Polio Oversight Board Meeting
Global Polio Eradication Initiative
8:00am-3:00pm • September 26, 2013 • New York
MEETING MINUTES

Context: This meeting was the first time that the Polio Oversight Board (POB) – made up of the heads of agencies of the GPEI core partners, including WHO, UNICEF, CDC, Rotary International and the Bill & Melinda Gates Foundation (BMGF) – met in person with representatives of donors, implementing partners and other key stakeholders to review progress on the GPEI Polio Eradication and Endgame Strategic Plan 2013-2018.

Objective: Review current program status, plans and risks with engaged stakeholders and incorporate feedback into GPEI responses.

Open Session 1: Progress and challenges in global eradication of poliovirus disease

The Chair welcomed POB members, partners, observers and participants with a brief assessment of current progress and challenges. He described his vision of the role for the POB in providing strong governance for the GPEI, including increasing transparency, providing a forum for robust mutual accountability and ensuring proactive actions to address risk. To ensure that the Board is comprehensively monitoring all aspects of the GPEI Strategic Plan, including geopolitical/security issues, the review of budgets and financing against those budgets, and ensuring that the partnership is effectively responding to the IMB and its recommendations, the POB is taking a number of key steps.

The POB is now tracking progress against a GPEI Strategic Plan dashboard to **improve performance accountability** and **effectively assess risk**. This includes broadening the mandate of the leadership body and adopting strong accountability mechanisms when needed. The POB will receive monthly reports from the Polio Steering Committee which will include updates on the security framework, budget and resource mobilization, as well as program strategy and management effectiveness. The POB members are committing to **strong, active leadership at the highest levels of their respective organizations** and will meet in person at least once a year and hold bimonthly conference calls to track progress. To **foster greater transparency** with its closest partners, the POB is expanding participation in their open meetings to the IMB, SAGE, key development partners and country representatives,

Overview of current polio transmission
The WHO Polio Director provided an overview of the status of polio eradication worldwide. Key areas of progress include: (1) no type 3 poliovirus has been reported globally since November 2012; (2) so far in 2013, there has been a 45% decline in endemic poliovirus transmission compared to the same period in 2012; (3) there has been no endemic transmission detected in Afghanistan since November 2012. However, challenges remain, including detection of wild poliovirus in sewage in Egypt, Israel, the West Bank and the Gaza Strip, as well as a large outbreak in the Horn of Africa. He concluded by highlighting challenges in the remaining endemic countries of Nigeria and Pakistan. Overall, approximately 2 million children are missing vaccination worldwide due to insecurity and vaccination bans as well as gaps in polio campaign quality.

Accelerating emergency action plans: Roundtable with Nigeria and Pakistan
The Executive Director/CEO of Nigeria's National Primary Healthcare Development Agency (NPHCDA) provided an update on polio eradication in Nigeria. Security challenges in Borno and Yobe states have hampered access to many Local Government Areas (LGAs) since May 2013, leading to several hundred thousand missed children. In accessible areas such as Kano, the main challenge remains operational gaps and accountability issues such as poor microplanning and team selection. Finally, political support for the program at the operational level has begun to wane in the run-up to presidential elections in 2015.

Actions being taken to address these challenges include firewalling of infected areas with transit area vaccination teams as well as a short interval additional dose (SIAD) vaccination strategy, in addition to efforts to expand health service delivery along with polio in security compromised areas through intensified maternal and child health services, health camps, free drugs/plusses in health facilities and Permanent Health Teams. To address operational gaps, the program has intensified supervision and accountability measures for poor performance, placed additional emphasis on improving team selection and microplanning, focused on high risk wards and strengthened staff deployment to Kano. Planned actions to improve political commitment include outreach by the President to the Chairmen of high risk LGAs, as well as a zonal meeting with Northeastern LGA Chairmen.

The Nigeria delegation asked the POB to consider five requests for support, including:

- Continued direct engagement of GPEI leadership with national/state leadership;
- Funding to support a robust 2014 implementation plan with effective outbreak response;
- Additional funds to improve program effectiveness in Borno and Yobe;
- Greater accountability of WHO, UNICEF and CDC field staff; and
- Support in developing a comprehensive plan for IPV introduction into the routine immunization schedule.

The Minister of Health thanked donors for providing increased funding in 2013 to help support the eradication effort and highlighted overall improvements in immunization quality leading to a 50% reduction in wild poliovirus cases since last year. A focus on addressing challenges posed by insecurity in the Northeast, improving quality in Kano and routine immunization are needed for success moving forward.

