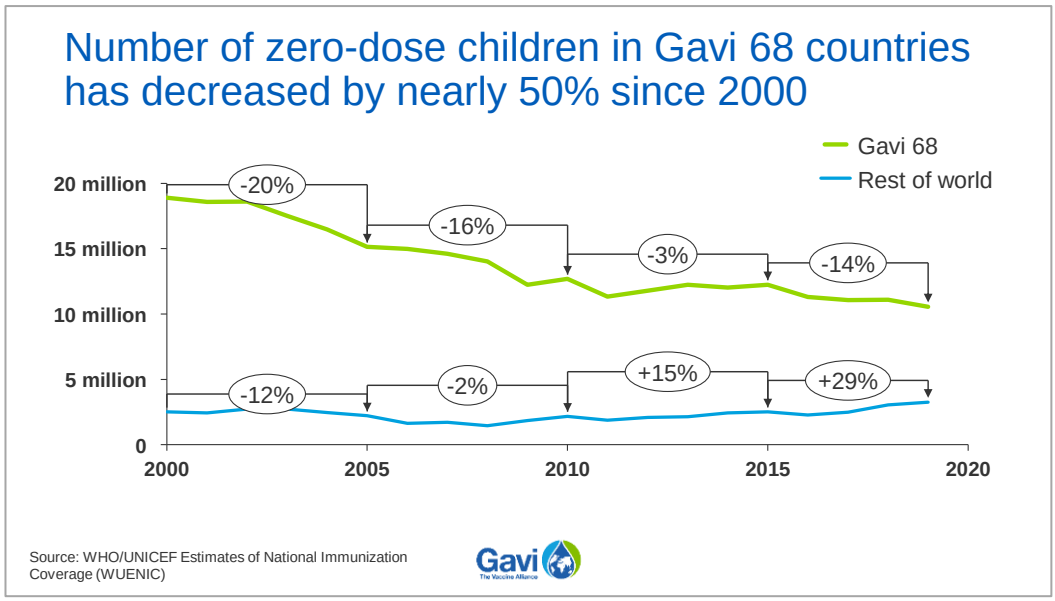


*Figure 2*

3.4 The Alliance will work with countries to shine a spotlight on these missed communities that are home to clusters of zero-dose children, design tailored strategies to reach them and provide the support required to deliver the full range of vaccines, paving the way for sustained and equitable primary health care. **Five steps have been identified to sustainably reach zero-dose children** as illustrated in Figure 3. This will form the basis of a deliberate and systematic approach in every Gavi-supported country.

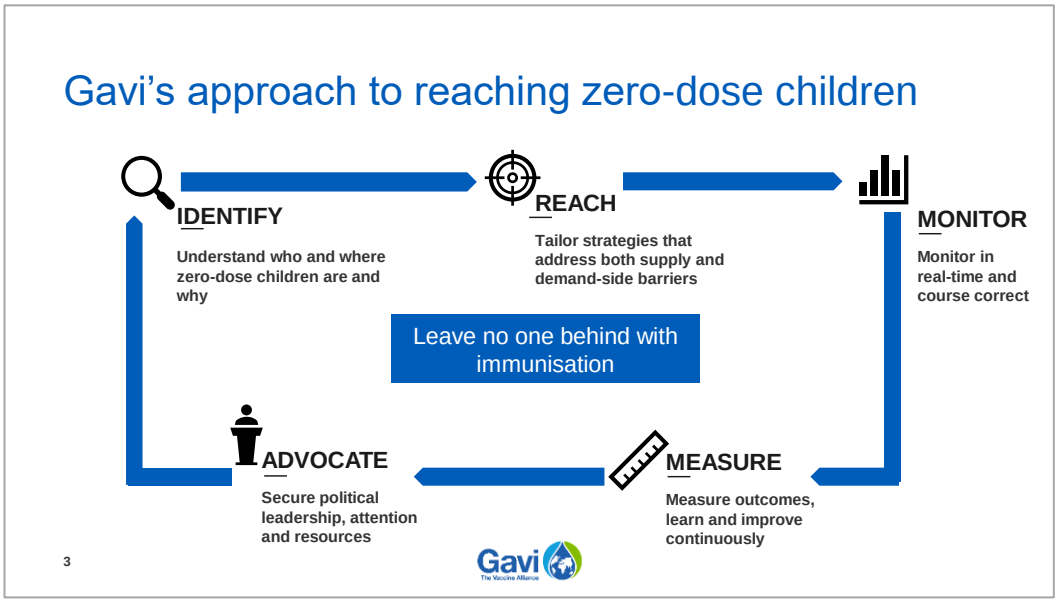


*Figure 3*

a) ***Advocate**:* Harnessing the full breadth of the Alliance (including Civil Society Organisations (CSOs)) to make zero-dose children and missed communities part of the political discourse, encourage governments to prioritise resources towards them and highlight immunisation as a pathfinder for universal primary healthcare. Gavi's experience from countries such as India, Pakistan and Democratic Republic of the Congo (DRC) have demonstrated that strong political leadership is one of the most important factors in catalysing rapid progress on immunisation equity.

