Agenda Item 7:

GPEI financing – 2016, changes to budget through endgame

Global Polio Eradication Initiative

Polio Oversight Board

September 25, 2015

Agenda

- GPEI financial update
  - Financials
  - Donor feedback on GPEI financials
  - Non-FRR spending
- MTR financial scenarios discussion

GPEI financial update

Executive Summary

Short-term funding

- $55M “gap” remains for 2015
- However, the GPEI Strategy Committee has prioritized remaining 2015 funds against most critical areas (e.g. all immunization activities covered)
- 2016 may have a substantial funding gap even after all pledged and projected funds are realized

Full PEESP funding

- Positive resource mobilization trends continue, although new scenario may require significant funding increases, especially in 2016 and 2017

GPEI Funding

$Ms	2013 Actuals	2014 Actuals	2015 Budgeted	13-'18 Projected
Objective 1	892	890	1,063	
Objective 2	38	117	283	
Objective 3	1	9	10	
Objective 4	-	-	-	
Total Expenditure / Requirements [A]	**931**	**1,016**	**1,355**	**5,525**
Funds Available* [B]	1,359	1,358	1,189[1]	3,285
Funding Surplus / (Gap) [B - A = C]	**428**	**342**	**(166)** [1]	**(2,240)**
Pledged + Projected Funds** [D]	-	-	111[1]	2,023
Funding Surplus / (Gap) [D + C = E]	**428**	**342**	**(55)** [1]	**(217)**

- Prioritization effort conducted by SC has decided which activities to deprioritize from a funding perspective due to $55M “gap.”
- All immunization activities for 2015 are fully covered
- At present most of the deprioritized spending is in outbreaks and deferred funding for open positions in 2015 until 2016.

1. Management estimate for most likely current year total

2015 gap detail

Remaining 2015 funding "gaps" for Q3 and Q4

Gaps With Confirmed + 75% Likely Funding (US$Ms)	Q3	Q4	Total
Immunization Activities			
Immunization Total	**0.0**	**0.0**	**0.0**
Surveillance and Response Capacity			
Surveillance and Lab	0.0	0.0	**0.0**
Environmental Surveillance	0.6	2.2	**2.7**
Emergency Response (Unicef)	8.8	8.8	**17.6**
Emergency Response (WHO)	0.0	5.5	**5.5**
Stockpiles for Emergency Response	1.2	0.0	**1.2**
Surveillance and Response Total	**10.6**	**16.5**	**27.1**
PolioVirus Containment			
Certification and Containment	2.7	2.7	**5.4**
Surveillance and Lab Enhancement for Certification	2.1	2.1	**4.3**
Containment Total	**4.8**	**4.8**	**9.7**
Core Functions and Infrastructure			
Ongoing QI	0.0	0.0	**0.0**
Surge Capacity (Unicef)	2.5	2.5	**5.0**
Surge Capacity (WHO)	0.0	0.0	**0.0**
Technical Assistance (WHO)	0.0	0.0	**0.0**
Technical Assistance (Unicef)	2.2	2.2	**4.4**
Community Engagement and Social Mobilization	4.5	4.5	**9.0**
R&D and Technology Transfer	0.0	0.0	**0.0**
Core Total	**9.2**	**9.2**	**18.4**
Grand Total	**24.6**	**30.5**	**55.1**

No 2015 gap for immun. activities

Unfunded ER >40% of total 2015 gap

Some new hires unfunded until 2016

Historical underspend suggests GPEI spend may be lower potentially erasing $55M gap

$M	2013				2014			
Objective	2013 Budget	2013 Actual	Difference ($)	Difference (%)	2014 Budget	2014 Actual	Difference ($)	Difference (%)
Objective 1	931	837	94	10%	962	835	127	13%
Objective 2	52	36	17	32%	111	110	1	1%
Objective 3	5	1	4	82%	9	8	0	4%
Objective 4	0	0	0		0	0	0	
Indirect Costs	65	58	8	12%	72	63	9	12%
Grand Total	**1,054**	**931**	**123**	**12%**	**1,154**	**1,016**	**137**	**12%**

In 2013/14 GPEI experienced slightly over 10% underspend driven primarily by the following

- Underspend in people categories due to vacancies throughout the year
- Delayed campaigns or campaigns with scope reduced due to security concerns
- Delays in operationalizing objective 2 & 3 work plans in early 2013

Concerted efforts have been in place to reduce vacancies and minimize 2015 underspend but we will not know exact expenditure figures until the books close in early 2016

2016 funding in pipeline >90% of projected need in original plan

Current funding projections:

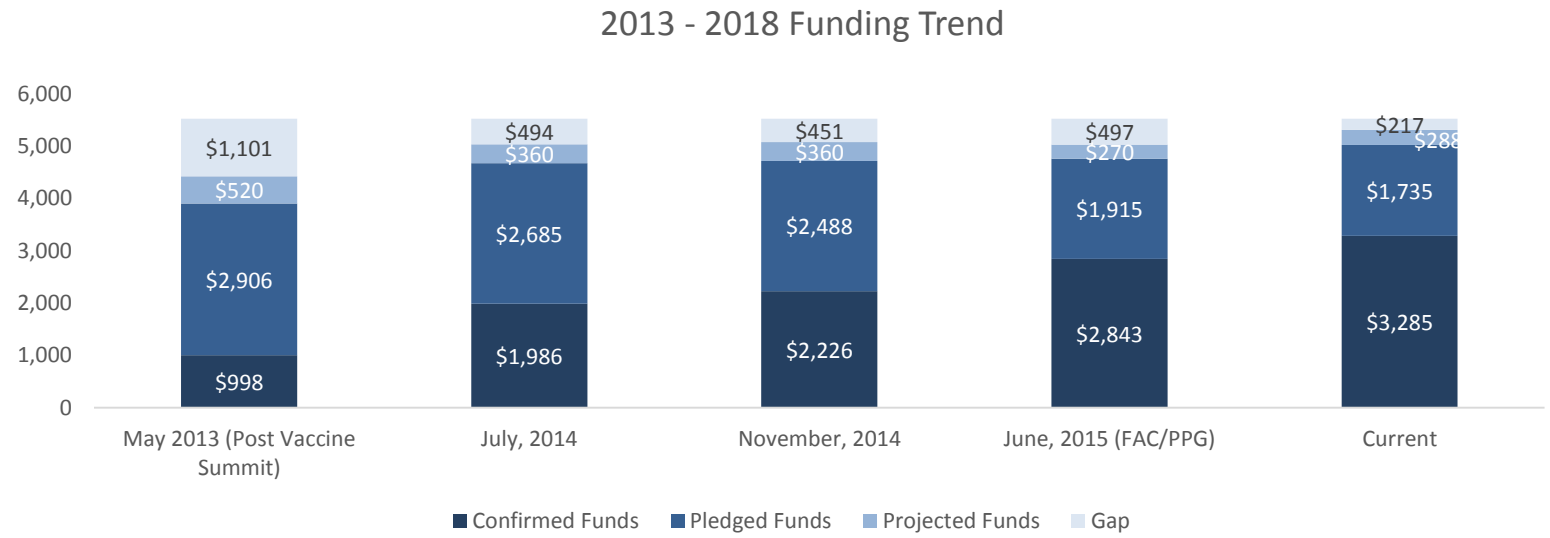
$Ms	2016 Projected
Confirmed Funding[1]	153
Pledged + Projected Funds[1,2]	692
Total Funds	**845**

