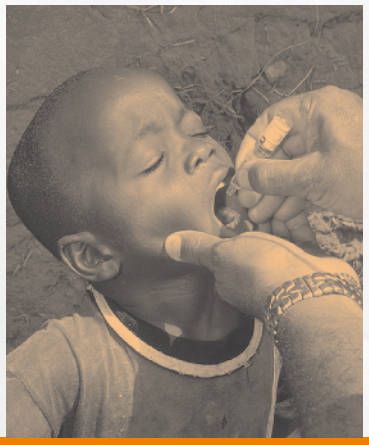

Global Polio Eradication Initiative

Financial resource requirements 2007 - 2009

as of August 2007

World Health Organization

unicef

Partners in the Global Polio Eradication Initiative

Design & Layout: Paprika

WHO/POLIO/07.01

Global Polio Eradication Initiative

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Acronyms and Abbreviations

ACPE	Advisory Committee on Polio Eradication
AFP	Acute Flaccid Paralysis
CDC	US Centers for Disease Control and Prevention
GAVI Alliance	Global Alliance for Vaccines and Immunization
GIVS	Global Immunization Vision and Strategy
IFFIm	International Finance Facility for Immunization
IHR	International Health Regulations
IPDs	Immunization Plus Days
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

In January 2007, the Global Polio Eradication Initiative entered a new phase, with the adoption of tailored and intensified approaches to reach the last children, in each of the last four polio-endemic countries, with new eradication tools. This shift to a tailored approach to polio eradication marks a new era for the Global Polio Eradication Initiative.

While the feasibility of polio eradication in the near-term was re-affirmed by global and national technical oversight bodies in the second half of 2006, the recommended intensification and tailoring of supplementary immunization activities present a financial challenge that will require unprecedented action on the part of both polio-affected countries and donors.

The Advisory Committee on Polio Eradication (ACPE), the independent oversight body of the Global Polio Eradication Initiative, and national polio oversight bodies in India, Nigeria, Pakistan and Afghanistan, in December 2006 established specific intensified supplementary immunization strategies tailored to address the unique challenges of each of the remaining infected areas and fully exploit new vaccines and diagnostics that are twice as effective in stopping polio transmission. Successful implementation of these strategies in the next 24 months will dictate the ultimate feasibility of polio eradication. Finally stopping wild poliovirus transmission everywhere will require a fresh surge of conviction from political leaders and the donor community.

The international community has over the past 19 years invested US$ 5.3 billion in polio eradication. Convinced that the next 24 months hold the key to stopping transmission of wild poliovirus, the Global Polio Eradication Initiative calls on both polio-affected countries and donors to make the extraordinary two-year financial commitment necessary to place us on the threshold of a polio-free world.

The Financial Resource Requirements 2007-2009 presents the estimated financial resources needed to stop polio transmission globally. The most urgent funding gap, for 2007-2008 intensified immunization and surveillance activities, stands at US$ 415 million, with US$ 60 million and US$ 355 million required for 2007 and 2008 respectively. A further US$ 220 million is needed for 2009.

Following the executive summary, pages 7 to 9 provide an overview of the Global Polio Eradication Initiative partnership summarize the financial contributions and pledges made to the Global Polio Eradication Initiative as at August 2007. Pages 10 to 12 describe the intensified activities for 2007-2008 and the funding required to implement them.

Protecting the world's 19-year investment in polio eradication requires polio-affected countries and donors to:

1) by November 2007, fill the immediate US$60 million funding gap, to ensure critical immunization and surveillance activities in Q1 2008 go ahead; and,
2) support the 24-month intensification strategy with multi-year pledges, to ensure the world seizes this opportunity to consign polio to the history books.

Figure 1: Global Polio Eradication Initiative Annual Expenditure, 1988-2006 and Financial Resource Requirements, Contributions, Funding Gap, 2007-2009

