



# Global Polio Eradication Initiative

## Financial resource requirements 2007 - 2009

as of January 2007



World Health  
Organization



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# **Global Polio Eradication Initiative**

## **Financial resource requirements 2007 - 2009**

**as of January 2007**

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## Acronyms and Abbreviations

<b>ACPE</b>	Advisory Committee on Polio Eradication
<b>AFP</b>	Acute Flaccid Paralysis
<b>CDC</b>	US Centers for Disease Control and Prevention
<b>GAVI Alliance</b>	Global Alliance for Vaccines and Immunization
<b>GIVS</b>	Global Immunization Vision and Strategy
<b>IFFIm</b>	International Finance Facility for Immunization
<b>IHR</b>	International Health Regulations
<b>IPDs</b>	Immunization Plus Days
<b>mOPV</b>	monovalent oral polio vaccine
<b>NIDs</b>	National Immunization Days
<b>OPV</b>	oral polio vaccine
<b>SIAs</b>	Supplementary Immunization Activities
<b>SNIDs</b>	Subnational Immunization Days
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	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.

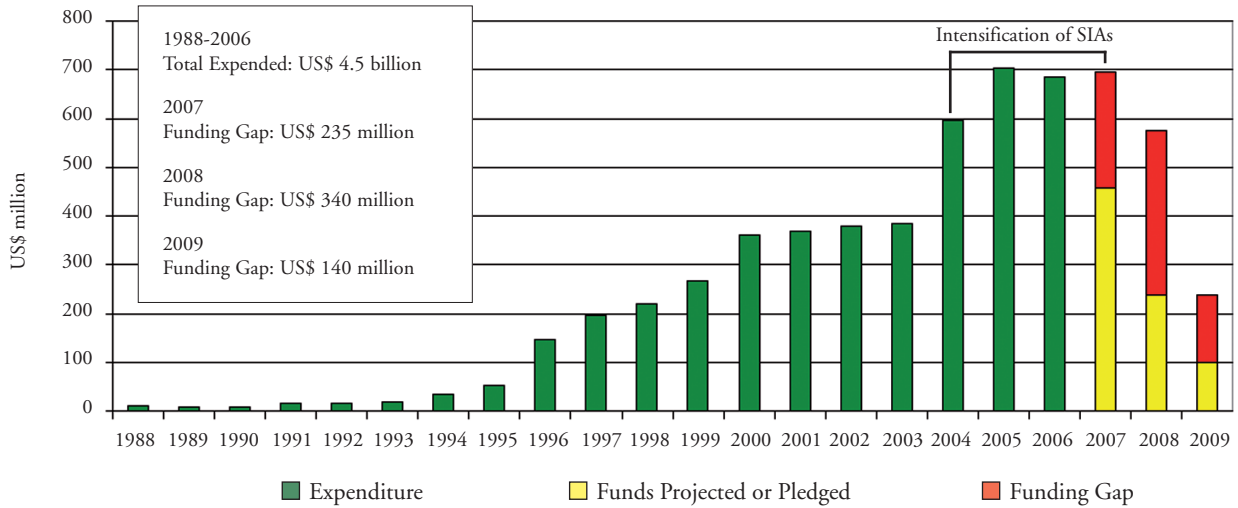
The Financial Resource Requirements 2007-2009 presents the estimated financial resources needed to stop polio transmission globally. The most urgent funding gap, for 2007-2008 intensified immunization and surveillance activities, stands at US\$ 575 million, with US\$ 235 million and US\$ 340 million required for 2007 and 2008 respectively. A further US\$ 140 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 January 2007. Pages 10 to 12 describe the intensified activities for 2007-2008 and the funding required to implement them.

