



Report to the GAVI Alliance Board

4-5 December 2012

Report of the Chief Executive Officer

27 November 2012

Dear Board Members,

It gives me great pleasure to provide this report on the eve of our Board meeting in the United Republic of Tanzania, which will begin a significant week for the Alliance as we see more than 600 friends of GAVI gather at our Partners' Forum to consider what progress we have together made and how we can collectively build upon it.

I would like to thank the Government of **Tanzania** – from the President down – for the support they have provided for the Board meeting and the Partners' Forum. Tanzania has much to be proud of. In 1999, 147 out of every 1000 children died before their fifth birthday. That figure was down to 67 in 2011, putting Tanzania on track to meet the Millennium Development Goal on child mortality. One of the reasons for that impressive reduction has been the work that Tanzania has done with our Alliance. In 2001, Tanzania was one of the first countries to be supported by GAVI to use the then new DTP-HepB combination vaccine. We then supported the introduction of pentavalent vaccine in 2009, which now reaches 90% of Tanzania's children. And Tanzania will take another dramatic step this week in protecting its children against the two biggest child killers – pneumonia and severe diarrhoea, which cause a quarter of under five deaths in Tanzania – by introducing pneumococcal and rotavirus vaccines.

The Forum will also give us the opportunity to mark a new phase in the **Decade of Vaccines** following the approval earlier in the year by the World Health Assembly of the Global Vaccine Action Plan. At the AFRO regional committee meeting in Angola two weeks before our Board meeting I had the chance to discuss with health ministers how they are planning to meet the ambitious Plan, and how GAVI can help. The week before that I was in Brazil, where the Brazilian government renewed its commitment to work with GAVI and start contributing to IFFIm—although the path through the Brazilian bureaucracy is still not entirely clear. I am sure that Dagfinn Høybråten, chair of the Board, will update the Board on his visit with Australian and New Zealand MPs and Helen Evans to Myanmar; from what I have heard and seen of the media coverage, it was a highly successful visit.

Accelerated introductions

The pace of the Alliance's work continues to accelerate: by the end of 2012 we will have seen a record total of 30 vaccine introductions into countries' routine schedules and 6 campaigns supported by GAVI over the course of the year. These include five pentavalent, seven rotavirus, ten pneumococcal, and eight measles second dose

vaccine introductions, and four Meningitis A and two yellow fever vaccine campaigns. And this activity is not just a larger number of introductions, but many in very challenging country situations such as North Korea, Yemen, Myanmar and Haiti. During this year, we also saw the first double launch of Pneumococcal and Rotavirus vaccines in Ghana—an impressive effort which will be repeated in Tanzania. The Alliance is supporting more launches, more vaccines and more antigens than ever before in its history and we can congratulate ourselves on the progress we have made. This scale up, however, is a marathon and not a sprint and the rate of introductions will accelerate further, with more than 50 expected in 2013, and additional growth after that. As pentavalent vaccine is now part of the routine schedule in almost all GAVI eligible countries, and we begin to roll out measles-rubella vaccine, the previous distinction between traditional and new vaccines is becoming less and less meaningful. I explore the implications for the future of this below.

Vaccine updates

We estimate that over 20 countries could be running **HPV** vaccine demonstration projects with GAVI support by 2015; as a result of these projects and full introductions, one million girls are projected to receive HPV vaccine by this date. We continue to be in learning mode along with our countries and just have completed IRCs for both country roll outs as well as demonstration projects. This impressive progress will be achieved with the engagement of a wide range of partners—many of them new to GAVI—including those involved in cancer control, adolescent health, and women's reproductive and sexual health.

In addition to supporting the introduction of second dose **measles** vaccines into the routine schedule, GAVI will fund measles campaigns in up to six large countries as part of a comprehensive strategy to strengthen routine measles coverage and support the addition of rubella vaccine in those countries. Applications from Ethiopia, DRC, and Nigeria will have been reviewed by the IRC by the time of the Board meeting. Due to changing epidemiologic patterns resulting from previous vaccination campaigns, we are already seeing some countries making requests to vaccinate wider age groups that originally proposed which needs further analysis and consideration.

GAVI has now become an official partner of the Measles Rubella Initiative. We are waiting for a response from the UN Foundation before we can finalise support for measles outbreak response, including proposed decision procedures on the use of the funds; and we need to reach agreement on the question of overhead fees.

