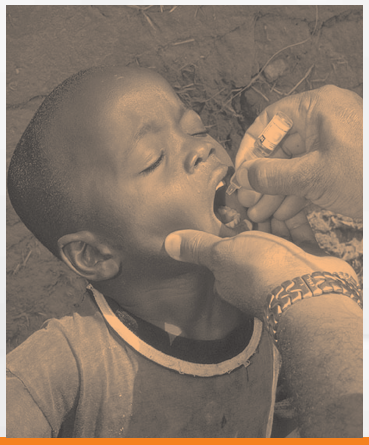

Global Polio Eradication Initiative

Financial resource requirements 2006 - 2008

as of September 2006

World Health Organization

unicef

Partners in the Global Polio Eradication Initiative

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Acronyms and Abbreviations

AFP	Acute Flaccid Paralysis
CDC	US Centers for Disease Control and Prevention
GAVI	Global Alliance for Vaccines and Immunization
GIVS	Global Immunization Vision and Strategy
IFFIm	International Finance Facility for Immunization
IHR	International Health Regulations
mOPV	monovalent oral polio vaccine
NIDs	national immunization days
OPV	oral polio vaccine
SIAs	supplementary immunization activities
SNIDs	subnational immunization days
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

The feasibility of the international goal of global polio eradication in the near future was reaffirmed in the second half of 2005. In October, the Advisory Committee on Polio Eradication (ACPE), the independent oversight body of the Global Polio Eradication Initiative, concluded that strong advances toward polio eradication in 2005, as well as the recent introduction of a new monovalent oral polio vaccine type 1 (mOPV1), had moved the polio eradication effort into its final phase in all countries but one. The ACPE stated that with sufficient resources and expanded use of mOPV1, all polio-affected countries except Nigeria can stop this disease by mid-2006. It concluded that Nigeria will require at least an additional 12 months to finish the job.

Advances included: the interruption of indigenous polio transmission in Egypt and Niger, thus reducing the number of polio-endemic countries from six to four; the interruption of polio transmission in 14 previously polio-free countries re-infected during the 2003-2005 multi-country epidemic; and a two-thirds reduction of polio cases in Asia (India and Pakistan) during the August-October peak transmission period. Since nation-wide polio immunization resumed in late 2004 in Nigeria, there has been an increasing geographic restriction of polio transmission and a marked reduction in the genetic biodiversity of Nigerian poliovirus. The stage is set for more dramatic progress in the coming months, thanks to strong government commitment to polio eradication and routine immunization, together with a strengthened local-level system to improve immunization quality, intensified monitoring and an expected targeted introduction of mOPV.

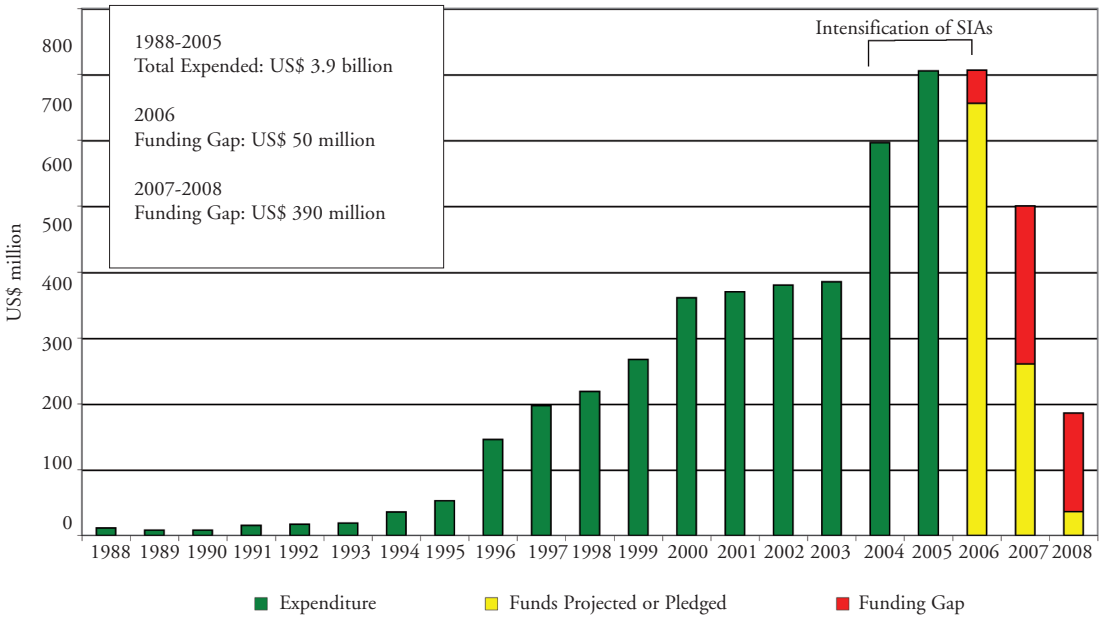
Unprecedented levels of financial support from long-standing and new contributors in 2005 ensured that intensified polio campaigns in Africa and Asia could proceed as planned and that the polio eradication infrastructure was strengthened and continued to be used to strengthen the public health infrastructure in many countries, particularly in Africa.

Financial Resource Requirements 2006-2008 presents the estimated financial resources needed from external sources to interrupt the final chains of polio transmission world-wide, to contain all stocks of wild poliovirus and to prepare for certification and oral polio vaccine (OPV) cessation, using strategies outlined in the *Global Polio Eradication Strategic Plan 2004-2008.*

Following the executive summary, pages 7 to 9 provide an overview of the Global Polio Eradication Initiative partnership, summarizing financial contributions and pledges made to the Global Polio Eradication Initiative as of September 2006. Pages 10 to 18 describe the activities planned for 2006-2008 and the funding required to implement them. The first part of this period will concentrate on stopping polio transmission and maintaining polio-free status, with the focus shifting to the containment of wild polioviruses and preparation for certification and OPV cessation in the latter half of the period. There is a US$ 150 million funding gap for 2006 activities: of this, US$ 75 million is required by March, and US$ 75 million is required by July. An additional US$ 425 million must be made available for 2007-2008 if planned activities are to be fully implemented.

