Report of the Chief Executive Officer

30 May 2018

Dear Board members,

We will meet at the mid-point of our current strategy period. With Gavi's Mid-Term Review taking place in Abu Dhabi in December, this is an important moment to take stock of our progress over the past two and a half years, adjust our approaches as needed, and to begin to look forward to Gavi 5.0 (our 2021-2025 strategy). We already began some of this discussion at our Retreat in March, and I have summarised below what we heard from the Board and how we are planning to move forward from that discussion.

To enable a more strategic Board discussion and respond to feedback from Board members and our Chair, we have sought to streamline the agenda for this meeting. We have integrated many of the updates which were previously standalone agenda items into two cross-cutting reports – the CEO Report and the Update on Implementation of the 2016-2020 strategy (which now integrates key updates on finance, risk, the Partners' Engagement Framework (PEF) and Gavi's programmes). In addition, we will present at the meeting a deep dive on some of the issues and challenges identified in these reports and how the Alliance is addressing these at global and country level. We hope these changes will allow us to discuss our progress, challenges, opportunities and risks in a more holistic manner, and allow more time for strategic discussion. This change has also enabled us to further streamline the Board papers, with a 35% reduction in the total number of pages compared to our last meeting. The Board will continue to have standalone discussions on finance and risk at the end of the year when it approves the Financial Forecast and Risk & Assurance Report, and detailed updates are still provided routinely to the relevant committees (these are available to Board members on BoardEffect).

Most of the Board agenda is now focused on items requiring a decision and we have sought to bring more coherence to these by explicitly grouping linked decision items into thematic areas (at this meeting, we will focus on enhancing sustainability of immunisation programmes, and shaping Gavi's future vaccine programme investments). The remaining items, which are not for decision, will be discussed at the end of the meeting. We have also heard the Board's feedback about wanting more systematic updates on how their decisions are implemented. We have therefore created a Board decision dashboard, which is available on

BoardEffect, providing a brief update on key developments since the last Board meeting on every decision taken since December 2015. I have highlighted in this report some of the decisions with the most significant progress or challenges.

We look forward to your feedback on these changes and how we can continue to better support the Board's discussions.

Key developments in our global landscape

Primary Healthcare and immunisation on the global agenda

In September 1978, governments came together to endorse the **Alma Ata declaration**, which called for urgent action to strengthen primary health care (PHC). It was the first international declaration to position PHC as the main lever to achieve WHO's goal of health for all, and predated the global community's endorsement of universal health coverage (UHC) as part of the Sustainable Development Goals (SDGs) by nearly 40 years. This focus on PHC was unusual at the time and forty years later, it remains highly relevant as we think about how to implement the UHC agenda. In October, leaders will reconvene in Kazakhstan to celebrate the 40th anniversary of Alma Ata and recommit to PHC. I will be attending and am on the Advisory Panel. This meeting is an important recognition that strong primary healthcare – and especially preventive health interventions – is critical to make universal health coverage achievable and affordable, and therefore ought to be a first priority for governments in implementing UHC.

Immunisation is the foundation of PHC in most countries and immunisation coverage is a tracer for the reach of primary healthcare services. This is why it was so important to identify robust **immunisation indicators within the third Sustainable Development Goal** (SDG3). I am delighted that the Inter-Agency and Expert Group on Sustainable Development Goal Indicators has now formally adopted the two immunisation indicators recommended by WHO's Strategic Advisory Group of Experts (SAGE) on Immunisation. These include a standalone immunisation indicator (3.b.1) which measures coverage across the life-course: a full course of diphtheria-tetanus-pertussis (DTP) containing vaccine (a proxy for traditional vaccines) and pneumococcal vaccine (PCV – a proxy for new vaccines) in the first year of life; a second dose of measles-containing vaccine (MCV) in the second year of life; and human papillomavirus vaccine (HPV) in adolescence. Immunisation is also tracked as part of the UHC indicator (3.8.1) which measures coverage with three doses of DTP-containing vaccine as a tracer for immunisation coverage. As we have previously discussed, it took a lot of work and collaboration across the Alliance to develop and secure endorsement of these indicators, but I now believe that we have a strong basis to measure and advocate for progress in immunisation as part of the 2030 Agenda, with all countries reporting on progress against these two indicators.

