Report of the Chief Executive Officer

24 November 2021

Dear Board members,

We will soon be entering our third year of the pandemic, and Gavi's work is increasingly relevant and urgent. Throughout the pandemic, we have dedicated ourselves to supporting countries in maintaining, restoring and strengthening routine immunisation, to finding new ways of reaching the most marginalised, and to ending the acute phase of the pandemic with immunisation. Looking ahead to 2022, we remain steadfast in this ambition, while also being cognisant of the risks. The Board will have an opportunity in this meeting to discuss the top risks described in the new Risk & Assurance Report. As per Gavi's updated Risk Appetite Statement, approved by the Board in its June 2021 meeting, these risks are worth taking, but we continue to actively monitor and mitigate them to the extent possible. Importantly, we are seeking to maintain the right balance between our support for routine immunisation, our Gavi 5.0 priorities and the need to put COVID-19 behind us. This new COVID-19 era and Gavi's engagement in the global response has thrown the organisation into the public spotlight in ways it has not been previously. We have put our hard-won reputation on the line in an effort to put equity at the centre of the response and are still engaged in the upward battle of filling the unconscionable gaps in COVID-19 coverage, particularly in lower-income countries.

This past year was also the **first year of Gavi 5.0 implementation**. Building off the Alliance's strong "Coverage & Equity" achievements from 2016–2019, we were poised to kick-start this new strategic period with an even sharper focus on equity, with reaching zero-dose children and missed communities as our markers of success. Unfortunately, the effects of the COVID-19 pandemic are not over and will likely continue for at least another few years. COVID-19 cases in Gavi-eligible countries account for ~22% of the reported global burden, with continued increase observed in some countries but with varying waves of disease in others. While there is a high degree of variability across countries, these trends of continuing disease, contracting fiscal space and the reduction in coverage reported in the 2020 WUENIC estimates have profound implications for Gavi-supported countries and our programmatic efforts. There are four key messages I would like to emphasise:

1. The pandemic disproportionately affected the most vulnerable populations, making our equity-driven goal of reaching zero-dose children and missed communities even more pressing.
2. Immunisation has demonstrated resiliency more than other health interventions, so the reduction in coverage, while disturbing, is less severe than expected. But we have to see what will happen as challenges persist, so continued vigilance is critical.
3. We continue to observe significant country and regional variations in immunisation performance. This underscores the importance of our differentiated and tailored approach towards addressing country-specific challenges and stagnating coverage.
4. Regardless of the scope of the operational platform, the Alliance will need to remain nimble and adaptive so that we are able to support countries in maintaining health services, fighting the pandemic and building back better – on none of which we can afford to fail.

It is in this moment that we must keep our long-standing critical focus on **the sustainability of our programmes and protecting gains in domestic financing**, which has always set Gavi apart. At the start of the pandemic, recognising the fiscal strain countries might face, the Board approved up to US$ 150 million in co-financing waivers. To date, just over US$ 20 million[1] has been utilised, reflecting the Alliance's intense engagement with countries to protect domestic investments in immunisation, and only applying waivers as a measure of last resort. We have not yet approved any additional waivers in 2021, although we do have requests from several countries facing fragility and conflict which are currently being reviewed in coordination with our partners. We know that countries will continue to suffer fiscal challenges in the short term, with the triple burden of funding essential health services; covering the COVID-19 response; and servicing higher debt levels - meaning continued engagement will be vital to safeguard domestic resources for immunisation and prevent backsliding.

Despite disruptions, we have managed to complete 26 **vaccine introductions and campaigns**[2] so far in 2021 against a target of 39. We have also seen overall improved visibility and monitoring of routine immunisation stock in countries; and we are closely monitoring stock and potential wastage. We have also successfully prioritised the zero-dose agenda across all Gavi funding levers. The Equity Accelerator Funding (EAF) – US$ 500 million in funding designed to incentivise investments that target the most marginalised – is now open, and we are expecting to receive 14 applications by the middle of next year. The roll-out is not as quick as we might have hoped, but against the backdrop of the pandemic, we are encouraged by the interest and ambition of these countries.

