Meeting of the Polio Oversight Board (POB)

23 March 2021| 6:00 – 8:45 PST/ 16:00 – 18:45 CET | Virtual Meeting

Meeting Minutes

POB Member Attendees: Chris Elias (POB Chair, BMGF); Tedros Adhanom Ghebreyesus (WHO); Henrietta Fore (UNICEF); Mike McGovern (Rotary); Rochelle Walensky (CDC); Seth Berkley (Gavi)

Summary of Action Items

Action Point	*Owner*	*Timeframe*
POB to approve the strategy executive summary and slide deck for submission to the World Health Assembly	POB Chair	By March 31
Plan POB visits to Afghanistan and Pakistan at the earliest opportunity	POB Chair	By May 15
Send communication regarding donor representation on the POB/ FAC/ SC once FAC ToRs are finalized	POB Chair	By April 30

Opening Remarks

Dr. Elias thanked attendees for joining the meeting and welcomed Dr. Rochelle Walensky, CDC Director, to her first POB meeting. The Chair expressed 2020 was a challenging year and voiced appreciation for the continued support of the polio program by all the key partners.

Review Progress: Action Items

The Chair noted the POB is committed to tracking the five points of concern raised by donors at the December POB meeting related to the governance review implementation, response to the IMB report, input into the strategy revision process, resource mobilization and active risk management. Many of these topics are included in the agenda and the POB will continue to have a standing update on these topics at each meeting.

Polio Situation Update: Endemics, nOPV2 Rollout, and Outbreaks
Presenter: Aidan O'Leary (WHO)
The following update was presented to the POB:

Endemics

- There has been widespread WPV transmission in Afghanistan and Pakistan over the past two years and the intended transformation of the program was stalled in 2020 due to the pandemic. This has been compounded by cVDPV outbreaks, and further challenged by more than 80% of these cases being concentrated in inaccessible areas. There has been a positive trajectory for the past six months with only 11 cases of wild poliovirus seen in Afghanistan and Pakistan.

However, the program is still seeing a high level of environmental surveillance positives, which represents an elevated level of transmission across both countries.

- In Pakistan, vaccine acceptance in marginalized communities is a continuing issue, with lack of trust driving higher rates of missed children and refusals. Priority Community Engagement (PCE) has been established as a new area of work under the new NEAP to address this. A new EPI manager and a new EOC coordinator have been appointed, however more local government oversight in the highest risk polio areas is needed. Other challenges include inappropriate frontline staffing and sub-optimal microplanning for campaigns, as well as poor routine immunization and access to basic health services in the highest risk areas.
- A key challenge for Afghanistan remains inaccessibility, with continuous anti-government element bans on vaccination in the Southern region of the country. Vaccine refusals and poor campaign quality in accessible areas compound the challenges faced by the program. A comprehensive plan for the Southern region has been developed, which brings together alternative vaccination strategies across the partnership. A key intervention to address program management issues has been the development of a new accountability framework and progress is being made in several regions to increase the number of female vaccinators.

nOPV2 Rollout

- Three countries are fully verified for nOPV2 rollout: Nigeria, Liberia, and Benin. Between March 13 – 16, the first successful rollout of nOPV2 took place in five states in Nigeria.
- Approximately thirty countries are under different stages of preparation and an additional twenty to thirty countries are yet to start. All countries at high risk of cVDPV2 outbreak should prepare for nOPV2 use now. It is important to note that if countries are not verified for nOPV2 use, it is essential that they proceed with mOPV2 or tOPV for timely response to outbreaks.
- The program will be working closely with the Vaccine Safety Subcommittee and the SAGE to progress to wider nOPV2 use in the third quarter of the year based on the safety data that is emerging. There are currently no red flags on safety issues.

Outbreaks

- With waning type 2 immunity, there are currently twenty-six outbreaks in twenty-seven countries. The program faces many challenges with outbreak response, including delays in detection as well as continued campaign delays, with some countries preferring to delay response until they receive approval to use nOPV2. There are also competing priorities at the country level and reluctance to declare a public health emergency once detections are announced.

<u>The POB was asked to assist with:</u>

- Direct advocacy with governments to 1) declare and respond to polio outbreaks as public health emergencies; and 2) respond quickly to outbreaks with the authorized vaccines that are available.

