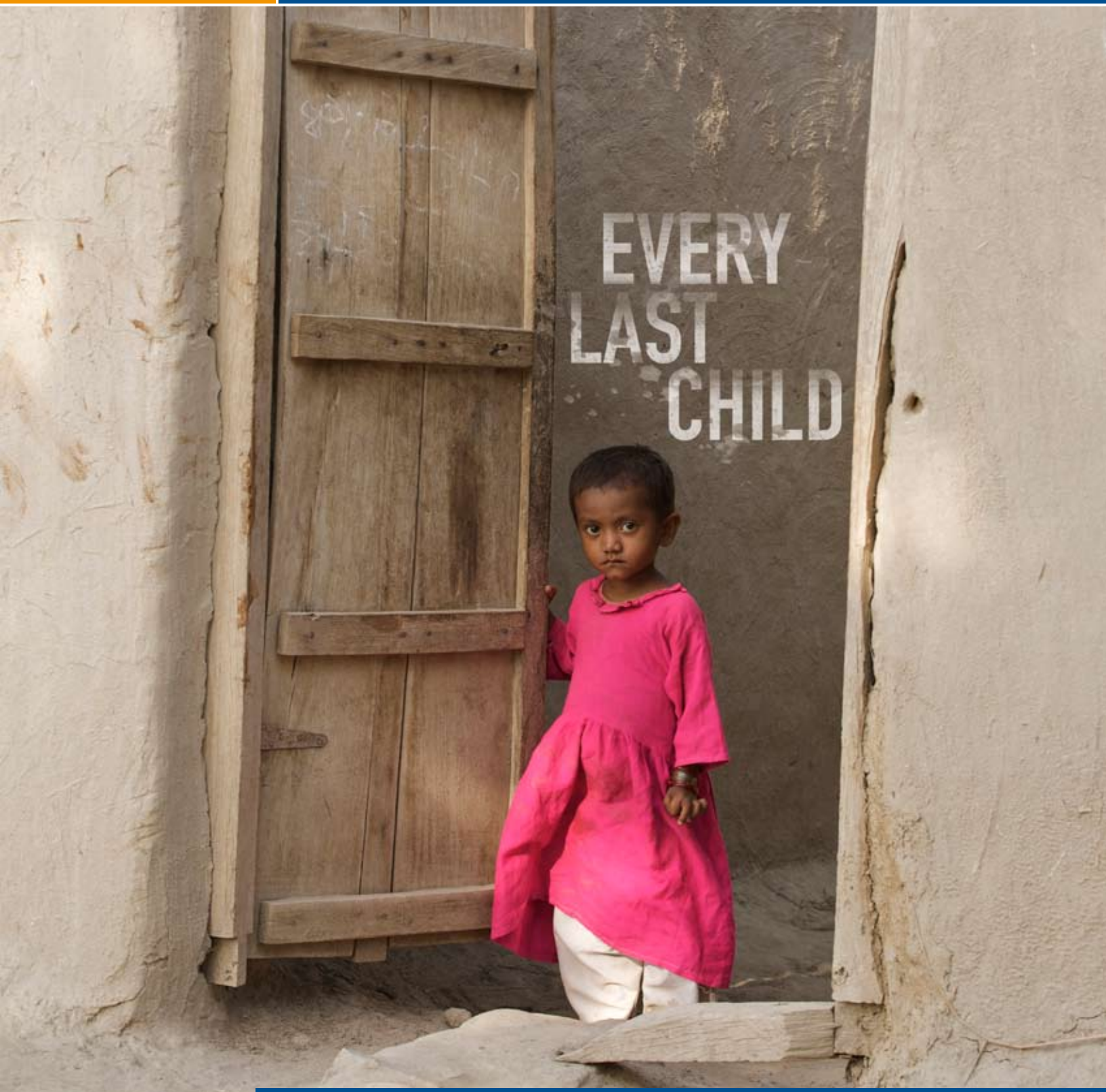
POLIO GLOBAL ERADICATION INITIATIVE

Financial Resource Requirements 2010-2012

As of 30 September 2010



World Health Organization

Partners in the Global Polio Eradication Initiative

unicef

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Acronyms and abbreviations

AFP	Acute flaccid paralysis
bOPV	Bivalent oral polio vaccine
CDC	US Centers for Disease Control and Prevention
GPEI	Global Polio Eradication Initiative
mOPV	Monovalent oral polio vaccine
NIDs	National Immunization Days
OPV	Oral polio vaccine
SIAs	Supplementary Immunization Activities
SNIDs	Sub-national Immunization Days
tOPV	Trivalent oral polio vaccine
UNICEF	United Nations Children's Fund
VAPP	Vaccine-associated paralytic polio
VDPV	Vaccine-derived poliovirus
WHO	World Health Organization
WPV	Wild poliovirus

1. Executive summary

The most recent edition of the Financial Resource Requirements series (FRR) was issued in May, in conjunction with the presentation of the new *Global Polio Eradication Initiative (GPEI) Strategic Plan 2010-2012* to the World Health Assembly. Since then, important steps have been made towards reaching the milestones set out in the *Strategic Plan* and in securing the funding necessary to do so.

The FRR details the funding – required and currently available – to finance the activities required by the *Strategic Plan 2010-2012,* successfully interrupt wild poliovirus transmission globally and prepare for the post-eradication era. Programme priorities and the FRR are updated quarterly, based on the prevailing epidemiological and financial situation.

New contributions/projections of US$ 495 million since May have reduced the 2010-2012 funding gap from US$ 1.3 million to US$ 810 million. The most pressing requirement is for flexible funding for surveillance, technical assistance and outbreak response. The 2010-2012 budget for core costs, planned supplementary immunization activities and emergency response, exclusive of WHO/UNICEF programme support costs, is US$ 2.57 billion, unchanged from May.

Within this budget, the 2010 budget increased by US$ 5 million and the 2011 budget decreased by the same amount, as a result of activities in Burundi, Rwanda and Nepal initially planned for 2011 being brought forward to the 4th quarter of 2010 in response to outbreaks in the Democratic Republic of Congo and Nepal. An increase in surveillance costs for the World Health Organization's European Region due to the outbreak in Central Asia and an increase in Pakistan's budget due to increases in security requirements were offset by UNICEF staff cost savings for social mobilization.

The four major targets of the new *GPEI Strategic Plan 2010-2012* are to stop wild poliovirus transmission:

- by mid-2010 in all countries with new outbreaks in 2009[1];
- by end-2010 in the countries with re-established transmission[2];
- by end-2011 in two of the four endemic countries[3];
- by end-2012 in the remaining two endemic countries.

As of 14 September, the prospects for meeting the first milestone of the *Strategic Plan* are positive: of those 15 countries[4], only two have reported cases within the past six months. While the second milestone is at higher risk, one of the four countries with re-established transmission of an imported virus, Sudan, has not reported cases for over a year; therefore the Horn of Africa may again be polio-free. The four endemic countries account for just 18% of global cases in 2010; most of the dramatic drop is driven by a decline of 99% in Nigeria and 88% in India over the past year.

This progress is fragile, with polio persisting in countries with re-established transmission: in Angola's high-risk Luanda province, 25% of children are still missed during Supplementary Immunization Activities (SIAs); the Democratic Republic of Congo has reported cases after a gap of one year; the devastating floods in Pakistan are complicating polio eradication efforts there, where the polio infrastructure is the foundation of the World Health Organization's health relief work.

The importance of eradicating polio in the endemic regions was drummed home by the importation of polio into the World Health Organization's European Region, with a large outbreak in Tajikistan accounting for 75% of all cases worldwide, spreading to the Russian Federation and the Caucasus. From the outbreak following importation in Nepal, WPV1 has been re-introduced into Bihar, which had not seen a case since November 2009, ending India's longest period without WPV1 in Bihar and Uttar Pradesh simultaneously.

Achieving the milestones will require – in addition to full ownership and engagement of the political leadership at all levels in the remaining polio-infected countries – the continued support of the international development community to rapidly make available the necessary financial resources.

This FRR summarizes budgets and gaps for the period of the *Strategic Plan 2010-2012*. Requirements beyond that time frame will depend on the epidemiological status. In mid-2011, half-way through the period covered in the

1 Validated when at least six months have passed without a polio case genetically linked to an importation event from 2009 (i.e. by Q4 2010)
2 Validated when at least 12 months have passed without a polio case genetically linked to the re-established transmission train (i.e. by Q4 2011)
3 Validated when at least 12 months have passed without a polio case genetically linked to an indigenous virus (i.e. by Q4 2012)
4 Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Guinea, Kenya, Liberia, Mali, Mauritania, Niger, Sierra Leone, Togo and Uganda. Mali and Mauritania had their most recent cases on 1 May and 28 April respectively.

Strategic Plan, the GPEI will publish post-2012 activity plan scenarios, together with ranges of funding that may be required in addition to the US$ 200 - 250 million that will be needed to meet the programme's core costs (e.g. surveillance, technical assistance, emergency response).

Failure to meet the financial requirements of eradication has human consequences, in terms of children paralysed for life by a disease which is entirely vaccine-preventable, as well as the economic consequences of ongoing supplementary immunization in perpetuity in order to maintain the current number of cases. But most compelling are the ethical consequences: failing to protect future generations when the tools are available to do so.