Observers applauded efforts to improve political commitment, particularly at the local level where widespread lack of commitment of LGA Chairmen is of critical importance. POB members supported the need to combine other interventions with polio vaccination to encourage greater uptake, especially those desired by local communities and political leadership, such as clean water. The Nigerian delegation agreed that working with LGA Chairmen, particularly Presidential outreach to the LGA Chairman of Borno and Yobe, would be critical to enhancing their commitment. The POB Chair reviewed key items critical to progress in the program including outreach to the Governor of Borno, the Chief of Defense and LGA Chairmen in Borno to discuss polio eradication and vaccinator security in the Northeast, as well as an offer for the BMGF to match a Government of Nigeria contribution of $50 million to help close the funding gap in 2014. Finally, stakeholders noted recent improvements in routine immunization coverage in Nigeria and emphasized the need for the polio program to continue to support routine immunization strengthening along with a focus on polio eradication. Examples of positive synergy included the tripartite agreement between Kano State, the Dangote Foundation and the Bill & Melinda Gates Foundation, as well as the EOC's effort to begin tracking other vaccines along with polio.

The Secretary of Pakistan's Ministry of National Health Services, Regulation & Coordination described progress against the National Emergency Action Plan (NEAP) for polio eradication, highlighting high level oversight being provided at the national level by the Polio Eradication Task Force, chaired by the Prime Minister, and the Prime Minister's Polio Monitoring Cell, and at the provincial level by Provincial Task Forces and Polio Control Rooms. No type 3 poliovirus cases have been detected in Pakistan since April 2012 and coverage has increased as indicated by LQAS surveys which show that lots achieving more than 90% coverage increased from 18 percent in 2011 to 73 percent in 2013. Still serious challenges remain, including a complete ban on polio campaigns in North and South Waziristan, difficulty conducting campaigns in Khyber Agency due to insecurity, and management and accountability issues posing barriers to campaign quality in Peshawar, Hyderabad and Quetta Block. Most importantly, it is critical to continue working with security forces and frontline works to address the atmosphere of intimidation after the killing of 22 polio workers since December last year.

To address these challenges, on September 20th the Presidential Taskforce agreed to re-invigorate oversight by mandating Provincial Task Force meetings, ensuring Polio Control Rooms be fully functional and placing greater accountability on the District Deputy Commissioner role for program quality. In order

to gain access to previously inaccessible areas, a special project is being launched in FATA and Khyber Pakhtunkhwa (KP) with the support of regional governments to provide infrastructural improvements as well as engagement with religious leaders and local communities, negotiate with anti-government elements and ensure armed forces security for campaigns. The Chief of Army Staff, Chief Minister and Governor of FATA will coordinate through a special committee to provide security to polio workers in FATA and KP. The delegation noted that they were indebted to the international community for financial support to the polio eradication effort in Pakistan and committed to put the funds to good use.

The Minister of National Health Services, Regulation & Coordination noted the impressive efforts of provincial, district and Union Council governments to address poliovirus transmission despite the challenges. It is critical to use specially tailored actions to address reservoirs such as FATA, Peshawar and Gadap where local socio-political factors will influence success, particularly accessibility and resentment of polio amongst the community. For example, special task forces are being established in Peshawar and Gadap. The Governor of KP is meeting with the Corps Commander and all elements of the community to develop strategies for success. Efforts to strengthen RI should be fully integrated with the polio program, including the focus of the Presidential Task Force. The Minister expressed thanks to international partners for their support, particularly the Islamic Development Bank (IsDB) and UAE government for supporting engagement in FATA, and committed to strong country ownership going into the October campaign.

Abdul Aziz, IsDB, invited the Minister to call on the IsDB for support whenever required and thanked the Government of Pakistan, WHO and BMGF for strong partner coordination. A good example of this coordination was the gathering of religious and tribal leaders – including those from other Muslim countries like Saudi Arabia – to communicate the importance of the campaign and exchange ideas on how to educate local communities. He expressed optimism that the IsDB's partnerships in Pakistan and Nigeria would yield progress in 2014.

The POB Chair thanked the IsDB for its involvement and for the personal support of the IsDB President. He also congratulated the Pakistan delegation on negotiating access to Bara and a violence-free campaign after just a few months in office. He commented that BMGF was heartened by discussions with Prime Minister Nawaz Sharif earlier in the week, particularly his knowledge of the polio situation in Pakistan and the energy in the new team at the Ministry of National Health Services, Regulation & Coordination. In response to questions regarding the appointment of a focal person for the National Task Force, the Minister noted that she was prepared to take on this position. Observers noted concern about transitions in national leadership for the program over the last year but felt encouraged by recent progress and the dedication of the current administration and Ministry staff, particularly the proactive measures of the Prime Minister to engage state and local leaders to encourage program ownership at all levels.