There is a US$50 million funding gap which must be filled by October 2006, in order to implement all planned activities for the rest of the year. An additional US$390 million must be made available for 2007-2008, of which US$50 million is needed by December 2006 for planned activities in Q1 2007, and US$50 million by March 2007 for planned activities in Q2 2007.

Figure 1: Global Polio Eradication Initiative Annual Expenditure 1988-2005, Financial Resource Requirements, Contributions, Funding Gap, 2006-2008



Protecting the world's 17-year investment in polio eradication requires the international community to:

1) By October 2006, fill the US$50 million funding gap, to ensure immunization activities planned for the rest of the year can proceed;
and,
2) make multi-year pledges for 2006-2008 to stop polio transmission, contain all stocks of wild polioviruses and implement certification and pre-OPV cessation activities.

Figure 2: Countries with active transmission of wild poliovirus as of September 2006

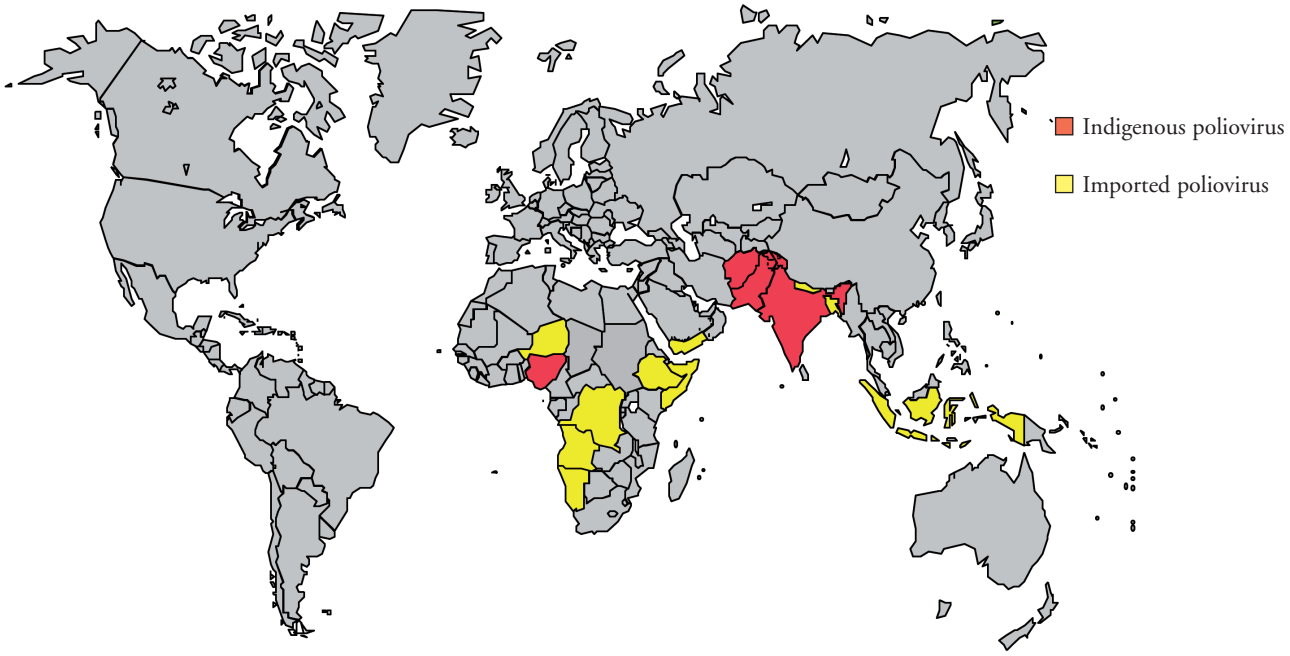


Table 1: Summary of external resource requirements by major category of activity, 2006-2008 (all figures are in US$ millions)

Activity Category	2006	2007	2008	2006-2008
Oral polio vaccine	$ 173.39	$ 112.78	$ -	$ 286.17
NIDs/SNIDs operations*	$ 176.36	$ 96.04	$ -	$ 272.40
Emergency response / mOPV evaluation	$ 163.07	$ 35.00	$ 20.00	$ 218.07
Surveillance**	$ 53.68	$ 36.87	$ 30.67	$ 121.22
Laboratory	$ 6.23	$ 7.90	$ 6.72	$ 20.85
Technical assistance***	$ 83.24	$ 71.51	$ 53.77	$ 208.52
Certification and containment	$ 2.50	$ 12.00	$ 12.00	$ 26.50
Product development for OPV cessation	$ 10.00	$ 5.00	$ 5.00	$ 20.00
Vaccine for post-eradiction era stockpile (finished product and bulk)	$ 37.50	$ 122.50	$ 56.00	$ 216.00
Subtotal	**$ 705.97**	**$ 499.60**	**$ 184.16**	**$ 1,389.73**
Contributions	**$ 655.92**	**$ 259.57**	**$ 35.88**	**$ 951.37**
Funding Gap	**$ 50.05**	**$ 240.03**	**$ 148.28**	**$ 438.36**
Funding Gap (rounded)	**$ 50.00**	**$ 240.00**	**$ 150.00**	**$ 440.00**

* *Operations costs include manpower and incentives, training and meetings, supplies and equipment, transportation, social mobilization and running costs.*

** *Country-level surveillance and laboratory summary for 2006 provided in Table 5.*

*** *Technical assistance includes the cost of human resources deployed through UN agencies. Country-level breakdown for 2006 provided in Table 6.*