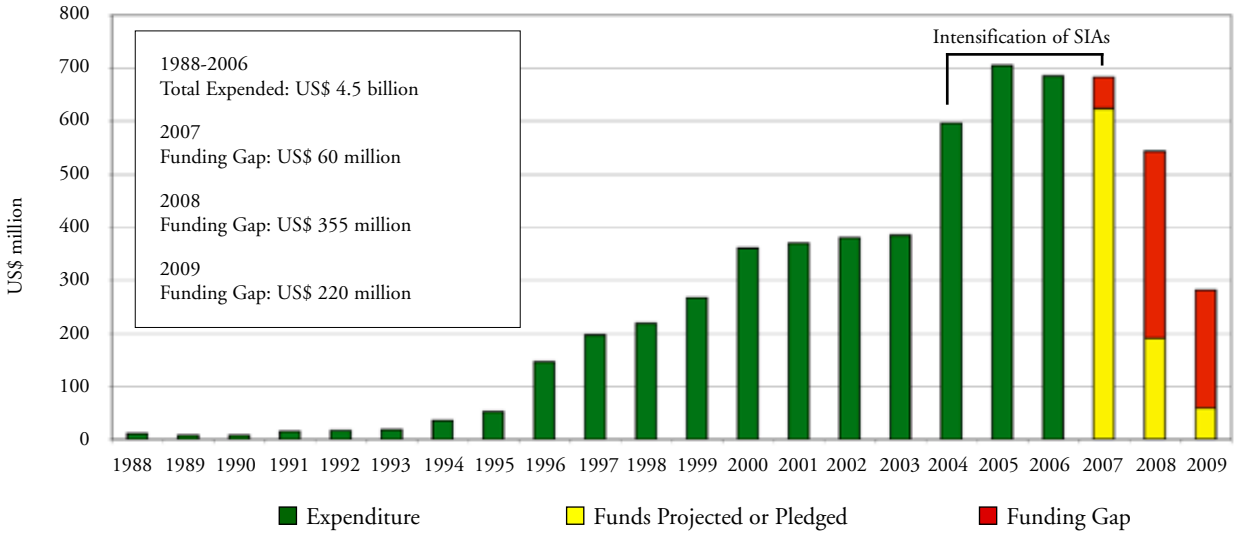


Figure 2: Countries with Active Transmission of Wild Poliovirus as of August 2007

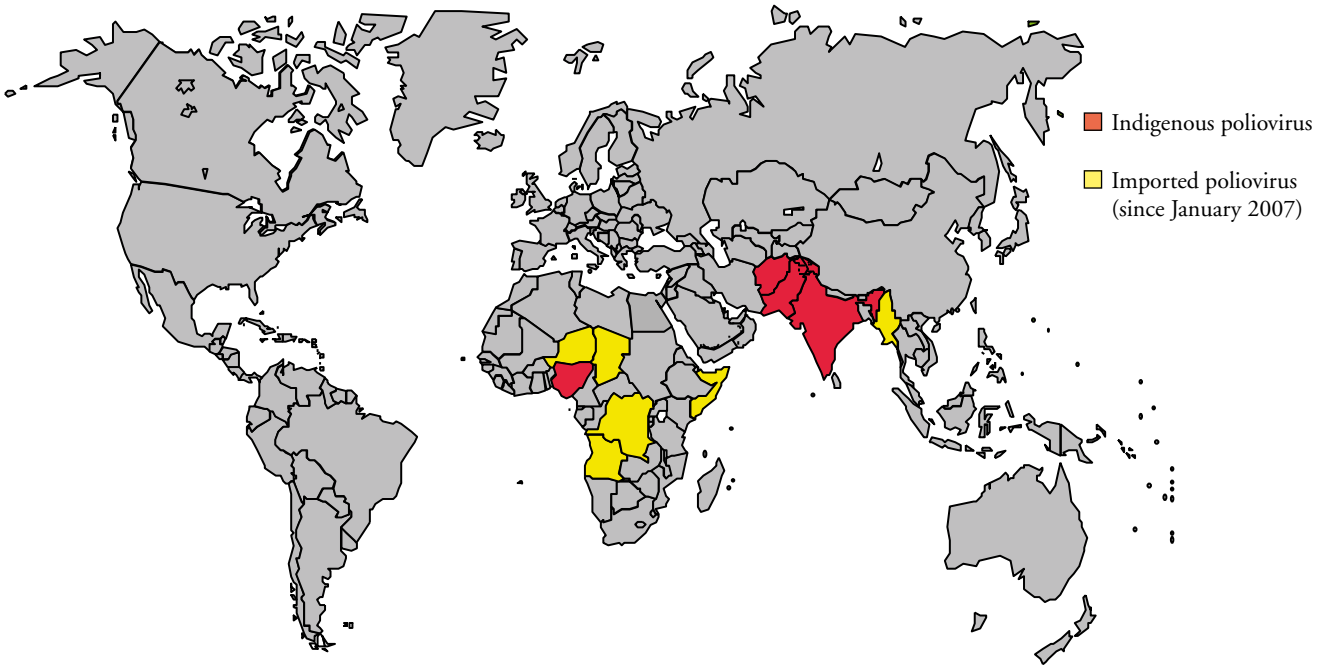


Table 1: Summary of External Resource Requirements by Major Category of Activity, 2007-2009
(all figures US$ millions)