The Director-General, WHO, noted that she and the WHO Regional Director for the Eastern Mediterranean Region (EMRO) would be in close touch with the Ministry to support the program. She noted that she would be working with the Regional Director to determine how the WHO could best assist, including filling key technical assistance positions in the region and changing the location of those positions from Cairo – where insecurity is a barrier to programmatic support – to another country. She also committed to providing strong support from WHO headquarters in Geneva, including smooth coordination to support cross-cluster responsibilities such as IPV introduction; restructuring to strengthen the polio cluster; establishment of a new unit to analyze insecurity and inaccessibility; and a new Endgame Management Team chaired by the Director General or Deputy Director General to closely track progress and ensure accountability.

The Executive Director of UNICEF restated his agency's "absolute commitment" to polio eradication and congratulated the stakeholders present on the increasing momentum, despite setbacks. He noted the effort to find strong leaders for the effort, including the new Polio Lead at UNICEF headquarters, Peter Crowley. While working closely with security services to ensure the safety of polio workers, it is important to also ensure that these forces are not perceived as a part of the efforts to defeat insurgents.

Operational barriers to eradication, and plans to address them

The WHO Polio Director then offered an overview of the situation in the two areas currently affected by polio outbreaks: (1) Kenya, Somalia and Ethiopia, and (2) Israel, Gaza Strip and the West Bank. The program mounted an aggressive response to the first cases reported in Somalia, conducing seven rounds of supplementary immunization activities (SIAs) – including several for all age groups – within 18 weeks. In accessible districts, it appears that the occurrence of cases is declining and transmission has already peaked, but stopping all transmission will require improved quality in inaccessible areas, where the program is still missing up to 500,000 children under five. More areas may become accessible as the political situation improves. In Israel, and now the Gaza Strip and the West Bank, where transmission was detected through environmental surveillance, the outbreak response has been slower. Immunization in a broader geographical area of that region has taken time to roll out and uptake has been slow (less than 50 percent of the target population in some areas). The WHO has increased its assessment of the risk of international spread of polio from this area from 'moderate' to 'high'.

To address the problem of inaccessibility worldwide as well as to manage risks related to ongoing challenges such as insecurity and violence against polio workers, gaps in campaign quality and delayed response to poliovirus detection, GPEI is taking the following actions: (1) setting clear operational goals to optimize the opportunity posed by the next 'low transmission season' and (2) developing area-specific plans tailored to local challenges.

Specifically, the GPEI partner agencies have established new partnerships to help re-profile the program and improve community engagement through tailored communications and "Polio Plus" health packages. An important example is the work being done to negotiate access to inaccessible areas with the support of the Islamic Advisory Group and critical partners such as Al Azhar in Egypt, the Islamic Fiqh Academy and IsDB in Saudi Arabia, and the UAE. At the same time, major emphasis is being placed on optimizing operational tactics such as SIADs, establishing new vaccination platforms through permanent polio teams and immunization at key transit points, and using polio assets to strengthen immunization services. Finally, improving management by optimizing GPEI agency staffing and improving oversight with dedicated area managers is critical to ensuring success in each of these areas.

The POB is taking a more active role in high level oversight for the GPEI partnership, which has reorganized around the objectives of the Polio Eradication and Endgame Strategic Plan. Based on actions agreed upon at the last POB meeting, outreach by POB members has been conducted with leadership of key polio affected countries and the program has been directed to develop cross-agency advocacy plans, establish low season priorities and explore the potential for travel requirements to be established for countries with uncontrolled WPV transmission. The POB Scorecard, provided to the attendees of the current meeting, is a new tool that captures critical areas of management focus on a single page to allow the POB to quickly assess key weaknesses and risks.

The WHO Director-General thanked the POB Chair for his leadership in the re-organization of the POB and emphasized that mechanisms such as the POB scorecard would ensure that not only countries, but also program partners would be held accountable for performance. She committed to doing her part to minimize international spread of the virus by supporting the strong efforts of the WHO Regional Office for Europe (EURO) with respect to the situation in Israel and writing to the Prime Minister of Israel to encourage his support for strong outbreak response. She noted that member states would raise the question of polio immunization requirements for international travel at the January Executive Board meeting.

