Report of the Chief Executive Officer

25 November 2015

Dear Board members

2015 is an important year for Gavi and for the world as we come to the end of the Millennium Development Goals and Gavi's 2011-15 strategy period, and look ahead to the post-2015 era. This report reviews how the Alliance has performed during the 2011-15 period, and how we are preparing for the 2016-20 strategy.

2011-15 strategy delivered unprecedented progress, but challenges persist

The Alliance set ambitious targets for 2011-15, and we are largely on track to deliver (we will have a full review of Gavi's performance during this strategy period in mid-2016 when the WHO-UNICEF estimates of immunisation coverage (WUENIC) are available for 2015). This period has seen unprecedented progress in immunisation with more children reached than ever before and a dramatic acceleration in vaccine introductions. However, we have not fully delivered on all our ambitions and these areas will be a key focus during the next strategy period.

WUENIC data showed **average coverage[1] in the 73 Gavi countries reached 81% in 2014**. This is the first time it has exceeded 80% and is an increase of 3 points since 2010, meaning nearly 65 million children in Gavi countries received three doses of a DTP-containing vaccine. 32 Gavi countries now have coverage of over 90%, a sign of the growing strength of many immunisation programmes. It also means that the unreached are increasingly concentrated in a set of large and fragile States, with 20 countries accounting for ~90% of under-immunised children. Despite progress in many of these countries (e.g., Ethiopia coverage improved from 61% to 77% 2010-2014 and Nigeria from 54% to 66%), there is a long way to go. The Alliance is not on track to achieve its target of a 6% increase in coverage by 2015 and coverage growth has slowed over Gavi's lifetime as the under-immunised become fewer and therefore harder to reach. This underscores the need for innovative approaches and robust data to identify and reach the

[1] All estimates of coverage and numbers of under-immunised children in this report are based on the number of children receiving three doses of a DTP-containing vaccine unless otherwise specified

remaining pockets of under-immunised children, and why the 2016-20 strategy's focus on equity is so important.

The primary focus of Gavi's 2011-15 strategy was accelerating the introduction of new vaccines. We set **ambitious targets for pentavalent, pneumococcal and rotavirus vaccine introductions, all of which we achieved in 2014** one year ahead of schedule. Three quarters of the 73 Gavi countries have now introduced pneumococcal vaccine and over half have introduced rotavirus. Nonetheless, we are not on track to achieve our coverage targets for either vaccine. In the case of pneumo, this is primarily due to delayed introduction in a few large countries (due to both country readiness and historic supply constraints), most of which have now begun introducing the vaccine. The situation with rota is more complex with 29 countries – including several large countries – yet to apply for the vaccine. As discussed in the *Country Programmes update*, there are a number of reasons for this and the Alliance is evaluating potential approaches to accelerate momentum.

The Board approved Gavi support for a number of new vaccines during the 2011-15 period including human papillomavirus vaccine (HPV), injectable polio vaccine (IPV), measles-rubella (MR) and Japanese Encephalitis (JE). As a result, Gavi now supports 12 vaccines including 18 different antigens, and countries are introducing these vaccines at an unprecedented rate. In total, we expect Gavi to have supported over 220 vaccine introductions and campaigns between 2011 and 2015, four times as many as during the previous period. While our strategy indicators focus on pentavalent, pneumococcal and rotavirus, many of these other programmes are also having a transformational impact. By the end of this year, **23 countries are expected to have introduced** HPV, either as a demonstration project or full national introduction, three years after the Board approved opening a support window. That represents nearly half of the countries originally eligible. In June 2015, the Board decided as part of the new eligibility policy to provide one-off catalytic support to another 15 countries who crossed Gavi's eligibility threshold before the HPV window opened, and many of these countries have also expressed an interest in applying. Gavi-supported HPV programmes are projected to immunise over 30 million girls by 2020, and the global cancer community presented Gavi with an award in November recognising the impact this will have in protecting millions of girls against cervical cancer.

