



Report to the GAVI Alliance Board

11-12 June 2013

Report of the Chief Executive Officer

4 June 2013

Dear Board Members,

Our meeting next week comes at a time when the vaccine landscape in the developing world is changing faster than ever before, and during a record year for growth in the Alliance's programmes.

From 2000 until 2012, the Alliance funded around one billion doses of vaccine. This year alone, we will fund over six hundred million doses. With Somalia's introduction of pentavalent vaccine in April, we are now supporting vaccine programmes in 72 countries. We are also starting funding for our newest vaccines: in the last two months the first GAVI-supported doses of human papilloma virus (HPV) vaccine was used by Kenya in a demonstration programme, and Rwanda introduced measles-rubella vaccine. Recent announcements have shown that we are successfully shaping vaccine markets. The tremendous attention that the new lower price for HPV vaccine attracted gave further evidence of the strength of the Alliance and the coalition working to tackle cancer and improve women and girls' health. In this record year we are expecting to support 33 vaccine introductions into routine schedules, 14 campaigns, and seven HPV vaccine demonstration programmes. In addition to the HPV and measles-rubella vaccine programmes, measles campaigns are also starting this year. When the Alliance raised funds to sustain GAVI up to 2015, we were aiming for the acceleration in vaccine introductions that we are now seeing. We are having a massive impact on the health and well-being of millions of people.

After almost two years as CEO, I would like in this report to give you an overview of the issues on the Board agenda, and some early thoughts on GAVI's next phase. First let me begin with an update on some of the exciting developments since the last Board meeting.

The December meeting was followed by the Partners' Forum, which brought together more than 650 leaders, experts and practitioners from across the vaccine world. During the Forum, **Tanzania** simultaneously launched pneumococcal and rotavirus vaccines. In an important example of south-to-south collaboration, Tanzanian programme managers before the launch visited and studied the experience of **Ghana**, which in April last year became the first country to launch the two vaccines simultaneously. When I returned to Ghana in March this year, with Bill Gates, we saw a country with a strong commitment to its primary healthcare system. What particularly impressed us was the extent to which data was collected and used at all levels to strengthen performance. There will be post-introduction evaluations in Tanzania and Ghana later this year; in both countries the early signs are that the introductions went well, with high levels of coverage being reported.

In April **Uganda** introduced the pneumococcal vaccine. The vaccine represents a great opportunity for the country, where more than one in ten of children's deaths before their fifth birthday is caused by pneumonia. However, introduction across the whole country will take several months, due to a lack of vaccine supply and of country readiness. The immunisation programme has had a number of difficulties – there has been no EPI manager for almost two years; there is also currently no supervisor for that post; staffing and funding is insufficient; and the vaccine supply chain needs to be strengthened. As a result, coverage levels are not what they should be. I attended the launch and had the opportunity to discuss this with partners, parliamentarians, officials and ultimately the President, who is certainly committed to immunisation and increasing coverage. I am hopeful that the issues will be addressed.

The challenges Uganda faces are in some ways particular to that country but we can also see that supply constraints and issues of country readiness have had a wider impact across our programmes. We remain on track to meet the **targets under our strategy** of supporting countries to immunise nearly a quarter of a billion children by 2015 – often with many vaccines – and prevent approximately four million future deaths. However, despite the rapid pace of new vaccine introductions, we are not fully meeting our coverage targets, and the estimates are slightly lower than those presented in December. In relation to pentavalent vaccine we are projecting a 2012 coverage level of 43% against a target of 50%; for pneumococcal vaccine, 10% against a target of 17%; and for rotavirus vaccine 3% against a target of 5%. We will learn more when WHO and UNICEF publish their coverage estimates for 2012 next month. I would note that the original targets were set without reference to potential constraints on supply or country readiness so it is not surprising that we are not tracking them exactly, but nevertheless, we need to take these trends seriously. On the supply issues, discussions are underway with manufacturers, and I will update the Board on these when we meet.