Streamlining the global architecture to deliver the SDGs

The global community continues to re-align itself to implement the full set of SDGs, especially to address the inter-sectoral nature of many of these goals. Antonio Guterres, the United Nations (UN) Secretary-General has developed a vision for **reform of the UN system** with a focus on improving coordination,

transparency and accountability. This includes redesigning the Resident Coordinator system and creating UN country teams, which are equipped with the specific skillsets needed to address each country's development priorities and needs. I met the Secretary-General in April and was encouraged by his clear vision as well as his strong support for Gavi, which he sees as a model for how the UN system can enhance its impact and cross-sectoral collaboration.

There are also a number of ongoing initiatives seeking to **streamline the current global health architecture**, increase collaboration between agencies and reduce transaction costs for countries. This is important to ensure that the global health community is fit for purpose and works together as effectively and efficiently as possible. Chancellor Merkel of Germany, President Akufo-Addo of Ghana and Prime Minister Solberg of Norway recently wrote to Dr. Tedros asking WHO to lead development of a *Global Action Plan for Healthy Lives and Wellbeing for All*. This is intended to provide a roadmap for how the global health community can collectively deliver SDG3. Gavi is very supportive of these efforts and we are working closely with WHO and other partners on it, including through discussions at Heads of Agency level. Dr. Tedros – who is a Board alumnus – will join us at this meeting to discuss his vision for WHO and this Action Plan.

Collaboration is of course at the heart of the Alliance model. It was designed to bring all organisations working in immunisation (and many working to strengthen health systems) together to deliver what none could achieve alone, harnessing our common objectives and the core competencies of every partner to maximise impact and value for money. Through the PEF, we have sought to further enhance the effectiveness, efficiency and transparency of our collaboration with core partners. We have also broadened our collaboration significantly and are now working with over 40 expanded partners and 30 private sector partners.

We are also working increasingly closely with the **Global Fund** across most areas of our business at headquarters and country level, as we will discuss at this meeting. Peter Sands and I are working closely together to make this collaboration more systematic, especially in key areas such as health systems, health financing and data, taking advantage of our imminent co-location to the Global Health Campus. We are also working closely with the Global Fund to explore how we can both collaborate more closely with the Global Financing Facility as it continues to refine its strategy and focus. And we continue to work with the Coalition for Epidemic Preparedness Innovations (CEPI), which has just announced its first investments. Norway wants to explore using the International Financing Facility for Immunisation (IFFIm) to frontload its financing to CEPI, which is consistent with IFFIm's mandate and could further strengthen collaboration. Norway brought an initial discussion on this to the Programme & Policy Committee (PPC) and will work with IFFIm, IFFIm donors, the World Bank and the Secretariat to further analyse feasibility and develop a concept note.

We are therefore working closely with many partners to enhance collaboration. At the same time, many of the agencies involved share some concern that there are now multiple parallel efforts to improve coordination in global health. This risks creating significant transaction costs and distracting from the efforts of every agency to deliver on their core missions. I am hopeful that these initiatives will

coalesce into a single effort and would welcome Board members' guidance on how we manage this and the associated trade-offs.

This issue also has relevance for Gavi 5.0. One way to minimise complexity in the global health architecture is to use existing agencies to tackle new health challenges as they arise. As we discussed at our March retreat, the Alliance platform could be used to catalyse improved access to non-immunisation interventions and to address emerging areas such as antimicrobial resistance and global health security. I look forward to continuing this discussion together.

Gavi's Mid-Term Review

We will have an initial conversation with donors about the early thinking on Gavi 5.0 (building on our Board Retreat discussions), at the **Mid-Term Review** (MTR), which will be hosted by Abu Dhabi on 10-11 December. You have received a separate paper on our MTR plans. It is an important accountability exercise for donors to show that the Alliance is delivering on its commitments in the Berlin investment case, discuss progress and challenges and to begin discussing the early thinking on Gavi's next strategy. It is also an important first step in preparing for our next replenishment, which will take place in 2020 in the context of a number of health and development replenishments in the coming two years.

Reporting back on previous Board decisions

In June last year, the Board approved revisions to the Alliance's **Fragility, Emergencies, Refugees** (FER) policy. This provided additional flexibilities to enable more responsive and tailored support for fragile countries. The policy has enabled us to reach high-risk groups more quickly and effectively, and therefore better help prevent or control disease outbreaks. To date, the flexibilities have been used in a number of countries including to reach refugees in Uganda with routine vaccines, to immunise Rohingya refugees in Bangladesh, and to support intensified efforts in Yemen to control diphtheria and measles (Gavi is also supporting a cholera vaccination campaign through our regular mechanisms). As we discussed at our Retreat, a growing share of Gavi-supported countries will be fragile (either nationwide or in certain regions) as stronger countries transition out of support, and fragile settings are home to a growing share of under-immunised children. We will therefore need to continue to differentiate and tailor our support to these countries. This is discussed further below.