I am pleased to report that despite continued challenges to increase coverage and reach all children with **polio** vaccination, only four wild polio cases (WPV) have been detected so far this year, including two confirmed just this month in Afghanistan. While it is not a surprise that there is some WPV still in circulation, genetic analysis indicates that circulation has been ongoing for more than a year

[1] US$ 4.4 million in 2020 and ~US$ 16 million for Pakistan approved in 2020 but disbursed in 2021
[2] 19 were campaigns, and 7 were routine immunisation introductions

without detection. On a more positive note, the area in which these cases were detected was recently vaccinated through door-to-door bOPV (bivalent oral polio vaccine) campaigns as part of the Taliban-endorsed resumption of polio campaigns. nOPV2 (novel oral polio vaccine type 2) is being used and now has experience in over 100 million children, with a good safety record. We are also encouraged that the Global Polio Eradication Initiative (GPEI)'s new strategy aligns with Gavi and the Immunization Agenda 2030 in calling for attention to zero-dose children, integration and gender. Inactivated polio vaccine (IPV) catch-up activities and second-dose (IPV2) roll-out are also emphasising this focus on integration; however, unfortunately we are continuing to see delays due to the impact of COVID-19. We are also watching with interest the upcoming deliberation on IPV schedules, particularly with regard to hexavalent use. The Gavi Board had approved in principle support in 2018, subject to regulatory and policy milestones. However, we note there is still some uncertainty around availability of hexa vaccines at acceptable prices. We are likely to return to the Board next year to consider whether to bring hexa vaccines into our programme of support.

As I finalise this report, I am in Pakistan on a mission with the Polio Oversight Board (POB) to draw renewed government leadership and political momentum to the programme to strive to reach persistently missed children. A key message of the POB is to reinforce integration synergies between polio eradication and the Expanded Programme on Immunization (EPI), especially among the most marginalised. I am impressed by the level of integration I am now seeing between these programmes, and this bodes well for future work on sustaining polio-free status once it is eradicated. We spent time emphasising the importance of the ongoing nationwide integrated measles-rubella + bOPV campaign, as well as looking at the delivery of COVID-19 vaccines. One thing that brought a smile to my face is how Pakistan is prioritising those in need. Asking members of the Lady Health Workers cadre if they are vaccinated against COVID-19 revealed that the majority are. It is good to see such important frontline health workers being prioritised.

COVID-19 has had a significant impact on **measles and rubella** activities, with only 1 routine introduction and 5 campaigns in 2020, in contrast to 32 Gavi-supported activities in 2019, noting that 2019 was a particularly intense year for measles and rubella activities. In 2021, so far we have seen 7 launches (2 routine introductions and 5 campaigns), with a few additional activities scheduled before the end of the year. Routine coverage of measles-containing vaccine (MCV) has also been affected, leading to inadequate levels of protection against measles and a greater risk of measles outbreaks. We are working with our partners to mitigate this risk in a number of ways and will be discussing at the Board the potential for improved strategies to measure the impact of targeting supplementary immunisation activities (SIAs) - for example, the proportion of children aged under five who had not yet received a single dose of measles-containing vaccine reached through SIAs. (If approved as part of the consent agenda, this would become Gavi 5.0 indicator S.1.6, which is a target of 50%.) Since Gavi's support for measles and rubella began in 2004, nearly US$ 1.4 billion has been invested across 114 programmes, and over 2.3 million deaths have been averted, translating into tremendous progress towards measles and rubella control in Gavi-supported countries. Restoring this progress is critical.

