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**Global**

# **Polio**

**E r a d i c a t i o n  
I n i t i a t i v e**

**Estimated financial  
resource requirements  
2001 – 2005  
as of 1 September 2000**

Figures in this document were developed jointly by  
WHO and UNICEF in collaboration with national ministries of health

Estimated resource requirements are updated on a six-monthly basis

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# 1. Background and overview

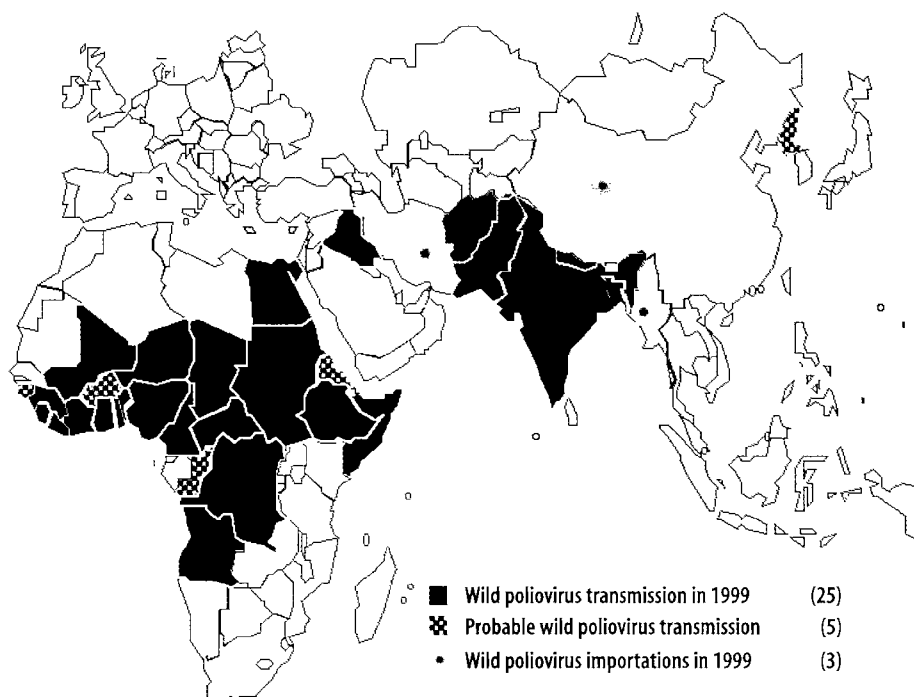
**T**his document outlines the estimated external financial resource requirements for implementation of the programme of work outlined in the *Global Polio Eradication Initiative Strategic Plan (WHO/Polio/00.05)*, 2001–2005. Figures were developed as of September 2000, and are updated every six months. □

## Introduction

Worldwide, the number of polio cases has declined by more than 95% from an estimated 350 000 cases in 1988 to 7143 reported cases during 1999.<sup>1</sup> Only 30 countries were endemic at the end of 1999 (Figure 1), down from 50 countries in 1998. In contrast, it required a decade to reduce the number of endemic countries from 125 in 1988 to 50 in 1998.

Poliovirus transmission is likely to continue in as many as 20 countries after the year 2000, the target date for eradication, albeit at low levels in most. Global certification in 2005 can still be achieved if high-quality intensified efforts are rapidly undertaken, and transmission interrupted in all countries within 12 to 24 months.

**Figure 1: 30 polio-endemic countries and the countries with imported wild poliovirus, end of 1999**



<sup>1</sup> Data as of 21 September 2000.

Among the key challenges to achieving certification of eradication are:

- securing access to all children, especially in conflict affected countries;
- ensuring adequate financial resources;
- maintaining political commitment.

### Benefits of polio eradication

Through eradication, no child will ever again be crippled by polio, no family will know the suffering of a crippled child, and the world will save an estimated US\$ 1.5 billion per year from the cessation of immunization and averted health care costs.<sup>2</sup> In contrast, the total cost of the initiative from through to 2005 will be \$2.5 billion.

Polio eradication is helping to build the public health infrastructure and capacity to tackle other diseases.<sup>3</sup> The 1990 Plan of action from the World Summit for Children<sup>4</sup> reaffirmed this. Already through polio eradication:

- public health infrastructure has been markedly strengthened, with substantial investments in people (over 1000 polio-funded national and international immunization staff), cold chain, transport and communications systems;
- national level interagency coordinating committees (ICCs) have been established – initially with a polio focus and now with a broader immunization agenda – that routinely bring together governments, WHO, Rotary, UNICEF and other major partners;
- immunization programme management, disease surveillance and laboratory services have markedly improved in many countries;
- about 10 million volunteers participate in global polio eradication activities;
- vitamin A supplements have been administered to children during national immunization days (NIDs) in over 60 countries, averting at least 250 000 deaths in 1999 alone.<sup>5</sup>

### External financial resource requirements

As of September 2000, US\$1 billion in external resources was estimated as required to implement polio eradication activities from 2001 until 2005. With existing and projected commitments at that time, the funding shortfall was estimated at US\$ 450 million. The majority of this shortfall, US\$ 263 million, is required during 2001 and 2002.

For every year eradication is delayed, especially due to a lack of financial resources to implement activities, at least US\$ 100 million in additional funds will be required. This makes it more imperative to provide sufficient finances in a timely manner to achieve what is technically feasible.

### Financial resource requirements: data collection process

Global estimates of the external resources required for polio eradication through the end of 2005 are updated every six months at WHO headquarters (HQ), Geneva during the global polio management team meetings. These meetings bring together the WHO staff responsible for the management and administration of the polio eradication initiative in each of the six WHO regions and WHO HQ.

To establish global cost estimates through 2005, the known costs for implementing each of the strategies at the country level are matched to the five-year global strategic plan for stopping polio transmission and certifying eradication. Confirmed and/or projected funding for polio eradication through 2005 is tracked, by funding source, at WHO HQ. The compilation of five-year cost estimates and confirmed/projected funding is used to monitor the global polio eradication funding gap and serve as the basis for strategic planning in resource mobilization.

<sup>2</sup> Bart KJ, Foulds J, Patriarca P. The global eradication of poliomyelitis: benefit-cost analysis. *Bulletin of the World Health Organization* 1996; 45:911-4.

<sup>3</sup> WHA41.28 Global eradication of poliomyelitis by the year 2000.

<sup>4</sup> *Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s*, UNICEF, 1990.

<sup>5</sup> Ching P. et al. The childhood mortality impact of integrating vitamin A supplements with immunization campaigns. *American Journal of Public Health* 2000 (in print)

**Underlying assumptions for polio eradication external resource requirements**

The global estimates of external resource requirements are based on the known costs of (1) implementing the eradication strategies at the country level and (2) managing the initiative through the UN implementing agencies (WHO & UNICEF) at the regional level. Costs covered by national governments are not included.