In December 2016, the Board decided that Gavi should support immunisation in **Syria**, a fragile country which was not Gavi-eligible, in view of the acute humanitarian crisis and uncertainty on whether its gross national income per capita had fallen below Gavi's eligibility threshold. The crisis in Syria is now in its eighth year with over 13m people in need of humanitarian assistance. Healthcare services continue to face severe challenges with less than half of health facilities functional, frequent power cuts and significant risk to healthcare workers and equipment, especially in hospitals. The Humanitarian Response Plan remains underfunded and only 50% of the intended humanitarian aid was delivered as planned in 2017. Gavi support has helped to maintain supply of vaccines and has contributed to an improvement in reported coverage in 2017, while the vaccine derived polio outbreak appears to be under control with the last detected case in

September 2017. Despite this progress, major challenges persist and the situation on the ground remains fluid. We have particular concerns on the risk of measles outbreaks, which is exacerbated by the number of inaccessible areas in the country and frequent population movement. Partners are conducting measles campaigns, with a focus on high-risk areas, to reduce this risk. The Alliance will continue to closely monitor the situation. Given that Alliance support was originally approved for 2017 and 2018 only, the Board will need to consider in November whether to provide further support for future years.

At the same meeting, the Board approved a further US$ 150 million investment in yellow fever (YF) to support WHO's Eliminating **Yellow Fever** Epidemics (EYE) strategy. This increased Gavi's total investment in yellow fever to over US$ 400 million between 2016 and 2020. In February, WHO hosted a retreat to review the first year of the EYE strategy. This noted some progress, including applications from Ghana and DR Congo for Gavi support for preventive mass campaigns and for Kenya to expand the geographical scope of its YF vaccination programme. However, the pace of progress remains inadequate given the continued risks, as illustrated by ongoing large-scale outbreaks in Brazil and possibly Nigeria.

Between July 2017 and March 2018, there were over 900 confirmed cases of yellow fever in Brazil, resulting in 300 deaths, a 50% increase over the previous year. Many of these cases were in peri-urban areas where the disease could potentially spread more rapidly. There have also been 11 cases in unvaccinated travellers to Brazil from Europe and Latin America highlighting the risk of cross-border spread. The government has carried out mass immunisation campaigns reaching approximately 20 million people. In Nigeria, over 1,700 suspected cases had been identified by mid-April with at least one suspected case in every State including in or around many of the country's major cities. However, the scale of the epidemic is much less clear than in Brazil due to weaknesses in the country's surveillance and diagnostic capacity. Nigeria had no reagents for yellow fever diagnosis in 2106 and or the first half of 2017, only 41 suspected cases had been confirmed by mid-April at the regional reference laboratory in Dakar and there is a significant backlog of samples to be tested. Despite the limited understanding of the scale of the outbreak, the International Coordinating Group has approved provision of over six million doses of Gavi-funded vaccines from the global stockpile given the potential devastating effect of a wide scale epidemic. Thanks to this response and the end of the rainy season, the number of new cases appears to be falling. However, given Nigeria's low routine YF vaccine coverage (estimated by the 2016-2017 NICS survey to be 39%), there is a significant risk of another outbreak when the rains return. The PPC discussed the significant risk that weak surveillance poses to yellow fever control and asked the Secretariat to explore options for Gavi to help address this for discussion at their next meeting.

Unfortunately, since our last meeting there has been another outbreak of **Ebola** in DR Congo. As of 28 May, there have been 51 reported cases (of which 35 have been confirmed) and 25 deaths. While the outbreak started in a remote, rural area, there have now been five confirmed cases in Mbandaka, a city of over one million people which is a major transportation hub on the Congo River. This increases the risk of a widescale outbreak and of potential spread to other parts

of DR Congo, Congo Republic or Central African Republic. This is the ninth Ebola outbreak in DRC so the country has extensive experience controlling the disease, and the government has mobilised rapidly with intense support from WHO and other partners. The government has requested use of investigational Ebola vaccines, 300,000 doses of which are available thanks to Gavi's Advance Purchase Commitment (APC). Over 7,500 doses have arrived in country and another 8,000 doses will arrive shortly. Gavi provided US$ 1 million to support operational costs and WHO has done an excellent job setting up the necessary cold chain. I recently visited the outbreak zone with Dr. Oly Ilunga, the Minister of Health, as the first vaccines were being administered. He and I both agree that while vaccines are an important component of the response, they are not a silver bullet and it is critical to strengthen the normal pillars of Ebola preventive and control efforts to contain the outbreak. We remain in close touch with government and WHO, as well as other partners, and will continue to support as required.