Section 1: Overview of Global Polio Eradication Initiative Partnership

The 17-year Global Polio Eradication Initiative, a public-private partnership spearheaded by the World Health Organization, Rotary International, the US Centers for Disease Control and Prevention and the United Nations Children's Fund (UNICEF), includes governments of countries affected by polio; donor governments (e.g. Australia, Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Iceland, Hungary, Ireland, Italy, Japan, Luxembourg, Malaysia, Malta, Monaco, the Netherlands, New Zealand, Norway, Oman, Portugal, Qatar, the Republic of Korea, the Russian Federation, Saudi Arabia, Singapore, Spain, Sweden, Switzerland, Turkey, the United Arab Emirates, the United Kingdom and the United States of America); the European Commission; private foundations (e.g. United Nations Foundation, Bill & Melinda Gates Foundation, the OPEC Fund and the AGFund); development banks (e.g. the World Bank and the African Development Bank); humanitarian and nongovernmental organizations (e.g. the International Federation of Red Cross and Red Crescent societies) and corporate partners (e.g. Sanofi Pasteur, De Beers, Wyeth).

Table 2 highlights contributions/pledges by major donors to the Global Polio Eradication Initiative for 1988 - 2008. Funding provided through external sources (including both multilateral and bilateral contributions) for the period totals more than US$ 4 billion. Forty-three private and public sector donors have contributed or pledged more than US$ 1 million each to polio eradication. Of these, 28 contributed US$ 5 million or more. Spearheading partner Rotary International has contributed more than US$ 500 million, a figure which will rise to more than US$ 600 million by the time the world is certified polio-free.

G8 leaders meeting at Gleneagles, Scotland in July 2005 reaffirmed their commitment to finishing the job of polio eradication by pledging to "support the Polio Eradication Initiative for the post-eradication period in 2006-2008 through continuing or increasing our own contributions towards the US$ 829 million target and mobilizing the support of others". The UK took immediate action, pledging £60 million for 2005-2008.

The polio partnership continued to expand in 2005: Sweden re-affirmed its long-standing commitment to children's health by making a US$ 30 million extraordinary contribution and several Organization of Islamic Conference (OIC) countries, including Saudi Arabia, Qatar and Turkey, joined Malaysia in taking action on polio resolutions made at the October 2003 OIC Summit in Putrajaya, Malaysia and at the June 2004 OIC Foreign Ministers' Meeting in Istanbul, Turkey. Spain and Monaco joined the Global Polio Eradication Initiative and Iceland, the Czech Republic and Singapore also made their first polio eradication pledges in 2005.

In a further affirmation of international commitment to polio eradication, the board of the Global Alliance of Vaccines and Immunization (GAVI) in July 2005 recommended that up to US$ 226.4* million be allocated from the International Finance Facility for Immunization (IFFIm) towards creation of a stockpile of mOPVs for the post-eradication era. Funds are expected to be made available in 2006.

** US$ 191 million in IFFIm funding was approved for the stockpile at the July 2005 GAVI Board meeting.*

Table 2: Donor profile for 1988-2008

Contribution (US$ million)	Public Sector Partners	Development Banks	Private Sector Partners
> 500	USA, United Kingdom		Rotary International
250 - 500	Japan	World Bank	
100 - 249	European Commission, Canada, Germany, Netherlands, IFFIm		Bill & Melinda Gates Foundation
25 - 49	Denmark, France, Norway, Sweden, UNICEF Regular Resources, WHO Regular Budget		United Nations Foundation
5 - 24	Italy, Australia, Russian Federation, Ireland, Luxembourg	Inter-American Development Bank	Sanofi Pasteur, IFPMA, UNICEF National Committees, American Red Cross
1 - 4	Belgium, Spain, Switzerland, Malaysia, New Zealand, Saudi Arabia, United Arab Emirates, Finland	African Development Bank	Advantage Trust (HK), De Beers, International Federation of Red Cross and Red Crescent Societies, Pew Charitable Trust, Wyeth, Shinnyo-en

External contributions to countries' polio eradication efforts have been matched by national resources, including both financial expenditures and non-monetary commitments such as the time spent by volunteers, health workers and others in the implementation of supplementary immunization activities (SIAs). Funds are expended by governments, the private sector and non-governmental organizations at national, state/province, district and local community levels to cover petrol, social mobilization, training and other costs*.