Meningitis A vaccine continues to be successfully introduced in Africa's meningitis belt, with an additional 50 million children and adults immunised in the final quarter of this year. By the end of the year, 100 million people will have been immunised in just under two years. In countries where the vaccine has been rolled out, this disease has been reduced from a serious burden on the people and health systems to just a few isolated cases in unimmunized individuals. GAVI and partners organizations can be very proud of this success story.

The number of **polio** cases is the lowest, and the geographical area is the smallest, ever recorded. Efforts to complete polio eradication remain an important feature of the immunisation landscape in a number of GAVI countries – most notably Nigeria, Pakistan and Afghanistan where polio remains endemic – and in India, where a large number of staff have been engaged in successfully eliminating polio. An important element of the new Polio Endgame Plan of the Global Polio Eradication Initiative is the strong emphasis on the importance of routine immunisation to achieve the eradication and containment of all polioviruses, and to secure the long-term gains of polio eradication by using the polio programme's infrastructure to strengthen routine immunisation. WHO's Strategic Advisory Group of Experts on Immunization (SAGE) in its November meeting has recommended that at least one dose of Inactivated Polio Vaccine (IPV) should be given as part of the routine schedule in countries which are using Oral Polio Vaccine. The EC agreed that we should consider strengthening cooperation between polio eradication efforts and GAVI, including potentially partnering in strengthening routine immunisation in countries of high priority to GAVI and the GPEI, supporting countries in their introduction of IPV, and using IFFIm to fund the routine immunisation strengthening aspects of polio eradication, while noting that GAVI's existing targets remain the Alliance's top priority. My view is that we have a real opportunity here to improve our impact in some of our key countries and play our part in the polio end game strategy, and I look forward to discussing this with the Board.

During World Immunisation Week 2013 the Gates Foundation and UNICEF will co-chair a Vaccine Summit that will bring together key vaccines stakeholders to demonstrate the progress and the potential of global immunisation efforts while providing opportunities for commitments primarily focusing on polio. We look forward to hearing more details on the Summit and working together on our shared commitment to immunisation.

One of the vaccines we have been watching closely is the RTS,S **malaria** vaccine. It is currently in a phase III clinical trial, including two places here in Tanzania (one of which Board members will have the chance to visit), and sites in five other GAVI-eligible countries. As I wrote to the Board in November, this is the first vaccine that is effective against a human parasitic disease, and therefore represents a scientific breakthrough. However, the new data on the vaccine in infants, delivered using an EPI schedule, demonstrated that it provided a lower level of protection (31%) than the efficacy demonstrated among slightly older children (56%). The duration of protection also seemed to be short, although longer term studies will be necessary to fully define this. We have also recently seen surprising trial results on a **dengue** vaccine – again with lower efficacy than originally hoped due to poor protection against one of the serotypes despite good antibody responses. These are not final data for either vaccine, and we await additional insights as clinical trials conclude around 2014, and the vaccines are considered by regulatory agencies and WHO's policy-making bodies.

Malaria, dengue, cholera vaccines, IPV, and others will be considered as part of the 2013 **Vaccine Investment Strategy** (VIS) review, which will underpin our next five year strategy and the resource mobilisation process. For me the VIS represents an opportunity to make global policy in the best way – with broad consultation, independent input, and a complex and data intensive process that carefully weighs

the scientific evidence, drawing on the strengths and capacities of our partners, particularly WHO. All of course within a reasonable timeframe, so that GAVI's stakeholders have the chance to plan for the long term. I am looking forward to discussions with GAVI stakeholders, and at the Board in June and December 2013.

In line with the vaccine supply and procurement strategy's aims of creating a healthy vaccine market by increasing the number of suppliers and therefore healthy competition, minimizing costs, and ensuring adequate supply of quality vaccines, we have completed the first roadmap for HPV vaccine, and the process is underway for pentavalent and yellow fever vaccines. Working in partnership with our suppliers and our countries, we have been successful in alleviating the short term pneumococcal vaccine supply shortage which had been in prospect earlier in the year. However, short term supply constraints continue for the two dose presentation of rotavirus vaccine. Countries were offered the three dose presentation but in part because of formulation issues including the larger size of the cold chain footprint and lack of a vaccine vial monitor, decided to wait for the two dose presentation. I am pleased that Merck, the manufacturer of the three dose presentation is now actively working to make the presentation more attractive to our countries. Achieving greater production capacity for the GSK two dose presentation will take some time: 36 months to achieve peak production; so we will continue to look at ways to mitigate this delayed deployment including encouraging use of the three dose presentation where appropriate. Primarily as a result of this supply capacity constraint we now project a cumulative total of 16-19 introductions of rotavirus vaccine by the end of 2013, versus a target of 23 in the Business Plan. The supply constraints mean that we now project 22% coverage of rotavirus vaccine by 2015 in GAVI eligible countries as compared to 31% projected in the Business Plan. This is the greatest current obstacle to meeting our 2015 goals and I can assure you that I am very focused on this and working hard with partners to address it.