The POB thanked the presenter, and the following observations and questions were raised:

- <u>Chris Elias</u> offered congratulations on the beginning use of nOPV2, noting that it is a historic moment for the program. He flagged that given the sensitivities in rollout of a new vaccine

under EUL, and particularly within today's challenging environment of mis/disinformation and additional complexity of concurrent COVID-19 vaccine rollout, the GPEI is following the lead of country and regional teams in a cautious communications approach during the initial stages of these first nOPV2 campaigns. He encouraged all stakeholders to coordinate with GPEI's communications approach to help minimize risks and support the success of this rollout.

- Mike McGovern thanked the SC Chair for joining the Afghanistan Technical Advisory Group meeting in person.
- Henrietta Fore noted the increasing number of women who are part of the vaccination teams and believes this is a good sign as it will build community trust.
- Rochelle Walensky expressed the CDC's commitment to the program under her leadership and support of ensuring a public health emergency can be declared when needed.

IMB/ TIMB Chair Statement

Presenter: Sir Liam Donaldson, IMB & TIMB Chair

The following statement was presented to the POB:

- This is the 10th year of the IMB, and the program has yet to create, or implement quickly enough, transformative solutions that match the complexity of the problems. In its later stages, the program has been slow to adapt to changing circumstances. It has clung too tightly to its technical program roots and has not dealt well with politics or grasped opportunities to work with other partners to achieve broader developmental action to help affected communities.
- The following key recommendations in Pakistan were highlighted:
    - Call for a stronger emergency culture in the program to treat polio as a public health emergency.
    - Ensure that the Special Assistant to the Prime Minister on Health and the EOC Coordinator spend more physical time in the provinces to increase alignment between the national and provincial levels, and push for accountability at both levels.
    - Invest in integrative services and public health infrastructure in the super-high risk Union Councils to build trust and create transformational potential.
    - Advocate for the World Bank planned investment to be implemented in polio high-risk areas.
    - Establish a regional commission so Polio is seen as a regional problem.
- In Afghanistan, access is the principal root of the problem. However, lack of clarity on the government's leadership role and the running conflict with the WHO and UNICEF country teams have created dysfunction. There are multiple ideas to address access in Afghanistan, including making access a pre-condition to peace negotiations, discussions at the highest level of the World Bank to include polio in the Sehatmandi Program, and the continuation of a mixture of local and international negotiations.
- The TIMB report highlights that the transition process has reached a crossroads, and a policy decision is needed whether the GPEI should continue to manage and coordinate all polio functions or whether a subset of functions should move permanently to other global management structures to advance polio transition. It also recommends that each of the twenty polio priority transition countries' plans be reassessed in light of COVID-19 to understand when these countries are able to assume responsibility for management and funding for polio essential services. Lastly, the TIMB recommends further development of a global comprehensive communicable disease surveillance system.

The POB thanked the presenter, and the following observations and questions were raised:

- Chris Elias noted that there has been engagement with the World Bank on how to optimize the investment in Pakistan, which both Gavi and the Gates Foundation plan to participate in, as well as the Global Financing Facility. There is a strong role for the World Bank in determining its disbursement indicators to help guide the programming to the most at-risk polio environments and the polio program will continue to advocate for that. Dr. Elias also noted that the POB is working to identify the earliest possible opportunity to visit both Pakistan and Afghanistan to try and galvanize political commitment.
- Ahmed Al-Mandhari (WHO) shared that a Regional Subcommittee meeting has recently taken place, attended by eleven member states. The ministers expressed strong commitment to support eradication efforts and agreed to meet quarterly, with specific focus on support at the regional and national levels.
- Aidan O'Leary (WHO) stated that in Afghanistan, there is agreement with the acting Health Minister, national EOC Coordinator, and incoming WHO and UNICEF representatives on the need for a one team approach that allows for open discussions around the direction of the program. An accountability framework is being drafted to create effective and efficient functioning going forward. Making this framework fit for purpose is a priority in the coming weeks.
- Beth Arthy (UK) thanked Sir Liam Donaldson and commented that these reports help frame the issues and challenge the program on some of the difficult choices under consideration in the new strategy.
- Henrietta Fore noted the importance of the one team approach in Afghanistan and believes this will be achieved with the incoming WHO and UNICEF representatives. She also expressed that integration does make a difference in building trust in communities and asked for additional funding to move this program forward at a faster pace.
- Dr. Tedros emphasized the importance of a POB visit to Afghanistan to strengthen relationships at the country level and proposed a visit in April.