Funds received and/or projected are used to calculate the global shortfall only if they are intended for

eradication activities in polio endemic countries. Therefore, funds used by donor countries for their own national immunization programmes, surveillance or laboratories are not included.

These figures provide an indicative target for resource mobilization. Exact figures fluctuate depending upon the epidemiological situation in the country and resulting polio eradication strategy and the results of resource mobilization efforts.





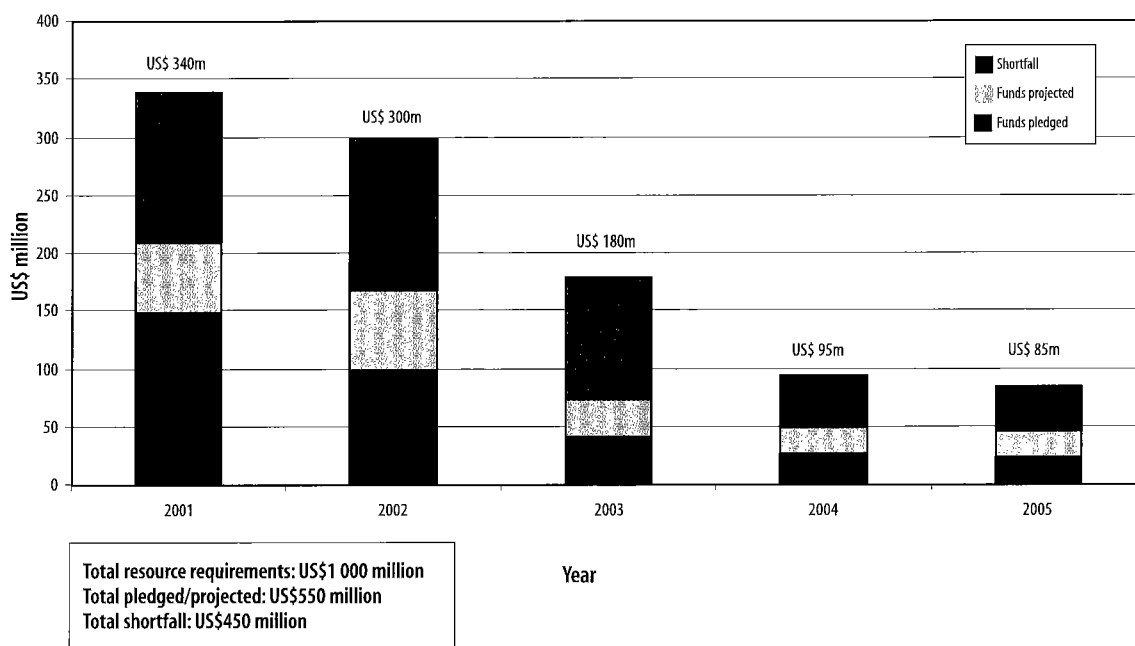
## 2. Global resource requirements, 2001-2005

*Chart 1: Status of financial resource requirements, 2001-2005*

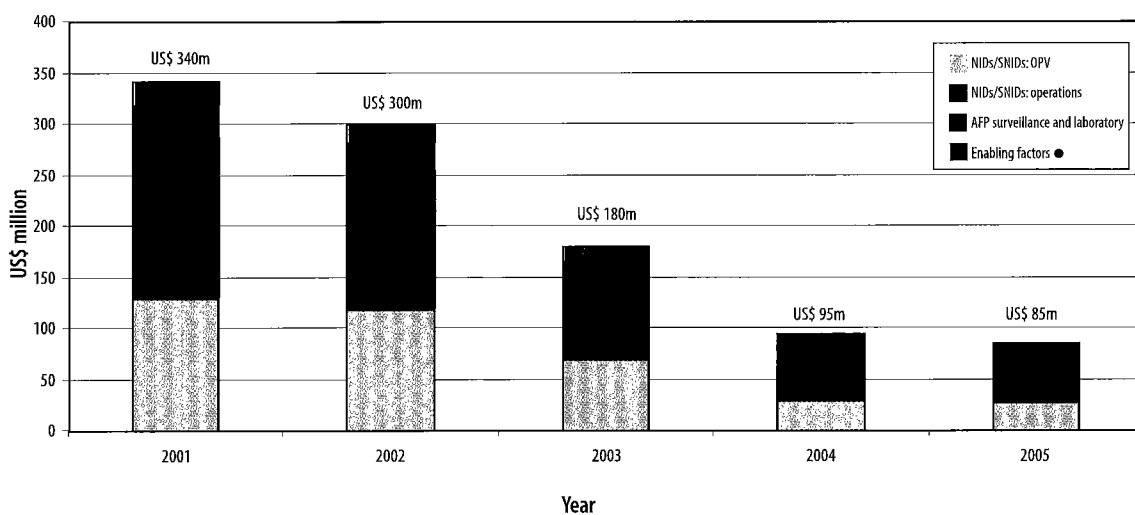
*Chart 2: Planned costs by activity, 2001-2005*