The Executive Director, UNICEF stated that despite recent immunization of over 1 million children in Syria increasing refugee movements due insecurity in Syria and Iraq could exacerbate the risk of international spread. The POB Chair noted a similar situation in Central African Republic and called for a vulnerability map to help the partnership think about areas at risk of future outbreaks. In response to questions about the origins of international spread to the Horn of Africa, the WHO Polio Director clarified that the virus originated in Nigeria and the detections in Somalia and Kenya were simultaneous, so the dynamics of importation – including the direction of spread or whether they were separate introductions – is not clear.

Stakeholders also raised concerns that the outbreak in Israel represented a new type of outbreak occurring outside of the transitional areas typified by poor development indicators and insecurity. They questioned whether such outbreaks could occur elsewhere in the world, such as Latin America or the US. In response, the WHO Polio Director noted that inactivated polio vaccine (IPV) used in Israel and other developed countries results in high serological immunity but limited mucosal immunity. Therefore, infections may be transmitted within the population without cases of paralysis. In Israel cessation of OPV more than 8 years ago and exclusive use of IPV is the most likely explanation of transmission. The delayed use and slow uptake of OPV after the onset of the outbreak has allowed circulation to continue.

Other stakeholders noted that countries currently protected from paralytic polio cases by IPV should see polio eradication globally as a “global public health good” and should be discouraged from seeing the outbreak in Israel as something that isn’t dangerous because it is only being detected in the environment and not causing paralysis. The CDC Director has communicated with the Israeli Ministry of Health to encourage a robust response to the detection of polio virus in the sewage system. The United States has updated its travel guidance to the region and the CDC is working with the Israeli government on analysis of specimens as part of a survey.

The IMB representative noted its position that the GPEI must ensure both a strong technical support infrastructure as well as a capacity for adaptive change through its management and staffing resources. Drawing on these strengths, the program must address urgent issues of inaccessibility as well as: (1) align local to national political commitment; (2) ensure high quality operations at all levels; and (3) improve demand for the vaccine in local communities.

The WHO Polio Director also addressed the question around quality of surveillance in the outbreak areas in Somalia. Surveillance is functioning even in inaccessible areas of Somalia. Genetic sequences of polioviruses isolated from cases are very closely related, indicating that surveillance is not missing transmission. Surveillance performance indicators are being closely tracked.

Communication and Demand Generation: Emergency actions to address gaps

The UNICEF Polio Team Leader and Rotary International PolioPlus Committee Chair presented the partnership’s plan to build trust in polio vaccination at the family and community levels to support eradication through:

- *Deployment of social mobilizers* – Since January, 40 percent more community mobilizers – totaling more than 8,300 worldwide – have been deployed to engage households in support of OPV. Many of these community mobilizers help address health needs beyond polio, such as in Nigeria where they are identifying and referring cases of malnutrition to the local malnutrition therapy program. In Pakistan, Rotary is helping to build community trust by reaching thousands of children in the highest risk areas with health camps, resource centers to address refusals, immunization centers within local health facilities and transit vaccination posts.
- *Engaging religious networks* – Over 1,000 influential religious leaders back the program in endemic countries and more than 30 fatwas have been issued in support of polio eradication. The program is putting religious publications in the hands of polio workers as tools to help persuade communities. Between January and July 2013, there was a global drop in the number of refusals attributed to religion from 50% of overall refusals to just 20%.
- *Innovative approaches to access* – Ten security analysts are being engaged globally to help the GPEI assess risk and channels for accessing children in insecure areas. A “Brain Trust” is bringing together experts on insecurity and community engagement to identify innovative solutions for Pakistan. For example, Shiwalikot, Afghanistan, was inaccessible from January until July because anti-government elements did not support polio campaigns. The program discovered that the objection was fueled by concerns about corrupt, incompetent district coordinators. After changing these positions to trusted individuals from the local area, all 18 clusters in Shiwalikot were accessible in the September campaign.

Overall, refusal of OPV has been reduced by 40 percent since January, to just 0.9 percent in remaining endemic areas. UNICEF and other GPEI partners are emphasizing careful selection of staff to ensure the appropriate local people are representing the program at the local level and that the right analysts and

interlocutors are being deployed to deal with issues of insecurity and distrust. In Nigeria, Rotary is promoting local polio ambassadors from sports, Nollywood, etc., and supporting communications in Hausa.

In response to the IMB's recent concerns about the communications capacity within the GPEI, the partnership reported that over 70 percent of vacant positions have now been filled at UNICEF headquarters. Partnerships with specialists and Harvard University, the BBC and Moby Media in Afghanistan are adding valuable reach and expertise to GPEI's communications sector.