On country readiness, there are encouraging signs in three large countries – Nigeria, Indonesia and India – which will have an impact on the coverage targets. In **Nigeria**, there has recently been a stronger focus on immunisation by the government and partners. This has been driven by a combination of alarm about coverage levels and stock-outs last year, an intense focus on polio and growing cooperation with the eradication effort, and the scale of new immunisation activities. These include completing the introduction of pentavalent vaccine, the proposed introduction subject to supply of pneumococcal vaccine at the end of the year, and campaigns against yellow fever and measles. The government is now reporting a decline of 53% from March 2012 to March 2013 in the number of unimmunised children and we look forward to seeing their official coverage numbers. Continued leadership by the government and cooperation among partners will be required to maintain momentum.

The government of **Indonesia** has recently confirmed that the roll-out of pentavalent vaccine, which usually takes three or four years in a large country, is now being fast tracked so that 100% of the infants are targeted to receive pentavalent vaccine by the end of 2014, following the planned launch in August 2013.

The elimination of polio in **India** has created renewed momentum on immunisation. Self-financed measles campaigns that have continued this year have reached around 119 million children (c.85% coverage). Pentavalent vaccine has now been introduced

with GAVI support in eight states, and Delhi has introduced the vaccine with its own resources. Ten further states have requested introductions and we are actively in discussion with the government about national roll out. We will have the opportunity to discuss this further at the Board meeting. I would also note that the roll out of pentavalent vaccine has been accompanied by the adoption of WHO's open vial policy, which means that when multi-dose vials are partially used, they are stored for a limited period for future use, instead of being discarded. Consequently the wastage rate for the ten dose vial in the states where pentavalent has been rolled out has fallen from 25% to 15%. A health systems strengthening (HSS) proposal for \$107m over three years was recommended for approval by the IRC, subject to clarifications, amongst other things to support India's innovative supply chain work and other system strengthening in low coverage states, including by redirecting some of the resources devoted to polio elimination to routine immunisation. Finally, India recently announced successful results of a phase III clinical trial of a new Indian rotavirus vaccine. Discussions are already underway about roll out of the vaccine as soon as it is licensed, which could be as soon as the end of this year.

At the end of last year, the Board approved a policy on a **country by country** approach and work is underway on these for the Democratic Republic of Congo (DRC), Nigeria and Pakistan. The government of **DRC** is showing an increased commitment to immunisation, and it is now funding routine vaccines for the first time. We approved the further roll out of pneumococcal vaccine last year when DRC had cleared its co-financing arrears, and introduction in all provinces is expected to be completed by October. However, the country is now in partial default of its co-financing obligations for 2012, although we have been assured that we will receive further payments shortly. We are continuing to discuss this with the government.

Pakistan is expected to complete the introduction of pneumococcal vaccine by October. We are working with the World Bank to strengthen the immunisation programme, and on a separate project to demonstrate the economic benefits of immunisation in Pakistan. GAVI's funding commitment to Pakistan is larger than to any other country, and the management and oversight of that funding has been particularly challenging during the period following the decision to abolish the federal ministry of health, because from a GAVI perspective some issues do need to be addressed across the whole country. The chair of our Evaluation Advisory Committee, Sania Nishtar, has been appointed a minister in the interim government, and my understanding is that discussions are underway to strengthen coordination at the federal level.

I would like to provide some background on the three ways we provide support for tackling **measles** (in addition to our funding for the Measles and Rubella Initiative). First, GAVI funds countries to introduce a second dose of measles vaccine into their routine immunisation systems. We expect 19 countries to take up this support by 2015, which represents an effective way of strengthening immunity to measles without the disruption and cost of a campaign. Second, in 2012, the Board approved funding of campaigns using measles-rubella vaccine, with the agreement that countries will then self-finance the introduction of the vaccine into their routine schedules. We forecast that 24 countries will have done this by 2015.

Third, in June 2012 the Board invited six countries at high risk of measles outbreaks (Afghanistan, Chad, DRC, Ethiopia, Nigeria and Pakistan) to apply for funding for

measles campaigns to control the disease before they had had the opportunity to introduce measles-rubella vaccine. Measles outbreaks led countries to submit applications earlier than expected. The window's costing based upon partners' advice assumed children up to the age of five would be covered by the campaigns, because most measles deaths are among this age group. The case for immunising older children is that it further decreases virus circulation in a population, and having taken a new look at the (imperfect) epidemiological data, Ethiopia and DRC applied earlier this year for campaign funding that included older children. The IRC recommended these applications for approval. At its meeting in Barcelona, the Executive Committee (EC) decided to limit GAVI support to measles campaigns for children under five. The feedback we have received is that countries have understood GAVI's decision and are seeking other funds where they have decided to cover older age groups.