Activity Category	2007	2008	2007-2008	2009
Oral polio vaccine	$ 227.98	$ 176.09	$ 404.07	$ -
NIDs/SNIDs operations*	$ 230.69	$ 163.81	$ 394.50	$ -
Emergency response/ mOPV evaluation	$ 50.00	$ 35.00	$ 85.00	$ 20.00
Surveillance**	$ 61.09	$ 59.47	$ 120.56	$ 45.05
Laboratory	$ 8.37	$ 8.45	$ 16.82	$ 7.66
Technical assistance***	$ 87.90	$ 83.35	$ 171.25	$ 65.07
Certification and containment	$ 12.00	$ 12.00	$ 24.00	$ 12.00
Product development for OPV cessation	$ 5.00	$ 5.00	$ 10.00	$ 5.00
Vaccine for post-eradication era stockpile (finished product and bulk)	$ -	$ -	$ -	$ 126.60
Subtotal	**$ 683.02**	**$ 543.17**	**$ 1 226.20**	**$ 281.38**
Contributions	$ 623.48	$ 190.69	$ 814.17	$ 59.00
Funding gap	**$ 59.54**	**$ 352.48**	**$ 412.03**	**$ 222.38**
Funding gap (rounded)	**$ 60.00**	**$ 355.00**	**$ 415.00**	**$ 220.00**

* *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 2007 provided in Table 5.*

*** *Technical assistance includes the cost of human resources deployed through UN agencies. Country-level breakdown for 2007 provided in Table 6.*

Overview of the Global Polio Eradication Initiative Partnership

The 19-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. Azerbaijan, Australia, Austria, Belgium, Canada, Cyprus, Denmark, Finland, France, Germany, Iceland, Hungary, Ireland, Italy, Japan, Kuwait, Liechtenstein, 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. Bill and Melinda Gates Foundation, United Nations Foundation); development banks (e.g. African Development Bank, the World Bank); humanitarian and nongovernmental organizations (e.g. the International Federation of Red Cross and Red Crescent societies) and corporate partners (e.g. British Airways, De Beers, Sanofi Pasteur, Wyeth).

Table 2 highlights contributions/pledges by major donor to the Global Polio Eradiation Initiative for 1988 - 2009. Funding provided through external sources (including both multilateral and bilateral contributions) total US$ 5.3 billion. Forty-four public and private sector donors have contributed more than US$ 1 million each to polio eradication. Of these, 27 have contributed US$ 5 million or more. Spearheading partner Rotary International has contributed more than US$ 600 million, a figure which will rise to more than US$ 650 million by the time the world is certified polio-free.

G8 leaders meeting in St Petersburg in July 2006 reaffirmed their commitment to finishing the job of polio eradication, pledging to «urgently call for mobilization of financial support» and to «continue to work collectively and with bilateral and multilateral donors to close the funding gap for 2007-2008 and to continue to work with others towards securing the resources necessary to finish the program and declare our planet polio-free in the near future». This commitment was further re-affirmed at the G8 Summit in Heiligendamm, Germany, in June 2007, where G8 leaders committed to make the upmost efforts to eradicate polio, vowing to work with other organizations to close the funding shortfalls.

In June 2007, the GAVI Fund Alliance finalized a reprogramming of US$ 104.6 million, to support the current intensified polio eradication efforts. These funds had originally been earmarked for the post-eradication era for 2009, and while they do not constitute new funding, they do free up much-needed cash to maintain surveillance and campaign activities for the rest of 2007.

