# FINANCIAL RESOURCE REQUIREMENTS

2013-2018 (As of 1 July 2014)

World Health Organization

PARTNERS IN THE GLOBAL POLIO ERADICATION INITIATIVE

unicef

POLIO GLOBAL ERADICATION INITIATIVE

Photo front cover: © Rotary International. All Rights Reserved. Alyce Henson/Senior Staff Photographer/Photo Editor.
Child receives the oral polio vaccine in an Azuretti Fishing Village. Cote d' Ivoire.

Photo back cover: © UNICEF Afghanistan/2012/ Aziz Froutan
An Afghan health worker marks finger of a boy after immunizing him during the National Immunization Days (NIDs) in Kabul on 22/04/2012. The second round of National Immunization Days (NID) in 2012 was organized in Afghanistan from April 22nd to April 24th, across the country. Trivalent OPV was used to immunize an estimated target of 8.1 million children under five years of age.

Design & Layout: www.acw.uk.com

# TABLE OF CONTENTS

# EXECUTIVE SUMMARY

*The Financial Resource Requirements (FRR) is the accompanying budget document to the Polio Eradication & Endgame Strategic Plan 2013-2018 of the Global Polio Eradication Initiative (GPEI). The FRR is updated every four months based on evolving epidemiology and available funding. This edition of the FRR provides detailed information for 2014 and high-level figures for 2015-2018. Subsequent publications will provide greater detail for future years. The financial needs reflected in this publication represent requirements for activities to be implemented by WHO and UNICEF in coordination with national governments and include agency overhead costs where applicable. The FRRs do not include estimations of costs incurred directly by national governments. For additional information, please see:* ***www.polioeradication.org/financing***

## A CLEAR, MULTI-YEAR BUDGET TO ACHIEVE SUCCESS

The budget for the Polio Eradication & Endgame Strategic Plan 2013-2018 (Endgame Plan) is US$ 5.5 billion, with costs peaking at US$ 1 154 million in 2014, then declining annually to US$ 721 million in 2018 (Table 1). The budget has four major cost categories (immunization activities, surveillance and response capacity, containment and certification, and core functions and infrastructure). The main assumptions that underpin the cost model behind the budget are based upon the key milestones and outcome indicators described in the Endgame Plan, including global certification of the eradication of polio by end-2018. For a full version of the Plan, please see: **www.polioeradication.org/Resourcelibrary/Strategyandwork.aspx**

## COMMITMENTS TO FULLY FUND THE PLAN

On 25 April 2013, the Endgame Plan was shared at the Global Vaccine Summit in Abu Dhabi. Global leaders, donor nations, and polio-affected countries signaled their confidence in the plan by pledging over US$ 4 billion towards the Endgame Plan's projected US$ 5.5 billion cost over six years. They also called upon the donor community at large to commit up front the additional US$ 1.5 billion needed to fully resource the Endgame Plan.

Top priorities for the GPEI are to continue to work with partners to convert the pledges into signed agreements and cash disbursements and to secure the additional resources required to close the funding gap[1].

As of 1 July 2014, for the period 2013-2018, the GPEI has received US$1 986 billion in contributions and is tracking over US$ 3 045 billion in pledges/projections, which if fully realized would result in a funding gap of US$ 494 million **(Table 1).**

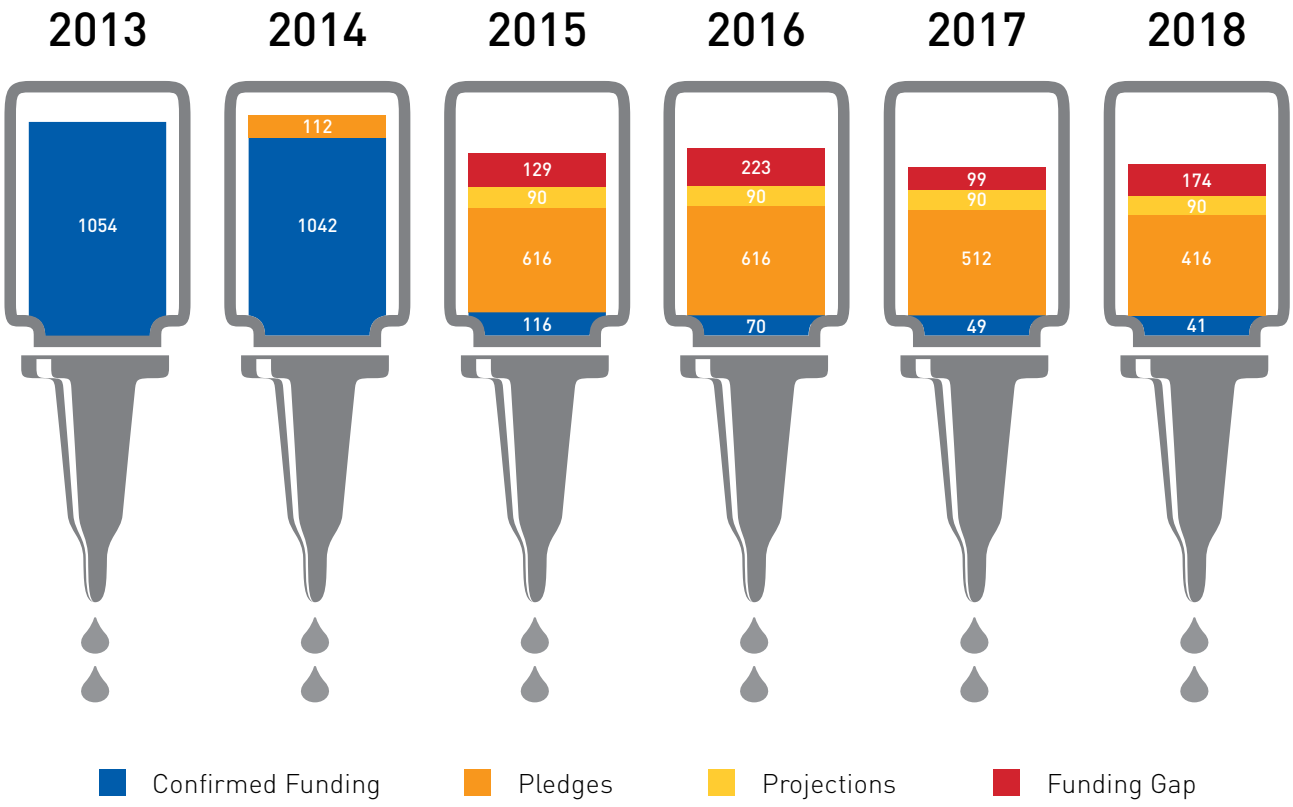
On 5 May 2014, on the advice of an Emergency Committee under the International Health Regulations (2005) (IHR), the Director-General of the World Health Organization (WHO) declared the international spread of wild poliovirus to be a Public Health Emergency of International Concern (PHEIC) and issued Temporary Recommendations for 'States currently exporting wild poliovirus' and 'States infected with wild poliovirus but not currently exporting'. Within this context, the Emergency Committee emphasized the importance of continued support to countries by partners, noting the additional challenges, both material and technical, in implementing the Temporary Recommendations.

## IMPROVING OVERSIGHT, ACCOUNTABILITY AND COORDINATION

An important aspect of the Endgame Plan's success is putting the right checks and balances in place to ensure not only that milestones are met and the programme is well-managed and effective, but also that the GPEI remains a good steward of financial resources. Governance mechanisms have been refined and broadened to further strengthen oversight, accountability and coordination for the duration of the Polio Eradication & Endgame Strategic Plan 2013-2018, including strengthening stakeholder engagement at global level through the Polio Partners Group participation in the Polio Oversight Board as well as consultation on major decisions impacting the programme (please refer to **Figure 4** "Governance Structure for the Implementation of the Plan").

1 The funding gap represents GPEI's public messaging, and public recognition, of contributions for the full period covered by the Strategic Plan and includes all confirmed and pledged funding. The cash gap represents GPEI's internal operating position in the near term, and includes funds available for expenditure by the programme. The GPEI also monitors the status of projected funding (against the funding gap) and pipeline funding plus pledges under negotiation (against the cash gap) to determine the potential future impact on both gaps.

**FIGURE 1**
**SUMMARY OF CONTRIBUTIONS AGAINST GPEI 2013-2018 REQUIREMENTS (all figures in US$ millions)**
**Note: data matches July FRR funding gap**




## THE MOST EFFECTIVE OPTION: THE ECONOMIC CASE FOR POLIO ERADICATION

The Endgame Plan has been developed to capitalize on the unique opportunity to eradicate a disease for only the second time in history. Over US$ 10 billion has been invested from 1988-2012, generating net benefits of US$ 27 billion, out of the total US$ 40-50 billion savings previously estimated for low income countries alone[2]. To build support to mobilize the additional resources required to implement the Endgame Plan's US$ 5.5 billion budget, a review of the economic case for continuing to invest in polio eradication was conducted in advance of the Global Vaccine Summit. Building on an existing body of work[3], the **Economic Case for Polio Eradication** provides a forward-looking perspective on the benefits of eradication using updated cost inputs that underpin the Endgame Plan. The Case argues that eradication remains unequivocally more cost effective than the alternatives of control or routine immunization alone. Cost-effectiveness increases further when accounting for the GPEI's contributions to health programs beyond polio and strengthening resource management. (For the full document, please see: **www.polioeradication.org/Portals/0/Document/Resources/StrategyWork/EconomicCase.pdf**

2 Duintjer Tebbens RJ, Pallansch MA, Cochi SL, Wassilak SGF, Linkins J, Sutter RW, Aylward RB, Thompson KM. Economic analysis of the Global Polio Eradication Initiative. Vaccine 2011;29(2):334-343.

3 Thompson KM, Duintjer Tebbens RJ. Eradication versus control for poliomyelitis: An economic analysis. The Lancet 2007; 369 (9570):1363-71.

## TABLE 1
## SUMMARY OF EXTERNAL RESOURCE REQUIREMENTS BY MAJOR CATEGORY OF ACTIVITY, 2013-2018
## (all figures in US$ millions)

| IMMUNIZATION ACTIVITIES | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | Total 2013 -18 |
|---|---|---|---|---|---|---|---|
| Planned OPV Campaigns (OPV) | 217 | 197 | 107 | 98 | 78 | 78 | 773 |
| Planned OPV Campaigns (WHO - Operational Cost) | 293 | 276 | 156 | 137 | 98 | 98 | 1 058 |
| Planned OPV Campaigns (UNICEF - Operational Cost) | 49 | 37 | 25 | 22 | 18 | 18 | 169 |
| Planned OPV Campaigns (Social Mobilization) | 48 | 55 | 26 | 15 | 10 | 10 | 165 |
| *Complementary OPV Campaigns | - | - | - | - | - | - | - |
| IPV in Routine Immunization | - | 47 | 119 | 102 | 87 | 79 | 433 |
| **Sub-Total** | **607** | **613** | **433** | **374** | **291** | **282** | **2 600** |
| | | | | | | | |
| **SURVEILLANCE AND RESPONSE CAPACITY** | | | | | | | |
| Surveillance and Running Costs (incl. Security) | 64 | 63 | 63 | 63 | 63 | 63 | 382 |
| Laboratory | 11 | 11 | 11 | 11 | 11 | 11 | 68 |
| Environmental Surveillance | - | 5 | 5 | 5 | 5 | 5 | 25 |
| Emergency Response (UNICEF) | - | 12 | 20 | 20 | 16 | 8 | 76 |
| Emergency Response (WHO) | - | 18 | 30 | 30 | 23 | 12 | 113 |
| Stockpiles for Emergency Response | - | 12 | - | 12 | - | - | 25 |
| **Sub-Total** | **76** | **122** | **130** | **142** | **119** | **100** | **688** |
| | | | | | | | |
| **POLIOVIRUS CONTAINMENT** | | | | | | | |
| Certification and Containment | 5 | 5 | 5 | 5 | 5 | 5 | 30 |
| Surveillance and Lab enhancement for Certification | - | 4 | 4 | 4 | 4 | 4 | 19 |
| **Sub-Total** | **5** | **9** | **9** | **9** | **9** | **9** | **49** |
| | | | | | | | |
| **CORE FUNCTIONS AND INFRASTRUCTURE** | | | | | | | |
| Ongoing quality improvement, surge capacity, endgame risk management, OPV cessation, additional innovations & programmatic adjustments | 75 | 98 | 84 | 81 | 51 | 50 | 438 |
| Technical Assistance (WHO) | 129 | 135 | 130 | 128 | 128 | 129 | 780 |
| Technical Assistance (UNICEF) | 33 | 34 | 34 | 34 | 34 | 34 | 205 |
| Community Engagement and Social Mobilization | 54 | 62 | 62 | 62 | 62 | 62 | 362 |
| R&D and Technology Transfer | 10 | 10 | 10 | 10 | 10 | 10 | 60 |
| **Sub-Total** | **301** | **339** | **320** | **316** | **285** | **285** | **1 844** |
| | | | | | | | |
| **Subtotal Direct Costs** | **988** | **1 082** | **892** | **841** | **703** | **676** | **5 181** |
| | | | | | | | |
| Indirect costs | 65 | 72 | 59 | 55 | 47 | 45 | 343 |
| **GRAND TOTAL** | **1 054** | **1 154** | **951** | **896** | **750** | **721** | **5 525** |
| | | | | | | | |
| Contributions (rounded), including 2012 carry-forward* | 1 054 | 657 | 116 | 70 | 49 | 41 | 1 986 |
| | | | | | | | |
| **Funding Gap** | **-** | **497** | **835** | **826** | **701** | **680** | **3 539** |
| | | | | | | | |
| Prospects/Projections (rounded) | | | | | | | 3 045 |
| | | | | | | | |
| **Best Case Gap** | | | | | | | **494** |

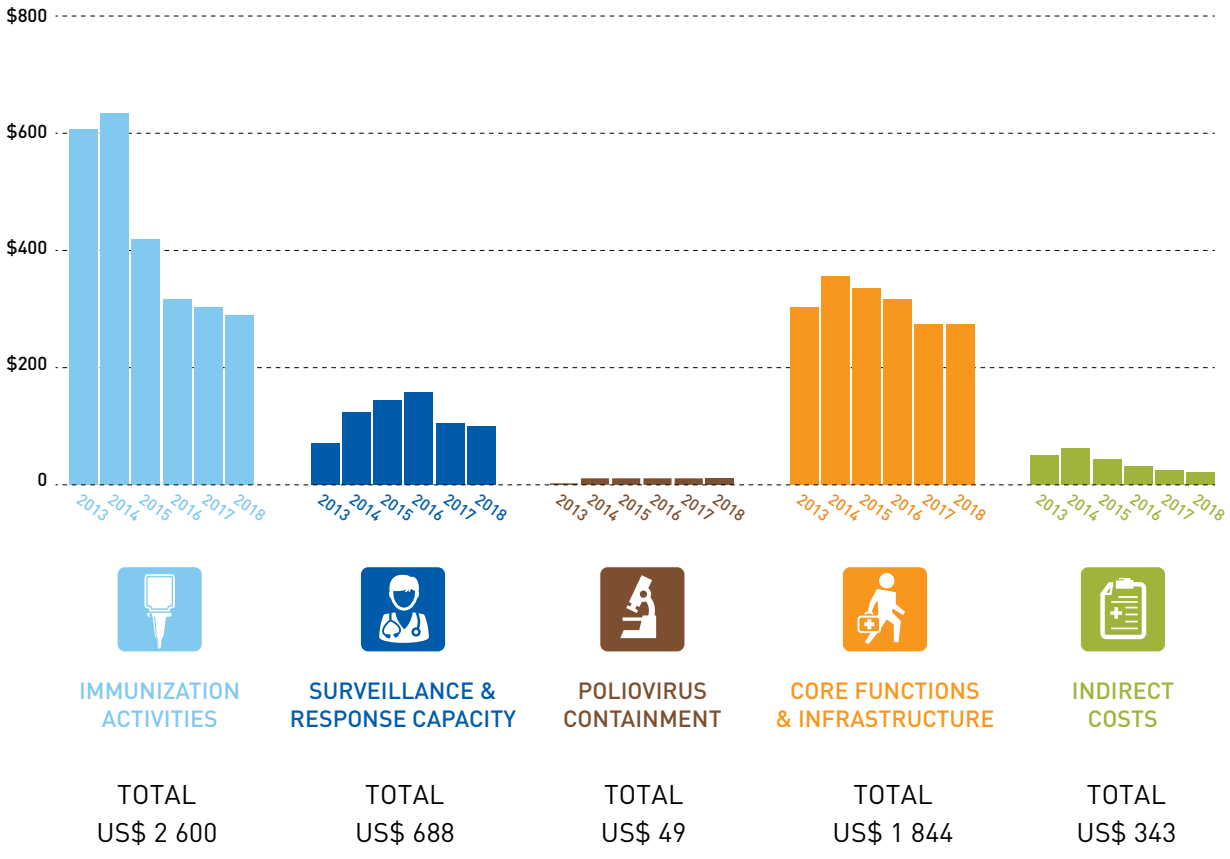
*Note: Complementary campaigns budget has been moved to planned inmunization activities

# 1) BUDGET ASSUMPTIONS & CATEGORIES

A thorough cost analysis was conducted by the Global Polio Eradication Initiative (GPEI) during the second half of 2012, resulting in the establishment of the budget of US$ 5.5 billion to achieve the Endgame Plan's objectives from 2013 through 2018. Based on evolving epidemiology and risk, the budget estimates were reviewed and updated during the first half of 2014. Recommended changes to annual budgets were approved by the Polio Oversight Board (POB) during their June 2014 meeting*. The overall budget remains US$ 5.5 billion.

The budget has four major cost categories **(Figure 2)** with accompanying assumptions **(Table 2)** that underpin the cost model.
While interruption of wild poliovirus globally cannot be guaranteed by a particular date, and various factors could intervene, the current budget reflects the overall goal of a polio-free world by 2018, with costs peaking at US$ 1 154 million in 2014 then declining annually to US$ 720 million in 2018.

**FIGURE 2**
**PLAN BUDGET BY MAJOR BUDGET CATEGORY (all figures in US$ millions)**




*http://www.polioeradication.org/Aboutus/Governance/PolioOversightBoard.aspx

**TABLE 2**
**COST ASSUMPTION BY MAJOR BUDGET CATEGORY**

| BUDGET CATEGORY | ASSUMPTIONS |
|---|---|
| **OPV Campaigns** | Represents Oral Polio Vaccine (OPV) costs, operations costs, and campaign-related social mobilization costs. See Annex B for additional details Calendar of Supplementary Immunization Activities, 2014 |
| **IPV in Routine Immunization** | Reflects IPV introduction assumptions outlined in the Strategic Plan: all OPV-only using countries introduce at least one dose of IPV into their routine immunization programmes starting in 2014 with 100% uptake before the end of 2015<br><br>Includes full annual IPV costs for all Gavi-eligible and Gavi graduate countries (excluding India and China); limited support is included for selected lower-middle income and upper-middle income OPV-using countries. A maximum amount of $US 45 million has been estimated for this purpose |
| **Surveillance/Laboratory** | Reflects 2013 surveillance and lab activity requirements being maintained on an annual basis until 2018 |
| **Environmental Surveillance** | Assumes up to US$5 million will be required on an annual basis from 2014 to 2018 |
| **Emergency Response** | Represents estimations for vaccine and operations costs for emergency response:<br>- 2013 US$ 49.5 million<br>- 2014 US$ 30 million (US$ 18 million for WHO & US$ 12 million for UNICEF/year)<br>- 2015 - 2016 US$ 50 million (US $30 million for WHO & US$ 20 million for UNICEF/year)<br>- 2017 US$ 39 million (US$ 23 million for WHO & US$ 16 million for UNICEF)<br>- 2018 US$ 20 million (US$ 12 million for WHO & US$ 8 million for UNICEF) |
| **Stockpile** | Represents Stockpile projections for 2014 and 2016 (US$ 12.3 million each year) based upon existing contracts with manufacturers; funds have already transferred to UNICEF |
| **Certification and Containment** | Represents annual provision for regional and country level activities as well as any enhancements that may be required to surveillance and lab capacity in preparation for certification and containment |
| **On-going quality improvements, surge capacity, risk management** | Reflects surge capacity in endemic and high-risk countries through 2016 that will support activities required to interrupt transmission; estimations for unanticipated innovations to achieve and sustain interruption and ongoing unanticipated risk management activities |
| **Technical Assistance** | Represents requirements for technical assistance defined during the September 2012 planning exercise for 2013-2018 conducted by WHO AFR, EMR and SEAR; other areas maintain technical assistance at 2013 levels through 2018 |
| **Community Engagement/ Social Mobilization** | Reflects 2013 ongoing community engagement and social mobilization activity requirements being maintained on an annual basis until 2018 |
| **Research/Product Development** | Assumes up to US$ 10 million will be required on an annual basis from 2013-2018 |

## DEFINITION OF BUDGET CATEGORIES AND KEY COST DRIVERS

The four major budget categories include the cost of reaching and vaccinating more than 250 million children multiple times every year; implementing monitoring and surveillance activities in more than 70 countries; ensuring the full application of relevant poliovirus biocontainment requirements globally; fulfilling national, regional and global certification requirements; and supporting core functions and securing the infrastructure required for polio eradication which could potentially benefit other health and development programmes. **Annex A** provides the cost details for endemic and high risk countries. For detailed information on each of the major categories, please see: **www.polioeradication.org/financing**

### 1. IMMUNIZATION ACTIVITIES

Interruption of wild polioviruses and vaccine-derived polioviruses (VDPVs) requires the raising of population immunity in the three remaining endemic countries, in re-infected countries and in high-risk areas prone to outbreaks and re-importations, to levels sufficient to stop transmission. This is done by vaccinating children with polio vaccines, through routine immunization and supplementary immunization activities (SIAs). **Annex B** provides an overview of the SIA schedule for 2014. Starting in 2014, the GPEI budget includes the cost of Inactivated Polio Vaccine (IPV) for introduction into routine immunization systems in OPV-using countries which are Gavi-eligible and Gavi graduates.