Gavi's support for inactivated polio vaccine (IPV) has been unprecedented in terms of the pace of applications and implementation. All 71 eligible countries applied and were approved for support within a year of Board approval and 30 have introduced to date. However, growing supply constraints – due to challenges faced by manufactures in scaling up production and the unexpected growth in use of IPV for campaigns – have delayed introduction significantly in some countries. To date, over 40 Gavi countries have faced delays, with 20 now not projected to introduce IPV until after the globally coordinated switch from

trivalent to bivalent oral polio vaccine in April 2016 (originally seen as a critical milestone for IPV introduction). Other countries who have already introduced face a risk of programme disruption. The Secretariat is working closely with the World Health Organization (WHO), UNICEF and countries to manage the risk of further delays and the programmatic impact of the changes, although this is complicated by evolving planning on the use of IPV in campaigns (over which Gavi has no control). We will also be discussing our engagement in the Polio Legacy as part of the *Country Programmes Update*. It will be critical for Gavi to work with countries and partners to strategically identify which polio assets and capabilities can best contribute to strengthening routine immunisation going forward, and how these should be repurposed, funded and integrated into national systems.

Gavi has been supporting Meningitis A vaccine campaigns in endemic countries in Africa since 2010. By the end of 2014, these campaigns had **immunised over 220 million children and young adults in 16 countries and helped nearly eliminate Meningitis A**. There were only four confirmed cases in the Meningitis Belt in 2013 and the only 2014 cases were in Guinea during the Ebola epidemic (before the vaccine was introduced, Group A meningococcus caused ~80% of meningitis cases and thousands of deaths). The priority now is to conduct campaigns in the remaining ten countries in the Meningitis Belt and to support introduction of the vaccine into routine immunisation in all 26 countries to prevent a resurgence of the disease in the future. At the same time as Men A cases have declined, incidence of other serotypes has risen. An outbreak of Meningitis C in Niger this year caused over 8,000 cases and approximately 1,500 deaths. Gavi's engagement in meningitis includes support for a stockpile of multivalent vaccine (protecting against Meningitis A, C, W and Y), which played a critical role in controlling the Niger outbreak. The original Board decision approved support for this stockpile until the end of 2015. We have agreed to a no-cost extension for this support into 2016, and will bring a proposal on Gavi's long-term role in Meningitis (beyond Meningitis A support) for Board consideration next year.

Following the December 2014 Board decision, Gavi will also support a **stockpile of Ebola vaccines** once a vaccine is licensed and WHO-recommended. With the decline in cases, the Alliance's immediate focus is to support recovery of routine immunisation programmes and health systems in the three affected countries, while our partners are helping to control the small number of remaining cases. In parallel, we are working with manufacturers to ensure investigational doses of vaccine are available prior to vaccines being licensed to mitigate the risk of a resurgence of the epidemic or a new outbreak. I will provide an update on the manufacturer discussions during the closed Board session and we will have a full discussion of Gavi's engagement in Ebola at this meeting (see *Ebola Update*).

The 2011-15 strategy period has seen **unprecedented financial commitment to immunisation**. **Since 2010, donors have committed over US $17 billion** to

Gavi, including contributions of US $7.5 billion for 2011-15 and commitments of US $9.5 billion for 2016-20. The latter includes US$ 7.5 billion of new pledges made at the Berlin Replenishment – including from four new sovereign donors and two new private sector donors – at a time of real pressure on many donors' budgets (the remainder are existing commitments to the International Financing Facility for Immunisation (IFFIm) and the Advanced Market Commitment (AMC)). As described in the *Resource Mobilisation Update*, we are making good progress in translating the Berlin pledges into signed agreements but with the refugee crisis putting even further strain on budgets, it is important to sign the remaining agreements as soon as possible. We will discuss how the Board can help maintain donors' focus on immunisation at this meeting.

Implementing countries have also significantly scaled up their investment in immunisation during this period. Co-financing of Gavi-supported programmes is projected to reach nearly $150 million for 2015, nearly five times higher than in 2010. Countries are co-financing more vaccine programmes than ever, and co-financing more programmes on time than ever. However, as the total value of co-financing has grown the share paid on time has fallen (it is still over 75%), and a few countries have become persistent defaulters. This underlines the importance of further enhancing engagement with countries during the 2016-20 period, when total co-financing is due to exceed US $1 billion. I was able to witness the impact that such engagement can have, even in the poorest countries, when I visited DR Congo last month. Despite budgetary challenges, the Prime Minister and Minister of Health have both made a personal commitment to immunisation and have nearly doubled health's share of the national budget from 4.8% in 2015 to 9% in 2016. As a result, after years of default, they appear on track to pay their 2015 co-financing on time and have their full 2016 obligation fully budgeted. This is the kind of leadership we need, and are seeking to build in every country. Our impact in building political commitment to immunisation has been recognised in a recent survey by Aid Data, which found Gavi had the most influence on countries' policy decisions of any bilateral or multilateral organisation relative to our expenditure.