I am also looking forward to our discussion on **malaria**, as we have an important decision ahead. While considerable progress in reducing malaria has been made since 2000, in recent years, this progress has slowed. We all recognise new tools are needed to revitalise the fight against malaria. In particular, African countries bear a disproportionately high burden: more than 90% of all malaria deaths globally, two thirds of which are in children under five. We also face increasing challenges of insecticide and drug resistance, as well as climate change, which will increase vector hospitability. In this context, the WHO recommendation for the RTS,S/AS01 vaccine represents a historic turning point – for the first time, an efficacious, safe and feasible vaccine against a human parasite is now available. We are pleased the investment made by Gavi, the Global Fund and Unitaid in the Malaria Vaccine Implementation Programme (MVIP) has yielded such meaningful results. I applaud WHO, PATH and GSK, and especially the governments and communities of Ghana, Kenya and Malawi, for their hard work in bringing us to this point. However, the next steps are no less daunting: this is an imperfect vaccine that will be most impactful when deployed in complement to, and not as a substitute for, the existing toolbox of likewise imperfect interventions. Global and national stakeholders will need to carefully review the evidence for rolling out this vaccine and consider trade-offs. While the impact of this vaccine will be considerable, it comes at a high cost. Strategies will be needed to address funding shortfalls, both nationally and globally. Synergies with existing malaria control interventions can and should be leveraged – I think we were all struck by the data from the seasonal delivery trials showing the additional impact of seasonal malaria chemoprevention and vaccine combined. At the same time, we still have much to learn about successful seasonal vaccination. While some of the questions we have can only be answered through implementation, there are opportunities to advance our equity and integration agendas, working with the Global Fund, the President's Malaria Initiative and other partners. Finally, while this is indeed the first vaccine we have against malaria, we hope it will not be the last, as there are other candidates in the pipeline; therefore, we have to already think about what we will need to do to develop a robust R&D pipeline.

In 2018, the Board approved a trial programme to address **yellow fever diagnostic** market failures and laboratory capacity gaps that were creating major problems for targeting use of finite quantities of yellow fever vaccine. When this effort started, there were no validated commercial yellow fever test kits available, but now with Gavi support a validated molecular test kit is available, with two antibody test kits under evaluation and at least one test kit for yellow fever protein in the queue. The number of African countries at high risk for yellow fever outbreaks able to confirm at least some yellow fever cases on their own has increased from one to four, with more expected as validated molecular test kits are rolled out. The amount of time needed to complete testing of samples for yellow fever at national laboratories, samples which can indicate the start of a new outbreak or the expansion of an existing one, has dropped from 106 days in 2017 to 39 days in 2020. Yellow fever diagnostic data stimulated Uganda to opt to introduce yellow fever vaccine into routine immunisation next year, leaving only two high-risk African countries without the vaccine in their routine programmes. Diagnostic data also demonstrated that at least two potential yellow fever outbreak response campaigns were not needed in 2019 and 2020, supporting a more efficient and effective use of available vaccines. Extending this programme through

Gavi 5.0 will allow this progress on yellow fever to be consolidated and built upon. Expanding our diagnostic support to cover additional diseases that require targeted vaccination programmes would similarly allow cholera, typhoid, meningococcal, measles and rubella vaccination programmes to become more efficient, effective and equitable. This is an important opportunity, which we will discuss in more detail during our upcoming meeting.

Gavi's **HPV (human papillomavirus) vaccine** programme also provides key opportunities for Gavi 5.0, IA2030 and other critical global health priorities (e.g. life course vaccination, gender equity). The recently launched (2016) programme is experiencing lower coverage linked to supply constraints and impact of the pandemic (due to school closures and low attendance) – the total number of girls reached by 2020 was more than 7.1 million. If such coverage trends continue, Gavi 5.0 targets will be at risk, and there is a risk of doses expiring in countries. Historically, we have also faced several significant supply challenges to our HPV vaccine programme. We expect increased supply availability in the 5.0 period, mainly from Merck, which is dramatically increasing its volumes, as well as new entrants to the market.[3] Pricing has also been a long-standing concern with HPV vaccine. Successful market entry of pipeline vaccines have the potential to lead to an overall decrease in the price of the programme longer term. In addition, clinical trials underway for a one-dose regimen look promising and, if validated, will have the potential to ease supply constraints while enhancing the feasibility and affordability of the programme. We are also looking to some strategic shifts to further optimise the programme, manage COVID-19 risks and improve coverage. And while the ambition will not change, there may potentially be a shift in how and when we anticipate reaching our target girls in this complex COVID-19 environment while supporting countries to sustainably routinise the HPV vaccine programme.