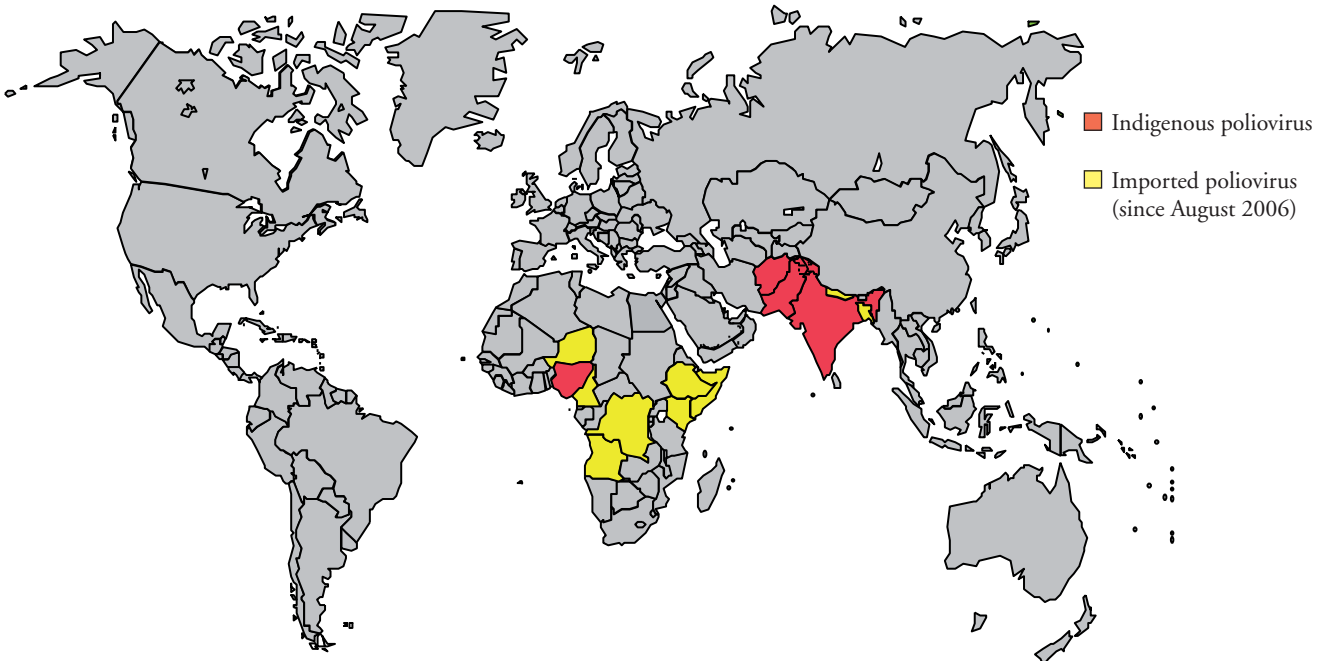
Protecting the world's 19-year investment in polio eradication requires polio-affected countries and donors to:

- 1) by March 2007, fill the immediate US\$ 100 million funding gap, to ensure critical immunization and surveillance activities in the first half of the year 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 January 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)	\$ 12.70	\$ 31.60	\$ 44.30	\$ 82.26
<b>Subtotal</b>	<b>\$ 695.72</b>	<b>\$ 574.77</b>	<b>\$ 1 270.50</b>	<b>\$ 237.04</b>
<b>Contributions</b>	<b>\$ 458.61</b>	<b>\$ 237.73</b>	<b>\$ 696.34</b>	<b>\$ 99.70</b>
<b>Funding gap</b>	<b>\$ 237.11</b>	<b>\$ 337.04</b>	<b>\$ 574.16</b>	<b>\$ 137.34</b>
<b>Funding gap (rounded)</b>	<b>\$ 235.00</b>	<b>\$ 340.00</b>	<b>\$ 575.00</b>	<b>\$ 140.00</b>

\* 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, 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 Eradication 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».

The Executive Committee of the GAVI Alliance Fund at its September 2006 meeting approved US\$ 191.28 million for the creation, procurement and evaluation of a polio vaccine stockpile as an investment case under the International Finance Facility for Immunization (IFFIm). This investment will provide the up-front financing needed to establish a monovalent oral polio vaccine (mOPV) stockpile that GAVI Alliance-eligible countries can access (as needed) after they stop trivalent oral polio vaccine use.

**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 Alliance/IFFIm		Bill & Melinda Gates Foundation
50 - 99	Norway, UNICEF Regular Resources, WHO Regular Budget		
25 - 49	Denmark, France, Sweden		United Nations Foundation
5 - 24	Italy, Australia, Russian Federation, Ireland, Luxembourg		Sanofi Pasteur, IFPMA, UNICEF National Committees, American Red Cross
1 - 4	Austria, Belgium, Saudi Arabia, Spain, New Zealand, Switzerland, Malaysia, Finland, 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.\*