This major budget category represents nearly 50% of the total requirements for the 2013-2018 period. The key cost drivers in this area are the date of interruption of transmission, and the number and quality of vaccination campaigns. The core functions budget category (described below) includes provisions for introducing additional innovations and improving the quality of OPV campaigns needed to boost the immunity levels of children in the hardest-to-reach areas of Afghanistan, Pakistan and Nigeria.

The sub-budget categories for SIAs are: oral polio vaccine (OPV) costs, operations costs, and campaign-related social mobilization costs (versus on-going social mobilization costs, which are budgeted separately under core functions and infrastructure – see **Annex C** for additional details).

#### OPV COSTS

This sub-budget category represents the cost of procuring OPV for use in supplementary immunization activities (SIAs), including the vaccine itself plus shipping and freight. 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. In 2013, more than 1.7w billion doses of OPV were procured by UNICEF Supply Division for use in 77 countries. The weighted average price of each OPV dose in 2012 was US$ 0.1374. For the 2013-2018 period, the assumed average cost is US$ 0.16.

#### OPERATIONS COSTS

This sub-budget category represents the costs of delivering vaccine during SIAs, including micro-planning, training, allowances for field personnel involved in SIAs, transport, logistics, supervision, monitoring, evaluation and general operating expenses.

#### CAMPAIGN-RELATED SOCIAL MOBILIZATION

This sub-budget category represents the costs of social mobilization and communication efforts required to ensure high levels of community demand for the vaccine, including production and dissemination of communication materials, media campaigns, engagement of local leaders, organization of community forums, and training and capacity building in key geographies (i.e. in endemic areas and areas of recurrent importations).

#### INACTIVATED POLIO VACCINE (IPV) IN ROUTINE IMMUNIZATION[4]

The major objectives of the Plan include the withdrawal of OPV in a phased manner, starting with type 2-containing OPV. In this context the Plan calls on all countries which currently use only OPV to introduce at least 1 dose of IPV into their routine immunization schedules by end-2015. Introduction of IPV will reduce the risks associated with type 2 OPV removal, facilitate outbreak control and interruption of polio transmission and hasten eradication.

4 This budget category does not include direct costs associated with routine immunization strengthening. See Section 4 for additional information on GPEI support to immunization strengthening.

With the support of Gavi, the Vaccine Alliance (Gavi), regional leadership, and high level advocacy, strong progress has been made by countries in the planning of IPV introduction within the Plan's timelines. As of July 2014, 72 countries are already using IPV, 49 countries have made a formal commitment to introduce and an additional 35 declared intent to introduce IPV in their routine immunization programme by the end of 2015. These countries account for approximately 96% of the global birth cohort.

Since mid-April 2013, GPEI core partners have been working together with Gavi through the Immunization Systems Management Group (IMG) to ensure Objective 2 – immunization systems strengthening and OPV withdrawal (which includes the introduction of IPV) - can be achieved. The IMG relies on the complementary strengths of each agency to ensure that this work is completed in synergy with other immunization and health sector activities in target countries.

In order to ensure the required vaccine is available, UNICEF Supply Division awarded a tender for the purchase of up to 580 million doses of IPV, covering both the Gavi and middle income country markets. The tender has given countries access to IPV at affordable prices, in appropriate packaging and presentation, and is helping establish a sustainable supply and a healthy IPV market. The cost per dose of IPV starts at approx. US$ 1.00/dose for the poorest countries for IPV packaged in 10 doses per vial and goes up to a cost of US$ 2.80/dose for IPV in a 1-dose vial for all countries.

Following a decision by the Gavi board at its November 2013 meeting, GPEI has worked with Gavi to provide support to the 72 Gavi countries eligible for IPV introduction support. This support includes: provision of one dose of IPV with no requirement for co-financing and a one-off introduction grant of the larger of $0.80 per birth cohort or $100K. In order to meet the Plan's timelines, Gavi has waived its minimum routine immunization coverage requirement and launched a streamlined application process for IPV.

GPEI is also working with its donors to provide time-limited, catalytic financial support to select non-Gavi eligible countries. This support is available only to those countries in highest need, and those at highest risk of an outbreak following OPV type 2 withdrawal. For such countries to be eligible for these funds, they will need to demonstrate that the government is able and committed to self-financing IPV after GPEI support ends and that, without the support, they would not be able to meet the Plan's introduction timelines.

**TABLE 3**
**IPV INTRODUCTION (all figures in US$ millions)**

| IPV INTRODUCTION BUDGET CATEGORY AND FUNDING CHANNELS | GPEI BUDGET CATEGORY | TOTAL 2014-2018 |
|---|---|---|
| Vaccine costs: Gavi | Immunization Activities: IPV in Routine Immunization | 342 |
| Introduction grants: Gavi | Immunization Activities: IPV in Routine Immunization | 46 |
| Introduction support: GPEI | Immunization Activities: IPV in Routine Immunization | 45 |
| IMG Technical assistance<br>· IPV: Gavi/GPEI<br>· RI Strengthening: Gavi/GPEI<br>· tOPV/bOPV switch: GPEI | Core Functions and Infrastructure: Ongoing Quality Improvement | 50 |
| **TOTAL** | | **483** |

The total budget for the IPV introduction component of the FRRs is US$483 million, of which US$ 433 million is budgeted under Immunization Activities: IPV in Routine Immunization, and US$ 50 million is budgeted under Core Functions and Infrastructure: Ongoing Quality Improvement. There are several assumptions which represent key points of potential variability in the budget. The most significant of these relates to the pace of country uptake and IPV introduction, and the assumption that India is self-financing IPV introduction. The validity of the assumptions made in this budget will be further refined by end of 2014, at which point cost projections for the remainder of the 2014-2018 time period will be revised and included in subsequent FRR publications.

### TRIVALENT OPV TO BIVALENT OPV SWITCH

At the end of 2013, planning began for the tOPV-bOPV switch. Five readiness criteria have to be met for the global withdrawal of tOPV:

1. **Introduction of at least one dose of IPV**
2. **All OPV-using countries must have access to a bivalent OPV that is licensed for routine immunization.**
3. **Implementation of surveillance and response protocols for type 2 poliovirus (including constitution of a stockpile of monovalent OPV type 2)**
4. **Completion of phase 1 poliovirus containment activities, with appropriate handling of residual type 2 materials**
5. **Verification of global eradication of wild poliovirus type 2**

Once all five criteria are met the trigger for trivalent withdrawal will be the demonstrated absence of all persistent circulating vaccine derived type 2 polioviruses for a period of at least 6 months. The withdrawal of type 2 OPV will happen in a synchronized manner across all OPV using countries through a global switch from trivalent OPV to bivalent OPV. Discussions on the timing and decision making process for the switch will be tabled at the next meeting of the WHO Executive Board.

While estimated costs for the tOPV-bOPV switch are already included in the FRRs, a complete budget for this area, including both global and country level needs is currently under development and will be completed by early 2015. Availability of funds to support country-level switch activities will be crucial to achieving the Plan's timelines.

## 2. SURVEILLANCE AND RESPONSE CAPACITY

The detection and investigation of acute flaccid paralysis (AFP) cases remains the core strategy for detecting all polioviruses. In addition, environmental surveillance continues to be scaled up as a critical complement to AFP surveillance activities.

The surveillance costs (detailed in **Annex D**) relate to maintaining an extensive and active surveillance network to detect and investigate more than 100,000 AFP cases annually, including the collection and testing of samples as well as sustaining the Global Polio Laboratory Network of more than145 laboratories.

In June 2014 the POB endorsed a more aggressive approach to outbreak response, both to wild poliovirus and cVDPVs based on lessons learned in the management of recent outbreaks. This includes ensuring highest level government commitment to the response, managing each outbreak as a 'zone of concern', rapid deployment of GPEI staff, and a step-change in response timelines. This approach applies to endemic countries and any countries affected by outbreaks. In addition to maintaining the flexibility to rapidly and comprehensively respond to outbreaks, per international outbreak response guidelines issued by the World Health Assembly (WHA), immunity levels and surveillance must be maintained in particular in high-risk countries to minimise the risk and consequences of eventual outbreaks.

### OVERVIEW OF THE GPEI "EMERGENCY RESPONSE" BUDGET LINES

The GPEI FRRs include budget lines for Emergency Response within the major budget category "Surveillance and response capacity". These budget lines are implemented by WHO and UNICEF, with annual combined budgets of between US$ 20-50 million at the beginning of the year. WHO and UNICEF maintain funding against this budget line at the global level to ensure that outbreak response activities can be supported immediately, regardless of where they occur. However, historically the 12-month rolling cash flow projections for the GPEI have been extremely tight, and have not allowed for more than US$ 5-10 million in outbreak response funds to be held by WHO or UNICEF for this purpose at any one point in time.

In order to ensure rapid response to outbreaks, upon notification of an outbreak situation, WHO provides an initial allocation for operations, and UNICEF ensures that the vaccine required for the initial response round is provided. While detailed response plans are being prepared, WHO and UNICEF HQ offices review the availability of funding and vaccine based on estimated requirements to quickly confirm support.

In addition, WHO and UNICEF Country Offices are encouraged to reach out to donors in country to raise resources for outbreak response, which can be financed rapidly by many donors using dedicated resources and mechanisms for emergencies. Local funding complements global resources, and ensures that the limited funding available at global level for outbreak response is not completely depleted.

## 3. POLIOVIRUS CONTAINMENT AND CERTIFICATION

The global certification of WPV requires ensuring highly sensitive poliovirus surveillance and full application of relevant poliovirus bio-containment requirements, across the entire world.
Bio-containment activities have started in all 6 WHO Regions. For the two regions not certified polio-free– Africa and the Eastern Mediterranean – the priority will be to close remaining gaps in AFP surveillance sensitivity by 2014 in advance of the trivalent OPV to bivalent OPV switch (budgeted under the surveillance and response category) and then to sustain certification-standard surveillance performance at the national and subnational level through regional and global certification.
For the four regions that are certified polio-free – the Americas, Europe, South-East Asia and the Western Pacific – the priority will be to achieve or maintain surveillance at certification-standard levels.

The draft of the third edition of the Global Action Plan to Minimize Poliovirus Facility Associated Risk after Eradication of Wold Poliovirus and Cessation of Routine OPV Use (GAPIII), which outlines biorisk management requirements for handling and storing wild, Sabin and Sabin-derived polioviruses, is being aligned with the timelines and strategies of the Plan.

The Global Commission for the Certification of the Eradication of Poliomyelitis (GCC) will be convened in 2014 to review data from all six WHO regions to determine whether there is sufficient evidence to formally conclude that wild poliovirus type 2 has been eradicated globally.

## 4. CORE FUNCTIONS AND INFRASTRUCTURE

National authorities are ultimately responsible for development of immunization plans and budgets and for implementing activities. WHO and UNICEF play an important supplementary and catalytic role in supporting countries through provision of core functions and infrastructure, including technical assistance (detailed in **Annex E**), innovations to improve SIA efficacy, technical assistance surge support, on-going quality improvement, community engagement, and research and development

### OVERVIEW OF ROUTINE IMMUNIZATION STRENGTHENING BUDGET LINES

WHO and UNICEF, along with the GPEI partners and Gavi in conjunction with immunization systems strengthening stakeholders have initiated a joint programme of work to support the strengthening of routine immunization systems in the 10 priority countries identified in the Plan[5]. The joint approach in these countries seeks to capitalize on Gavi's

5 Afghanistan, Angola, Chad, Democratic Republic of the Congo, Ethiopia, India, Nigeria, Pakistan, Somalia and South Sudan.

investments in health systems strengthening and to exploit fully the substantial **technical assistance** deployed through the GPEI. As per the Plan, GPEI staff will focus on immunization strengthening across four activity areas: management, microplanning, mobilization and monitoring. In 2013, the immunization plans in 6 countries (Chad, the Democratic Republic of the Congo, Ethiopia, India, Nigeria and Pakistan) were reviewed and revised to include specific actions for ensuring that the infrastructure of the GPEI systematically contributes to improving routine immunization coverage. In addition the contribution of GPEI to routine immunization strengthening is measured by the reduction in the number of DTP3 unvaccinated children in the 10 focus countries, year-on-year.

In early 2014, US$ 4.8 million was made available through the IMG workplan to support country activities using polio assets to support Routine Immunization (RI) strengthening. Eight of the ten priority countries had already developed 2014 plans of action which includes RI strengthening activities; however, with these new resources countries were encouraged to identify key activities to increase the percentage of time spent by polio–funded staff on improving routine immunization in a sustainable way.

From the US$ 4.8 million, between US$ 300 000-US$ 500 000 has been allocated to each of the 10 focus countries to support a joint WHO and UNICEF proposal and budget for 2014-2015 activities. The main types of activities planned include: training of polio-funded staff on RI, using polio staff to assist with RI microplanning, implementing Reaching Every District (RED) activities, and activities to improve cold chain, vaccine management and data quality.

Additionally, US$ 1 million has been made available to support special studies related to using polio assets to strengthen RI. These studies will be launched by the end of 2014. **Table 4** below outlines the total investment to RI strengthening included in the GPEI FRR from 2013 to 2018.

### PILOT EFFORTS SHOW ENCOURAGING RESULTS

The potential to strengthen RI through polio assets is now clearer than ever, thanks to a US$ 6 million grant awarded by the Bill & Melinda Gates Foundation in early 2013. The grant, shared between WHO and UNICEF in Chad, Democratic Republic of the Congo, and Nigeria, has already led to an increase in Pentavalent3 coverage in the majority of the districts/LGAs supported.

In the 39 polio high-risk LGAs in 10 northern states in Nigeria where the project has been launched, the number of immunization sessions held has nearly doubled.

Polio surge capacity was used to train, supervise and also assist in the implementation of the routine immunization activities.

**TABLE 4**
**TOTAL ROUTINE IMMUNIZATION (RI) STRENGTHENING 2013 – 18 (all figures in US$ millions)**

| Budget Category and Funding Channels | GPEI Budget Category | Total 2013-2018 |
|---|---|---|
| Technical Assistance GPEI* | Core Functions and Infrastructure: Technical Assistance (WHO) | 228 |
| IMG Technical assistance 2014 - 15** RI Strengthening Gavi | Core Functions and Infrastructure: Ongoing Quality Improvement | 5 |
| One-time RI strengthening activities 2013 GPEI | Core Functions and Infrastructure: Ongoing Quality Improvement | 8 |
| **TOTAL RI Strengthening** | | **241** |

*In 10 priority countries: 50% of field staff time at sub-national levels; 25% at national levels. **Costing included under the IMG work plan/IPV introduction

# 2) BUDGET PROCESS, OVERSIGHT, ACCOUNTABILITY & MONITORING

## BUDGETING PROCESS, FUNDS ALLOCATION AND PRIORITY SETTING

A robust system of estimating costs drives the development of the global budget figures from the micro-level up **(Figure 3)**. The budgets that underpin the FRR are prepared by WHO, UNICEF and the national governments that manage the polio eradication activities. The funds to finance the activities flow from multiple channels, primarily through these stakeholders. Both UN agencies support the governments in the preparation and implementation of activities.

For immunization activities in particular, the schedule is developed based on the guidance of national and regional Technical Advisory Groups (TAGs), Ministries of Health and the country offices of WHO and UNICEF. 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 at the local level and take into consideration local costs for all elements of the activities, as described in the "budget categories" section above.

The national GPEI budget development is paired with a regular, interactive process of reviewing and reprioritizing activities in light of evolving epidemiology and available resources. The in-depth weekly epidemiological and SIA review is complemented by weekly and bi-weekly teleconferences between WHO and UNICEF headquarters and regional offices which provide opportunities to adjust funding allocations, based on any major epidemiological changes and resulting priorities.

Requests to release operations funds for SIAs include submission of the final activity budget, which is reviewed and validated at the regional office and headquarters levels, prior to the release of funds (usually four to six weeks before SIAs). In the case of an outbreak, initial funds may be released while pending full budget review. For staff and surveillance funds are disbursed on a quarterly or semi-annual basis, depending on the GPEI cash flow, against long-term human resources (HR) plans and surveillance activity plans, which are developed and reviewed during the FRR development process. For most countries, funds for OPV and social mobilization are released by UNICEF six to eight weeks before SIAs.

Historically the GPEI has been faced with the recurrent challenge of changing plans and cancelling immunization campaigns due to a lack of funding and/or unpredictable funding flows. In the event that sufficient funds are not available to fully support the GPEI budget in a given year, available resources will be allocated according to the following priority order.