We also had a challenging EC discussion around Pakistan's application for support for a measles campaign. The context was that several Alliance partners with offices in Pakistan had expressed concern about the application, the quality of the coverage data, and the technical support being provided, and the EC asked for further work to be done.

We are now planning to use our support for measles campaigns as a way of strengthening GAVI's approach to **campaigns** more generally. For the first time in GAVI's history, countries applying for measles campaigns are asked to include specific activities related to the campaigns, which will also strengthen routine immunisation. This is a learning process, but why should it not be the norm for all planned, preventative campaigns that they strengthen routine programmes rather than disrupting health services? We also need to make sure that we are clear about the boundary between planned campaigns, which use GAVI's approval process, and emergency responses, which are for the Measles and Rubella Initiative. We have started some work on these issues, which will be brought to the Board in due course.

As we discussed at the Board retreat, we continue to work hard to ensure that **health system strengthening** (HSS) funding targets bottlenecks in country health systems and is linked to improving immunisation outcomes as well as strengthening systems. To take an example of this, for the first time in GAVI's history, the HSS IRC in April approved 100% of the applications before it. They commented on the quality of the applications, the strength of the linkages to immunisation systems and measurable outcomes, and noted that countries had made progress on equity and gender issues, although more focus was needed in these areas. Grants totalling \$611 million have been approved, of which \$447 million has been disbursed (and \$22m for Nigeria soon to be disbursed), reflecting increases from \$512 million and \$410 million, respectively, in December 2012. Performance based funding has now been introduced in 17 countries. The renewed momentum behind the International Health Partnership (IHP+), which was the focus of a special event at the World Health Assembly hosted by Margaret Chan and Jim Kim, is welcome and offers the possibility of better cooperation with partners around country plans. We have been participating actively in the IHP+ process since it started and we will be working to ensure that any steps taken are practical and actually improve outcomes on the ground.

Board agenda

I will now turn to some specific items that will be discussed at the meeting next week; more details are in the Board papers, and in some cases on MyGAVI.

GAVI's success rests on dispassionate analysis of the evidence, including in the selection of the vaccine portfolio that GAVI will support. The **Vaccine Investment Strategy (VIS)** process is underway and at this meeting we will take a look at the results so far (agenda item 6). By scanning the vaccine horizon now, GAVI can signal what vaccine developments are most important in achieving our mission, making our programming predictable to countries and informing our long term resource needs. We need to weigh carefully the health impact of a particular vaccine against the cost and feasibility of implementation. We also need to consider vaccines with global impact versus those targeted on particular areas or groups. And of course, we need to understand country priorities and system readiness. There has been a wide consultation, including input from an Independent Expert Committee, on the VIS's framework for decision making. This culminated in agreement that the primary basis should be health impact, along with value for money and epidemic potential, for prioritising potential investments for further evaluation in the next phase.

There has also been detailed analysis and widespread consultation on the application of that framework, which has filtered the range of candidate vaccines from the original 15 and has at this stage assessed that malaria and rabies vaccines, and influenza for maternal immunisation, have relatively high potential for health impact, with cholera and yellow fever (renewed funding for campaigns in high risk countries) also included on the basis of their capacity to combat epidemics, and value for money. The PPC supported the framework, and the preliminary results, and asked that the outcomes of the analysis in the next phase should be benchmarked against the vaccines in GAVI's current portfolio. This last point is important: we need to understand whether and how GAVI could expand its portfolio. At this stage the Board is asked to consider the PPC's recommendations to move the work forward, so that a decision can be brought to the Board in November.

For the past 12 years, GAVI and the Global **Polio Eradication** Initiative (GPEI) have frequently focused on the same countries – because where immunisation systems are weak, polio has been toughest to stop – but often using parallel systems. At the end of last year the Board supported GAVI playing a complementary role to the GPEI in eradicating polio, including through strengthening routine immunisation, and we have been working up what this complementary role should be (agenda item 7).