Figure 1: Annual Expenditure, 1988-2009, Financial Resource Requirements, Contributions, Funding Gap, 2010-2012 (All figures in US$ Millions)

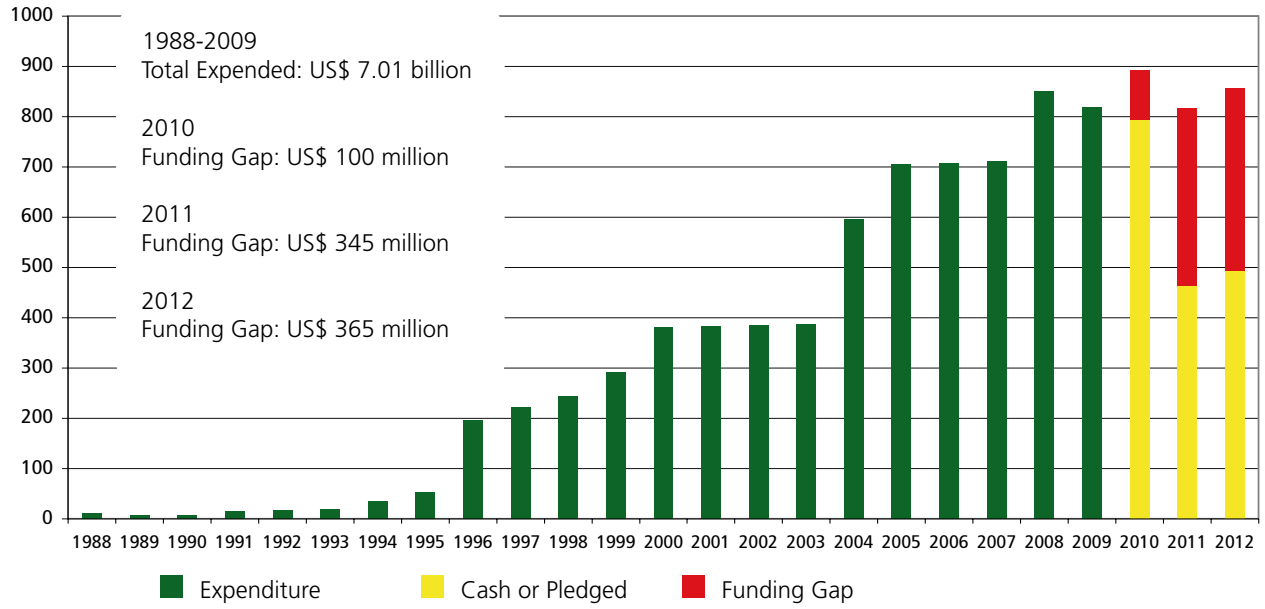
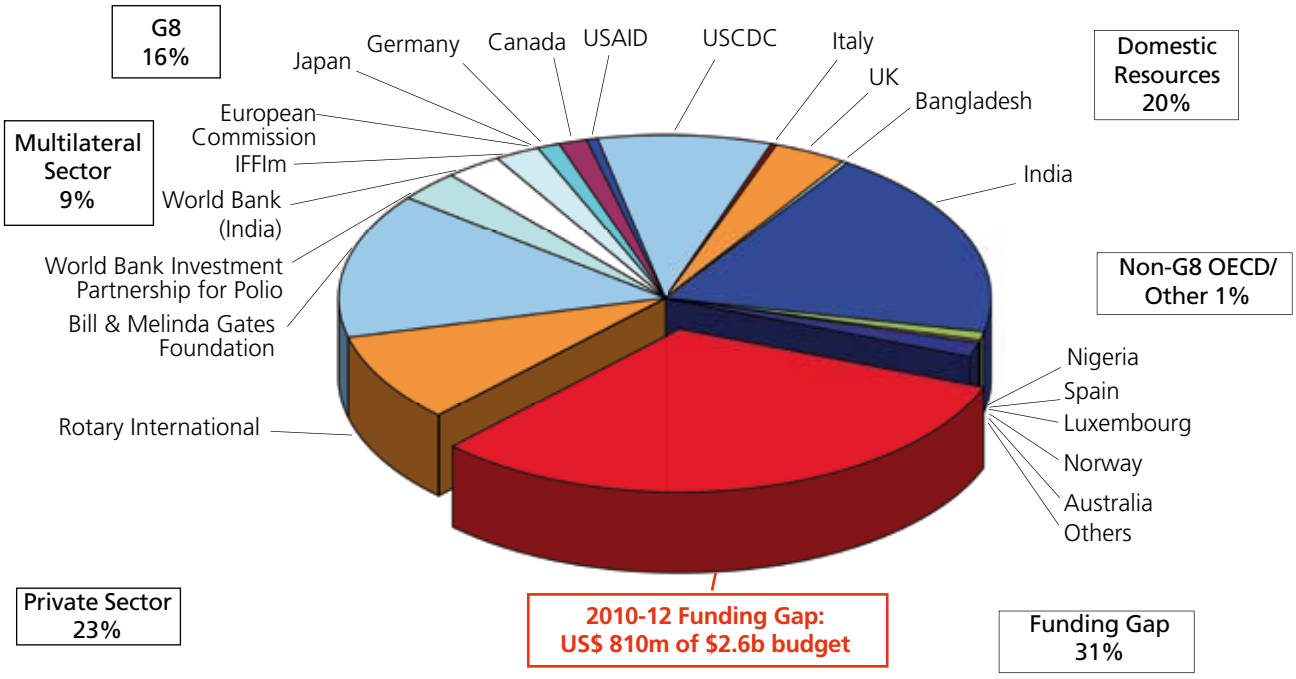


Figure 2: Global Polio Eradication Initiative Financing 2010 to 2012



'Other' includes: the Governments of Angola, Finland, Kazakhstan , Monaco, Portugal, Qatar, Turkey, Central Emergency Response Fund (CERF), Islamic Development Bank, UNICEF Regular and Other Resources.

Table 1: Summary of external resource requirements by major category of activity, 2010-2012 (all figures in US$ millions).

Core Costs	2010	2011	2012	2010-2012
Emergency Response* (OPV and Operations**)	$45.00	$35.00	$25.00	$105.00
Surveillance and Running Costs	$58.57	$63.75	$65.65	$187.97
Laboratory	$8.08	$8.46	$8.69	$25.23
Technical Assistance	$130.92	$138.16	$141.94	$411.02
Social Mobilization Annual Costs	$21.69	$18.83	$15.32	$55.84
Certification and Containment	$2.61	$10.00	$10.00	$22.61
Product Development for OPV Cessation	$18.84	$5.00	$5.00	$28.84
Post-eradication OPV Stockpile	$12.30	-	$36.92	$49.22
Supplementary Immunization Activities				
Oral Polio Vaccine	$294.36	$264.06	$276.38	$834.80
NIDs/SNIDs Operations	$278.17	$240.14	$246.14	$764.45
Social Mobilization for SIAs	$26.43	$28.92	$25.92	$81.26
Subtotal	**$896.96**	**$812.32**	**$856.95**	**$2 566.23**
Contributions	**$796.77**	**$465.38**	**$493.63**	**$1 755.78**
Funding Gap	**$100.19**	**$346.94**	**$363.32**	**$810.45**
Funding Gap (rounded)	**$100.00**	**$345.00**	**$365.00**	**$810.00**

* Emergency Response Includes response activities, and takes into account cost fluctuation for planned activities.
** Operations cots include manpower and incentives, training and meetings, supplies and equipment, transportation and running costs.

2. Financial Resource Requirements 2010-2012

This Financial Resource Requirements document (FRR) outlines the budget to implement the core strategies to stop polio and – in keeping with the country-driven *Strategic Plan 2010-2012* – to institutionalize innovations to improve the quality of intensified SIAs, increase technical assistance to countries with re-established polio transmission, enhance surveillance, systematize the synergies between immunization systems and polio eradication and expand pre-planned vaccination campaigns across the "importation belt" of sub-Saharan Africa. Filling sub-national surveillance gaps, revitalizing surveillance in polio-free regions and implementing new global surveillance strategies are also costed in the 2010-2012 budget.

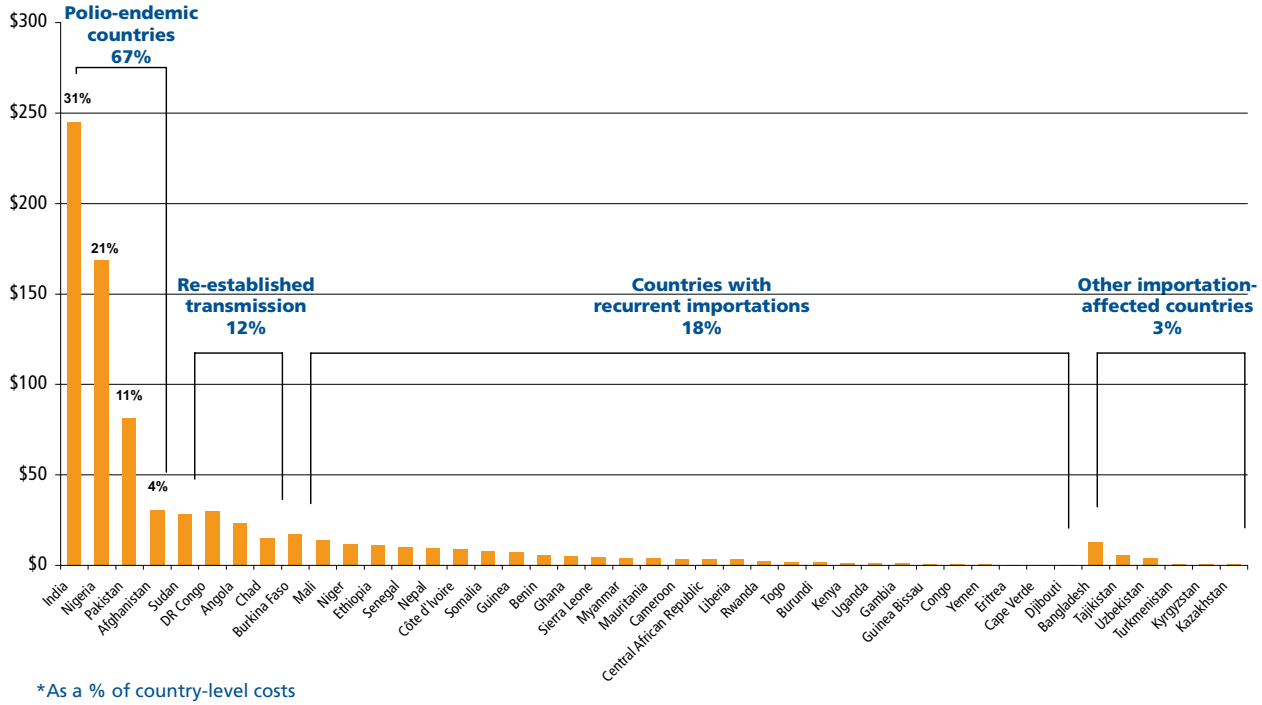
The FRR is updated quarterly based on evolving epidemiology; this is the third issue of the year[5]. Financial requirements detailed here represent country requirements and are exclusive of agency (i.e. WHO and UNICEF) overhead costs.

If funding is insufficient to fund core costs and all supplementary activities, priority will be placed on covering core costs and implementing activities in areas of ongoing poliovirus transmission, followed by activities to reduce the risk of international spread. See Annex A for a prioritized calendar of SIAs.

Endemic countries account for 67% of the country budgets; countries with re-established transmission for 12%; re-infected countries and areas at high risk for 18%.

Recent studies on the cost-effectiveness of polio eradication demonstrate that where eradication is feasible, "control" is never the most cost-effective option. In contrast to the US$ 2.6 billion budget presented here, an estimated US$ 10 billion would be needed over a 20-year period to maintain polio cases at current levels, were the goal of eradication to be abandoned[6]. Just as high-cost control of polio transmission is not sustainable, low-cost control is not effective, since depending on routine immunization alone would lead to 200,000 to 250,000 cases per year. Neither scenario is optimal when eradication is feasible.[7]

Figure 3: Comparison of Budgets for Countries Conducting SIAs in 2010*



*As a % of country-level costs

5 While the FRR provides overall budget estimates, detailed budgets are available upon request.
6 Thompson KM, Tebbens RJ. Eradication versus control for poliomyelitis: an economic analysis. Lancet. 2007; 369(9570): 1363-71.
7 Barrett S, Economics of eradication vs control of infectious diseases, *Bulletin of the WHO,* Volume 82, Number 9, September 2004, 639-718.