I would like to flag some changes to GAVI's **targets**. Last year, in light of the annual update of coverage estimates from WHO and UNICEF, we increased the estimates of our impact, and reflecting the new baselines, our targets were adjusted to be more ambitious. This year, there were two changes of note in the WHO/UNICEF estimates of immunisation coverage. The first is that there was a major retrospective revision in coverage estimates for earlier years. Last year, WHO/UNICEF estimated coverage in GAVI eligible countries to be 78% in 2010; this year they revised the 2010 estimate to 76%. The second change is that WHO and UNICEF have, for the first time in a decade, estimated that immunisation coverage has decreased from one year to the next. WHO/UNICEF estimate that DTP3 coverage in GAVI eligible countries dropped from 76% in 2010 to 74% in 2011, primarily driven by decreases in Nigeria, Pakistan, Cote d'Ivoire and Chad.

In the light of the retrospective change in baseline coverage for 2010, I informed the Executive Committee that we would need to once again adjust our baselines and targets. We have maintained the same incremental target for improving immunisation coverage and applied that to the revised baseline. In other words, our ambition is the same that it has always been in relative terms, and indeed the new 2015 target for DTP3 coverage (82%) is still higher than it was when the Board approved the 2015 strategy in 2010 (79%). Despite the issues with rotavirus vaccine supply, we still expect to meet our target by 2015 of averting nearly 4 million future deaths.

Accurate immunisation data are critical for estimating immunisation coverage, purchasing the right quantities of vaccines, and estimating impact as well as developing supply, financial and fundraising forecasts. As I have highlighted previously to the Board, confidence in coverage data is low in the majority of GAVI countries, as assessed by WHO and UNICEF's welcome new Grade of Confidence ratings, and there are frequently significant discrepancies between what countries report from administrative data, UNICEF/WHO estimates and household surveys. The changes in estimates noted above continue to raise questions. Although there is lots of work underway across the Alliance, I do not yet see a game changing plan to address this. I am therefore calling a **data summit** in January to ensure that we are all focused on the critical goal of improving coverage data quality and doing what we can about it, and I will report back to the Board on progress.

Being accountable for results at country level is a cornerstone of the GAVI model. One way to facilitate this is to publish what is being spent where, by whom, and with what results. In October "Publish What You Fund" distributed its 2012 **transparency** index, which ranks 72 aid organisations across the world, from country donors to private foundations on the availability, accessibility, and comparability of the information they publish. I am pleased to report that, following a concerted effort over the past year, GAVI moved up 28 percentage points, taking us from 35th place in 2011 to 13th place in 2012. With an overall score of 62%, the report congratulates GAVI for the "publication of high quality, current activity data" and calls on us "to continue to lead on aid transparency." Aid transparency is an important issue for donors and implementing countries alike – for example, transparency is one of the new indicators in the Busan Partnership for Effective Development Co-operation. GAVI needs to continue to make progress in this area; I believe we should also expect and demand transparency from the organisations and countries we work with.

I have previously flagged the issue of **thimerosal** with the Board. The 5th and final United Nations Environment Programme meeting to consider a global ban on mercury is taking place in Geneva from 13-18 January. Thimerosal is an organic compound of mercury, which is assessed by WHO to be safe – this message came out loud and clear from the SAGE meeting in November – and is important in vaccine production and as a preservative. A ban is still a possible outcome of the negotiations, which would increase the cost of vaccines, disrupt production, and create a challenge for cold chain capacity as some multi-dose vial presentations would not be viable. I re-emphasize my request to Board members that are involved or potentially involved in the negotiations to do all they can to prevent a ban.