The last day of the 2011-15 period will also be the last day of Gavi financial support for the **first four countries to fully transition** under the formal transition process. Bhutan, Honduras, Mongolia and Sri Lanka are all on track to transition with programmes which are financially and programmatically sustainable. Nine other countries will begin fully financing at least one vaccine programme at the end of 2015 and we expect most will do so without major challenges. However, there is a major risk that programmes in Angola and Congo Republic will not be sustained. Both countries are recurrent defaulters on co-financing and have failed to make timely payment for 2014 and 2015. Since they should be paying for most doses at this stage in their transition (as Gavi support ramps down), this has led to stockouts in both countries. Moreover, if they fail to pay their 2014 co-financing by the end of this year, Gavi's policy would be to suspend vaccine support (which

would be the first time this aspect of the policy was applied). As described in the *Country Programmes Update*, the Secretariat and partners have made extensive efforts to help both countries. However, despite engaging at the highest levels – including my meeting with Ministers from both Governments, and attempts by Anuradha and me separately to visit Congo Republic to meet the President (both cancelled at short notice by the Government) – we have not convinced either country to prioritise immunisation financing. We will continue to engage but face a real risk that the gains achieved with Gavi support will be reversed and it will be important for the Board to discuss how to respond if this does occur.

One reason why most countries will be able to transition sustainably out of Gavi support is our success in creating **healthier vaccine markets** over recent years. Gavi now procures from 15 manufacturers, three times more than in 2000. This has contributed to improved supply security for many Gavi-supported vaccines and to reduced pricing with the weighted average price of fully immunising a child with penta, rota and pneumo falling by nearly 40% since 2010. This average reduction masks the fact that manufacturers have only slightly reduced prices for pneumo and more sustainable pricing will remain a focus going forward. There are also challenges with supply of yellow fever vaccine, oral cholera vaccine and IPV (as discussed above), and a need to manage supply security for measles-rubella (MR), so strengthening the supply base for those vaccines is a priority.

Strong routine immunisation a critical platform for global post-2015 agenda

Gavi's 2016-20 strategy focuses on strengthening the coverage, equity and sustainability of immunisation. Fundamentally, this is about enabling countries to build **strong, well-integrated routine immunisation programmes.** This is a continuing evolution in the Alliance's strategy from a focus in its early years on accelerating introduction of new and under-utilised vaccines. It also represents a change for the broader global immunisation community from a historic approach of fragmented vertical programmes (such as polio, measles, EPI vaccines, new vaccines, outbreak response) towards a focus on supporting every country to build a single, robust routine immunisation programme.

Strong RI programmes with high equitable coverage can make an important contribution to the post-2015 agenda. The Global Goals for Sustainable Development are all about delivering an equitable future leaving no one behind. The third goal commits the world to universal health coverage (UHC) and a target of providing "vaccines for all". The Lancet's Commission on Investing in Health proposed that UHC should be attained through "Progressive Universalism" and immunisation, one of the most cost-effective and equitable health interventions (reaching over four out of five of the world's children), is the logical place to start. As discussed above, nearly 65 million children in the Gavi 73 receive three doses of DTP-containing vaccine each year. This equates to almost 200 million contacts

between these children and the primary health system annually (the total number of contacts is far higher since other vaccines are delivered at a different time). This can provide a robust delivery platform for other health interventions. And as we work to improve coverage and equity of immunisation – which will require us, among other things, to reach new communities with immunisation services, build new infrastructure, expand the health workforce, strengthen the supply chain, and improve data on service provision – this will further extend and strengthen the primary health system. While investments in RI could be perceived as "vertical", they can – if designed correctly – provide a backbone for extending health services and delivering UHC. Moreover, the Alliance's emphasis on equity will focus attention at country level on the political, economic and social barriers which constrain access not only to immunisation, but to a range of other services.

Given this focus on equity and the fact that immunisation is one of the few truly global health programmes, **Gavi continues to advocate for a standalone immunisation indicator** to measure progress on Target 3.8 ("Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all"). Since the Inter-Agency and Expert Group on Sustainable Development Goal Indicators has not reached consensus on how to measure progress against Target 3.8 and the monitoring framework is due to be finalised in early 2016, there is a window of opportunity to secure support for a standalone immunisation indicator. A growing number of member states have indicated their support and we welcome the ongoing support of Board members.