GPEI Strategy Presentation

GPEI Strategy and Revised GPEI Structure Presentations
Presenters: Aidan O'Leary (WHO) & Rebecca Martin (CDC)
The following update was presented to the POB:
GPEI Strategy

- As the program saw increasing wild polio virus cases in endemic countries and a rising number of circulating vaccine-derived polio virus outbreaks, it became clear that the previous 2019 – 2023 Polio Endgame Strategy did not adequately address a number of key strategic elements on the path to eradication. The emergence of the COVID-19 pandemic fundamentally changed the world in terms of public health priorities and has had a dramatic impact on the financial environment the program faces. To address these challenges, the GPEI engaged in an extensive and collaborative strategy process, with engagement across over 300 stakeholders, including donors, country governments, and advisory groups.

- The resulting strategy seeks to drive a shift in two key ways across both endemic and outbreak countries:
    - *Emergency focus:* re-establishing polio eradication as a public health emergency of the highest order and holding governments, GPEI agencies and global partners accountable for rapid progress as a means of cementing the emergency nature of the program.
    - *Collective engagement:* better reflecting the needs, voices, and capabilities of the broad spectrum of stakeholders on whom eradication depends, and rebalancing capacity and decision-making away from HQ-level towards regional and country teams.
- The new strategy looks to achieve eradication and sustain a polio-free world through two goals: 1) to permanently interrupt all poliovirus transmission in the final polio-endemic countries by the end of 2023; and 2) to stop cVDPV2 transmission and prevent outbreaks in WPV-free regions in order to certify eradication of WPV1 and validate the absence of cVDPV2 by 2026.
- The GPEI will focus on transforming its approach through five strategic objectives that reflect the changes needed to make rapid progress toward eradication:
    - Create urgency and accountability through advocacy to generate greater political will by re-envisioning the relationship with governments and systematizing political advocacy.
    - Generate vaccine demand through context-adapted community engagement that reduces refusals and increases communities' commitment to child immunization.
    - Expedite progress through expanded integration efforts and unified partnerships that reflect a targeted approach and decision-making framework on future integration opportunities.
    - Improve frontline success through changes to campaign operations, including the recognition and empowerment of the frontline workforce.
    - Enhance detection and response through sensitive surveillance and containment that provides the program with essential information for action.
- Successful implementation of the strategy will also require strong collaboration, adequate resources, and key metrics to measure progress, including the following enabling factors: risk, monitoring & evaluation; finance and costing; communications; vaccine supply; research; a GPEI structure fit for purpose; and gender equality and equity, which is a critical programmatic imperative. Focusing on these enabling factors will allow clear oversight, tracking and the related accountability for all stakeholders going forward.
- Key challenges to goal 1 include lack of access in AGE-controlled areas of Afghanistan, partnership with Pashto speaking communities which represent 10% of the population but 85% of cases in Pakistan, sub-optimal SIA performance, government ownership, and "polio fatigue" from polio-only campaigns. The key strategic areas where the program will work to institute change are: political advocacy, including a more proactive and strategic approach to partnering with governmental stakeholders; community engagement to foster greater co-ownership and vaccine receptivity; campaigns to reach all children through SIAs that directly address and resolve current government ownership and community resistance challenges; integration to ensure mutual reinforcement of polio and other health/ development programs; and surveillance that evolves towards monitoring for polio and other vaccine preventable disease.
- For goal 2, challenges include nOPV rollout and monitoring, a lack of emergency posture and operations from both nations experiencing outbreaks and the GPEI, declining immunity level to

all types of poliovirus, and the reach and quality of surveillance. To address these challenges, the program will focus on the following objectives: increase surveillance capacity to more rapidly detect, sequence, and initiate response activities; political advocacy to ensure emergency posture and resourcing to accelerate outbreak response; campaigns to cover a large enough area with the right tools to ensure interruption of transmission; integration to drive coordination and co-delivery with parallel RI programs; and sustained community engagement through activities which persist even in the absence of polio.

- There is no single silver bullet to achieve eradication; it will require a hard press across all interventions and across all geographies.