Over 90% of the funding need for original 2016 plan of $904M[3]

- New 2016 operational plan will be higher due to continued transmission of WPV in Afghanistan and Pakistan and additional campaigns to mitigate risk for April switch
- We expect the new 2016 operational budget to be >$1,000M, which will require GPEI to raise additional funds in a relatively short amount of time

1. Includes money expected at the end of 2015 for use in 2016 2. Pledges with no signed agreement + projections for donors making annual contributions to GPEI
3. Original plan figure based on published February 2013 FRR document

Resource Mobilization Trends



- More than $0.4B in pledges confirmed since the June FAC, reaching $3.3B in confirmed funds
- $2.0B in pledges yet to be confirmed
- Additional $0.2B needed to fill funding gap against original PEESP
- Intermediate A as new funding goal would require raising an additional $1.5B to cover eradication through 2019

Donor feedback: GPEI Qtrly Financials

Major Donor	Contact(s)	Comment
Australia	Bill Costello, Mika Kontiainen, Geoff Clark, Tim Poletti	Australia feedback has been received, and shared with FAC members
Canada	Diane Jacovella, Sara Nicholls, Catherine Palmier, JoAnn Purcell, Julie MacCormack	Canada feedback has been received, and shared with FAC members
DFID	Donal Brown, Jason Lane, Nick Wintle	DFID feedback has been received, and shared with FAC members
Germany	Annika Calov, Ingrid Hoven, Marcus Koll, Marga Kowalewski, Reinhard Tittel-Gronefeld, Wolfgang Weth	No responses to date
Islamic Development Bank	Daouda Malle, Ben Ba	Islamic Development Bank has responded with the IsDB's desire to provide feedback. No feedback received yet.
Japan	Takeshi Osuga, Hiroyuki Yamaya	No responses to date
Norway	Tore Godal, Lene Lothe, Beate Stiro, Mari Grepstad	Norway has responded with Norway's desire to provide feedback. No feedback received yet.
UAE	Hala Ghandour, Najla Kaabi, Nassar A. Al Mubarak, Anita Niazi	UAE feedback has been received, and shared with FAC members
USG	Jimmy Kolker, Susan McKinney, Ellyn Ogden, Ariel Pablos-Méndez, Katie Taylor, Mitchell Wolfe, Elizabeth Noonan, Siobhan Girling	USG feedback has been received, and shared with FAC members
World Bank	Tim Evans , Robert Oerlichs	No responses to date

Consistent requests received so far:

- Current year actual expenditure/YTD expenditure
- Inclusion of country self-financing figures
- Interest in understanding Legacy Planning

First request for feedback sent on August 5th

Annual Non-FRR Financial Reporting

- As agreed in the June FAC, the FAC will oversee the production of an annual accounting of non-FRR expenditures in support of Polio eradication.

- The Gates Foundation and CDC are developing a template for non-FRR expenditure, and accompanying narrative briefly describing the activities, using each organization's non-FRR investments.

- The FMT is tasked with developing some options for guidance as to what should be included in these estimates, which will be reviewed and approved by the FAC.

- The guidance will then be shared with donors in order to produce the report in Q1 2016.

MTR financial scenarios update

Background

- One major deliverable of the GPEI Midterm Review was a modeling exercise to estimate the cost to eradicate Polio by examining a number of possible financial scenarios GPEI could face in the Polio endgame given different epidemiological and cost scenarios.
- These scenarios were presented to frame the potential financial requirements to certify the world as Polio free at the in-person FAC with major donors in June.
  - In June, it was early to be able to say whether Polio transmission had been interrupted in Nigeria and more time was needed to assess transmission trends in Afghanistan and Pakistan.
  - Therefore, it was decided that in the September Polio Oversight Board the relevant data could be assessed and an endorsement of the likely scenario faced by GPEI could be made.
- <u>The POB is requested to endorse a scenario to develop an updated GPEI operational plan and budget.</u>

Scenarios presented in the June FAC

Scenario:	1	2	3	4
	Optimistic	**Intermediate (A)**	**Intermediate (B)**	**Pessimistic**
Nigeria interrupts:	• 2014	• 2014	• 2014	• 2015
Pak/Afg. interrupt:	• 2015	• 2016	• 2017	• 2017
All other assumptions:	• Optimistic	• Intermediate	• Intermediate	• Pessimistic
Global interruption:	• 2015	• 2016	• 2017	• 2017
Global certification:	• 2018	• 2019	• 2020	• 2020
Post-certification costs:	• 2019-2025	• 2020-2026	• 2021-2027	• 2021-2027
	'13 – cert. / Post-cert.	'13 – cert. / Post-cert.	'13 – cert. / Post-cert.	'13 – cert. / Post-cert.
	$5.7B / $0.9B	**$7.0B / $0.9B**	**$7.8B / $0.9B**	**$8.8B / $1.2B**