Strong immunisation programmes are also important for Global Health Security (GHS). This is a growing global priority in the context of Ebola and broader concerns about the spread of infectious disease. The refugee crisis has focused European attention on the risks of large transnational population flows, and worldwide more people are displaced today than at any point since the Second World War. As people move, pathogens move with them. Like Ebola, Middle Eastern Respiratory Syndrome (MERS) has shown that in an interconnected world, spread of disease is a global concern. Concentrated in Saudi Arabia and neighbouring countries, MERS spread to the Republic of Korea where it has caused over 100 cases, and cases have been reported in 26 countries as far afield as China, Greece and the USA. Influenza – one of the greatest pandemic threats – has also been on the rise with more human cases of bird flu in 2015 than any year on record. Globally, the US Centers for Disease Control and Prevention (CDC) reports that there were 140 disease outbreaks in 107 countries between March 2014 and July 2015, underscoring the growing threat of epidemics as populations and diseases become increasingly globalised.

Immunisation is one of 11 Action Packages which CDC and the US Government have identified to strengthen global health security. It one of the most effective

tools to protect populations against infectious diseases and strong immunisation programmes can provide many of the key public health capabilities needed to control epidemics (as demonstrated by the role of the Polio programme in controlling Ebola in Nigeria). However, Ebola highlighted gaps in our ability to respond, both at country level and globally. Key challenges included weak public health systems lacking capabilities for detecting and responding to outbreaks; unclear roles and responsibilities, limited capacity and poor coordination mechanisms among organisations involved in the response; a lack of proven vaccines due to market failure; and challenges reaching vulnerable populations with routine vaccines in situations where the health system is not functioning.

The world is currently evaluating how to learn the lessons of Ebola and enhance outbreak preparedness and response. Gavi is already engaged in outbreak response, funding vaccine stockpiles for yellow fever, cholera, meningitis and potentially Ebola, as well as measles outbreak response. While Gavi support for these programmes was approved on a case-by-case basis, it raises the question of what role Gavi should play in global efforts to prevent outbreaks and enhance response going forward. Similarly, as the world discusses options to accelerate availability of vaccines for diseases with epidemic potential Gavi needs to decide how to engage, if at all, especially for vaccines where there is a risk of market failure. The *Ebola Update* raises some of the key questions on which the global community is reflecting in the wake of Ebola. We propose to discuss lessons learned and Gavi's role going forward more fully at the April Board Retreat.

Shaping our approach to deliver on coverage, equity and sustainability

The Board has approved a bold 2016-20 strategy – seeking to deliver a step change in the coverage, equity and sustainability of immunisation. In June 2015, the Board agreed on most of the indicators to track progress in delivering this strategy. At this meeting, you will decide on the remaining **indicators, and targets** to define our ambition against each indicator. The proposed targets have been developed through a consultative process with experts, partners and Board constituencies. They seek to achieve a balance between defining ambitious goals which will stretch all members of the Alliance, while being realistic and achievable to maintain Gavi's credibility and track record of delivering on its commitments.

The target for routine immunisation coverage has been most challenging to get this balance right. Given our focus on coverage and equity during the 2016-20 period, it is clear we need this target to be bold. At the same time, historical data shows that as countries reach more of their birth cohort, they encounter a ceiling effect and are unable to maintain historic rates of coverage growth (as described in the *Gavi Alliance Strategy 2016-2020: goal level indicators and targets* paper). The Programme and Policy Committee (PPC) recommended that the target should be a 5% increase by 2020 (compared to 2015) on average across the 68

countries who will receive at least one year of Gavi support during the 2016-20 period. This is below the 6% target for the current period and will likely not be sufficient to achieve the Global Vaccine Action Plan (GVAP) goal of 90% coverage. However, achieving this target will require that on average countries achieve a 50% acceleration in coverage growth compared to historical average performance, when taking their current coverage level into account. The baseline also includes 15 countries which will transition out of Gavi financing before 2020, so where Gavi's direct support will end during the strategy period.

Business as usual will not be sufficient to deliver on our targets. No one has all the answers on how to accelerate progress in coverage and equity or ensure sustainability and the answer is unlikely to be the same in every country. To succeed, the Alliance will need to innovate, measure, learn, scale and innovate again. We will need to bring new thinking to the challenges countries face, collect robust data to track results, be transparent in discussing what is working and what is not, and each take accountability for performance. And we will need to leverage the full range of available tools, from grants to technical support to market shaping. To this end, the Alliance is introducing four key innovations, which we believe will enable us to work in new and improved ways with countries to support sustainable improvements in coverage, equity and sustainability.