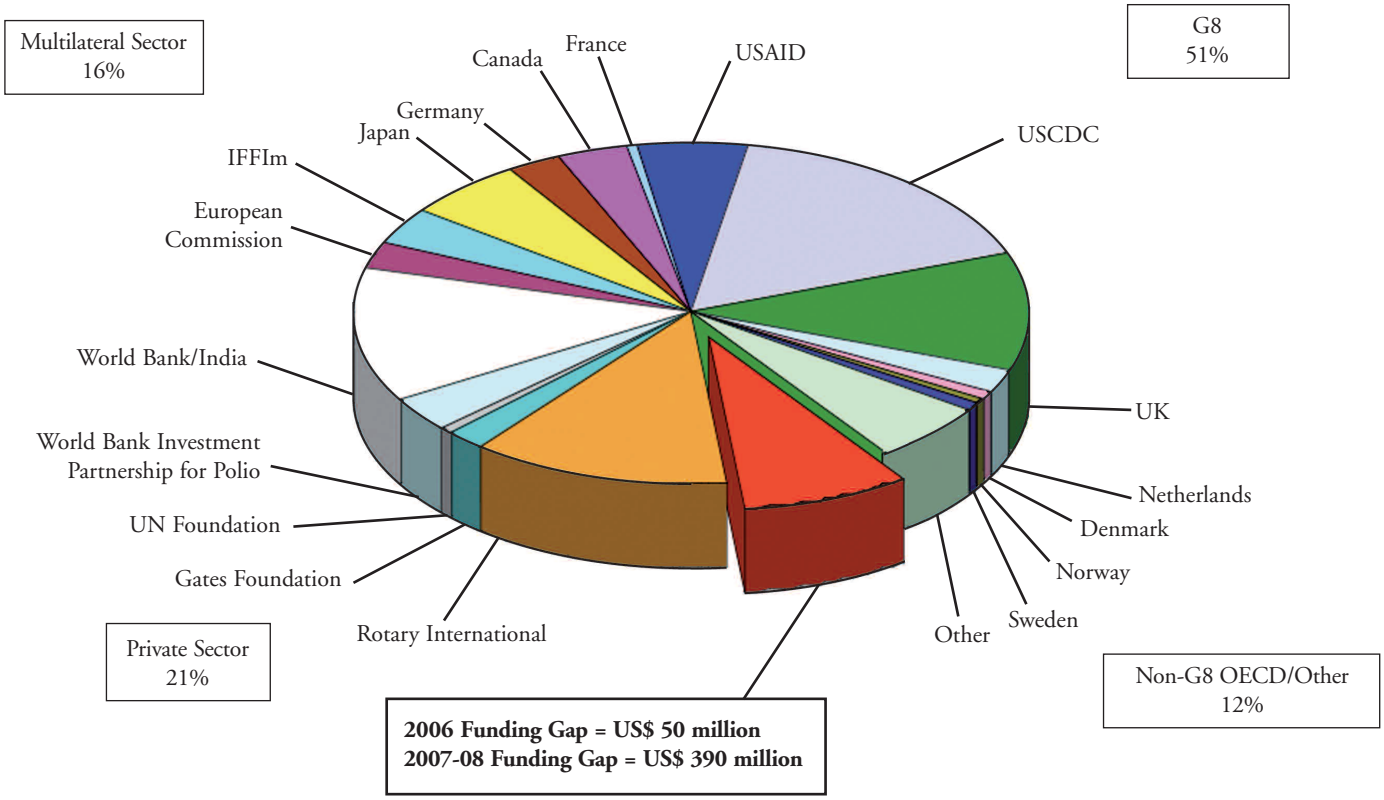
The world now has a tremendous opportunity to ensure that everyone shares equally in the benefits of a polio-free world. The economic justification is compelling. Regardless as to long-term polio immunization decisions, eradication would be cost-saving for low-income developing countries. Globally, the cost-effectiveness ratio of polio eradication would be an impressive US$ 52.50 per disability-adjusted life year (DALY) saved. Failure to completely eradicate polio, on the other hand, would result in at least 10.6 million new cases of polio worldwide in the next 40 years, representing the loss of 60 million DALYs, nearly all in low-income developing countries*.

** Aylward R, et al, Politics and practicalities of polio eradication, Global Public Goods for Health. Health Economic and Public Health Perspectives, eds Smith, R, Beaglehole R, Woodward D, Drager N, Oxford, Oxford University Press, 2003.*

Budgets in this document were developed by ministries of health, WHO and UNICEF, and are based on the costs of implementing polio eradication strategies at the country level and the costs of managing the Global Polio Eradication Initiative through the United Nations implementing agencies (WHO and UNICEF) at the country, regional and global levels.

Figure 3 summarizes the external financial contributions since 1988, as well as the 2006-2008 funding gap. All donors highlighted in the pie chart have contributed more than US$ 25 million to the global polio eradication effort.

Figure 3: External Financial Contributions and 2006-2008 Funding Gap



Note: Donor contributions of US$ 25 million or more are represented in the pie chart

'Other' includes: the Governments of Austria, Australia, Belgium, Czech Republic, Finland, Hungary, Iceland, Ireland, Italy, Luxembourg, Malaysia, Monaco, New Zealand, Oman, Pakistan, Portugal, Qatar, Republic of Korea, Russian Federation, Saudi Arabia, Singapore, Spain, Switzerland, Turkey, the United Arab Emirates; African Development Bank; AG Fund; American Red Cross; De Beers, Inter-American Development Bank, International Federation of Red Cross and Red Crescent Societies, Oil for Food Programme, OPEC Fund, Sanofi Pasteur; Saudi Arabian Red Crescent Society, Smith Kline Biologicals, UNICEF National Committees, UNICEF Regular and Other Resources, United Arab Emirates Red Crescent Society, WHO Regular Budget and Wyeth.

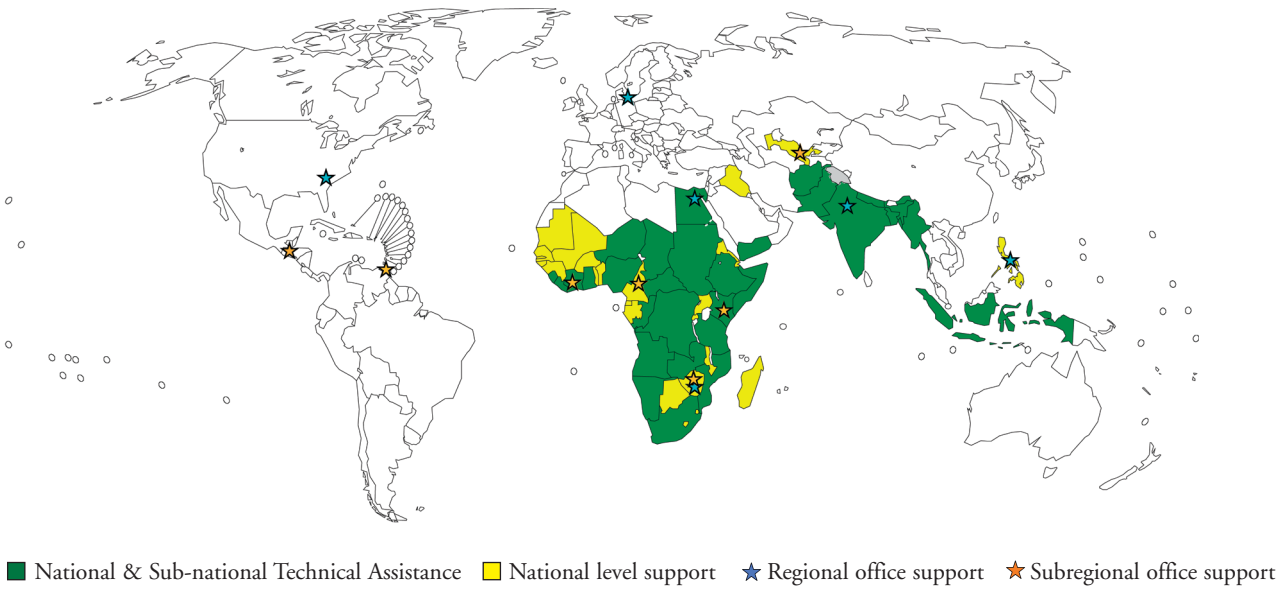
Section 2: Financial requirements for 2006-2008