b) ***Identify**:* A clear understanding of who, where, how many and why zero-dose children and missed communities have not been reached is a critical step in developing robust plans to reach them. These communities are often not visible through existing data systems and assessments. They face more profound barriers to vaccination including gender barriers, living in inaccessible or unrecognised settlements, migration, economic challenges and social or political stigma. Interventions including triangulation of existing subnational data, both within immunisation and other sectors (including nutrition and education), better enumeration of the distribution of zero-dose children, and geospatial mapping can better support countries to identify and develop improved plans for addressing both supply and demand-side barriers to immunisation. In Pakistan, triangulating data from the Electronic Immunisation registry with polio-line-listing data helped identify pockets of zero-dose children in large districts and urban areas. In Kenya, administrative data of coverage combined with geospatial estimates of coverage, socio-economic and gender variables from a population-based survey (i.e. Demographic and Health Survey (DHS)) and estimated denominators from WorldPop helped improve the understanding of who zero-dose children and missed communities are, and how to target them (see Figure 4 and Annex A).

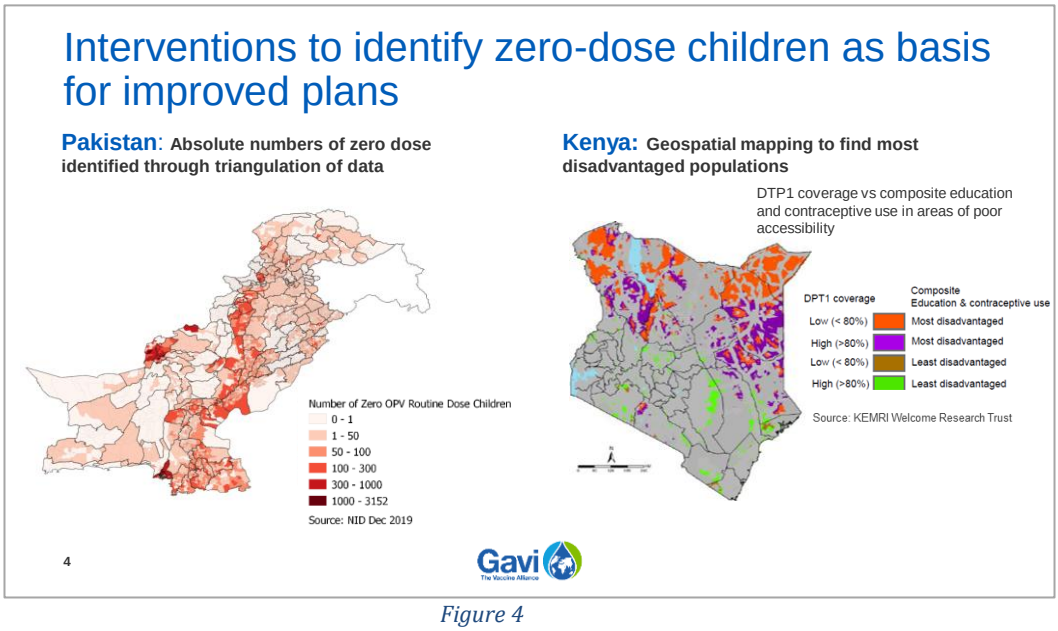


*Figure 4*

c) **Reach:** Zero-dose children and missed communities will be at the heart of Gavi's programmatic strategies. New partnerships, innovations and flexible approaches will be needed to overcome supply and demand side barriers. On the supply side, the Alliance will work with countries to be more deliberate in designing appropriate service delivery strategies for missed communities, grounded in strong routine immunisation and utilising the full spectrum of approaches from fixed post immunisation to outreach, mobile strategies, periodic intensification of immunisation, child health days and other supplementary activities. This will be done with a specific focus on gender-related barriers that prevent girls from accessing immunisation services (e.g. in Pakistan, fewer girls were reached with catch-up immunisation as services resumed after the COVID-19 lockdown) or mothers to bring their children for vaccination (e.g. due to unsuitable timing or inconvenient location of immunisation services, experience of poor service, stigmatisation).