3. Roles and Responsibilities of Spearheading Partners

The spearheading partners of the GPEI are the World Health Organization (WHO, Rotary International, the United States Centers for Disease Control and Prevention (CDC) and the United Nations Children's Fund (UNICEF). Rotary International is the leading private-sector donor to polio eradication, advocates with governments and communities and provides field-level support in SIA implementation and social mobilization. CDC deploys a wide range of public health assistance in the form of staff and consultants, provides specialized laboratory and diagnostic expertise and contributes funding.

The budgets that underpin the FRR are prepared by WHO, UNICEF and national governments.

The funds to finance polio eradication activities flow from multiple channels, primarily through these stakeholders. The national governments manage polio eradication activities; UNICEF usually takes the lead in procuring vaccine and conducting social mobilization activities and WHO provides technical assistance and supports surveillance. Both UN agencies support the government in the preparation and implementation of Supplementary Immunization Activities (SIAs).

4. Definition of the GPEI Activities and Budget Estimates

A robust system of estimating costs drives the development of the global budget estimates from the micro-level up. A schedule for SIAs is drawn up based on the guidance of national technical advisory groups (TAGs), Ministries of Health and the country offices of WHO and UNICEF. In 2009, for example, 2.2 billion doses of OPV were administered to more than 361 million children during 273 polio vaccination campaigns.[8]

The recommended schedule of SIAs is used by national governments, working with WHO and UNICEF, to develop budget estimates. These are based on plans drawn up for SIAs at the local level and take into consideration local costs for all elements of an activity – trainings, community meetings, posters, announcements, vaccinator payments, vehicles, fuel, supplies, etc.

4.1. Cost Drivers of the GPEI Budget

The key cost drivers of the GPEI budget are oral polio vaccine (OPV) and SIA operations, followed by surveillance and technical assistance (See Table 1, Page 5).[9]

4.1.1. ORAL POLIO VACCINE

UNICEF is the agency that procures vaccine for the GPEI, and works to ensure OPV supply security (with multiple suppliers), at a price that is both affordable to governments and donors and reasonably covers the minimum needs of manufacturers.

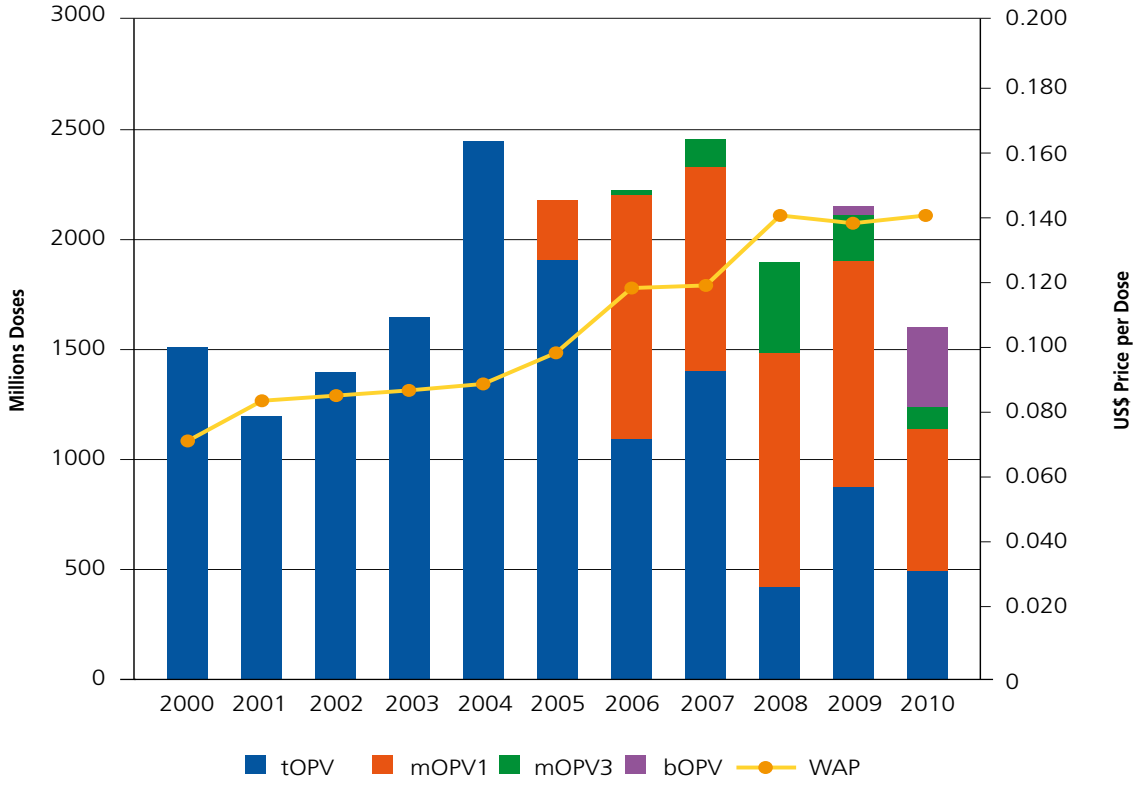
8 OPV was given during 102 National Immunization Days, 122 Sub-national Immunization Days, 28 mop-up campaigns and 21 Child Health Days). Children may have received more than one dose of OPV.

9 For 2010, for example, OPV accounts for 35% of the budget, operations for 40%, technical assistance for 14% and surveillance for 8%, the remainder being dedicated to laboratories, research activities, etc.

For activities in areas with active poliovirus transmission, more than 1.5 billion doses of OPV will be required in 2010. The supply landscape has become more complex since 2005 with the introduction of two types of monovalent OPV (types 1 and 3) and, in 2010, bivalent OPV. This has contributed to a rise in the weighted average price of OPV from US$ 0.08 per dose to approximately US$ 0.14 per dose since 2000. The flexibility of manufacturers, to adjust production based on the OPV formulation required, comes at a cost. Currency fluctuations, the demand for high titres and the finite lifespan of OPV – for which demand will drop after the eradication of polio – also contribute to this price increase.

Despite these factors, the weighted average price of each OPV dose in 2009 (US$ 0.137) and 2010 (US$ 0.141) is lower than that in 2008 (US$ 0.142).

Figure 4: OPV Supply & Weighted Average Price, 2000 to 2010



4.1.2. OPERATIONS COSTS

SIAs are vast operations to deliver vaccine to every household: micro-plans have to be drawn up or updated for every dwelling in the area to be covered, whether a single district or an entire country. Vaccine has to be delivered to distribution centres throughout the target area. Vaccinators have to be trained to vaccinate children and mark fingers and houses, to document their work, to report their activities, to communicate with families appropriately, and so on. Vaccinators have to visit every household; supervisors and monitors have to scour every street for unvaccinated children.

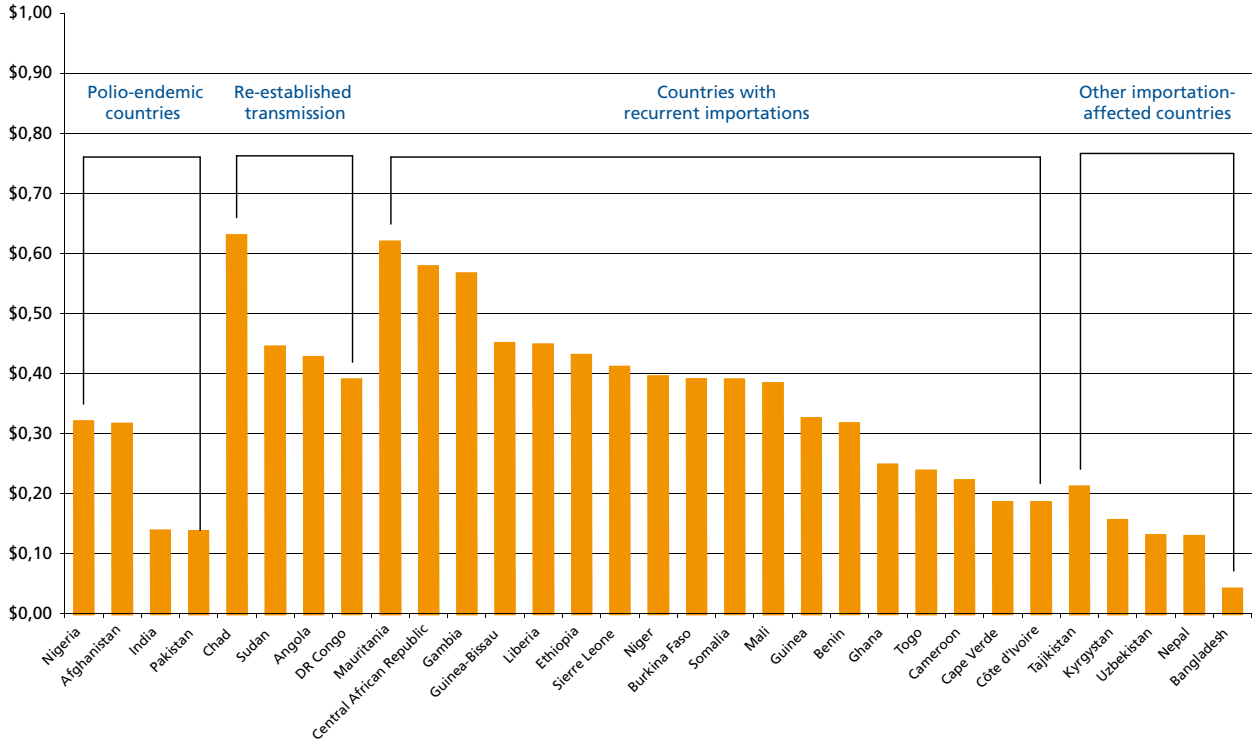
Major factors affecting operations costs are the relative strength of the local infrastructure – whether it be roads, telecommunications or any of a host of facilities – and the local health system, the local economy, availability of semi-skilled workers, security conditions and population density. In 2009, 1.4 million paid vaccinators worked in SIAs; vaccinator per diems – to cover basic needs such as food and transport – constitute a large portion of operations costs.[10]

10 Based on local rates for semi-skilled labour and government remuneration for similar tasks.

Additionally, communications support for immunization outreach must overcome limitations imposed through geography, literacy and local capacity to engage communities both through health workers and more traditional networks, and especially to target high risk groups who are typically underserved and have less access to health services.