Table 2: Donor Profile for 1988-2009

Contribution (US$ million)	Public Sector Partners	Development Banks	Private Sector Partners
> 1,000	USA		
500 - 1,000	United Kingdom		Rotary International
250 - 499	Japan	World Bank	
100 - 249	European Commission, Canada, Germany, Netherlands, GAVI/IFFIm		Bill & Melinda Gates Foundation
50 - 99	Norway, UNICEF Regular Resources, WHO Regular Budget		
25 - 49	Denmark, France, Sweden		United Nations Foundation
5 - 24	Australia, Ireland, Italy, Luxembourg, Russian Federation, Spain		Sanofi Pasteur, IFPMA, UNICEF National Committees, American Red Cross
1 - 4	Austria, Belgium, Finland, Kuwait, Malaysia, New Zealand, Saudi Arabia, Switzerland, United Arab Emirates	Inter-American Development Bank, 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.*

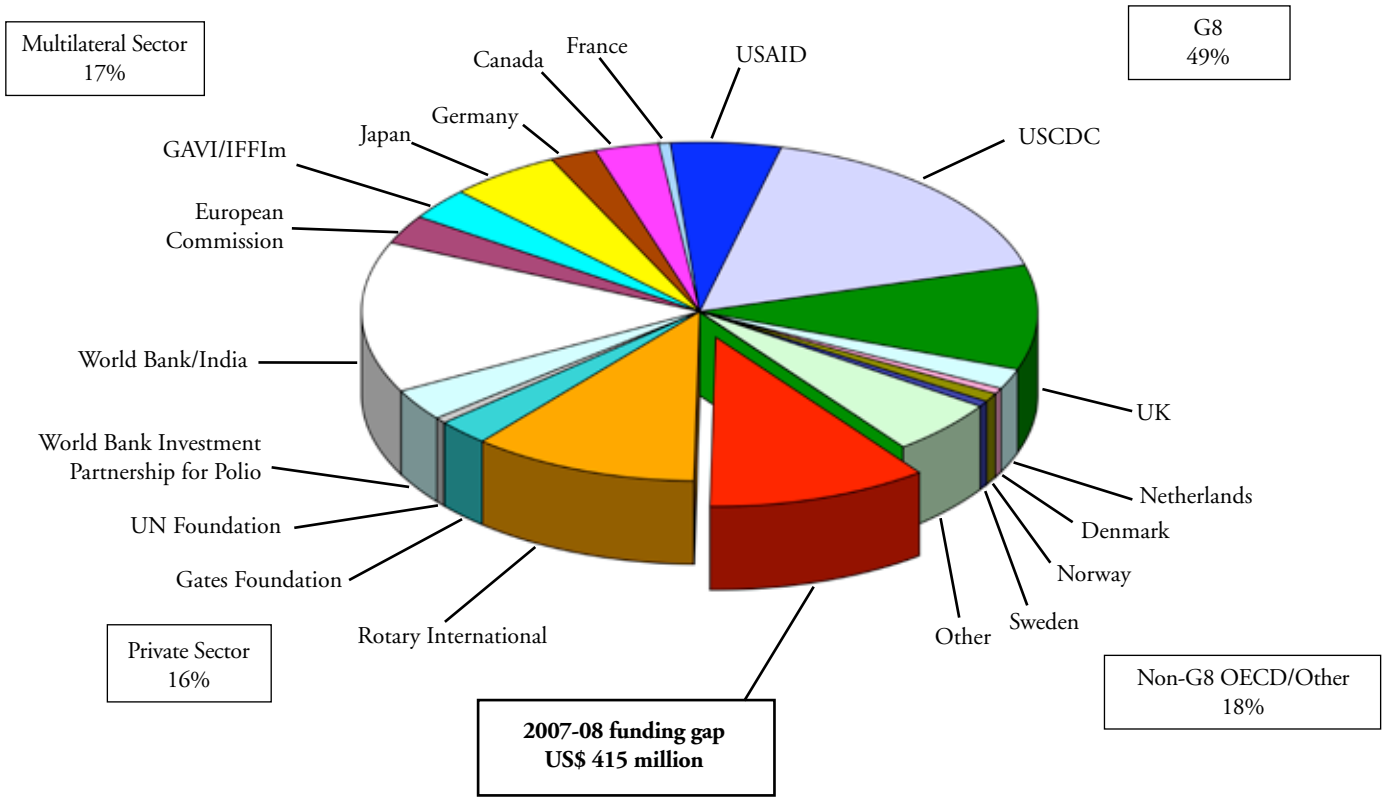
The world now has a tremendous opportunity to ensure that everyone shares equally in the benefits of a polio-free world. The economic justification is compelling. Regardless as to long-term polio immunization decisions, eradication would be cost-saving for low-incoming developing countries. Globally, the cost-effectiveness ratio of polio eradication would be an impressive US$ 52.50 per disability-adjusted life year (DALY) saved. Failure to completely eradiate 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 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 external contributions since 1988, as well as the 2007-2009 funding gap.