*Chart 3: Contributions pledged and projected by major donors 2001-2005*

**Chart 1: Status of financial resource requirements, 2001-2005**

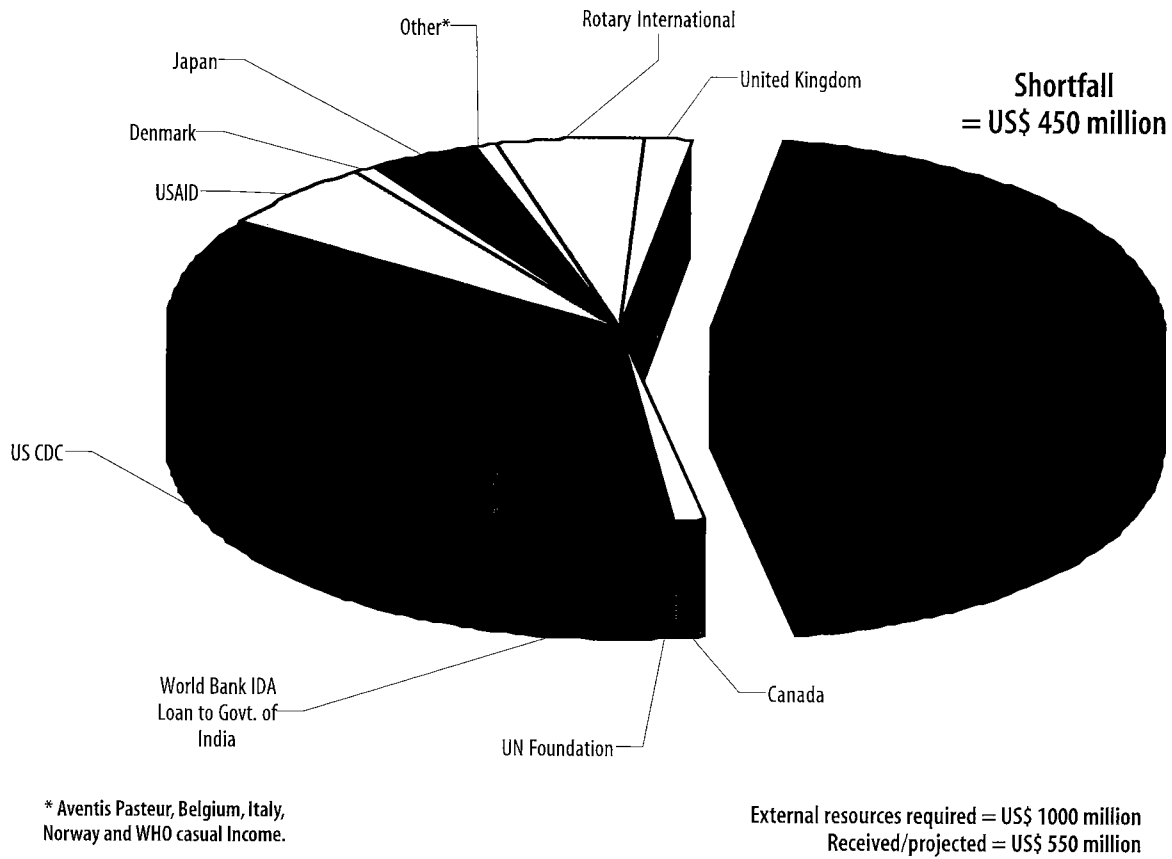


**Chart 2: Planned costs by activity, 2001-2005**



- As outlined in *Global Polio Eradication Initiative: Strategic Plan, 2001-2005* enabling factors are activities required to:
  - (i) certify polio eradication
  - (ii) contain laboratory stocks of wild poliovirus
  - (iii) develop a consensus strategy for stopping polio immunization
  - (iv) strengthen management and administration
  - (v) advocacy, communication and social mobilization
  - (vi) training and deployment of human resources

Chart 3: Contributions pledged and projected by major donors 2001-2005







### 3. Overview of costs by polio endemic status, 2001-2005

*Definition of endemic status*

*Chart 4: Map: Distribution of countries by endemic status*

*Table 1: List of countries by endemic status*

*Chart 5: Planned costs by polio endemic status, 2001-2005*

*Chart 6: Planned costs by endemic status and activity, 2001-2005*

### Definition of endemic status

#### Endemic countries

**Definition:** countries with virological and/or epidemiological evidence of endemic poliovirus circulation during the past 12 months.

Number: 30 countries at end of year 1999.

#### Recently endemic/high-risk countries

**Definition:** countries with no polio detected for > 1 year, but at high-risk of ongoing low-level indigenous virus or sustained transmission of imported virus due to: (1) geographic proximity to an endemic country, (2) low routine immunization coverage, and/or (3) inadequate surveillance.

Number: 25 countries at end of year 1999.

#### Low-risk countries

**Definition:** countries with no polio detected for > 1 year and at low risk of indigenous virus or sustained transmission of imported virus due to (1) high routine immunization coverage; (2) lack of proximity to endemic countries; and/or (3) maintenance of high quality surveillance.

Number: 101 countries at end of year 1999.

#### Countries certified polio-free

**Definition:** countries certified polio-free by a regional certification commission (only AMR as of 15 August 2000).

Number: 36 countries at end of year 1999

Chart 4: Distribution of countries by endemic status\*

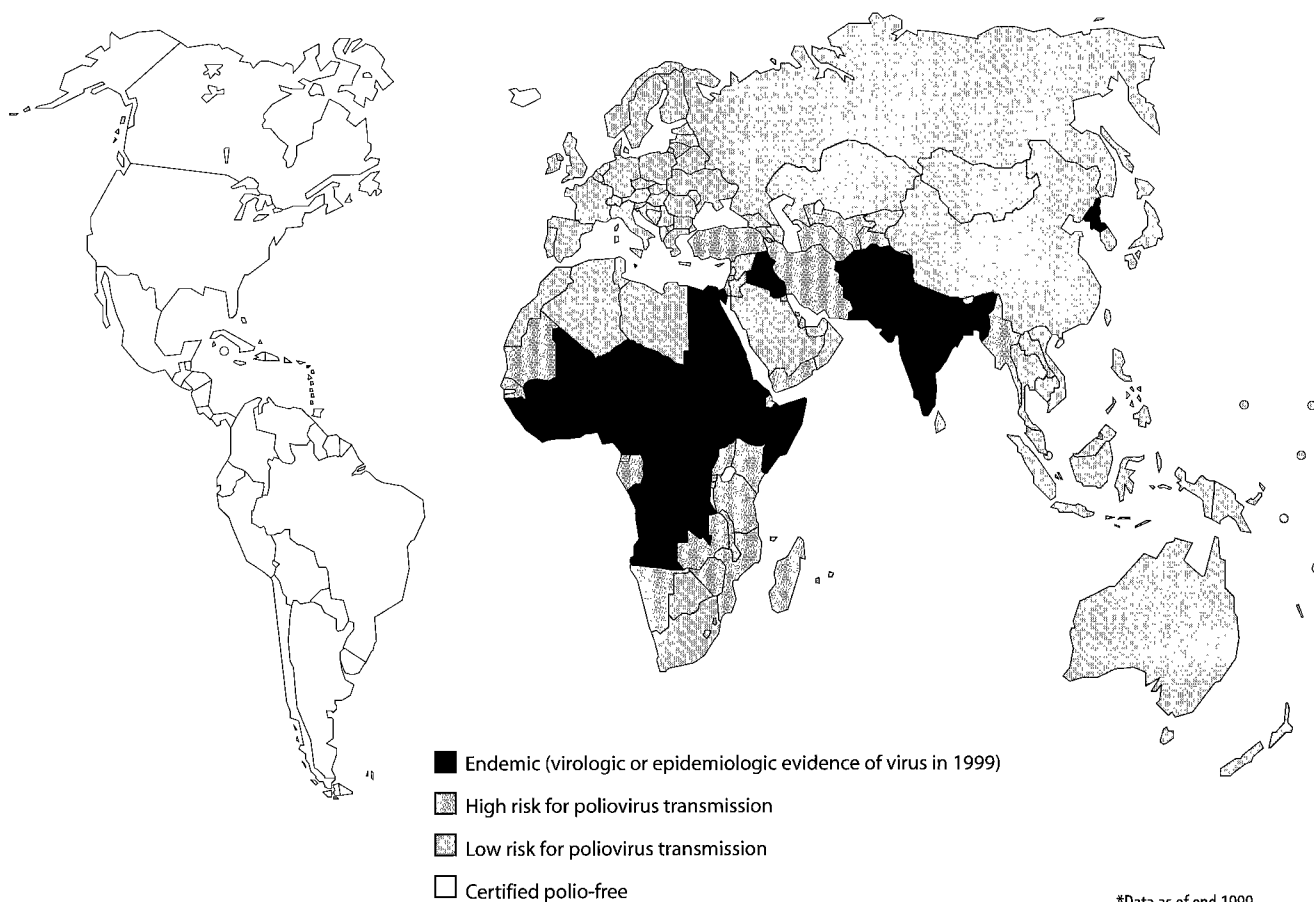
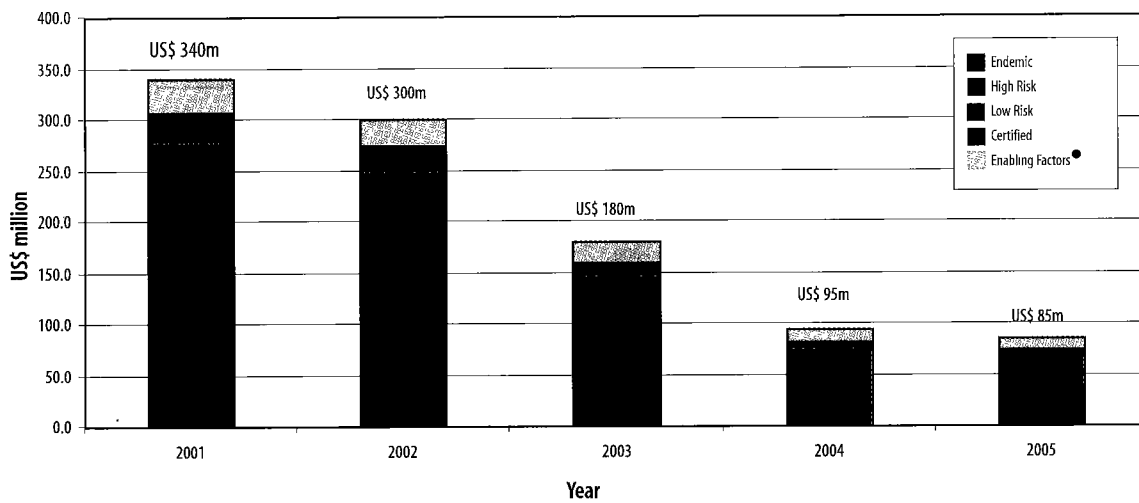