Together, these factors contribute to the differences in operations costs, both between and within countries. In India, where operations costs are among the lowest in the endemic countries (cost per child US$ 0.14 in 2010), high population density allows a single health or communication initiative to reach large swathes of the community. Chad, on the other hand, is one of the most expensive places in the world to conduct polio eradication operations (cost per child US$ 0.63 in 2010), as interventions must reach a sparse and widely scattered population in a country with a very weak health infrastructure. While there is variability from one country to another as well as within countries, the average SIA operational costs per round per child has varied little from 2000 to the present (US$ 0.24 per child to $ 0.20 per child, inflation-adjusted).

Figure 5: Operations Cost Per Child, 2010* (All figures in US$)



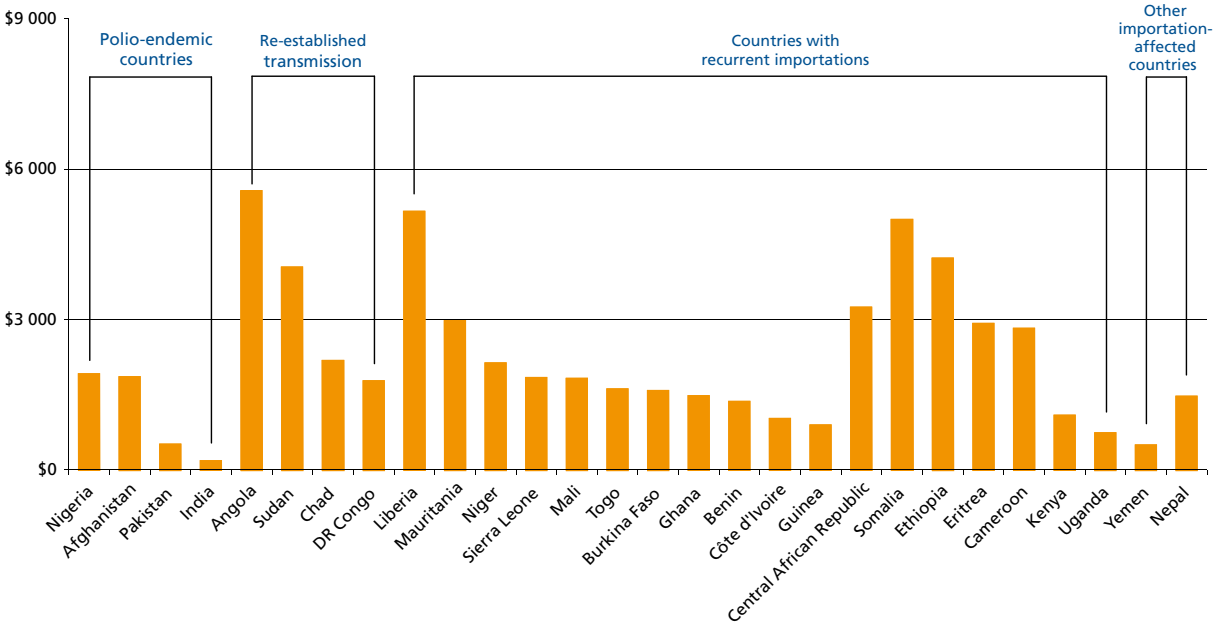
* Inflation-adjusted and excluding vaccine

4.1.3. SURVEILLANCE

Surveillance budgets cover the detection and reporting of acute flaccid paralysis (AFP) cases, through both an extensive informant network of people who first report cases of AFP and active searches in health facilities for such cases. Subsequent case investigation is followed by collection of two stool samples, transportation to the appropriate laboratory, testing and genetic sequencing, the range of activities related to the management of the information and data generated. The Global Polio Laboratory Network comprises 145 facilities, which in 2009 tested over 150,000 stool samples (from nearly 90,000 cases of AFP and other sources).

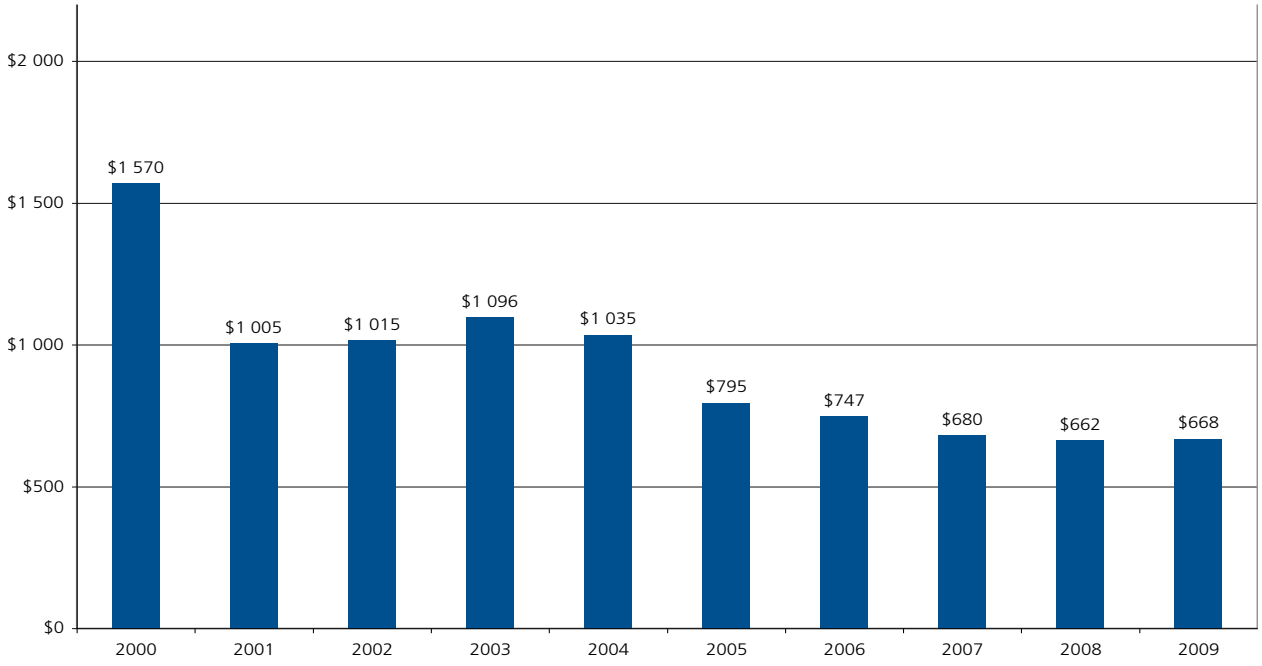
Some of the other activities included under surveillance budget lines are the training of personnel to carry out each of the steps outlined above, as well as regular reviews of the surveillance systems and the purchase and maintenance of equipment, from photocopiers to vehicles. In locations where there are security risks for polio staff, items such as armoured vehicles and appropriate communication equipment may be included in the surveillance budgets. The average cost per AFP case reported dropped from a high of more than US$ 1,500 in the year 2000, when there was heavy investment in establishing the infrastructure for AFP surveillance to approximately US$ 700 per case since 2006. The range among countries in cost per AFP case investigated is based on factors similar to those which affect differences in SIA costs.

Figure 6: Surveillance cost per AFP cases analysis for 2009 (All figures in US$)



To be updated for 2010 at the end of the year.

Figure 7: Average Cost Per AFP Case Reported in Endemic Regions (All figures in US$)*



*AFR, EMR, SEAR Adjusted for inflation (2009 US$)

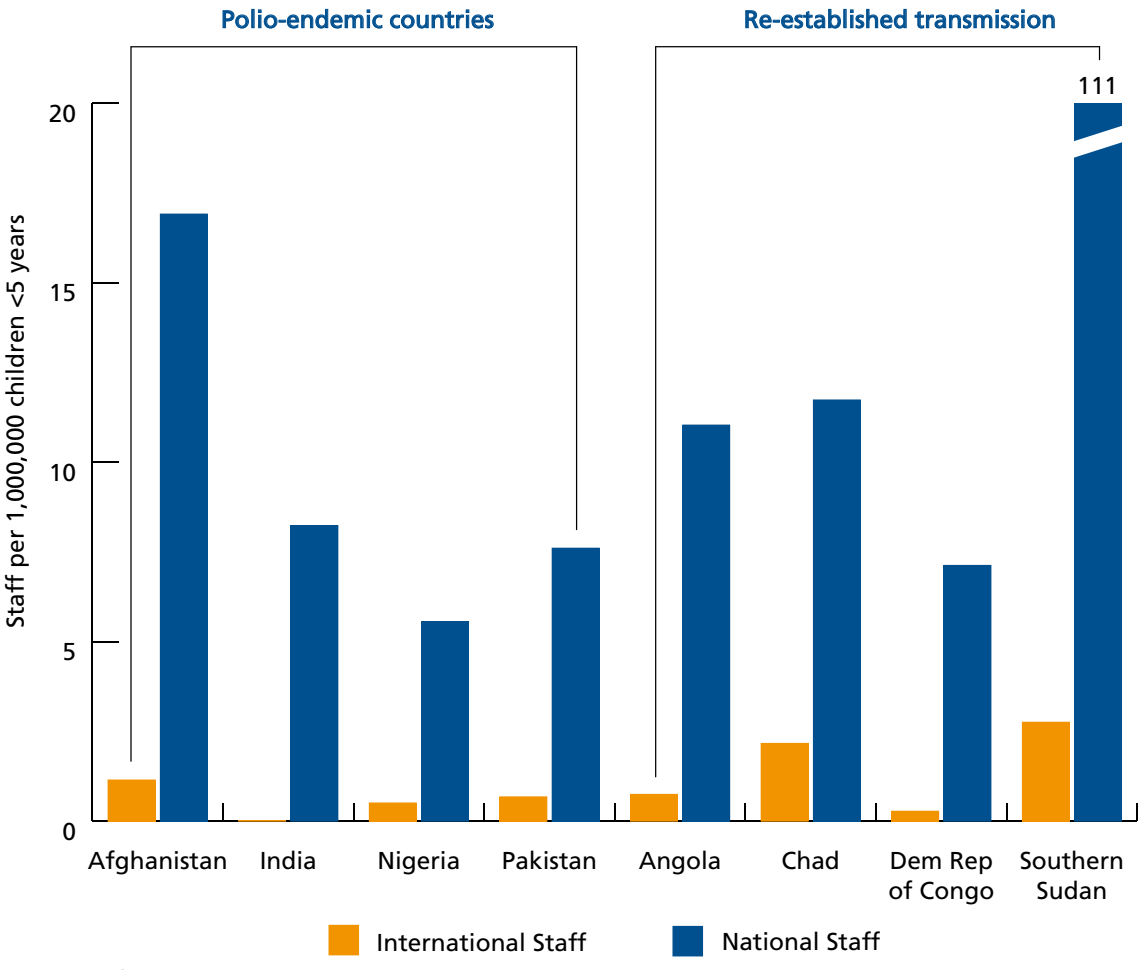
4.1.4. TECHNICAL ASSISTANCE

GPEI-funded technical assistance (staff and consultants) is deployed to fill capacity gaps when relevant skills are not available within a national health system, to build capacity and to facilitate international information exchange. The priorities for technical assistance are therefore driven by the relative strength of health systems in polio-affected countries as well as how critical the country is to global polio eradication. Matched against the number of children under the age of five years (i.e. the "target population"), technical assistance in countries with re-established transmission is on a par with – or even above – that in endemic countries (Figure 9).