PRIORITY 1

**Technical assistance (6 months funding)**

PRIORITY 2

**Surveillance/Laboratory network (quarterly)**

PRIORITY 3

**Endemic country SIAs (quarterly)**

PRIORITY 4

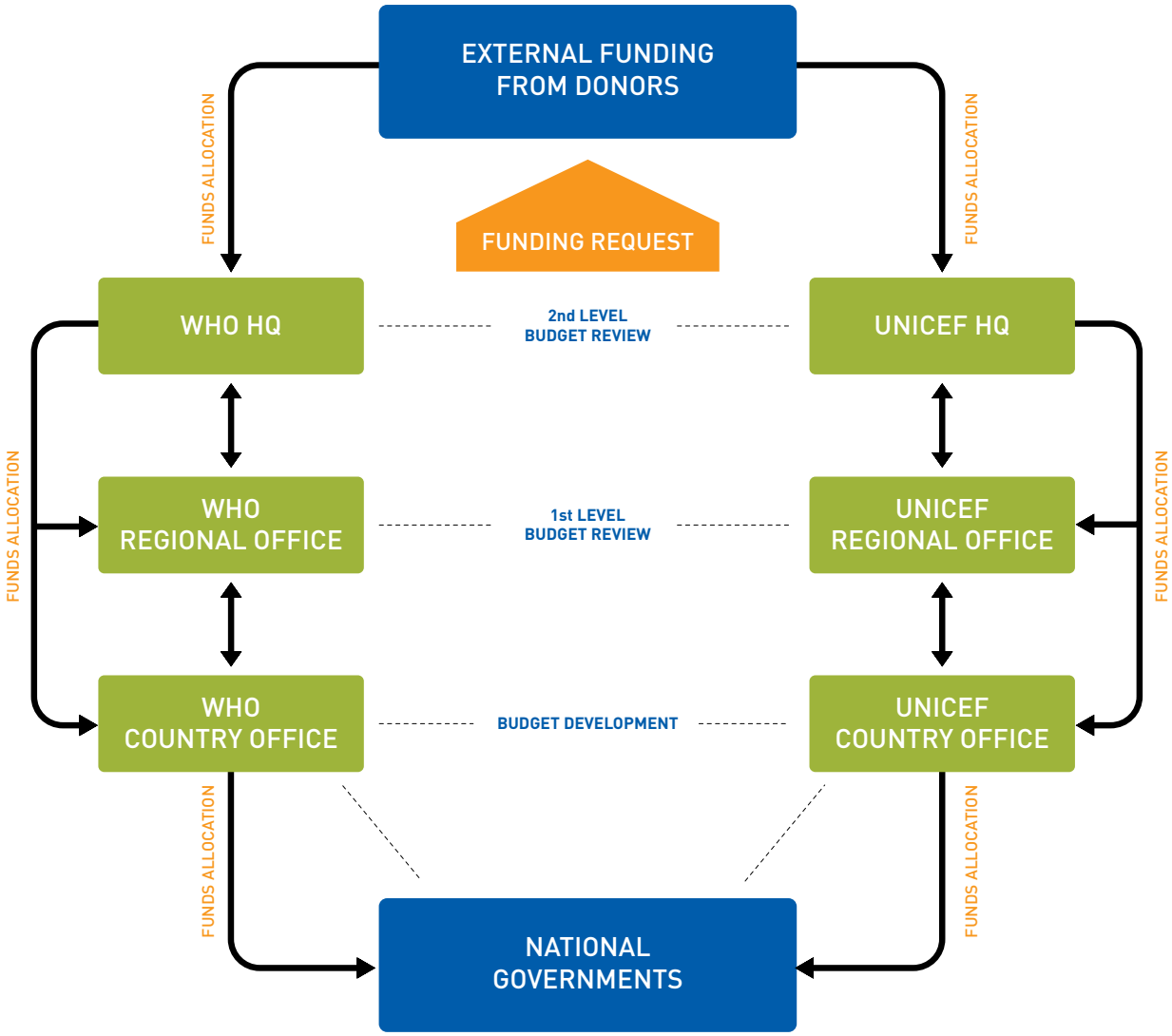
**Outbreak response**
**(3 months funding maintained at Global level)**

PRIORITY 5

**High-risk/other country SIAs (as required)**

This prioritized list will continue to be updated with the evolving epidemiology and will be revised by early 2015 to reflect new priority activities in Objectives 2 and 3 of the Plan, especially IPV introduction.

**FIGURE 3**
**BUDGET REVIEW AND FUND ALLOCATION PROCESS**

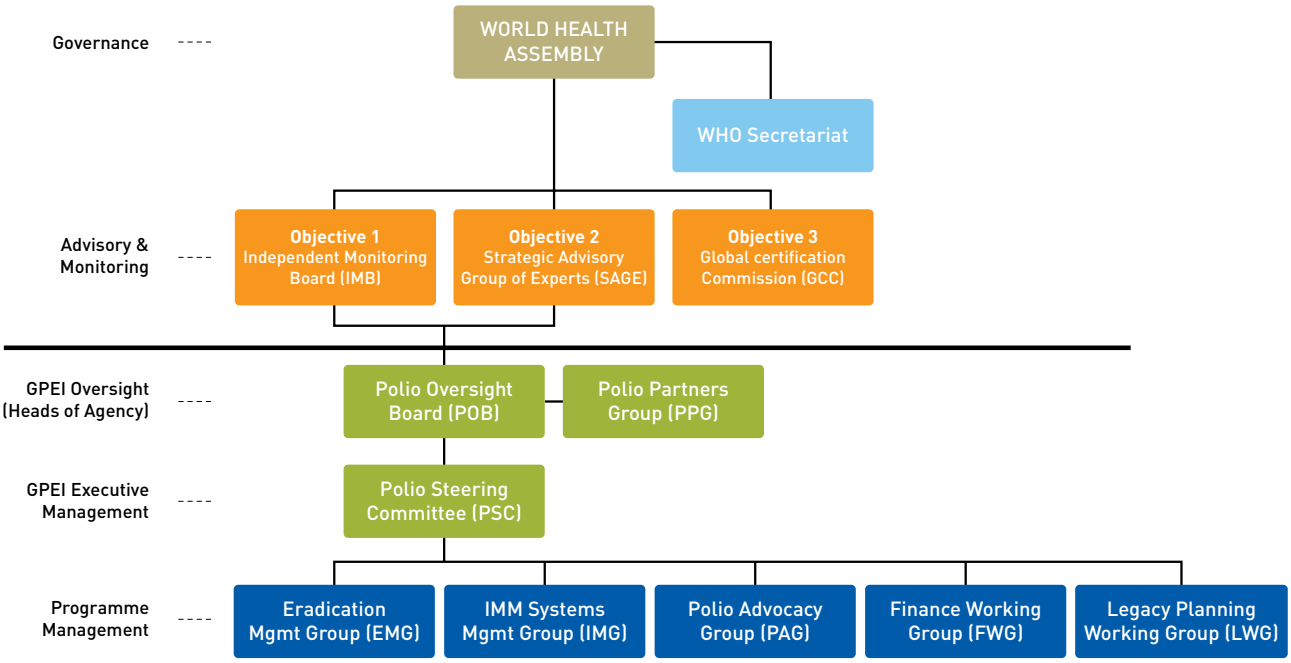



## BUDGET OVERSIGHT, ACCOUNTABILITY AND COORDINATION

*Please also refer to Section 11 of the Plan for a full description of governance, monitoring, oversight and management for the GPEI.* ***www.polioeradication.org/Resourcelibrary/Strategyandwork.aspx***

**Figure 4** provides an overview of GPEI's governance, oversight and management structure. As the primary WHO decision-making body, the **World Health Assembly (WHA)**, comprised of all 194 WHO Member States, provides the highest level of governance of the GPEI. National governments are both the owners and beneficiaries of the GPEI. Polio-affected countries undertake the full range of activities detailed in their country plans and take primary responsibility for the achievement of the major objectives of the Plan.

**FIGURE 4**
**GOVERNANCE STRUCTURE FOR THE IMPLEMENTATION OF THE PLAN**




**The Polio Oversight Board (POB),** comprised of the heads of agencies of core GPEI partners, provides oversight of the GPEI and programme management, and ensures high-level accountability across the GPEI partnership. The POB receives and reviews inputs from various advisory and monitoring bodies which include the Independent Monitoring Board of the GPEI (IMB) which evaluates progress in eradication the Strategic Advisory Group of Experts on immunization (SAGE), and the Global Commission for Certification of the Eradication of Poliomyelitis (GCC). The POB invites major donors to its in-person meetings to involve them in decision-making on key issues. The POB meets at least quarterly. The POB's deliberations are also informed by the Global Polio Partners Group (PPG).

**The Global Polio Partners Group (PPG)** serves as the stakeholder voice for the GPEI in the development and implementation of eradication strategic plans and fosters greater engagement among polio-affected countries, donors and other partners to ensure GPEI has the necessary political commitment and financial resources to reach the goal of polio eradication. The PPG meetings are held at the Ambassadorial/senior-officials level and results are reported to the POB. The PPG co-Chairs attend POB in-person meetings.

**The Polio Steering Committee (PSC)** is the senior management body of the GPEI. The PSC oversees the work of the GPEI through its dedicated management groups that include the **Eradication Management Group (EMG)**, the **Immunization systems Management Group (IMG)**, and the **Legacy planning Working Group (LWG).**

**The Polio Advocacy Group (PAG)** has responsibility for developing and implementing a cross-agency resource mobilization strategy to ensure that the required financing is available to fully implement the Plan. The PAG is responsible for securing new commitments and operationalizing commitments.

**The Polio Finance Working Group (FWG)** is responsible for closely tracking and managing the short and long-term financing needs, developing consistent and accurate financial information for strategic decision-making and establishing processes to support predictability of financing. It aims to ensure stronger cost control, accountability and resource management, and to act on the findings of a study in 2012 on "value for money". The Group is also responsible for developing and reviewing the FRRs.

There are three additional management groups that report to the PSC and have responsibility for the implementation of the Endgame plan: the **Eradication Management Group (EMG)** responsible for the overall management of activities under Objective 1; the **Immunization Systems Management Group (IMG)** responsible for activities under Objective 2; and the **Legacy Planning Working Group (LWG).**

### MONITORING AND EVALUATION

In finalizing the Plan, the GPEI developed a high-level Monitoring Framework to assess progress year-on-year against the four major objectives laid out in the Plan. In response to requests, a detailed monitoring framework has now been developed which more clearly shows progress in eradication, reported across a six month timeframe. This framework follows a logical results-based framework and includes reporting on all major activities and progress in eradication.

The GPEI provides detailed reporting on progress against key indicators to its oversight and governance bodies at agreed intervals to inform their strategic guidance and decision-making. National plans should be referred to for details of national responsibilities, targets and progress indicators.

The GPEI has a strict set of internationally accepted process and outcome indicators for monitoring the performance and quality of country-level polio eradication activities. These include indicators for the performance of supplementary immunization activities (SIAs), surveillance for acute flaccid paralysis (AFP) and the coordination of quality-assurance for the Global Polio Laboratory Network (GPLN). New and more rigorous monitoring tools have, since 2012, enabled a clearer epidemiological picture and allowed for a more targeted response, including the expanded use of Lot Quality Assurance Sampling (LQAS) and real-time and concurrent monitoring of immunization activities, and expanded use of environmental surveillance to supplement the AFP surveillance network.

# 3) MOBILIZING THE FUNDING: CURRENT STATUS

While the grand total of the GPEI FRRs published as of July 2014 remains unchanged from that published in February 2014, there have been significant changes in the SIA calendar and activities planned in 2014, with reductions in flexible budget lines in later years of the FRRs to accommodate these changes.

By mid-2014, increased requests for financing of eradication activities in 2014 exceeded the original projected US$ 1 033 million budget for 2014 (as of the February 2014 FRR) by US$ 121 million. The main drivers for the increases included: an additional US$ 102 million for outbreak response and risk mitigation in Africa; an additional US$ 11 million for additional surge support; and US$ 8 million in related indirect costs.

To reconcile these requests with available financing, the Polio Oversight Board endorsed the following principles:

- **Stay within 2013-2018 US$ 5.5 billion budget envelope as per strong feedback from donors;**
- **Preserve the budget line for responding to new or persistent outbreaks;**
- **Maintain core expenditures at 2013 levels (incl. technical assistance, surveillance, lab, social mobilization); and**
- **Finance the increase in 2014 immunization activity costs by reducing the budget line for complementary OPV campaigns and emergency response in future years.**

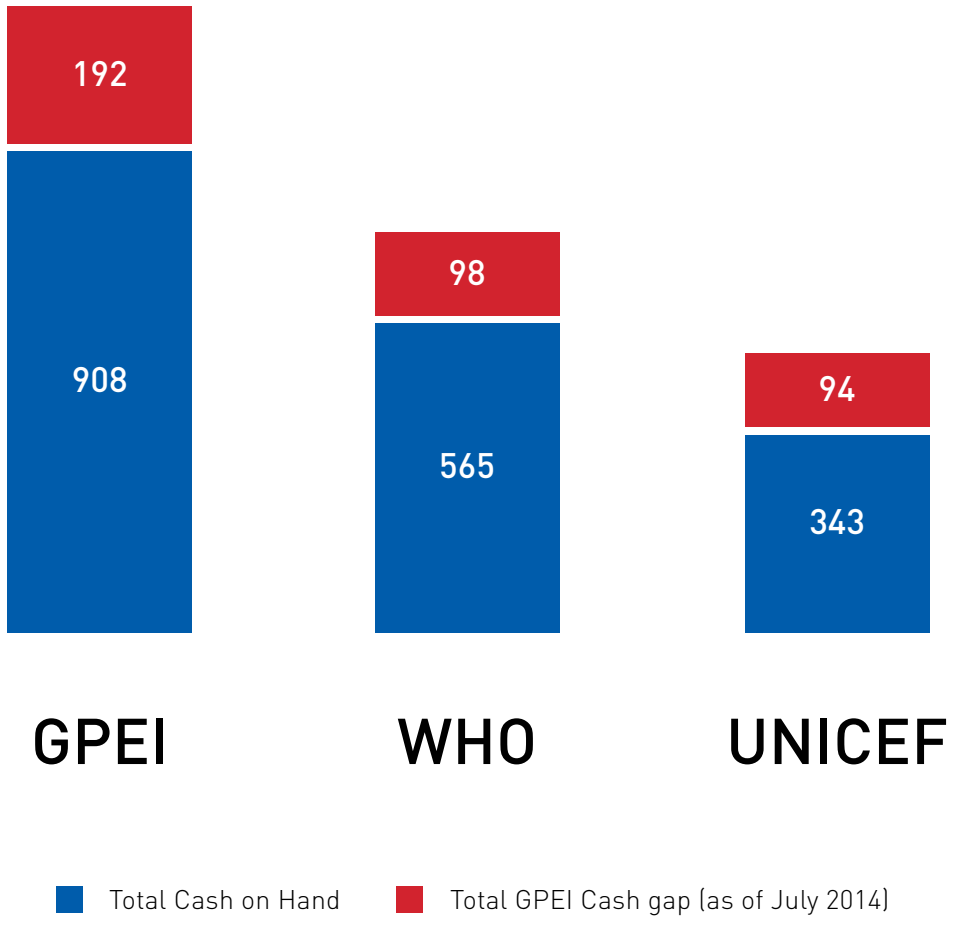
OPV campaign plans for 2014 were revised early in the first half of the year to optimize the probability of stopping wild and cVDPV poliovirus transmission with emphasis on the African continent, by (a) starting from the proposed schedules of the

endemic countries, (b) including response/mop-up schedules in the outbreak countries as per the Plan, (c) sustaining activities in highest-risk areas bordering infected countries, and (d) introducing risk mitigation immunization activities in western Africa.

As of 1 July 2014, the cash gap for 2014 including only funds available is US$ 192 million. **Figure 5** provides an overview of funds available or cash on hand, which is essential for the implementing partners (WHO and UNICEF) to be able to conduct activities and ensure continuity of the program. Just as important is the ability for the implementing partners to have funding that is flexible. The most recent IMB report states:

**For those delivering the program, cash flow remains a major challenge. Funding partners could help by reducing the extent to which their contributions are earmarked for particular countries or activities. A lot of time and effort goes into matching program activities against funds that have been provided with particular conditions. In some instances, vaccination campaigns are delayed because of the inflexibility that earmarking creates. When the program's objectives were broadened and extended by the 2013-18 Strategic Plan, this issue grew. The IMB strongly advises funding partners to reduce the earmarking of funds. There is potential for reciprocity, with the program enhancing its reporting and engagement arrangements, and funding partners reviewing the flexibility of their arrangements*.**

**FIGURE 5**
**CASH ON HAND AND CASH GAP FOR 2014 (all figures in US$ millions)**




*http://www.polioeradication.org/Portals/0/Document/Aboutus/Governance/IMB/10IMBMeeting/10IMB_Report_EN.pdf

**Figure 6a** presents detail on 2014 GPEI budget allocations by funding type. Availability of cash and the flexibility of these funds allows the GPEI to be able to react more quickly to changes in programmatic requirements and activities.

**FIGURE 6A**
**2014 GPEI TOTAL BUDGET ALLOCATIONS (US$1.15B) BY FUNDING TYPE WITH CASH GAP (US$192 MILLION)**

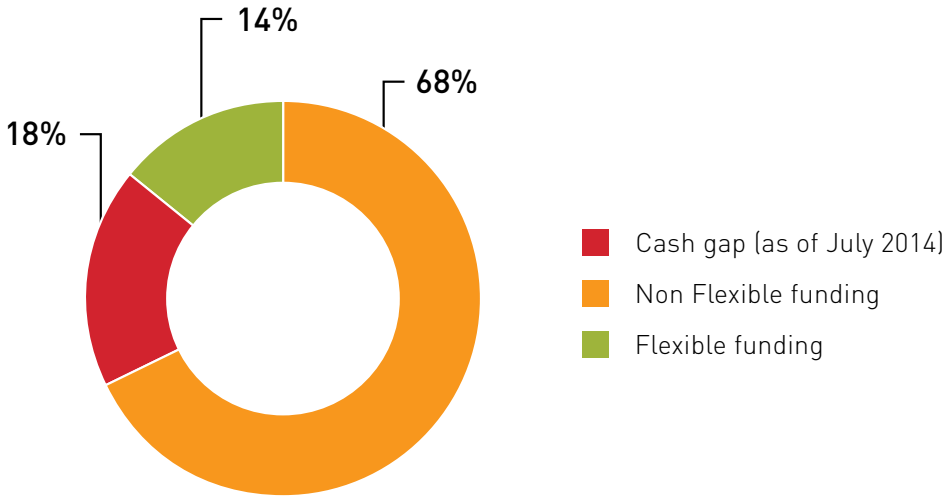



**Figure 6b** provides further detail of the allocation of funds types against the specific budget categories. This detail demonstrates the 2014 status between the use of earmarked funding, flexible funding and the remaining cash gap.

