# Global Polio Eradication Initiative

## Estimated external financial resource requirements 2004-2008

as of December 2003

WHO

unicef

Partners in the Global Polio Eradication Initiative

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# ERR ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **AFP** | acute flaccid paralysis |
| **AFR** | WHO African Region |
| **AMR** | WHO Region of the Americas |
| **CDC** | Centers for Disease Control and Prevention (USA) |
| **CIDA** | Canadian International Development Agency |
| **cVDPV** | circulating vaccine-derived poliovirus |
| **EMR** | WHO Eastern Mediterranean Region |
| **EUR** | WHO European Region |
| **NGOs** | nongovernmental organizations |
| **NIDs** | national immunization days |
| **OPV** | oral polio vaccine |
| **SEAR** | WHO South-East Asia Region |
| **SIAs** | supplementary immunization activities |
| **SNIDs** | subnational immunization days |
| **UNICEF** | United Nations Children's Fund |
| **WHO** | World Health Organization |
| **WPR** | WHO Western Pacific Region |

# EXECUTIVE SUMMARY

*THE world has a tremendous opportunity to ensure that all people everywhere share equally in the benefits of a polio-free world, possibly into perpetuity. Nearly five million children are walking who would otherwise have been paralysed by polio and 1.25 million childhood deaths have been averted by distributing vitamin A during polio immunization campaigns. The world stands to reap impressive financial benefits from forgone polio treatment and rehabilitation costs. Depending on national immunization decisions on the future use of polio vaccines, these savings could exceed US$ 1 billion annually. Importantly, the substantive and symbolic impact of polio eradication will build momentum for other development and health initiatives.*

There has been extraordinary progress toward the goal of polio eradication. By the end of 2003, indigenous poliomyelitis had been eliminated from all but six countries[1], three of which – Nigeria, India and Pakistan – accounted for 95% of cases in 2003 and 65 % of the Global Polio Eradication Initiative's financial resource requirements for 2004–2005. With levels of polio transmission at their lowest ever in the high season in India, Pakistan, Afghanistan and Egypt, there is an unprecedented opportunity to stop polio transmission forever. The urgency to do so now is underscored by the vulnerability of countries to polio importations: in 2003, poliovirus from Kano, Nigeria was imported into seven neighbouring countries. Emergency response activities to importations cost US$ 20 million in 2003 and necessitated the reintroduction of preventive immunization campaigns in certain countries in 2004–2005.

The *Global Polio Eradication Strategic Plan 2004–2008* outlines activities required to interrupt poliovirus transmission by the end of 2004, to achieve global certification by 2008, to develop products to facilitate the cessation of oral polio vaccine (OPV) and to mainstream the polio eradication infrastructure. The *Estimated external financial resource requirements 2004–2008* presents the estimated resources required to achieve these four major objectives of the Strategic Plan. Budgets were developed through an iterative consultative process by WHO, ministries of health and UNICEF.

Section 1 provides an overview of the Global Polio Eradication Initiative partnership, summarizing financial contributions and pledges made to the Initiative as of December 2003.

Section 2 summarizes the funding requirements for 2004–2005, when the primary focus is on interrupting polio transmission globally. To fully implement planned activities during this period, a US$ 130 million funding gap, against projected costs of US$ 765 million, must urgently be filled. Contingency planning and associated costs are summarized for the two major assumptions that underpin the budgets: that wild poliovirus transmission will be interrupted globally by the end of 2004, or at the latest in the first half of 2005, and that circulating vaccine-derived polioviruses (cVDPVs) will continue to be rare events requiring only intermittent mop-up campaigns.

Section 3 describes the funding required to implement the 2006–2008 programme of work to achieve global certification, develop products for the cessation of OPV use and mainstream the polio eradication infrastructure. It is estimated that US$ 380 million will be required during this period.

Annex 1 provides details of the planned costs in polio-endemic and high-risk countries in 2004–2005.

From 1988 to 2005, more than US$ 3 billion will have been invested by the international community to stop transmission of polio globally. A significant proportion of that investment will have been to strengthen health systems, with hundreds of thousands of health workers trained, and millions of volunteers mobilized to support immunization campaigns and conduct acute flaccid paralysis surveillance. Figure 1 highlights

[1] Countries with ongoing indigenous wild polioviruses in 2003, in order of intensity of transmission were: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt.

the total annual expenditure from 1988 to 2003, together with the requirements, confirmed or projected contributions and funding gap for 2004–2005, as well as the requirements for the 2006–2008 programme of work.

Figure 1: Global Polio Eradication Initiative annual expenditure 1988–2003, pledged/projected contributions and funding gap for 2004–2005, and financial resource requirements for 2006–2008