In the 2010 budget, technical assistance is heavily weighted towards the polio-endemic countries (44% of cost), with the next concentration of funds in countries with re-established transmission (17% of cost) and re-infected countries and high-risk areas (12% of cost).[11]

This assistance provides the human resources necessary for immunization campaign planning, including communication and social mobilization strategy development and implementation, micro-planning, logistics, forecasting and supply management. Funding ensures resources are in place for overall communication capacity development, management skills in strategic planning, finance, human resources and social mobilization in a programme that manages some 20 million workers and volunteers, and communication efforts that help reach over 360 million children each year multiple times with OPV. Finally, technical assistance maintains the surveillance network, which provides reporting on AFP incidence from every district in the world on a weekly basis.

Figure 8:Technical Assistance by target population*



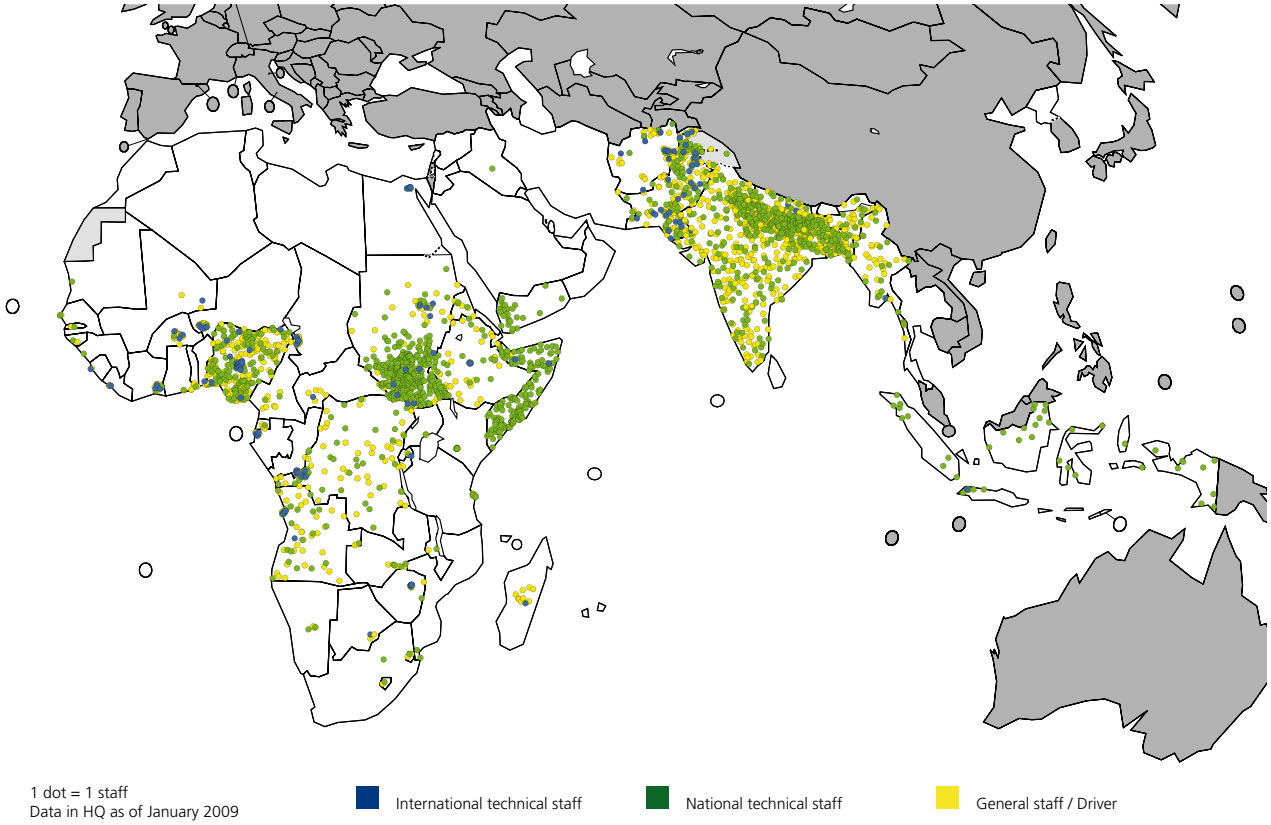
* as of March 2010

11 The remaining 26% is allocated to polio-free regions, regional offices and headquarters.

Table 2: WHO Technical Assistance by category of polio-infected country, 2010 (All figures in US$)

Category	Total Cost	% of Cost	International	National
Endemic	$51 170 000	44%	58	1 704
Countries with re-established transmission	$19 911 000	17%	26	583
Countries with recurrent importations	$11 134 000	10%	7	77
Other Importation-Affected Countries	$2 680 000	2%	37	795
Outbreak response	$0	0%		
Polio-Free	$7 760 000	7%	7	0
Regional Offices	$4 645 000	4%	23	23
HQ	$17 720 250	15%	56	0
GRAND TOTAL	**$115 030 250**		**214**	**3 182**

Figure 9: Geographic distribution of WHO technical assistance for polio eradication



Technical assistance on this scale is unique in public health and essential to finishing polio eradication. Polio eradication staff now constitute the single largest resource of technical assistance for immunization in low-income countries. For example, in 2009, of the 998 immunization staff in the WHO African Region, 940 (94%) were funded by the polio programme; at national or sub-national level, this proportion sometimes rose to 100%. In each component of a strong immunization system – logistics, service delivery, monitoring and supervision, surveillance and community participation – polio eradication staff have a wealth of experience.

Working to contribute to the objectives of the Global Immunization Vision and Strategy[12], GPEI staff will designate a minimum of 25% of their time to specific 'high impact' tasks and activities to strengthen immunization systems. Capacity-building workshops on the intersections between immunization systems and polio eradication are also part of the *Strategic Plan 2010-2012.* Priority will be given to areas at highest risk of outbreaks following importations, especially those in sub-Saharan Africa.

5. Polio Research

In the GPEI *Strategic Plan 2010-2012,* the role of research continues to expand. The research agenda helps identify ways to reach more children and to enhance both humoral and mucosal immunity in targeted populations. *The Independent Evaluation of Major Barriers to Interrupting Poliovirus Transmission* endorsed the programmatic decision to intensify operational research. Scientific and operational research are guided by the Polio Research Committee, composed of experts in epidemiology, public health communications, virology and immunology.

Going forward, the research agenda encompasses expanded work in operational as well as scientific research. The former includes intervention studies to evaluate innovative approaches to further increase vaccination coverage and population immunity; to develop and evaluate tools to improve SIA and AFP surveillance management; and to evaluate vaccinator performance and assess ways to improve performance.

Among the studies being carried out or planned are those to improve understanding of both the evolving epidemiology of wild poliovirus and potential interventions to boost mucosal or "gut" immunity to address low vaccine efficacy in northern India, where the "threshold" to protect children is higher than anywhere else on earth.[13] Research will also focus on ways to lower that threshold, through add-ons such as zinc, as well as water and sanitation measures. Studies will be implemented to investigate the risk factors for decreased mucosal immunity; to evaluate possible interventions to boost mucosal immunity; and if possible, to assess potential surrogate measures of mucosal immunity against poliovirus.

12 *Global Immunization Vision and Strategy 2006-2015*. World Health Organization / UNICEF, 2005.
13 Population immunity levels must reach at least 95% to interrupt transmission of poliovirus in northern India, whereas levels of 75-80% have sufficed in Africa.

6. Review of the GPEI Budgets and Allocation of Funds

The GPEI budget development is paired with a regular, interactive process of reviewing and reprioritizing activities in light of evolving epidemiology and available resources.

Twice a year, the Global Polio Management Team (GPMT) formally reviews the epidemiology of poliovirus globally and the SIA priorities, guided by the advice of national and regional technical advisory groups as well as the Strategic Advisory Group of Experts on Immunization (SAGE). The newly-formed Independent Monitoring Board (IMB) will evaluate on a quarterly basis the progress towards each of the major milestones of the Strategic Plan 2010-2012, determine the impact of any 'mid-course corrections' that are deemed necessary, and advise on additional measures appropriate.

An in-depth weekly epidemiological review is complemented by weekly and bi-weekly teleconference check-ins between WHO and UNICEF headquarters and regional offices which provide opportunities to adjust allocations. The FRR is therefore updated regularly to adapt to the changing epidemiology and priorities.

After a budget review process at the regional office and headquarters levels, funds for country SIAs are released from WHO and UNICEF headquarters to regions and then countries. For staff and surveillance, funds are disbursed on a quarterly or semi-annual basis, depending on the GPEI cash flow. For most countries, funds for OPV are released by UNICEF six to eight weeks before SIAs.

7. Post-eradication era

After interruption of wild poliovirus transmission and certification of that achievement, the budget of the GPEI will be driven primarily by the costs of maintaining AFP surveillance and laboratory capacity and outbreak response capacity for circulating vaccine-derived poliovirus. This capacity will be required until and during the cessation of routine OPV use globally and the subsequent verification of the elimination of vaccine-associated paralytic polio (VAPP) and vaccine-derived polioviruses (VDPV).

Consequently, annual financial resource requirements of the GPEI in the post-eradication period will be significantly lower than the (current) costs associated with the intensified polio eradication effort. The annual costs of these activities during the VAPP/VDPV Elimination Phase are estimated to be US$ 200-250 million. The major uncertainty pertaining to GPEI costs during this period is the extent to which low- and low/middle-income countries will use IPV, how they will use it (e.g. fractional doses, reduced dose schedules) and how IPV will be produced at that time.

The costs of the GPEI will stop once VAPP/VDPV elimination is verified. All long-term functions will by that point have been incorporated into existing mechanisms for managing the residual risks associated with eradicated and/or dangerous pathogens (e.g. smallpox) and routine immunization programmes.