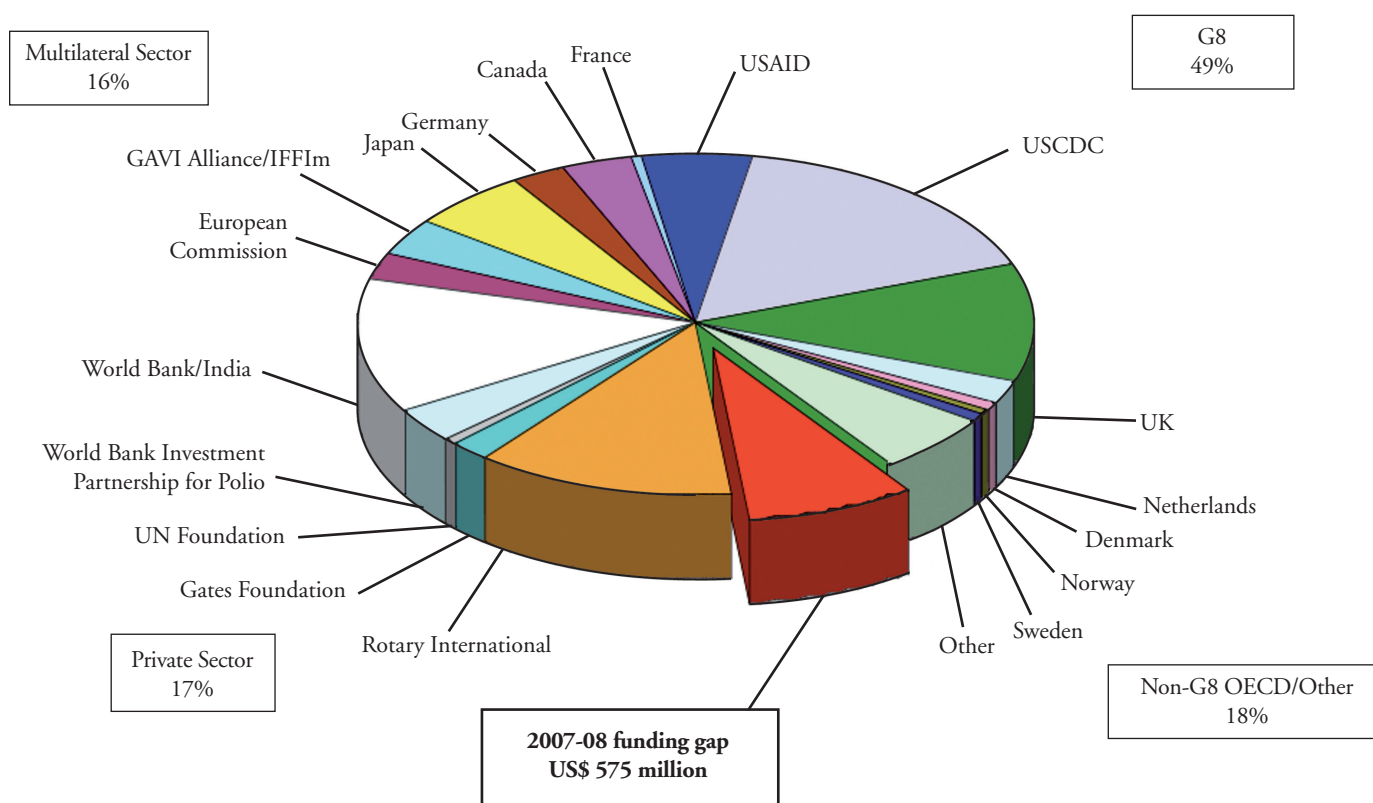
The world now has a tremendous opportunity to ensure that everyone shares equally in the benefits of a polio-free world. The economic justification is compelling. Regardless as to long-term polio immunization decisions, eradication would be cost-saving for low-income developing countries. Globally, the 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 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 Austria, Australia, Azerbaijan, Bangladesh, Belgium, Cyprus, Finland, Hungary, Iceland, Indonesia, Ireland, Italy, 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), Global Alliance for Vaccines and Immunization (GAVI Alliance), 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