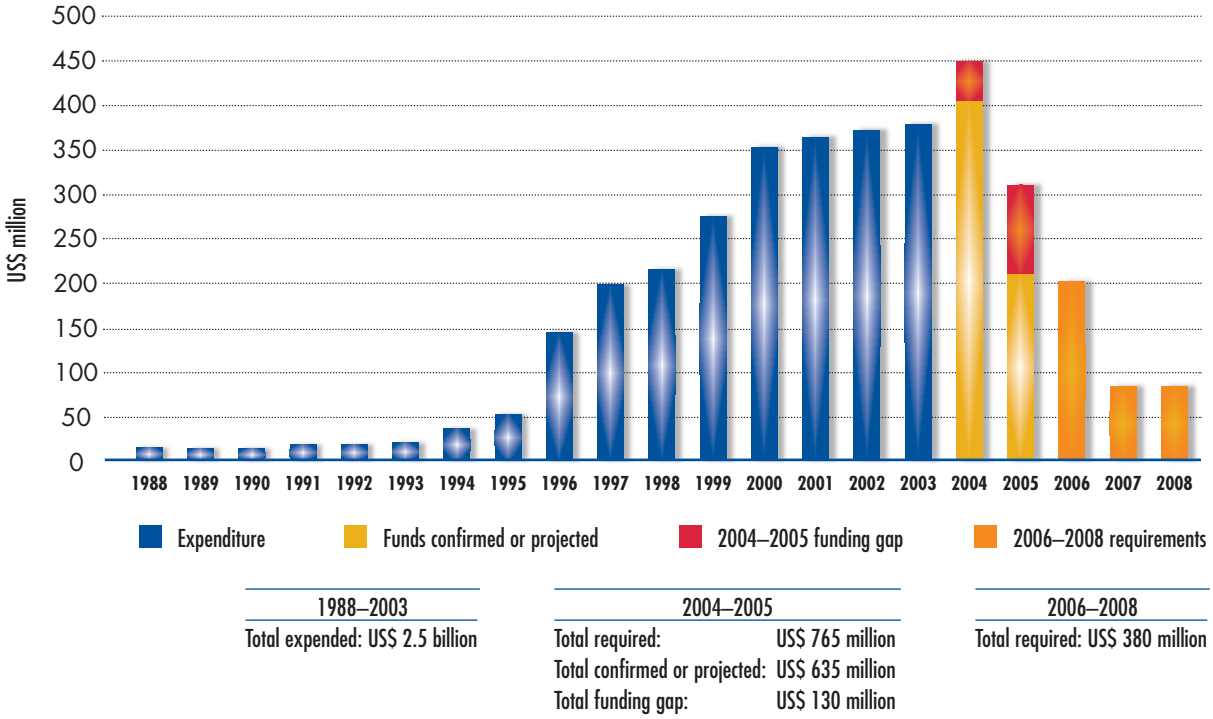



Table 1 summarizes the external financial resource requirements by major activity category for 2004–2008 (e.g. OPV, operations costs for national immunization days (NIDs) and subnational immunization days (SNIDs), emergency response, surveillance and laboratory, technical assistance, containment and certification, mainstreaming and OPV cessation product development).

At this critical point in the Polio Eradication Initiative flexible, multi-year funding is essential to ensure that the funding gap of US$ 130 million can be met, emerging programme needs can be responded to in a timely manner and global surveillance capacity can be strengthened. ❐

Table 1: Summary of global resource requirements by major activity category, 2004–2008 (all figures are in US$ millions)

| | *2004–2005* | | *2006–2008* | | |
|---|---|---|---|---|---|
| ***Activity category*** | 2004 | 2005 | 2006 | 2007 | 2008 |
| Oral polio vaccine | 184.97 | 106.40 | 69.17 | 0 | 0 |
| NIDs/SNIDs operations* | 149.93 | 97.93 | 43.01 | 0 | 0 |
| Emergency response mop-ups | 15.00 | 15.00 | 7.50 | 7.50 | 7.50 |
| Surveillance** | 32.44 | 32.14 | 25.78 | 25.78 | 25.68 |
| Laboratory | 6.43 | 6.43 | 5.00 | 5.00 | 5.00 |
| Technical assistance*** | 53.57 | 49.08 | 37.24 | 36.24 | 36.10 |
| Certification and containment | 0.90 | 0.87 | 7.50 | 7.50 | 7.50 |
| Post-certification | 5.00 | 5.00 | 5.00 | 5.00 | 5.00 |
| Utilization of lessons | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 |
| **Subtotal** | **450.24** | **314.85** | **202.20** | **89.02** | **88.78** |

*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 2004–2005 provided in Table 6.
***Technical assistance includes the cost of human resources deployed through UN agencies. Country-level breakdown for 2004 provided in Table 7.

A global partnership spearheaded by WHO, Rotary International, the US Centers for Disease Control and Prevention (CDC) and UNICEF supports the efforts of national governments to eradicate polio. The polio partnership includes private foundations (e.g. United Nations Foundation, Bill & Melinda Gates Foundation); development banks (e.g. the World Bank); donor governments (e.g. Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, the Russian Federation, the United Kingdom and the United States of America); the European Commission; humanitarian and nongovernmental organizations (NGOs) (e.g. the International Red Cross and Red Crescent societies) and corporate partners (e.g. Aventis Pasteur, De Beers and Wyeth).

Table 2 highlights polio eradication contributions by major donor for 1988–2005. Funding provided through external sources (including both multilateral and bilateral donations) for the period total US$ 3 billion. Between 1988 and 2005, 29 private and public sector donors contributed or pledged more than US$ 1 million each to polio eradication. Of these, 22 contributed US$ 5 million or more. By 2005, Rotary International, the largest private sector donor of the Initiative, will have contributed over US$ 560 million.