8. Donors

Since the 1988 World Health Assembly (WHA) resolution to eradicate polio, funding commitments have totalled US$ 8.8 billion. In addition to contributions by national governments to their own polio eradication efforts, 45 public and private donors have each given more than US$ 1 million, with 19 of these having given US$ 25 million or more.

Donors to the GPEI include a wide range of donor governments, private foundations (e.g. Rotary International, BMGF, UN Foundation), multilateral organizations, development banks, NGOs and corporate partners. Several of these partners have contributed in excess of US$250 million to the global eradication effort, including the United States of America, Rotary International, India, the United Kingdom, the World Bank, BMGF, Germany, Japan and Canada.

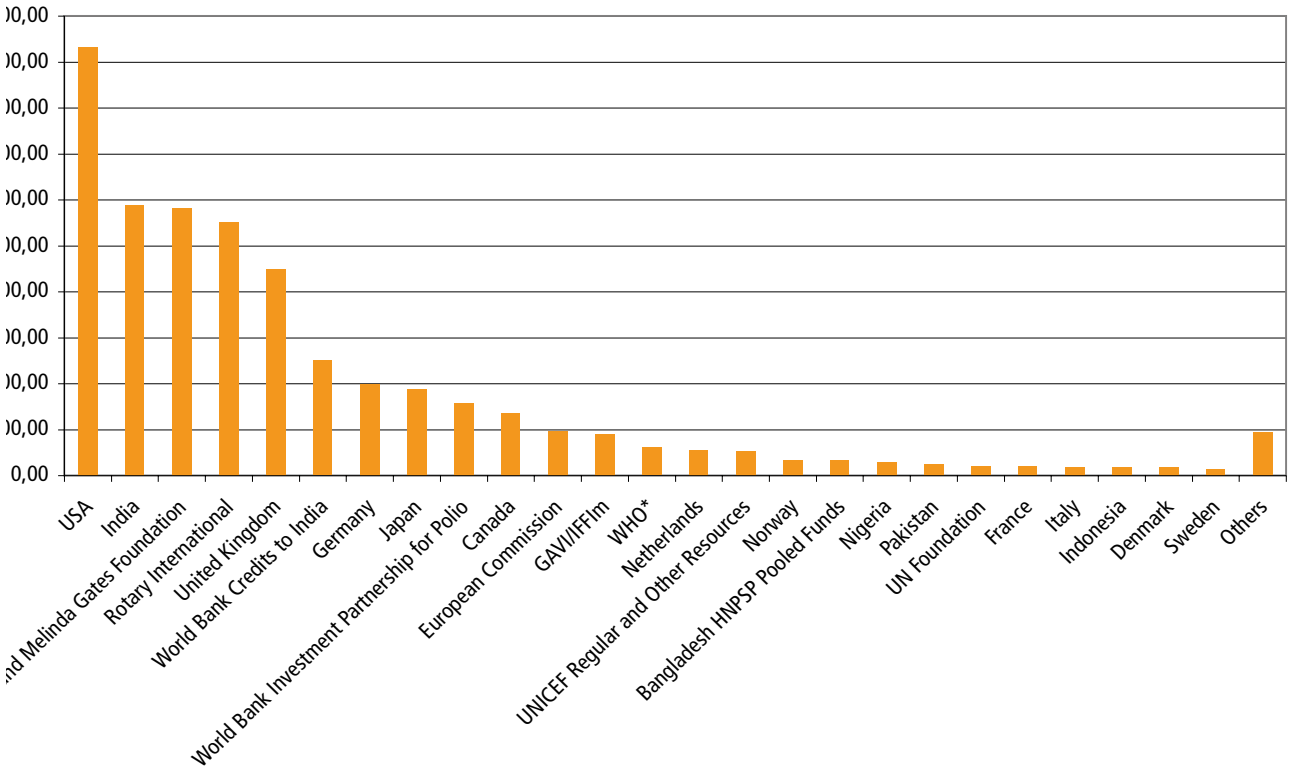
International contributions to national polio eradication efforts have been complemented by domestic resources. Of note, India has largely self-financed for the past several years, and in September 2009 re-affirmed its commitment by setting aside US$ 657 million of its budget for polio eradication in the 2010-2012 period. Nigeria and Pakistan have also provided substantial domestic resources towards eradicating polio. Other contributions from polio-affected countries – including both financial and non-monetary expenditures, and in-kind contributions such as the time spent by volunteers, health workers and others in the planning and implementation of SIAs – are estimated to have a dollar value approximately equal to that of international financial contributions.[14]

Table 3: Donor profile for 1985-2012

Contribution (US$ million)	Public Sector Partners	Development Banks	Private Sector Partners
> 1.000	United States of America		Rotary International, Bill & Melinda Gates Foundation
500 - 1.000	United Kingdom	World Bank	
250 - 499	Japan, Canada, Germany		
100 - 249	European Commission, Netherlands, GAVI/IFFIm, WHO Regular Budget, UNICEF Regular Resources		
50 - 99	Norway		
25 - 49	Denmark, France, Italy, Sweden, Russian Federation		United Nations Foundation
5 - 24	Australia, Ireland, Luxembourg, Spain		Sanofi Pasteur, IFPMA, UNICEF National Committees, American Red Cross, Oil for Food Program
1 - 4	Austria, Belgium, Finland, Kuwait, Malaysia, New Zealand, Portugal, Saudi Arabia, Switzerland, United Arab Emirates	Inter-American Development Bank, African Development Bank	Advantage Trust (HK), Central Emergency Response Fund (CERF), De Beers, International Federation of Red Cross and Red Crescent Societies, Pew Charitable Trust, Wyeth, Shinnyo-en, OPEC

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

Figure 10: Contributions and Pledges to the Global Polio Eradication Initiative, 1985-2012 (all figures in US$ millions)



*including impact of reduced Programme Support Costs

9. Annexes

ANNEX A: Supplementary immunization activities required for polio eradication, 2010-2012 as of 20 September 2010 (All activities are expressed in percentages)

Implemented activities | Not implemented activities | Outbreak response | ***Child Health Day*** | Countries with poliovirus within the last 6 months | Countries with poliovirus between 6 and 12 months | Countries with no poliovirus for more than 12 months

Region/Country	2010												2011												2012											
	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
1. Endemic Countries																																				
Afghanistan	5	50	100		100	78	50		18	100	100	50		100	100	30	30	100			30	30	30	30			100	100	30	30			30	30	30	30	
India	100	100	20	40	20	20	20	5	43	4	40			100	100	40	40				40	40					100	100	40	40			40	40			
Pakistan	64	100	50	100	52		100		53	***21***	50	100	50	100	100	30	30				30	30	30	30			100	100	30	30			30	30	30	30	
Nigeria		100	100	66		75		23	67	67	***100***			100	100	30	30				30	30	30	30			100	100	30	30			30	30	30	30	
2. Countries with re-established transmission																																				
Chad		100	97	100	25	95	21	14	79	100	100			100	100								100	100			100	100						100	100	
Angola				5	50	8	100	7	100	100	100						50	50	100	100									50	50	100	100					
DR Congo					5				33	46	87	64	10				40	60	40	60	40	60							35	65	35	65	35	65			
Sudan		100	25			75					65	65		100	100							100	100			100	100							100	100	
3. Countries with recurrent importations																																				
West Africa																																				
Niger			100	100	44					80	80			100	100						100	100				100	100						100	100		
Mali			100	21 100	95	95	10			100				100	100						100					100	100						100			
Senegal		20	100	100 100	100	100				100				100	100											100	100									
Mauritania		100	100	100 100	100	100	16			100				100	100						100					100	100						100			
Liberia			100	100	100	100				100				100	100						100					100	100						100			
Sierra Leone			100	100	100	100				100				100	100						100					100	100						100			
Guinea			100	100 100	100	100		100		100				100	100						100					100	100						100			
Burkina Faso			100	100	100	68		68		100	100			100	100						100	100				100	100						100	100		
Benin			67	100						100	100			100	100						100	100				100	100						100	100		
Côte d'Ivoire			100	100						100				100	100						100					100	100						100			
Gambia			100	100	100	100								100	100											100	100									
Guinea Bissau			100	100	100									100	100											100	100									
Ghana			100	100										100	100											100	100									
Togo			100	100										100	100											100	100									
Cape Verde			100	100										100	100											100	100									
Horn of Africa																																				
Ethiopia					17	85	85		17		***90***		***10***	50	50	50	50										20	80	20	80							
Somalia					25	25	75		75	***100***				100	100						100	100				100	100						100	100		
Kenya					10	40	10	40						10	40	10	40									10	10									
Uganda					10	40	10	40						10	40	10	40									10	10									
Djibouti					100		100							100	100											100	100									
Eritrea					100		100							100	100											100	100									
Yemen					100		100									100						100				100	100									
Central Africa																																				
Cameroon			50	50			21	21						50	50											50	50									
Burundi		100				100					100	100																								
CAR			100	100						100	100			100	100						100	100				100	100						100	100		
Tanzania										10																										
Rwanda			100	100							100	100																								
Congo			100	100										100	100											100	100									
Other importation-affected countries																																				
Southeast Asia																																				
Nepal				100	100	56	29	29	50	29	23		100	100													50	50	50	50							
Bangladesh	100	100												100	100											100	100									
Myanmar				39	39																															
Europe																																				
Tajikistan					100	100	100	100			52	100	100																							
Uzbekistan					100		100		100			100																								
Kazakhstan											100																									
Turkmenistan								100	100	100																										
Kyrgyzstan				100				100	100																											

Annex B: Details of external funding requirements in polio-endemic and highest-risk countries, 2010-2012, as of 16 September 2010 (all figures in US$ millions)