Figure 3: External Contributions since 1988, and Funding Gap for 2007-2009



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

'Other' in the pie chart includes: the Governments of Angola, Austria, Australia, Azerbaijan, Bangladesh, Belgium, Cyprus, Czech Republic, Finland, Hungary, Iceland, Indonesia, Ireland, Italy, Kuwait, Liechtenstein, Luxembourg, Malaysia, Monaco, Namibia, New Zealand, Nigeria, 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, Central Emergency Response Fund (CERF), 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.

Financial requirements for 2007-2008

PRIORITIES AND ACTIVITIES

During 2006, the Global Polio Eradication Initiative saw important progress towards the goal of a polio-free world. In January 2006, Egypt and Niger were officially removed from the list of polio-endemic countries, reducing the number of remaining endemic countries to four, the lowest number in history (India, Nigeria, Pakistan and Afghanistan).

Strong progress was achieved in curbing outbreaks in previously polio-free countries, thanks to the rapid implementation of new outbreak response guidelines adopted at the World Health Assembly (WHA) in May 2006. Of the 27 countries re-infected since 2003, only six continued to report polio cases in 2007. Fewer than 6% of all new polio cases in 2006 were in re-infected countries, compared with more than 50% in 2005.

In total, more than 2.1 billion doses of oral polio vaccine (OPV) were administered to more than 375 million children, during 187 SIAs in 37 countries. Countries around the world maintained acute flaccid paralysis (AFP) surveillance, including 79 countries in polio-endemic regions, requiring substantial technical assistance (as per figure 4).

Figure 4: Polio-funded Technical Assistance by Country

In northern Nigeria, which remains one of two global epicentres of polio transmission, a radical change to improve polio eradication activities was implemented in May 2006. 'Immunization Plus Days' (IPDs) offered additional health benefits to OPV, including measles and DPT vaccination, de-worming tablets and Vitamin A supplements. These IPDs substantially increased community and political engagement at the local level and, as importantly, reduced the proportion of never-immunized children in northern states from >50% at end-2005 to an average of 20% at end-2006.

Despite this progress, however, the Global Polio Eradication Initiative faced important new challenges in 2006. In India, a new outbreak originating in western Uttar Pradesh resulted in a 10-fold increase in cases compared to the previous year. By end-2006, however, the outbreak was declining at its original epicentre as well as in previously polio-free areas within Uttar Pradesh and neighbouring states that had been re-infected. In parts of Afghanistan and Pakistan, cross-border polio transmission continues to be sustained among populations to whom access is hampered, due to either insecurity or population movements. And in northern Nigeria - despite significant improvements since the introduction of IPDs - more than 25% of children continue to be missed in Kano, Katsina and Jigawa.

In December 2006, national technical oversight bodies established specific strategies tailored to address the unique challenges in each of the remaining polio-endemic areas. In India, large-scale campaigns with mOPV will now be held on average every four weeks, targeting specifically very young children, to rapidly fill a remaining immunity gap among under-two year olds. In Nigeria, all activities will be state-driven, with particular focus on Kano, Katsina and Jigawa. And in Afghanistan and Pakistan, both campaign and surveillance activities will be increasingly coordinated between the two countries. Successful implementation of these strategies in the next 24 months will dictate the ultimate feasibility of polio eradication.

As intensification of eradication activities continues, the capacity and experience of the polio eradication network remains instrumental in scaling up routine immunization services and the polio infrastructure is used to detect and respond to outbreaks of other communicable diseases. The integration of the 'Reaching Every District' (RED) strategy to enhance routine immunization coverage - initiated in 2002 - is based on the polio eradication model of reaching entire populations through detailed planning at district levels. More than 50 countries across Africa and southeast Asia are today implementing RED strategies. Polio-funded staff have been instrumental in its implementation, working closely with national immunization authorities and key partners, such as the GAVI Alliance. RED is today helping to identify under-performing districts and hard-to-reach populations, and is significantly increasing routine immunization coverage rates at the district level, with many countries nearly halving the number of un-immunized children.