- The GPEI program believes the data confirm that scenario 2 is the most likely
- The following slides will explain the range and drivers of the range from the most optimistic scenario (1) between the most likely (2), as well as the rationale for the proposal that the POB endorse scenario 2

A closer look at cost drivers from the most optimistic to the most likely scenario

Scenario:	1a	1b	1c	2
Interruption years:	**Optimistic**	**Optimistic**	**Optimistic**	**Intermediate (A)**
Nigeria interrupts:	• 2014	• 2014	• 2014	• 2014
Pak/Afg. interrupt:	• 2015	• 2015	• 2015	• 2016
All other assumptions:	**Optimistic** • Fastest SIA decrease • Fastest people decrease (TA/SocMob) • Lowest level of outbreaks • Lowest IPV dose demand	**Intermediate** • Intermediate SIA decrease • Intermediate people decrease (TA/SocMob) • Intermediate level of outbreaks • Intermediate IPV dose demand	**Pessimistic** • Slowest SIA decrease • Slowest people decrease (TA/SocMob) • Highest level of outbreaks • Highest IPV dose demand	**Intermediate** • Intermediate SIA decrease • Intermediate people decrease (TA/SocMob) • Intermediate level of outbreaks • Intermediate IPV dose demand
Global interruption - certification:	• 2015 - 2018	• 2015 - 2018	• 2015 - 2018	• 2016 - 2019
	'13 – cert. / **Post-cert.**	**'13 – cert.** / **Post-cert.**	**'13 – cert.** / **Post-cert.**	**'13 – cert.** / **Post-cert.**
	$5.7B / **$0.9B**	**$6.2B** / **$0.9B**	**$6.6B** / **$0.9B**	**$7.0B** / **$0.9B**

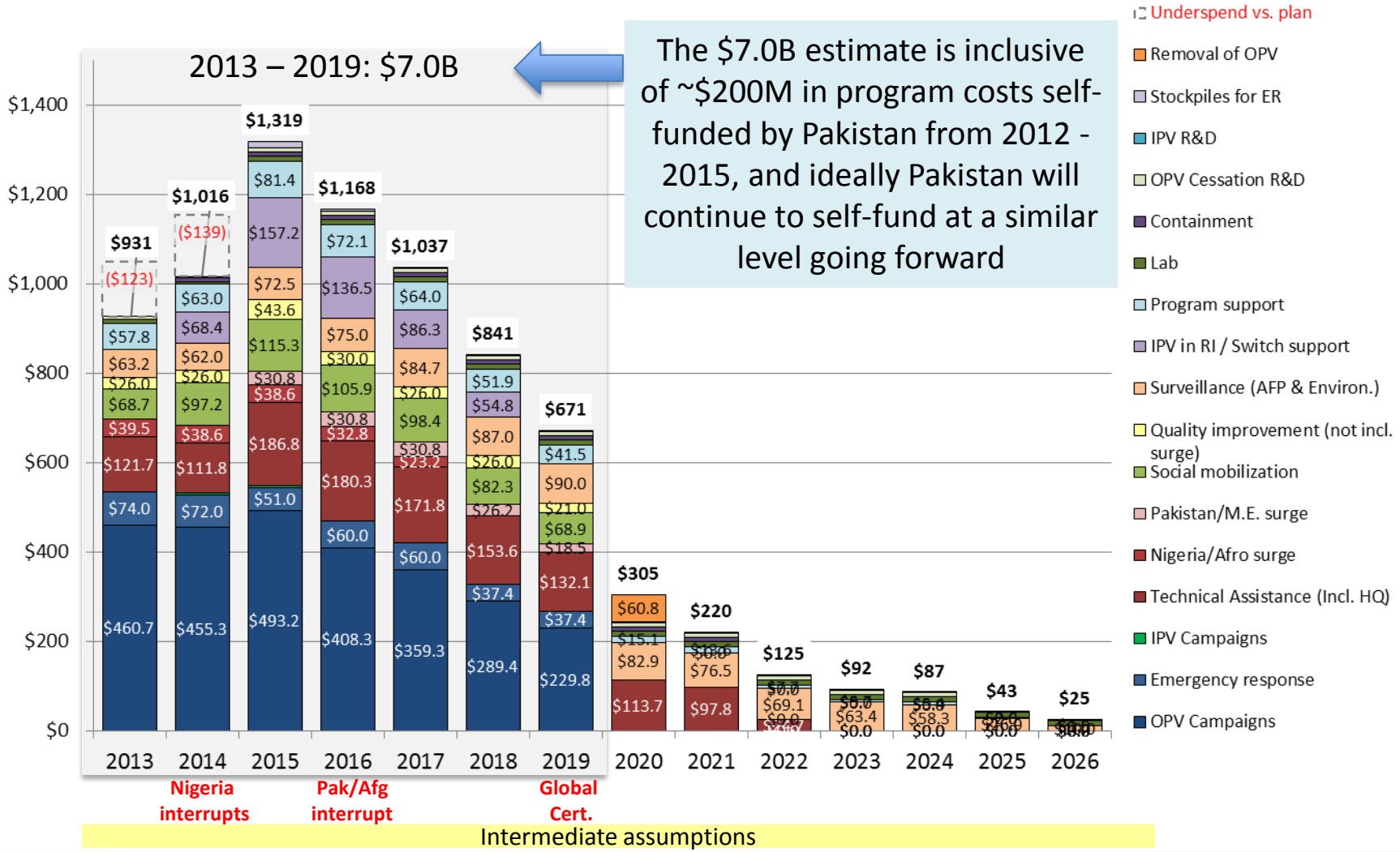
- ***The time of year of interruption and outbreaks are key drivers from most optimistic to likely scenario***
- ***Given that there have still been recent cases in Pakistan/Afghanistan, the most optimistic scenario is not likely and we are more likely facing scenario 1c at best and mostly likely scenario 2***

Scenario 2 Rationale

- The GPEI program is now more confident that as more than one year has passed since the last Polio case in Nigeria that Polio transmission has been interrupted.
- While cases in Afghanistan and Pakistan are down significantly from last year it appears likely that the program will need another low season to interrupt transmission in Afghanistan and Pakistan.
- The scenarios developed for the MTR highlight point estimates; however, they are in fact ranges that are determined by actual cost levels given a certain date of interruption.
- The FAC believes that assuming intermediate costs levels for things like SIA, technical assistance, and social mobilization drawdown, outbreaks levels, IPV demand, and surveillance is the most appropriate for planning.
- **Recommendation: POB endorse scenario 2 for planning purposes going forward.**