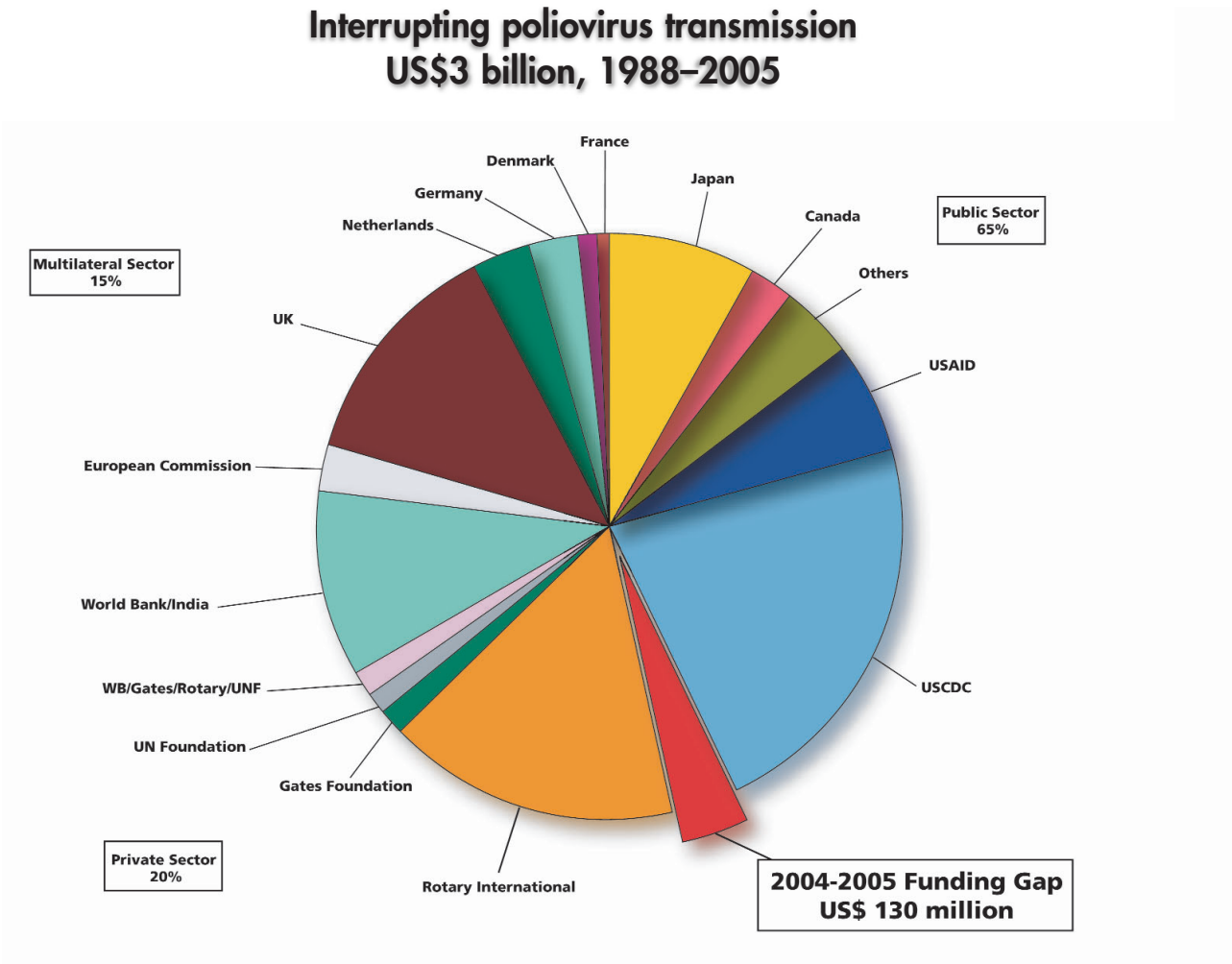
Table 2: Donor profile for received and confirmed contributions, 1988–2005

| Contribution (US$ million) | Public Sector Partners | Development Banks | Private Sector Partners |
|---|---|---|---|
| > 500 | USA | | Rotary International |
| 250 – 500 | Japan, United Kingdom | | |
| 100 – 249 | Netherlands | World Bank | |
| 50 – 99 | Canada, Germany, European Commission | | Bill & Melinda Gates Foundation |
| 25 – 49 | Denmark, UNICEF Regular Resources | | United Nations Foundation |
| 5 – 24 | Australia, Belgium, France, Norway, WHO Regular Budget | Inter-American Development Bank | Aventis Pasteur, IFPMA, UNICEF National Committees |
| 1 – 4 | Ireland, Italy, Luxembourg, Russian Federation, Switzerland | | Advantage Trust (HK), De Beers, Pew Charitable Trust, Wyeth |

The polio eradication effort is also supported by substantial 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 NGOs at national, state/province, district and local community levels to pay for petrol, social mobilization, training and other costs. It has been estimated that between 1988 and 2005, polio-endemic and polio-affected countries will have contributed more than US$ 2.35 billion in volunteer time alone for polio eradication activities.

This document outlines only the external financial resource requirements for 2004–2008. Budgets were developed by WHO, ministries of health and UNICEF, and are based on the costs of implementing polio eradication strategies at the country level and the costs of managing the Initiative through the UN implementing agencies (WHO and UNICEF) at the country, regional and global levels. ❐

Figure 2: External financial contributions and funding gap, 1988–2005



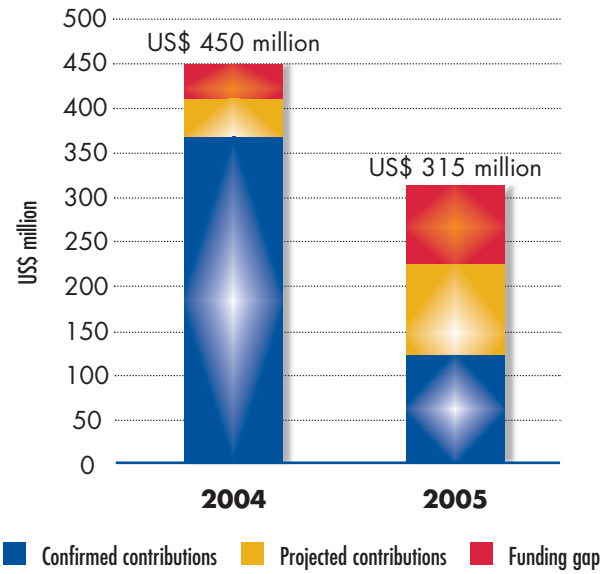

*"Other" includes: the governments of Australia, Belgium, Finland, Ireland, Italy, Luxembourg, Malaysia, New Zealand, Norway, Oman, Republic of Korea, Russian Federation, Switzerland, Saudi Arabia, the United Arab Emirates; Aventis, De Beers, Inter-American Development Bank, International Federation of Red Cross and Red Crescent Societies, Millennium Fund, Oil for Food Programme, OPEC Foundation, Smith Kline Biologicals, UNICEF National Committees, UNICEF Regular Resources, Saudi Arabian Red Crescent Society, United Arab Emirates Red Crescent Society, WHO Regular Budget and Wyeth.*