The Democratic Republic of the Congo (DRC) Ministry of Health (MoH) declared a new **Ebola virus disease (EVD)** outbreak on 8 October 2021 in Beni Health Zone, North Kivu province, after confirming the presence of Ebola virus in a child who died from symptoms compatible with Ebola. This is the thirteenth Ebola outbreak reported in the DRC and the fifth outbreak reported since 2017. To date, eight confirmed and three probable cases have been reported by the MoH, including nine deaths from three areas of Beni Health Zone. Considering the availability of 12,900 investigational doses of rVSV-ZEBOV in the country, the MoH, in consultation with WHO and the International Coordinating Group on Vaccine Provision (ICG), decided to use 1,000 of these doses to start conducting ring vaccination as quickly as possible. In parallel, the MoH, with the support of WHO, submitted a request to the ICG for the Merck Ebola vaccine, which is WHO prequalified. On 5 November 2021, 4,800 doses of the vaccine safely arrived in DRC, of which 2,400 doses were sent to Goma and are ready to be used. This has been the first shipment from the recently created Ebola vaccine stockpile, which currently has 267,950 doses of the Merck vaccine available for immediate shipment. The MoH has authorised the off-label use of the vaccine for children aged under 18, pregnant and lactating women, as per SAGE (Strategic Advisory

[3] Innovax HPV2 just received WHO prequalification, while Walvax HPV2 and Serum Institute of India (SII) HPV4 are expected to go through regulatory approval by 2024–2025.

Group of Experts on Immunization) recommendations. Overall, 621 people have been vaccinated, of which 72 are frontline workers.

On 28 September 2021, WHO published the Final Report of the Independent Commission appointed to investigate allegations of sexual exploitation and abuse during the response to the tenth EVD epidemic in North Kivu and Ituri provinces. The findings are devastating, and it is our shared responsibility as leaders in global health to ensure that there is no place for such blatant abuse of power in public health programmes or anywhere. Dr Tedros vowed to ensure that justice will be done - and acknowledged the responsibility of the international community, and the need to rebuild trust in development and humanitarian organisations – and I would like to take this opportunity to echo these sentiments. Although Gavi was not involved in any of the allegations, nevertheless, following the release of the report, Gavi's risk team convened a risk committee meeting to re-evaluate the risks specific to Gavi; and start the discussion on what more can be done to safeguard against such abuses, beyond our current mitigation measures and zero-tolerance policy.

Overall, 13 **vaccine stockpile** distribution requests have been received by the ICG in 2021 (10 were approved and 3 partially approved), including the two for Ebola previously mentioned. The other 11 include 8 for oral cholera vaccine (OCV) and 3 for meningococcal vaccines.[4] No yellow fever vaccine stockpile requests have been received so far in 2021, although transmission signals are under investigation, and imminent requests are expected from Ghana, Cameroon, Chad and Central African Republic. The number of OCV requests remains lower than in previous years (8 so far in 2021 compared to an average of 14 annual requests between 2016 and 2019). However, three large requests in response to outbreaks in Nigeria, Niger and Bangladesh were approved in September for a total of 10.4 million doses, momentarily depleting the global OCV stockpile at the end of the month. Pressure on OCV supply is anticipated to remain during the next coming months, since approximately 5 million doses remain to be shipped to complete second rounds, and new signals are being investigated in Cameroon, Afghanistan and Mozambique. The manufacturers are responding to this surge in demand, with 3.1 million doses made available in October, and 6.7 million doses anticipated between November and December. As a mitigation strategy, ICG has recommended an increase in the size of the OCV stockpile (from 3 to 5 million doses at all times). Gavi has requested the ICG Secretariat and WHO to provide a detailed analysis on the assumptions supporting this recommendation and are awaiting the response to ensure the sustained increase is warranted.