**FIGURE 6B**
**2014 DETAIL ON BUDGET CATEGORY ALLOCATIONS BY FUNDING TYPE**

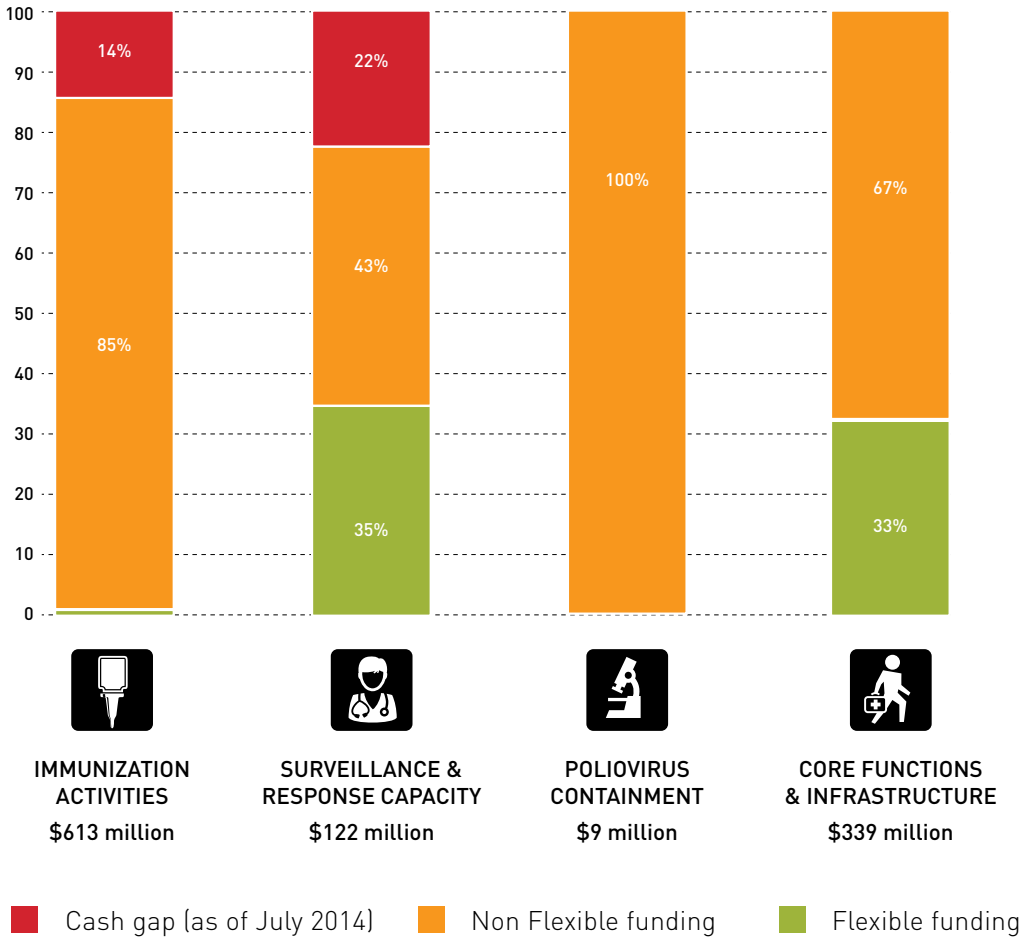
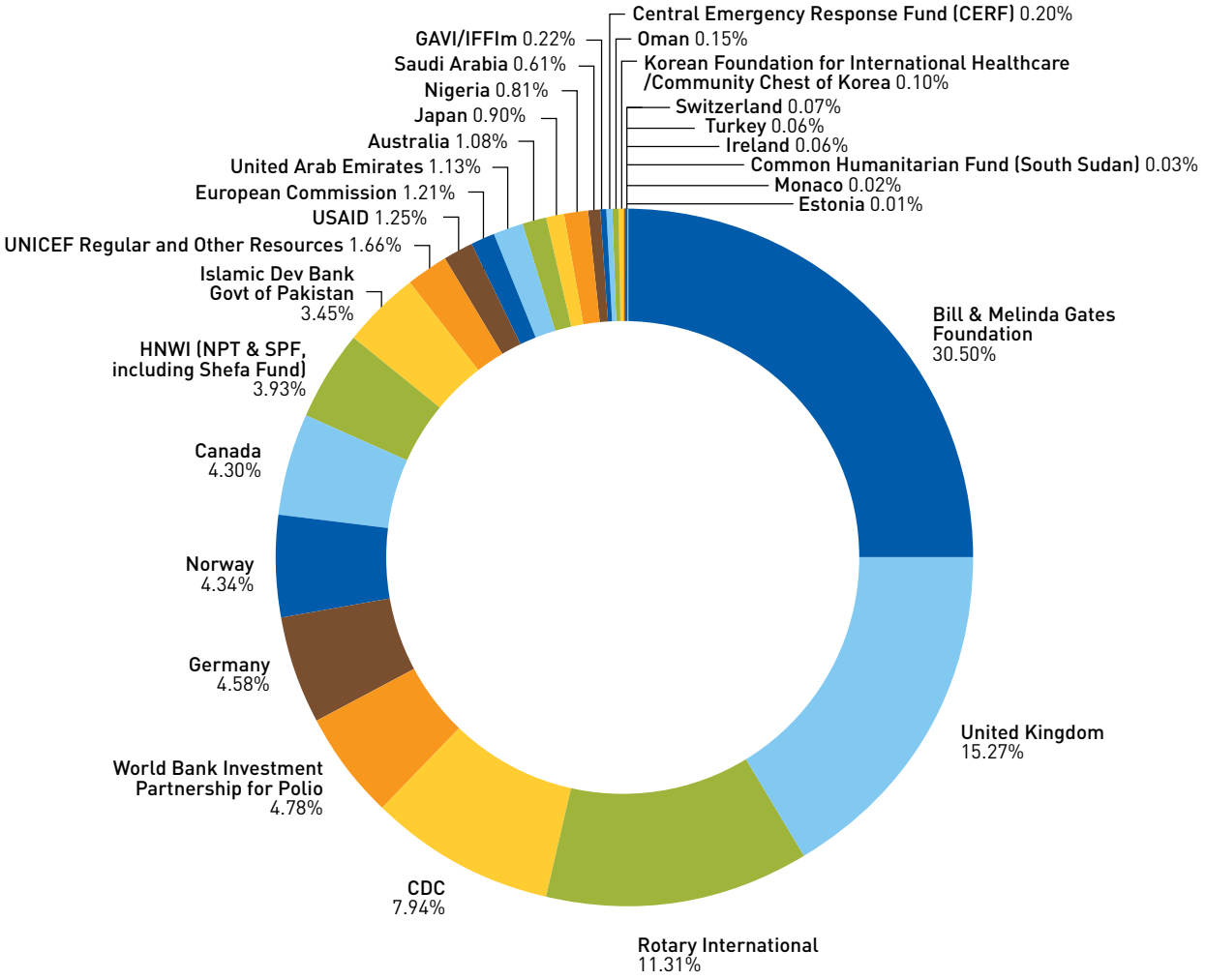


**Figure 7** is an overview of the GPEI cash on hand of US$908 million to date in 2014 by donor.

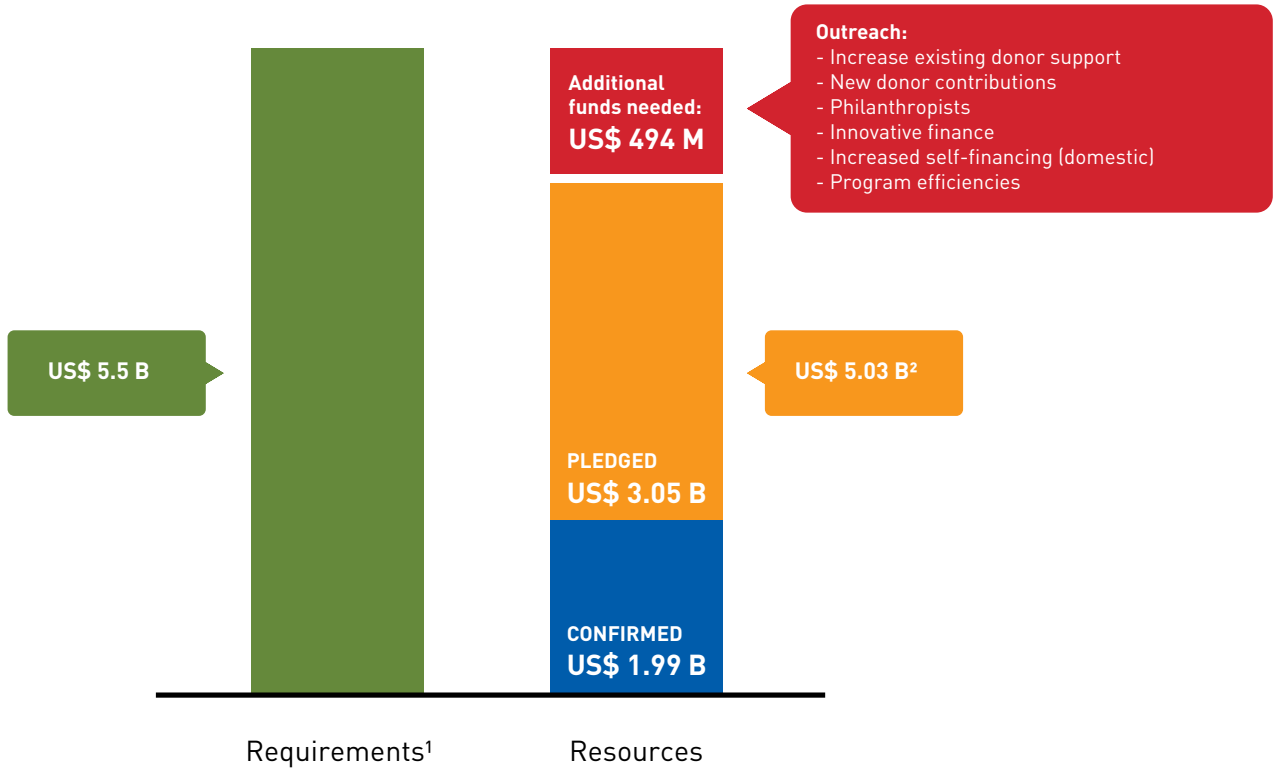
**FIGURE 7**
**DONORS AGAINST CONFIRMED CASH RECEIVED FOR 2014**




On 25 April 2013, the new Plan was shared at the Global Vaccine Summit in Abu Dhabi. Global leaders, donor nations and polio-affected countries signalled their confidence in the plan by pledging over US$ 4 billion towards the Plan's projected US$ 5.5 billion cost over six years. Since then, the GPEI has continued to work with partners to convert the pledges into signed agreements and cash disbursements and to secure the remaining US$ 1.5 billion in additional resources.

As of 1 July 2014, with the inclusion of all confirmed and pledged funding, the overall best-case funding gap for the 2013-2018 period has been reduced to US$ 494 million **(Figure 8)**. **Table 5** provides an update on the status of the funds pledged at the Global Vaccine Summit. The confirmed funding represents what has been operationalized through signed contribution agreements and/or cash payments. The pledged funding represents donor commitments for which no signed agreement nor cash payments have been received.

**FIGURE 8**
**MEETING THE PLAN'S FUNDING REQUIREMENTS**




¹ Based on GPEI Long-term cost model as of end 2012, not including Government of India's self-financing.
² Based on breakdown of pledges made to the GPEI at the April 2013 Global Vaccine Summit as well as pledges made since the Summit.

## TABLE 5
## SUMMARY OF CONFIRMED FUNDING AGAINST THE VACCINE SUMMIT COMMITMENTS
## (all figures in US$ millions)

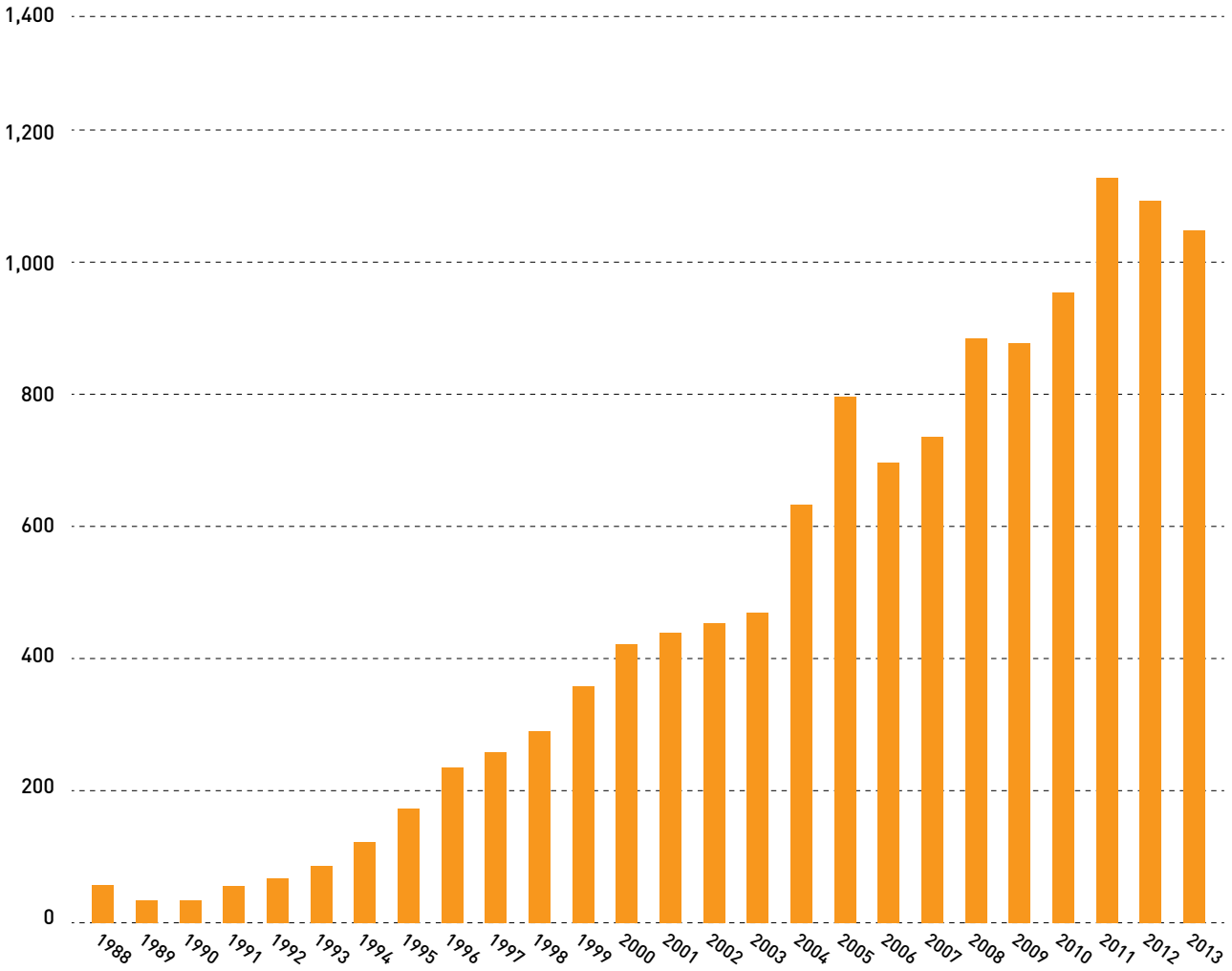
| | Funds Committed by April 2013 Vaccine Summit | Confirmed Funding against the GPEI FRRs, as of 31st July 2014 |
|---|---|---|
| **G7 & EC** | | |
| Canada | 243.53 | 102.72 |
| European Commission | 6.50 | 13.96 |
| Germany | 151.70 | 53.96 |
| Japan | 9.70 | 21.24 |
| United Kingdom | 457.00 | 297.64 |
| USA | 90.60 | 190.58 |
| **Non-G7 OECD Countries** | | |
| Australia[1] | 34.55 | 34.55 |
| Finland | 0.53 | 0.53 |
| Ireland | 6.50 | 6.63 |
| Luxembourg | 0.70 | 1.05 |
| Norway | 252.45 | 172.45 |
| **Other Donor Countries** | | |
| Brunei Darussalem | 0.05 | 0.05 |
| Isle of Man | 0.14 | 0.05 |
| Liechtenstein | 0.02 | 0.02 |
| Monaco | 0.35 | 0.58 |
| Saudi Arabia | 15.00 | 15.00 |
| **Private Sector/ Non-Gov't Donors** | | |
| Al Ansari Exchange | 1.00 | 1.00 |
| Abu Dhabi-Crown Prince | 120.00 | 24.00 |
| Bill & Melinda Gates Foundation[2] | 1 800.00 | 411.65 |
| Korean Foundation for International Healthcare/Community Chest of Korea | 1.00 | 2.00 |
| Private Philanthropists/High Networth Individuals | 335.00 | 78.30 |
| Rotary International3 | 76.81 | 160.00 |
| UN Foundation | 0.75 | 0.07 |
| **Multilateral Sector** | | |
| Gavi/IFFIm | 24.00 | 36.92 |
| Islamic Development Bank/ Government of Pakistan | 227.00 | 137.28 |
| UNICEF | 64.50 | 40.75 |
| World Bank (Grant to Afghanistan) | 10.00 | 10.00 |
| World Bank Investment Partnership, Bank Portion | 50.00 | 50.00 |
| World Health Organization | 4.27 | 10.40 |
| **Domestic Resources** | | |
| Angola | 7.30 | 6.54 |
| Bangladesh | 10.00 | 10.00 |
| Nepal | 0.90 | 0.67 |
| Nigeria | 40.00 | 28.30 |
| **TOTAL** | **4 042** | **1 919** |
| Additional contributions were received since February 2014 from the following donors | | |
| Chile | **0.03** | |
| Oman | **3** | |
| Central Emergency Response Fund (CERF) | **2** | |
| Common Humanitarian Fund (Sudan) | **0.2** | |

1 In June 2014 Prime Minister Tony Abbot reaffirmed the pledge of US$ 80 million towards the Polio Eradication Strategic Plan and Endgame

2 Funds for 2013 under the US$ 355 Million Challenge Grant from the Bill & Melinda Gates Foundation to Rotary International are reflected in the Rotary International contribution lines, though the contribution is only counted once in the GPEI totals. In 2013, Rotary pledged up to US$ 175 million for 2013-2018, which will be matched 2:1 by the Bill & Melinda Gates Foundation. Contributions from both under this match scheme will be reflected as and when funds are confirmed. Rotary's contributions to the GPEI are through the Rotary Foundation.

Since the 1988 WHA resolution to eradicate polio, 77 public and private sector donors have contributed over US$ 11 billion to the GPEI **(Figure 9)**. The GPEI has continued to reach out to new donors, philanthropists and organizations to ensure a broad spectrum of support and to provide the financing needed to fully implement the plan.

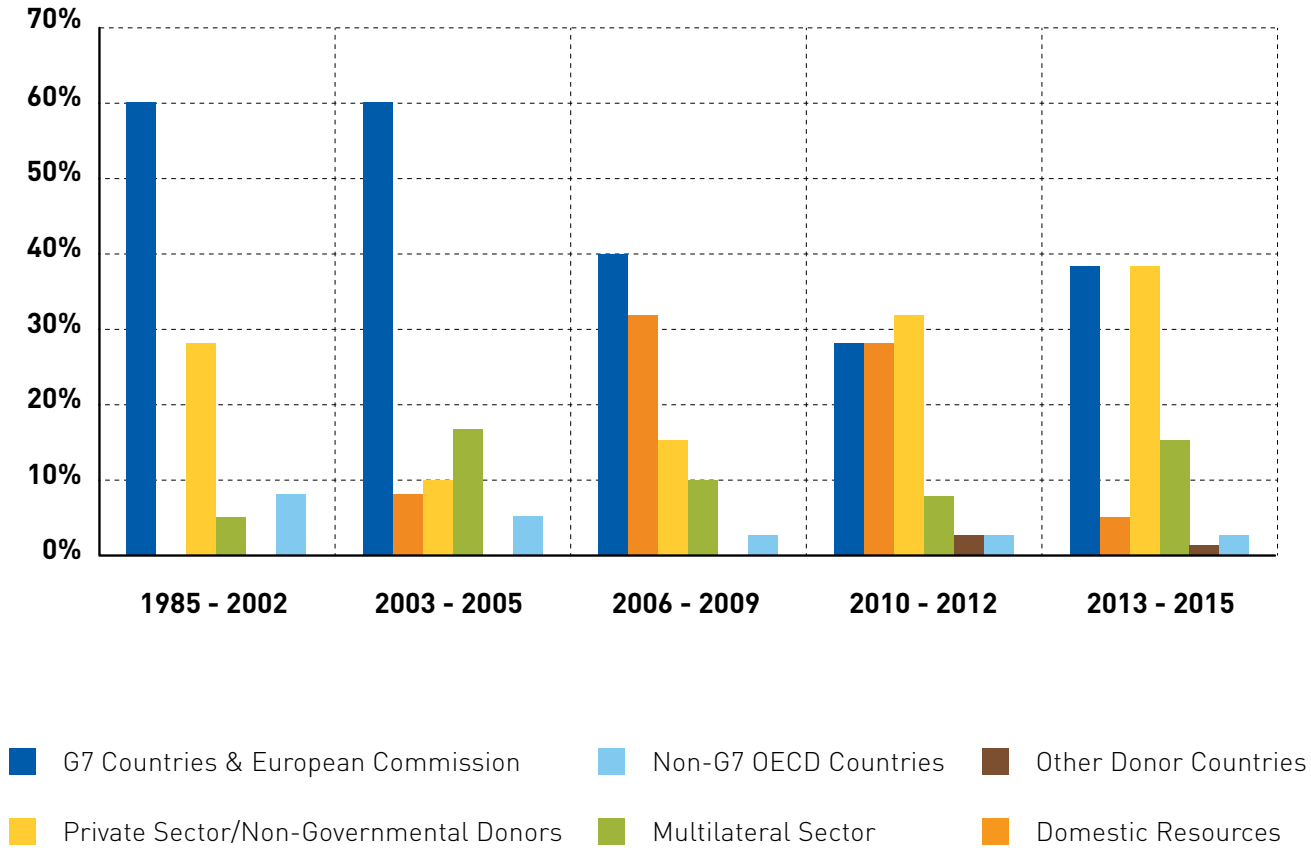
**FIGURE 9**
**ANNUAL CONTRIBUTIONS 1988-2013 (all figures in US$ millions)**