Since the last meeting, the manufacturer with whom we signed the APC has informed Gavi of a further delay in submitting the application for licensure due to an issue at their manufacturing facility. We are currently evaluating the implications of this delay and will bring a recommendation on how to manage it to the Market Sensitive Decisions Committee in due course.

In December 2016, the Board approved a strategy to accelerate scale-up of **HPV vaccine.** As we have previously discussed, implementation has been delayed significantly due to unanticipated supply constraints. Tanzania and Zimbabwe have both introduced the vaccine so far in 2018 (including a multi-age cohort introduction in Zimbabwe) and Ethiopia and Senegal plan to introduce before the end of the year. These introductions should reach approximately seven million more girls by 2020. However, introductions in many other countries continue to be delayed and we remain in close dialogue with both manufacturers to try to secure additional capacity as quickly as possible, and maximise the number of women and girls who can be protected against cervical cancer. This will also be critical to achieve WHO's target (in its Global Programme of Work) of reaching 50% of girls with HPV vaccine by 2023 and universal access by 2030.

At its last meeting, the Board approved the opening of a window for **typhoid** vaccine, which was first prioritised in the 2008 Vaccine Investment Strategy (VIS). Pakistan has become the first country to apply for Gavi support for the vaccine. This is partly in response to a recent widespread outbreak caused by an extensively drug-resistant strain of typhoid. This strain has a genetic mutation rendering five of the six antibiotics typically used to treat typhoid ineffective (and could potentially become resistant to Azithromycin, the last effective antibiotic, if it continues to mutate). The continuing growth in antibiotic resistance is a worrying development given that over 20 million people contract typhoid each year, and could result in a significant increase in mortality (currently approximately 160,000 people die from typhoid each year). This example illustrates why the VIS, which the Board is discussing at this meeting, includes impact on antimicrobial resistance (AMR) as one of the criteria to evaluate future vaccine investments.

Moving forward from the Board Retreat

At our March Retreat, we reviewed our progress on **coverage and equity** (C&E). There seemed to be a general consensus that we are making progress in most countries, but that we are facing particular challenges to improve C&E in fragile settings. I heard an appetite for Gavi to continue to differentiate its support based on each country context, to be more flexible in its support – including potentially having a higher risk appetite in some settings – and to deepen its focus on robust sub-national data and tailor interventions accordingly. We had already begun to work in this direction including through more focused and data-driven discussions in joint appraisals, more targeted health systems strengthening (HSS) and PEF support with a focus on specific areas or bottlenecks, and updating the FER as discussed above. The Secretariat also worked with the UN High Commissioner for Refugees (UNHCR) to ensure that preventive healthcare and immunisation are explicitly prioritised in the recently agreed Refugees Compact.

Following the Retreat, the PPC recommended two policy changes that will enable further flexibility in Gavi's programming (and are on the Board consent agenda). The first enables countries to programme up to 25% more HSS funding if they can demonstrate it will be directly targeted at improving coverage and equity. The second allows a 50% increase in HSS for all fragile countries (and not just those in emergency). Given historic absorption rates of HSS, these changes are not anticipated to result in HSS disbursements exceeding the Board-approved envelope of US$1.3 billion. We will keep reflecting on what more the Alliance can do to accelerate progress on C&E and continue our discussions with the Board.

At the Retreat, we also had our first discussion of **Gavi 5.0** on some of the broad trends that will influence our strategy. A number of potential themes emerged that we will explore further. I heard particular focus on the following four questions:

- How do we finish the job of reaching every child with all vaccines in eligible countries? What will this take in an increasingly fragile portfolio of countries?
- What role – if any – does Gavi have to help support increased access to immunisation in middle income countries (e.g., though supply and procurement tools, advocacy, technical support)?
- Should Gavi further enhance its role in supporting global health security?
- How can the immunisation / Alliance platform be used to further support integration / accelerate access to other primary healthcare interventions?