Health systems strengthening

Although much remains to be done to increase the impact of GAVI's health systems strengthening (HSS) funding, there has been some welcome progress. In line with the Board's request, new applications for HSS are much more focused on immunisation outcomes. The November IRC recommended for approval 100% of applications, in contrast to the February IRC, which recommended 56% of proposals. With the new secretariat staff capacity and lots of hard work by partners, reprogramming work with countries has also been stepped up – since the last Board meeting, \$42M of programmes have been reprogrammed. Since 2007 80% of approved grants have been disbursed. Total disbursements are accelerating and

timelines for disbursement from approval are improving but we are still not at the 15-25% of the total funding envelope spent on cash-based programmes that the Board has mandated. Furthermore, I am not convinced that we are having maximal impact; as a result and given the critical importance this work has for our mission, I am personally focusing much more attention in this area.

As I have previously flagged, we have created the **Technical Advisory Group for Health System Strengthening (TAG-HSS)**, composed of HSS experts, to advise me on GAVI's engagement in health system strengthening. The TAG-HSS had a rich discussion at its first meeting in September. Its report and recommendations (which are publicly available on my page on the GAVI website) are being considered and in some cases are already being implemented; these will be further reflected in the March Board retreat discussion on HSS.

The development of the implementation framework for **Performance Based Financing (PBF)** is in its final stage; this has taken far longer than I would have wanted. We have carried out intensive country consultations and drawn upon TAG-HSS guidance to fine tune and adapt the model to country needs and GAVI's operational model, for example so that countries that perform well can receive fixed and performance payments that will exceed their overall HSS envelope. The PBF will be introduced in January 2013, in the 10 countries recently approved for HSS support, and the plan is that all countries submitting HSS applications from 2013 onwards will have a PBF component unless, for example, they do not have the systems in place due to an extremely fragile environment and require the types of flexibilities proposed in the country by country approach. We will proceed cautiously, evaluating our performance as PBF is introduced, reporting its progress to the Board and making changes as needed.

We are working with our partners to focus our joint efforts on countries that require more intensive support and attention – in particular **underperforming countries** and countries with high levels of **immunisation inequality**—a major priority of this year's business plan. My view is that the Alliance has not performed well in this area and I am determined that we see progress in 2013, of course recognising that underperformance will not be sorted out by quick fixes by outside agencies.

Our approach will be helped by the proposed new policy on a **country-by-country approach** that will be considered at this Board meeting. In the past, GAVI has applied a standard model to all countries and extended flexibilities where appropriate. This policy allows GAVI to respond to different contexts in a more transparent manner and to give special attention to those countries most in need of tailored support. The aim is not that GAVI should move into emergency relief, but rather to equip GAVI with tools to better respond to countries' or implementing partners' requests – in line with GAVI's mandate – where a country is fragile or an emergency has occurred.

Financial position

In June, additional resources of \$131m were forecast to be needed by 2015, for future programmes, over and above the resources we expected to receive up to 2015. As a result of lower updated estimates for programme implementation – i.e. delayed vaccine introductions, primarily as a result of supply constraints, no

additional resources are now expected to be required up until 2015, beyond those expected through pledges and extensions. However, that is dependent on all pledges being contributed and donors who haven't yet pledged for 2014 and 2015, doing so; thus expected resources are unlikely to be provided without continued efforts by the Secretariat and on the part of donors. We also need to continue to pursue new donors and grow existing donors to prepare for replenishment in 2015. This is complicated by the perception of some donors that we do not have funding needs, due to the success of our fundraising efforts. In the midst of the severe budgetary constraints affecting our donors, our resource mobilisation efforts have allowed us thus far to convert US\$6 billion into grant agreements of the US\$7.2 billion that has been pledged. Challenges still persist as evidenced by recent announcements of aid budget cuts by donors. Securing the remaining US\$1.2 billion will require the prompt renewal of annual grants, extensions of pledges from donors which could not pledge for the full 5 years, and new pledges from donors matched by our sovereign challenge grants.

The funding decisions that the Board is invited to take include provision for a budget envelope, in accordance with the decision taken by the Board in June. I believe that this envelope will allow us to manage health systems funding and the global vaccine supply chain more responsively (see below), as well as making better use of staff, Board and EC members' time.