GPEI Revised Structure

- As the program develops the strategy and functions, the GPEI has also focused on revising the governance structure to ensure it is fit for purpose.
- The core of the structural change is to refocus capacity and decision making closer to where operations and programs are being implemented. The Regional Operations groups will support country-led eradication efforts while holding countries accountable for progress against eradication targets. These groups will report up through the new Executive Management Unit (EMU) to the Strategy Committee (SC) on overall performance accountability. Within this level, the EMRO/ MENA Regional Incident Management Support Team (IMST) and the Sub-Saharan Africa Rapid Response Team (RRT) will work across the partnership to coordinate outbreak response, conduct risk assessments, develop budgets, and support integration opportunities. The Afghanistan and Pakistan Endemics Hub will be responsible for operational and budget decisions in the two remaining endemic countries.
- The Global Program Support groups will provide strategic, financial, and operational guidance across the entire program, as well as provide resources for implementation in support of the Regional Operations activities. These groups will also report up through the EMU to the SC.
- The Strategic Leadership level, including the POB, FAC, and SC, is accountable for developing and adapting GPEI's strategy, ensuring the availability of sufficient programmatic resources, and program oversight to achieve and sustain polio eradication. What is new at this level is the EMU, which will be responsible for the day-to-day operations of the program at the global level, reporting to the Strategy Committee. The EMU will coordinate, manage, and monitor across the partnership to address cross-cutting issues, including integration and gender. The ToRs are being finalized for this group and the SC is targeting an interim structure for the EMU being in place by June 2021.
- There is also a Global Advisory & Consultative Support function to support GPEI. These groups will provide independent external feedback and technical support to the program on key strategic issues.

The POB thanked the presenters and raised the following observations and questions:

- Chris Elias stated that due to the volume and quality of feedback received on the strategy, the program has not had time to fully digest and incorporate this input. Therefore, the POB has not been asked to approve the strategy at this meeting. By the end of March, the program will have finalized an executive summary and slide deck that will be put forward to the World Health

Assembly, which will be circulated virtually for approval by the POB. The Chair will convene a meeting if necessary, to discuss any final aspects of these documents.

- Seth Berkley noted it is critical to get the strategy right, with a coherent and compelling rationale, and the program should take the time to do so. He also called out the importance of explicitly stating the differences between this strategy and the previous one to truly show the shift that will move the program to achieving eradication. On timelines, he asked if the program can realistically interrupt transmission by the end of 2023 and noted the importance of showing both optimism and realism. He flagged the opportunity to strengthen the collaboration around the zero-dose agenda and linking to IA 2030 to help focus resources in the right areas and improve both polio vaccination and access to essential services. He voiced concern that integration could get lost without a dedicated group that would be responsible for prioritizing and moving it forward.
    - Chris Elias offered his perspective that, based on the final years of the eradication programs in Nigeria and India, the two-year timeline for interruption is sufficient. It will require the POB to be vigilant and closely follow progress and key performance indicators.
- Rochelle Walensky noted the strategy reflects an enormous amount of work, but it is not fully solidified, and more time is needed to increase the clarity and cohesion of the document. The program will need resources and these need to be reflected in the strategy to overcome the challenges presented and demonstrate the program will be good stewards of these resources.
- Beth Arthy (UK) raised the point that when the strategy is released, the program must stress that eradicating polio is critical to ending poverty and to global health security, so this messaging is not lost amid other priorities at the World Health Assembly. She acknowledged the timeline feels very tight to finalize a critically important strategy and encouraged being realistic about the timeframe. She also agreed that it will be important to better articulate what the program is doing differently with this strategy and that now more than ever, the program will need to focus on collaboration and integration and tell that story more clearly. Lastly, she spoke to the need to be transparent on the budget choices the program will make in this resource constrained environment, with an emphasis on nimbleness to both respond to opportunities but also adapt when the political will is not there.
- Birgit Pickel (Germany) agreed that it is important to take the time to get the strategy right but cautioned the program should not lose the sense of urgency to finish the strategy. She noted the new structure reflects the need to be more agile and stated the importance of updating the POB regularly to understand if the structure is producing the anticipated benefits. She also noted it will be essential to align the various GPEI processes, particularly the strategy and resource mobilization processes, to be effective. Risk management must be a key part of the new strategy and she asked when the risk management approach will be shared. Additionally, she welcomed that integration features strongly in the strategy but urged that integration be included in the core GPEI budget for the new strategy. The TIMB report highlighted that countries are struggling to secure sufficient funding for integration of relevant polio assets into their national systems so GPEI support cannot wind down in some countries and needs to be reflected in the costing model. Lastly, she noted the importance of working in partnership to leverage resources and political impact.