Graph Updated: 24 February 2014

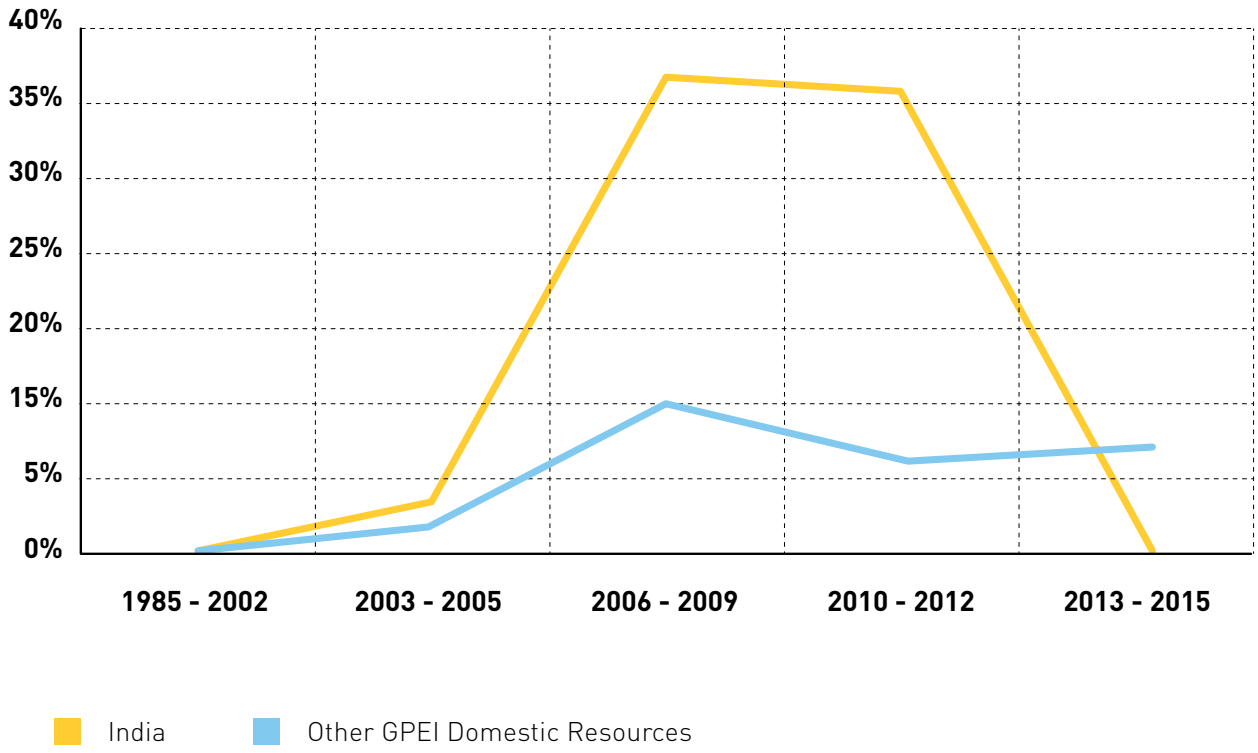
Since 2008, there has been a gradual increase in the private philanthropists and foundations support to the GPEI. With the success of the Global Vaccine Summit, GPEI saw the greatest increase of support from private philanthropists and foundations **(Figure 10)**. Rotary International, which pledged US$ 175 million in June 2013 after the Global Vaccine Summit, and the Bill & Melinda Gates Foundation (BMGF) remain the top private sector contributors to the GPEI. Multilateral funding has also increased reflecting funding for endemic countries via loans or innovative financing mechanisms. The decrease in domestic resources as a proportion of funding to GPEI reflects changes in the way that national government contributions are recorded.

**FIGURE 10**
**TREND IN GPEI FINANCING 1985 TO 2015***
*Figures include only confirmed contributions. India was removed from tracking as of 2012.



In **Figure 11**, you will see the government of India's domestic contribution separated from the grouped domestic contributions. The decrease in India's domestic contribution does not reflect a decrease in their support of Polio, but rather a transition from Endemic to Polio free status. Looking at the other domestic contributions, you will see that in general the programme's support from domestic contributions has been relatively stable for at least the last five years.

**FIGURE 11**
**TREND IN GPEI DOMESTIC FUNDING 1985 TO 2015***
*Figures include only confirmed contributions. India was removed from tracking as of 2012.



# 4) POLIO ENDEMIC COUNTRIES: FUNDING REQUIREMENTS

At the start of 2014, three countries remained endemic for wild poliovirus transmission – Nigeria, Pakistan and Afghanistan. In all three endemic countries, the polio programmes are operating under national emergency action plans, overseen in each instance by the respective head of state and supported by tailored, locally-driven approaches to unique operational challenges.

By the end of 2013, the impact of the emergency plans was clear in Afghanistan – where cases are mostly linked to cross-border transmission from Pakistan – and Nigeria, where cases were reduced by nearly 60%. Pakistan is developing new ways to reach children who have been the victims of insecurity and inaccessibility, including folding polio into broader health interventions under strong local ownership. International commitment remains high in 2014 as the goal comes into clearer view.

The estimated total cost for the three endemic countries is approximately US$ 2.43 billion, representing 44% of the US$ 5.5 billion budget **(Figure 12)**. **Figure 13** and the following three visuals provide a breakdown of costs associated with SIAs, surveillance and technical assistance in the remaining endemic countries for 2013-2015.

**FIGURE 12**
**COMPARISON OF THE PLAN'S COSTS – ENDEMIC COUNTRIES VS. ALL OTHER COSTS (ENDEMIC COUNTRIES REPRESENT 44% OF TOTAL BUDGET OF $5.5 BILLION)**
**(all figures in US$ millions including indirect costs)**

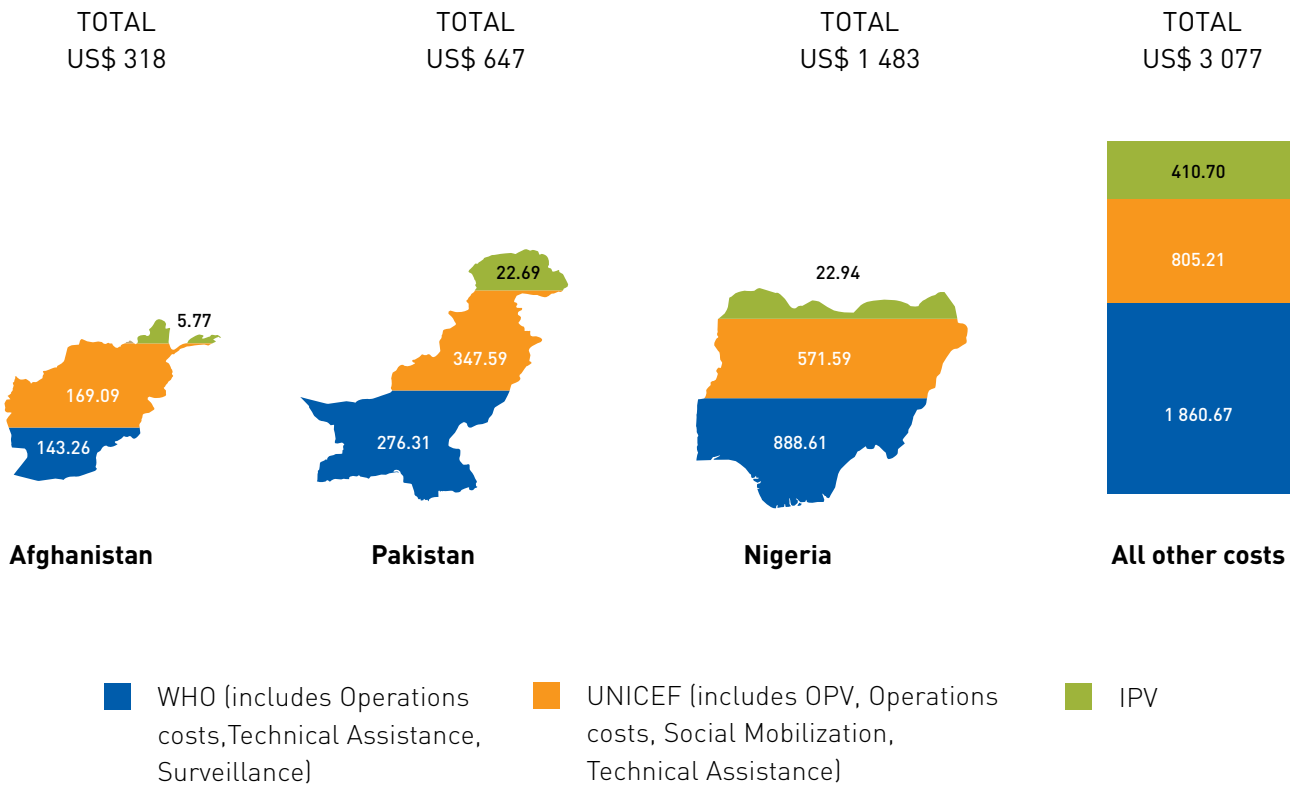
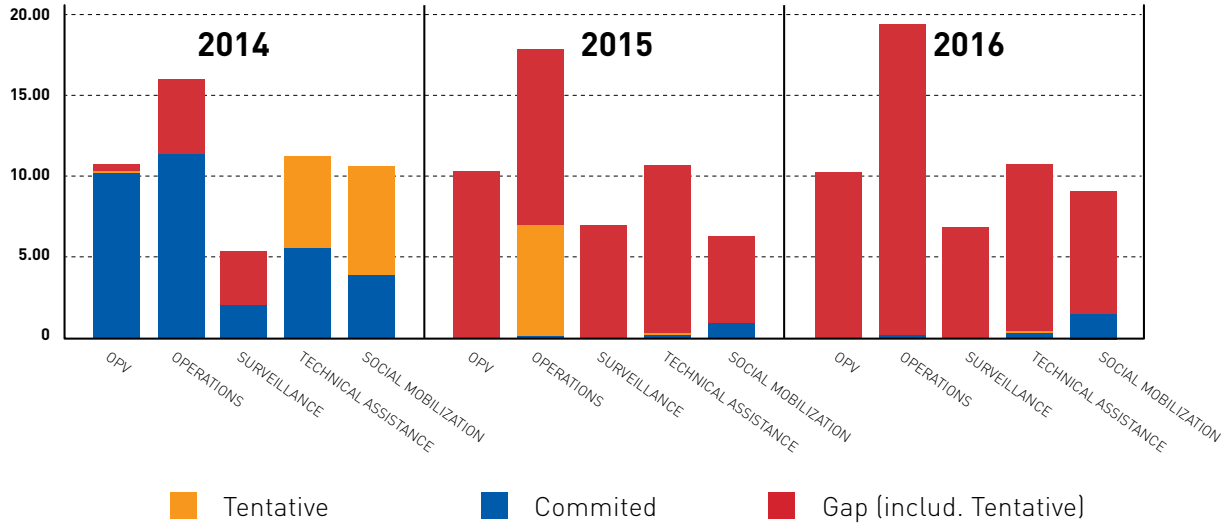
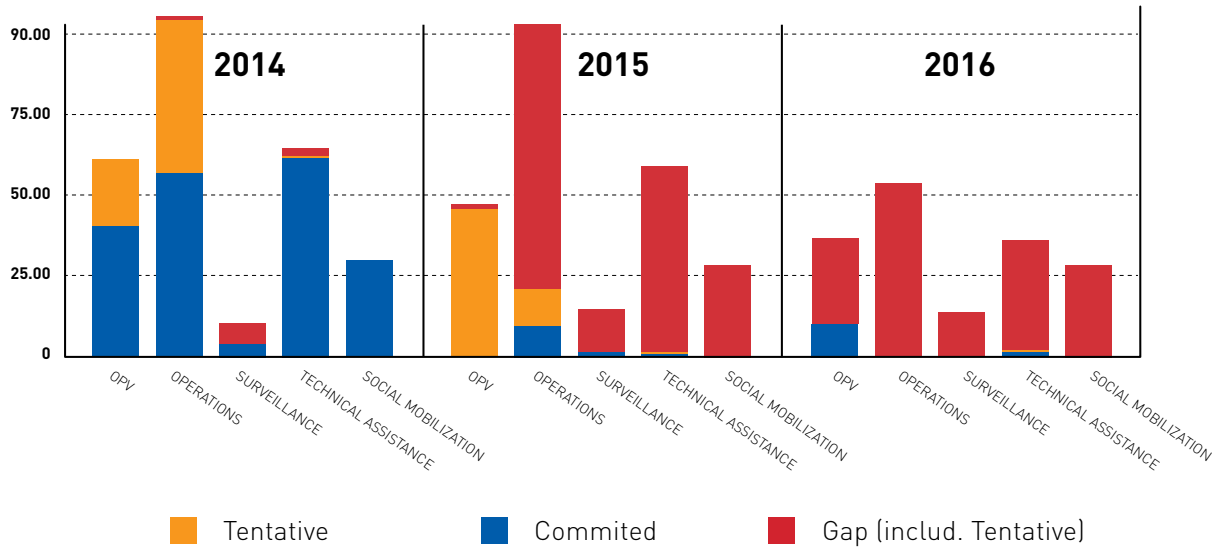


**FIGURE 13**
**REQUIREMENTS AND FUNDING GAP FOR ENDEMIC COUNTRIES**

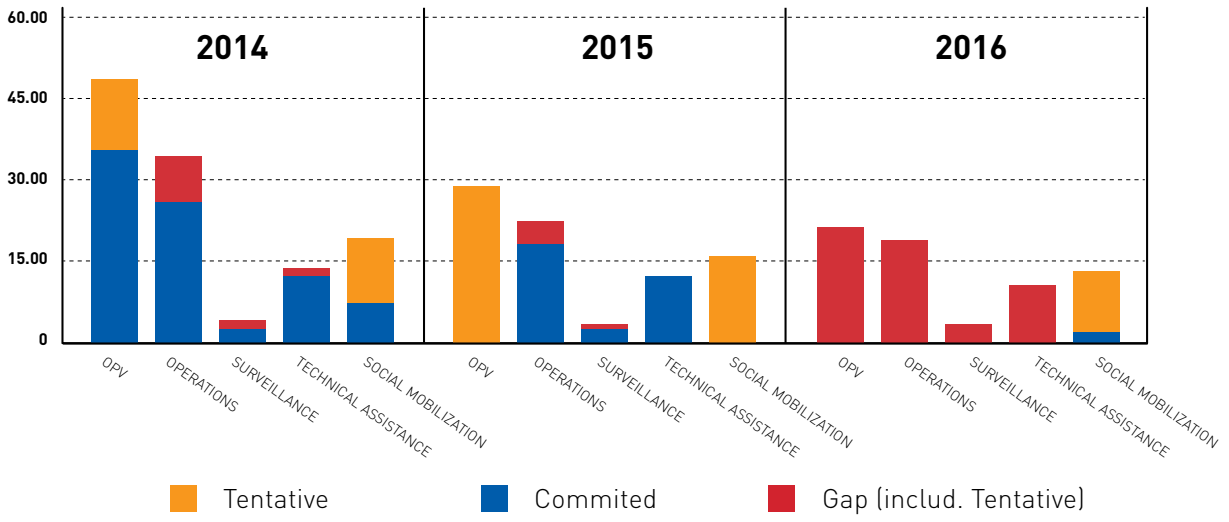
**AFGHANISTAN REQUIREMENTS & FUNDING GAP (all figures in US$ millions)**




**NIGERIA REQUIREMENTS & FUNDING GAP (all figures in US$ millions)**




**PAKISTAN REQUIREMENTS & FUNDING GAP (all figures in US$ millions)**



# ENDEMIC COUNTRY REQUIREMENT AND GAP DETAILS, 2014-2016

## AFGHANISTAN (all figures in US$ millions excluding indirect costs)

| | | 2014 | 2015 | 2016 | 2014-2016 |
|---|---|---|---|---|---|
| | **National Immunization Days (NIDs)** | **4** | **4** | **4** | **12** |
| | **Sub-national Immunization Days (SNIDs)** | **4** | **4** | **4** | **12** |
| | **Mop ups** | **6** | **2** | **2** | **10** |
| | **Short Interval Additional Dose (SIADS)** | **4** | **2** | **2** | **8** |
| | **Cross border and transit** | **Year-round** | **Year-round** | **Year-round** | **Year-round** |
| | **Permanent Polio Teams (PPTs)** | **4** | **4** | **4** | **12** |
| **ORAL POLIO VACCINE** | **REQUIREMENTS** | **12.73** | **10.58** | **10.80** | **34.11** |
| | **CONFIRMED FUNDING** | **10.98** | **0.00** | **0.00** | **10.98** |
| | Japan (UNICEF) | 0.98 | 0.00 | 0.00 | 0.98 |
| | Saudi Arabia (UNICEF) | 1.50 | 0.00 | 0.00 | 1.50 |
| | Canada (UNICEF) | 1.20 | 0.00 | 0.00 | 1.20 |
| | UNICEF Regular Resources (UNICEF) | 4.00 | 0.00 | 0.00 | 4.00 |
| | Rotary International (UNICEF) | 1.80 | 0.00 | 0.00 | 1.80 |
| | World Bank (UNICEF) | 1.50 | 0.00 | 0.00 | 1.50 |
| | **TENTATIVE FUNDING*** | **0.30** | **0.00** | **0.00** | **0.30** |
| | IsDB (UNICEF) | 0.30 | 0.00 | 0.00 | 0.30 |
| | **FUNDING GAP (exclusive of tentative funding)** | **1.75** | **10.58** | **10.80** | **23.14** |
| | **FUNDING GAP (inclusive of tentative funding)** | **1.45** | **10.58** | **10.80** | **22.84** |
| **OPERATIONAL COSTS**** | **REQUIREMENTS** | **19.20** | **18.34** | **19.66** | **57.20** |
| | Operational costs (WHO) | 5.29 | 17.74 | 19.01 | 42.04 |
| | Operational costs (UNICEF) | 13.91 | 0.60 | 0.65 | 15.16 |
| | **CONFIRMED FUNDING** | **12.79** | **0.60** | **0.65** | **14.04** |
| | Canada (UNICEF) | 4.00 | 0.60 | 0.65 | 5.25 |
| | Rotary International (UNICEF) | 1.81 | 0.00 | 0.00 | 1.81 |
| | UNICEF Regular Resources (UNICEF) | 0.00 | 0.00 | 0.00 | 0.00 |
| | Japan (UNICEF) | 1.69 | 0.00 | 0.00 | 1.69 |
| | Rotary International (WHO) | 3.81 | 0.00 | 0.00 | 3.81 |
| | Canada (WHO) | 1.48 | 0.00 | 0.00 | 1.48 |
| | **TENTATIVE FUNDING** | **0.00** | **7.00** | **0.00** | **7.00** |
| | KfW-Germany (WHO) | 0.00 | 7.00 | 0.00 | 7.00 |
| | **FUNDING GAP (exclusive of tentative funding)** | **6.41** | **17.74** | **19.01** | **43.16** |
| | WHO | 0.00 | 17.74 | 19.01 | 36.75 |
| | UNICEF | 6.41 | 0.00 | 0.00 | 6.41 |
| | **FUNDING GAP (inclusive of tentative funding)** | **6.41** | **10.74** | **19.01** | **36.16** |
| | WHO | 0.00 | 10.74 | 19.01 | 29.75 |
| | UNICEF | 6.41 | 0.00 | 0.00 | 6.41 |
| **WHO SURVEILLANCE** | **REQUIREMENTS** | **6.85** | **7.55** | **7.55** | **21.95** |
| | Surveillance (WHO) | 3.13 | 3.13 | 3.13 | 9.39 |
| | Security (WHO) | 1.58 | 2.28 | 2.28 | 6.14 |
| | Security (UNICEF) | 2.14 | 2.14 | 2.14 | 6.42 |
| | **CONFIRMED FUNDING** | **2.53** | **0.00** | **0.00** | **2.53** |
| | DFID (WHO) | 0.78 | 0.00 | 0.00 | 0.78 |
| | BMGF (WHO) | 0.75 | 0.00 | 0.00 | 0.75 |
| | Rotary International (WHO) | 1.00 | 0.00 | 0.00 | 1.00 |
| | **TENTATIVE FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **FUNDING GAP (exclusive of tentative funding)** | **4.32** | **7.55** | **7.55** | **19.42** |
| | WHO | 2.18 | 5.41 | 5.41 | 13.00 |
| | UNICEF | 2.14 | 2.14 | 2.14 | 6.42 |
| | **FUNDING GAP (inclusive of tentative funding)** | **4.32** | **7.55** | **7.55** | **19.42** |
| | WHO | 2.18 | 5.41 | 5.41 | 13.00 |
| | UNICEF | 2.14 | 2.14 | 2.14 | 6.42 |