Business plan

The draft 2013-2014 Business plan which will be considered by the Board is the culmination of a substantial process of consultation across the Alliance, involving a substantial number of workshops, Board committees and members. I would like to acknowledge the commitment of our partners and their openness to frank discussions throughout the process. Allocating funding across the Alliance and to new partners is inevitably going to be challenging and will involve considerable debate; this needs to be balanced against the time required from the various parties at the various stages of the process. I am pleased that the judgement of the Board's Committees is that the process has worked better this year than last, but I believe we should continue to scrutinise the process for efficiency improvements in developing and reviewing the Business Plan investments.

While we tried to keep the spirit of the partnership, and trusting the relevance of the partners' requests, Helen and I significantly challenged the submissions by all teams including the Secretariat's, checking that deliverables and activities were on the critical path and that there was a clear division of roles and responsibilities. The draft plan represents a consolidation of activities for the Secretariat and WHO, and an increase for UNICEF. For UNICEF Programme Division this will involve an additional focus on the in-country supply chain, social mobilisation, and equity—particularly in inequitable and low performing countries. For UNICEF Supply Division, it will involve management of significantly increased volumes and more antigens than ever before procured for GAVI.

I would like to flag that the Plan provides for \$4 million in 2013 to fund additional partners on activities to support new introductions, improvement in coverage and targeted HSS technical assistance, particularly in countries where there needs to be a

more tailored approach. Separately, I am pleased that it has not been necessary to draw upon the “CEO reserve” which was allocated under the Business plan for 2013, and there is no request for such a provision in the Business Plan for 2013-2014.

Country updates

India’s roll-out of pentavalent vaccine is proceeding well, with positive evaluations of the introductions in two states that happened at the end of last year, six states planning to introduce in the next few months (and we now have confirmation that supply will be available for this), and consideration of introductions in another nine states. It was particularly encouraging that the evaluations showed that vaccine wastage had been significantly reduced through the implementation of a new policy by the government. Much remains to be done to strengthen India’s immunisation system: India is the biggest producer of GAVI-funded vaccines and the country with the most unimmunised children, there are no immediate plans to introduce pneumococcal and rotavirus vaccine, and the supply chain has significant issues at federal and state levels. We welcome the government’s consideration of an HSS application for catalytic systems improvements in low performing states which along with catalytic support for new vaccines could help to support change.

The decline in DTP3 coverage estimate to 47% in **Nigeria** was shocking and the government, supported by partners particularly DFID, are rightly taking urgent action to address this. The reprogramming of Nigeria’s HSS funding will play a part in this, and we are looking at what steps we can take with partners to strengthen the relationship with State Governors, as well as addressing supply chain issues (stock outs are a major problem). Nigeria is the highest priority for the GPEI with a massive investment and one of the highest for GAVI with many different vaccines introduced or approved for introduction. It is here that the call for routine immunization strengthening and the synergy with the polio end game strategy is most compelling.

In October, pneumococcal vaccine was introduced in **Pakistan’s** Punjab province, which has around 55% of the countries’ 180m population. The abolition of the federal health ministry and devolution to the provinces has meant that it is unclear whether we have a partner to work with at federal level and if so who this is. It has not therefore been possible to agree on further health systems funding, despite the fact that previous funding has had a positive impact. We continue to explore ways around this. While the impact of pneumococcal vaccine will be very significant there are a number of risks to the programme, partly as a result of devolution, and so we are closely monitoring the Government’s proposed expansion to other provinces.

A new Government in the **Democratic Republic of Congo (DRC)** has taken steps to revitalise the immunisation programme, but much remains to be done. The Government has cleared its 2010 co-financing arrears, paid the majority of the 2011 arrears and appears determined to clear its 2011 commitment, which will allow the expansion of pneumococcal vaccine to four additional states. Importantly, they are also now investing in routine vaccines. I am planning to visit DRC with partners shortly after the Board meeting to encourage the government to build on the progress that has already been made, although recent events demonstrate the fragility of these improvements.

In November, **Madagascar** became the 21st country to introduce the pneumococcal vaccine. Despite a prolonged political crisis which resulted to a donor aid freeze (apart from GAVI and the Global Fund which support has been on-going) and an economic crisis, the Malagasy government has continued to make immunisation a priority and build on the support provided by GAVI since 2001. With drying bilateral flows to the country and immunization progress at risk (200,000 fewer children were immunized this year), partners and donors on the ground have lauded GAVI for the sustained critical support being provided to the most vulnerable segment of the population. To prevent a reversal of hard fought immunization progress and protect children's health, partners have called on GAVI to continue its programmes. This illustrates the importance of our country by country approach and how critical it is to be able to tailor our programmes to country circumstances particularly for the most fragile states

As I indicated to the Board in my last report, the Rostropovich Foundation on behalf of the **Occupied Palestinian Territories** asked GAVI to advocate with manufacturers for lower prices for pneumococcal and rotavirus vaccines. I am pleased to report that one manufacturer has agreed to lower prices, and that procurement of pneumococcal vaccine by UNICEF will begin soon. We do not have any indication that recent developments in the region will prevent this.