Consideration of investment in inactivated polio vaccine (IPV) was presented to the PPC within the framework of the VIS (see above). But the PPC noted that the VIS criteria do not help us understand the case for IPV in the way they help us understand the case for malaria or cholera vaccines. IPV would be part of a strategy to complete and secure eradication, as it can boost the immune response and does not cause the vaccine-derived cases that oral polio vaccine (OPV) rarely can. This is why IPV has been used in wealthy countries for many years. The PPC recommendation to the Board, given the urgency of the polio eradication effort, was that preparations for procurement and implementation of GAVI support for the introduction of IPV should begin. The PPC also recommended that approval should be subject to sufficient additional funding being available, as there is no current

provision for IPV in GAVI's budget. We would of course not want support for IPV to undermine GAVI's capacity to achieve its existing targets.

I know from previous discussions with the Board that there is a clear appreciation of the risks involved in GAVI contributing to the routine aspect of polio eradication. Eradication has taken longer than initially forecast. It is controversial in some countries, and is associated with parents or communities refusing vaccination. Other countries ask why they should pay for IPV when they have eliminated polio with high routine OPV coverage. And questions have been asked about how the polio eradication effort – which has relied so heavily on campaigns for so long – has coordinated with and impacted on routine immunisation.

My view is that the risks are worth the rewards, because the clear evidence from the Vaccine Summit in April was that GPEI – and its donors – absolutely understand the importance of routine immunisation. The GPEI's Polio Eradication and Endgame Strategic Plan, which was launched at the World Health Assembly in May, has had input from GAVI staff and strengthening routine immunisation is one of its main objectives. Discussions have been underway, both globally and in key countries such as Nigeria, to make this shared objective operational. For example, the plan includes a commitment by GPEI to support improvement in DTP3 coverage of at least 10% annually in 80% of high risk districts of all focus countries, and also proposes that by the end of 2014, polio-funded field personnel will devote 50% of their time to strengthening routine immunisation.

In addition, the costs and risks of GPEI becoming the vehicle for the widespread introduction of IPV, a new injectable vaccine, into routine immunisation systems, in parallel to GAVI's work to support the introduction of new vaccines into country immunisation systems, are clear. We have at this moment the opportunity to bring greater resources and relevant experience to bear on strengthening routine immunisation, as well as securing and advancing the gains of polio eradication. I would therefore encourage the Board to accept the PPC's recommendation that, even though a series of policy questions remain and will need to be resolved, preparations for IPV introduction should begin.

The change process in GAVI last year looked at how countries apply for funding, applications are considered, and programmes are monitored and reviewed, and found that transaction costs were high but that we did not manage the risks in GAVI's programmes well enough. We brought together a group from across the Alliance to make recommendations for improvements to the **grant application, approval, monitoring and review** process (agenda item 12). We have consulted widely on the group's proposals, including with existing IRC members. I would stress that the proposed new system cannot in itself remove the risks in GAVI's programmes: the aim is to make sure risks are better understood, to tailor our efforts better according to a programme's particular risks, thereby improving decision making, and to strengthen accountability for programme decisions. These issues came out clearly in the PPC discussion, and I welcome the PPC's support for the changes.

All of you know that there are significant **risks** inherent in GAVI's work, and I have flagged some of them above. We make progress not by avoiding those risks but by clearly acknowledging and addressing them, recognising that there will be an irreducible core that we cannot fully mitigate or eliminate: we will have the chance to discuss this during the meeting (agenda item 15). Internal Audit is one of several

resources available to GAVI to help us manage that process; Simon Lamb, who became Managing Director Internal Audit at the beginning of this year, is currently undertaking an audit of our risk management process with a fresh set of eyes, and he will be able to discuss that with you during his report (agenda item 16).