IMB representatives present at the meeting congratulated the GPEI partners for a robust response to the IMB's concerns and acknowledged encouraging progress in social engagement data. They suggest instituting the collection of rolling public attitude data that could be displayed in such a way that all stakeholders could gauge community response.

Partners noted additional efforts to generate community demand: For example, CDC is leveraging Voice of America in Northern Nigeria to reach 20 million with Hausa language polio content and Rotary held 77 health camps and polio corrective surgery camps in Nigeria. USAID encouraged the polio program to use the body of evidence on behavior change to further these efforts.

Open Session 2: Key actions critical to securing the gains in polio eradication

IPV introduction in context of polio eradication

The WHO EPI Director presented four of the five work streams (the fifth, routine immunization, is presented in the following section) being undertaken to support global IPV introduction by 2015. This work is being managed by the GPEI's Immunization Strengthening Management Group (IMG), with members from relevant clusters of GPEI partner agencies as well as the GAVI Alliance and the Taskforce for Global Health.

IPV implementation (readiness, supply and demand) – Based on the SAGE recommendation that countries introduce at least one dose of IPV into their routine immunization system by 2015, the IMG recommends prioritizing the approach to introduction within four tiers of countries. Tier 1 contains 14 polio endemic or VDPV-affected countries (including India and China), which together make up 61% of the current OPV birth cohort.

IPV financing – For most countries, the biggest concern is vaccine price sustainability. There has been progress on financing strategies since the donor meeting in London on September 10th. The GAVI policy on IPV financing will be discussed this week and at the November GAVI Board meeting. The estimated five-year cost for IPV introduction ranges from $328 million to $449 million.

bOPV/IPV regulatory processes – A database on the status of product registration by country has been established and regulatory authorities of OPV producing countries will be meeting to assess barriers to bOPV licensing.

Communications – An FAQ document has been circulated and an IPV introduction webpage will be added to the GPEI website next week. An information kit for countries is under development.

Despite progress on these work streams, the risk of delays due to prolonged country decision-making processes or delays to introduction itself remain. Since all countries must introduce IPV over a short period of time, close coordination with industry and strong technical assistance is critical. The IMG suggests that the POB: (1) encourage the GAVI Board to take a decision on IPV financing; (2) advocate for early decision-making by countries; and (3) ensure partner Country Representatives receive strong messages on the polio endgame rationale, timelines and targets, including IPV introduction.

The Pakistan country delegation noted their concern about the expense of IPV and asked for further support to understand the rationale for introduction and IPV effectiveness as well as prepare an

introduction strategy. They noted that IPV would be widely accepted in Pakistan given widespread community confidence in injectable vaccines but that introduction would require nurses or other trained health workers to ensure safe administration. The Nigeria country delegation noted that Nigeria is open to IPV introduction in the routine immunization program by 2015, with some caution. First, introducing IPV in a campaign setting would pose serious operational, technical and managerial challenges. Second, anti-OPV factions within the country might use the introduction of IPV to further challenge the legitimacy of the program. An in-country meeting should be organized with all stakeholders to organize next steps.

POB members and observers expressed strong support for the close coordination between GPEI and GAVI to support IPV introduction, calling it a unique example of synergy within the global health community. Questions of accountability and governance for IPV introduction were discussed, however, with calls for greater role clarity. The POB Chair will be representing the POB at the next Polio Partners Group (PPG) meeting in November and will try to bring some clear answers to that discussion. CDC indicated a willingness to support this body of work.

GPEI partners noted that OPV will continue to be the main tool for eradication, but that IPV would serve an important role as eradication becomes imminent and type 2 VDPV risk from tOPV use must be managed. In response to questions about additional costs associated with syringes needed for IPV, the GAVI and GPEI representatives clarified that financing for IPV would include bundled packages with support for the vaccine itself, the necessary syringes as well as (for GAVI-eligible countries) a vaccine introduction grant to support the administrative costs of introduction. Other stakeholders expressed support for engaging pediatricians effectively to support IPV introduction and encouraged use of IPV in areas with limited accessibility to rapidly boost immunity in populations where accessibility is intermittent or brief.