   Gavi will also work with new partners based on their comparative advantage – such as strengthening engagement with humanitarian and emergency organisations in conflict settings, and collaborating more closely with other financing organisations to co-fund delivery of a broader package of Primary Health Care (PHC) services to these communities in addition to immunisation. On the demand side, it will take much more tailored strategies to engage communities, change behaviours and ensure services meet their needs. This will be even more important in countries where COVID-19 has generated new rumours and mistrust of immunisation, pushing up numbers of zero dose children.

d) ***Monitor & Measure***: Investments to improve measurement including targeted sub-national surveys and assessments, assistance to build capacity and tools for generating insights from monitoring dashboards and analytics, real-time monitoring and country-specific learning approaches will better enable the Alliance to monitor progress on a continuous basis and course correct when needed. In Rwanda, for example, Gavi supported the nationwide launch of an immunisation e-tracker that is linked with birth registry. This provides live data on vaccination coverage, which was particularly useful during the pandemic to monitor the impact on coverage.

3.5 **The Alliance will systematically learn across a subset of countries** through working with local partners to develop learning hubs. Routine monitoring will be supplemented by going deeper in measurement, analysis and understanding of factors influencing implementation and performance of approaches to reach zero-dose children. Learning hubs will support cross-country synthesis, inform key strategy and policy questions, and help identify best practices to be shared across countries.

3.6 **Additional resources are needed to support countries in reaching zero-dose children and missed communities.** Given the core focus on

equity in Gavi 5.0 and the fact that reaching zero-dose children and missed communities is much more complex and costly**,** the Secretariat proposes to **top up the HSS disbursement envelope by US$ 500 million to allow countries to access up to 50% additional HSS on top of their existing grant for dedicated activities to reach zero dose children and missed communities.** This builds on the HSS flexibilities approved by the Board midway through Gavi 4.0, which allowed countries to access an additional 25% above their existing HSS ceilings for targeted investments in coverage and equity. The new top-up would apply for the full strategic period and reflects the increased ambition and expected higher cost of reaching zero-dose children particularly in the challenging context of the current global emergency. The proposed additional funding amount is similar to additional HSS funds that application of the Fragility, Emergencies, Refugees (FER) policy would provide in recognition of the higher cost of operating in the face of an emergency.

3.7 While access to funding would follow a similar process to core HSS, **the proposed extra funds would not be an entitlement but would be made available based on a clear commitment and robust plans from countries to identify, reach, monitor and measure zero dose children.** The proposed approach would generate political focus on zero-dose children, create an incentive for countries to invest in identifying them and ensure that incremental funding is targeted to successfully reaching them. By investing in primary prevention, countries would break a vicious cycle of outbreak response and antigen specific campaigns which are not only highly expensive but often fail to reach the consistently missed children.

3.8 This approach could also serve as a **catalyst for other donors and financiers to add complementary funding** to expand access to other essential PHC services e.g. skilled birth attendance, contraception, prevention of child marriages and teenage pregnancies, bed-nets, malaria and TB treatment, deworming, nutritional support and supplementation, early childhood development, school education.

3.9 **The risk of not allocating additional HSS funds for equity is that more than 50 million children could go unvaccinated over 2021-2025** (>10.5 million zero-dose children per year based on 2019 WUENIC estimates), in addition to a large but unknown number of additional zero-dose children resulting from the COVID-19 pandemic. This would lead to large numbers of unnecessary outbreaks and necessitate the Alliance to invest large sums of money in outbreak response and campaigns. A clear focus on reaching zero-dose children and missed communities with routine immunisation services is thus an efficient, cost effective investment in prevention.

3.10 Given that countries require urgent additional HSS support in light of the impact of COVID-19 pandemic and the FER policy is applicable in this case**, the Secretariat requests the Board to approve this additional HSS support**. This will enable the Alliance to proceed in operationalising the

approach as soon as possible. The Secretariat will continue to provide more details and regular updates at the upcoming PPC and Board meetings.

## 4. Pacing the Expansion of Breadth of Protection

4.1 **The Alliance has exceeded expectations on expanding the breadth of protection in Gavi 4.0.** Between 2016 to 2019, 259 million children were immunised with Alliance support, saving an estimated 5.4 million lives. Over the past four years, the average coverage of Gavi-supported vaccines that children receive through routine immunisation has nearly doubled (from 30% to 56%), meaning that more children are protected against more serious diseases than ever before. While the pandemic has led to the delay of at least 15 vaccine launches, these are expected to resume soon.