The first change is to move towards more **integrated, country-centric and pro-active Gavi support for countries**. We want to make Alliance support more aligned and focused on the key bottlenecks to coverage, equity and sustainability which countries prioritise. To this end, we are conducting a policy review to assess how our direct financial support (including health system strengthening, vaccine introduction grants and campaign operational costs) can be better targeted, more integrated and impactful. We are also redesigning some of the key mechanisms for engaging with countries. At the centre of this new approach is the joint appraisal (JA), a country-centric process through which the country's immunisation team and partners review progress and identify key bottlenecks in each country. JAs are reviewed at the newly created High-Level Review Panel (HLRP), which includes partners and members of the Independent Review Committee) to assess the performance of Gavi's grants. Collectively, these processes inform decisions on Gavi's future financial and technical support. 2015 is the first time all countries undertook a JA and based on the learning to date, we will further refine the approach going forward. Proactive grant management by Senior Country Managers (SCMs) will also be critical to better support countries, enhance programme outcomes and better manage risk. To further move in this direction, the Secretariat has increased the number of SCMs over the past year and reallocated country portfolios to enable more intensive grant management; standardised operational guidelines for how SCMs manage grants; launched cross-Secretariat Country Teams for key countries to ensure SCMs have the necessary support; and launched a capability-building programme.

A second key element of Gavi's approach will be **prioritising progress in the countries where the most under-immunised children live**. As discussed above, around 90% of under-immunised children across the Gavi 73 are in 20 countries. Many of these countries are also fragile or conflict-affected. While Gavi will maintain its current support to all eligible countries, the Alliance will enhance its engagement with priority countries – including intensified technical support under the PEF and greater engagement from partners and the Secretariat.

Thirdly, the Alliance is introducing a **new mechanism for planning, budgeting and monitoring the activities of Alliance partners through the Partners' Engagement Framework.** The largest component of PEF funding will be for targeted country assistance (TCA) – technical support to countries in areas which they identify as priorities, much of which will be provided by staff permanently based in partners' country offices. This is a major shift from the previous model under the Business Plan, where activities were largely defined and funded at global or regional level. The second largest component of the PEF is foundational support, which provides core partners with predictable, long-term funding to enable them to better plan and implement their "core" contributions to the Alliance. The PEF also includes funding for global and regional activities conducted by partners in the strategic focus areas (SFAs). The Board approved funding envelopes for foundational support in June 2015 and will be reviewing funding for TCA and SFAs as part of the *Engagement Framework And Budget For Partners And Secretariat For 2016-2017* at this meeting.

The last key element of our new approach is a focus on **strategic focus areas.** These are critical enablers for coverage, equity and sustainability – largely identified in the 2016-20 strategy framework – where it may be possible to have transformational impact by defining a cross-cutting Alliance strategy. The Board has already approved a strategy for the supply chain SFA and will be reviewing a proposed data strategy at this meeting. The Secretariat is working with partners to explore other potential SFAs – leadership, management and coordination; political will; sustainability; and demand generation (others may be identified over time) – and determine whether cross-cutting strategies can deliver greater impact (they will remain priority areas for routine support to countries regardless). To inform work on the SFAs, we have started a time-limited effort in priority countries to better understand the most critical bottlenecks to coverage and equity, identify innovative and targeted approaches to address these including examples of positive deviance, and assess how Gavi's support can be optimised. To date this work has been piloted in five countries (Pakistan, India, Madagascar, Kenya and Chad) and will be extended to another five countries in 2016.

Most investment in the SFAs will be through existing mechanisms, primarily HSS and the PEF. The one exception to date is **the Cold Chain Equipment (CCE) Optimisation Platform**, which the Board approved in June 2015 recognising that

a new approach could transform the market and country cold chain infrastructure. A team of partners led by UNICEF and the Secretariat is working to implement the platform so countries can apply from January 2016. The Alliance has been engaging with eligible countries to assess their technical assistance needs and build a better demand forecast, and a number of countries have already indicated strong interest. Partners have created a comprehensive technical assistance package to help countries develop CCE management and maintenance plans, and select appropriate equipment based on total cost of ownership. Building on expertise and methodology from vaccine market shaping, we are also developing supply and procurement roadmaps for key cold chain equipment segments.