# SECTION 2: FINANCIAL REQUIREMENTS FOR 2004–2005

THE highest priority for the Global Polio Eradication Initiative and the focus for 2004–2005 is the rapid interruption of polio transmission in the 6 remaining polio-endemic countries.[2] Three countries – Nigeria, India and Pakistan – accounted for 95% of polio cases worldwide in 2003[3] and account for 65% of the financial resources requirements in 2004–2005. SIAs are planned for the six polio-endemic countries, and a limited number of countries which are either recently-endemic or at high risk of polio importations.

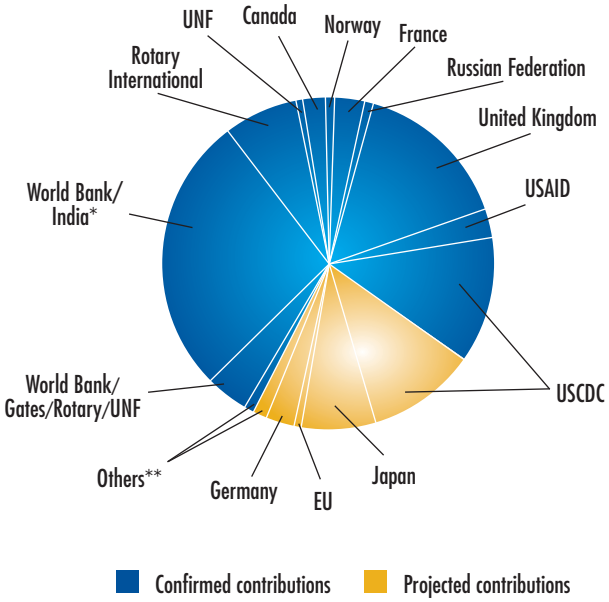
The estimated external financial resource requirements for the period 2004–2005 are US$ 765 million, against which there is a funding gap of US$ 130 million, as at December 2003 (Figure 3). The funding gap, which is updated twice annually, is dependant on programme priorities, new contributions and the degree of flexibility in contributions. Specific details are available from WHO and UNICEF upon request.

Figure 3: Interrupting poliovirus transmission 2004–2005




Total required: US$ 765 million
Total confirmed or projected: US$ 635 million
Total funding gap: US$ 130 million

Confirmed and projected contributions




* "World Bank" includes: supplementary IDA credits to India and buy-down for Pakistan and Nigeria.
** "Others" includes: the governments of Australia, Italy, Netherlands, Portugal, Aventis Pasteur.



[2] Countries with ongoing indigenous wild polioviruses in 2003, in order of intensity of transmission were: Nigeria, India, Pakistan, Niger, Afghanistan and Egypt.
[3] As of December 2003.

Table 3 summarizes planned SIAs – NIDs and SNIDs – for 2004–2006 (SIAs are required for at least 12 months after the last case of poliovirus, to ensure high population immunity through the period required to confirm the interruption of transmission). These activities are the major cost driver for the Global Polio Eradication Initiative (see Annex 1, Table 5 for details of planned costs by country for 2004–2005). SIAs are needed in polio-endemic countries (see Priority A countries in Table 3) to interrupt transmission of wild poliovirus and in high-risk/recently endemic countries (see Priority B countries in Table 3) to ensure high population immunity. Priority B countries are countries without indigenous transmission that have low routine OPV coverage, a high risk of importations from endemic countries and/or high population density/numbers.

Table 3: Baseline NIDs and SNIDs required for polio eradication, 2004–2006, as of December 2003*

| Baseline | | NIDs/SNIDs | | |
|---|---|---|---|---|
| Priority | Country | 2004 | 2005 | 2006 |
| **A** Endemic countries | Afghanistan | 4/1 | 2/0 | |
| | Egypt | 4/1 | 2/0 | |
| | India | 5/1 | 2/2 | 2/0 |
| | Niger | 4/0 | 0/2 | |
| | Nigeria | 4/2 | 4/2 | 2/0 |
| | Pakistan | 5/2 | 2/2 | 2/0 |
| **B** Highest risk countries | | | | |
| Countries at highest risk of importations from Nigeria | Benin | 4/0 | | |
| | Burkina Faso | 4/0 | | |
| | Cameroon | 0/5 | | |
| | CAR | 2/2 | | |
| | Chad | 2/3 | | |
| | Côte d'Ivoire | 2/0 | | |
| | Ghana | 4/0 | | |
| | Togo | 4/0 | | |
| Recently endemic | Angola | 2/0 | 0/2 | |
| | DR Congo | 0/2 | | |
| | Ethiopia | 0/2 | | |
| | Somalia | 2/2 | 0/2 | |
| | Sudan | 0/2 | | |
| Countries at highest risk of importations from India | Bangladesh | 2/0 | | |
| | Nepal | 2/0 | | |

** Note: In addition, large scale mop-up campaigns will be required to stop the final chains of transmission in many of these areas.*

Table 3 presents the minimum SIAs required assuming that polio transmission is interrupted by the end of 2004. Should emergency response mop-up campaigns be required in 1-2 countries in the first 6 months of 2005, there would not be a substantial impact on this plan.