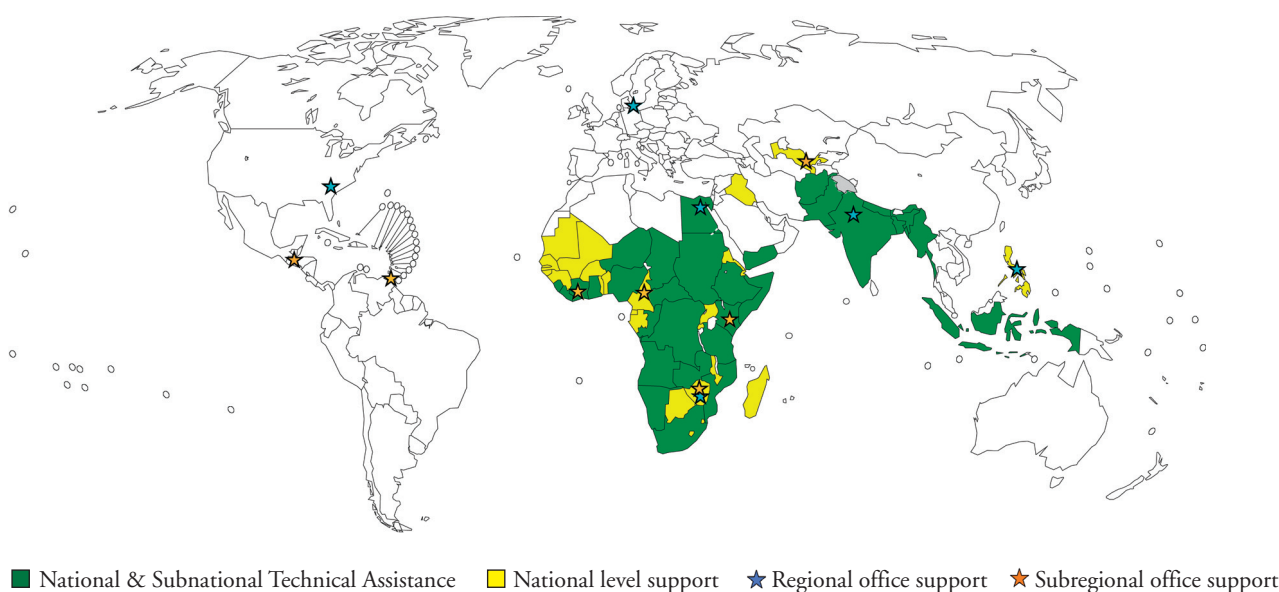
## PRIORITIES AND ACTIVITIES

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 26 countries re-infected since 2003, only nine continued to report polio cases in the second half of 2006. As a result, fewer than 6% of all new polio cases in 2006 were in re-infected countries, compared to nearly 60% 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\$ 695 million, against which there is a funding gap of US\$ 235 million. Of this, US\$ 100 million is needed by March to fully implement activities in the first half of the year. The funding gap for 2008 is pegged at US\$ 340 million and an additional US\$ 140 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 January 2007

Activity plan for 2007-2008

NIDs: National Immunization Days

SNIDs: Subnational Immunization Days

IPDs: Immunization Plus Days

Activity ■ NIDs ■ SNIDs ■ IPDs

Region/ Country	Data	2007												2008											
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
<b>Polio Endemic</b>																									
Afghanistan	% targeted	50	50	100	100	50	50		50		100		50		100	100					50	50			
India	% targeted	100	100		50	50			50	50	50	50			100	100	50	50			50	50			
Nigeria	% targeted	100	40			40				100	50	50			100	100	50	50			50	50			
Pakistan	% targeted	100	35	35	100	35	35		100		100		35		100	100					50	50			
<b>Countries Bordering Polio-endemic Countries</b>																									
Bangladesh	% targeted		100	100					100	100					100	100									
Benin	% targeted	100																							
Cameroon	% targeted	25																							
Chad	% targeted	100	55																						
Nepal	% targeted								50	50					100	100									
Niger	% targeted		100	100					50	50					100	100					50	50			
<b>Horn of Africa Outbreak Countries</b>																									
Ethiopia	% targeted	5	100	100					10	10															
Somalia	% targeted	30	100	100					100	100															
Sudan	% targeted			100	100																				
<b>Southern Africa Outbreak Countries</b>																									
Angola	% targeted			100	100																				
DR Congo	% targeted	50	50																						