I look forward to hearing the Board's thoughts on whether these are the right questions and if there are other questions we should be looking at. The process to develop the strategy will continue throughout the rest of this year and into 2019. We will bring a paper to the November Board fleshing out the factbase in the areas prioritised by the Board, and have a deep dive at our Retreat next year. Our aim is for the overall strategy framework to be approved before the end of 2019 to enable us to develop our investment case for the next Replenishment, though we will continue to refine the details and plan for implementation over the course of 2020. Of course, we will make our very first decisions about the next

strategy period this year through deliberations on the VIS and polio, both of which are on the agenda for this meeting with final decisions in November.

Agenda for this Board meeting – two major themes

As discussed above, there are two major themes underlying the decisions on the Board agenda: enhancing the **sustainability** of immunisation programmes and shaping Gavi's future vaccine programme investments. The afternoon of the first day includes decisions arising from our 2017 Retreat where the Board asked for tailored approaches to countries facing high transition risks. We will consider an exceptional, multi-year strategy to try to strengthen **Nigeria's** immunisation programme and help prepare the country for a successful and sustainable transition. This strategy reflects the principles approved by the Board at its last meeting and follows an intensive cross-Alliance process, working closely with the Government of Nigeria. The PPC was supportive of the strategy, but recognised the need for humility given the significant challenges to success. The PPC also emphasised that Gavi support should be conditional on the Government meeting its commitments, with an annual process – led by the Gavi CEO and Nigerian Minister of Health – to review progress before approving continued support.

We will also consider proposed approaches to post-transition engagement with **Angola, Congo Republic and East Timor** – which the Board identified as at high risk and have already transitioned. The PPC endorsed these approaches but questioned whether they were adequate in scope and timeframe to mitigate the risks these countries face. They requested more analysis and country-by-country plans for consideration at its next meeting. The PPC had also requested a presentation of the challenges facing middle income countries (MICs) in general. The analysis (which is available to Board members on BoardEffect and some of which I will show in my verbal report) showed that on average non-Gavi MICs spend significantly more on immunisation but have worse outcomes on many dimensions (e.g., vaccine introductions, coverage, institutional capacity). It also showed that low income countries, with Alliance support, are performing better on many of these indicators. WHO and UNICEF described how they are working to help MICs but acknowledged that there are significant gaps and funding challenges, especially to provide adequate technical support. This is a topic that we will need to consider further as part of our discussions on Gavi 5.0.

The second morning of the meeting will discuss two topics which will shape our **future vaccine investments**. The Board is being asked to agree on a shortlist of candidates for Gavi's third **Vaccine Investment Strategy,** that will further analysed to inform a final decision in November. The PPC recommended that we include six candidates for endemic disease control, including both cholera and rabies vaccines which were supported as part of a learning agenda in the last VIS. The PPC also endorsed the recommended approach to evaluate vaccines for epidemic use, recognising this may need to be refined with experience, as well as the idea of maintaining "living assessments" as we learn more about the vaccines and the diseases they are intended to prevent. An investment case for pandemic influenza preparedness will be brought to the Board in November.

We will also discuss Gavi's future role in **polio**. This is a complex discussion with three components. The first is Gavi's support for inactivated polio vaccine (IPV)

after 2020. To safeguard eradication, SAGE has recommended that countries maintain use of IPV for at least a decade after polio is certified as eradicated and oral polio vaccine has been withdrawn (at least 2032). The question for Board guidance is whether Gavi should fund this – and if so, whether it should do so using the existing policy waivers (which will cost Gavi more but maximise the probability of countries maintaining IPV use given many are expressing concerns on having to self-finance polio costs after certification). This decision could add nearly US$ 1 billion to Gavi's expenditure in the next strategic period and may therefore require an additional "ask" at our next Replenishment on top of our core programmes (for which our overall ask is forecasted to be lower than in this strategic period). The second component of the discussion is if Gavi should agree to a request from the Polio Oversight Board to finance the cost of IPV in 2019 and 2020 given the Global Polio Eradication Initiative (GPEI) is facing a budget shortfall. This would cost approximately US$ 200 million, especially as the recent tender will result in a significant increase in IPV prices in the short term. Gavi can accommodate the request within existing resources but this would limit our flexibility to invest in other opportunities and may be seen as tacit agreement to finance IPV after 2020 (we will decide on post-2020 support in November). Lastly, the Secretariat is seeking Board guidance on how Gavi should engage in discussions on the Post Certification Strategy, which is being developed to maintain essential functions and some core polio assets after GPEI sunsets.

