POLIO GLOBAL ERADICATION INITIATIVE

FINANCIAL RESOURCE REQUIREMENTS

2013–2019 (AS OF 1 APRIL 2016)

PARTNERS IN THE GLOBAL POLIO ERADICATION INITIATIVE

World Health Organization

unicef

POLIO GLOBAL ERADICATION INITIATIVE

FINANCIAL RESOURCE REQUIREMENTS

2013–2019 (AS OF 1 APRIL 2016)

PARTNERS IN THE GLOBAL POLIO ERADICATION INITIATIVE

World Health Organization

unicef

Photo front cover: © @unicefusa/Ibrahim
All polio immunization activities took place at Posyandu (integrated health post) RW 11, on Tuesday, 15 March 2016 in Cilicing, a subdistrict of North Jakarta. The neighbourhood is poor, located near Jakarta's docks and industrial areas. National Immunization Week, which took place from 8-15 March, targeted 95% of Indonesia's children aged under 5 years with more than 300 000 vaccination posts set up across 32 provinces. In all, some 23 million children were targeted.

Photo back cover: © UNICEF Afghanistan/2016/Melissa Corkum
Young child receives bivalent oral polio vaccine in Dara-I-Nur district of Nangarhar in eastern Afghanistan. Nangarhar province is one of the priority areas for polio eradication efforts in Afghanistan.

Graphic design and artwork
ACW, London, UK
www.acw.uk.com

CONTENTS

WHO/POLIO/2016.03

OVERVIEW

This Financial Resource Requirements (FRRs) report is the budget document accompanying the Polio Eradication & Endgame Strategic Plan 2013-2018 *(PEESP) of the Global Polio Eradication Initiative (GPEI). The FRRs are updated twice per year based on evolving epidemiology and available funding. The financial needs reflected in this publication represent the requirements for activities to be implemented by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and Gavi, the Vaccine Alliance (Gavi) in coordination with national governments, and include agency indirect costs where applicable. The FRRs do not include estimations of costs incurred directly by national governments.*

While the FRRs only cover the direct budget requirements for WHO, UNICEF and Gavi to implement activities as per the PEESP, the annual Non-FRR Report captures self-reported donor contributions to areas supportive of polio eradication, but that are outside of the FRRs. Non-FRR contributions are either in kind or in cash and are for activities that directly increase the likelihood of the success of the polio eradication programme, but they are not a part of eradication or other activities included in this FRR document. Non-FRR contributions do not decrease outstanding donor commitments to FRR activities.

For additional financing information, see ***http://www.polioeradication.org/Financing.aspx***

STOPPING TRANSMISSION: THE MOST CRITICAL COST DRIVER

When the PEESP was launched in 2013, it laid out four objectives, a concrete timeline and a monitoring framework. It was also agreed that the initiative would regularly assess progress. In mid-2015, the GPEI partners conducted a midterm review (MTR) to evaluate progress against the PEESP and to recommend any needed course corrections, along with any financial implications. The MTR evaluated the programme's financial situation and outlined four cost scenarios based on potential timelines for interrupting transmission. The single largest cost driver for the GPEI is the date of interruption of wild poliovirus (WPV) in the endemic countries.

At the September 2015 Polio Oversight Board (POB) meeting and in light of WHO removing Nigeria from the list of polio endemic countries, with only Afghanistan and Pakistan remaining, the four cost scenarios outlined in the MTR were deliberated.

The POB subsequently adopted "intermediate scenario A", which brings the estimated budget from US$ 5.5 billion over the 2013-2018 period to US$ 7.0 billion from 2013 to 2019 – an additional US$ 1.5 billion over the next four years.

While 2015 saw significant achievement towards the PEESP's four objectives, challenges must still be addressed in 2016 to achieve a polio-free world. Although the MTR reconfirmed that the PEESP is the right plan, it also highlighted the most significant challenges that impede the eradication goals and outlined eleven recommendations. The GPEI has developed an implementation plan to align partners and donors on a single set of programme activities over the 2016-2019 period. The costs associated with the implementation plan have been incorporated into the FRRs.

For the full Polio Eradication & Endgame Midterm Review July 2015 report, see **http://www.polioeradication.org/Portals/0/Document/Resources/StrategyWork/GPEI-MTR_July2015.pdf**

UPDATING THE GPEI BUDGET, 2013-2019

The original budget for the PEESP totalled US$ 5.5 billion and had four major cost categories (immunization activities, surveillance and response capacity, poliovirus containment and certification, and core functions and infrastructure) with global certification in 2018. However, with the September 2015 POB endorsement of an additional US$ 1.5 billion, the budget increased to US$ 7.0 billion with global certification pushed to 2019. This required the GPEI to undertake a major financial planning and budget revision process for the 2016-2019 period. The POB endorsed the revised budget in April 2016, which was reviewed by the Finance and Accountability Committee (FAC) in February 2016 **(Table 1)**. The budget details for the 2016-2019 period are presented in this document.