- Pierre Blais (Canada) stated his appreciation for the work that has been done and feels the strategy is going in the right direction. He asked how donors will be able to contribute to the finalization of the strategy and if there has been a decision on donor representation at the GPEI strategic leadership level. He noted the biggest challenge facing the program is unprecedented uncertainty and this must be at the core of the strategy. He highlighted three areas of importance for managing the strategy: better governance and having the right voices at the table; risk management to be ready to adapt to different scenarios; and better accountability to enable all partners to act quickly and rapidly share information. Regarding timelines, he stressed the need to use appropriate language that does not translate the timeline into a hard commitment, but rather a planning tool to retain flexibility. Lastly, the program should be realistic when setting the budget to retain the ability to be nimble.
    - Chris Elias shared that the POB has approved the terms of reference for the POB and SC, including adding donor representation to these governing bodies. The ToRs for the FAC are being finalized based on donor input and once complete, the Chair will send a communication on this and plans to have formal donor representation added to the POB and other committees by the June board meeting.
- Heather McBride (Canada) stated that without a strong gender component, transmission will not be halted. She expressed appreciation that gender is now explicitly called out in the GPEI structure and stated the need for a dedicated gender budget to maintain momentum and urgency in the gender strategy.
- Akhil Iyer (UNICEF) noted there is work to be done on the length of the strategy document and some details, such as operational plans, can be reflected elsewhere. He is encouraged the revised strategy gives more prominence to integration in high-risk polio geographies and feels there are integration opportunities, particularly when it comes to EPI integration, that are crucial to the program having an effective access strategy. He agreed that gender is critical to program success and flagged the need for more gender expertise in a program of this size. Lastly, he stated UNICEF's commitment to a less vertical program and cautioned against transferring the verticality from the global to the regional level.
- Sir Liam Donaldson (IMB/ TIMB Chair) agreed that work needs to be done to make the written strategy document more compelling, noting that the program could benefit from including more human-interest stories. On governance, he expressed that the GPEI is a membership organization, and it is very difficult to instill accountability. He put forward the idea for a trial period to devolve the budget to the Regional Council discussed earlier for allocation and to set out performance criteria. Additionally, he flagged the need for a more in-depth discussion on what tools can be used if performance fails. Lastly, given the increased speed of vaccine development, he noted the idea of producing a vaccine which provides gut immunity for a five-year period rather than a few months as this would create a very different situation for ending polio transmission.
- Mike McGovern recognized the overriding issue of accountability and noted that the key performance indicators should rise to the attention of the POB. The Board needs to strengthen the accountability process by reviewing the KPIs for key challenges and including these strategic discussions at future POB meetings.

- George Laryea-Adjei (UNICEF) noted that all partners need to align on what it means to have a public health emergency approach to polio. On access, he noted that a key assumption of the strategy is the need to revisit approaches in Afghanistan and parts of Pakistan, and this will mean the program needs to bring in different partners and provide support to build these partnerships. He shared his belief that for the endemics, a structure is needed closer to both Afghanistan and Pakistan, the Hub in Amman is too far to achieve integration in an operational way. To hold the program and partners accountable, he stated that ownership, from the community level to the government level, cannot be taken for granted and the strategy could put incentives in place to drive accountability. Lastly, he voiced his commitment to ensuring that the program objectives are achieved.
- Ahmed Al-Mandhari (WHO) expressed his commitment to make this mission successful. He emphasized that in working to shift to a more horizontal program, it is important to not push the current heavy burden of the GPEI coordination process down to the regional level so that regions can remain agile and flexible. He also reiterated his commitment to ensure that partners who are hosted at the Hub are fully and adequately supported. He called on partners to fully commit to the Hub by deploying senior staff to consolidate decision making at this platform.
- Dr. Tedros expressed his appreciation for the collaborative nature of the strategy process and for donors' support and involvement. He agreed with the timeline of interruption by the end of 2023, noting that this is an ambitious goal. It will be important to do more to ensure there is ownership by the government and communities, and the program will need to make sure it is addressing the broader community needs to be successful. Political commitment is critical, and he believes the program should consider the ideas on access put forward by Sir Liam Donaldson to face the challenges head on. Regarding timing of the strategy process, he noted the program should take the time needed to revise the document but encouraged finishing as soon as possible and asked for support from donors if the strategy is a late submission to the World Health Assembly.
- Aidan O'Leary (WHO) made the following responses to the comments:
    - *Strategy document:* he recognized the need to articulate the order of magnitude of the changes more crisply. He noted implementation will be key to instilling confidence in the new approaches.
    - *Integration:* this has been the most deliberated part of the strategy, and he emphasized that it includes a wide range of activities that need to run in parallel and the program will work to better capture the essence of what that involves.
    - *Access:* he noted that the goal is to ensure the program reaches and maintains access to all children and all options are on the table to address that.
    - *Key performance indicators and risk management:* this is what most distinguishes this strategy from the previous one, and how the program manages risk and tracks performance is ultimately how we will hold ourselves accountable.
    - *Costing model:* he noted that moving forward, the program will take the assumptions from the model and turn these into a more detailed process grounded in the epidemiology and actual performance. He appealed to donors to limit earmarked funding as this limits the agility of the program to respond.