Table 1: List of countries by endemic status

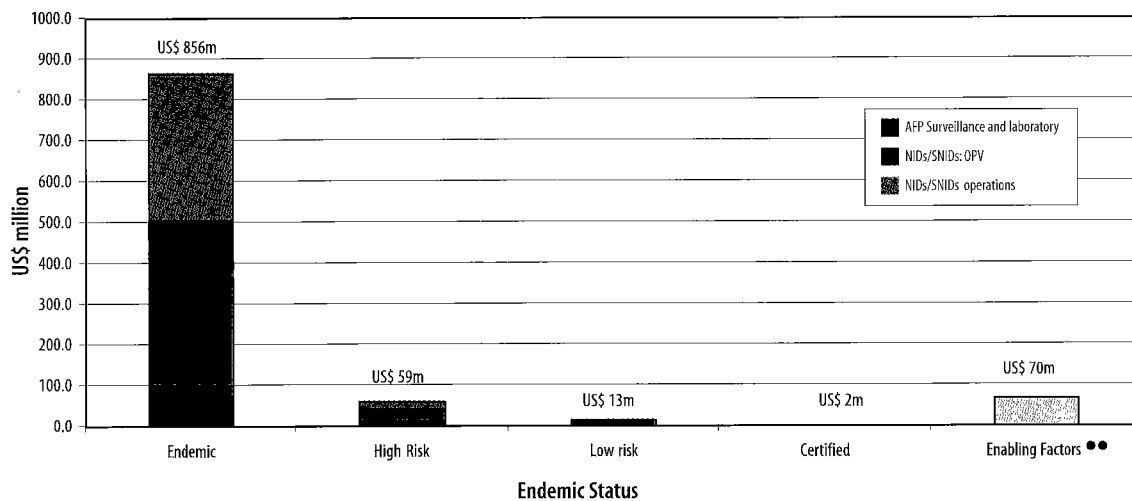
<b>Endemic (30 countries at end of year 1999)</b>				
Afghanistan	Central African Republic	Egypt	India	Nigeria
Angola	Chad	Eritrea	Iraq	Pakistan
Bangladesh	Congo	Ethiopia	Liberia	Sierra Leone
Benin	Côte d'Ivoire	Ghana	Mali	Somalia
Burkina Faso	Dem. People's Rep. of Korea	Guinea	Nepal	Sudan
Cameroon	Dem. Rep. of the Congo	Guinea-Bissau	Niger	Togo
<b>Recently endemic/high-risk (25 countries at end of year 1999)</b>				
Burundi	Iran (Islamic Republic of)	Mozambique	Sri Lanka	Uganda
Djibouti	Kenya	Myanmar	Tajikistan	Uzbekistan
Equatorial Guinea	Madagascar	Namibia	United Rep. of Tanzania	Yemen
Gabon	Malawi	Rwanda	Turkey	Zambia
Gambia	Mauritania	Senegal	Turkmenistan	Zimbabwe
<b>Low-risk (101 countries at end of year 1999)</b>				
Albania	Cyprus	Kuwait	New Zealand	Solomon Islands
Algeria	Czech Republic	Kyrgyzstan	Niue	South Africa
Andorra	Denmark	Lao People's Dem. Rep	Norway	Spain
Armenia	Estonia	Latvia	Oman	Swaziland
Australia	Fed. States of Micronesia	Lebanon	Palau	Sweden
Austria	Fiji	Lesotho	Papua New Guinea	Switzerland
Azerbaijan	Finland	Libyan Arab Jamahiriya	Philippines	Syrian Arab Republic
Bahrain	France	Lithuania	Poland	Thailand
Belarus	Georgia	Luxembourg	Portugal	Tonga
Belgium	Germany	FYR of Macedonia	Qatar	Tunisia
Bhutan	Greece	Maldives	Republic of Korea	Tuvalu
Bosnia and Herzegovina	Hungary	Malaysia	Romania	Ukraine
Botswana	Iceland	Malta	Russian Federation	United Arab Emirates
Brunei	Indonesia	Marshall Islands	Samoa	United Kingdom
Bulgaria	Ireland	Mauritius	San Marino	Vanuatu
Cambodia	Israel	Republic of Moldova	Sao Tome and Principe	Viet Nam
Cape Verde	Italy	Monaco	Saudi Arabia	Yugoslavia
China	Japan	Mongolia	Seychelles	
Comoros	Jordan	Morocco	Singapore	
Cook Islands	Kazakhstan	Nauru	Slovak Republic	
Croatia	Kiribati	Netherlands	Slovenia	
<b>Certified (36 countries at end of year 1999)</b>				
Antigua and Barbuda	Chile	Grenada	Panama	Trinidad and Tobago
Argentina	Colombia	Guatemala	Paraguay	United States of America
Bahamas	Costa Rica	Guyana	Peru	Uruguay
Barbados	Cuba	Haiti	Puerto Rico	Venezuela
Belize	Dominica	Honduras	Saint Kitts and Nevis	
Bolivia	Dominican Republic	Jamaica	Saint Lucia	
Brazil	Ecuador	Mexico	St Vincent/Grenadines	
Canada	El Salvador	Nicaragua	Suriname	