PRIORITIES AND ACTIVITIES

The highest priorities for the Global Polio Eradication Initiative and the focus for 2006 are : the rapid interruption of polio transmission in polio-endemic countries and in countries where polio was re-introduced following the major epidemic that originated in west Africa in 2003; and protecting the polio-free status of these countries while Nigeria finishes the job. In October 2005, the Global Polio Eradication Initiative's independent oversight body, the ACPE, concluded that Nigeria would take at least 12 months longer than anywhere else in the world to stop polio transmission.

By the end of 2006, at least 24 countries will have vaccinated more than 342 million children with multiple doses of oral polio vaccine. 201 countries will maintain Acute Flaccid Paralysis (AFP) surveillance, 54 of them in polio-endemic regions requiring substantial technical assistance. Figure 4 shows the countries receiving technical support at the national, provincial and district levels.

Figure 4: Polio-funded technical assistance by country



Importantly, the polio infrastructure is also being used to detect and respond to outbreaks of other communicable diseases such as Cholera, Marburg Fever, Ebola and Yellow Fever. Countries are also using polio immunization campaigns for the systematic delivery of other health interventions, including Vitamin A, measles vaccine, malaria bed nets and anti-helminthics. The polio infrastructure underpinned the recent boosting of routine immunization coverage in the African region from 52% to 66% between 1999 and 2004, and strengthened micro planning and activities of the 'Reaching Every District' strategy. Other areas of reinforcement include renewal of the cold chain in many countries, development of more sustainable transportation for outreach activities, and the addition of external quality assessment programmes to public health laboratories.

In 2006-2008, the polio infrastructure will also be used to help countries implement the revised International Health Regulations (IHR) and to build capacity for routine immunization as part of the Global Immunization Vision and Strategy (GIVS).

Realization of the full humanitarian and economic benefits of polio eradication requires not only the interruption of poliovirus transmission worldwide, but also containment of wild poliovirus stocks, completion of the certification processes, and the eventual cessation of OPV for routine immunization.

Preparing for global certification requires sustained surveillance in all regions, rapid responses to circulating vaccine-derived polioviruses (cVDPVs), and completion of appropriate poliovirus containment activities as detailed in the *WHO Global Action Plan for Laboratory Containment of Wild Polioviruses, second edition* (WHO/V&B/03.11).

The following are prerequisites for cessation of OPV use:
1. Confirmation of interruption of transmission and appropriate containment of wild polioviruses;
2. Continued highly sensitive surveillance for poliovirus circulation;
3. Development of an international stockpile of mOPV and response mechanisms;
4. Implementation of IPV requirements in bio-hazard settings;
5. International consensus on procedure for synchronous OPV cessation;
6. Appropriate biocontainment of Sabin polioviruses.

The development of a third edition of the WHO global action plan to minimize poliovirus facility-associated risk in the post-eradication/post-OPV era (detailing final containment requirements for all polioviruses), as well as the development, licensing and stockpiling of 3 monovalent oral polio vaccines (mOPV I, II, III) are included among the prerequisites outlined for policy-makers. A stockpile of mOPV will be created to protect countries against the inadvertent reintroduction of polio after global cessation of routine immunization with OPV. A breakdown of the costs by major activity category can be found in Table 1 on page 6.

FINANCIAL RESOURCE REQUIREMENTS

The financial resource requirements for 2006 are estimated at US$705 million, against which there is a funding gap of US$50 million, which is needed by October 2006, in order to implement all planned activities for the rest of the year. The funding gap for 2007-2008 is pegged at US$390 million, of which US$50 million is needed by December 2006 for planned activities in Q1 2007, and US$50 million by March 2007 for planned activities in Q2 2007.

Table 3 summarizes the schedule of intensified supplementary immunization activity plans for 2006 and 2007. Supplementary immunization activities are the major cost driver for the Global Polio Eradication Initiative in 2006-2007 (see Annex 1, Table 4 for details of planned costs by country for 2006-2007). In addition to the planned activities summarized in Table 3, the Global Polio Eradication Initiative requires approximately US$130 million for emergency response to poliovirus importations in 2006-2008. Emergency response activities will also be used for mOPV evaluation as part of the development of the mOPV stockpile for the post-eradication era.

Table 3: Supplementary immunization activities required for polio eradication, 2006-2007, as of September 2006.