Although endemic transmission of poliovirus has become more geographically restricted within countries, poliovirus importations have continued to spread across borders to paralyse children in polio-free areas. In 2003, for the first time, the number of countries suffering polio cases due to importations was higher than the number of countries with endemic polio transmission. Emergency response activities in these countries cost more than US$ 20 million in 2003 and necessitated the reintroduction of preventive immunization campaigns in certain countries in 2004–2005. An additional US$ 30 million has been budgeted for emergency response in 2004–2005.

Table 4 summarizes the surveillance, laboratory and technical assistance costs by region for 2004–2005. Further details are provided in Annex 1.

Table 4: Surveillance, laboratory and technical assistance by region, 2004–2005 (all figures are in US$ millions)

| | 2004 | 2005 |
|---|---|---|
| ***Surveillance and laboratory*** | | |
| African Region | 18.16 | 18.16 |
| Region of the Americas | 0.60 | 0.60 |
| Eastern Mediterranean Region | 5.53 | 5.23 |
| European Region | 0.64 | 0.64 |
| South-East Asia Region | 8.90 | 8.90 |
| Western Pacific Region | 0.37 | 0.37 |
| WHO/HQ | 4.67 | 4.67 |
| **Subtotal** | **38.87** | **38.57** |

| | 2004 | 2005 |
|---|---|---|
| ***Technical assistance*** | | |
| African Region | 21.09 | 19.01 |
| EMR | 10.45 | 9.66 |
| EUR | 0.82 | 0.82 |
| SEAR | 10.44 | 8.51 |
| WPR | 1.80 | 1.80 |
| UNICEF | 3.00 | 4.80 |
| WHO/HQ | 5.97 | 4.48 |
| **Subtotal** | **53.57** | **49.08** |

## Contingency plans and associated costs

The external financial resource requirements for 2004–2005 are based on two key assumptions (described in the Strategic Plan under "Major Challenges to the Interruption of Poliovirus Transmission"): first, that poliovirus transmission will be interrupted globally by end-2004 (or at the latest in the first half of 2005), and second, that circulating vaccine-derived polioviruses (cVDPVs) will continue to be rare events requiring only intermittent OPV mop-up campaigns to halt transmission, as opposed to preventive campaigns to limit their emergence.

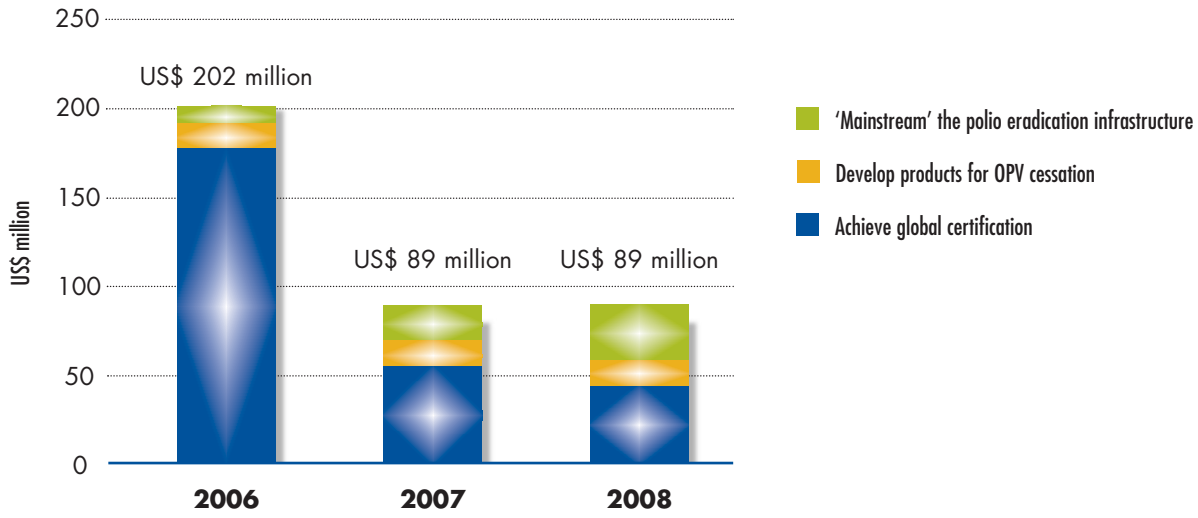
If poliovirus transmission continues into the second half of 2005, additional SIAs will be required. In a worst case scenario of transmission continuing in all six polio endemic countries at the end of 2004, the baseline 2004 plans for SIAs in the endemic and high-risk countries will be repeated in 2005; the baseline SIA plans for 2005 in the endemic and high-risk countries will be repeated in 2006; and Nigeria, India and Pakistan will conduct an additional two rounds of NIDs (100%) during the period 2007–2008. This worst-case scenario would result in total additional costs of US$ 340 million due to the increase in activities: US$ 128 million in 2005 and US$ 212 million for 2006–2008.

If the risk of cVDPVs is found to be significant, the Global Polio Eradication Initiative's technical oversight body could recommend that all low coverage areas (e.g. less than 80% OPV3 coverage) conduct two rounds of NIDs or SNIDs, as appropriate, every three years. This scenario could result in additional costs of up to US$ 149 million for 2006–2008. ❐

# SECTION 3: FINANCIAL REQUIREMENTS FOR 2006–2008

REALIZATION of the full humanitarian and economic benefits of polio eradication requires not only the interruption of poliovirus transmission worldwide, but also completion of the global certification process, the cessation of OPV use and mainstreaming of the polio eradication infrastructure to strengthen health systems and initiatives for the control of other important diseases. The 2006–2008 external financial resource requirements for these areas of work are estimated at US$ 380 million. A breakdown of the costs by major activity category can be found in Table 1.