Part of the budget revision process included aligning the major cost categories with the four objectives of the PEESP: (1) poliovirus detection and interruption; (2) immunization systems strengthening and oral polio vaccine (OPV) withdrawal of type 2 (OPV2); (3) containment and certification; and (4) transition (formerly, legacy) planning. It also involved significant consultation with the oversight and management groups within the GPEI.

The main assumptions that underpin the cost model behind the revised budget are based on the key milestones and outcome indicators described in the PEESP and incorporate the recommendations from the MTR.

For a full version of the *Polio Eradication & Endgame Strategic Plan 2013-2018*, see **http://www.polioeradication.org/Resourcelibrary/Strategyandwork.aspx**

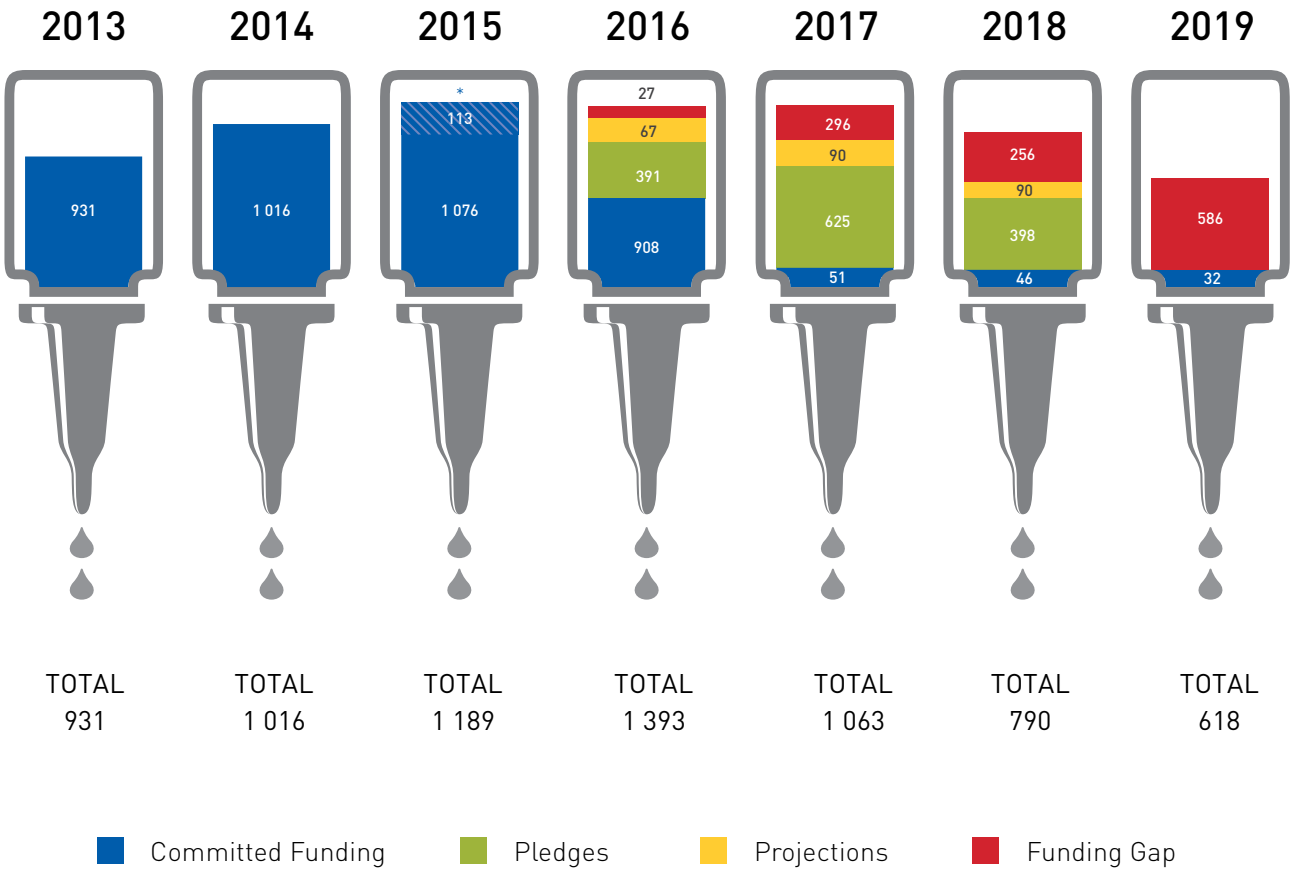
SECURING THE ADDITIONAL US$ 1.5 BILLION

On 25 April 2013, the PEESP was shared at the Global Vaccine Summit in Abu Dhabi, United Arab Emirates. Global leaders, donor nations and polio-affected countries signalled their confidence in the plan by pledging over US$ 4.0 billion towards its projected US$ 5.5 billion cost over six years. By end-March 2016, the GPEI had received US$ 4.0 billion in contributions and was tracking an additional US$ 1.7 billion in pledges and projections.