Activity plan for 2006-2007

NID: National Immunization Day
SNID: Sub-national Immunization Day
IPD: Immunization-plus Day

Activity NID SNID IPD

		2006												2007											
Region/Country	**Data**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Polio Endemic																									
Afghanistan	% targeted	75		100	100	30	30	35	100	100		30		100		100	50								
India	% targeted	50	50		100	100	25	40		50		100		100		50	50	50							
Nigeria[1]	% targeted		100	100		35	35			50	50	30	100		100	100	50								
Pakistan	% targeted	100		100	100	40	35	100		100		100		100		100	50								
WHO African Region																									
Angola[2]	% targeted			33				100		100	100														
Benin	% targeted					100	100																		
Cameroon	% targeted			35	35																				
Chad	% targeted			100	100																				
Congo - Brazzaville	% targeted						90	90	90																
Côte d'Ivoire	% targeted					100																			
DR Congo[3]	% targeted						10	45	45	30	10														
Equ Guinea[4]	% targeted	100	100																						
Ethiopia	% targeted		75		45	10	10	10		10		10	100		100										
Gabon[4]	% targeted		100	100																					
Kenya	% targeted				10		5	5		5															
Namibia[5]	% targeted						100	100	100																
Niger	% targeted			100	100	60				60		100	100		100	100									
WHO Eastern Mediterranean Region																									
Djibouti	% targeted			100						100															
Egypt	% targeted			100	100																				
Somalia	% targeted	75	100	100		100	100	100		100		100	100		100	100									
Sudan[6]	% targeted		100		100							100	25												
Yemen	% targeted	100			70	70																			
WHO South-East Asia Region																									
Bangladesh	% targeted				100	100	100		100			100	100		100	100									
Indonesia[7]	% targeted	20	100		100		15			15					25										
Myanmar	% targeted									40	40														
Nepal	% targeted	60	60				25	25			100	100		100											

1 *In Nigeria, October SNID is to take place with measles round, therefore no operational cost incurred. December SIA is to take place as IPD in the North and polio-only SNID in the South.*
2 *In Angola, July NID is to take place with measles round, therefore no operational cost incurred. August NID is to be funded by local resources, cost not reflected in country-level external funding requirements in Table 4.*
3 *In DR Congo, October SNID is to take place with measles round, therefore no operational cost incurred.*
4 *Equatorial Guinea and Gabon postponed their 2005 Q4 SIAs to early 2006.*
5 *In Namibia, June and July SIAs are nation-wide campaigns covering all ages. August NID covers children under age 5.*
6 *In Sudan, SNID in October will take place in the south.*
7 *The Government of Indonesia has covered the cost of two NIDs, cost not reflected in country-level external funding requirements in Table 4. February 2007 SNID will take place with measles round.*

Section 3: Contingency Plans

The external financial resource requirements for 2006-2008 are based on the assumptions that polio transmission will be stopped in the Horn of Africa and in west and central Africa, with the exception of Nigeria, by the end of the first quarter of 2006; that polio transmission will be stopped in Asia by mid-2006; and that Nigeria will stop polio transmission by end-2006. Continued transmission of polio beyond that date would result in increased costs, as summarized below:

Scenario 1: Transmission of wild poliovirus continues in Nigeria until end-2007

Under this scenario, additional SIAs would be conducted through end-2008 in Nigeria, through end-2007 in Niger and through mid-2007 in Benin, Cameroon and Chad. Additional emergency response funding of US$ 30 million is also envisioned under this scenario.

Financial implications: up to US$ 152.5 million in additional costs for 2006-2008.

Scenario 1: Transmission of wild poliovirus continues in Nigeria until end-2007

			2006												2007												2008											
Region	Country		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
AFRO	Niger	Base		100	100	50					50	100	100			100	100																						
		Contingency		100	100	50					50	100	100			100	100	50					50	100	100			50	50										
AFRO	Nigeria	Base		100	100	50	50			50	50	100	100			100	100	50																				
		Contingency		100	100	50	50			50	50	100	100			100	100	50	50			50	50	100	100			100	100					50	50			
AFRO	Chad	Base		100	100																																
		Contingency		100	100							100	100			100	100																						
AFRO	Cameroon	Base		30	30																																
		Contingency		50	50							50	50			50	50																						
AFRO	Benin	Base		100	100																																
		Contingency		100	100							100	100			100	100																						

Scenario 2: Transmission of imported wild poliovirus continues in west and central Africa until the third quarter of 2006

Under this scenario, additional SIAs would be conducted in the second half of 2006 in Burkina Faso, the Central African Republic (CAR), Côte d'Ivoire, and Mali (and in the first quarter of 2007 in Benin, Cameroon and Chad, as above).

Financial implications: up to US$ 27.5 million in additional costs in 2006.

Scenario 2: Transmission of imported wild poliovirus continues in west/central Africa until Q3 2006

			2006												2007											
Region	**Country**		**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
AFRO	CAR	Base																								
		Contingency			100	100					100	100														
AFRO	Cote d'Ivoire	Base				100																				
		Contingency			100	100	100				100	100														
AFRO	Burkina Faso	Base																								
		Contingency			100	100					100	100														
AFRO	Mali	Base																								
		Contingency			100	100	100				100	100														

Note: Other high-risk west/central African countries are reflected in Scenario 1

Scenario 3: Transmission of wild poliovirus continues in the Horn of Africa until mid-2006

Under this scenario, additional SIAs would be conducted in 2006 in Sudan, Yemen, Eritrea and Ethiopia; and Somalia and south Sudan upto the first quarter of 2007.

Financial implications: up to US$ 52 million in additional costs for 2006-2007.

Scenario 3: Transmission of wild poliovirus continues in the Horn of Africa until mid- 2006

			2006												2007											
Region	**Country**		**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
EMRO	Somalia	Base	100	100		100	100																			
		Contingency	100	100	100	100		100	100	100						100	100									
EMRO	Sudan	Base		100	100					25	25					25	25									
		Contingency		100	100	100	100			100	100															
EMRO	Yemen	Base	100																							
		Contingency		100	100						100	100														
AFRO	Eritrea	Base																								
		Contingency		100	100	100	100				100	100														
AFRO	Ethiopia	Base	25	100																						
		Contingency		100	100	50	50				100	100														

Scenario 4: Transmission of wild poliovirus continues in infected countries in Asia until end-2006

Under this scenario, additional SIAs would be conducted in Indonesia in 2006 and in Afghanistan, Pakistan and India in 2006 and 2007.