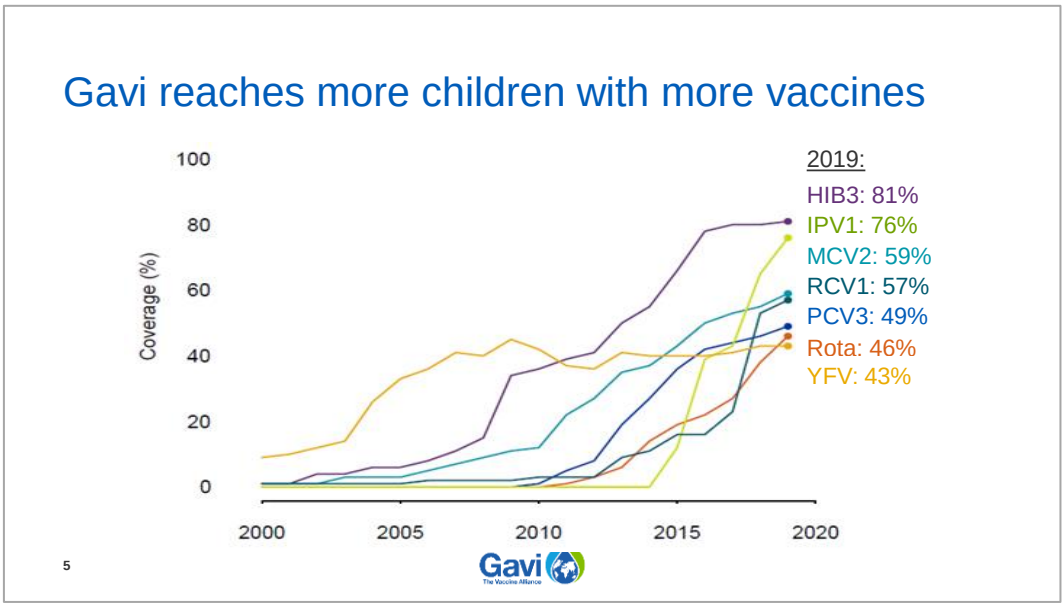


*Figure 5*

4.2 **In Gavi 5.0 the Alliance will prioritise the conclusion of long-standing introductions and scale-up programmes** including measles second dose, rubella, yellow fever, rotavirus and pneumococcal vaccines along with the continued scale-up of human papillomavirus (HPV) and Typhoid Conjugate Vaccine (TCV). **However, the pace of new vaccine introductions is likely to be impacted by the duration and intensity of the pandemic.**

4.3 **Coverage for Pneumococcal conjugate vaccine (PCV), Rota and Hib vaccines in Gavi-supported countries is now higher than the worldwide average**, reflecting decades of progress and hard work by countries and Alliance partners to support introductions and scale up coverage. The scale-up of PCV in Indonesia and India is expected to drive the largest vaccine uptake and the Alliance will also strengthen support to fragile countries with strong political will to introduce PCV. In addition, in the next strategic period Gavi expects increased HPV vaccine supply from both existing and new manufacturers. If these supply expectations materialise and the impact of COVID-19 on demand and country uptake is minimised,

**Gavi's HPV programme may reach 75 million adolescent girls during the 5.0 period.**

4.4 Gavi will **continue its investments in preventive programmes for diseases with outbreak potential as well as stockpile investments, including endemic cholera and multivalent meningitis** (approved through the Vaccine Investment Strategy (VIS)). Since the beginning of Gavi's support for Oral Cholera Vaccine (OCV) both available supply and country demand have rapidly increased. While supply capacity from existing and new manufacturers is expected to increase in 5.0, the short- to medium-term impact of COVID-19 is still to be fully understood, meaning supply planning will remain challenging. For multivalent meningococcal vaccines, suitable immunisation product(s) are set to be added later in the new strategic period.

4.5 **Support for other VIS vaccines including rabies, Hepatitis B birth dose and DTP boosters, would be paused during the acute phase of the pandemic**. The lead candidate for **respiratory syncytial virus (RSV)** did not meet its primary endpoint and therefore will not meet the timelines seen in the VIS**.** These **delays are forecasted to incur an estimated savings of US$ 72 million**[4] during Gavi 5.0. Gavi will reassess the decision to defer the addition of new vaccines to its portfolio on a periodic basis, taking into account the effect of the pandemic on introductions from ongoing vaccine programmes and country specific financial and programmatic capacity to add more vaccines to their schedules.

4.6 For the regular portfolio of vaccines, Gavi **currently forecasts about 160 routine introductions and campaigns (ex. IPV) across the Gavi 5.0 period**. Countries forecasted to conduct IPV catch-up campaigns could add 15 introductions to this total. Gavi will also support countries with incorporating a second dose of IPV into their routine immunisation schedules, in line with GPEI and SAGE recommendations. A further 50 launches could come from OCV and multivalent meningococcal vaccines. While the forecasted estimate factors in a **certain level of slowing down of introductions from the impact of the pandemic** during the acute phase, it does not reflect the required effort in introducing a potential COVID-19 vaccine from countries causing other vaccine launches to be potentially delayed.