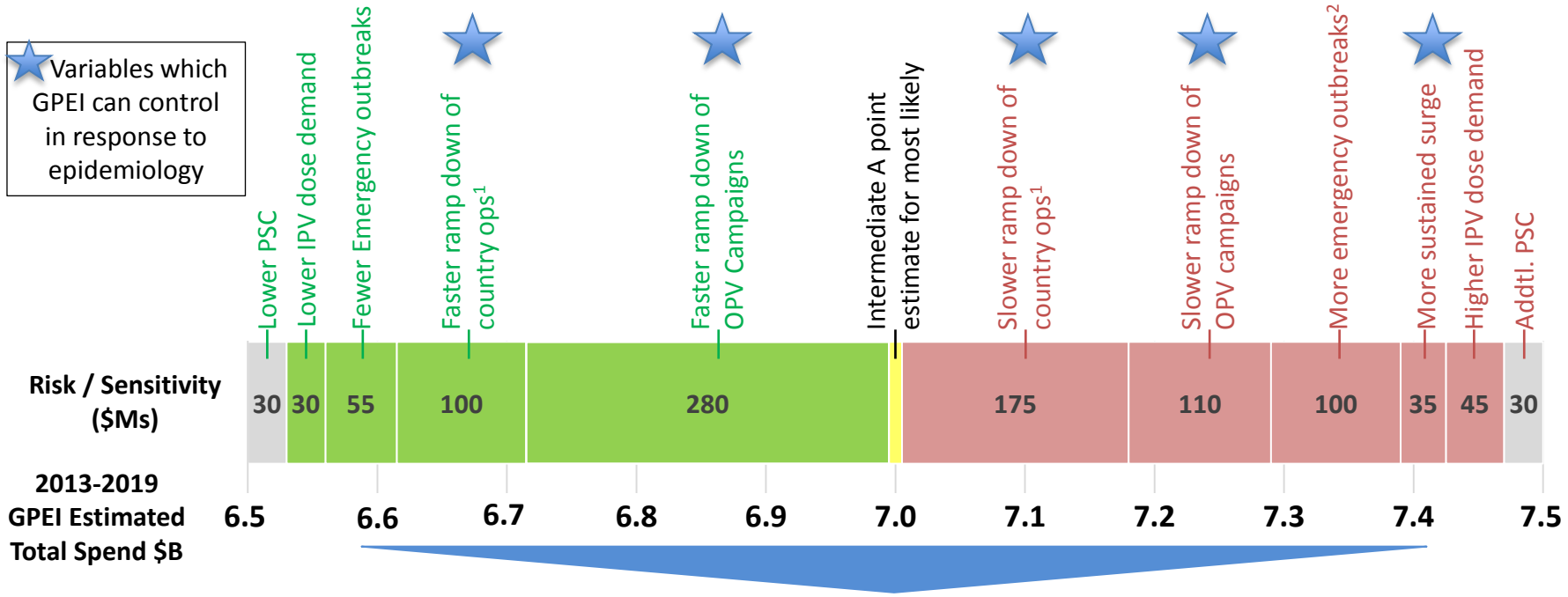
2 Scenario 2 estimate is $7.0B to global certification

Estimated Costs for Polio Eradication by Activity ($USM, not including India self-funded costs)



Intermediate assumptions

True cost to eradication could fall along spectrum based largely on evolving epidemiology, outbreaks



Key enablers for lower GPEI cost on controllable variables:

- Interrupt Pak/Afg early in 2016, then ramp down can begin sooner
- High surveillance quality increases confidence SIAs can ramp down sooner
- Timely legacy planning and transition from GPEI funding for currently Polio-funded personnel

1. Country ops includes TA, Core social mobilization, and Surveillance staff 2. Accounts for outbreaks equivalent to severity of the Horn of Africa outbreaks in 2013 and 2014

Next Steps

- After POB endorses a scenario, GPEI will develop a revised operational plan and budget, which will be the basis for future spending and resource mobilization targets.
- Under the direction of the GPEI Strategy Committee, GPEI has already begun early preparations to develop the operational plan and budget pending the POB decision on the chosen scenario.
- The model has provided a reliable estimate for Midterm Review purposes, but in order to ensure that there are actionable budget targets at the country, region and work group level further work is required by GPEI.
- The operational plan/budget will be completed before the end of 2015, and it will be reviewed by the FAC prior to presentation to the POB for final approval.
- The model and selected scenario will be the basis for new resource mobilization targets and continued outreach to donors to fund the remainder of the program.

APPENDIX

Top 15 countries by total spend in 2014

		2014 Actual Expenditures $Ms				
Rank	Country	Objective 1	Objective 2	Objective 3	Objective 4	Total
1	Nigeria	259.8	16.2	0.0	0.0	**276.1**
2	Pakistan	112.4	6.5	-	-	**118.9**
3	Ethiopia	39.6	1.9	0.1	0.0	**41.6**
4	Afghanistan	36.7	2.7	-	-	**39.5**
5	DRC	28.2	4.6	-	1.2	**33.9**
6	India	32.3	0.5	0.3	0.0	**33.1**
7	Cameroon	28.5	0.1	-	-	**28.7**
8	Kenya	26.0	2.4	0.0	-	**28.4**
9	Somalia	26.4	1.7	-	-	**28.1**
10	Chad	17.2	1.9	0.0	0.6	**19.6**
11	South Sudan	14.5	1.0	-	0.0	**15.5**
12	Niger	14.1	1.2	0.0	-	**15.4**
13	Sudan	13.3	0.1	0.3	-	**13.7**
14	Burkina Faso	12.9	0.7	-	-	**13.6**
15	Angola	8.2	3.3	0.0	0.0	**11.6**

Important assumptions behind new estimate (1)