Country	2010					Total Costs
	AFP Surveillance	Social Moblization	Technical Assistance	OPV	Op Costs	
1. Endemic Countries						
Afghanistan	$2.54	$1.08	$3.97	$9.77	$13.20	$30.54
India	$8.26	$14.00	$15.91	$120.53	$86.09	$244.78
Pakistan	$2.86	$7.80	$7.39	$44.13	$23.85	$86.04
*Nigeria	$10.50	$10.25	$31.19	$50.49	$66.27	$168.69
2. Countries with re-established transmission						
Chad	$0.81	$1.91	$2.23	$3.02	$7.15	$15.13
Sudan	$2.19	$2.09	$5.89	$5.59	$12.24	$28.00
Angola	$1.46	$2.28	$5.07	$4.87	$9.65	$23.40
Dem Rep of Congo	$2.03	$1.06	$6.37	$6.17	$14.22	$29.85
3. Countries with recurrent importations						
West Africa						
Niger	$0.53	$0.41	$1.49	$3.33	$6.25	$12.01
Benin	$0.16	$0.39	$0.39	$2.05	$2.66	$5.66
Burkina Faso	$0.24	$0.14	$0.20	$5.69	$10.88	$17.15
Côte d'Ivoire	$0.26	$0.49	$1.30	$3.38	$3.60	$9.03
Sierra Leone	$0.20	$0.34	$0.72	$1.11	$2.07	$4.44
Guinea	$0.16	$0.21	$0.34	$2.71	$3.95	$7.37
Liberia	$0.20	$0.11	$0.44	$0.63	$1.78	$3.16
Mali	$0.23	$0.23	$0.41	$4.39	$8.33	$13.58
Mauritania	$0.16	$0.10	$0.06	$0.83	$2.52	$3.67
Senegal	$0.48	$0.26	$0.47	$2.97	$5.75	$9.93
Guinea-Bissau	$0.06	$0.09	$0.12	$0.15	$0.34	$0.76
Gambia	$0.05	$0.10	$0.05	$0.28	$0.51	$0.99
Cape Verde	$0.04	$0.03	$0.05	$0.02	$0.08	$0.22
Togo	$0.12	$0.14	$0.22	$0.49	$0.74	$1.71
Ghana	$0.33	$0.27	$0.10	$1.86	$2.33	$4.89
Horn of Africa						
Ethiopia	$2.76	$0.74	$2.84	$2.93	$1.80	$11.07
*Somalia	$0.63	$0.42	$2.60	$1.68	$2.26	$7.59
Kenya	$0.40	-	$0.96	-	-	$1.36
Uganda	$0.36	$0.05	$0.59	-	-	$1.00
Eritrea	$0.12	$0.01	$0.11	-	-	$0.24
Yemen	$0.18	-	$0.18	-	-	$0.36
Djibouti	$0.10	-	$0.08	-	-	$0.17
Central Africa						
Cameroon	$0.37	$0.25	$0.60	$1.03	$1.08	$3.33
Central African Republic	$0.42	$0.16	$0.61	$0.53	$1.50	$3.23
Congo	$0.12	-	$0.60	-	-	$0.72
United Rep of Tanzania	$0.37	-	$0.34	$0.16	$0.30	$1.16
**Burundi	$0.08	-	$0.04	$0.64	$0.80	$1.56
**Rwanda	$0.10	$0.28	$0.64	$0.62	$0.75	$2.39
4. Other Importation-Affected Countries						
Southeast Asia						
Bangladesh	$0.90	-	$1.42	$7.79	$2.71	$12.82
Myanmar	$0.52	-	$0.43	$2.22	$0.70	$3.87
**Nepal	$0.71	$0.21	$1.40	$4.22	$3.04	$9.58
Europe						
Tajikistan	$0.65	-	-	$3.08	$2.08	$5.81
Uzbekistan	$0.10	-	-	$3.03	$0.68	$3.80
Kazakhstan	-	-	-	$0.33	-	$0.33
Turkmenistan	-	-	-	$0.60	$0.11	$0.71
Kyrgyzstan	$0.03	-	-	$0.23	$0.17	$0.43

* CHD/measles: Somalia & Nigeria only OPV is costed

** Q1 2011 Activities in Burundi, Rwanda (2 SIAs) and Nepal (1 SIA) being brought forward to 2010

Annex B (continued)

Country	2011					Total Costs
	AFP Surveillance	Social Moblization	Technical Assistance	OPV	Op Costs	
1. Endemic Countries						
Afghanistan	$2.59	$1.08	$5.69	$7.64	$10.23	$27.22
India	$9.66	$18.43	$15.78	$124.08	$66.57	$234.51
Pakistan	$2.50	$7.83	$7.49	$28.21	$11.45	$57.49
*Nigeria	$9.89	$8.11	$34.99	$34.93	$48.10	$136.01
2. Countries with re-established transmission						
Chad	$0.72	$1.81	$2.95	$2.24	$6.11	$13.82
Sudan	$2.44	$2.05	$6.42	$7.69	$14.81	$33.41
Angola	$1.85	$1.71	$5.45	$4.09	$4.60	$17.70
Dem Rep of Congo	$2.58	$1.06	$6.57	$8.99	$16.67	$35.86
3. Countries with recurrent importations						
West Africa						
Niger	$0.68	$0.40	$1.53	$3.48	$5.82	$11.90
Benin	$0.21	$0.40	$0.83	$2.24	$3.30	$6.97
Burkina Faso	$0.35	$0.57	$0.27	$3.75	$7.45	$12.40
Côte d'Ivoire	$0.33	$0.57	$1.48	$3.99	$2.53	$8.89
Sierra Leone	$0.31	$0.25	$0.46	$0.76	$1.76	$3.54
Guinea	$0.15	-	$0.35	$1.50	$3.79	$5.80
Liberia	$0.31	$0.11	$0.48	$0.54	$1.30	$2.73
Mali	$0.25	$0.61	$0.45	$2.77	$5.39	$9.46
Mauritania	$0.15	$0.29	$0.08	$0.38	$0.71	$1.61
Senegal	$0.29	-	$0.76	$0.90	$2.34	$4.30
Guinea-Bissau	$0.07	$0.11	$0.13	$0.11	$0.21	$0.64
Gambia	$0.06	$0.11	$0.05	$0.28	$0.37	$0.87
Cape Verde	$0.05	-	$0.10	$0.05	$0.06	$0.27
Togo	$0.15	$0.07	$0.40	$0.63	$0.61	$1.86
Ghana	$0.41	$0.29	$0.10	$2.01	$3.06	$5.87
Horn of Africa						
Ethiopia	$3.84	$0.74	$3.19	$5.62	$8.99	$22.38
*Somalia	$0.77	$0.42	$2.72	$1.55	$2.94	$8.41
Kenya	$0.50	-	$0.97	$1.01	$1.89	$4.39
Uganda	$0.45	$0.92	$0.59	$0.98	$0.57	$3.52
Eritrea	$0.23	$0.07	$0.11	$0.23	$0.26	$0.89
Yemen	$0.18	-	$0.19	$0.95	$3.08	$4.40
Djibouti	$0.10	-	$0.16	$0.03	$0.29	$0.58
Central Africa						
Cameroon	$0.45	$0.31	$0.63	$0.97	$0.54	$2.89
Central African Republic	$0.54	$0.20	$0.63	$0.56	$1.25	$3.17
Congo	$0.15	-	$0.61	$0.28	$0.57	$1.62
United Rep of Tanzania						
**Burundi	$0.14	-	$0.04	-	-	$0.19
**Rwanda	$0.21	$0.11	$0.67	-	-	$0.99
4. Other Importation-Affected Countries						
Southeast Asia						
Bangladesh	$0.94	-	$1.46	$9.64	$2.05	$14.09
Myanmar	$0.54	-	$0.44	$0.00	$0.00	$0.98
**Nepal	$0.63	$0.12	$1.46	$0.98	$0.56	$3.75
Europe						
Tajikistan	$0.15	-	-	-	-	$0.15
Uzbekistan	$0.10	-	-	-	-	$0.10
Kazakhstan	-	-	-	-	-	$0.00
Turkmenistan	-	-	-	-	-	$0.00
Kyrgyzstan	$0.03	-	-	-	-	$0.03

* CHD/measles: Somalia & Nigeria only OPV is costed

** Q1 2011 Activities in Burundi, Rwanda (2 SIAs) and Nepal (1 SIA) being brought forward to 2010

Annex B (continued)

Country	2012					Total Costs
	AFP Surveillance	Social Moblization	Technical Assistance	OPV	Op Costs	
1. Endemic Countries						
Afghanistan	$2.66	$1.08	$5.84	$6.41	$8.17	$24.17
India	$8.76	$15.60	$16.25	$127.81	$65.40	$233.82
Pakistan	$2.58	$7.81	$7.69	$29.93	$12.02	$60.03
*Nigeria	$10.18	$4.66	$36.06	$37.05	$53.17	$141.13
2. Countries with re-established transmission						
Chad	$0.74	$1.77	$3.01	$2.37	$6.32	$14.21
Sudan	$2.51	$1.67	$6.62	$8.16	$15.45	$34.41
Angola	$1.91	$1.89	$5.60	$4.34	$4.41	$18.14
Dem Rep of Congo	$2.65	$1.06	$6.80	$9.54	$17.44	$37.48
3. Countries with recurrent importations						
West Africa						
Niger	$0.70	$0.40	$1.58	$3.69	$6.02	$12.39
Benin	$0.21	$0.42	$0.61	$2.38	$3.40	$7.01
Burkina Faso	$0.36	$0.57	$0.28	$3.98	$7.69	$12.88
Côte d'Ivoire	$0.34	$0.61	$1.51	$4.23	$2.57	$9.26
Sierra Leone	$0.32	$0.24	$0.48	$0.81	$1.82	$3.67
Guinea	$0.16	-	$0.41	$1.59	$3.90	$6.06
Liberia	$0.32	$0.11	$0.50	$0.40	$1.33	$2.65
Mali	$0.25	$0.60	$0.46	$2.94	$5.50	$9.76
Mauritania	$0.16	$0.29	$0.08	$0.57	$0.73	$1.83
Senegal	$0.30	-	$0.77	$0.81	$2.41	$4.29
Guinea-Bissau	$0.07	$0.13	$0.14	$2.13	$0.20	$2.67
Gambia	$0.06	$0.10	$0.05	$0.67	$0.37	$1.26
Cape Verde	$0.05	-	$0.11	$0.93	$0.07	$1.16
Togo	$0.16	$0.07	$0.42	$0.11	$0.62	$1.38
Ghana	$0.42	$0.30	$0.11	$0.29	$3.10	$4.22
Horn of Africa						
Ethiopia	$3.96	$0.49	$3.27	$5.96	$9.33	$23.01
*Somalia	$0.80	$0.42	$2.84	$1.65	$3.03	$8.74
Kenya	$0.52	-	$1.00	$1.07	$1.95	$4.55
Uganda	$0.47	-	$0.43	$1.04	$1.03	$2.97
Eritrea	$0.23	$0.07	$0.12	$0.24	$0.25	$0.91
Yemen	$0.18	-	$0.19	$1.01	$3.00	$4.39
Djibouti	$0.10	-	$0.17	$0.03	$0.30	$0.60
Central Africa						
Cameroon	$0.47	$0.37	$0.66	$1.03	$0.50	$3.03
Central African Republic	$0.55	$0.20	$0.65	$0.59	$1.33	$3.32
Congo	$0.16	-	$0.63	$0.30	$0.58	$1.67
United Rep of Tanzania						
**Burundi	$0.15	-	$0.04	-	-	$0.19
**Rwanda	$0.21	$0.34	$0.72	-	-	$1.27
4. Other Importation-Affected Countries						
Southeast Asia						
Bangladesh	$0.97	-	$1.51	$10.23	$2.11	$14.81
Myanmar	$0.55	-	$0.46	$0.00	$0.00	$1.01
**Nepal	$0.65	$0.22	$1.52	$2.08	$1.14	$5.61
Europe						
Tajikistan	$0.15	-	-	-	-	$0.15
Uzbekistan	$0.10	-	-	-	-	$0.10
Kazakhstan	-	-	-	-	-	$0.00
Turkmenistan	-	-	-	-	-	$0.00
Kyrgyzstan	$0.03	-	-	-	-	$0.03