Looking to the future

I have received a great deal of positive comment about **GAVI's strategy** for 2011-2015. Its logical structure, cascading from the mission to the strategic goals, objectives and indicators has been referred to as a model for other organisations, and has, I believe, helped to bring rigour to the Alliance's work. The process of developing a new strategy for 2016-2020 has begun, under the supervision of the EC. This process is starting with an analysis of the landscape that GAVI faces, and interviews that Helen Evans has been conducting with each Board member. Using this as a base, we will consult widely to test the emerging findings. I am grateful to you for the enthusiasm you have all brought to the process so far. At the November Board meeting we will consider possible strategic shifts, develop the picture in more detail at next year's Board retreat, and bring a final draft of the strategy to the Board meeting in June 2014.

At our last Board meeting we spoke about the importance of improving the **vaccine supply chain**, and work is underway to develop a cross-Alliance strategy that will be brought to the Board in November and will provide one of the inputs to next year's Business Plan. There is much that we can learn from the private sector on this issue, and discussions have been underway with a number of companies and private foundations that are interested in helping by providing expertise and funds. With Steve Davis, CEO of PATH, I held a stimulating discussion at the TED conference about new directions on the supply chain and how we can better use technology, and we are continuing to follow up these discussions.

A number of areas of work are being taken forward under the supply chain strategy, with the aim of ensuring that viable vaccines are available when they are needed, and utilisation of vaccines is increased (i.e. wastage is reduced). For example, we know that the **cold chain** in many countries is not sufficiently reliable: according to an overview of other studies by PATH, a large proportion of vaccines have some exposure to freezing temperatures, which risks making them ineffective. And the cold chain needs to continue to be scaled up to accommodate the powerful new vaccines which countries are introducing. By shaping the cold chain equipment market – just as we have shaped vaccine markets, though they are of course very different – we can advance the introduction of new and appropriate technologies at lower costs that will meet this need. Another workstream involves setting a standard for **bar codes** on vaccine packaging, potentially automating data capture from one end of the supply chain to the other, strengthening stock management and patient safety. This and our other work on the supply chain needs to be considered from the perspective of health workers – are we increasing the time they have to immunise kids and track and serve the unimmunised?

We will only be able to achieve an improvement in our supply chain if we increase transparency, so that data can be used to strengthen management at all levels, and the same applies to other areas of the Alliance's work. Board members will have noticed that **improving data** is a regular theme of my reports. We held a data summit in January and following this we are making a coordinated effort with WHO,

the Global Fund and others to help countries strengthen mechanisms for assessing data quality and tracking improvements through report cards. We are also looking at how the gaps between survey rounds can be reduced. For example, in Nigeria we are working with UNICEF and others to use an existing nutrition survey to cover immunisation, with the first round later this year to assess coverage of the GAVI supported measles campaign and sub-national estimates of routine coverage. And through the full country evaluations – currently being rolled out in Mozambique, Uganda, Zambia, Bangladesh and also being considered with India – we are exploring ways to address discrepancies between coverage estimates. We hope eventually to standardise these methods to make them available in other settings, and to use biomarkers to inform an understanding of the immunological impact of vaccination.

The new GAVI strategy will be central to our **resource mobilisation** efforts (agenda item 13). Our first task is to make sure that pledges for the current replenishment cycle are extended through 2015 and are turned into deposits with GAVI. Out of \$7.4 billion pledged for 2011-2015, \$6.6 billion has been secured through signed legal agreements, the majority multi-year. Based on current expenditure estimates until 2015, and in line with the discussion with the EC and at the Board Retreat in Barcelona, an additional \$431million is required to meet funding needs until 2015. While some existing donors were not able to pledge through 2015, confirmation at this stage of their 2014-2015 pledges will be crucial to enable programmes to be approved in time to meet country needs.

At the **Vaccine Summit** in Abu Dhabi in April, \$4bn over six years was pledged to polio eradication. The Summit provided an opportunity to build the case for immunisation and for GAVI. We will be able to take this further in Stockholm at the end of October at the **Mid Term Review (MTR)**. The Ministerial meeting which will follow the MTR creates an appropriate context: the subject is “Reinvesting in health in the post-2015 agenda.” I am grateful to Sweden and to Anders Nordström personally for supporting and hosting the MTR. Following our discussion on the new strategy in June 2014, a replenishment meeting could take place at the end of 2014 or the beginning 2015, depending on our resource position and the election cycles of our key donors.