Collectively, these changes represent a very significant shift in how the Alliance works with countries. Initial implementation will put significant demands on partners and the Secretariat, and we will need to learn as we go on what works and what does not work. **We are therefore taking a phased approach to roll-out.** For example, we are prioritising defining TCA for priority countries within the PEF and are focusing initially on two SFAs – for data and supply chain. We will continue to roll-out these changes over the course of 2016, and will be reviewing progress and lessons learned regularly to course correct as needed over time. At the same time, it is important that the **Alliance remains focused on supporting vaccine introductions**. This is essential to ensure equity in vaccine access across countries – while a record number of countries have introduced Gavi-supported vaccines there is a long way to go to ensure these are universally available. Gavi is currently projected to support more introductions in the 2016-20 period than 2011-15, and this will require sustained focus and effort at the same time as the Alliance is seeking to make the major changes outlined above.

The Board will also be considering strategies for **measles-rubella and India** at this meeting, which will shape Gavi's ability to impact coverage, equity and sustainability. Gavi has been engaged in measles since 2004 when it began supporting the Measles Initiative before opening a window for routine measles second dose in 2007, and measles-rubella (MR) vaccine in 2013. However, the four elements of Gavi's measles programme (measles second-dose; outbreak response; MR; measles campaigns in 6 high-burden countries) were approved at different times and to address specific needs. As a result, our support has been fragmented and has not focused on routine measles immunisation coverage, which has been stagnant in Gavi countries since 2010. With the world off-track to achieve the GVAP goals – including elimination – for measles and rubella, there is an opportunity to develop a more coherent strategy for Gavi's engagement and ensure we maximise the impact of our investment.

The Steering Committee which provided guidance on the proposed strategy comprised many leading global measles and rubella experts – including three current and former Chairs of the WHO's Strategic Advisory Group of Experts on

Immunisation (SAGE). The proposed strategy, which has been recommended by the PPC, focuses on improved disease control as part of a continuum towards elimination. Critically, it puts **strengthening routine immunisation at the centre of a more comprehensive approach to tackling measles and rubella**, complemented by higher quality, better planned and more data-driven campaigns. This has not been a focus historically with an over-reliance on repeated large-scale campaigns to compensate for inadequate routine coverage.

I witnessed some of the challenges with the current approach when I visited DR Congo, which is suffering measles outbreaks despite a recent national campaign that reported over 100% administrative coverage. Given the vaccine is highly effective, this suggests the campaign was not of high quality and coverage was lower than reported (despite being signed-off by the Inter-Agency Coordinating Committee (ICC)). The country and partners are already responding to these outbreaks and preparing for more campaigns. We need to fix this cycle and focus on building strong RI programmes with high coverage, supplemented as needed by better campaigns. This will require countries' leadership, which is also critical for sustainability, and the strategy therefore seeks to build country ownership by requiring countries to develop long-term plans and co-finance Gavi support.

Country leadership, robust planning and quality campaigns were critical to India's success in eliminating polio and maternal neonatal tetanus. It is mainstreaming these capabilities into its RI programme leveraging Gavi's HSS support. It has also launched a short-term effort, Mission Indrahanush, to strengthen coverage and equity of immunisation in over 200 underserved districts, building on some of these assets. It is one manifestation of renewed political commitment to immunisation in India, with Prime Minister Modi also committing to introduce four new vaccines. The combination of this leadership and India's upcoming transition out of Gavi financing at the end of 2021 means **there is a unique window of opportunity for Gavi to help accelerate progress in India further**. It accounts for over a quarter of the under-immunised children in the Gavi 73 (nearly twice as many as any other country), a number of states remain poor with gross national income per capita below many low income countries and Gavi's eligibility threshold, and the Government does not yet have firm plans to introduce critical vaccines such as pneumo and HPV despite having the highest global burden of these diseases. The PPC-recommended strategy seeks to use Gavi support as a catalyst to address these challenges, resulting in an additional 440,000-880,000 deaths averted (on top of existing projected impact). The strategy also seeks to develop a robust plan for the country's transition out of Gavi support, and to build a partnership on market shaping recognising that after transition India will be among the largest buyers of vaccines worldwide. India has committed to pick up full financing of Gavi-supported programmes following a defined period of support and I will visit India in January to discuss this further with the Government.