* CHD/measles: Somalia & Nigeria only OPV is costed

** Q1 2011 Activities in Burundi, Rwanda (2 SIAs) and Nepal (1 SIA) being brought forward to 2010

Annex B (continued)

Country	2010 - 2012					Total Costs 2010-2012
	Total AFP Surveillance	Total Social Moblization	Total Technical Assistance	Total OPV	Total Op Costs	
1. Endemic Countries						
Afghanistan	$7.78	$3.24	$15.50	$23.81	$31.60	$81.93
India	$26.68	$48.03	$47.93	$372.41	$218.06	$713.11
Pakistan	$7.94	$23.44	$22.58	$102.27	$47.32	$203.56
*Nigeria	$30.57	$23.02	$102.23	$122.47	$167.53	$445.82
2. Countries with re-established transmission						
Chad	$2.28	$5.49	$8.19	$7.63	$19.58	$43.16
Sudan	$7.15	$5.81	$18.93	$21.44	$42.50	$95.82
Angola	$5.23	$5.88	$16.11	$13.30	$18.65	$59.17
Dem Rep of Congo	$7.26	$3.17	$19.74	$24.69	$48.33	$103.19
3. Countries with recurrent importations						
West Africa						
Niger	$1.91	$1.20	$4.61	$10.50	$18.09	$36.30
Benin	$0.58	$1.21	$1.82	$6.67	$9.35	$19.63
Burkina Faso	$0.95	$1.28	$0.75	$13.42	$26.02	$42.43
Côte d'Ivoire	$0.93	$1.67	$4.29	$11.60	$8.70	$27.19
Sierra Leone	$0.83	$0.83	$1.66	$2.68	$5.65	$11.65
Guinea	$0.48	$0.21	$1.10	$5.80	$11.64	$19.23
Liberia	$0.83	$0.32	$1.42	$1.57	$4.41	$8.54
Mali	$0.73	$1.43	$1.33	$10.10	$19.22	$32.80
Mauritania	$0.48	$0.68	$0.23	$1.78	$3.95	$7.11
Senegal	$1.07	$0.26	$2.01	$4.68	$10.50	$18.52
Guinea-Bissau	$0.20	$0.33	$0.39	$2.39	$0.75	$4.07
Gambia	$0.18	$0.30	$0.15	$1.23	$1.25	$3.12
Cape Verde	$0.14	$0.03	$0.26	$1.00	$0.21	$1.65
Togo	$0.43	$0.28	$1.04	$1.24	$1.97	$4.96
Ghana	$1.17	$0.86	$0.31	$4.16	$8.49	$14.99
Horn of Africa						
Ethiopia	$10.56	$1.96	$9.30	$14.51	$20.12	$56.45
*Somalia	$2.20	$1.26	$8.16	$4.89	$8.23	$24.74
Kenya	$1.42	-	$2.94	$2.09	$3.84	$10.29
Uganda	$1.28	$0.97	$1.62	$2.02	$1.60	$7.49
Eritrea	$0.58	$0.14	$0.34	$0.47	$0.51	$2.04
Yemen	$0.54	-	$0.56	$1.97	$6.08	$9.15
Djibouti	$0.30	-	$0.41	$0.05	$0.59	$1.35
Central Africa						
Cameroon	$1.29	$0.93	$1.89	$3.03	$2.12	$9.25
Central African Republic	$1.51	$0.56	$1.89	$1.68	$4.08	$9.71
Congo	$0.43	-	$1.84	$0.58	$1.15	$4.01
United Rep of Tanzania	$0.37	-	$0.34	$0.16	$0.30	$1.16
**Burundi	$0.37	-	$0.12	$0.64	$0.80	$1.94
**Rwanda	$0.52	$0.73	$2.03	$0.62	$0.75	$4.65
4. Other Importation-Affected Countries						
Southeast Asia						
Bangladesh	$2.80	-	$4.39	$27.66	$6.87	$41.72
Myanmar	$1.61	-	$1.33	$2.22	$0.70	$5.86
**Nepal	$1.99	$0.54	$4.38	$7.28	$4.74	$18.93
Europe						
Tajikistan	$0.95	-	-	$3.08	$2.08	$6.11
Uzbekistan	$0.29	-	-	$3.03	$0.68	$4.00
Kazakhstan	-	-	-	$0.33	-	$0.33
Turkmenistan	-	-	-	$0.60	$0.11	$0.71
Kyrgyzstan	$0.08	-	-	$0.23	$0.17	$0.48

* CHD/measles: Somalia & Nigeria only OPV is costed

** Q1 2011 Activities in Burundi, Rwanda (2 SIAs) and Nepal (1 SIA) being brought forward to 2010

ANNEX C: Surveillance and laboratory costs by country and region, 2010

(all figures in US$ millions)

WHO African Region	2010
Algeria	$0.05
Angola	$1.46
Benin	$0.16
Botswana	$0.08
Burkina Faso	$0.24
Burundi	$0.08
Cameroon	$0.37
Cape Verde	$0.04
Central African Republic	$0.42
Chad	$0.81
Comoros	$0.04
Congo	$0.12
Côte d'Ivoire	$0.26
Democratic Republic of Congo	$2.03
Equatorial Guinea	$0.04
Eritrea	$0.12
Ethiopia	$2.76
Gabon	$0.08
Gambia	$0.05
Ghana	$0.33
Guinea	$0.16
Guinea-Bissau	$0.06
Kenya	$0.40
Lesotho	$0.04
Liberia	$0.20
Madagascar	$0.33
Malawi	$0.16
Mali	$0.23
Mauritania	$0.16
Mauritius	$0.02
Mozambique	$0.24
Namibia	$0.12
Niger	$0.53
Nigeria	$10.50
Rwanda	$0.10
Sao Tome and Principe	$0.01
Senegal	$0.28
Seychelles	$0.01
Sierra Leone	$0.20
South Africa	$0.24
Swaziland	$0.07
Togo	$0.12
Uganda	$0.36
United Republic of Tanzania	$0.37
Zambia	$0.33
Zimbabwe	$0.22
Regional surveillance and laboratory	$4.37
Subtotal	**$29.38**

WHO Region of the Americas	2010
Regional surveillance and laboratory	$0.60

WHO Eastern Mediterranean Region	2010
Afghanistan	$2.54
Djibouti	$0.10
Egypt	$0.35
Iraq	$0.10
Pakistan	$2.86
Somalia	$0.63
Sudan	$2.19
Yemen	$0.18
Regional surveillance and laboratory	$1.15
Subtotal	**$10.08**

WHO South-East Asia Region	2010
Bangladesh	$0.90
India	$8.26
Indonesia	$1.08
Myanmar	$0.18
Nepal	$0.71
Regional surveillance and laboratory	$3.28
Subtotal	**$14.41**

WHO European Region	2010
Tajikistan	$0.65
Uzbekistan	$0.10
Kyrgyzstan	$0.03
Regional surveillance and laboratory	$0.97
Subtotal	**$1.74**

WHO Western Pacific Region	2010
Regional surveillance and laboratory	$1.02

WHO/HQ	2010
WHO/HQ	$9.41

Global	2010
Total	**$66.65**

ANNEX D: Technical assistance, country-level details, 2010

(all figures in US$ millions)

WHO African Region	2010
Angola	$4.77
Benin	$0.39
Botswana	$0.23
Burkina Faso	$0.20
Burundi	$0.04
Cameroon	$0.50
Central African Republic	$0.61
Chad	$1.73
Congo	$0.45
Côte d'Ivoire	$1.19
Democratic Republic of Congo	$5.05
Equatorial Guinea	$0.14
Eritrea	$0.11
Ethiopia	$2.55
Gabon	$0.37
Gambia	$0.05
Ghana	$0.10
Guinea	$0.10
Guinea-Bissau	$0.12
Kenya	$0.83
Lesotho	$0.07
Liberia	$0.44
Madagascar	$0.25
Malawi	$0.07
Mali	$0.39
Mauritania	$0.06
Mozambique	$0.27
Namibia	$0.13
Niger	$1.49
Nigeria	$26.87
Rwanda	$0.31
Senegal	$0.16
Sierra Leone	$0.40
South Africa	$0.31
Swaziland	$0.09
Togo	$0.19
Uganda	$0.41
United Republic of Tanzania	$0.34
Zambia	$0.57
Zimbabwe	$0.12
IST (Central block)	$1.46
IST (South/East block)	$1.24
IST (West block)	$1.01
Regional Office	$1.48
Subtotal	**$57.81**

WHO European Region	2010
Regional Office/Countries	$0.50
Subtotal	**$0.50**

WHO/HQ	$10.23
Short Term Tech Assistance	$7.50

Global WHO-Unicef	2010
Total	**$130.92**

* IST= Inter-country Support Team

WHO Eastern Mediterranean Region	2010
Afghanistan	$3.58
Djibouti	$0.00
Egypt	$0.03
Iran	$0.01
Iraq	$0.00
Pakistan	$6.53
Somalia	$2.00
Sudan	$5.34
Yemen	$0.18
Regional Office	$1.17
Subtotal	**$18.85**

WHO South-East Asia Region	2010
Bangladesh	$1.42
India	$14.18
Indonesia	$0.88
Myanmar	$0.43
Nepal	$0.84
Regional Office	$0.77
Subtotal	**$18.52**

WHO Western Pacific Region	2010
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	**$1.61**

UNICEF	2010
Unicef/HQ	$2.50
Afghanistan	$0.38
Angola	$0.29
Cameroon	$0.09
Cape Verde	$0.05
Chad	$0.50
Congo	$0.14
Côte d'Ivoire	$0.10
Dem Rep of Congo	$1.31
Djibouti	$0.08
Ethiopia	$0.28
Guinea	$0.23
India	$1.73
Kenya	$0.12
Mali	$0.01
Nepal	$0.56
Nigeria	$4.32
Pakistan	$0.86
Rwanda	$0.32
Senegal	$0.31
Sierra Leone	$0.31
Somalia	$0.60
Sudan	$0.55
Togo	$0.03
Uganda	$0.17
Subtotal	**$15.90**

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