4.7 The Secretariat requests the Board to **provide perspectives and guidance on the approach to vaccine introductions explained above.**

## 5. Delivering COVID-19 vaccines

5.1 **Significant efforts are underway to help countries prepare for COVID-19 vaccine delivery.** Based on current assumptions, the focus will initially be on immunising frontline workers in health and social care settings, and then on other high-risk groups including those over 65 years or those with co-morbidities. Targeting and delivery strategies are still being developed.

[4] Financial forecast is based on assumption that introductions will resume in 2023

Uncertainties related to vaccine profiles (e.g. dose schedule, cold chain requirements, efficacy/effectiveness and safety) require the Alliance and countries to plan for multiple delivery scenarios (for further detail see Doc 03).

5.2 **Despite these uncertainties, countries need to begin planning for vaccine introductions now.** Alliance support will be urgently needed in the coming weeks and months to meet the anticipated timelines for in-country delivery. This is particularly relevant for services that have long lead times, including the procurement of cold chain equipment (CCE), as well as technical assistance to support effective delivery planning and execution at country level.

5.3 **Given the urgency of preparing for the introduction, the Board is being requested to allocate US$ 150 million from core resources** for the operationalisation of COVID-19 vaccine programmes and vaccine deployment[5]. Further details, including on the decision point, can be seen in Doc 03.

## 6. Safeguarding domestic financing of immunisation

6.1 **The continued worldwide spread of COVID-19 has significant impact on macro-economic and fiscal stability**. To ensure immunisation services were not disrupted, the Board exceptionally approved flexibility by granting the CEO the authority to provide waivers of 2020 co-financing on a case-by-case basis and upon request by a country. This has been applied judiciously, with the Alliance's engagement geared towards finding possible alternative solutions and ensuring that waivers are granted only in exceptional circumstances. As such, the **Secretariat has been working closely with Alliance partners, in particular the World Bank, to protect the significant gains achieved in strengthening the financial sustainability of immunisation programmes.** As of August 2020, over US$ 85 million (57%) of 2020 co-financing obligations had already been transferred by countries. Furthermore, out of eleven countries that have requested co-financing waivers[6], four have now indicated that they expect to fulfil their obligations.

6.2 Nevertheless, given the continued low visibility on the pandemic's impact in 2021 and beyond, Gavi's response must remain flexible and agile. It is therefore **proposed to roll over the unused US$ 85 million of the US$ 150 million originally envisaged for co-financing waivers in 2020 into 2021**, which will only be used as a last resort.

6.3 **The macroeconomic impact of the pandemic is likely to affect countries' transition trajectories and their expected co-financing. The fiscal squeeze resulting from the pandemic may exacerbate the risk**

[5] Proposal is based on the precedent set by the 2016 approval for core resources to be used to jumpstart the Ebola program while external fundraising was ramped up.
[6] At its May 2020 meeting, the Board has granted the CEO the authority to provide select waivers for 2020 co-financing.

**that countries are unable to co-finance vaccines.** This could, in certain scenarios, result in a much larger share of countries remaining in the initial self-financing phase by 2025 compared to previous projections, thus decreasing the total amount of co-financing expected in the next strategic period.

6.4 Because of these multiple effects, total expected co-financing could thus be reduced substantially in 2021 to 2025. A reduction of **US$ 150-200 million in co-financing has been reflected in Gavi's financial forecast for 2021- 2025.**

## 7. Other priorities with potential future resourcing implications

7.1 **The Alliance is working through further programmatic priorities critical for delivering on Gavi 5.0.** These includes innovation, VPD (vaccine-preventable disease) disease surveillance, support to former and never Gavi-eligible countries, the strategic partnership with India as well as fiduciary risk assurance and financial management. These are briefly described in the following paragraphs. The Secretariat is **seeking guidance from the Board on the broad direction of the priorities** to be able to develop them further in the coming months and bring back to the PPC and the Board.

7.2 *Innovation:* **Achieving Gavi's strategic goals and objectives will require the Alliance to implement and scale-up innovative approaches based on country needs.** Over the last five years, the Alliance has invested in and learned from a range of experiments in accessing and promoting innovation. This experience suggests that building an innovation ecosystem that is firmly grounded in the needs of countries requires further efforts in market shaping, coordination and support across Alliance stakeholders. At the December Board meeting, the Alliance will present an innovation strategy which includes a revised process for governing, financing and coordinating investments in scaling up practices, services and products that would **catalyse Gavi's strategic objectives including the approach to identifying and reaching zero-dose children and missed communities, and to successfully deliver COVID-19 vaccine** (e.g. through leapfrogging digital systems).