**CONTINUED →**

* Tentative funding is indicative and subject to change pending final negotiations and formal agreements.
** From mid-2014 onwards, operational costs will be transferred to WHO.

| | | | | | |
|---|---|---|---|---|---|
| TECHNICAL ASSISTANCE | **REQUIREMENTS** | **12.17** | **11.77** | **11.77** | **35.71** |
| | Technical assistance(WHO) | 4.51 | 4.51 | 4.51 | 13.53 |
| | Surge Capacity (WHO) | 3.30 | 3.30 | 3.30 | 9.90 |
| | Technical assistance (UNICEF) | 4.36 | 3.96 | 3.96 | 12.28 |
| | **CONFIRMED FUNDING** | **6.07** | **0.49** | **0.00** | **6.56** |
| | CDC (WHO) | 0.25 | 0.00 | 0.00 | 0.25 |
| | Rotary International (WHO) | 1.46 | 0.00 | 0.00 | 1.46 |
| | Japan (UNICEF) | 0.41 | 0.00 | 0.00 | 0.41 |
| | BMGF (UNICEF) | 1.64 | 0.00 | 0.00 | 1.64 |
| | Canada (UNICEF) | 1.67 | 0.49 | 0.00 | 2.16 |
| | Rotary International (UNICEF) | 0.64 | 0.00 | 0.00 | 0.64 |
| | **TENTATIVE FUNDING** | **6.10** | **0.50** | **0.00** | **6.60** |
| | KfW-Germany (WHO) | 6.10 | 0.50 | 0.00 | 6.60 |
| | **FUNDING GAP (exclusive of tentative funding)** | **6.10** | **11.28** | **11.77** | **29.15** |
| | WHO | 6.10 | 7.81 | 7.81 | 21.72 |
| | UNICEF | 0.00 | 3.47 | 3.96 | 7.43 |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.00** | **10.78** | **11.77** | **22.55** |
| | WHO | 0.00 | 7.81 | 7.81 | 15.62 |
| | UNICEF | 0.00 | 3.47 | 3.96 | 7.43 |
| UNICEF SOCIAL MOBILIZATION | **REQUIREMENTS** | **11.21** | **8.75** | **9.60** | **29.56** |
| | **CONFIRMED FUNDING** | **4.72** | **2.40** | **2.35** | **9.47** |
| | Canada (UNICEF) | 1.20 | 2.40 | 2.35 | 5.95 |
| | Rotary International (UNICEF) | 3.52 | 0.00 | 0.00 | 3.52 |
| | **TENTATIVE FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **FUNDING GAP (exclusive of tentative funding)** | **6.49** | **6.35** | **7.25** | **20.09** |
| | **FUNDING GAP (inclusive of tentative funding)** | **6.49** | **6.35** | **7.25** | **20.09** |
| SUMMARY | **TOTAL REQUIREMENTS** | **62.16** | **56.99** | **59.38** | **178.53** |
| | WHO | 17.81 | 30.96 | 32.23 | 81.00 |
| | UNICEF | 44.35 | 26.03 | 27.15 | 97.53 |
| | **TOTAL FUNDING GAP (exclusive of tentative funding)** | **25.07** | **53.50** | **56.38** | **134.95** |
| | WHO | 8.28 | 30.96 | 32.23 | 71.47 |
| | UNICEF | 16.79 | 22.54 | 24.15 | 63.48 |
| | **TOTAL FUNDING GAP (inclusive of tentative funding)** | **18.67** | **46.50** | **56.38** | **121.55** |
| | WHO | 2.18 | 23.96 | 32.23 | 58.37 |
| | UNICEF | 16.49 | 22.54 | 24.15 | 63.18 |

# NIGERIA (all figures in US$ millions excluding indirect costs)

| | | 2014 | 2015 | 2016 | 2014-2016 |
|---|---|---|---|---|---|
| | **National Immunization Days (NIDs)** | **2** | **2** | **2** | **6** |
| | **Sub-national Imm. Days (SNIDs)** | **7** | **4** | **3** | **14** |
| | **Special revaccination campaigns in selected LGAs[1]** | **0** | **2** | **2** | **4** |
| | **Provision for outbreak response (mop-ups)[1]** | **Yes** | **Yes** | **No** | |
| ORAL POLIO VACCINE | **REQUIREMENTS** | **55.83** | **48.18** | **34.52** | **138.53** |
| | **CONFIRMED FUNDING*** | **39.96** | **0.00** | **0.00** | **39.96** |
| | World Bank Buy-down | 39.96 | 0.00 | 0.00 | 39.96 |
| | **TENTATIVE FUNDING**** | **15.87** | **47.07** | **10.77** | **73.71** |
| | Gov't of Japan to FGoN (UNICEF) | 15.87 | 47.07 | 10.77 | 73.71 |
| | **FUNDING GAP (exclusive of tentative funding)** | **15.87** | **48.18** | **34.52** | **98.57** |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.00** | **1.11** | **23.75** | **24.86** |
| OPERATIONAL COSTS | **REQUIREMENTS** | **102.85** | **92.38** | **53.93** | **249.16** |
| | Operational costs (WHO)[2] | 79.76 | 73.32 | 43.15 | 196.23 |
| | Operational costs (UNICEF, including campaign-related social mobilization) | 23.09 | 19.06 | 10.78 | 52.93 |
| | **CONFIRMED FUNDING** | **59.79** | **10.59** | **0.00** | **70.38** |
| | DFATD-Canada(WHO) | 2.19 | 1.25 | 0.00 | 3.44 |
| | KfW-Germany (WHO) | 15.62 | 0.00 | 0.00 | 15.62 |
| | FGoN (WHO) (carryover from 2013, transferred in 2014) | 2.58 | 0.00 | 0.00 | 2.58 |
| | BMGF (WHO) (outbreak response)-carried over from 2013 | 1.91 | 0.00 | 0.00 | 1.91 |
| | BMGF (WHO) (Eng't of traditional leaders)-carryover from 2013 | 2.23 | 0.00 | 0.00 | 2.23 |
| | BMGF (WHO) (IPDs operations) | 9.62 | 9.34 | 0.00 | 18.96 |
| | BMGF (WHO) (Eng't of traditional leaders) | 1.55 | 0.00 | 0.00 | 1.55 |
| | BMGF (WHO) (outbreak response) | 7.35 | 0.00 | 0.00 | 7.35 |
| | USAID (WHO) (independent monitors and LQAs) | 2.57 | 0.00 | 0.00 | 2.57 |
| | EU (WHO) | 0.03 | 0.00 | 0.00 | 0.03 |
| | Rotary International (UNICEF) (including rolled over fund) | 6.45 | 0.00 | 0.00 | 6.45 |
| | KfW-Germany (UNICEF) | 7.46 | 0.00 | 0.00 | 7.46 |
| | AusAid (UNICEF) | 0.23 | 0.00 | 0.00 | 0.23 |
| | **TENTATIVE FUNDING** | **42.64** | **13.18** | **0.00** | **55.82** |
| | European Union (WHO) | 0.00 | 13.18 | 0.00 | 13.18 |
| | Federal Government of Nigeria (WHO) | 34.11 | 0.00 | 0.00 | 34.11 |
| | Federal Government of Nigeria (UNICEF) | 8.53 | 0.00 | 0.00 | 8.53 |
| | **FUNDING GAP (exclusive of tentative funding)** | **43.06** | **81.79** | **53.93** | **178.78** |
| | WHO | 34.11 | 62.73 | 43.15 | 139.99 |
| | UNICEF | 8.95 | 19.06 | 10.78 | 38.79 |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.42** | **68.61** | **53.93** | **122.96** |
| | WHO | 0.00 | 49.55 | 43.15 | 92.70 |
| | UNICEF | 0.42 | 19.06 | 10.78 | 30.26 |
| WHO SURVEILLANCE | **REQUIREMENTS** | **15.44** | **14.72** | **14.72** | **44.88** |
| | Surveillance | 14.41 | 14.72 | 14.72 | 43.85 |
| | Security (WHO) | 1.03 | 0.00 | 0.00 | 1.03 |
| | **CONFIRMED FUNDING** | **6.47** | **0.68** | **0.00** | **7.15** |
| | DFID (WHO) | 4.75 | 0.00 | 0.00 | 4.75 |
| | CDC (WHO) | 0.12 | 0.00 | 0.00 | 0.12 |
| | DFATD-Canada (WHO) | 0.67 | 0.68 | 0.00 | 1.35 |
| | Korea Foundation for International Healthcare (KOFIH) | 0.93 | 0.00 | 0.00 | 0.93 |
| | KfW-Germany (WHO) | 0.00 | 0.00 | 0.00 | 0.00 |
| | **TENTATIVE FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **FUNDING GAP (exclusive of tentative funding)** | **8.97** | **14.04** | **14.72** | **37.73** |
| | **FUNDING GAP (inclusive of tentative funding)** | **8.97** | **14.04** | **14.72** | **37.73** |
| | **REQUIREMENTS** | **67.70** | **60.06** | **36.57** | **164.33** |
| | Technical Assistance (WHO) | 39.08 | 28.57 | 28.57 | 96.22 |
| | Surge capacity (WHO) | 20.41 | 23.73 | 0.00 | 44.14 |
| | Technical assistance (UNICEF) | 8.21 | 7.76 | 8.00 | 23.97 |

**CONTINUED →**

* Requirements for 2016 are tentative pending final review by the Nigeria Financing Sub-Committee of the ICC. ** Tentative funding is indicative and subject to change pending final negotiations and formal agreements.

Notes:1) For outbreak response, assumed that 3 non-endemic states may experience outbreak per semester. For 2014 and 2015, 2 rounds of revaccination activities in poor performing areas in HR states planned. 2) Operational costs under WHO (for 2013/14) and UNICEF (2014/15) include traditional leaders engagement

| | | | | | |
|---|---|---|---|---|---|
| TECHNICAL ASSISTANCE | **CONFIRMED FUNDING** | **62.69** | **0.81** | **0.84** | **64.34** |
| | BMGF (WHO) | 0.14 | 0.00 | 0.00 | 0.14 |
| | BMGF-Surge (WHO) carried over from 2013 | 9.81 | 0.00 | 0.00 | 9.81 |
| | BMGF (Surge capacity) (WHO) | 14.77 | 0.00 | 0.00 | 14.77 |
| | CDC (WHO) | 0.96 | 0.00 | 0.00 | 0.96 |
| | DFID (WHO) | 11.12 | 0.00 | 0.00 | 11.12 |
| | Rotary (WHO) | 3.50 | 0.00 | 0.00 | 3.50 |
| | KfW-Germany (WHO) | 15.52 | 0.00 | 0.00 | 15.52 |
| | BMGF (UNICEF) | 2.17 | 0.00 | 0.00 | 2.17 |
| | Rotary International (UNICEF) | 1.95 | 0.00 | 0.00 | 1.95 |
| | CDC (UNICEF) | 0.53 | 0.00 | 0.00 | 0.53 |
| | AusAid (UNICEF) | 0.16 | 0.00 | 0.00 | 0.16 |
| | Japan Natcom (UNICEF) | 0.39 | 0.00 | 0.00 | 0.39 |
| | UNICEF Regular Resources (UNICEF) | 1.51 | 0.81 | 0.84 | 3.16 |
| | Misc. sources (UNICEF) | 0.16 | 0.00 | 0.00 | 0.16 |
| | **TENTATIVE FUNDING** | **0.35** | **0.53** | **0.55** | **1.43** |
| | Rotary International (UNICEF) | 0.35 | 0.00 | 0.00 | 0.35 |
| | CDC (UNICEF) | 0.00 | 0.53 | 0.55 | 1.08 |
| | **FUNDING GAP (exclusive of tentative funding)** | **5.01** | **59.25** | **35.73** | **99.99** |
| | WHO | 3.67 | 52.30 | 28.57 | 84.54 |
| | UNICEF | 1.34 | 6.95 | 7.16 | 15.45 |
| | **FUNDING GAP (inclusive of tentative funding)** | **4.66** | **58.72** | **35.18** | **98.56** |
| | WHO | 3.67 | 52.30 | 28.57 | 84.54 |
| | UNICEF | 0.99 | 6.42 | 6.61 | 14.02 |
| SPECIAL POLIO IMMUNIZATION ACTIVITIES | **REQUIREMENTS** | **11.82** | **9.50** | **0.00** | **21.32** |
| | WHO | 4.35 | 5.50 | 0.00 | 9.85 |
| | UNICEF | 7.47 | 4.00 | 0.00 | 11.47 |
| | **CONFIRMED FUNDING** | **1.65** | **0.00** | **0.00** | **1.65** |
| | BMGF (WHO)-Borno Yobe special intervention (2013 carry over) | 0.62 | 0.00 | 0.00 | 0.62 |
| | BMGF (UNICEF)-health camp | 1.03 | 0.00 | 0.00 | 1.03 |
| | **TENTATIVE FUNDING** | **6.92** | **0.00** | **0.00** | **6.92** |
| | KfW (WHO) Borno Yobe special intervention | 3.16 | 0.00 | 0.00 | 3.16 |
| | BMGF (WHO) Introduction of IPV | 0.30 | 0.00 | 0.00 | 0.30 |
| | BMGF (UNICEF) Introduction of IPV | 0.30 | 0.00 | 0.00 | 0.30 |
| | KfW (UNICEF) support for security challenged areas | 3.16 | 0.00 | 0.00 | 3.16 |
| | **FUNDING GAP (exclusive of tentative funding)** | **10.17** | **9.50** | **0.00** | **19.67** |
| | WHO | 3.73 | 5.50 | 0.00 | 9.23 |
| | UNICEF | 6.44 | 4.00 | 0.00 | 10.44 |
| | **FUNDING GAP (inclusive of tentative funding)** | **3.25** | **9.50** | **0.00** | **12.75** |
| | WHO | 0.27 | 5.50 | 0.00 | 5.77 |
| | UNICEF | 2.98 | 4.00 | 0.00 | 6.98 |
| UNICEF SOCIAL MOBILIZATION | **REQUIREMENTS** | **27.54** | **26.82** | **26.82** | **81.18** |
| | **CONFIRMED FUNDING** | **27.54** | **0.00** | **0.00** | **27.54** |
| | BMGF (UNICEF) | 24.95 | 0.00 | 0.00 | 24.95 |
| | CDC (UNICEF) | 0.06 | 0.00 | 0.00 | 0.06 |
| | Japan Natcom (UNICEF) | 0.25 | 0.00 | 0.00 | 0.25 |
| | Rotary International (UNICEF) | 0.14 | 0.00 | 0.00 | 0.14 |
| | KfW (UNICEF) | 2.14 | 0.00 | 0.00 | 2.14 |
| | **TENTATIVE FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **FUNDING GAP (exclusive of tentative funding)** | **0.00** | **26.82** | **26.82** | **53.64** |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.00** | **26.82** | **26.82** | **53.64** |
| SUMMARY | **TOTAL FRR REQUIREMENTS** | **281.18** | **251.66** | **166.56** | **699.40** |
| | WHO | 159.04 | 145.84 | 86.44 | 391.32 |
| | UNICEF | 122.14 | 105.82 | 80.12 | 308.08 |
| | **FUNDING GAP (exclusive of tentative funding)** | **83.08** | **239.58** | **165.72** | **488.38** |
| | WHO | 50.48 | 134.57 | 86.44 | 271.49 |
| | UNICEF | 32.60 | 105.01 | 79.28 | 216.89 |
| | **FUNDING GAP (inclusive of tentative funding)** | **17.30** | **178.80** | **154.40** | **350.50** |
| | WHO | 12.91 | 121.39 | 86.44 | 220.74 |
| | UNICEF | 4.39 | 57.41 | 67.96 | 129.76 |

**CONTINUED →**

| | | | | | |
|---|---|---|---|---|---|
| INTRODUCTION OF IPV | **FRR ENABLING ACTIVITIES** | | | | |
| | **REQUIREMENTS (UNICEF)** | **2.74** | **0.00** | **0.00** | **2.74** |
| | **CONFIRMED FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **TENTATIVE FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **FUNDING GAP (exclusive of tentative funding)** | **2.74** | **0.00** | **0.00** | **2.74** |
| | **FUNDING GAP (inclusive of tentative funding)** | **2.74** | **0.00** | **0.00** | **2.74** |
| OTHER IN-BETWEEN IPDS ACTIVITIES | **REQUIREMENTS** | **17.96** | **17.32** | **3.89** | **39.17** |
| | RI Intensification (UNICEF) | 1.00 | 1.00 | 1.00 | 3.00 |
| | Engagement of traditional leaders (non-campaign related) (UNICEF) | 0.00 | 0.39 | 0.39 | 0.78 |
| | Reaching the underserved/isolated communities in HR states (UNICEF) | 5.60 | 5.60 | 0.00 | 11.20 |
| | Reaching the underserved/isolated communities in HR states (WHO) | 7.83 | 7.83 | 0.00 | 15.66 |
| | Engagement of traditional leaders (non-campaign related) (WHO) | 0.39 | 0.00 | 0.00 | 0.39 |
| | RI Intensification (WHO) | 3.14 | 2.50 | 2.50 | 8.14 |
| | **CONFIRMED FUNDING** | **17.96** | **0.00** | **0.00** | **17.96** |
| | BMGF (hard to reach community project) (WHO) | 7.83 | 0.00 | 0.00 | 7.83 |
| | BMGF (eng't of traditional leaders) (WHO) | 0.39 | 0.00 | 0.00 | 0.39 |
| | BMGF (RI Intensification) (WHO) | 3.14 | 0.00 | 0.00 | 3.14 |
| | BMGF (UNICEF) | 6.60 | 0.00 | 0.00 | 6.60 |
| | **TENTATIVE FUNDING** | **0.00** | **0.00** | **0.00** | **0.00** |
| | **FUNDING GAP (exclusive of tentative funding)** | **0.00** | **17.32** | **3.89** | **21.21** |
| | WHO | 0.00 | 10.33 | 2.50 | 12.83 |
| | UNICEF | 0.00 | 6.99 | 1.39 | 8.38 |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.00** | **17.32** | **3.89** | **21.21** |
| | WHO | 0.00 | 10.33 | 2.50 | 12.83 |
| | UNICEF | 0.00 | 6.99 | 1.39 | 8.38 |
| SUMMARY | **TOTAL FRR ENABLING REQUIREMENTS** | **20.70** | **17.32** | **3.89** | **41.91** |
| | WHO | 3.53 | 2.50 | 2.50 | 8.53 |
| | UNICEF | 17.17 | 14.82 | 1.39 | 33.38 |
| | **FUNDING GAP (exclusive of tentative funding)** | **2.74** | **17.32** | **3.89** | **23.95** |
| | WHO | 0.00 | 10.33 | 2.50 | 12.83 |
| | UNICEF | 2.74 | 6.99 | 1.39 | 11.12 |
| | **FUNDING GAP (inclusive of tentative funding)** | **2.74** | **17.32** | **3.89** | **23.95** |
| | WHO | 0.00 | 10.33 | 2.50 | 12.83 |
| | UNICEF | 2.74 | 6.99 | 1.39 | 11.12 |
| TOTAL NIGERIA ACTIVITIES | **TOTAL FRR & FRR ENABLING REQUIREMENTS** | **301.88** | **268.98** | **170.45** | **741.31** |
| | WHO | 162.57 | 148.34 | 88.94 | 399.85 |
| | UNICEF | 139.31 | 120.64 | 81.51 | 341.46 |
| | **FUNDING GAP (exclusive of tentative funding)** | **85.82** | **256.90** | **169.61** | **512.33** |
| | WHO | 50.48 | 144.90 | 88.94 | 284.32 |
| | UNICEF | 35.34 | 112.00 | 80.67 | 228.01 |
| | **FUNDING GAP (inclusive of tentative funding)** | **20.04** | **196.12** | **158.29** | **374.45** |
| | WHO | 12.91 | 131.72 | 88.94 | 233.57 |
| | UNICEF | 7.13 | 64.40 | 69.35 | 140.88 |