Financial implications: up to US$ 142.8 million in additional costs in 2006-2007.

Scenario 4: Transmission of wild poliovirus continues in infected countries in Asia until end-2006

			2006												2007											
Region	**Country**		**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
EMRO	Afghanistan	Base		60	60	100	100				25	25				100	100										
		Contingency		100	100	60	60			60	100	100	60			100	100	50					50	50		
EMRO	Pakistan	Base		100	100	50					100	100	50			100	100									
		Contingency		100	100	50	50			50	100	100	50			100	100	50					100	100		
SEARO	India	Base	50	50		100	100				50	50				100	100									
		Contingency	50	50		100	100			50	50	50	50			100	100	50	50							
SEARO	Indonesia	Base	25	100	100	25																				
		Contingency	100	100	30	30				50	50															

Annex 1: Details of Country-Level External Funding Requirements for 2006-2007, as of September 2006.

Table 4: Details of external funding requirements in polio-endemic and highest-risk countries, 2006-2007 (all figures are in US$ millions)

	2006				2007				2006 to 2007			
Country	NIDs/ SNIDs: OPV	NIDs/ SNIDs: Op Costs	AFP Surveillance and Laboratory	Total Costs 2006	NIDs/ SNIDs: OPV	NIDs/ SNIDs: Op Costs	AFP Surveillance and Laboratory	Total Costs 2007	NIDs/ SNIDs: OPV	NIDs/ SNIDs: Op Costs	AFP Surveillance and Laboratory	Total Costs 2006 to 2007
Polio-Endemic												
Afghanistan	$7.33	$9.68	$1.90	$18.91	$3.57	$4.33	$1.16	$9.06	$10.90	$14.01	$3.06	$27.97
India	$116.97	$99.76	$3.70	$220.43	$63.24	$48.77	$5.72	$117.73	$180.21	$148.53	$9.42	$338.16
Nigeria	$32.94	$43.61	$9.67	$86.22	$17.74	$19.32	$6.38	$43.45	$50.68	$62.93	$16.05	$129.66
Pakistan	$39.66	$21.69	$2.10	$63.45	$15.38	$8.01	$1.50	$24.89	$55.03	$29.70	$3.60	$88.34
WHO African Region												
Angola	$2.97	$3.97	$1.39	$8.33	$0.00	$0.00	$1.65	$1.65	$2.97	$3.97	$3.04	$9.98
Benin	$0.70	$1.28	$0.16	$2.14	$0.00	$0.00	$0.19	$0.19	$0.70	$1.28	$0.35	$2.33
Cameroon	$0.41	$0.74	$0.36	$1.51	$0.00	$0.00	$0.24	$0.24	$0.41	$0.74	$0.60	$1.75
Chad	$0.83	$2.67	$0.30	$3.80	$0.00	$0.00	$0.32	$0.32	$0.83	$2.67	$0.62	$4.12
Congo - Brazzaville	$0.33	$0.59	$0.14	$1.06	$0.00	$0.00	$0.17	$0.17	$0.33	$0.59	$0.31	$1.23
Côte d'Ivoire	$0.71	$1.01	$0.46	$2.17	$0.00	$0.00	$0.27	$0.27	$0.71	$1.01	$0.73	$2.45
DR Congo	$2.83	$6.49	$2.38	$11.70	$0.00	$0.00	$2.03	$2.03	$2.83	$6.49	$4.41	$13.72
Equatorial Guinea	$0.02	$0.12	$0.02	$0.17	$0.00	$0.00	$0.02	$0.02	$0.02	$0.12	$0.04	$0.19
Ethiopia	$5.25	$19.32	$3.18	$27.75	$2.09	$7.03	$2.33	$11.45	$7.34	$26.35	$5.52	$39.21
Gabon	$0.07	$0.36	$0.12	$0.54	$0.00	$0.00	$0.01	$0.01	$0.07	$0.36	$0.21	$0.64
Kenya	$0.25	$0.99	$0.36	$1.60	$0.00	$0.00	$0.42	$0.42	$0.25	$0.99	$0.78	$2.02
Namibia[1]	$0.67	$0.42	$0.21	$1.30	$0.00	$0.00	$0.09	$0.09	$0.67	$0.42	$0.30	$1.40
Niger	$2.83	$7.75	$0.40	$10.98	$1.19	$3.26	$0.34	$4.78	$4.02	$11.01	$0.74	$15.76
WHO Eastern Mediterranean Region												
Djibouti	$0.08	$0.27	$0.01	$0.44	$0.00	$0.00	$0.01	$0.01	$0.08	$0.27	$0.20	$0.54
Egypt	$3.76	$1.43	$0.37	$5.56	$0.00	$0.00	$0.37	$0.37	$3.76	$1.43	$0.74	$5.93
Somalia	$1.91	$6.88	$0.86	$9.65	$0.60	$1.61	$0.68	$2.89	$2.51	$8.49	$1.54	$12.54
Sudan	$3.79	$7.90	$1.55	$13.25	$0.00	$0.00	$1.25	$1.25	$3.79	$7.90	$2.81	$14.50
Yemen	$1.49	$3.06	$0.18	$4.73	$0.00	$0.00	$0.18	$0.18	$1.49	$3.06	$0.35	$4.90
WHO South-East Asia Region												
Bangladesh[2]	$0.00	$0.00	$0.75	$0.75	$0.00	$0.00	$0.56	$0.56	$0.00	$0.00	$1.31	$1.31
Indonesia[3]	$2.42	$2.03	$1.40	$5.85	$0.00	$0.00	$1.40	$1.40	$2.42	$2.03	$2.80	$7.25
Myanmar	$0.87	$0.28	$0.27	$1.42	$0.00	$0.00	$0.20	$0.20	$0.87	$0.28	$0.47	$1.62
Nepal	$3.15	$2.12	$0.50	$5.77	$0.74	$0.40	$0.37	$1.51	$3.89	$2.52	$0.87	$7.28