7.3 A **cohesive, structured and systematic approach to innovative investments** will help the Alliance to *advocate* for missed communities more effectively, for example via digital engagement and behavioural interventions; *identify* missed and under-immunised communities, using techniques such as geospatial data analysis; *reach* children through new products such as micro-array patches, heat-stable vaccines, barcoding and other products that have the potential to transform immunisation delivery systems; *monitor* the implementation of programmes via live planning, real-time monitoring of campaigns, optimised vaccine supply chain management and e-LMIS-enabled logistics; and *measure* effectiveness and efficiency by empowering district health teams and alliance partners to visualise coverage, stock, surveillance and population data. In India for example,

Gavi supported the Rapid Immunization Skill Enhancement (RISE) training module to strengthen the ongoing training of frontline health workers engaged in routine immunisation using mobile learning solutions. This was particularly effective during the pandemic where lockdowns and physical distancing measures required new ways of preparing frontline health workers. Such interventions will be scaled up.

7.4 **As an early estimate, an additional US$ 150 to 200 million of dedicated innovation funding may provide the needed impetus to catalyse and accelerate innovation.**

7.5 *VPD surveillance:* **Vaccine-preventable disease (VPD) surveillance enables more effective, efficient, sustainable and equitable use of vaccines** by helping countries to identify children and communities missed by immunisation more quickly and supporting the targeted use of vaccines. However, significant barriers to scaling up and strengthening VPD surveillance remain in Gavi-eligible countries. The COVID-19 pandemic has underscored the importance of adequate surveillance data for all countries in order to guide decisions about disease prevention and control measures as a critical part of global health security.

7.6 **US$ 75 to 100 million is proposed as the Alliance investment in VPD surveillance** contingent on developing a concrete proposal in collaboration with Alliance partners for consideration by PPC and the Board. For example, Gavi's catalytic support on strengthening yellow fever diagnostics during the current strategic period appears to be successful. Similar efforts to strengthen laboratory testing for public health needs where there is an important gap could be considered for other vaccine preventable diseases. Without this investment, the ability of countries to detect an outbreak, and respond with speed is compromised. This is more critical now as polio investments in surveillance are winding down.

7.7 *Former and never Gavi-eligible countries:* In Gavi 4.0 the Alliance has been providing technical support through post-transition engagement for former Gavi-eligible countries. In light of COVID-19, the Board recently approved an initial allocation of US$ 20 million to provide targeted support to mitigate programmatic backsliding and help recover coverage levels in former Gavi-eligible countries highly affected by the pandemic. **As part of Gavi 5.0, the Board requested the Secretariat to develop an overarching approach for engagement with former and select never Gavi-eligible countries and allocated up to 3% of planned expenditure in Gavi 5.0 for this engagement.** This approach aimed to prevent backsliding in former Gavi-eligible countries and support the introduction of new vaccines in some never Gavi-eligible countries. This work was temporarily put on hold due to COVID-19 and the immediate focus of countries and partners on responding to it.

7.8 However, the originally envisaged objectives are more relevant than ever. Therefore, the **Secretariat will present a high-level view of a future strategy to the Board in December**, taking into account the heightened risks of backsliding due to COVID-19 and the additional need to support

countries to introduce a future COVID-19 vaccine. In the meantime, our active dialogue and work with these countries as part of the COVAX Facility will facilitate our engagement with them on this work. The Secretariat will continue to reflect and learn from the impact of the pandemic on both countries and the Alliance, ahead of bringing back the detailed approach to the Board later on.

7.9 *Strategic Partnership with India:* The Secretariat has initiated work on an investment case to continue the strategic partnership with **India, which does not receive formulaic support from Gavi given its large birth cohort and financing implications.** Instead a strategic partnership between Gavi and India was established in Gavi 4.0 to provide catalytic support of US$ 500 million for introduction of new vaccines and HSS.

7.10 **India used to have the highest number of under-immunised children in the world.** Due to the intense effort by the Indian government to reach them, they are now second in number. India is expected to transition out of Gavi support at the end of 2021 although the substantial financial effects of the COVID-19 pandemic may put this at risk. The country has the highest number of COVID-19 cases in all Gavi-supported countries, individually accounting for 70% of all cases. This has led to large scale disruption of services but more notably a massive fall in economic growth.