Less positively, as I have already reported to the Board, a Financial Management Assessment in **Sierra Leone** has revealed the misuse of funds: US\$ 1.1 million, out of a total amount disbursed to date of US\$ 1.7 million. We are in discussions with the government, and will insist that the misused amounts are repaid, in accordance with our policy.

The revised **co-financing** policy introduced in 2010 has been implemented, so that countries' contributions to their vaccines are better based on their ability to pay. \$38m was contributed in 2011 by 62 governments, representing 7% of GAVI's total support to these governments. 25 countries contributed more than required, demonstrating real commitment to their immunisation programmes. All countries with the exception of DRC (see above) are meeting their requirements, although Angola, the Central African Republic and Togo paid late.

Secretariat update and change process

In my June report to the Board I updated you on some key recruitments in the Secretariat as part of the 2012 business plan. These and some restructuring in the Secretariat are a pro-active response to the changes in the operating environment of the GAVI Alliance – the progressive introduction of powerful but also more expensive vaccines, the rapid increase in the rate of vaccine introductions, the stubborn problem of lifting coverage in some challenging large and low coverage countries, and difficult supply situations, as well as the Board's strong focus on risk management, accountability and results. The overall aim is through strengthening our capacity, that we can manage and mitigate risk whilst achieving the ambitious goals we have set ourselves.

Hind Khatib-Othman started as Managing Director of Country Programmes at the beginning of September. With her arrival we moved the Vaccines Implementation team (formerly known as the AVI team) across to Country Programmes to ensure much closer links and collaboration with the Country Support team. Stefano Malvotti started as Director of the Vaccine Implementation team in early November, and will be known to many of you from his various roles in the Alliance. As part of the strengthened focus on implementation, one of Stefano's responsibilities in the Secretariat will be supply chain and he will work jointly with Daniel Thornton on this, including the development of a strategy referred to below. The last structural change I have made in Country Programmes is to appoint Alan Brooks to a newly created position of Special Advisor for Immunisation in Country Programmes. Alan will work to ensure that the design and implementation of GAVI support strengthens routine immunisation. This appointment is an indication of the importance we are giving to strengthening routine immunisation which is also highlighted in the paper going to the Board on firming up our engagement with the Global Polio Eradication Initiative, focusing on routine immunisation activities. These new senior appointments, along with the substantially increased capacity in Country Programmes are, I believe, already showing results.

I advised the Board in July of changes in the structure of the External Relations department. With Jeffrey Rowland moving from the Director of Media and Communications it seemed an appropriate time to review the overall structure of the department. I advised the board in July that because of the need to strengthen and enhance our work in the area of communications and also my close engagement with resource mobilisation which will only increase as we move to our midterm review and then replenishment, we had decided that these two areas should report directly to me. As a consequence we concluded that there would no longer be a need for a managing director ERO and so, after three years of dedicated service to GAVI, Joelle Tanguy will be leaving GAVI. I want to record my appreciation for her achievements particularly highlighting her masterminding of the highly successful and flawlessly executed Pledging meeting in London. As part of these changes we are considering how we strengthen advocacy across the Alliance, how this links and aligns with communications and the most appropriate structure in the Secretariat. At the same time we are giving high priority to the recruitment of a new leader of Communications.

We also announced recently, the planned departure of Steven Bloom, our director of Operations after six years of service. We will use this opportunity to look at how our operations are being managed and are currently recruiting a new leader.

Following an international search and selection process involving the Chairs of the Board and the Audit and Finance committee, Simon Lamb has been appointed as Managing Director Internal Audit. Although he does not start in the position until January, I am delighted that Simon is able to join us at the Board meeting and Partners' Forum. I want to thank Cees Klumper for his substantial contribution to GAVI. As our first Internal Auditor and at a time of considerable change, Cees pioneered this role and leaves a strong legacy for Simon to build on. I also want to thank Cees for his willingness to work jointly for GAVI and the Global Fund during the interim period.