1 *The Government of Namibia contributed approx. $3.9m for operational cost. The cost here only reflects external funding requirements.*

2 *The Government of Bangladesh covers OPV and operations cost for all SIAs in 2006 and 2007.*

3 *The cost excludes the OPV and Operational cost of two NIDs in 2006, which were covered by Government of Indonesia.*

Table 5: Surveillance and laboratory costs by country and region, 2006 (all figures are in US$ millions)

WHO African Region	2006
Algeria	$0.03
Angola	$1.39
Benin	$0.16
Botswana	$0.10
Burkina Faso	$0.33
Burundi	$0.10
Cameroon	$0.36
Cape Verde	$0.05
Central African Republic	$0.39
Chad	$0.30
Comoros	$0.04
Congo	$0.14
Côte d'Ivoire	$0.46
Democratic Republic of Congo	$2.38
Equatorial Guinea	$0.02
Eritrea	$0.14
Ethiopia	$3.18
Gabon	$0.12
Gambia	$0.07
Ghana	$0.47
Guinea	$0.17
Guinea-Bissau	$0.07
Kenya	$0.36
Lesotho	$0.06
Liberia	$0.27
Madagascar	$0.42
Malawi	$0.20
Mali	$0.24
Mauritania	$0.15
Mauritius	$0.01
Mozambique	$0.20
Namibia	$0.21
Niger	$0.40
Nigeria	$9.67
Rwanda	$0.11
Sao Tome and Principe	$0.01
Senegal	$0.36
Seychelles	$0.01
Sierra Leone	$0.24
South Africa	$0.07
Swaziland	$0.06
Togo	$0.12
Uganda	$0.27
United Republic of Tanzania	$0.24
Zambia	$0.49
Zimbabwe	$0.12
Regional surveillance and laboratory	$3.03
Subtotal	**$27.76**

WHO Region of the Americas	2006
Regional surveillance and laboratory	$0.50

WHO Eastern Mediterranean Region	2006
Afghanistan	$1.90
Djibouti	$0.10
Egypt	$0.37
Iraq	$0.10
Pakistan	$2.10
Somalia	$0.86
Sudan	$1.55
Yemen	$0.18
Regional surveillance and laboratory	$1.55
Subtotal	**$8.70**

WHO South-East Asia Region	2006
Bangladesh	$0.75
India	$3.70
Indonesia	$1.40
Myanmar	$0.27
Nepal	$0.50
Regional surveillance and laboratory	$3.13
Subtotal	**$9.74**

WHO European Region	2006
Armenia	$0.00
Azerbaijan	$0.01
Bosnia and Herzegovina	$0.01
Bulgaria	$0.01
Georgia	$0.01
Kazakhstan	$0.06
Kyrgystan	$0.01
Republic of Moldova	$0.01
Romania	$0.01
Russian Federation	$0.08
Tajikistan	$0.08
Turkey	$0.05
Turkmenistan	$0.03
Ukraine	$0.01
Uzbekistan	$0.03
Serbia and Montenegro	$0.01
Regional surveillance and laboratory	$0.40
Subtotal	**$0.79**

WHO Western Pacific Region	2006
Regional surveillance and laboratory	$0.90

WHO/HQ	2006
	$11.52

Global	2006
Total	$59.91

Table 6: Technical assistance, country-level details 2006 (all figures are in US$ millions)

WHO African Region	2006
Angola	$2.34
Benin	$0.21
Botswana	$0.01
Burkina Faso	$0.24
Cameroon	$0.07
Central African Republic	$0.21
Chad	$0.85
Congo	$0.23
Côte d'Ivoire	$0.67
Democratic Republic of Congo	$4.89
Equatorial Guinea	$0.05
Eritrea	$0.04
Ethiopia	$1.40
Gabon	$0.02
Gambia	$0.02
Ghana	$0.34
Guinea	$0.19
Guinea-Bissau	$0.05
Kenya	$0.19
Lesotho	$0.04
Liberia	$0.29
Madagascar	$0.09
Malawi	$0.04
Mali	$0.15
Mauritania	$0.14
Mozambique	$0.22
Namibia	$0.20
Niger	$1.11
Nigeria	$16.13
Rwanda	$0.19
Senegal	$0.21
Sierra Leone	$0.23
South Africa	$0.16
Swaziland	$0.08
Togo	$0.16
Uganda	$0.24
United Republic of Tanzania	$0.31
Zambia	$0.35
Zimbabwe	$0.06
ICP-Central*	$0.72
ICP-East*	$0.73
ICP-South*	$0.73
ICP-West*	$0.76
Regional Office	$3.68
Subtotal	**$39.02**

WHO Eastern Mediterranean Region	2006
Afghanistan	$1.71
Djibouti	$0.14
Egypt	$0.15
Iran	$0.004
Iraq	$0.17
Pakistan	$4.56
Somalia	$1.11
Sudan	$2.95
Yemen	$0.28
Regional Office	$0.90
Subtotal	**$11.96**

WHO South-East Asia Region	2006
Bangladesh	$1.01
India	$7.94
Indonesia	$0.36
Myanmar	$0.29
Nepal	$0.51
Regional Office	$2.00
Subtotal	**$12.11**

WHO European Region	2006
Regional Office	$0.82
Subtotal	**$0.82**

WHO Western Pacific Region	2006
Cambodia	$0.16
China	$0.47
Fiji	$0.16
Lao PDR	$0.16
Philippines	$0.16
Papua New Guinea	$0.17
Viet Nam	$0.31
Regional Office	$0.93
Subtotal	**$2.50**

WHO/HQ	$6.43
UNICEF	$10.40

Global	2006
Total	**$83.24**

* *ICP= Inter-country Programme*