Figure 4: Certifying the eradication of polio and mainstreaming the polio eradication infrastructure, US$ 380 million, 2006–2008




Achieving global certification requires addressing persistent surveillance gaps in the remaining endemic regions, establishing national plans of action for rapidly responding to wild poliovirus importations and 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).

Cessation of OPV use requires the development of a third edition of the Global Action Plan for the Laboratory Containment of Wild Polioviruses (detailing final containment requirements for all polioviruses), as well as the development, licensing and stockpiling of a range of products such as monovalent OPV and, for countries which might choose to introduce such a vaccine, Sabin IPV.

Mainstreaming the polio eradication infrastructure requires transitioning or integrating the existing infrastructure, human resources and institutional arrangements to other initiatives, as well as incorporating the future containment, surveillance, stockpile and response capacity into existing national and international mechanisms and structures for managing other serious pathogens. ❐

# ANNEX 1: DETAILS OF COUNTRY-LEVEL PLANNED COSTS FOR 2004–2005

Table 5: Details of planned costs in polio-endemic and highest-risk countries, 2004–2005
(all figures are in US$ millions)

| | 2004 | | | |
|---|---|---|---|---|
| Country | NIDs/SNIDs: OPV | NIDs/SNIDs: Operations costs | AFP Surveillance and laboratory | Total costs 2004 |
| **Polio-endemic** | | | | |
| Afghanistan | 3.52 | 5.31 | 0.68 | 9.51 |
| Egypt | 0.00 | 3.05 | 0.13 | 3.18 |
| India | 127.55 | 90.03 | 4.50 | 222.08 |
| Niger | 1.77 | 4.93 | 0.38 | 7.09 |
| Nigeria | 29.82 | 26.76 | 3.60 | 60.18 |
| Pakistan | 30.81 | 12.53 | 0.90 | 44.24 |
| **Highest-risk countries** | | | | |
| *Countries with highest risk of importations from Nigeria* | | | | |
| Benin | 1.05 | 1.48 | 0.11 | 2.63 |
| Burkina Faso | 1.42 | 1.92 | 0.20 | 3.55 |
| Cameroon | 0.97 | 0.60 | 0.15 | 1.72 |
| CAR | 0.20 | 0.22 | 0.14 | 0.56 |
| Chad | 0.82 | 2.37 | 0.22 | 3.41 |
| Côte d'Ivoire | 1.06 | 1.70 | 0.13 | 2.89 |
| Ghana | 2.57 | 3.40 | 0.20 | 6.17 |
| Togo | 0.60 | 0.97 | 0.06 | 1.63 |
| *Recently-endemic* | | | | |
| Angola | 1.26 | 3.99 | 1.96 | 7.21 |
| DR Congo | 0.99 | 3.61 | 2.40 | 6.99 |
| Ethiopia | 1.95 | 4.32 | 1.80 | 8.07 |
| Somalia | 0.55 | 1.85 | 1.02 | 3.42 |
| Sudan | 0.96 | 2.28 | 1.19 | 4.43 |
| *Countries with highest risk of importations from India* | | | | |
| Bangladesh | 0.00 | 0.00 | 0.44 | 0.44 |
| Nepal | 0.00 | 0.00 | 0.56 | 0.56 |

(all figures are in US$ millions)

| Country | 2005 NIDs/SNIDs: OPV | NIDs/SNIDs: Operations costs | AFP Surveillance and laboratory | Total costs 2005 |
|---|---|---|---|---|
| **Polio-endemic** | | | | |
| Afghanistan | 1.76 | 2.53 | 0.75 | 5.04 |
| Egypt | 0.00 | 1.62 | 0.13 | 1.75 |
| India | 72.65 | 55.34 | 4.50 | 132.49 |
| Niger | 0.48 | 1.27 | 0.38 | 2.13 |
| Nigeria | 29.73 | 27.06 | 3.60 | 60.39 |
| Pakistan | 20.44 | 6.19 | 0.85 | 27.48 |
| **Highest-risk countries** | | | | |
| *Countries with highest risk of importations from Nigeria* | | | | |
| Benin | 0.00 | 0.00 | 0.11 | 0.11 |
| Burkina Faso | 0.00 | 0.00 | 0.20 | 0.20 |
| Cameroon | 0.00 | 0.00 | 0.15 | 0.15 |
| CAR | 0.00 | 0.00 | 0.14 | 0.14 |
| Chad | 0.00 | 0.00 | 0.22 | 0.22 |
| Côte d'Ivoire | 0.00 | 0.00 | 0.13 | 0.13 |
| Ghana | 0.00 | 0.00 | 0.20 | 0.20 |
| Togo | 0.00 | 0.00 | 0.06 | 0.06 |
| *Recently-endemic* | | | | |
| Angola | 0.41 | 1.24 | 1.96 | 3.60 |
| DR Congo | 0.00 | 0.00 | 2.40 | 2.40 |
| Ethiopia | 0.00 | 0.00 | 1.80 | 1.80 |
| Somalia | 0.25 | 0.79 | 0.86 | 1.90 |
| Sudan | 0.00 | 0.00 | 1.04 | 1.04 |
| *Countries with highest risk of importations from India* | | | | |
| Bangladesh | 0.00 | 0.00 | 0.44 | 0.44 |
| Nepal | 0.00 | 0.00 | 0.56 | 0.56 |