7.11 **Given India's large birth cohort, deep inequities, lack of introduction of key vaccines such as HPV and potential for public health impact, a new strategic partnership will be developed for Gavi 5.0.** As India is also a major vaccine producer with the world's largest birth cohort, the Alliance's work in market shaping is also critical. India has received a total of US$ 905 million in Gavi support to date, which in per child terms is the lowest among Gavi countries (except Ukraine). Countries with much smaller birth cohorts have received much higher Gavi support in absolute terms (Nigeria, with a birth cohort of 16.6 million less than India but GNI (gross national income) higher than India has received US$ 1,154 million; Pakistan, which has a birth cohort of 18 million less than India has to date received US$ 1,470 million).

7.12 **Support in India is envisaged to be highly catalytic in the next strategic period accounting for US$ 200 to 250 million** to address the large subnational inequities, gaps in breadth of coverage and country-specific challenges related to COVID-19.

7.13 *Fiduciary risk assurance and financial management:* **Investments** in fiduciary risk assurance and strong financial management in countries are **critical to ensure timely, efficient and equitable funding of immunisation activities while minimising the risk of misuse and increasing the share of funds flowing through governments**. Rapid funding for the immediate COVID-19 response may entail a higher risk of misuse and thus increase the needs for such investments. At the same time, the focus zero-dose children and missed communities increases the need for timely funding of activities at sub-national level and will require strong financial management capacity of involved actors.

7.14 Early **cost estimates for fiduciary risk assurance and financial management capacity building range from US$ 75 to 125 million**. The Secretariat will come back to the Board in December with a refined estimate.

## 8. Partners' Engagement Framework (PEF) for Gavi 5.0

8.1 **Partnerships are at the heart of the Gavi model.** The Partners' Engagement Framework (PEF) was introduced in 2016 to leverage the comparative advantage of WHO, UNICEF, World Bank, Centers for Disease Control and Prevention (CDC), Civil Society Organisations (CSOs) and other partners. Besides global and regional levels, partners are funded at country level to provide technical support.

8.2 The latest financial forecast presented to the Board in July 2020 had allocated an increased amount of US$ 1,365 million for PEF's programmatic activities in 2021-25, taking into account the surge needed for 2020-2021. Given increased demands on partner's capacity in light of COVID-19, and Gavi's ambition on zero-dose children and missed communities, **an additional US$ 148 to 157 million for 2021-2025 may be necessary** encompassing increase in funding to partners at global and regional levels under the Foundational Support (FS) and special investments in Strategic Focus Areas (SFAs) and at country level under TCA. TCA funding would be through a five-year envelope, approved as part of the financial forecast, which countries can access over the strategic period.

8.3 **At a global and regional level**, an increase of US$ 48 to 53 million in Foundational Support (FS) and Strategic Focus Areas (SFA) may be needed to accelerate normative guidance and transformative tools, particularly in reaching zero dose children and missed communities. Understanding and addressing **gender-related barriers** which are important to reaching zero-dose children would be an area of focus. There is a need to quickly design gender responsive and transformative interventions, undertake implementation research and rapidly document and disseminate what works. This will greatly assist in implementing Gavi's ambitious gender policy. In addition, to mitigate the risks of **vaccine hesitancy**, a more systematic approach to social listening and engagement needs to be rapidly developed. This will help develop a common taxonomy and approach for addressing misinformation, with critical new partnerships bringing new skills and expertise to the Alliance.

8.4 At a **country level**, increased technical assistance would be needed to support countries to maintain, restore and strengthen immunisation in the wake of COVID-19 and for the equity agenda. There is broad recognition that successfully identifying and reaching zero dose children will require working with local partners such as CSOs, faith-based organisations and humanitarian actors that work at grassroots level and are trusted by communities. **An increase of US$ 80 to 84 million is proposed for PEF TCA**, bringing the total amount for Gavi 5.0 to US$ 500 million. Around 30% of this total would be focused on local partnerships for zero-dose children and missed communities.

8.5 Finally, **US$ 20 million would advance the zero-dose learning agenda** at a country and global level (reflected under PEF Targeted Assessments).

8.6 **Without dedicated additional funding for Alliance partners and community organisations, Gavi's investments are unlikely to yield the required results.** Partner support is necessary given countries require technical knowledge as well as hands-on, operational support in difficult and underserved settings to maintain, restore and strengthen immunisation services and define appropriate strategies for identifying missed communities and zero dose children. In addition, funds allocated as part of Gavi 5.0 are at the same level as Gavi 4.0- despite additional needs.

## 9. Secretariat capacity and resourcing

9.1 The Secretariat has been highly stretched owing to growing complexity, volume and breadth of work. **Additional capacity is needed to equip it to exercise effective stewardship of resources and priorities. Resources** for 2021-2025 for the Secretariat might be required to be increased by 15 to 20%, corresponding to US$ 84-112 million, which would be substantiated and confirmed as part of the ongoing organisational review of the Secretariat. The Secretariat will bring back the approach for adjusting Partner and Secretariat resourcing to the next meetings of the AFC and Board.