The polio infrastructure has mobilized a network of more than 20 million volunteers and health workers to implement the polio eradication strategies. These are the people who deliver polio vaccine to children, and this workforce is also being used to deliver other basic health services, including Vitamin A and more recently, bednets to prevent malaria. More than 10 million bednets have been distributed during polio eradication activities in Angola, the Democratic Republic of the Congo, Ethiopia, Ghana, Indonesia, Kenya, Namibia, Niger, Nigeria and Togo.

Realization of the full humanitarian and economic benefits of polio eradication requires not only success in eradicating polio, but in ensuring that it remains eradicated. At its October 2006 meeting, the ACPE reviewed and endorsed a six-pronged strategy to minimize and manage the risks of polio re-emergence and/or re-introduction into a polio-free world:

- confirmation of the interruption and containment of wild poliovirus globally;
- the use of highly sensitive surveillance for polioviruses and immediate notification of their presence;
- establishment of a stockpile of mOPV for responding to emergent or reintroduced circulating poliovirus;
- maintenance of high (>90%) nationwide coverage of inactivated polio vaccine (IPV) in all countries with poliovirus (essential) facilities as defined and provided for in the third edition of the WHO global action plan to minimize poliovirus facility-associated risk in post-eradication/post-OPV era (GAP III);
- synchronous global cessation of the use of OPV for routine immunization; and,
- containment of Sabin poliovirus strains.

FINANCIAL RESOURCE REQUIREMENTS

The financial resource requirements for 2007 are estimated at US$ 683 million, against which there is a funding gap of US$ 60 million, needed by November 2007 to fully implement activities in Q1 2008. The funding gap for 2008 is pegged at US$ 355 million and an additional US$ 220 million is required in 2009.

Table 3 summarizes the schedule of intensified supplementary immunization activity plans for 2007 and 2008. Supplementary immunization activities are the major cost driver for the Global Polio Eradication Initiative in 2007-2008 (see Annex 1, Table 4 for details of planned costs by country for 2007-2008). In addition to funding for planned activities, the Global Polio Eradication Initiative has budgeted US$ 105 million for emergency response to poliovirus importations. 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, 2007-2008, as of August 2007

Activity plan for 2007-2008

NIDs: National Immunization Days
SNIDs: Subnational Immunization Days
IPDs: Immunization Plus Days

Activity NIDs SNIDs IPDs

		2007												2008											
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	50	50	100	100	85	55	20	100		100		50		100	100					50	50			
India	% targeted	100	100	60	50	55		45	40	40	40		40		100	100	50	50			50	50			
Nigeria	% targeted	100		30	15		40	40		50		50			100	100	50	50			50	50			
Pakistan	% targeted	100	50	35	100	35	35	10	100		100		35		100	100					50	50			
Countries Bordering Polio-endemic Countries																									
Bangladesh	% targeted			100	100	5		5			100		100		100	100									
Benin	% targeted				100																				
Cameroon	% targeted	25		25																					
Chad	% targeted	100	75			25			100	100															
Myanmar	% targeted					10	45	45	50	100	100														
Nepal	% targeted				15	55		40					100		100	100									
Niger	% targeted			100	100				50	50					100	100					50	50			
Horn of Africa Outbreak Countries																									
Ethiopia	% targeted	5			15		100				100	10													
Kenya	% targeted		30	30																					
Somalia	% targeted	30	100	100	25	45	35	100	100	50															
Sudan*	% targeted			100	100				75	75															
Southern Africa Outbreak Countries																									
Angola	% targeted		15				100	100	100																
Congo (Brazzaville)	% targeted						55																		
DR Congo	% targeted		25	25	20		20																		

For Sudan, the August/September SNIDs only take place in the North

Annex 1: Details of Country-Level Funding Requirements for 2007-2008, as of August 2007

Table 4: Details of Funding Requirements in Polio-Endemic and Highest-Risk Countries, 2007-2008 (all figures US$ millions)