- Rebecca Martin (CDC) acknowledged that while there is not a group specifically recognized in the organigram to lead on integration, there is a working group at the global level that has linked with other organizations and groups on potential areas for integration. In the new structure, countries will need to define concrete opportunities for integration and the regional operations groups will support countries in this and be accountable for monitoring risk. The global groups will coordinate across the program on integration. She also addressed the comment made on knowledge management, noting that both internally within GPEI as well as externally, operations, accountability, and mitigating risk are essential enabling factors supporting the organizational structure and the program is working on clear processes and systems for these areas.

Strategy Costing Model and Resource Mobilization Presentations
Presenters: Britta Tsang (BMGF) & Ikuko Yamaguchi (UNICEF)
The following update was presented to the POB:
Costing Model

- In parallel with the strategy development, the program also developed an initial costing model to understand what the cost might be to implement this strategy. Four scenarios were developed to understand the sensitivity of costs around various potential timelines for interruption, and scenario B ties to the strategy document timeline of two years to interrupt WPV transmission, with certification of eradication three years after that.
- The primary differentiator in the five-year trajectory of costs for the different scenarios is the date of WPV interruption. In scenario B, WPV interruption occurs at the end of year 2, and year 3 shows post-interruption ramp down of activities and costs.
- The biggest cost drivers in scenario B are the SIA calendar, robust surveillance, outbreak response, and OPV stockpiles. The program has taken a conservative risk position on outbreaks in order to have adequate resources should these outbreaks occur, however these costs are different than some of the planned activities as they are, by nature, unpredictable.
- The program will use the costing model as initial parameters and assumptions to guide further budget planning, recognizing the scenario estimates are indicative rather than definitive. These estimates will enable some transparency around the cost drivers to allow for discussion on the risk level of trade-offs that might need to be considered in light of resourcing constraints.

Resource Mobilization

- The program is aware of the challenging resource mobilization context in the coming years, including the impact of the COVID—19 pandemic, programmatic challenges in the polio program, and multiple ongoing replenishments in global health financing this year. The pandemic has shown the world the fragility of progress in global health, but governments and donors are in search of ways to build more resilient health systems. Continued investment in polio infrastructure will help strengthen systems for pandemic preparedness and response, including potential support for the roll-out of COVID-19 vaccines. It is vital to leverage existing programmatic capacity that donors have invested in to achieve polio eradication and to facilitate integration.

- The Resource Mobilization Group is working to diversify the donor base through not only new donors but looking at innovative mechanisms in domestic resources and expanding private sector partnerships. Resource mobilization will be guided by the new strategy and costing discussions to really understand the fundraising needs and cash gap.

The POB Chair thanked the presenters and raised the following observations:

- Chris Elias summarized the budget situation as facing tremendous uncertainty, both in the sources and uses of funds. It is a difficult time to be asking for additional funding, given the pressures of COVID-19 and the global recession; however, the costing model shows a great deal of uncertainty, particularly in 2022 and 2023. There is a large and conservative SIA budget for outbreaks, and we know from experience outbreaks are unpredictable. There's also skepticism from the donors on whether the program could fully implement a budget as high as $1.3B a year. Due to the pause in campaigns in 2020, the program will roll over a higher percentage of the budget than in recent years, which will help close the cash gap in 2021. The program will now need to turn the costing scenarios into actual budgets with a good deal of scrutiny as we continue to raise resources. The POB will need to focus on the prioritization of available funding as the program may face a significant cash gap going into 2022.

Closing Remarks

The Chair thanked the attendees for their engagement and discussion. The meeting was followed by a 15-minute closed executive session.