## 10. Summary of priorities and indicative investment amounts

10.1 Table 1 gives an **overview of the recalibrated programmatic priorities and indicative amounts for the associated investments**. These are based on initial high-level assumptions and indicate the underlying relative prioritisation of the various programmatic areas.

*Table 1: Programmatic priorities and indicative investments*

| **Programmatic priority** | **Approved investments (US$ million)** | **Indicative additional investments (US$ million)** *Lower range* *Higher range* |
|---|---|---|
| *Available funds for current investments as per financial forecast presented to AFC in Sept. 2020* | | *1,662*[7] |
| **Recalibrated priorities** *(requiring urgent action)*: | | |
| **Maintaining, restoring and strengthening immunisation services** | 1,200 | 0 |
| **Reaching zero-dose children and missed communities** | 0 | 500 |
| **Pacing the expansion of new vaccines** | - | N/A[8] |
| **Delivering COVID-19 vaccines** | - | 150 |
| **Impact on co-financing** | - | 150 - 200[9] |
| **Further priorities** *(to note and to be brought back to the Board at a later stage)* | | |
| - Innovation | - | 150 - 200 |
| - VPD surveillance | - | 75 - 100 |
| - Former and never Gavi-eligible countries | 281[10] | TBD[11] |
| - Strategic partnership with India | - | 200 - 250 |
| - Fiduciary risk assurance and financial management | - | 75 - 125 |
| **Alliance partner and Secretariat resources** *(to note and to be brought back to the Board at a later stage)* | | |
| - Partnership Engagement Framework (PEF) | 1,365 | 148 - 157 |
| - Gavi Secretariat | 557 | 84 - 112 |
| **Total of indicative additional investments** | | **1532 - 1794** |

10.2 Funds raised through the June 2020 replenishment included US$ 413 million for Strategic Investments[12], enabling Gavi to allocate funds to emerging priorities. If all of the above priorities were adopted at their lower

[7] Includes US$ 413 million of Provision for Strategic Investments allocated to Available Resources
[8] Savings of US$ 72 million have been included in the financial forecast presented to AFC in September 2020.
[9] Corresponds to anticipated reduction in co-financing amounts, not additional investment.
[10] In June 2019 the Board approved an envelope of up to 3% of then projected Gavi 5.0 expenditure for the MICs Approach, equal to approximately US$ 281 million
[11] Financial implications of new approach on former and never Gavi-eligible countries to be presented at later stage.
[12] This amount is included in the total available funds of US$ 1,662 million

range, US$ 130 million[13] would remain as strategic reserve. Given the uncertainties on the impact of the COVID-19 pandemic, **Gavi will retain its ability to reallocate funds accordingly and guided by the Board.** The experience from previous strategic periods shows that reallocations remain possible as not all funding will be firmly committed until later in the strategic period and not all of the above priorities would be adopted at their maximum range.

## Section C: Actions requested of the Board:

The Gavi Alliance Board is requested to:

a) **Provide guidance** on the recalibration of programmatic priorities and how they reflect appropriate trade-offs in light of COVID-19 and the successful replenishment;

b) **Approve** an additional US$ 500 million to the HSS allocation of US$ 1.2 billion for the strategic period 2021-2025 as dedicated funding for zero-dose children and missed communities. This amount is in addition to the funding amounts included in the forecast presented and previously approved by the Board at its July 2020 meeting;

c) **Approve** the carry-forward of an amount of US$ 85 million in co-financing waivers and **extend** to 2021 the authority granted by the Board in May 2020 to waive 2020 co-financing obligations on a case-by-case basis upon request from a country;

d) **Note** that US$ 500 to 675 million may be required in 2021-2025 for innovation, vaccine-preventable disease (VPD) surveillance, the strategic partnership with India, and fiduciary risk assurance and financial management capacity, and will be brought back to the Board for decision in due course per guidance provided at the September 2020 Board meeting;

e) **Note** that to deliver on the recalibrated priorities an increase in PEF spending in the order of US$ 148 to 157 million may be required, and that the details of this request will be brought to the upcoming meetings; and

f) **Note** that additional Secretariat resources of approximately US$ 84 to 112 million may be required in 2021-2025, to be confirmed by the ongoing Organisational Review, and would be brought back to the October 2020 AFC and December 2020 Board meetings respectively.

## Annexes

**Annex A:** Zero-dose and equity approach to immunisation: best practices

[13] Based on lower range estimates for additional investments.