# PAKISTAN (all figures in US$ millions excluding indirect costs)

| | | 2014 | 2015* | 2016* | 2014-2016 |
|---|---|---|---|---|---|
| | **National Immunization Days (NIDs)** | **5** | **2** | **2** | **9** |
| | **Sub-national Immunization Days (SNIDs)** | **4** | **4** | **2** | **10** |
| | **Short Interval Additional Dose (SIADS)** | **9** | **0** | **0** | **9** |
| | **Case response (mop-ups)** | **13** | **0** | **0** | **13** |
| ORAL POLIO VACCINE | REQUIREMENTS | 57.53 | 29.58 | 18.50 | 105.61 |
| | CONFIRMED FUNDING | 39.52 | 0.00 | 0.00 | 39.52 |
| | Japan | 2.20 | 0.00 | 0.00 | 2.20 |
| | World Bank Buy-down (2nd Add. Financing) | 1.87 | 0.00 | 0.00 | 1.87 |
| | Government of Pakistan - IsDB (UNICEF) | 35.45 | 0.00 | 0.00 | 35.45 |
| | TENTATIVE FUNDING | 18.01 | 29.58 | 0.00 | 47.59 |
| | Islamic Development Bank/Government of Pakistan | 18.01 | 29.58 | 0.00 | 47.59 |
| | **FUNDING GAP (exclusive of tentative funding)** | **18.01** | **29.58** | **18.50** | **66.09** |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.00** | **0.00** | **18.50** | **18.50** |
| OPERATIONAL COSTS | REQUIREMENTS | 37.60 | 22.74 | 17.76 | 78.10 |
| | Operational costs (WHO) | 37.60 | 22.74 | 17.76 | 78.10 |
| | Operational costs (UNICEF) | 0.00 | 0.00 | 0.00 | 0.00 |
| | CONFIRMED FUNDING | 28.32 | 17.94 | 0.00 | 46.26 |
| | Government of Pakistan - IsDB (WHO) | 28.32 | 17.94 | 0.00 | 46.26 |
| | TENTATIVE FUNDING | 0.00 | 0.00 | 0.00 | 0.00 |
| | **FUNDING GAP (exclusive of tentative funding)** | **9.28** | **4.80** | **17.76** | **31.84** |
| | WHO | 9.28 | 4.80 | 17.76 | 31.84 |
| | UNICEF | 0.00 | 0.00 | 0.00 | 0.00 |
| | **FUNDING GAP (inclusive of tentative funding)** | **9.28** | **4.80** | **17.76** | **31.84** |
| | WHO | 9.28 | 4.80 | 17.76 | 31.84 |
| | UNICEF | 0.00 | 0.00 | 0.00 | 0.00 |
| WHO SURVEILLANCE | REQUIREMENTS | 4.85 | 4.41 | 4.41 | 13.67 |
| | Surveillance | 3.33 | 3.41 | 3.41 | 10.15 |
| | Security (MOSS) | 1.52 | 1.00 | 1.00 | 3.52 |
| | CONFIRMED FUNDING | 3.32 | 3.64 | 0.00 | 6.96 |
| | Government of Pakistan - IsDB (WHO) | 3.32 | 3.64 | 0.00 | 6.96 |
| | TENTATIVE FUNDING | 0.00 | 0.00 | 0.00 | 0.00 |
| | **FUNDING GAP (exclusive of tentative funding)** | **1.53** | **0.77** | **4.41** | **6.71** |
| | **FUNDING GAP (inclusive of tentative funding)** | **1.53** | **0.77** | **4.41** | **6.71** |
| TECHNICAL ASSISTANCE | REQUIREMENTS | 20.34 | 20.48 | 31.01 | 71.83 |
| | Technical assistance (WHO) | 7.05 | 8.06 | 6.44 | 21.55 |
| | Technical assistance (UNICEF) | 5.44 | 4.57 | 4.57 | 14.58 |
| | Surge (WHO) | 7.85 | 7.85 | 20.00 | 35.70 |
| | CONFIRMED FUNDING | 18.80 | 0.00 | 0.00 | 18.80 |
| | Rotary International (WHO) | 3.47 | 0.00 | 0.00 | 3.47 |
| | DFID (WHO) | 4.00 | 0.00 | 0.00 | 4.00 |
| | BMGF (WHO) | 5.89 | 0.00 | 0.00 | 5.89 |
| | BMGF (UNICEF) | 3.59 | 0.00 | 0.00 | 3.59 |
| | Rotary International (UNICEF) | 1.24 | 0.00 | 0.00 | 1.24 |
| | CDC (UNICEF) | 0.61 | 0.00 | 0.00 | 0.61 |
| | TENTATIVE FUNDING | 0.00 | 0.00 | 0.00 | 0.00 |
| | **FUNDING GAP (exclusive of tentative funding)** | **1.54** | **20.48** | **31.01** | **53.03** |
| | WHO | 1.54 | 15.91 | 26.44 | 43.89 |
| | UNICEF | 0.00 | 4.57 | 4.57 | 9.14 |
| | **FUNDING GAP (inclusive of tentative funding)** | **1.54** | **20.48** | **31.01** | **53.03** |
| | WHO | 1.54 | 15.91 | 26.44 | 43.89 |
| | UNICEF | 0.00 | 4.57 | 4.57 | 9.14 |

CONTINUED →

* Note that 2015- 2016 Immunization activities based on 2012-13 calendar information; updated activity calendar will be published in the next 2014 FRR update.

| | | | | | |
|---|---|---|---|---|---|
| UNICEF SOCIAL MOBILIZATION | **REQUIREMENTS** | **25.67** | **15.46** | **15.46** | **56.59** |
| | **CONFIRMED FUNDING** | **9.68** | **0.00** | **0.00** | **9.68** |
| | BMGF | 1.07 | 0.00 | 0.00 | 1.07 |
| | Canadian NatComm | 0.25 | 0.00 | 0.00 | 0.25 |
| | USAID | 0.35 | 0.00 | 0.00 | 0.35 |
| | Islamic Development Bank | 8.00 | 0.00 | 0.00 | 8.00 |
| | Brunei | 0.01 | 0.00 | 0.00 | 0.01 |
| | **TENTATIVE FUNDING** | **15.99** | **15.46** | **2.88** | **34.33** |
| | BMGF | 5.80 | 0.00 | 0.00 | 5.80 |
| | Government of Pakistan - IsDB (UNICEF) | 5.69 | 15.46 | 2.88 | 24.03 |
| | Rotary | 4.50 | 0.00 | 0.00 | 4.50 |
| | **FUNDING GAP (exclusive of tentative funding)** | **15.99** | **15.46** | **15.46** | **46.91** |
| | **FUNDING GAP (inclusive of tentative funding)** | **0.00** | **0.00** | **12.58** | **12.58** |
| SUMMARY | **TOTAL REQUIREMENTS** | **145.99** | **92.67** | **87.14** | **325.80** |
| | WHO | 57.35 | 43.06 | 48.61 | 149.02 |
| | UNICEF | 88.64 | 49.61 | 38.53 | 176.78 |
| | **FUNDING GAP (exclusive of tentative funding)** | **46.35** | **71.09** | **87.14** | **204.58** |
| | WHO | 12.35 | 21.48 | 48.61 | 82.44 |
| | UNICEF | 34.00 | 49.61 | 38.53 | 122.14 |
| | **FUNDING GAP (inclusive of tentative funding)** | **12.35** | **26.05** | **84.26** | **122.66** |
| | WHO | 12.35 | 21.48 | 48.61 | 82.44 |
| | UNICEF | 0.00 | 4.57 | 35.65 | 40.22 |

# ANNEXES

## ANNEX A
## DETAILS OF EXTERNAL FUNDING REQUIREMENTS IN POLIO-ENDEMIC AND HIGHEST-RISK COUNTRIES, AREAS AND TERRITORIES, 2014, EXCLUDING INDIRECT COSTS (all figures in US$ millions)

| | 2014 | | | | | |
|---|---|---|---|---|---|---|
| **Country** | **AFP Surveillance** | **Social Mobilization** | **Technical Assistance** | **OPV** | **Operations Costs** | **Total Costs 2014** |
| **West/South Asia** | | | | | | |
| Afghanistan | 6.85 | 11.21 | 12.17 | 12.73 | 19.20 | 62.16 |
| Pakistan | 4.85 | 25.67 | 20.34 | 57.53 | 37.60 | 145.99 |
| India | 6.80 | 12.96 | 18.71 | 0.00 | 8.15 | 46.62 |
| Nepal | 0.49 | 0.00 | 1.63 | 0.00 | 0.00 | 2.12 |
| **West/Central Africa** | | | | | | |
| Nigeria | 15.44 | 27.54 | 67.70 | 55.83 | 102.85 | 269.36 |
| Chad | 0.90 | 1.71 | 5.36 | 2.73 | 5.52 | 16.22 |
| Cameroon | 0.41 | 3.66 | 0.35 | 7.35 | 6.60 | 18.37 |
| Niger | 0.59 | 1.07 | 1.27 | 5.27 | 9.43 | 17.63 |
| Mali | 0.25 | 0.36 | 0.11 | 1.80 | 5.93 | 8.45 |
| Burkina Faso | 0.27 | 0.66 | 0.16 | 4.46 | 6.50 | 12.05 |
| Benin | 0.18 | 0.31 | 0.16 | 1.61 | 2.44 | 4.70 |
| Guinea | 0.18 | 0.22 | 0.06 | 1.65 | 2.09 | 4.20 |
| Côte d'Ivoire | 0.29 | 0.42 | 0.84 | 3.99 | 4.66 | 10.20 |
| Central African Republic | 0.47 | 0.67 | 0.40 | 0.58 | 1.20 | 3.32 |
| Democratic Republic of the Congo | 2.25 | 5.97 | 11.09 | 6.75 | 12.96 | 39.02 |
| Angola | 1.40 | 0.80 | 7.02 | 2.21 | 0.24 | 11.67 |
| Liberia | 0.23 | 0.14 | 0.18 | 0.34 | 0.91 | 1.80 |
| Gabon | 0.09 | 0.30 | 0.27 | 0.37 | 0.40 | 1.43 |
| Equatorial Guinea | 0.05 | 0.53 | 0.13 | 0.18 | 1.70 | 2.59 |
| Congo | 0.14 | 0.96 | 0.33 | 0.72 | 1.03 | 3.18 |
| Sierra Leone | 0.23 | 0.30 | 0.43 | 0.52 | 1.07 | 2.55 |
| Mauritania | 0.18 | 0.20 | 0.06 | 0.23 | 0.74 | 1.41 |
| Ghana | 0.36 | 0.27 | 0.12 | 1.83 | 2.64 | 5.22 |
| Senegal | 0.32 | 0.31 | 0.08 | 0.92 | 0.92 | 2.55 |
| Gambia | 0.05 | 0.11 | 0.06 | 0.15 | 0.21 | 0.58 |
| Guinea Bissau | 0.06 | 0.07 | 0.13 | 0.10 | 0.29 | 0.65 |
| Togo | 0.14 | 0.23 | 0.14 | 0.64 | 0.85 | 2.00 |
| Cape Verde | 0.05 | 0.04 | 0.00 | 0.03 | 0.10 | 0.22 |
| **Horn of Africa** | | | | | | |
| Somalia | 1.41 | 4.61 | 6.20 | 3.49 | 10.35 | 26.06 |
| Ethiopia | 2.56 | 1.64 | 2.01 | 4.29 | 19.63 | 30.13 |
| Kenya | 0.44 | 1.59 | 1.02 | 4.18 | 17.41 | 24.64 |
| South Sudan | 0.53 | 1.06 | 3.15 | 1.19 | 6.35 | 12.28 |
| Sudan | 1.27 | 0.82 | 0.62 | 2.70 | 8.47 | 13.88 |
| Uganda | 0.40 | 0.10 | 0.66 | 1.93 | 3.28 | 6.37 |
| Yemen | 0.19 | 0.42 | 0.26 | 1.81 | 3.60 | 6.28 |
| **Middle East** | | | | | | |
| Syria | 0.00 | 1.41 | 0.00 | 1.18 | 6.37 | 8.96 |
| Egypt | 0.38 | 0.46 | 0.07 | 0.00 | 1.70 | 2.61 |
| Jordan | 0.00 | 0.33 | 0.00 | 0.36 | 1.70 | 2.39 |
| Lebanon | 0.00 | 0.94 | 0.00 | 0.24 | 3.42 | 4.60 |
| Iraq | 0.06 | 0.94 | 0.00 | 2.44 | 0.80 | 4.24 |
| West Bank and Gaza Strip | 0.00 | 0.01 | 0.00 | 0.33 | 0.20 | 0.54 |
| Turkey | 0.00 | 0.06 | 0.00 | 0.28 | 0.00 | 0.34 |
| Israel | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

## ANNEX B
## SUPPLEMENTAL IMMUNIZATION ACTIVITY SCHEDULE, 2014
## (All activities are expressed in percentages)

| TRANSMISSION ZONE / COUNTRY | NEW 2014 SIA CALENDAR (AS OF JUNE 26 2014) | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JAN | | | | FEB | | | | MAR | | | | APR | | MAY | | | JUN |
| **West/South Asia** | | | | | | | | | | | | | | | | | | |
| Afghanistan | 17 | | | | 77 | | | | 100 | | 4 | | | | 12 | | 100 | 40 |
| Pakistan | 25 | | 100 | | 32 | | 100 | | 27 | | 100 | | 51 | | 65 | | | |
| India | 100 | | | | 100 | | | | | | | | | | | | | 50 |
| Nepal | 100 | | | | | | | | | | | | | | | | | |
| **West/Central Africa** | | | | | | | | | | | | | | | | | | |
| Nigeria | 45 | | | | | | | | 100 | | | | 100 | | 45 | | | 45 |
| Cameroon | 100 | | 17 | | 52 | | 66 | | 100 | | | | 100 | | 100 | | | 100 |
| Chad | | | | | 100 | | | | 100 | | | | | | 49 | | | |
| Niger | | | | | 100 | | | | | | | | 100 | | 70 | | | |
| Mali | | | | | | | | | | | | | 100 | | 100 | | | |
| Burkina Faso | | | | | | | | | | | | | 100 | | 100 | | | |
| Benin | | | | | | | | | | | | | 100 | | 100 | | | |
| Guinea | | | | | | | | | | | | | | | | | | |
| Côte d'Ivoire | | | | | | | | | | | | | | | 100 | | | |
| Sierra Leone | | | | | | | | | | | | | | | | | | |
| Liberia | | | | | | | | | | | | | | | | | | |
| Mauritania | | | | | | | | | | | | | | | | | | |
| Ghana | | | | | | | | | | | | | | | | | | |
| Senegal | | | | | | | | | | | | | | | | | | |
| Gambia | | | | | | | | | | | | | | | | | | |
| Guinea-Bissau | | | | | | | | | | | | | | | | | | |
| Togo | | | | | | | | | | | | | | | | | | |
| Cape Verde | | | | | | | | | | | | | | | | | | |
| Central African Republic | | | | | | | | | | | | | CHD 43 | | 100 | | | |
| Angola | | | | | | | | | | | | | | | | | | |
| Democratic Republic of the Congo | | | | | | | | | CHD 19 | | | | | | CHD 23 | | | CHD 18 |
| Congo | | | | | | | | | | | | | | | 100 | | | 100 |
| Gabon | | | | | | | | | | | | | | | | | | 100 |
| Equatorial Guinea | | | | | | | | | | | | | 100 | | 100 | | 100 | 100 |
| **Horn of Africa** | | | | | | | | | | | | | | | | | | |
| Somalia | 100 | | 6 | | 56 | | CHD 55 | | 100 | | 6 | | 58 | | 100 | | | 70 |
| Ethiopia | 30 | | | | | | | | 34 | | | | | | 10 | | | 33 |
| Kenya | 100 | | | | 6 | | | | | | | | 66 | | 66 | | | 100 |
| Yemen | | | | | | | | | | | | | 100 | | | | | |
| South Sudan | | | | | | | | | | | | | 100 | | 100 | | | |
| Sudan | | | | | | | | | | | | | 100 | | 65 | | | |
| Uganda | | | | | | | | | | | | | | | 28 | | | |
| Djibouti | | | | | | | | | | | | | | | | | | 41 |
| **Middle East** | | | | | | | | | | | | | | | | | | |
| Syria | 100 | | | | 100 | | | | 100 | | | | 100 | | 100 | | | 100 |
| Iraq | 35 | | | | | | | | 100 | | | | 100 | | 100 | | | 55 |
| Egypt | | | | | | | | | | | | | 100 | | | | | |
| Jordan | | | | | | | | | 100 | | | | | | | | | 20 |
| Lebanon | | | | | | | | | 100 | | | | 100 | | | | | |
| West Bank and Gaza Strip | 100 | | | | | | | | | | | | | | | | | |
| Turkey | | | | | 7 | | | | | | | | 8 | | | | | |
| **Europe** | | | | | | | | | | | | | | | | | | |
| Israel | | | | | | | | | | | | | | | | | | |
| Russian Federation | | | | | | | | | | | | | | | | | | |
| Georgia | | | | | | | | | | | | | | | | | | |
| Tajikistan | | | | | | | | | | | | | 100 | | 100 | | | |
| Uzbekistan | | | | | | | | | | | | | | | | | | |
| Kyrgyzstan | | | | | | | | | | | | | | | | | | |
| Ukraine | | | | | | | | | | | | | | | | | | |

CONTINUED →

Countries with poliovirus within the last 6 months

Countries with no poliovirus for more than 12 months

Additional Activities from April

Countries with poliovirus between 6 and 12 months

Non-Costed Activities

Additional Activities from June

Categorization includes cVDPVs - Child Health Day (CHD)

| TRANSMISSION ZONE / COUNTRY | NEW 2014 SIA CALENDAR (AS OF JUNE 26 2014) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | | NOV | | DEC | |
| **West/South Asia** | | | | | | | | | |
| Afghanistan | | 100 | 40 | 100 | | 40 | | 10 | |
| Pakistan | | 25 | 50 | 51 | | 100 | 50 | 100 | 25 |
| India | | | 50 | | | 50 | | | |
| Nepal | | | | | | | | | |
| **West/Central Africa** | | | | | | | | | |
| Nigeria | | 45 | 45 | | | 45 | | 45 | |
| Cameroon | 100 | | 100 | 100 | | | | | |
| Chad | | | 100 | 100 | | 50 | | 50 | |
| Niger | 70 | | 100 | 60 | | 60 | | | |
| Mali | | | 100 | 50 | | | | | |
| Burkina Faso | | | 100 | 100 | | | | | |
| Benin | | | 100 | | | | | | |
| Guinea | 100 | | 100 | 100 | | | | | |
| Côte d'Ivoire | | | 100 | 100 | | | | | |
| Sierra Leone | | | 100 | 100 | | | | | |
| Liberia | | | 100 | 100 | | | | | |
| Mauritania | | | 100 | 100 | | | | | |
| Ghana | | | 100 | 100 | | | | | |
| Senegal | | | 100 | 100 | | | | | |
| Gambia | | | 100 | 100 | | | | | |
| Guinea-Bissau | | | 100 | 100 | | | | | |
| Togo | | | 100 | 100 | | | | | |
| Cape Verde | | | 100 | 100 | | | | | |
| Central African Republic | 100 | | | 100 | | 100 | | | |
| Angola | | | | CHD 100 | | 100 | | | |
| Democratic Republic of the Congo | CHD 15 | 50 | 30 | 50 | | | | | |
| Congo | 100 | | 100 | | | | | | |
| Gabon | 100 | 100 | 100 | | | | | | |
| Equatorial Guinea | 100 | 100 | | | | | | | |
| **Horn of Africa** | | | | | | | | | |
| Somalia | 20 | 126 | 100 | 100 | | | | | |
| Ethiopia | 33 | 20 | 100 | 100 | | | | | |
| Kenya | | | 40 | 40 | | 40 | | | |
| Yemen | | 100 | 50 | 50 | | | | | |
| South Sudan | | | | 100 | | 100 | | | |
| Sudan | | | | 100 | | | | | |
| Uganda | | | 100 | 50 | | | | | |
| Djibouti | | | 100 | 100 | | | | | |
| **Middle East** | | | | | | | | | |
| Syria | | 70 | | 100 | | 100 | | | |
| Iraq | | | 50 | 100 | | 100 | | | |
| Egypt | | | | 30 | 70 | | | 37 | |
| Jordan | | 20 | | 100 | | 100 | | | |
| Lebanon | | | 100 | 100 | | | | | |
| West Bank and Gaza Strip | | | 100 | 100 | | | | | |
| Turkey | | | 7 | 7 | | | | | |
| **Europe** | | | | | | | | | |
| Israel | | | | | | | | | |
| Russian Federation | | | | | | | | | |
| Georgia | | | | | | | | | |
| Tajikistan | | | | | | | | | |
| Uzbekistan | | | | | | | | | |
| Kyrgyzstan | | | | | | | | | |
| Ukraine | | | | | | | | | |

Countries with poliovirus within the last 6 months

Countries with no poliovirus for more than 12 months

Additional Activities from April

Countries with poliovirus between 6 and 12 months

Non-Costed Activities

Additional Activities from June

Categorization includes cVDPVs - Child Health Day (CHD)

## ANNEX C – SOCIAL MOBILIZATION COSTS, 2014

Social mobilization and communication efforts are essential to ensuring high levels of community demand for oral polio vaccine, and to gain trust and acceptance in the most challenging areas. The activities can be broadly separated into two categories - on-going and campaign-related (see Section 3.1.1).