Routine immunization strengthening

UNICEF's Expanded Programme on Immunisation (EPI) Director reviewed GPEI's efforts to strengthen routine immunization (RI) based on the indicators included in the Polio Eradication and Endgame Strategic Plan monitoring framework. In order to achieve the goal of developing annual national immunization improvement plans in at least five of the ten focus countries, the GPEI has established a framework to identify the polio program assets and areas of expertise that can be devoted to RI strengthening. This framework establishes three main operating principles: (1) efforts should be concentrated at the country level, not directed from the global level; (2) rather than develop new operational plans, support should be implemented using existing cMYPs and annual country plans; and (3) flexible 'packages' of polio program support for RI must be developed as appropriate to the local context. Six of GPEI's ten focus countries for RI strengthening have developed EPI plans that leverage polio assets to strengthen RI. In Pakistan, for example, polio support for RI strengthening is being implemented initially in 16 districts, where integrated IEC materials and polio-RI microplanning and district oversight as well as partner staff training is being rolled out.

It is difficult to measure the goal of achieving 50 percent of polio-funded field staff time dedicated to RI strengthening by 2014. Still, the partnership is measuring progress using proxy means – i.e., work plans. The terms of reference (TORs) of polio staff already include RI responsibilities in Nigeria, Chad, India, Pakistan, DRC, and Ethiopia and training is being rolled out in these same countries. The third objective, to achieve a 10% year-on-year relative improvement in DTP3 coverage in high risk districts of at least five focus countries beginning in 2014, is an aspirational goal that is easier to achieve where baseline coverage is low. Work to strengthen RI microplans using polio microplans is underway in Chad, Pakistan, India, and DRC. High risk districts have been selected based on a range of factors including RI coverage, poliovirus presence and surveillance indicators.

Significant challenges exist to progress in RI strengthening, including a global focus on IPV, rather than RI; a lack of available funding for RI improvements; difficulty measuring progress; and difficulty balancing polio staff focus on RI versus wild poliovirus transmission. Ensuring government ownership is paramount, since parallel systems should not be built through the polio program that would affect RI sustainability in the long run. The EPI Director laid out three actions that the POB can take to support RI strengthening, including: (1) sending a strong message throughout each partner organization on the importance of RI

strengthening; (2) advocating with governments and donors to ensure political and financial support; and (3) include monitoring of RI strengthening efforts as a standing item on the POB Scorecard.

Stakeholders acknowledged that the polio program should not be expected to fix RI on its own, but that the areas where GPEI is focused also tend to be the areas where RI coverage is low, leading to a real opportunity for impact. Greater linkages should be created between GAVI Health Systems Strengthening (HSS) application process and the work that GPEI is doing to support RI. The Nigerian country delegation emphasized the critical nature of RI strengthening to support polio eradication and noted the improvements achieved in RI coverage in Nigeria over the last year, from 51 to 70 percent nationally.

Other attendees noted the value of RI strengthening to the polio legacy and encouraged GPEI to actively reach out to those stakeholders who feel the polio program has historically had a negative impact on RI to engage them on this new effort and ensure it is included in the polio legacy. The polio program's ability to deliver frontline care to vulnerable communities and reach places that other programs have not is a broader asset that can benefit RI strengthening as well as other areas of development. Differentials in salaries of polio program staff versus those of other programs, however, could be a barrier for which early planning is needed. The POB Chair committed to including a discussion on polio legacy planning at a future meeting.

Financing Eradication – 2013-2014

The WHO Chief of Programme Operations & Cluster Management joined via a telephone line to present GPEI's current financial situation. For 2013-2018, the program faces a 'best case' funding gap of $560 million. The proportion of confirmed funding drops significantly beginning in 2014, due in large part to difficulties in operationalizing donor pledges made at the Global Vaccine Summit in April. The program's current cash gap for 2014 (reflecting the degree of funding in hand) stands at $892 million. Taking into account allocated funds in the pipeline ($116.24 million) and pledges under negotiation ($661.68 million), the 2014 cash gap drops to $114 million.

Current GPEI budget risks include delays in eradication, leading to escalating costs in endemic countries; extraordinary funding needs for outbreak response; and financial requirements for potential early introduction of IPV. GPEI partner agencies have limited budget flexibility to address these risks. The program is actively working to avoid additional risks by attracting funding to close the funding gap for 2013-2018, address delays in filling the 2014 cash gap by operationalizing pledges and commitments, and achieving eradication targets to avoid additional campaign costs in Nigeria and increased costs associated with the Horn of Africa outbreak.