Key developments in the Secretariat and partners

The development community has recently been rocked by a series of stories about **sexual misconduct** in major international and humanitarian organisations. The reported behaviours, and inadequate management responses in some organisations, are abhorrent and particularly shocking given the missions of these organisations. We take these issues very seriously at Gavi. The Secretariat has a clear policy framework to support a safe work environment including a code of conduct, a respectful workplace policy, a whistle-blower hotline and an ombudsman allowing issues to be raised anonymously and addressed. That being said, these developments demonstrate that we cannot be complacent and I have asked a senior team led by our Directors of Legal and Human Resources to review our current practices and how we can strengthen these further including through training and relevant workshops. We are also working with the Global Fund on a common training approach and with other partners to understand their approaches and best practices. Contractors and Gavi grantees will be required to take appropriate preventive and remedial steps against such behaviour.

I recently announced a limited **re-organisation of the Secretariat,** creating a new Vaccines & Sustainability department which brings together teams working on policy, market shaping, vaccine implementation and immunisation financing and sustainability. This will enable us to take a more holistic approach to how we design and manage our vaccine programmes, policies and financing. The department will be led by Aurelia Nguyen, who is well known to the Board after serving as Director of Policy and Market Shaping for the past seven years, and who has now been promoted to Managing Director. Country Programmes, led by Hind Khatib-Othman, remains our largest department (including the Country Support, Health Systems and Immunisation Strengthening and Programme

Finance teams) and will continue to focus on directly supporting countries. The Resource Mobilisation and Private Sector Partnerships department has also been reorganised and now includes the Innovative Finance team, which supports IFFIm. These changes will enable us to increase the Secretariat's effectiveness, better deliver our current strategy and prepare for the next strategic period.

Later this month, the Secretariat will relocate to the **Global Health Campus** (GHC). As we have previously discussed, the GHC will provide a modern and flexible workspace at a significantly lower cost than our current premises. 50% of the space is for collaborative working, helping us work better together across the Secretariat and with our fellow occupants, especially the Global Fund. Peter Sands and I – along with our respective teams – are meeting regularly to discuss how to optimise this collaboration. We look forward to discussing our approach at this Gavi Board, with Peter joining us on the first day of the meeting.

The GHC will also help us to strengthen collaboration across the Alliance. Within a short walk of WHO headquarters, it will also enable Secretariat staff to connect directly with partner offices around the world by videoconference. This will be important as we follow-up on the second **Alliance Health Survey**, whose results have just been published. They showed a slight increase in satisfaction across the Alliance with continued pride and belief in the mission and clear improvement in the "rational" aspects of how we work together (e.g., Alliance processes, clarity of strategic objectives, and communication). However, it also showed that we have work to do on the "emotional" aspects of our collaboration to build greater trust, respect and a feeling of belonging to the Alliance. This is particularly true at headquarters where, like last year, sentiments were less positive than in-country.

Gavi's **governance** bodies are of course critical for enhancing cross-Alliance collaboration and trust, and effectively supporting those bodies is among the highest priorities of the Secretariat. To ensure we deliver on this, we track how effectively we plan governance meetings as one of our KPIs. We were less successful at this in 2017 than in previous years – with over 50 Board and Committee meetings taking place during the year, 50% above our planned level of 35. Many of these were impromptu meetings, called at relatively short notice. This may have been partly due to the reappointment of the CEO and Board Chair but this trend has continued in 2018 with an additional 12 meetings to date in addition to the 35 which were scheduled for the year. This does create strains on the Secretariat, who are not resourced to support an average of one governance meeting every week, and for Board and Committee members who are asked to make themselves available at short notice. We will continue to track this metric so that we can discuss mitigating strategies as a Board if the trend continues.

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Our next meeting will take place at our new home in the Global Health Campus. We will meet in the weeks before the MTR, where we discuss how we are delivering on our promises made at our replenishment conference in Berlin whilst aggressively tackling our challenges and begin to discuss ideas for the next strategic period, based on the Board's initial thinking. The Campus will provide an exciting platform for us to think and work in new ways in the Secretariat, Alliance and across the global health community as we look forward to Gavi 5.0 and the next iteration of the Gavi journey. We look forward to introducing you to it!