As of the date this report is released, I am pleased to report that **COVAX** has successfully allocated more than 1 billion doses and delivered nearly 536 million doses to 144 countries, of which more than 434 million doses were to Gavi COVAX AMC countries. Of these, more than 170 million were from dose donations. By the end of the year, we aim to have between 800 million and 1 billion doses received in country, with the vaccine supply available to double this by the end of Q1 2022. COVAX's overall **supply forecast** saw a significant deterioration leading into and over the summer, which we quickly sought to course correct through further

[4] A total of 25 million doses were requested, and 21.5 million doses were approved (21 million for OCV and 600,000 for meningococcal).

diversification of the portfolio, discussions with existing COVAX manufacturers and dose donations – and we are now at 1.3 billion doses of supply through the end of 2021. The supply forecast reflects the doses that we have contracted from suppliers and their agreed timelines, as well as donations with agreed timelines. To translate this supply into doses received in country requires a number of steps - confirmation of availability of contracted doses with manufacturers, dose allocation, acceptance of doses by the country, import permits, legal paperwork and agreements between countries and manufacturers to receive/release the doses, storage capacity checks as required, logistics of sourcing flights and coordinating delivery timing with the country. The supply forecast provides important transparency on how we are building the COVAX portfolio, while also holding manufacturers publicly accountable to their agreements with COVAX. The forecast of doses received in country, however, will provide a better view on what is happening at country level - something we are working to see if we can accurately provide.

Despite current relative supply stability following intensive mitigation efforts over the summer, several manufacturers continue to struggle with their supply, and some of the delays are dramatic. For example, J&J made a firm order commitment to provide 200 million doses by the end of 2021. They reduced this to 110 million, which was reflected in our 8 September 2021 supply forecast. This has deteriorated further; between now and the end of the year, we are expecting fewer than 10 million doses out of the 200 million pursuant to our advance purchase agreement (APA). Separately, we will receive another approximately 130 million in the form of donations (82 million doses from the European Union and 48 million doses from the United States of America, with 24 million already delivered). This 95% volume reduction to our APA has been reportedly due to difficulty in manufacturing and regulatory approvals impacting the supply site for COVAX. J&J has stated that they have not been able to supply COVAX from alternative manufacturing sites, but there has been no transparency as to whether such severe reductions were applied to other customers - or only to that supplying the poorest countries. AstraZeneca has also struggled with issues of production from specific sites and failed to supply COVAX from alternative sites in a timely way. These cases are a good illustration of why we are continuing to press for increased transparency from manufacturers: to allow advance planning and to make their supply plans and schedules public; and to ensure that lower-income countries are given access to supply from all available sites, and not being deprioritised disproportionally.

Although not part of the original plans for COVAX, with export bans severely affecting our supply, we asked countries to consider **dose donations**. These donations have complemented supply from our APAs, and we appreciate the response and support from donors. We have seen a push towards the end of the year, with donations ramping up. We have now either received confirmation of supply or already shipped 470 million doses, 430 million of which are expected to go to Gavi COVAX AMC countries this year - with further doses expected next year. Management of these donations is becoming ever more complicated. To best support recipient countries, we continue to request that doses be donated with long shelf lives, longer lead times, provision of sufficient ancillaries and without

earmarking. We look forward to steadily moving back toward stronger reliance on APA doses in 2022.