(all figures are in US$ millions)

| Country | Total 2004–2005 NIDs/SNIDs: OPV | NIDs/SNIDs: Operations costs | AFP Surveillance and laboratory | Total costs 2004–2005 |
|---|---|---|---|---|
| **Polio-endemic** | | | | |
| Afghanistan | 5.28 | 7.84 | 1.43 | 14.55 |
| Egypt | 0.00 | 4.67 | 0.26 | 4.93 |
| India | 200.20 | 145.37 | 9.00 | 354.57 |
| Niger | 2.25 | 6.20 | 0.76 | 9.22 |
| Nigeria | 59.55 | 53.82 | 7.20 | 120.57 |
| Pakistan | 51.25 | 18.73 | 1.75 | 71.73 |
| **Highest-risk countries** | | | | |
| *Countries with highest risk of importations from Nigeria* | | | | |
| Benin | 1.05 | 1.48 | 0.22 | 2.74 |
| Burkina Faso | 1.42 | 1.92 | 0.41 | 3.76 |
| Cameroon | 0.97 | 0.60 | 0.30 | 1.87 |
| CAR | 0.00 | 0.00 | 0.28 | 0.28 |
| Chad | 0.82 | 2.37 | 0.44 | 3.63 |
| Côte d'Ivoire | 1.06 | 1.70 | 0.26 | 3.01 |
| Ghana | 2.57 | 3.40 | 0.40 | 6.37 |
| Togo | 0.60 | 0.97 | 0.12 | 1.69 |
| *Recently-endemic* | | | | |
| Angola | 1.66 | 5.22 | 3.92 | 10.81 |
| DR Congo | 0.99 | 3.61 | 4.80 | 9.39 |
| Ethiopia | 1.95 | 4.32 | 3.60 | 9.87 |
| Somalia | 0.79 | 2.65 | 1.88 | 5.32 |
| Sudan | 0.96 | 2.28 | 2.23 | 5.47 |
| *Countries with highest risk of importations from India* | | | | |
| Bangladesh | 0.00 | 0.00 | 0.89 | 0.89 |
| Nepal | 0.00 | 0.00 | 1.11 | 1.11 |

*Notes: 2004 OPV and operations costs for Bangladesh and Nepal were funded in the fourth quarter of 2003.*
*January–February 2004 OPV and operations costs for India were funded in the fourth quarter of 2003.*
*US$ 5.1 million of Pakistan's 2004 OPV costs and US$ 2 million of Pakistan's 2004 operations costs were funded in the fourth quarter of 2003.*
*US$ 11.6 million of Nigeria's 2004 OPV costs and US$ 10.5 million of Nigeria's 2004 operations costs were funded in the fourth quarter of 2003.*
*AFP surveillance and laboratory costs do not include staff costs.*
*Sudan includes requirements for both north and south Sudan.*
*Mop-up costs are not included in country level figures. These costs are estimated at the global level under "emergency response".*

Table 6: Surveillance and laboratory costs by country and region, 2004–2005 (all figures are in US$ millions)

| | 2004 | 2005 |
|---|---|---|
| ***AFR*** | | |
| Algeria | 0.07 | 0.07 |
| Angola | 1.96 | 1.96 |
| Burkina Faso | 0.20 | 0.20 |
| Benin | 0.11 | 0.11 |
| Botswana | 0.08 | 0.08 |
| Burundi | 0.08 | 0.08 |
| CAR | 0.14 | 0.14 |
| Cameroon | 0.15 | 0.15 |
| Cape Verde | 0.02 | 0.02 |
| Chad | 0.22 | 0.22 |
| Comoros | 0.08 | 0.08 |
| Congo | 0.14 | 0.14 |
| Côte d'Ivoire | 0.13 | 0.13 |
| DRC | 2.40 | 2.40 |
| Equatorial Guinea | 0.01 | 0.01 |
| Eritrea | 0.10 | 0.10 |
| Ethiopia | 1.80 | 1.80 |
| Gabon | 0.10 | 0.10 |
| Gambia | 0.07 | 0.07 |
| Ghana | 0.27 | 0.27 |
| Guinea | 0.09 | 0.09 |
| Guinea Bisssau | 0.06 | 0.06 |
| Kenya | 0.40 | 0.40 |
| Lesotho | 0.04 | 0.04 |
| Liberia | 0.11 | 0.11 |
| Madagascar | 0.32 | 0.32 |
| Malawi | 0.16 | 0.16 |
| Mali | 0.13 | 0.13 |
| Mauritania | 0.18 | 0.18 |
| Mauritius | 0.06 | 0.06 |
| Mozambique | 0.76 | 0.76 |
| Namibia | 0.09 | 0.09 |
| Niger | 0.38 | 0.38 |
| Nigeria | 3.60 | 3.60 |
| Rwanda | 0.09 | 0.09 |
| Sao Tome | 0.01 | 0.01 |
| Senegal | 0.20 | 0.20 |
| Seychelles | 0.01 | 0.01 |
| Sierra Leone | 0.20 | 0.20 |
| South Africa | 0.06 | 0.06 |
| Swaziland | 0.04 | 0.04 |
| Togo | 0.06 | 0.06 |
| Uganda | 0.30 | 0.30 |
| United Republic of Tanzania | 0.20 | 0.20 |
| Zambia | 0.36 | 0.36 |
| Zimbabwe | 0.07 | 0.07 |
| Regional office | 2.05 | 2.05 |
| **Subtotal for AFR** | **18.16** | **18.16** |
| ***AMR*** | | |
| Regional office | **0.60** | **0.60** |