**Chart 5: Planned costs by polio endemic status\*, 2001–2005**



- Classification as at end of 1999
- As outlined in *Global Polio Eradication Initiative: Strategic Plan, 2001-2005* enabling factors are activities required to:
  - (i) certify polio eradication
  - (ii) contain laboratory stocks of wild poliovirus
  - (iii) develop a consensus strategy for stopping polio immunization
  - (iv) strengthen management and administration
  - (v) advocacy, communication and social mobilization
  - (vi) training and deployment of human resources

**Chart 6: Planned costs by endemic status\* and activity, 2001–2005**



- Classification as at end of 1999
- As outlined in *Global Polio Eradication Initiative: Strategic Plan, 2001-2005* enabling factors are activities required to:
  - (i) certify polio eradication
  - (ii) contain laboratory stocks of wild poliovirus
  - (iii) develop a consensus strategy for stopping polio immunization
  - (iv) strengthen management and administration
  - (v) advocacy, communication and social mobilization
  - (vi) training and deployment of human resources



## 4. Detailed country-level costs, 2001-2002

*Chart 7: Planned costs in 10 global priority countries, 2001-2002*

*Table 2: Details of planned costs in endemic and high-risk countries, 2001-2002*

### Preamble to Table 2

WHO and UNICEF developed figures for the 10 global priority countries (Afghanistan, Angola, Bangladesh, DR Congo, Ethiopia, India, Nigeria, Pakistan, Somalia, Sudan) and Chad, Congo, Iraq and Niger in collaboration with national ministries of health. All other figures were developed by WHO Regional and country offices in collaboration with national ministries of health.

***\*Note for the Democratic Republic of the Congo:*** Operational and surveillance costs are contingent upon negotiation of an official exchange rate

consistent with the market exchange rate. The figure in brackets indicates the cost should current exchange rates apply in 2001 and 2002.

***\*\*Note for Nigeria:*** Final external resources required for operational costs depend on national government contributions and cold chain rehabilitation costs being covered from other sources. The figure in brackets indicates total costs should external financing be required for all operational costs.

## Global priority countries for polio eradication

Among the 30 polio endemic countries at the end of 1999, 10 are noted in the Strategic Plan 2001-2005<sup>6</sup> as global polio priority countries because they face unique challenges that place them at high risk of sustaining polio transmission in 2001.

### Reservoir countries

*Bangladesh, Democratic Republic of the Congo<sup>7</sup>, Ethiopia, India, Nigeria, Pakistan.*

These countries are characterized by large high-density populations, high birth rates, low immunization coverage in large areas of the country, and suboptimal sanitation. Historically, these countries have served as "global reservoirs" of the virus, exporting poliovirus to other countries.

*Nigeria*, the most populous country in Africa, is firmly committed to polio eradication, providing US\$ 15 million in national resources for oral polio vaccine (OPV) during 1999. However, Nigeria is a poliovirus reservoir, and will need to conduct five annual NIDs rounds in 2001 and 2002 to reach all children aged less than five years. In addition, surveillance must be improved so that poliovirus can be rapidly detected throughout the country.

*India*, the most populous remaining endemic country, has made spectacular progress towards eradication, with only 124 polio cases reported up to August 2000. When the polio eradication initiative was launched in 1988, India accounted for about 70% of cases – and now accounts for only about 10%. Most polio cases occur in the northern states of Bihar and Uttar Pradesh. Surveillance throughout the country is of very good quality. During 2001 and 2002, two NIDs are planned with two additional subnational immunization days (SNIDs) in northern states.

*Pakistan* has engaged in intense polio eradication activities since 1996. However, wide spread poliovirus transmission continues throughout the country, and Pakistan currently reports more polio cases during 2000 than any other country. To interrupt transmission, five NIDs rounds will be needed during 2001 and four NIDs rounds in 2002.

*Bangladesh* has made steady progress towards polio eradication with no polio cases reported during 2000, in the light of good surveillance. NIDs have also been successfully used to administer vitamin A. During 2001 and 2002, Bangladesh must continue NIDs, with four annual rounds to reach the 14.7 million target children aged less than five years.

*Ethiopia's* NID coverage of the 10.8 million target children has been greater than 80% since 1997. However, the recent conflict has made implementation difficult with polio reported during 2000. Surveillance must be strengthened throughout the country so that ongoing poliovirus transmission is rapidly detected.

### Conflict affected countries

*Afghanistan, Angola, Democratic Republic of the Congo (DRC), Somalia, Sudan.*

The ongoing conflict in these countries makes implementation of vaccination and surveillance activities particularly challenging, compounded by a non-existent or weakened infrastructure.

*Afghanistan* has conducted polio eradication activities since 1994 despite ongoing conflict. During 1999 and 2000, NIDs reached more than 80% of the four million target children aged less than five years. During 2001, these children will be targeted to receive OPV during five NIDs rounds and four NIDs rounds in 2002.

*Angola*, at war for more than a generation, has suffered serious damage to its health infrastructure, with only about 40% of infants receiving routine immunizations. This low coverage, particularly among displaced groups, contributed to the largest ever African polio outbreak occurring in Angola during 1999 (more than 1100 cases and 89 reported deaths.) NIDs have been conducted since 1996, reaching more than 80% of children aged less than five years in accessible areas. Major challenges during 2001 and 2002 include ensuring that the annual NIDs rounds reach the 2.3 million target children in all areas of the country.

<sup>6</sup> Strategic Plan 2001-2005.WHO/Polio/00.05

<sup>7</sup> The Democratic Republic of the Congo is a reservoir and conflict-affected country, with the compounded difficulties posed by both challenges.

**Democratic Republic of the Congo (DRC)** is a particular challenge as a country in conflict and a global polio reservoir. Poliovirus from DRC has reseeded polio into neighbouring countries, threatening progress in East and Southern Africa. The first full NIDs were conducted in 1999, facilitated by Days of Tranquillity negotiated by UN Secretary-General Kofi Annan. NIDs were conducted in 2000, reaching most areas of the country. During 2001 and 2002, three annual NIDs rounds are planned with a call by the UN Secretary-General for cessation of conflict to facilitate these activities.