### On-going activities

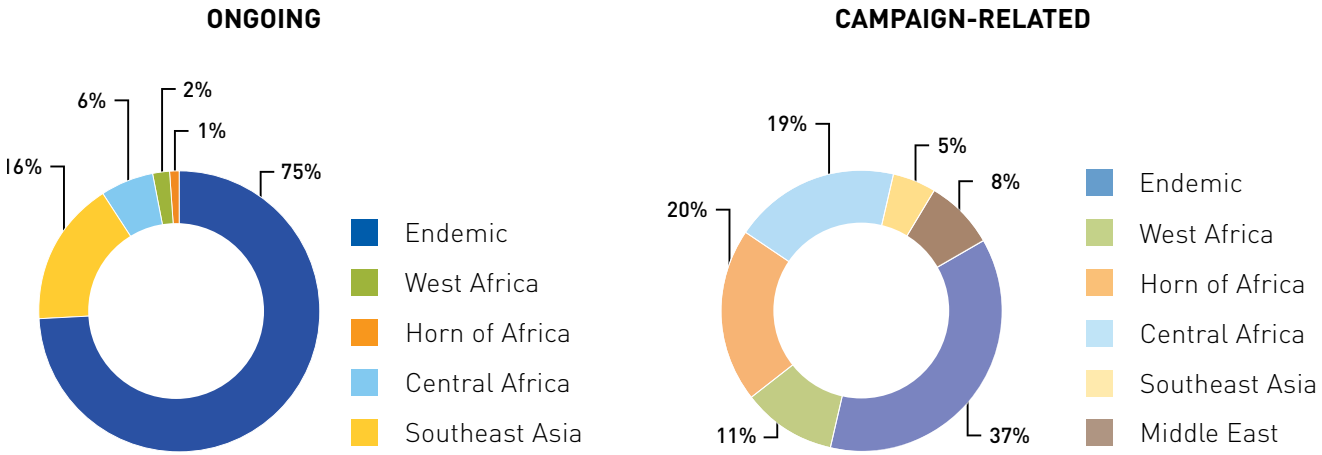
On-going activities are those conducted continuously throughout the year in support of the polio eradication programme and broader EPI, in order to lay the foundation for campaign work, but also to promote routine immunization and increase families and communities understanding and demand for vaccination beyond campaigns and beyond OPV. Convergence activities (integration with other sectors) also fall under this category.

### Campaign-related activities

Campaign-related activities are required to support the immediate implementation of an SNID/NID/SIAD/ mop-up. This may include different communication activities such as community dialogue, engagement with influencers, traditional and religious leaders to gain their support, door to door mobilization through frontline workers, printing of materials to announce campaign dates, airing of campaign-specific radio or TV spots, specific trainings, operations and logistical costs.

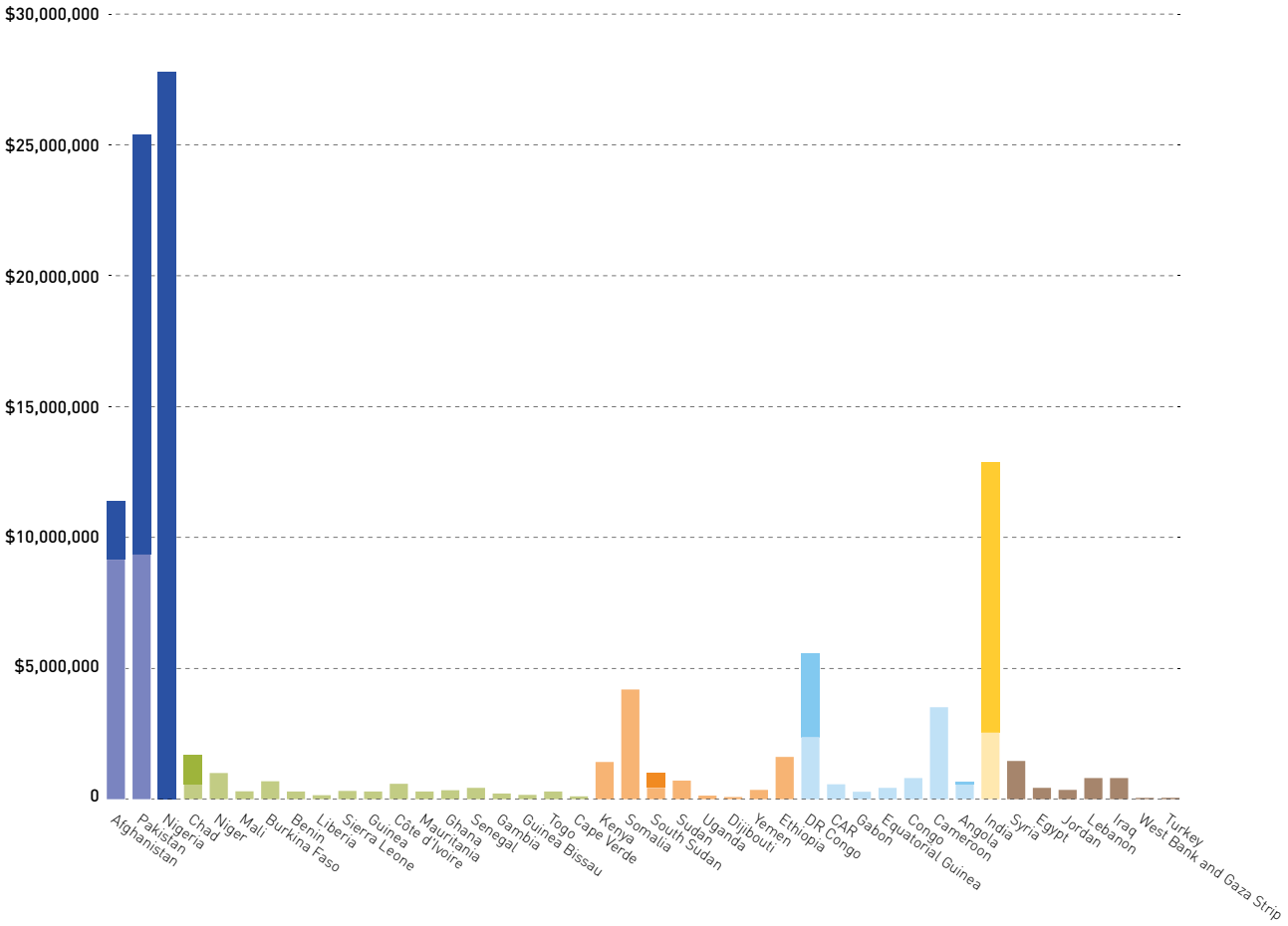
In the majority of countries, the campaign-related budget is larger than the on-going activity budget. Exceptions are found in India, Pakistan, Chad, Angola and Nigeria where the concentration is more on the on-going activities (see figures below).

**ANNEX C**
**2014 SOCIAL MOBILIZATION REQUIREMENTS, BY CATEGORY (ONGOING & CAMPAIGN-RELATED)**




Ongoing social mobilization requirements do not reflect HQ or Regional Office requirements and campaign-related requirements do not include Europe.

**ANNEX C**
**2014 SOCIAL MOBILIZATION REQUIREMENTS, BY COUNTRY AND BY CATEGORY (ONGOING & CAMPAIGN-RELATED) (all figures in US$ millions)**




**ONGOING SOCIAL MOBILIZATION**

- Endemic
- West Africa
- Horn of Africa
- Central Africa
- Southeast Asia

**CAMPAIGN-RELATED SOCIAL MOBILIZATION**

- Endemic
- West Africa
- Horn of Africa
- Central Africa
- Southeast Asia
- Middle East

## ANNEX D
## LABORATORY, SURVEILLANCE (INCLUDING SECURITY) AND RUNNING COSTS BY COUNTRY AND REGION, 2014. EXCLUDING INDIRECT COSTS (all figures in US$ millions)

| WHO African Region | 2014 |
|---|---|
| Algeria | 0.03 |
| Angola | 1.40 |
| Benin | 0.18 |
| Botswana | 0.09 |
| Burkina Faso | 0.27 |
| Burundi | 0.09 |
| Cameroon | 0.41 |
| Cape Verde | 0.05 |
| Central African Republic | 0.47 |
| Chad | 0.90 |
| Comoros | 0.05 |
| Congo | 0.14 |
| Côte d'Ivoire | 0.29 |
| Democratic Republic of the Congo | 2.25 |
| Equatorial Guinea | 0.05 |
| Eritrea | 0.14 |
| Ethiopia | 2.56 |
| Gabon | 0.09 |
| Gambia | 0.05 |
| Ghana | 0.36 |
| Guinea | 0.18 |
| Guinea Bissau | 0.06 |
| Kenya | 0.44 |
| Lesotho | 0.05 |
| Liberia | 0.23 |
| Madagascar | 0.40 |
| Malawi | 0.18 |
| Mali | 0.25 |
| Mauritania | 0.18 |
| Mauritius | 0.02 |
| Mozambique | 0.27 |
| Namibia | 0.14 |
| Niger | 0.59 |
| Nigeria | 14.41 |
| Rwanda | 0.11 |
| Sao Tome and Principe | 0.01 |
| Senegal | 0.32 |
| Seychelles | 0.01 |
| Sierra Leone | 0.23 |
| South Africa | 0.27 |
| South Sudan | 0.53 |
| Swaziland | 0.07 |
| Togo | 0.14 |
| Uganda | 0.40 |
| United Republic of Tanzania | 0.41 |
| Zambia | 0.36 |
| Zimbabwe | 0.25 |
| Regional surveillance and laboratory | 4.95 |
| **Subtotal** | **35.33** |

| WHO Region of the Americas | 2014 |
|---|---|
| Regional surveillance and laboratory | 0.62 |

| WHO Western Pacific Region | 2014 |
|---|---|
| Regional surveillance and laboratory | 0.83 |

| WHO Eastern Mediterranean Region | 2014 |
|---|---|
| Afghanistan | 3.13 |
| Djibouti | 0.05 |
| Egypt | 0.38 |
| Iraq | 0.06 |
| Pakistan | 3.33 |
| Somalia | 0.64 |
| Sudan | 1.27 |
| Yemen | 0.19 |
| Regional surveillance and laboratory | 1.55 |
| **Subtotal** | **10.60** |

| WHO South-East Asia Region | 2014 |
|---|---|
| Bangladesh | 1.06 |
| India | 6.80 |
| Indonesia | 0.79 |
| Myanmar | 0.42 |
| Nepal | 0.49 |
| Regional surveillance and laboratory | 5.15 |
| **Subtotal** | **14.71** |

| WHO European Region | 2014 |
|---|---|
| Armenia | 0.01 |
| Azerbaijan | 0.03 |
| Bosnia | 0.08 |
| Georgia | 0.03 |
| Kazakhstan | 0.01 |
| Kyrgyzstan | 0.01 |
| Moldova | 0.01 |
| Tajikistan | 0.13 |
| Turkey | 0.01 |
| Turkmenistan | 0.03 |
| Ukraine | 0.04 |
| Uzbekistan | 0.03 |
| Regional surveillance and laboratory | 0.69 |
| **Subtotal** | **1.11** |

| WHO/HQ laboratory Global | 2014 |
|---|---|
| laboratory | 2.03 |

| WHO/HQ Infrastructure Global | 2014 |
|---|---|
| WHO/HQ Infrastructure Global | 0.93 |
| Afghanistan | 0.98 |
| Pakistan | 1.09 |
| Somalia | 0.24 |
| **Subtotal** | **3.24** |

| WHO/HQ Security Global | 2014 |
|---|---|
| Security /HQ Global | 1.64 |
| Afghanistan | 0.60 |
| Pakistan | 0.43 |
| Somalia | 0.53 |
| Nigeria | 1.03 |
| **Subtotal** | **4.23** |

| UNICEF/HQ Security Global | 2014 |
|---|---|
| Afghanistan | 2.14 |
| **Subtotal** | **2.14** |

| Global | 2014 |
|---|---|
| **Total** | **74.84** |

## ANNEX E
## TECHNICAL ASSISTANCE, INCLUDING SURGE CAPACITY BY COUNTRY AND REGION, 2014
## EXCLUDING INDIRECT COSTS (all figures in US$ millions)

| WHO African Region | 2014 |
|---|---|
| Angola | 5.60 |
| Benin | 0.16 |
| Botswana | 0.15 |
| Burkina Faso | 0.16 |
| Burundi | 0.12 |
| Cameroon | 0.35 |
| Central African Republic | 0.40 |
| Chad | 2.28 |
| Congo | 0.33 |
| Côte d'Ivoire | 0.84 |
| Democratic Republic of the Congo | 4.73 |
| Equatorial Guinea | 0.13 |
| Eritrea | 0.18 |
| Ethiopia | 1.12 |
| Gabon | 0.27 |
| Gambia | 0.06 |
| Ghana | 0.12 |
| Guinea | 0.06 |
| Guinea-Bissau | 0.13 |
| Kenya | 0.73 |
| Lesotho | 0.09 |
| Liberia | 0.18 |
| Madagascar | 0.07 |
| Malawi | 0.09 |
| Mali | 0.11 |
| Mauritania | 0.06 |
| Mozambique | 0.37 |
| Namibia | 0.24 |
| Niger | 0.87 |
| Nigeria | 39.08 |
| Rwanda | 0.19 |
| Senegal | 0.08 |
| Sierra Leone | 0.43 |
| South Africa | 0.45 |
| South Sudan | 2.59 |
| Swaziland | 0.15 |
| Togo | 0.14 |
| Uganda | 0.41 |
| United Republic of Tanzania | 0.40 |
| Zambia | 0.56 |
| Zimbabwe | 0.18 |
| IST (Central block) | 0.92 |
| IST (South/East block) | 1.40 |
| IST (West block) | 1.01 |
| Regional Office | 1.09 |
| **Subtotal** | **69.07** |

*** IST= Inter-country Support Team**

| WHO Eastern Mediterranean Region | 2014 |
|---|---|
| Afghanistan | 4.51 |
| Djibouti | 0.01 |
| Egypt | 0.07 |
| Iraq | 0.01 |
| Pakistan | 7.05 |
| Somalia | 2.54 |
| Sudan | 0.53 |
| Yemen | 0.26 |
| Regional Office | 1.87 |
| **Subtotal** | **16.85** |

| WHO Western Pacific Region | 2014 |
|---|---|
| Regional Office | 0.68 |
| **Subtotal** | **0.68** |

| WHO South-East Asia Region | 2014 |
|---|---|
| Bangladesh | 1.45 |
| India | 16.59 |
| Indonesia | 0.80 |
| Myanmar | 0.39 |
| Nepal | 1.63 |
| Regional Office | 1.56 |
| **Subtotal** | **22.42** |

| WHO European Region | 2014 |
|---|---|
| Regional Office/Countries | 1.65 |
| **Subtotal** | **1.65** |

| WHO | 2014 |
|---|---|
| WHO/HQ | 13.42 |
| Short Term Tech Assistance | 11.81 |
| **Subtotal** | **25.23** |

| UNICEF | 2014 |
|---|---|
| UNICEF HQ/RO | 4.81 |
| Afghanistan | 4.37 |
| Angola | 0.00 |
| Benin | 0.00 |
| Burkina Faso | 0.00 |
| Cameroon | 0.00 |
| Chad | 0.72 |
| Côte d'Ivoire | 0.00 |
| Democratic Republic of the Congo | 4.74 |
| Ethiopia | 0.25 |
| Guinea | 0.00 |
| India | 2.12 |
| Kenya | 0.25 |
| Nepal | 0.00 |
| Niger | 0.00 |
| Nigeria | 8.21 |
| Pakistan | 5.44 |
| Somalia | 2.50 |
| South Sudan | 0.56 |
| Sudan | 0.09 |
| Uganda | 0.25 |
| **Subtotal** | **34.31** |

| WHO Surge Capacity | 2014 |
|---|---|
| Afghanistan | 3.30 |
| Angola | 1.42 |
| Chad | 2.36 |
| Democratic Republic of the Congo | 1.62 |
| Kenya | 0.04 |
| Ethiopia | 0.64 |
| Nigeria | 20.41 |
| Niger | 0.40 |
| Uganda | 0.002 |
| Pakistan | 7.85 |
| Somalia | 1.15 |
| Regional Office | 1.26 |
| **Subtotal** | **40.45** |

| Global WHO-UNICEF | 2014 |
|---|---|
| **Total** | **210.66** |

# GLOSSARY OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AusAID | Australian Government Overseas Aid Program |
| AFP | Acute flaccid paralysis |
| AFR | African Region |
| BMGF | Bill & Melinda Gates Foundation |
| bOPV | Bivalent oral polio vaccine |
| CDC | US Centers for Disease Control and Prevention |
| cVDPV | Circulating vaccine-derived poliovirus |
| DFATD | Canadian Department of Foreign Affairs, Trade and Development |
| DFID | UK Department for International Development |
| EMR | Eastern Mediterranean Region |
| FRR | Financial Resource Requirements |
| FWG | Finance Working Group |
| Gavi | Gavi, the Vaccine Alliance |
| GPEI | Global Polio Eradication Initiative |
| GPLN | Global Polio Laboratory Network |
| IDB | Islamic Development Bank |
| IHR | International Health Regulations (2005) |
| IMB | Independent Monitoring Board |
| IPV | Inactivated Polio Vaccine |
| JICA | Japan International Cooperation Agency |
| mOPV | Monovalent oral polio vaccine |
| NIDs | National Immunization Days |
| OPV | Oral polio vaccine |
| PAG | Polio Advocacy Group |
| PPG | Global Polio Partners Group |
| PSC | Polio Steering Committee |
| SAGE | Strategic Advisory Group of Experts on immunization |
| SEAR | South East Asia Region |
| SIAs | Supplementary Immunization Activities |
| SIADs | Short Interval Additional Dose |
| SNIDs | Sub-national Immunization Days |
| TAG | Technical Advisory Group |
| tOPV | Trivalent oral polio vaccine |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VAPP | Vaccine-associated paralytic polio |
| VDPV | Vaccine-derived poliovirus |
| WHA | World Health Assembly |
| WHO | World Health Organization |
| WPV | Wild poliovirus |

**www.polioeradication.org**

EVERY LAST CHILD