We continue to receive votes of confidence from donors, for example through the 17-donor MOPAN evaluation of GAVI, which was published in January and which highlighted financial management, accountability, country ownership, and relationship management as particular strengths. We were also pleased with the announcements of funding extensions from Japan, Germany and the USA, as well as Canada’s increased support for measles (\$20 million). However, we need to continue to demonstrate impact amidst challenging economic times for many of our donors.

We have been working hard to do this. I have just returned from Japan and the Tokyo International Conference on African Development (TICAD) V where we had great meetings with many different levels of the Japanese government including the Prime and Foreign Ministers. I was pleased to hear the Prime Minister say that Japan was seeking a growing relationship with GAVI over the mid and long term. Dagfinn visited Washington DC in February and had excellent meetings with both sides of the aisle in Congress and I will be following up with a visit after the Board meeting. Anders Nordström visited Germany in April, and Dagfinn will visit Brussels

later this month. Visits are being scheduled to most of our donors. And I would draw attention to Comic Relief, which has raised \$24m (including match funding) for GAVI in the last year, and through Red Nose day in March brought awareness of immunisation and GAVI to millions in the UK and around the world.

Another task in the resource mobilisation effort is to build new relationships. **China** provides a good example of this. China has played an important role in GAVI from the beginning. At the end of last year an evaluation was published on GAVI's partnership with China from 2002-2011 to introduce Hepatitis B vaccine and auto-disable syringes. GAVI's role was to catalyse the introduction of the vaccine; China provided 50% of the costs, and eventually funded introduction beyond the project area across the rest of the country. Because of China's size and the prevalence of Hepatitis B, introduction had a massive impact: almost 4m infections and 700,000 future deaths were prevented in project areas. China is now the world's second largest economy, and provides significant development assistance to many GAVI-eligible countries. There have been encouraging discussions with the Chinese government about how our partnership can move into a new phase, and in August Dagfinn will attend the Ministerial Conference of the Forum on China-Africa Cooperation.

Another good example is the **Islamic Development Bank**. In March I signed a memorandum of understanding with the Bank, and discussions are underway about how we can take this relationship further, given the importance of GAVI's work in Organisation of Islamic States member countries. I was also encouraged by my visit to **Saudi Arabia** in March, in particular by the keen interest of the Minister of Health in immunisation and GAVI. No country better appreciates the importance of immunisation than the host of the Hajj and Umrah pilgrimages.

As the replenishment process develops, we will set out GAVI's funding requirements in detail. At this point, I would note that the nature of the vaccine industry and immunisation programmes means long-term, predictable funding is critical. The international financing facility for immunisation (**IFFIm** - agenda item 14) continues to provide efficient long term funding to GAVI, most recently through a \$139m Japanese "uridashi" bond. Although as a result of downgrades of IFFIm's donors, IFFIm's rating has also been downgraded, the IFFIm Board, the Secretariat and the World Bank have taken action to prevent this from restricting GAVI programme approvals. IFFIm has continued to borrow at attractive rates, especially when compared to the weighted average borrowing costs of its donors, despite the downgrades. We need to make IFFIm a key part of our next replenishment. Another important element is contributions from the private sector. I have referred above to the expertise that we are drawing upon in our supply chain strategy. The **GAVI Matching Fund** has raised \$85 million (including matching) in its first two years and remains on track to reach its target of raising \$260 million by the end of 2015.

Leaving the process for raising funds from donors, there are three issues which are both important in themselves and also provide a vital context for the resource mobilisation efforts. The first of these are **countries' own resources**, which needs to play a significant role in the next replenishment. Co-financing does not happen automatically: several countries are in partial or complete default of their co-financing obligations for 2012. However, the fact that most countries met their obligations, many of which are increasing under the new co-financing policy, represents a

significant strengthening in political commitment by countries to fund their own immunisation programmes. By the end of 2013, around \$90m will have been provided by countries in co-financing. Renewed efforts are required by countries and the Alliance as a whole to make sure that as countries grow, more of their resources are devoted to health and immunisation.