| | 2004 | 2005 |
|---|---|---|
| ***EMR*** | | |
| Afghanistan | 0.68 | 0.75 |
| Djibouti | 0.10 | 0.10 |
| Egypt | 0.13 | 0.13 |
| Iraq | 0.10 | 0.10 |
| Pakistan | 1.09 | 1.03 |
| Somalia | 1.02 | 0.86 |
| Sudan | 1.19 | 1.04 |
| Yemen | 0.18 | 0.18 |
| Regional office | 1.04 | 1.04 |
| **Subtotal for EMR** | **5.53** | **5.23** |
| ***EUR*** | | |
| Armenia | 0.00 | 0.00 |
| Azerbaijan | 0.01 | 0.01 |
| Bosnia | 0.01 | 0.01 |
| Bulgaria | 0.01 | 0.01 |
| Georgia | 0.01 | 0.01 |
| Kazakhstan | 0.06 | 0.06 |
| Kyrgystan | 0.01 | 0.01 |
| Moldova | 0.01 | 0.01 |
| Romania | 0.01 | 0.01 |
| Russian Federation | 0.08 | 0.08 |
| Tadjikistan | 0.08 | 0.08 |
| Turkey | 0.05 | 0.05 |
| Turkmenistan | 0.03 | 0.03 |
| Ukraine | 0.01 | 0.01 |
| Uzbekistan | 0.03 | 0.03 |
| Yugoslavia | 0.01 | 0.01 |
| Regional office | 0.22 | 0.22 |
| **Subtotal for EUR** | **0.64** | **0.64** |
| ***SEAR*** | | |
| Bangladesh | 0.44 | 0.44 |
| Bhutan | 0.02 | 0.02 |
| DPRKorea | 0.15 | 0.15 |
| India | 4.50 | 4.50 |
| Indonesia | 1.12 | 1.12 |
| Maldives | 0.16 | 0.16 |
| Myanmar | 0.08 | 0.08 |
| Nepal | 0.56 | 0.56 |
| Sri Lanka | 0.16 | 0.16 |
| Thailand | 0.14 | 0.14 |
| Regional office | 1.57 | 1.57 |
| **Subtotal for SEAR** | **8.90** | **8.90** |
| ***WPR*** | | |
| Regional office | **0.37** | **0.37** |
| ***WHO/HQ*** | | |
| HQ | **4.67** | **4.67** |
| ***GLOBAL*** | | |
| **Total** | **38.87** | **38.57** |

*Note: "Regional Office" includes laboratory costs for the entire region.*
*All figures are rounded to two decimal places.*

Table 7: Technical assistance by country, 2004 (all figures are in US$ millions)

| | 2004 |
|---|---|
| **AFR** | |
| Angola | 1.94 |
| Benin | 0.16 |
| Botswana | 0.13 |
| Burkina Faso | 0.17 |
| CAR | 0.29 |
| Cameroon | 0.04 |
| Chad | 0.51 |
| Central ICP office | 0.42 |
| Congo | 0.22 |
| Côte d'Ivoire | 0.22 |
| DRC | 2.98 |
| Eastern ICP office | 0.57 |
| Equatorial Guinea | 0.02 |
| Eritrea | 0.06 |
| Ethiopia | 1.02 |
| Gabon | 0.14 |
| Gambia | 0.14 |
| Ghana | 0.24 |
| Guinea | 0.13 |
| Guinea Bissau | 0.11 |
| Kenya | 0.23 |
| Lesotho | 0.02 |
| Liberia | 0.27 |
| Madagascar | 0.12 |
| Malawi | 0.03 |
| Mali | 0.21 |
| Mauritania | 0.13 |
| Mozambique | 0.24 |
| Namibia | 0.16 |
| Niger | 0.49 |
| Nigeria | 5.34 |
| Rwanda | 0.16 |
| Senegal | 0.14 |
| Southern ICP office | 0.46 |
| Sierra Leone | 0.14 |
| South Africa | 0.06 |
| Swaziland | 0.10 |
| Togo | 0.14 |
| Uganda | 0.10 |
| United Republic of Tanzania | 0.21 |
| Western ICP office | 0.45 |
| Zambia | 0.22 |
| Zimbabwe | 0.02 |
| Regional office | 2.14 |
| **Subtotal** | **21.09** |
| **AMR** | |
| **Subtotal** | **0.00** |

| | 2004 |
|---|---|
| **SEAR** | |
| Bangladesh | 1.13 |
| India | 6.90 |
| Indonesia | 0.45 |
| Myanmar | 0.38 |
| Nepal | 0.52 |
| Regional office | 1.06 |
| **Subtotal** | **10.44** |
| **EMR** | |
| Afghanistan | 1.80 |
| Djibouti | 0.00 |
| Egypt | 0.23 |
| Iraq | 0.17 |
| Lebanon | 0.00 |
| Libya | 0.00 |
| Pakistan | 3.63 |
| Somalia | 1.21 |
| Sudan | 2.46 |
| Yemen | 0.12 |
| Regional office | 0.83 |
| **Subtotal** | **10.45** |
| **EUR** | |
| Kazakstan | 0.16 |
| Turkey | 0.00 |
| Regional office | 0.66 |
| **Subtotal** | **0.82** |
| **WPR** | |
| Viet Nam | 0.28 |
| Cambodia | 0.14 |
| China | 0.14 |
| Fiji | 0.14 |
| Laos | 0.14 |
| Philippines | 0.14 |
| Regional office | 0.84 |
| **Subtotal** | **1.80** |
| **WHO/HQ** | **5.97** |
| **UNICEF** | **3.00** |

| | 2004 |
|---|---|
| **Total** | **53.57** |

*Note: Assignment of technical assistance by country in 2005 will be dependant on the epidemiological situation at the end of 2004.*