Preparing the Alliance for Gavi 4.0

While innovating *what* we do will be critical to deliver on our 2016-20 goals, it will be equally important to strengthen *how* we work as an Alliance. The Secretariat is working with partners to **improve and simplify Alliance processes** especially those impacting countries. The updated Programme Funding policy, which is on the Board consent agenda having been recommended by the Audit and Finance Committee (AFC), is designed to streamline Board decision-making and improve operational effectiveness. The Secretariat is reviewing how grant management, disbursement and review processes can be similarly streamlined, strengthened and better aligned with country cycles (while maintaining robust oversight). We will bring options to the PPC in May to make these processes simpler and more efficient. We are also examining how to strengthen systems underpinning the Alliance's interface with countries as part of our ongoing knowledge management work. In 2016, we will launch a new Country Portal to which countries, partners and the Secretariat will all have access. This online platform will streamline communications, replacing multiple current systems and documents, and ensure that all members of the Alliance – and particularly countries – can input, access and analyse the same data on Gavi's grants and countries' programmes.

The Country Portal is one of a number of mechanisms which will help increase **transparency and accountability** across the Alliance. This will be critical to enable an open dialogue on Gavi's performance, what is working and not working, and to learn and adjust as we test new approaches to coverage, equity and sustainability. The PEF will be the key platform for such dialogue. While implementation of the PEF is still in the early stages, we are already seeing how an enhanced country focus, more transparent programming and stronger fora for cross-Alliance engagement (e.g., PEF Management team) can enhance the Alliance's support to countries and we will have the opportunity to discuss some concrete examples at the Board meeting. The proposed Alliance Accountability Framework will provide a more formalised structure to monitor and discuss Alliance performance. The framework has two components – a set of strategy indicators and Alliance key performance indicators (KPIs) to provide the Board with a strategic overview of Alliance performance over time, and a set of operational mechanisms for countries, partners and the Secretariat to manage performance. The PPC reviewed a draft of the framework, including proposed Alliance KPIs. The Secretariat will work with partners to further refine it based on the PPC's feedback, and begin reporting to the Board in 2016.

Enhanced risk management will be another important tool to strengthen the Alliance's delivery model and improve programmatic outcomes. In December 2014, the Board approved a new risk policy and risk management approach. We have made good progress in implementing the plan initially focused on the Secretariat, which has launched a new organisational structure based on the

three lines of defence, designed and implemented new risk processes and systems and recruited additional resources in key risk-related functions. As part of these changes, we created a dedicated risk function and the new Head of Risk will update the Board on implementation of the plan, share his priorities going forward and also initiate a discussion on how to enhance engagement with the Board on risk. We recognise that we are still early in a multi-year journey to enhance our risk management systems, and thereby ensure we take the right level of risk in the right places given our shared goals and the Board's risk appetite. Nonetheless, we are already starting to see the impact of stronger risk controls on programmatic outcomes. For example, the Secretariat has begun monitoring vaccine stocks at country level using a dedicated tool to assess where there are risks of stockout, or potential overstock increasing the risk of wastage. Earlier this year, the team identified a risk of an imminent stockout in Pakistan and alerted the Government and in-country partners, who checked stock levels and confirmed this was the case. Based on this information, UNICEF Supply Division worked with manufacturers to expedite shipment of additional doses, preventing a serious disruption to the country's immunisation programme.

Risk management is one of the priority areas for **enhanced collaboration with the Global Fund** (e.g., by sharing country intelligence, aligning audit plans, sharing fiduciary agents and leveraging the knowledge of Global Fund local fund agents (LFAs) where relevant). Gavi and Global Fund leadership teams have met regularly over the past year to review and deepen our partnership. Mark Dybul, Global Fund Executive Director, and I had intended to jointly present on our collaboration at this Board but he had a conflicting engagement. We now hope to do this at the June 2016 meeting. I did have the opportunity to participate in a panel on the Fund's approach to partnerships at their November Board. Malaria vaccine has been a key area of recent collaboration – the first time we have brought together all teams in the two organisations on one topic. We will have the opportunity to discuss this further during the *Malaria Vaccine Update*. We will be even better able to collaborate once Gavi and the Global Fund move to the planned Health Campus. I am therefore delighted that the building permit has finally been issued and will keep the Board updated on the project's progress.

The **Board and Committees** will obviously have a critical role in stewarding the Alliance through the 2016-20 period. The Secretariat is working to respond to Board members' feedback on how governance meetings can be more effective and efficient. This includes making Board and Committee papers more concise, focused and strategic – the papers for the June 2015 Board had 50% more pages than the pack for this meeting. The *Financial Forecast* paper also includes a comprehensive picture of the financial implications and trade-offs associated with the decisions on the Board agenda. This standard template will be provided for all PPC and Board meetings going forward and in future the AFC will meet in advance of the PPC to confirm if funding is available for decisions on the PPC

agenda. The Secretariat is working with the Chair of the Governance Committee to review and prioritise a number of other issues raised by Board members. The upcoming Board and Committee self-assessment will be an opportunity to identify further ways to strengthen the Alliance's governance mechanisms, such as reducing the high turnover of Board members (six Board members will rotate off after this meeting, meaning 18 Board members – two thirds of the Board – will have rotated off since December 2014) and resulting loss of institutional memory.