Clarification was provided on the types of funding support reflected in the GPEI program budget, including: *Partner agency costs* (e.g., internal CDC operational budgets and BMGF research funding) are not reflected. The United States Government contribution is considered confirmed funding but is reflected as a projection for 2014-2018, since final commitments are negotiated within Congress on an annual basis. *IPV introduction costs* are included in the GPEI budget estimates. While the original projection was $322 million, current projections indicate the cost of IPV introduction will range from $328 million to $449 million. There is some additional buffer built into other GPEI budget line items that may cover higher IPV introduction costs but the final cost of IPV will determine the ultimate budget need.

Some donors indicated concern through the PPG regarding contradictory messages about the availability of *outbreak response costs* within the current budget, i.e., that the program has budgeted for outbreak response yet is still mobilizing funds to support the response to the Horn of Africa outbreak. The GPEI agreed that it needs to improve communication to avoid such confusion in the future but clarified that the outbreaks in Israel and the Horn of Africa represented extraordinary circumstances that have exceeded outbreak response budget estimates built on 10 years of budget trends, at a time when the program still faced a funding gap. Although the GPEI budget allows for annual outbreak response costs of up to $50 million, the programmatic need for 2013 outbreaks has been $65 million to date.

The Nigerian delegation noted that a cost efficiency analysis in Nigeria might help identify where some activities could be scaled down without compromising quality. Technical assistance and social

mobilization are some of the biggest drivers of increased costs in Nigeria. Other stakeholders noted the need to communicate clearly to all stakeholders regarding GPEI's budget outlook, and focus on avoiding cash gaps by operationalizing commitments on time. The POB Chair noted that the BMGF is committed to polio as its top priority. As a result, it is willing to do all it can to operationalize commitments from High Net Worth Individuals (HNWIs) as well as use its own spending flexibility to improve GPEI's budget flexibility where other donors may be constrained in operationalizing commitments on time.

Wrap-up and Next Steps
The POB Chair reiterated his commitment to ensuring the GPEI agency leadership fully supports countries to achieve eradication in a way that promotes accountability and transparency to all stakeholders. The assembled stakeholders expressed positive feedback on the meeting and thanked the POB members for providing a unique forum for their engagement and feedback. It was noted that the POB, SAGE and IMB are highly aligned, leading to strong program leadership at the highest levels, and the GAVI-GPEI partnership has shown unprecedented strength. Specifically, attendees suggested that: (1) in-person POB meetings should be held regularly to ensure face-to-face interaction; and (2) GPEI meetings such as the POB be held in coordination with GAVI meetings (e.g., Board) so that stakeholders can attend both.

Others called for continued efforts to improve accountability and the strength of GPEI governance to complement efforts by the PPG to engage a broad range of stakeholders. Others expressed an interest in engaging in the future to further clarify the contributions of donors and other stakeholders to eradication as well as the legacy planning effort. The POB members thanked participants for their engagement and feedback. The WHO Director-General noted that such a forum provides an example of WHO reform efforts on ways to engage non-state actors to contribute to health solutions.

POB Closed Session

GPEI governance

POB members received positive feedback from open session meeting attendees on the new positioning of the POB with the GPEI, particularly related to increased transparency. The POB Chair emphasized the need to continue the flow of information with stakeholders, including his engagement with the PPG in November.

Subsequent to the September 10th IPV donor meeting, GAVI and GPEI received a letter from donors asking for "a voice, clear tracking and dedicated avenues for donors to engage on IPV introduction and the broader global polio eradication effort…" Examples of the kinds of decisions that donors may want to engage with include whether the overall polio eradication budget envelope should be increased or the direction of the polio legacy discussion. Many donors are used to a particular board governance structure, based on their experience with GAVI. Within GPEI, however, accountability is to individual implementing agencies rather than to the POB, which is an oversight body. Donors want enhanced engagement with GPEI.

All POB members acknowledged that creating a 'heavy', board-like governance structure for GPEI at this juncture would not add value to the mission of the initiative. The WHO Director-General offered her support for increasing donor involvement in decision-making based on the fact that they deserve accountability for their large financial contributions. The CDC Director echoed this support, noting the need to be responsive to stakeholder concerns. The UNICEF Polio Lead noted that from an in-country perspective, more decision-making and oversight bodies increase the burden on country teams to provide country-level data to inform their deliberations.

POB action: POB will review a range of options related to engaging donors in the GPEI governance structure during their next teleconference. The Polio Steering Committee will seek input from donor agencies to develop the range of options for review by POB.

POB meeting structure and operations

Members discussed POB meeting structure and cadence. Members generally supported stakeholders' request for scheduling POB meetings in conjunction with GAVI Board meeting. They also discussed the benefits of closed versus open meeting sessions. The original suggestion for POB in-person meetings was twice per year. POB members agreed that rather than adhere to a strict schedule, in-person meetings should be held when they make strategic sense. For the next POB meeting, all agreed that late spring would be an ideal time to focus on country performance after the low season and the Horn of Africa outbreak mop-up.