On other recent positive developments, there is exciting data on Clover against all variants including Delta; Novavax has submitted for WHO EUL (emergency use listing) (as well as UK MHRA (Medicines and Healthcare products Regulatory Authority), EMA (European Medicines Agency), Canada, Australia approvals); and India has informally announced that it will permit Serum Institute of India (SII) to release its first 20 million doses of Covishield to COVAX since the export restrictions were enacted in early March 2021. Earlier this week, the Market-Sensitive Decisions Committee agreed to procure an additional 150 million doses of Moderna for 2022, bringing the total APA up to 650 million. J&J has agreed to waive indemnity and liability (I&L) for humanitarian agencies operating in Gavi COVAX AMC territories and allocated doses from the COVAX Humanitarian Buffer, as well as for humanitarian agencies operating in non-AMC territories (and therefore not benefiting from the COVAX NFC) with a cap of 1.5 million doses. With this, J&J joins three other manufacturers that had already agreed to supply the Humanitarian Buffer without any I&L requirements – Sinopharm, Sinovac and Clover – and we have publicly urged other manufacturers to follow suit. We have two approved **Humanitarian Buffer** applications, and a further two are under review. The first delivery to Iran for people displaced by regional conflict took place on 16 November, and we expect the second vaccine shipment to a humanitarian agency in Thailand to take place in the coming weeks and to be delivered before the new year - I look forward to providing a further update at our meeting.

Our **resource mobilisation** efforts are in lockstep with our ambitions for 2022. Funding estimates reflect continued support to Gavi COVAX AMC countries to meet their vaccination targets and strategies; and to provide for a Pandemic Vaccine Pool to account for the many uncertainties in supply - and likely increases in demand, due to a need for additional doses and boosters. This Pool is born of our hard-learned lessons from 2021, when despite contracting doses and putting together a strong mix of products for participant countries, the supply did not come through as expected, and demands have continued to increase. In addition, we are asking for funding for ancillary costs so that dose donations can continue, and further financing support for in-country delivery. In all of this, we need to continue to focus on equity and particularly countries facing fragility and lower-income countries, so that they have security of supply to scale up their programmes. We have had a previous Board discussion, two Programme and Policy Committee (PPC) discussions and a technical briefing on the COVAX 2022 strategy, and I am looking forward to concluding these discussions at our meeting, recognising that one of the most important principles in this pandemic is the need to stay as flexible as possible to accommodate unforeseen supply- and demand-side shocks as the pandemic continues to evolve.

Related to this, the conversations on **global vaccination targets** have been quite complicated. The IMF (International Monetary Fund) has put forward aspirational targets which have since been supported by WHO. The first was a target of 10% coverage by the end of September. Fifty-six countries missed that target. The next is 40% by the end of the year, which is likely to be missed by as many as 100

countries.[5] The final is 70% by June 2022. During the U.S.-hosted Global COVID-19 Summit, President Biden similarly supported the 70% target but rather by the next UN General Assembly in late September 2022. The African Union has also embraced the 70% target, although country-level targets still vary. Getting to 70% country population coverage level will require vaccinations in adolescents; and, in many countries, in children under aged five, for which most vaccines are not yet approved (and none have been approved by WHO). Against this backdrop, our 2022 ambition is designed to support country-level vaccination targets and strategies, recognising they will look to the WHO global strategy for guidance, while allowing for a host of uncertainties including increasing demand for boosters, guidance on vaccination of children, and evolving scientific understanding of the vaccines and the epidemiology of the pandemic.