	Optimistic (Low)	Intermediate (Base)	Pessimistic (High)
Date of interruption (Last regional case)	**2014** for Nigeria, **2015** for Pakistan/Afghanistan	**2014** for Nigeria, **2016/17** Pakistan/Afghanistan (Scenarios 2 / 3)	**2015** for Nigeria, **2017** for Pakistan/Afghanistan
OPV campaign costs	**Non-endemic SIAs** start dropping in **1st** calendar year after last regional case, **endemics** start in **2nd** year after[1] Drop rate estimated to be faster than current country plans (~25% / yr.) Campaigns drop to **zero 2** calendar years after last **global** case of **WPV**[3]	**Non-endemic SIAs** start dropping in **1st** calendar year after last regional case, **endemics** start in **2nd** year after[1] Drop rate roughly equivalent to **WHO FRR** forecast and current **country plans** (~22% / yr.)[2] Campaigns drop to **zero 3** calendar years after last **global** case of **WPV**[4]	**Non-endemics** and **endemics** start dropping in **2nd** calendar year after last regional case Drop rate slower than current country plans (~19% / yr.) Campaigns drop to **zero 3** calendar years after last **global** case of **WPV**[4]
Country operation costs (e.g. TA, Soc Mob, Surveillance)	Surveillance **increases** by **30%** after last **regional** case, begins decreasing at **global certification**[5] TA & Soc Mob start dropping after **regional interruption** is confirmed[6] Taper **more gradually** than **campaign reduction** in optimistic scenario[7]	Surveillance **increases** by **35%** after last **regional** case, begins decreasing at **global certification**[5] TA & Soc Mob start dropping after **regional interruption** is confirmed[6] Taper **more gradually** than **campaign reduction** in Intermediate scenario[7]	Surveillance **increases** by **40%** after last **regional** case, begins decreasing at **global certification**[5] TA & Soc Mob start dropping after **regional certification** is confirmed[6] Taper **more gradually** than **campaign reduction** in Pessimistic scenario[7]

1 . Non-endemic decrease in first year pragmatically reflects pressure from country offices to drop SIAs once interruption is *suspected* in nearest endemic neighbor. Endemic decrease does not begin until second year, after interruption has been *confirmed* 2. Based on avg. decrease reflected in current country plans for first year after interruption across various scenarios 3. Roughly equivalent to global certification for the end of Polio if last country interrupted in Q1 of year of interruption 4. Equivalent to global certification for the end of Polio if interruption occurred in 2nd half of the year of interruption 5. Surveillance increase reflects internal pressure to ensure Polio has been eradicated and increased quality of surveillance needed to confirm global certification and end SIA activity. Surveillance goes to zero 7 years after certification 6. For TA and core SocMob. Campaign portion of social mobilization (~40%) drops and rises at same timing and rate as SIAs. 7. Taper rate is 75% as quickly as OPV SIAs (e.g. more slowly than SIAs) Soc Mob goes to zero after global certification, TA goes to zero two years afterwards

Important assumptions behind new estimate (2)

	Optimistic (Low)	Intermediate (Base)	Pessimistic (High)
Outbreak costs	Current **FRR** budget[1] held constant through **regional interruption,** **B**udget for **cVDPV2** response added to 2016-2017[2] Costs begin to taper at **regional interruption**, fall to zero with **global certification**	Current **FRR** budget[1] held constant through **regional interruption,** Budget for **cVDPV2** response added to 2016-2017[2] Costs begin to taper at **regional certification**, fall to zero with **global certification**	**Avg.** yearly outbreak cost for past **two years**[3] held constant through **regional interruption** Budget for **cVDPV2** response added to 2016-2017[2] Costs begin to taper at **regional certification**, fall to zero with **global certification**
Special Strategy costs (quality improvement, surge)	Current **surge** funding **constant** for 1 calendar year after last regional case (then tapered **through certification**)	Current **surge** funding **constant** for 1 calendar year after last regional case (then tapered **through certification**)	**Added** surge funding **above** current levels until Pakistan confirms interruption (then tapered **through certification**)
IPV Introduction and switch Costs	**Gavi low** dose demand[4] **Low switch** cost estimate	**Gavi intermediate** dose demand **Medium switch** cost estimate	**Gavi high** dose demand[5] **High switch** cost estimate

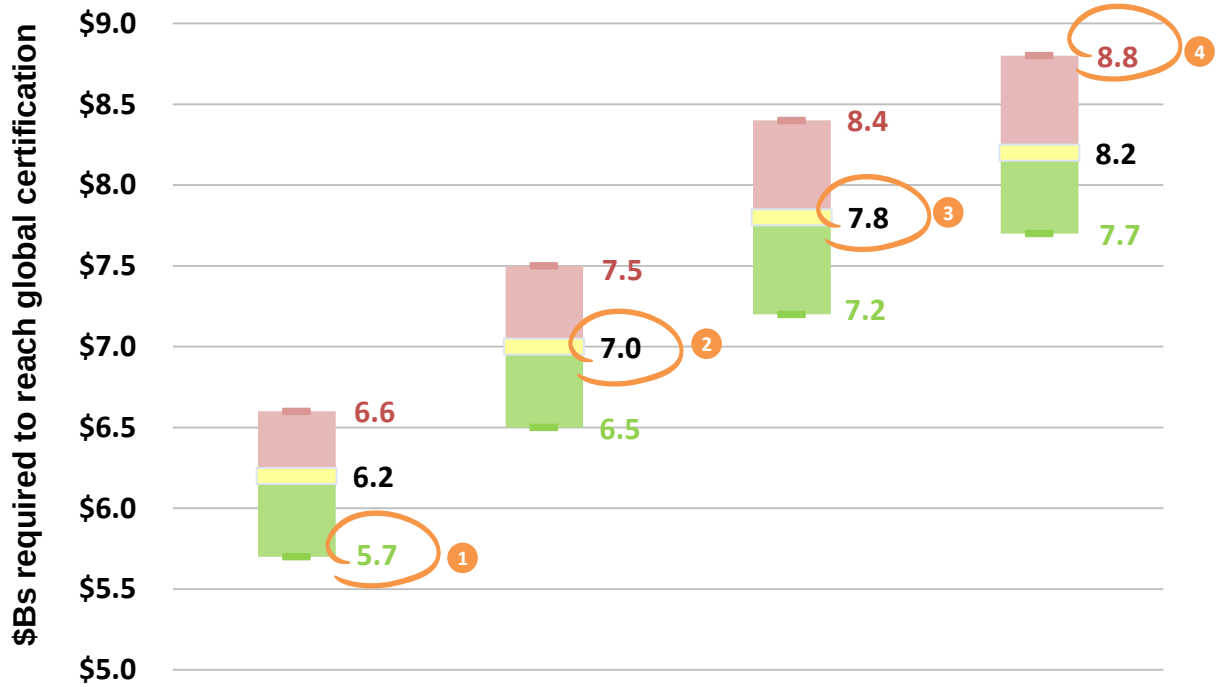
	All scenarios
General assumptions	• 2013-2015 costs based on **FRR from May 2015**[6] • 2016+ costs based on assumptions built through feedback from GPEI working committees • Non-endemic costs vary with **nearest endemic neighbor's** date of interruption