POB action: Explore dates for the next POB in-person meeting between April and June based on the GAVI Board calendar as well as availability for participation from key stakeholders (e.g., IMB, World Bank).

Regular teleconferences of POB will continue.

There was agreement with the earlier suggestion to increase transparency by placing the POB meeting minutes on the GPEI website.

POB action: Place the minutes of each in-person POB meeting on the GPEI website.

Members reviewed the POB Scorecard, noting that it was an evolving tool to improve management and accountability. Additional suggestions were made to improve the use of the scorecard. In response to the POB Chair's request for additional clarity on areas of risk, program staff agreed that a Risk Registry would be included as an addendum to the Scorecard for the next meeting.

POB action: Risk Registry to be provided to POB members for consideration at their next teleconference.

POB stakeholder engagement

The POB Chair emphasized calls for greater POB engagement with donors to increase their knowledge of the program's latest updates. POB members agreed with earlier suggestions that the POB Chair provide quarterly communications to donors, as well as issue a media statement by Monday, September 30th.

POB actions: POB Chair (BMGF) to send quarterly communications to donors. POB members will be given the opportunity to provide feedback on the content of these communications before release. Media statement on the outcomes of this POB meeting will be released by Monday, September 30th after being reviewed by all GPEI implementing partners.

Key actions to support Nigeria

POB members agreed that it was important to continue to advocate for strong leadership of the polio eradication effort in Nigeria, given the importance of engaging national, state, and LGA stakeholders. POB members said that they were continuing their engagement with the federal Minister of Health, who has been a staunch supporter of the polio program, and would be ready to work with whomever the President appointed to fill the current vacancy of State Minister of Health and Chair of the Presidential Task Force on Polio Eradication.

POB action: POB members advocate for continued strong leadership for the Nigeria program through appropriate channels.

The urgency of establishing a clear recommendation for Nigeria's 2014 SIA calendar was discussed. It was agreed that the EMG should provide a single, united recommendation to the Nigeria Government by mid-October.

POB action: POB members to work with their respective technical teams to ensure that the EMG has what it needs to provide a single recommendation to the Nigerian Government regarding the 2014 SIA calendar by mid-October.

Key actions to support Pakistan

Members discussed action they could take to support the Prime Minister's stated intention to designate a national focal person for the Prime Minister's Polio Monitoring Cell. They encourage the appointment of a Secretary-level official as coordinator of the Prime Minister's Polio Monitoring Cell.

POB action: The POB will continue to monitor the functioning of the Prime Minister's Polio Monitoring Cell and provide support to the Government as required.

Key actions to support IPV introduction

Members agreed that the GPEI-GAVI partnership model was effective in leveraging new vaccine introduction expertise to support the IPV introduction effort. They also agreed with recommendations that the POB take action to support a GAVI board decision in support of IPV introduction, as well as advocacy to countries. It was not clear, however, what type of POB communication would be most effective. In response to CDC's request for clarification on the status of communications with Middle Income Countries, WHO clarified that once IPV is discussed at Regional Committee meetings, it will be clearer which countries will have difficulties with IPV financing. Finally, members agreed to take action on the Pakistan delegation's call for support in preparing an IPV introduction work plan.

POB actions:

- POB members would continue to engage GAVI board members around the importance of IPV introduction, especially in the lead-up to the next GAVI board meeting.
- WHO to provide clarity on the type of POB communication to countries that would be most effective in encouraging action on IPV introduction.
- GPEI partners to ensure Pakistan receives support for creating an IPV introduction plan.

Key actions to support routine immunization strengthening

Members agreed with the request that the POB ensure strong messaging within each partner organization on the importance of RI strengthening.

POB action: The POB will keep track of strengthening of routine immunization as a standing action point for POB meetings and will include appropriate indicators of progress on the POB scorecard.

Key actions to support communications

POB members felt that stakeholder responses to the IMB's recommendations on communications were positive. UNICEF agreed to condense the presentation provided to the POB for the IMB meeting in London on October 1.

GPEI partner agency staffing

CDC offered to second staff to support key positions within WHO Headquarters. The WHO Director-General noted that she has given instructions to reduce bureaucracy and streamline recruitment for polio positions, given that it is operating in emergency mode.

POB action: WHO and CDC to follow up on the potential for additional CDC secondees to WHO.