Gavi is playing an active role in supporting countries in their **COVID-19 vaccine delivery**, having mobilised almost US$ 1 billion. The funds are being used to support the COVID-19 Vaccines Delivery Support (CDS) Early Access Grants, and the provision of technical assistance and cold chain equipment. We have already supported over 400 UNICEF and WHO in-country short-term positions; provided 5,900 vaccine fridges and freezers (in addition to the nearly 66,000 pieces of new cold chain equipment provided over the last five years); 180 walk-in cold rooms; and 150,000 passive transport devices. Nearly 90% of Gavi COVAX AMC countries have so far requested support through the CDS; of the US$ 225 million requested, we expect almost all of it to be disbursed before the Board meets. Following the CDS Early Access window, in October we launched a needs-based CDS window to support countries in operationalising their national plans. Speed is paramount, and this is why we are leveraging the fast-track process from the CDS Early Access window and will be requesting during our Board meeting continued authority to allocate US$ 799 million without the usual useful but slower independent review processes. Gavi Senior Country Managers (SCMs) continue to serve a central role in this effort, and we are continuing to work closely with Alliance and other partners, including through the Country Readiness and Delivery workstream of the COVAX Pillar, to ensure that country needs are being met. While delivery funding remains complicated, with multiple sources and different funding requests coming from various partners – as well as having large-scale multilateral development bank (MDB) grants available, but not always accessible to all countries in a timely fashion. Costs also remain unclear, with different top-down estimates widely divergent due to different assumptions. To develop a better view, the Alliance is working to develop more detailed bottom-up country estimates depending on the different strategies countries are pursuing. In the meantime, we are continuing to work closely with our partners to better support countries in navigating the support available, and we are becoming increasingly agile and adaptive in our response.

Since the start of the year, COVAX has been actively aligning with partners engaged in COVID-19 vaccine supply and delivery. Specifically for Africa, we have held regular meetings with the African Vaccine Acquisition Task Team (AVATT) at

[5] Source: WHO, Our World in Data (OWID): 100 countries (out of 232) are currently under 40% coverage, accounting for vaccinations from all sources. Coverage is proxied by the Estimated Vaccination Rate (EVR) from the WHO (OWID data is incorporated for missing WHO data), last pulled on 23 November 2021. 92 of these 100 countries are COVAX countries, and 71 are AMC.

the leadership and technical levels to provide updates, supply forecasts and delivery schedules; discuss salient and timely country intelligence; and synchronise delivery funding (where possible). In September, COVAX and AVATT leadership met in Geneva; and in October, Africa CDC, Gavi and Alliance partners held meetings at the working level to discuss coordination efforts on the continent's COVID-19 vaccine delivery. We have a team right now in Morocco participating in an African Union COVID-19 delivery workshop with 13 countries and their implementing partners. Both AVATT and COVAX are committed to working together to not only increase supply of vaccines to Africa, but to also ensure conditions are in place for countries to absorb delivered doses to save lives.

We are in active learning mode as we have finally started to **pivot from a supply-constrained environment to a demand-driven one** in some countries. Some countries are expressing strong preference for certain vaccines over others. In addition, increasingly we are facing issues such as vaccine hesitancy (sometimes specific to a particular COVID-19 vaccine); countries' inability to handle larger volumes even when there is demand; ultra-cold chain (UCC) capacity for larger volumes of Pfizer; the complexity of donations with short shelf lives; and uncoordinated supply from other sources, all of which puts a strain on countries and affects their ability to absorb doses and deliver at pace. We are leveraging the full bench strength of the Alliance in working with countries to mitigate these impediments, delivering more UCC fridges, and coordinating more closely than ever with key delivery and country support partners. While we are continuing and will continue to operate based on the principle of equity, we need to be prepared that not all lower-income countries are able to absorb doses at the same rate. Based on another key COVAX principle that no dose should lay idle, we may see coverage go up at different rates in some instances.

There is also an **emerging risk to global supply of autodisable (AD) syringes** through to end 2022. It is particularly concerning, as it will disproportionately affect Gavi COVAX AMC countries, impacting COVID-19 vaccination efforts and threatening the stability of routine immunisation programmes. We have already put in place urgent risk mitigation strategies and are working with partners to further mitigate. Prefunding has been provided to UNICEF for all 2022 syringe requirements and to rebuild our strategic stocks. We are working with donors to ensure that AD syringes are provided as part of the dose sharing programme and that as much visibility is provided ahead of delivery so the syringes can be pre-positioned in country. We will keep you updated as the situation continues to evolve.