1. Current budget of $50M / year allows for ~4 avg. size outbreaks or 1 major Africa outreak + 2 minor outbreaks, etc. 2. Increased vDCVP budget allows for use of IPV in response to all type 2 outbreaks – allows for 2-3 outbreaks / yr. in Zone 1 and 1 outbreak / yr. in zone 2 countries 3. Past two years have seen major outbreaks in Horn of Africa and West Africa costing ~$70M / yr. 4. Based on UNICEF pop estimates 5. Uses Penta3 demand as a proxy 6. As 2015 FRR has not been fully approved by SC we were forced to use some judgment about which costs to include

Given interruption dates, cost ranges affected primarily by post-interruption country behavior and other optimistic vs pessimistic assumptions

Highlighted scenario

Estimated cost to certification based on dates of interruption, behavior & demand assumptions



Nigeria Interrupts	2014	2014	2014	2015
Pak/Afg. Interrupt	2015	2016	2017	2017
Costs incurred:	2013 - 2018	2013 - 2019	2013 - 2020	2013 - 2020

Factors that will influence where costs land

Pessimistic
- Interrupt later in the year
- Slower SIA draw down rate
- High emergency outbreaks
- Higher IPV RI dose demand

(Lower risk tolerance)

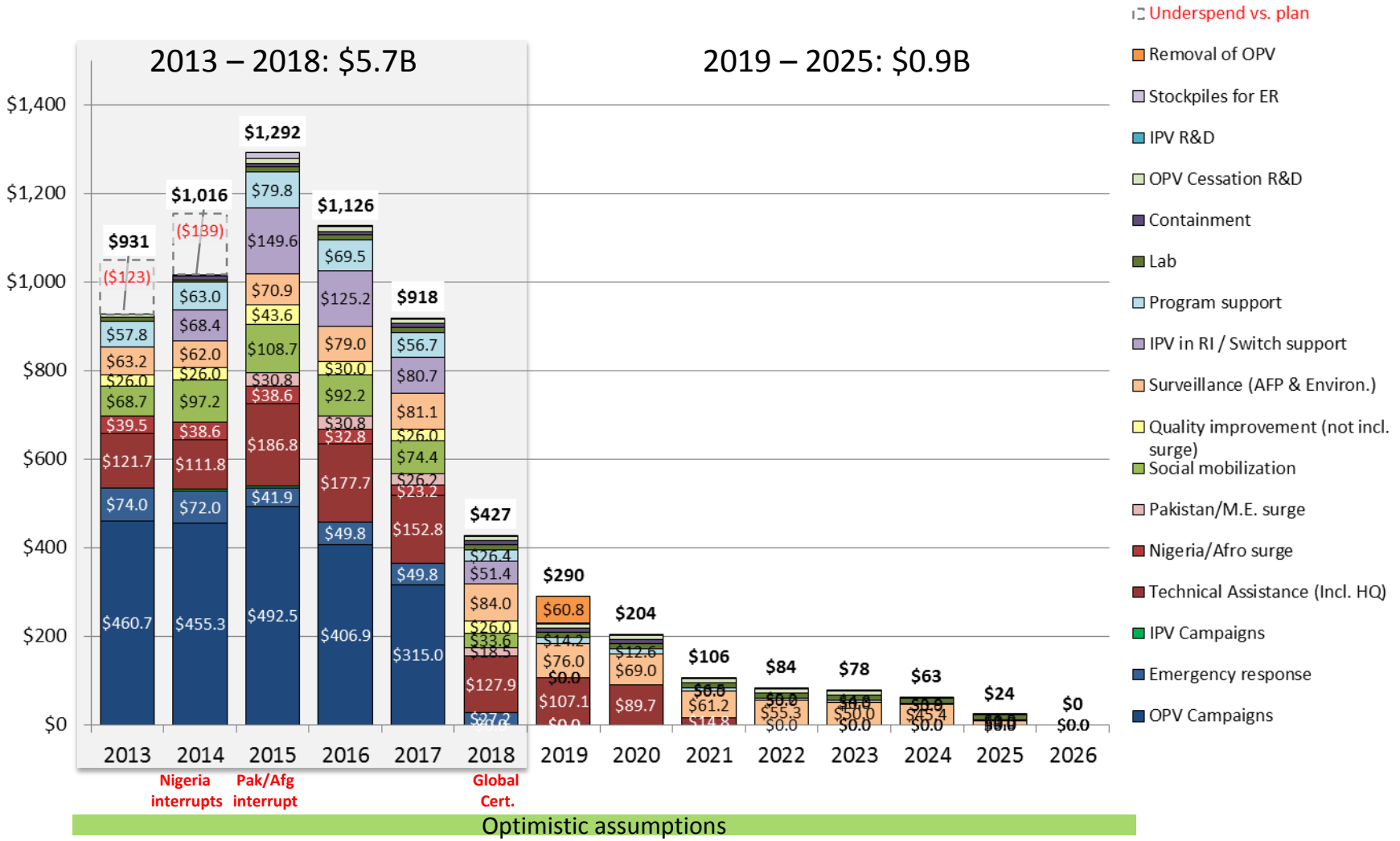
Intermediate

Optimistic
- Interrupt early in the year
- Faster SIA draw down rate
- Low emergency outbreaks
- Lower IPV RI dose demand