A second area that is important both for implementing our existing strategy successfully and for resource mobilisation is **shaping vaccine markets**. After the first full year of implementing the vaccine supply and procurement strategy, we are making good progress, working closely with the BMGF and UNICEF Supply Division. The weighted average price per course of pentavalent, pneumococcal and rotavirus vaccines fell by almost a third from 2011 to 2012. The recent tenders for pentavalent vaccine resulted in one supplier contracting for the record low price of \$1.19 per dose, and for HPV vaccine there was another record price of as low as \$4.50 per dose to start our roll outs; as volumes increase, we expect to see the price to come down. Roadmaps for yellow fever and pentavalent vaccines were completed and work is underway on measles-rubella and rotavirus vaccines, with the aim of completing all roadmaps by the third quarter of 2013.

We have been engaging with civil society organisations (CSOs) on the issue of ensuring that vaccines are available to CSOs working on humanitarian emergencies and routine immunisation programmes in GAVI countries. CSOs regularly work with governments to access government stocks (secured at GAVI prices) and facilitate delivery to some of the hardest to reach communities. We were disappointed that Médecins Sans Frontières (MSF) chose to use a public campaign to address this issue with GAVI – which was already on the PPC agenda – but we remain committed to finding a solution through our discussions with the CSO steering committee and UNICEF Supply Division.

At the December 2012 Board meeting the Secretariat was asked to benchmark GAVI's vaccine procurement arrangements. A consultancy has been contracted to support this benchmarking, and the results will be brought to the November Board meeting.

While the discussion we held at the Board retreat on **graduation** made clear that there was no appetite to change GAVI's eligibility threshold, a recurring theme in the strategy interviews with Board members is that relying only on the GNI threshold may be too narrow an approach. There was also support at the retreat for the idea that we should look at the question of health system capacity in graduating countries, and perhaps consider additional technical assistance. The Board asked at the retreat that we work to ensure access to appropriately priced vaccines for graduating countries after their access to GAVI pricing ends, and perhaps to other **lower middle income countries** (LMICs) through tiered pricing and other initiatives. The UNICEF Supply Division tender for HPV, rotavirus and pneumococcal vaccines for these markets is one of the mechanisms under development to support the needs of LMICs; we are watching with interest how this is working, and remain committed to help if we can add substantial value.

The third area that is vital for our continuing work and for resource mobilisation is **making the case for immunisation**. The Secretariat and our Alliance partners continue to take every opportunity to do this. Beyond all the other work they do, Board members have been making a great contribution as advocates: in addition to

the examples set out elsewhere in this report, at the Africa Union Summit last month, Richard Sezibera chaired a breakfast on health, immunisation and GAVI; Dorothée Gazard, Minister of Health of Benin, co-chaired the GAVI update meeting at the World Health Assembly (which was standing room only, in a much bigger venue than last year); and I heard Awa Coll-Seck's voice loud and clear at Women Deliver last week in Kuala Lumpur.

Underpinning this advocacy is an evidence base on the **value of vaccines**. We convened 25 experts in health economics and other disciplines in January to help develop this. In line with discussions with the Board, there was agreement that we need a stronger focus on morbidity, disability, social and economic benefits, development and equity. We are conducting further analytical work on the fully immunised child, and agreed that we need both more empirical data – for example on equity and cognitive function – and to make better use of existing data sources, such as clinical trials and health and demographic surveillance sites. We are exploring the possibility of working with these sites to measure the impact of multiple vaccines administered simultaneously. Finally, we agreed to convene a group of experts to drive this work forward, and to produce a commentary on the value of vaccines.

The Lancet has gathered health leaders and experts in a Commission on Investing in Health to look at progress since the 1993 World Development Report. Flavia Bustreo and I are pleased to be Commission members, and based on the discussions so far the report will help to situate immunisation in its wider development context. Last month the World Health Assembly in Geneva endorsed a new Global Action Plan for the Prevention and Control of Non-Communicable Diseases (NCDs) and through our collective efforts the plan included indicators on HPV and Hepatitis B vaccines. The growing political attention and investments in tackling NCDs now takes better account of the value of vaccines. The Decade of Vaccines update was also discussed; overall vaccines were an important part of the deliberations at the Assembly.