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

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

Country	2007				2008				2007 to 2008			
	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
<b>Polio-Endemic</b>												
Afghanistan	\$7.20	\$11.03	\$1.70	\$19.93	\$3.71	\$5.65	\$1.70	\$11.06	\$10.91	\$16.68	\$3.40	\$30.99
India	\$126.41	\$99.04	\$5.13	\$230.58	\$110.00	\$81.43	\$5.39	\$196.82	\$236.41	\$180.47	\$10.52	\$427.40
Nigeria	\$26.00	\$50.84	\$9.64	\$86.48	\$32.46	\$55.13	\$9.64	\$97.23	\$58.46	\$105.97	\$19.28	\$183.71
Pakistan	\$32.95	\$22.25	\$1.68	\$56.88	\$17.71	\$12.12	\$1.50	\$31.33	\$50.66	\$34.37	\$3.18	\$88.21
<b>Countries Bordering Polio-Endemic Countries</b>												
Bangladesh	\$16.85	\$5.70	\$0.75	\$23.30	\$8.68	\$2.93	\$0.75	\$12.36	\$25.52	\$8.63	\$1.50	\$35.65
Benin	\$0.39	\$0.77	\$0.20	\$1.36	\$0.00	\$0.00	\$0.20	\$0.20	\$0.39	\$0.77	\$0.40	\$1.56
Cameroon	\$0.17	\$0.17	\$0.33	\$0.67	\$0.00	\$0.00	\$0.33	\$0.33	\$0.17	\$0.17	\$0.66	\$1.00
Chad	\$0.67	\$2.13	\$0.30	\$3.10	\$0.00	\$0.00	\$0.30	\$0.30	\$0.67	\$2.13	\$0.60	\$3.40
Nepal	\$0.81	\$0.73	\$0.50	\$2.04	\$1.67	\$1.51	\$0.37	\$3.55	\$2.48	\$2.24	\$0.87	\$5.59
Niger	\$1.82	\$4.90	\$0.66	\$7.38	\$1.87	\$5.05	\$0.66	\$7.58	\$3.69	\$9.95	\$1.32	\$14.96
<b>Horn of Africa Outbreak Countries</b>												
Ethiopia	\$6.25	\$16.22	\$3.73	\$26.20	\$0.00	\$0.00	\$3.73	\$3.73	\$6.25	\$16.22	\$7.46	\$29.93
Somalia	\$1.30	\$3.89	\$0.95	\$6.14	\$0.00	\$0.00	\$0.95	\$0.95	\$1.30	\$3.89	\$1.90	\$7.09
Sudan	\$2.86	\$6.26	\$2.41	\$11.53	\$0.00	\$0.00	\$1.75	\$1.75	\$2.86	\$6.26	\$4.16	\$13.28
<b>Southern Africa Outbreak Countries</b>												
Angola	\$2.01	\$3.56	\$1.58	\$7.15	\$0.00	\$0.00	\$1.58	\$1.58	\$2.01	\$3.56	\$3.16	\$8.73
DR Congo	\$2.29	\$3.20	\$2.30	\$7.79	\$0.00	\$0.00	\$2.30	\$2.30	\$2.29	\$3.20	\$4.60	\$10.09

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

<b>WHO African Region</b>	<b>2007</b>	<b>WHO Eastern Mediterranean Region</b>	<b>2007</b>
Algeria	\$0.03	Afghanistan	\$1.70
Angola	\$1.58	Djibouti	\$0.10
Benin	\$0.20	Egypt	\$0.37
Botswana	\$0.10	Iraq	\$0.10
Burkina Faso	\$0.34	Pakistan	\$1.68
Burundi	\$0.18	Somalia	\$0.95
Cameroon	\$0.33	Sudan	\$2.41
Cape Verde	\$0.05	Yemen	\$0.18
Central African Republic	\$0.58	Regional surveillance and laboratory	\$1.78
Chad	\$0.30	<b>Subtotal</b>	<b>\$9.27</b>
Comoros	\$0.05	<b>WHO South-East Asia Region</b>	<b>2007</b>
Congo	\$0.15	Bangladesh	\$0.75
Côte d'Ivoire	\$0.32	India	\$5.13
Democratic Republic of Congo	\$2.30	Indonesia	\$1.30
Equatorial Guinea	\$0.05	Myanmar	\$0.27
Eritrea	\$0.22	Nepal	\$0.50
Ethiopia	\$3.73	Regional surveillance and laboratory	\$3.11
Gabon	\$0.15	<b>Subtotal</b>	<b>\$11.06</b>
Gambia	\$0.10	<b>WHO European Region</b>	<b>2007</b>
Ghana	\$0.48	Albania	\$0.009
Guinea	\$0.15	Armenia	\$0.002
Guinea-Bissau	\$0.07	Azerbaijan	\$0.010
Kenya	\$0.49	Belarus	\$0.007
Lesotho	\$0.06	Bosnia and Herzegovina	\$0.021
Liberia	\$0.30	Bulgaria	\$0.007
Madagascar	\$0.55	Georgia	\$0.014
Malawi	\$0.23	Kazakhstan	\$0.006
Mali	\$0.24	Kyrgyzstan	\$0.009
Mauritania	\$0.15	Republic of Moldova	\$0.007
Mauritius	\$0.02	Romania	\$0.005
Mozambique	\$0.22	Russian Federation	\$0.165
Nambbia	\$0.15	Slovak Republic	\$0.005
Niger	\$0.66	Slovenia	\$0.002
Nigeria	\$9.64	Tajikistan	\$0.065
Rwanda	\$0.28	Turkmenistan	\$0.042
Sao Tome and Principe	\$0.01	Turkey	\$0.036
Senegal	\$0.28	Ukraine	\$0.023
Seychelles	\$0.01	Uzbekistan	\$0.031
Sierra Leone	\$0.30	Regional surveillance and laboratory	\$0.498
South Africa	\$0.10	<b>Subtotal</b>	<b>\$0.96</b>
Swaziland	\$0.10	<b>WHO Western Pacific Region</b>	<b>2007</b>
Togo	\$0.20	Regional surveillance and laboratory	\$1.45
Uganda	\$0.44	<b>WHO/HQ</b>	<b>2007</b>
United Republic of Tanzania	\$0.30	WHO/HQ	\$14.17
Zambia	\$0.45	<b>Global</b>	<b>2007</b>
Zimbabwe	\$0.20	<b>Total</b>	<b>\$69.46</b>
ICST* (Central block)	\$0.64		
ICST (South/East block)	\$1.15		
ICST (Western block)	\$1.00		
Regional surveillance and laboratory	\$2.42		
<b>Subtotal</b>	<b>\$32.00</b>		
<b>WHO Region of the Americas</b>	<b>2007</b>		
Regional surveillance and laboratory	\$0.55		