(Higher risk tolerance)

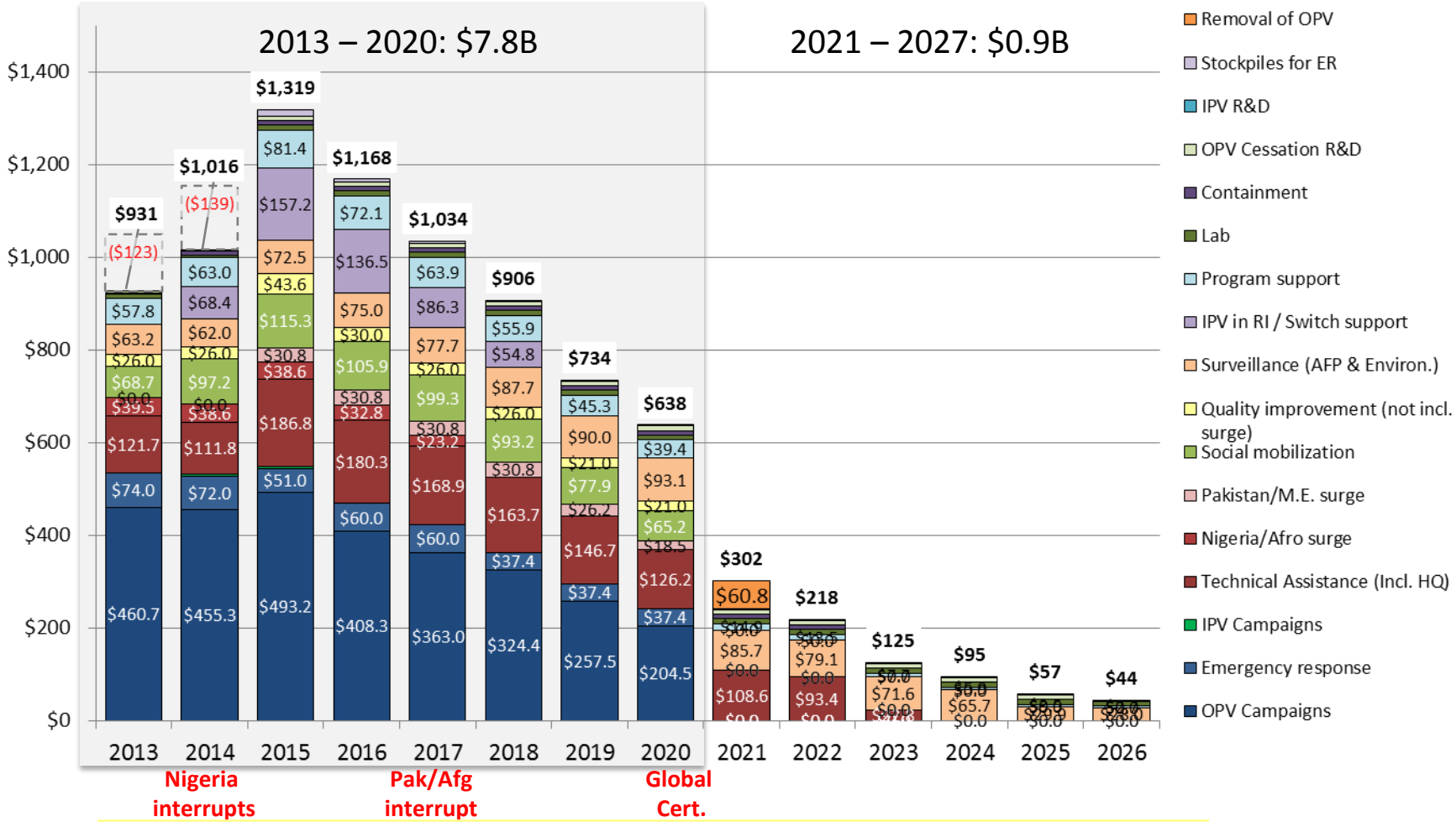
1 Scenario 1 estimate is $5.7B to global certification

Estimated Costs for Polio Eradication by Activity ($USM, not including India self-funded costs)



3 Scenario 3 estimate is $7.8B to global certification

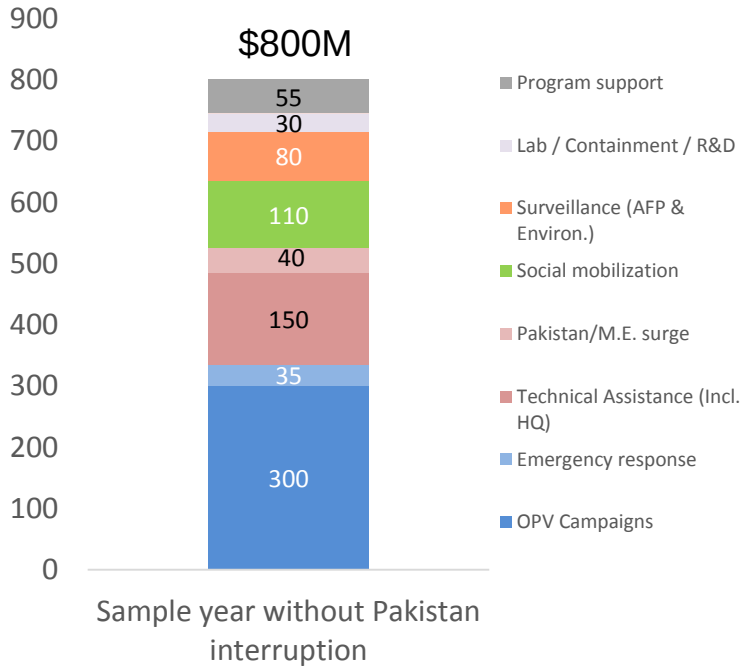
Estimated Costs for Polio Eradication by Activity ($USM, not including India self-funded costs)