Building on your encouragement in Dar es Salaam, the Secretariat continues to engage selectively to ensure that health and immunisation are central to the **post-2015 development agenda**, while also accelerating efforts to reach the Millennium Development Goals. Earlier this year the leadership of the main health agencies and I authored a commentary in the Lancet arguing that health is critical to advancing global prosperity. In March, I participated in a Global Health Leaders meeting in Botswana which marked the culmination of a consultative dialogue on health post-2015. The final report cites GAVI as an example of an innovative public private partnership critical to managing the complexity of 21st century development challenges, and refers to “the fully immunised child” as an ambitious but practical indicator, refocusing measurement on people, rather than on diseases. The High Level Panel which reported last week also called for a target on the percentage of people fully immunised, and recognised the power of immunisation to build stronger societies and economies.

Finally last month GAVI produced with other health partnerships a joint statement calling on the G8 to support the partnerships in this year's summit declaration, which will focus on nutrition. I wrote to David Cameron and the G8 sherpas to share the scientific evidence that preventing infectious disease with immunisation can have far reaching benefits in tackling malnutrition.

Secretariat update

I am delighted to have two senior staff join the secretariat in early June. Pascal Barollier is the new Director Media and Communications. He comes to GAVI with extensive experience as a journalist at AFP and elsewhere, and most recently as head of communications at Sanofi Pasteur. I am grateful to Dan Thomas for his interim leadership of the media team. We have also been joined by Alex de Jonquières, as the new Chief of Staff. Alex has extensive experience across the public and private sectors in healthcare and development. He joins GAVI from McKinsey and has worked on multiple projects with the Alliance over the past few years, including on the market-shaping and supply chain strategies. With Alex's arrival, Daniel Thornton has now taken up the post of Director Strategic Initiatives.

I am sorry to announce that Bakhuti Shengalia, Director of Technical Support, is returning to the World Bank. I would like to thank Bakhuti: he has left the health systems strengthening programme significantly stronger than when he arrived two years ago. We will also be sorry to say goodbye to Alex Palacios, Special Representative to the US, who will be joining the Global Partnership for Education at the end of June. Alex came to GAVI from senior positions in UNICEF and the US administration, and has been with the GAVI family for more than a decade, serving in several different roles in programme funding and external relations. I want to thank Alex for his great contribution and commitment to GAVI.

I am pleased that the Government of Norway will be funding two staff to work at GAVI for two years through the Junior Professional Officer scheme. This is a first for GAVI and for Norway which has only previously funded staff on this scheme within the UN.

As another of our organisational change initiatives, we are working to improve our knowledge management inside the secretariat, which I believe will contribute to better management of our key processes, and our transparency. We have run our third staff engagement survey, which had a 95% response rate. The results will be shared with the secretariat this week, and I will report on the high-level outcomes at the Board meeting. As I noted at the retreat, in line with sound HR practices, we have commissioned a review of the salary scale and its compensation and benefits policies to ensure market alignment and competitiveness against peers. This will be completed at the end of the year. The last year has been a period of consolidation in the Secretariat, as the new headcount authorised by the Board at the end of 2011 has been recruited and staff have settled in. I have received positive feedback on the impact of this, for example on the role that the strengthened team of Country Responsible Officers has been playing.

We discussed a proposal at the last Board meeting as to whether we should move to a new Health Campus, which is being created by the canton of Geneva for non-commercial organisations involved in global health. After a slight delay in the planning approval process, construction is back on track, but discussions with the building developer on the terms of a lease have not yet progressed because of the delay.

In **conclusion**, I would like to highlight a theme that has run through this report, which is the importance of seeing our work as part of a greater whole. To take one example, in April WHO and UNICEF launched a new Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea, which highlighted the



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central role of vaccines in preventing these major child killers as part of a broader approach to disease control, such as access to clean water and antibiotics. Similarly one of the issues I noted both before and since I came to GAVI was the siloed and fragmented nature of the immunisation community. I believe we are making steady progress in supporting countries to build strong and comprehensive immunisation systems. This needs to use fixed facilities, outreach and where necessary, campaigns, but each of these needs to be part of one integrated system, supported by strong data and fully owned by the countries. This is the best and most sustainable way for all of us to achieve our objectives, and our collective mission.

I look forward to seeing you and having a rich discussion in Geneva next week.