Change is always difficult; we have worked to create an enabling environment where staff appreciate the rationale for and own the changes. As this process has unfolded, I continue to be impressed with the high level of commitment and professionalism of the staff in the Secretariat, and I thank them for this.

We are continuing to use the successful approach of putting together cross cutting teams from the Secretariat and partners, supported by an external consultant experienced in change management and organisational development, to review and where appropriate change the way we carry out our business. We trialed this in the first half of 2012 on the question of how fit for purpose is our current business model and processes for delivering in and with countries. Two key areas urgently needing redesign that came out of that process were supply chain management and GAVI's grant application, monitoring and review processes.

The **supply chain** has certainly received attention by the Alliance in the past but the focus has tended to be on particular parts of the chain rather than the looking at it from end to end. So we need to look at how the approval, tendering, financing, and procuring flows work across multiple systems and organisations. What stocks are in which part of the supply chain? What is the real-time status of the cold chain? What is the forecast requirement for vaccines, based on robust data? These are questions that any business would put at the centre of its strategy. And so we must, while remembering that our mission is about saving lives, not dollars. I am excited by the work that has been done, for example by Project Optimize to introduce real time temperature monitoring in Senegal, and working with UNICEF to strengthen stock management in South Sudan using mobile phones. Just as countries need to strengthen their supply chains, so the global supply chain needs to be more responsive to countries. If we ask countries to manage their doses more carefully, potentially with fewer doses immediately available, we need to be able to respond rapidly if it becomes clear that a country needs more doses. The changes to the approval process that the Board agreed in June to introduce a funding envelope – a decision on the size of the envelope will be considered during this Board meeting – will help to make decision-making quicker and more responsive.

Pulling all of these different elements together, I would like to bring an Alliance-wide supply chain strategy to the Board next year. This strategy needs to reach from one end of the supply chain – the decision by the manufacturers to produce or allocate a vaccine for GAVI eligible countries – to the other end where a child is immunized and it is documented and reported, working with the partners to define clear roles for each in relation to the supply chain, deciding how to scale up useful technologic improvements, and providing the context for the funding provided under the Business Plan for supply chain work. Innovative thinking will be essential to address the myriad issues and complexities related to supply. In addition to our work with the partners, we must also think of how to bring in other ones to encourage new ways of thinking. Along these lines, for the first time this year, the globally renowned TED (Technology, Entertainment and Design) conference that takes place every year in California convening some of the brightest minds in these fields is adopting the GAVI supply challenge as the first of its new program of TED Challenges. It's an opportunity to share and explore solutions with some of the world's most fascinating thought leaders before, after and during the week of the conference.

We have also convened a cross-Alliance group to redesign GAVI's **grant application, monitoring, and review processes** which is of course linked to creating a responsive supply chain. I am pleased at the richness of the discussions so far and am confident that we will create more robust and efficient processes, while retaining independent review to provide assurance to the Board, to better fulfill our mission.

A third area needing urgent attention in the Secretariat is knowledge management. As a learning organisation that has a strong commitment to measurement, results and transparency we have to improve the way we manage and store information, and have started exploring a process for doing this.

To ensure that these initiatives are taken forward using the cross-cutting approach referred to above, both in areas where there are existing line managers and where there are not, we created a new senior position of Director of Strategic Initiatives. We have assigned Daniel Thornton to this role and this appointment will take effect as soon as a new Chief of Staff is recruited and on board. In the interim, Daniel will continue to carry out his core responsibilities as Chief of Staff, while at the same time, he will begin to devote some attention to his new role.

The Board has before it a paper on options for the secretariat's accommodation. One option would be to move to a **new health campus** which is being created by the canton of Geneva for non-commercial organisations involved in global health. Rent will be lower in the campus, representing annual savings of \$500,000-600,000. Being part of the campus would also provide the opportunity to develop synergies with other organisations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, which will be the largest tenant. Against this should be set the risks to GAVI's identity of sharing a relatively small part of a large campus. The alternative options involve seeking an extension of the lease on GAVI's existing building, seeking a new building at commercial rent rates, or more radical approaches such as moving some functions to other locations. These are likely to be more expensive and/or disruptive than the campus. Subject to the Board's views, this will be an early subject of conversation with the Global Fund's new Executive Director, Mark Dybul.