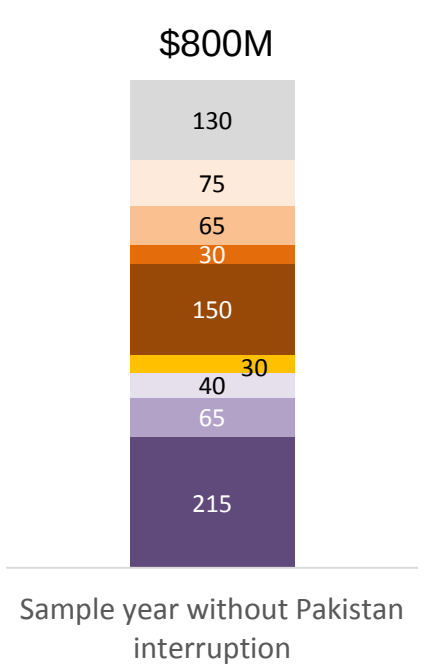
Intermediate assumptions

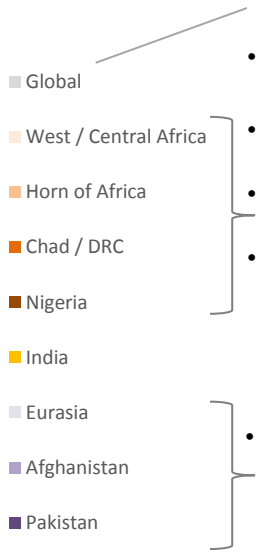
Every year we fail to interrupt in Pakistan and Afghanistan will cost an additional ~$800M / yr.[1]

Costs by activity



Costs by geography





Major costs

- TA, lab, stockpile, environmental, surveillance, containment
- PSC costs

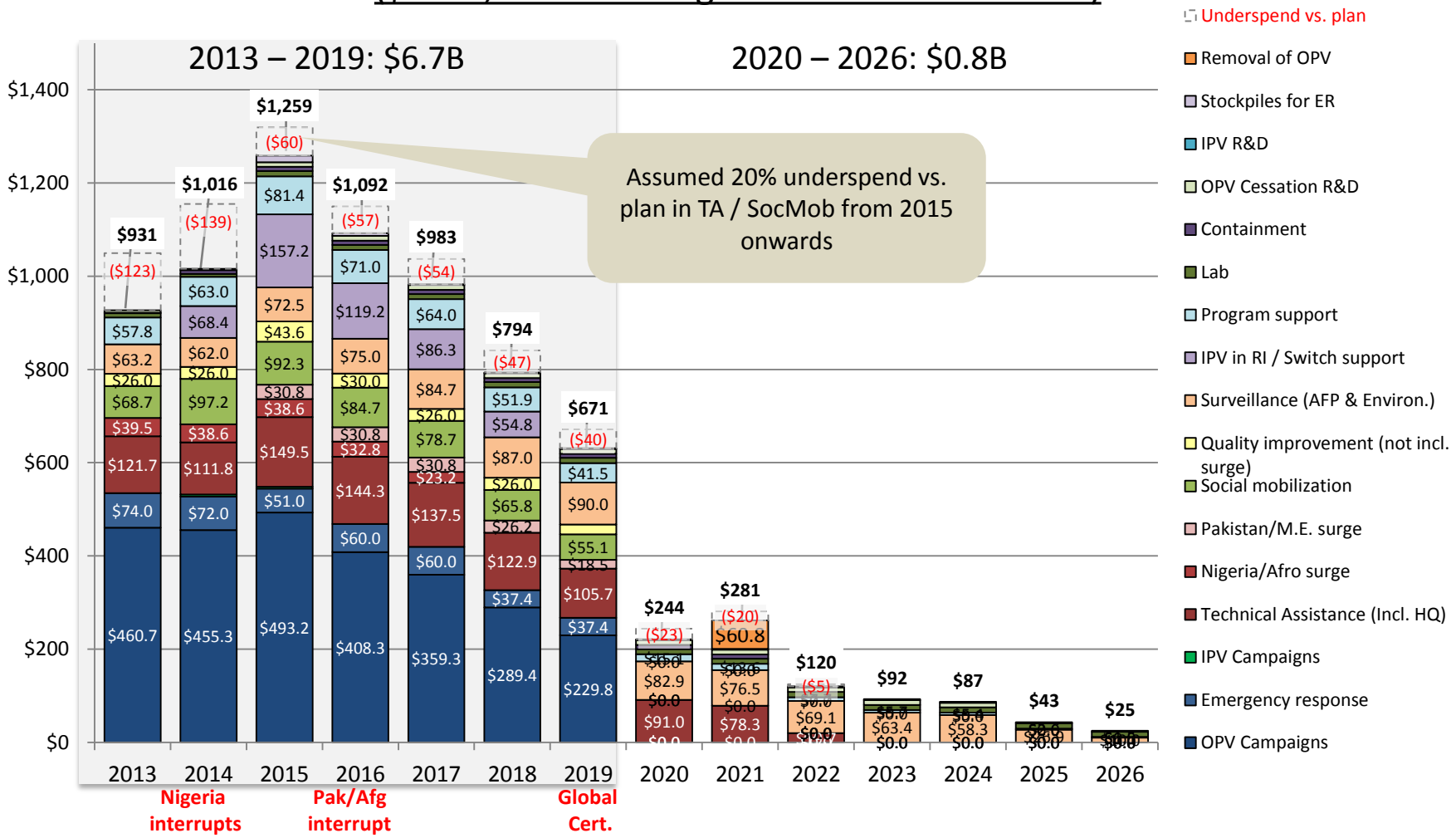
- ~50% of peak SIA activity
- Continued high surveillance
- Partial outbreak response budget

- Full SIA campaign activity and outbreak response

1 Assumes Nigeria has interrupted and remains (as well as high-risk non-endemics) at a lower level of SIA activity, as well as related activities until Af/Pak interruption

Backup: Under spend of 20% in TA and SocMob[1] would lead to a reduction in actual costs of ~$300M in scenario 2[2]

Estimated Costs for Polio Eradication by Activity ($USM, not including India self-funded costs)



1. Slightly lower than under spend % in both 2013 and 2014 2. Would result in $230M reduction in Scenario 1, $350M reduction in Scenario 3, and $440M reduction in Scenario 4

Unpacking the changes in cost to eradication from original eradication plan of $5.5B to Scenario 2