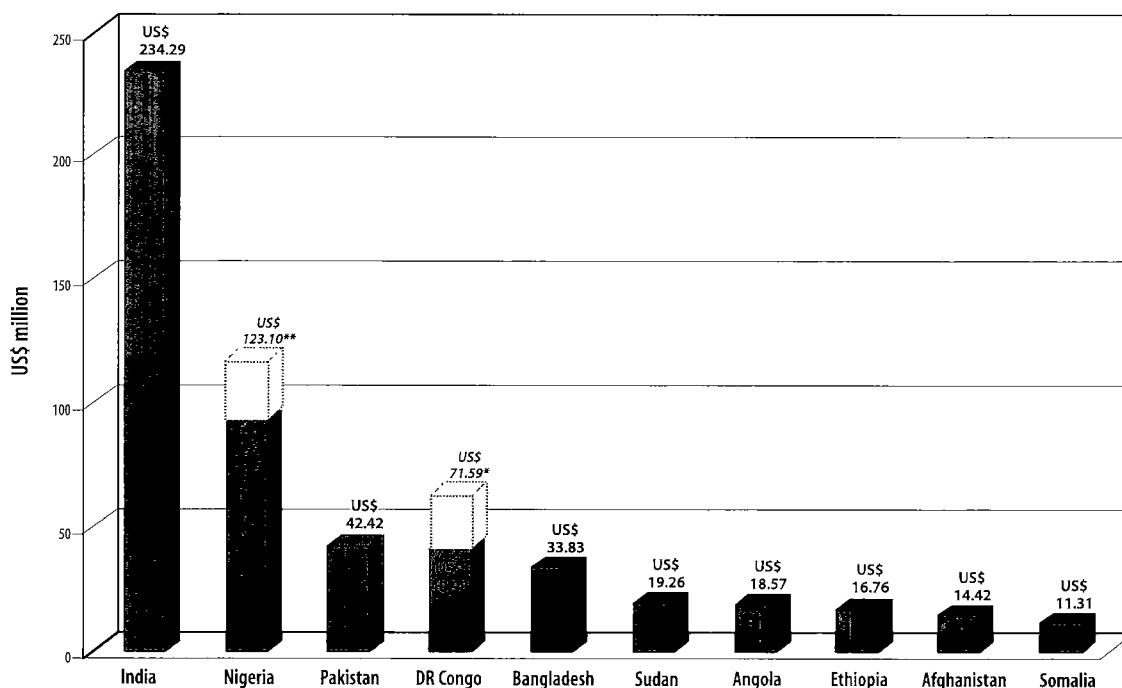
**Somalia**, without a central government and shaken by factional fighting, has been in a state of complex emergency since the early 1990s. The first NIDs

were conducted in late 1998, and have occurred annually since then. Demand for immunization has been so strong that rebel leaders banned carrying of arms and de-mined roads to permit access for immunization teams. However, poliovirus transmission continues during 2000, with an ongoing outbreak in the capital of Mogadishu.

In **Sudan**, generation-long civil war has prevented the delivery of routine immunization services in the southern states for more than 20 years. Under the auspices of Operation Lifeline Sudan (OLS), the first NIDs were conducted in 1998 with participation of 26 nongovernmental organizations. To interrupt polio transmission, five NIDs rounds will be needed during 2001 and four rounds during 2002.

**Chart 7: Planned costs in 10 global priority countries, 2001–2002**

all figures in US\$ million



\*/\*\* Please see Table 2 for detailed notes on country-level requirements

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### **Other strategic priorities**

In addition to these 10 countries, the initiative regularly identifies other strategic priorities which require particular attention and resources. It is anticipated that Chad, Congo-Brazzaville, Iraq and Niger will continue to be strategic priorities through end 2002.

*Chad* has extremely intense poliovirus transmission, and constitutes one of the most intense areas of transmission in the world. To stop poliovirus transmission, five annual NIDs rounds are planned for 2001 and 2002. These NIDs must reach all of the 1.3 million children aged less than five years. Surveillance in Chad has improved, however, efforts during 2001 must ensure that certification-standard surveillance is established.

*Congo-Brazzaville* experienced a polio outbreak in 2000, with at least nine laboratory confirmed cases.

To stop the transmission, NIDs will be conducted during the fall. In 2001 and 2002, three annual NIDs rounds are planned, and surveillance must be improved.

*Iraq* experienced a polio epidemic in 1999 with 72 laboratory confirmed cases. Polio transmission has continued during 2000. During 2001, four NIDs rounds are planned and two are planned for 2002 to administer OPV to all the 3.3 million target children.

*Niger* conducted high quality house-to-house SNIDs during spring 2000, that reached more than 10% more children than previously. During 2001 and 2002, four annual NIDs rounds are planned, and surveillance quality should be further improved.

Table 2: Details of planned costs in endemic and high-risk countries 2001-2002

(US\$ million)

		Year 2001			
Endemic status	Country	Type of activity			Total costs 2001
		NIDs/SNIDs: OPV	NIDs/SNIDs: operations	AFP surveillance and laboratory	
<b>Priority 10</b>					
	Afghanistan	\$2.86	\$4.55	\$0.40	\$7.82
	Angola	\$1.65	\$7.29	\$0.84	\$9.78
	Bangladesh	\$11.79	\$4.38	\$1.16	\$17.34
	DR Congo*	\$5.37	\$12.00 (\$26.90)	\$2.73	\$20.10 (\$35.00)
	Ethiopia	\$3.53	\$6.41	\$0.80	\$10.74
	India	\$51.98	\$55.65	\$9.62	\$117.26
	Nigeria**	\$17.10	\$27.45 (\$45.65)	\$1.60	\$46.15 (\$64.35)
	Pakistan	\$16.04	\$6.29	\$0.91	\$23.24
	Somalia	\$0.69	\$3.57	\$1.32	\$5.58
	Sudan	\$3.57	\$4.58	\$1.98	\$10.13
<b>Other endemic</b>					
	Benin	\$0.40	\$0.80	\$0.31	\$1.51
	Burkina Faso	\$0.80	\$1.60	\$0.20	\$2.60
	Cameroon	\$1.00	\$1.80	\$0.11	\$2.91
	Central African Rep.	\$0.20	\$0.70	\$0.19	\$1.09
	Chad	\$0.55	\$1.80	\$0.23	\$2.59
	Congo	\$0.19	\$0.85	\$0.35	\$1.39
	Côte d'Ivoire	\$1.00	\$2.50	\$0.15	\$3.65
	DPRKorea	\$0.50	\$0.70	\$0.40	\$1.60
	Eritrea	\$0.09	\$0.10	\$0.05	\$0.24
	Ghana	\$1.20	\$2.40	\$0.21	\$3.81
	Guinea	\$0.50	\$0.90	\$0.08	\$1.48
	Guinea-Bissau	\$0.02	\$0.09	\$0.02	\$0.14
	Iraq	\$1.75	\$2.35	\$0.33	\$4.43
	Liberia	\$0.40	\$1.60	\$0.08	\$2.08
	Mali	\$0.20	\$0.50	\$0.15	\$0.85
	Nepal	\$1.27	\$3.82	\$1.10	\$6.19
	Niger	\$1.19	\$4.76	\$0.31	\$6.27
	Sierra Leone	\$0.80	\$5.00	\$0.10	\$5.90
	Togo	\$0.30	\$0.50	\$0.20	\$1.00
<b>High risk</b>					
	Burundi	\$0.08	\$0.10	\$0.09	\$0.27
	Equatorial Guinea	\$0.05	\$0.20	\$0.01	\$0.26
	Gabon	\$0.08	\$0.80	\$0.30	\$1.19
	Gambia	\$0.02	\$0.02	\$0.01	\$0.06
	Kenya	\$1.10	\$2.00	\$0.81	\$3.91
	Madagascar	\$0.40	\$0.70	\$0.15	\$1.25
	Malawi	\$0.00	\$0.00	\$0.15	\$0.15
	Mauritania	\$0.01	\$0.10	\$0.03	\$0.15
	Mozambique	\$0.60	\$1.00	\$0.15	\$1.75
	Myanmar	\$1.32	\$1.11	\$0.39	\$2.82
	Namibia	\$0.06	\$0.15	\$0.05	\$0.26
	Rwanda	\$0.09	\$0.23	\$0.10	\$0.42
	Senegal	\$0.19	\$0.20	\$0.11	\$0.50
	Sri Lanka	\$0.11	\$0.30	\$0.19	\$0.60
	Tajikistan	\$0.19	\$0.02	\$0.04	\$0.25
	Tanzania	\$0.65	\$1.00	\$0.45	\$2.10
	Turkey	\$1.19	\$0.40	\$0.12	\$1.71
	Turkmenistan	\$0.10	\$0.01	\$0.02	\$0.14
	Uganda	\$0.40	\$0.90	\$0.05	\$1.35
	Uzbekistan	\$0.47	\$0.03	\$0.04	\$0.53
	Yemen	\$1.25	\$0.80	\$0.31	\$2.36
	Zambia	\$0.00	\$0.00	\$0.09	\$0.09
	Zimbabwe	\$0.00	\$0.00	\$0.10	\$0.10