We are also looking internally at our own structures and processes to support COVID-19 vaccination, with an eye toward increased integration. The Gavi COVAX AMC is a ten-year instrument. While we would expect the nature of our engagement to change over the course of the next decade, as scientific questions like duration of protection are resolved and country needs evolve, we do need to start thinking about how to integrate better internally. This is to ensure that we continue to leverage Secretariat resources optimally and are presenting Alliance programmes to countries in a holistic and cohesive manner – as in many countries, the same health professionals are running routine immunisation, investing in

finding zero-dose children and missed communities, and rolling out COVID-19 vaccines. Over the course of 2022, we will be exploring this further.

In addition to the ongoing efforts to put the worst of COVID-19 behind us, global discussions on the **future of pandemic preparedness and response** are in full swing. The Secretariat and the Alliance have been at the fore of the COVID-19 response, and we were well positioned to step in based on our previous work with outbreaks and epidemic vaccines such as Ebola, cholera, yellow fever and meningococcal. Based on the past 20 months, we have even more to share with the many architects of the future health security infrastructure. I was pleased to attend in person the G20 Health Ministers' Meeting as well as the Finance and Health Ministers' Meeting. We plan to continue to remain actively engaged in the G20 discussions; and based on a request from WHO Member States, Gavi staff also provided a briefing during one of their consultations on the proposed pandemic treaty. While COVAX has had and continues to face a number of challenges, I do believe that a networked approach that builds on existing infrastructure and alliances is the right path to maintain flexibility and best leverage one another's competencies. Another lesson is the need for early contingent financing so that organisations like Gavi can quickly surge and are not busy fundraising while, for example, high-income countries are already locking in early doses of vaccine - this time delay ensures that lower-income countries remain at the back of the queue, and this should not be repeated. We are trying to get ahead of this during this pandemic with the proposed Pandemic Vaccines Pool, which creates the necessary buffer to allow for supply and demand shocks. Again, looking forward to your input on the lessons learned and the role for Gavi and the Alliance in this future planning.

I am delighted to share that as of 1 November, we have started a partial and voluntary return to the office with a maximum of 40% occupancy. Our Geneva office has been reorganised to accommodate the additional COVAX staff and our new ways of working, with more meeting spaces; the ability for hybrid in-person and remote participation; and with teams organised in neighbourhoods, rather than the traditional one-person-per-desk set-up. Just over one month in, and the feedback is positive, but we remain in listening mode to ensure that we are making the right choices to support our staff long-term while being vigilant in the face of a recent uptick in COVID-19 cases in the region and even in some of our staff. For our Washington DC office, while the physical space remains unchanged, we are mirroring the process and safety protocols that we have now established in Geneva, despite a recent lowering of safety requirements by the DC government, and again are continuing to monitor the situation.

We also continue to look for new ways to support staff struggling from the stress of the heavy workloads and the uncertainty wrought by the pandemic. A couple of weeks ago, I was pleased to have participated in a mental health workshop organised by the Health and Wellbeing Committee, a staff-organised committee that reports directly to the Executive Office. The Committee also organised two resilience workshops earlier this month, which were well attended. In early November, we also held our first in-person Gavi Leadership Team retreat since the start of the pandemic. The purpose was to set priorities for the coming year, and to continue to deprioritise as much as possible – although this is getting

increasingly difficult as the pandemic wears on, and our core work must be brought back on track.

In every one of my reports since the start of the pandemic, I have taken the opportunity to highlight its effects on our staff and staff across the Alliance. I have also highlighted the increased strain due to the proliferation of governance meetings – we have had over 100 this year, a new record. I would like to work with you to figure how to ensure that you are receiving the information you need to do your essential work, but while also minimising this strain on our staff.

As always, I look forward to seeing you (albeit remotely)! Please let me know if you have any questions or comments.