MOPAN brings together sixteen donors committed to conducting joint evaluations of international organisations which they fund. It has conducted a review of GAVI, which will be available to the Board and published soon. At this stage I can report that GAVI was rated adequate, strong or above for 17 out of 18 Key Performance Indicators on the basis of a desk review, and 18 out of 18 on the basis of a perception survey. In addition there is minimal discrepancy between document review findings and survey respondents - apparently this is not the case with all of the organisations that MOPAN has reviewed. I am grateful to the MOPAN reviewers and members, and we will carefully consider the recommendations that they make. I know that the MOPAN members are considering how best to adapt the methodology to an organisation and Alliance like GAVI which has small secretariat and a strong results orientation, and I hope that the MOPAN donors will take sufficient assurance from the process and positive outcome of the exercise that it will not be necessary for them to continue to conduct separate evaluations.

Several **evaluations** will be available to the Board, once the Evaluation Advisory Committee has considered them, early next year: GAVI's support to China, our gender policy, and the evaluation of the design and process of the AMC. We should also have the Inception report of the Full country evaluations by end December. These evaluations are critical tools for a learning organization and will help as we continue to refine our programmes and policies.

Looking ahead

Revised estimates of our impact up to 2020 and beyond will soon be available. We need to continue to widen our understanding of the full impact of immunisation, and the Alliance has called a meeting of experts in January to focus on the broader **value of vaccines**, explore new areas of work, and help to define a new research agenda.

These projections of our long term impact provide the context for our discussion of GAVI's **Long Term Funding Strategy**. As we make the case for new funding beyond 2015, we will need to continue to demonstrate both that we have cost-effectively achieved a substantial health and development impact, and what we can achieve over the next replenishment cycle. This impact will be demonstrated both in terms of GAVI's existing vaccine portfolio through new introductions and increases in coverage in terms of vaccines that could be added to the portfolio through the Vaccine Investment Strategy as well as our demonstration of the impact of our health systems strengthening work. We will need to make our initial case at our Mid Term Review towards the end of 2013, and our full case by the time of our replenishment meeting, which will take place between the end of 2014 and mid-2015.

Secondly, to maximise our impact on vaccine markets and to allow countries to plan, we need long term commitments. From 2011-2015, 80% of funding commitments are of four or more years. Clearly IFFIm can form an important element of the long term approach, as it has the benefit of providing balance sheet flexibility as well as long term credibility. Flexibility is also required in the allocation of funding: most of our funding needs to be un-earmarked for particular countries, vaccines or programmes so that we can maintain flexibility and keep transaction costs down.

Thirdly, sustainability needs to be at the heart of our Strategy: countries will need to demonstrate progress in meeting co-financing requirements and investing in their health budgets and immunisation programmes. This combined with active shaping of the vaccine market will allow a sustained immunisation effort.

Fourthly, we will need to make progress in diversifying our donor base, although continued support from our existing donors will be critical. An important part of this will be expanding the numbers of significant core donors. Also important will be GAVI's relationship with the private sector. The private sector's expertise whether it be in finance or in delivery is an important part of this relationship (although of course the funding is important too).

Fifthly, we need to establish a more predictable replenishment cycle – a five year cycle is proposed. I am looking forward to hearing the Board's views on the Strategy.

Finally, discussions are well under way to shape the **post-2015 development agenda**. I had the privilege of representing the health sector at the first meeting of the Secretary General's high level panel in September. The next set of development goals represents an opportunity for us to set an ambitious new agenda, and make sure that health and the power of immunisation have a central role in this. Since 1974, DTP vaccine coverage has been the usual proxy for immunisation coverage. By 2015 all GAVI eligible countries will have gone beyond DTP by introducing pentavalent vaccine and we have so many important antigens that target critical causes of morbidity and mortality in our populations. So my view is that it is time to celebrate the progress we have made – from DTP3 coverage in low income countries in single figures in the early 1970s to 80% today – to build upon it by extending DTP3 coverage further, and also to be more ambitious by focusing on a target which captures the power of new vaccines. We need a 21st Century indicator that challenges the world to ensure that all children benefit from the protection of all available vaccines. Attached to this report is a thought piece for Board consideration and discussion.

I look forward to seeing you in Dar es Salaam, during what will be an exciting, and productive week for GAVI, for immunisation, and most of all for Tanzania as the power of new vaccines is further extended to the country's children.