Ensuring the Secretariat is fit for purpose

Both partners and the Secretariat committed to zero-basing their budgets in preparation for the 2016-20 strategy period. In June, we discussed a review by McKinsey of the **Secretariat's resourcing and performance**. This identified a number of areas which appeared under-resourced, particularly in the key delivery teams (Country Programmes and Policy & Performance). Building on McKinsey's findings, every Secretariat team has built a new budget from scratch with a focus on finding ways to improve efficiency (e.g., insourcing capabilities to reduce costly consulting spend and retain key skills and experience). In developing these budgets, we have sought to balance Board guidance to keep the Secretariat as lean as possible and the increased complexity of our work and need for stronger grant and risk management in the next period. The *Engagement Framework And Budget For Partners And Secretariat For 2016-2017* proposes a budget which significantly strengthens the key delivery teams, but remains some way below McKinsey's recommendation. This will enable us to build incrementally and optimise efficiency before assessing if additional resources are required in future.

Over the past 12 months, the Secretariat leadership team has been working to review ways to **enhance efficiency and effectiveness**. We have combined teams to capture synergies – including Resource Mobilisation, Private Sector Partnerships and the Gavi Campaign; and Communications, Advocacy & Public Policy and Knowledge Management (recognising that communications, advocacy and public policy work must all be grounded in robust data and knowledge). A team of Directors from Country Programmes and Policy & Performance has been working to identify opportunities to improve core Secretariat processes, systems and structures and this will lead to some further changes in the coming months. We are also having an ongoing dialogue on how to improve collaboration, including through several retreats focused on the effectiveness of the leadership team. Some of the key issues which have been prioritised include greater delegation to teams, fewer meetings and enhanced internal communication.

Gavi's human resources team is working to **strengthen performance and talent management** in the Secretariat. We are introducing a behavioural competency model which will underpin how we evaluate and develop talent. We have made a number of changes to strengthen the performance management process and are

also increasing availability of training in response to McKinsey's finding that Secretariat staff have insufficient opportunity for professional development. Underpinning many of these changes is a new HR Information System, which is designed to automate many HR processes and provide more robust tools and up-to-date data for managers and staff. The first phases have been rolled out and include tools for on-boarding, managing employee personal data, other employee information, and a recruitment module to track and manage applicant data. In the seven months since launch, we have registered 3,500 applicants in the system, providing a rich database of potential talent. Future phases will include additional modules covering performance management, and learning and development.

A key priority for our Operations team has been to **improve security for Gavi staff**, especially when travelling. This was a capability gap within the Secretariat until recently, and I have wanted to ensure we are better able to take care of our staff wherever they are in the world. The team has developed a comprehensive programme, working with expert security firms to train and brief Secretariat staff before they travel, remain in-touch, ensure staff have adequate security while in the field, and to provide crisis management support in case of problems.

Lastly I wanted to let the Board know that Geoff Adlide, one of the longest-serving members of the Secretariat leadership team, will shortly be taking up a new position with the Global Partnership for Education. During his eight years with Gavi, Geoff played a critical role in raising the profile of immunisation and the Alliance, including most recently in the Global Goals. I know many of you have had the chance to work with Geoff and will join me in wishing him well.

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At a retreat with the Secretariat leadership team earlier this year, I identified six priorities for us to focus on: Delivering on current commitments; Stripping out inefficient processes; Better understanding what's going on at country level; Beginning to meaningfully implement the PEF; Jump-starting work on Coverage and Equity; and making a step change in data capture in key countries. I hope this report illustrates the progress we are already making across these areas. That being said, we recognise that we have a lot still to do and we all need to up our game if we are going to deliver on our shared 2016-20 aspirations.

I hope this report also illustrates the Alliance's progress during the 2011-15 strategy period. I wanted to personally acknowledge the role that Dagfinn has played in our success and to thank him for everything he has done for Gavi and for his support to me as CEO. We will all miss his commitment and passion around the Board table but I know he will remain a dedicated and engaged advocate. I look forward to celebrating his achievements with all of you, and to welcoming Ngozi Okonjo-Iweala as our Chair-Elect, when we meet.