\*\*/\*\* See notes for Nigeria and DR Congo on page 13

		Year 2002			
Endemic status	Country	Type of activity			Total costs 2002
		NIDs/SNIDs: OPV	NIDs/SNIDs: operations	AFP surveillance and laboratory	
<b>Priority 10</b>					
	Afghanistan	\$2.66	\$3.64	\$0.30	\$6.60
	Angola	\$1.70	\$6.11	\$0.98	\$8.79
	Bangladesh	\$10.69	\$4.53	\$1.28	\$16.49
	DR Congo*	\$5.54	\$12.00 (\$27.71)	\$3.34	\$20.88 (\$36.59)
	Ethiopia	\$1.68	\$3.54	\$0.80	\$6.02
	India	\$59.50	\$50.96	\$6.57	\$117.03
	Nigeria**	\$17.10	\$27.45 (\$39.45)	\$2.20	\$46.75 (\$58.75)
	Pakistan	\$13.07	\$5.21	\$0.90	\$19.18
	Somalia	\$0.79	\$3.38	\$1.57	\$5.74
	Sudan	\$3.08	\$4.10	\$1.95	\$9.13
<b>Other endemic</b>					
	Benin	\$0.40	\$0.80	\$0.31	\$1.51
	Burkina Faso	\$0.80	\$1.50	\$0.10	\$2.40
	Cameroon	\$6.00	\$2.20	\$0.11	\$3.31
	Central African Rep.	\$0.20	\$0.70	\$0.11	\$1.01
	Chad	\$0.57	\$2.25	\$0.20	\$3.01
	Congo	\$0.19	\$0.95	\$0.35	\$1.49
	Côte d'Ivoire	\$1.00	\$2.50	\$0.15	\$3.65
	DPRKorea	\$0.48	\$0.90	\$0.38	\$1.76
	Eritrea	\$0.03	\$0.10	\$0.05	\$0.17
	Ghana	\$1.00	\$2.40	\$0.21	\$3.61
	Guinea	\$0.50	\$0.90	\$0.08	\$1.48
	Guinea-Bissau	\$0.02	\$0.09	\$0.02	\$0.14
	Iraq	\$0.95	\$1.68	\$0.30	\$2.93
	Liberia	\$0.40	\$1.50	\$0.08	\$1.98
	Mali	\$0.30	\$0.80	\$0.10	\$1.20
	Nepal	\$0.00	\$0.00	\$1.20	\$1.20
	Niger	\$1.24	\$4.91	\$0.32	\$6.46
	Sierra Leone	\$0.40	\$3.00	\$0.10	\$3.50
	Togo	\$0.30	\$0.50	\$0.10	\$0.90
<b>High risk</b>					
	Burundi	\$0.13	\$0.20	\$0.09	\$0.42
	Equatorial Guinea	\$0.05	\$0.20	\$0.01	\$0.26
	Gabon	\$0.08	\$0.80	\$0.30	\$1.18
	Gambia	\$0.01	\$0.01	\$0.01	\$0.04
	Kenya	\$0.50	\$1.00	\$0.46	\$1.96
	Madagascar	\$0.00	\$0.00	\$0.10	\$0.10
	Malawi	\$0.00	\$0.00	\$0.10	\$0.10
	Mauritania	\$0.01	\$0.05	\$0.03	\$0.09
	Mozambique	\$0.00	\$0.00	\$0.15	\$0.15
	Myanmar	\$1.50	\$1.10	\$0.39	\$2.99
	Namibia	\$0.06	\$0.10	\$0.05	\$0.21
	Rwanda	\$0.07	\$0.13	\$0.07	\$0.26
	Senegal	\$0.10	\$0.10	\$0.10	\$0.30
	Sri Lanka	\$0.11	\$0.30	\$0.19	\$0.60
	Tajikistan	\$0.17	\$0.02	\$0.04	\$0.22
	Tanzania	\$0.35	\$0.75	\$0.48	\$1.58
	Turkey	\$0.60	\$0.40	\$0.12	\$1.12
	Turkmenistan	\$0.10	\$0.01	\$0.02	\$0.14
	Uganda	\$0.20	\$0.45	\$0.05	\$0.70
	Uzbekistan	\$0.55	\$0.01	\$0.04	\$0.59
	Yemen	\$0.75	\$0.45	\$0.30	\$1.50
	Zambia	\$0.00	\$0.00	\$0.09	\$0.09
	Zimbabwe	\$0.00	\$0.00	\$0.10	\$0.10