\* ICST = Inter-country Support Team



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

WHO African Region	2007	WHO Eastern Mediterranean Region	2007
Angola	\$3.02	Afghanistan	\$2.51
Benin	\$0.22	Djibouti	\$0.02
Botswana	\$0.20	Egypt	\$0.21
Burkina Faso	\$0.09	Iran	\$0.004
Burundi	\$0.02	Iraq	\$0.19
Cameroon	\$0.19	Pakistan	\$6.37
Central African Republic	\$0.40	Somalia	\$2.01
Chad	\$0.80	Sudan	\$3.75
Congo	\$0.30	Yemen	\$0.29
Côte d'Ivoire	\$0.60	Regional Office	\$0.79
Democratic Republic of Congo	\$3.22	<b>Subtotal</b>	<b>\$16.14</b>
Equatorial Guinea	\$0.10		
Eritrea	\$0.05	<b>WHO South-East Asia Region</b>	<b>2007</b>
Ethiopia	\$1.57	Bangladesh	\$1.36
Gabon	\$0.22	India	\$9.30
Gambia	\$0.03	Indonesia	\$0.97
Ghana	\$0.30	Myanmar	\$0.39
Guinea	\$0.02	Nepal	\$0.63
Guinea-Bissau	\$0.08	Regional Office	\$1.58
Kenya	\$0.66	<b>Subtotal</b>	<b>\$14.23</b>
Lesotho	\$0.05		
Liberia	\$0.29	<b>WHO European Region</b>	<b>2007</b>
Madagascar	\$0.21	Regional Office	\$1.03
Malawi	\$0.04	<b>Subtotal</b>	<b>\$1.03</b>
Mali	\$0.20		
Mauritania	\$0.03	<b>WHO Western Pacific Region</b>	<b>2007</b>
Mozambique	\$0.13	Cambodia	\$0.10
Namibia	\$0.13	China	\$0.30
Niger	\$0.74	Fiji	\$0.10
Nigeria	\$16.59	Lao PDR	\$0.10
Rwanda	\$0.23	Philippines	\$0.10
Senegal	\$0.25	Papua New Guinea	\$0.10
Sierra Leone	\$0.29	Viet Nam	\$0.10
South Africa	\$0.23	Regional Office	\$0.70
Swaziland	\$0.08	<b>Subtotal</b>	<b>\$1.60</b>
Togo	\$0.21		
Uganda	\$0.24	WHO/HQ	\$6.50
United Republic of Tanzania	\$0.21	UNICEF	\$10.40
Zambia	\$0.38		
Zimbabwe	\$0.06	<b>Global</b>	<b>2007</b>
ICST* (Central block)	\$1.10	<b>Total</b>	<b>\$87.90</b>
ICST (South/East block)	\$1.23		
ICST (West block)	\$1.48		
Regional Office	\$1.53		
<b>Subtotal</b>	<b>\$38.00</b>		

\* ICST= Inter-country Support Team