	2007				2008				2007 to 2008			
Country	**NIDs/ SNIDs: OPV**	**NIDs/ SNIDs: Op Costs**	**AFP Surveillance**	**Total Costs 2007**	**NIDs/ SNIDs: OPV**	**NIDs/ SNIDs: Op Costs**	**AFP Surveillance**	**Total Costs 2008**	**NIDs/ SNIDs: OPV**	**NIDs/ SNIDs: Op Costs**	**AFP Surveillance**	**Total Costs 2007 to 2008**
Polio-Endemic												
Afghanistan	$8.48	$11.70	$1.70	$21.89	$3.71	$5.65	$1.70	$11.06	$12.19	$17.35	$3.40	$32.95
India	$152.47	$102.53	$5.13	$260.12	$110.00	$81.43	$5.39	$196.82	$262.47	$183.96	$10.52	$456.94
Nigeria	$22.86	$43.50	$9.64	$76.00	$32.46	$55.13	$9.64	$97.23	$55.32	$98.63	$19.28	$173.23
Pakistan	$32.94	$23.91	$1.68	$58.53	$17.71	$12.12	$1.50	$31.33	$50.65	$36.03	$3.18	$89.86
Countries Bordering Polio-Endemic Countries												
Bangladesh	$16.85	$5.82	$0.75	$23.41	$8.68	$2.93	$0.75	$12.36	$25.52	$8.75	$1.50	$35.77
Benin	$0.39	$0.80	$0.20	$1.39	$0.00	$0.00	$0.20	$0.20	$0.39	$0.80	$0.40	$1.59
Cameroon	$0.43	$0.31	$0.33	$1.07	$0.00	$0.00	$0.33	$0.33	$0.43	$0.31	$0.66	$1.40
Chad	$1.53	$5.26	$0.30	$7.09	$0.00	$0.00	$0.30	$0.30	$1.53	$5.26	$0.60	$7.39
Myanmar	$2.78	$1.63	$0.27	$4.67	$0.00	$0.00	$0.20	$0.20	$2.78	$1.63	$0.47	$4.88
Nepal	$1.61	$1.63	$0.50	$3.74	$1.67	$1.51	$0.37	$3.55	$3.28	$3.14	$0.87	$7.30
Niger	$1.82	$3.70	$0.66	$6.19	$1.87	$5.05	$0.66	$7.58	$3.69	$8.75	$1.32	$13.77
Horn of Africa Outbreak Countries												
Ethiopia	$5.80	$16.18	$3.73	$25.72	$0.00	$0.00	$3.73	$3.73	$5.80	$16.18	$7.46	$29.45
Kenya *	$0.52	$1.79	$0.49	$2.79	$0.00	$0.00	$0.49	$0.49	$0.52	$1.79	$0.97	$3.28
Somalia	$1.79	$4.16	$0.95	$6.89	$0.00	$0.00	$0.95	$0.95	$1.79	$4.16	$1.90	$7.84
Sudan	$4.16	$10.87	$2.41	$17.44	$0.00	$0.00	$1.75	$1.75	$4.16	$10.87	$4.16	$19.19
Southern Africa Outbreak Countries												
Angola	$2.79	$6.69	$1.58	$11.06	$0.00	$0.00	$1.58	$1.58	$2.79	$6,69	$3.16	$12.64
Congo (Brazzaville) *	$0.01	$0.15	$0.15	$0.32	$0.00	$0.00	$0.15	$0.15	$0.01	$0.15	$0.31	$0.47
DR Congo	$2.45	$8.57	$2.30	$13.32	$0.00	$0.00	$2.30	$2.30	$2.45	$8.57	$4.60	$15.62

*For Kenya and Congo (Brazzaville), figures shown do not represent total budget, but requirements for external fund.

Table 5: Surveillance and Laboratory Costs by Country and Region, 2007 (all figures US$ millions)

WHO African Region	2007
Algeria	$0.03
Angola	$1.58
Benin	$0.20
Botswana	$0.10
Burkina Faso	$0.34
Burundi	$0.18
Cameroon	$0.33
Cape Verde	$0.05
Central African Republic	$0.58
Chad	$0.30
Comoros	$0.05
Congo	$0.15
Côte d'Ivoire	$0.32
Democratic Republic of Congo	$2.30
Equatorial Guinea	$0.05
Eritrea	$0.22
Ethiopia	$3.73
Gabon	$0.15
Gambia	$0.10
Ghana	$0.48
Guinea	$0.15
Guinea-Bissau	$0.07
Kenya	$0.49
Lesotho	$0.06
Liberia	$0.30
Madagascar	$0.55
Malawi	$0.23
Mali	$0.24
Mauritania	$0.15
Mauritius	$0.02
Mozambique	$0.22
Nambia	$0.15
Niger	$0.66
Nigeria	$9.64
Rwanda	$0.28
Sao Tome and Principe	$0.01
Senegal	$0.28
Seychelles	$0.01
Sierra Leone	$0.30
South Africa	$0.10
Swaziland	$0.10
Togo	$0.20
Uganda	$0.44
United Republic of Tanzania	$0.30
Zambia	$0.45
Zimbabwe	$0.20
ICST* (Central block)	$0.64
ICST (South/East block)	$1.15
ICST (Western block)	$1.00
Regional surveillance and laboratory	$2.42
Subtotal	**$32.00**