\*/\*\* See notes for Nigeria and DR Congo on page 13

		Year 2001-2002 Total			
Endemic status	Country	Type of activity			Total costs 2001-2002
		NIDs/SNIDs: OPV	NIDs/SNIDs: operations	AFP surveillance and laboratory	
<b>Priority 10</b>					
	Afghanistan	\$5.53	\$8.19	\$0.70	\$14.42
	Angola	\$3.36	\$13.40	\$1.82	\$18.57
	Bangladesh	\$22.48	\$8.91	\$2.44	\$33.83
	DR Congo*	\$10.91	\$24.00 (\$54.61)	\$6.07	\$40.98 (\$71.59)
	Ethiopia	\$5.21	\$9.95	\$1.60	\$16.76
	India	\$111.49	\$106.61	\$16.19	\$234.29
	Nigeria**	\$34.20	\$54.90 (\$85.10)	\$3.80	\$92.90 (\$123.10)
	Pakistan	\$29.11	\$11.50	\$1.81	\$42.42
	Somalia	\$1.48	\$6.95	\$2.89	\$11.31
	Sudan	\$6.65	\$8.68	\$3.93	\$19.26
<b>Other endemic</b>					
	Benin	\$0.80	\$1.60	\$0.62	\$3.02
	Burkina Faso	\$1.60	\$3.10	\$0.30	\$5.00
	Cameroon	\$2.00	\$4.00	\$0.22	\$6.22
	Central African Rep.	\$0.40	\$1.40	\$0.30	\$2.10
	Chad	\$1.12	\$4.05	\$0.43	\$5.60
	Congo	\$0.38	\$1.80	\$0.70	\$2.88
	Côte d'Ivoire	\$2.00	\$5.00	\$0.30	\$7.30
	DPRKorea	\$0.98	\$1.60	\$0.78	\$3.36
	Eritrea	\$0.12	\$0.20	\$0.09	\$0.41
	Ghana	\$2.20	\$4.80	\$0.42	\$7.42
	Guinea	\$1.00	\$1.80	\$0.16	\$2.96
	Guinea-Bissau	\$0.04	\$0.18	\$0.04	\$0.27
	Iraq	\$2.70	\$4.03	\$0.63	\$7.36
	Liberia	\$0.80	\$3.10	\$0.16	\$4.06
	Mali	\$0.50	\$1.30	\$0.25	\$2.05
	Nepal	\$1.27	\$3.82	\$2.30	\$7.39
	Niger	\$2.43	\$9.67	\$0.63	\$12.73
	Sierra Leone	\$1.20	\$8.00	\$0.20	\$9.40
	Togo	\$0.60	\$1.00	\$0.30	\$1.90
<b>High risk</b>					
	Burundi	\$0.21	\$0.30	\$0.18	\$0.69
	Equatorial Guinea	\$0.09	\$0.40	\$0.02	\$0.51
	Gabon	\$0.17	\$1.60	\$0.60	\$2.37
	Gambia	\$0.04	\$0.04	\$0.03	\$0.10
	Kenya	\$1.60	\$3.00	\$1.27	\$5.87
	Madagascar	\$0.40	\$0.70	\$0.25	\$1.35
	Malawi	\$0.00	\$0.00	\$0.25	\$0.25
	Mauritania	\$0.02	\$0.15	\$0.06	\$0.23
	Mozambique	\$0.60	\$1.00	\$0.30	\$1.90
	Myanmar	\$2.82	\$2.21	\$0.79	\$5.81
	Namibia	\$0.11	\$0.25	\$0.10	\$0.46
	Rwanda	\$0.16	\$0.35	\$0.17	\$0.67
	Senegal	\$0.28	\$0.30	\$0.21	\$0.80
	Sri Lanka	\$0.22	\$0.60	\$0.37	\$1.19
	Tajikistan	\$0.36	\$0.04	\$0.07	\$0.47
	Tanzania	\$1.00	\$1.75	\$0.93	\$3.68
	Turkey	\$1.79	\$0.80	\$0.24	\$2.83
	Turkmenistan	\$0.21	\$0.03	\$0.04	\$0.27
	Uganda	\$0.60	\$1.35	\$0.10	\$2.05
	Uzbekistan	\$1.02	\$0.04	\$0.07	\$1.13
	Yemen	\$2.00	\$1.25	\$0.61	\$3.86
	Zambia	\$0.00	\$0.00	\$0.18	\$0.18
	Zimbabwe	\$0.00	\$0.00	\$0.20	\$0.20

\*/\*\* See notes for Nigeria and DR Congo on page 13



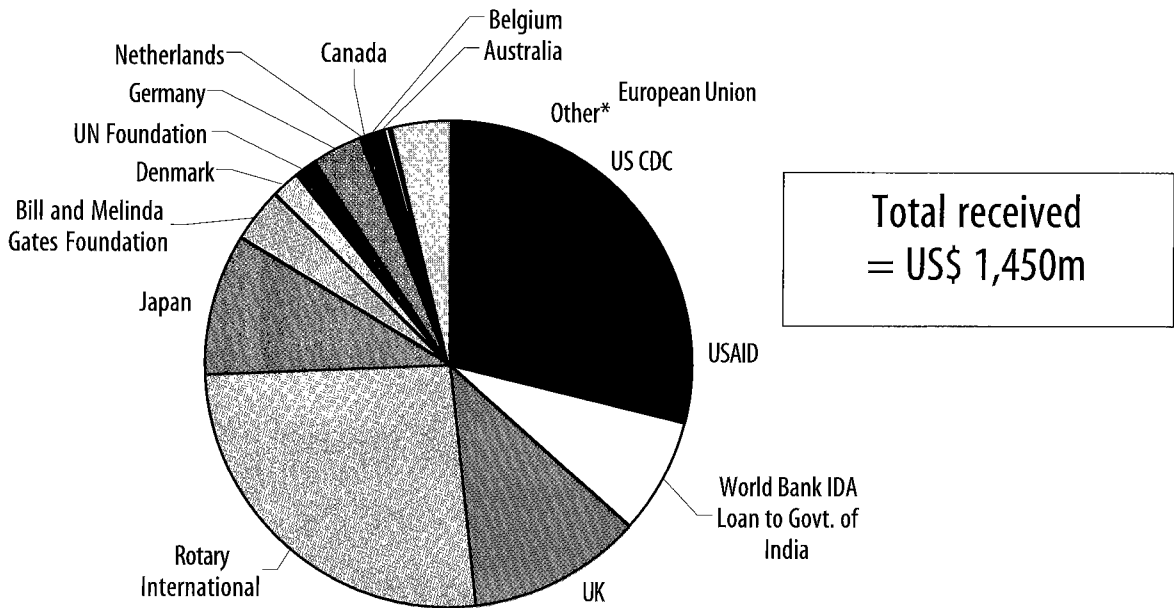


## 5. Historical costs and contributions

*Chart 8: Donor contributions to polio eradication, 1985-2000*

*Chart 9: Annual contributions received and projected to polio eradication, 1985-2005*

**Chart 8: Donor contributions to polio eradication, 1985-2000**



\* "Other" includes past contributions from the Agency for Cooperation in International Health, (Japan); American Association for World Health (USA); Aventis Pasteur; Custom Monoclonals International (USA); De Beers; Finland; Institut Merieux; Miss Martina Hingis; Italy; Japanese Committee for "Vaccines for the World's Children"; Malaysia; Millennium Fund; Norway; Portugal; Republic of Korea (GOK); Smith Kline Biologicals (Belgium); Switzerland; United Arab Emirates; WHO casual income; WHO regular budget; and UNICEF.

**Chart 9: Annual contributions received and projected to polio eradication, 1985-2005**