WHO Region of the Americas	2007
Regional surveillance and laboratory	$0.55

WHO Eastern Mediterranean Region	2007
Afghanistan	$1.70
Djibouti	$0.10
Egypt	$0.37
Iraq	$0.10
Pakistan	$1.68
Somalia	$0.95
Sudan	$2.41
Yemen	$0.18
Regional surveillance and laboratory	$1.78
Subtotal	**$9.27**

WHO South-East Asia Region	2007
Bangladesh	$0.75
India	$5.13
Indonesia	$1.30
Myanmar	$0.27
Nepal	$0.50
Regional surveillance and laboratory	$3.11
Subtotal	**$11.06**

WHO European Region	2007
Albania	$0.009
Armenia	$0.002
Azerbaijan	$0.010
Belarus	$0.007
Bosnia and Herzegovina	$0.021
Bulgaria	$0.007
Georgia	$0.014
Kazakhstan	$0.006
Kyrgystan	$0.009
Republic of Moldova	$0.007
Romania	$0.005
Russian Federation	$0.165
Slovak Republic	$0.005
Slovenia	$0.002
Tajikistan	$0.065
Turkmenistan	$0.042
Turkey	$0.036
Ukraine	$0.023
Uzbekistan	$0.031
Regional surveillance and laboratory	$0.498
Subtotal	**$0.96**

WHO Western Pacific Region	2007
Regional surveillance and laboratory	$1.45

WHO/HQ	2007
WHO/HQ	$14.17

Global	2007
Total	**$69.46**

* *ICST= Inter-country Support Team*

Table 6: Technical Assistance, Country-Level Details 2007 (all figures US$ millions)

WHO African Region	2007
Angola	$3.02
Benin	$0.22
Botswana	$0.20
Burkina Faso	$0.09
Burundi	$0.02
Cameroon	$0.19
Central African Republic	$0.40
Chad	$0.80
Congo	$0.30
Côte d'Ivoire	$0.60
Democratic Republic of Congo	$3.22
Equatorial Guinea	$0.10
Eritrea	$0.05
Ethiopia	$1.57
Gabon	$0.22
Gambia	$0.03
Ghana	$0.30
Guinea	$0.02
Guinea-Bissau	$0.08
Kenya	$0.66
Lesotho	$0.05
Liberia	$0.29
Madagascar	$0.21
Malawi	$0.04
Mali	$0.20
Mauritania	$0.03
Mozambique	$0.13
Namibia	$0.13
Niger	$0.74
Nigeria	$16.59
Rwanda	$0.23
Senegal	$0.25
Sierra Leone	$0.29
South Africa	$0.23
Swaziland	$0.08
Togo	$0.21
Uganda	$0.24
United Republic of Tanzania	$0.21
Zambia	$0.38
Zimbabwe	$0.06
ICST* (Central block)	$1.10
ICST (South/East block)	$1.23
ICST (West block)	$1.48
Regional Office	$1.53
Subtotal	**$38.00**

WHO Eastern Mediterranean Region	2007
Afghanistan	$2.51
Djibouti	$0.02
Egypt	$0.21
Iran	$0.004
Iraq	$0.19
Pakistan	$6.37
Somalia	$2.01
Sudan	$3.75
Yemen	$0.29
Regional Office	$0.79
Subtotal	**$16.14**

WHO South-East Asia Region	2007
Bangladesh	$1.36
India	$9.30
Indonesia	$0.97
Myanmar	$0.39
Nepal	$0.63
Regional Office	$1.58
Subtotal	$14.23

WHO European Region	2007
Regional Office	$1.03
Subtotal	$1.03

WHO Western Pacific Region	2007
Cambodia	$0.10
China	$0.30
Fiji	$0.10
Lao PDR	$0.10
Philippines	$0.10
Papua New Guinea	$0.10
Viet Nam	$0.10
Regional Office	$0.70
Subtotal	**$1.60**

WHO/HQ	$6.50
UNICEF	$10.40

Global	2007
Total	**$87.90**

* *ICST= Inter-country Support Team*