Further to the MTR and the resulting budget increase from US$ 5.5 billion to US$ 7.0 billion, additional funds will need to be secured to cover the 2016-2019 period **(Figure 1)**. The GPEI continues to work with donors to fully disburse their Vaccine Summit pledges and to provide additional funds. Donors have expressed commitment to continuing to support polio eradication until certification. For example, on 28 November 2015, leaders at the Commonwealth Heads of Government Meeting in Malta gathered during a high-level event hosted by the Prime Minister of Malta to commend the historic progress and reaffirm their commitment towards making polio eradication a global priority. In 2015, the Ministers of Health and Ministers of Foreign Affairs from the Organisation of Islamic Cooperation advocated for continued mobilization towards the eradication of polio and encouraged potential donors, including in the Organisation's member states, to contribute generously to the GPEI to support activities towards the eradication endgame.

To mobilize contributions against the additional US$ 1.5 billion, the GPEI has developed the *Investment Case*, available at **http://www.polioeradication.org/Portals/0/Document/Financing/InvestmentCase.pdf** It showcases the broader benefits and innovations of the polio programme, what is at stake if the job is not finished, and how the initiative is working to ensure success by focusing on innovation and improving quality. Fully funding the remainder of the budget is critical to ensure the programme can react to new challenges with equal speed, continue executing the long-term components of the PEESP, and make sure the polio infrastructure benefits other health programmes. The additional funding will solidify and protect the significant health gains that the polio programme has fostered.

FIGURE 1 | SUMMARY OF CONTRIBUTIONS AGAINST GPEI REQUIREMENTS, 2013–2019
(All figures in US$ millions)



* US$ 113 million budgetary adjustments to future years due to 2015 funds allocated against 2016 requirements.

IMPLEMENTING THE PEESP AND THE RECOMMENDATIONS OF THE 2015 MIDTERM REVIEW

OBJECTIVE 1: INTERRUPTING POLIOVIRUS

By the end of 2015, strong progress continued towards each of the PEESP's four objectives. From removing Nigeria from the list of polio endemic countries, to declaring wild poliovirus type 2 (WPV2) eradicated, to ending several outbreaks, progress against polio has accelerated in its remaining strongholds. WPV is more geographically constrained than it has been at any point in recorded history. Pakistan and Afghanistan, the two remaining polio endemic countries, reported 74 cases in 2015, all caused by WPV type 1.

Throughout 2015, the international spread of WPV and vaccine-derived poliovirus (VDPV) remained a "Public Health Emergency of International Concern" under the International Health Regulations (IHR, 2005). Polio was first declared a Public Health Emergency of International Concern in May 2014 by the Director-General of the WHO, who issued Temporary Recommendations and requested a reassessment of the situation by the Emergency Committee every three months. Partners continue to support countries in implementing the Recommendations. Further to the eighth meeting of the Emergency Committee in February 2016, the Temporary Recommendations under the IHR (2005) remain in effect.

OBJECTIVE 2: WITHDRAWAL OF OPV2

While WPV cases are at an all-time low, VDPVs are of increasing significance. In 2015, more countries were affected by circulating vaccine-derived polioviruses (cVDPVs) than by WPVs. With WPV2 declared eradicated, the Strategic Advisory Group of Experts on immunization gave the go-ahead for the globally synchronized trivalent to bivalent OPV switch in April 2016, removing the type 2 component contained in trivalent OPV. This withdrawal will play an important role in preventing the emergence of cVDPVs, as the type 2 component in tOPV has caused 90% of VDPVs in recent years. Ahead of the switch in April 2016, efforts are intensifying to fully stop residual circulating vaccine-derived poliovirus type 2 transmission everywhere.

OBJECTIVE 3: CONTAINMENT

A key step in global eradication is the destruction of all polioviruses or their containment at essential facilities. In December 2014, WHO published the third edition of its Global Action Plan (GAPIII) for poliovirus containment aimed at minimizing the risks associated with the likelihood of accidental or deliberate poliovirus release from facilities after the eradication of WPVs and the cessation of OPV use. GAPIII has an accelerated timeline with three implementation phases. It was endorsed by the World Health Assembly in May 2015. Throughout 2015, WHO Member States worked on Phase I containment preparation activities, with 101 countries meeting the reporting requirement by the end of the year.

OBJECTIVE 4: TRANSITION PLANNING (FORMERLY, LEGACY PLANNING)

Planning has also advanced to ensure that the polio infrastructure continues to pay dividends for other health programmes once polio has been eradicated. Discussions have been held at WHO regional committees and polio Technical Advisory Groups. Transition planning guidelines, part of the Legacy Planning Toolkit, were developed and disseminated in June 2015. The GPEI Transition Management Group was expanded in 2015 and will work with countries and their respective regions to support the process. The Independent Monitoring Board (IMB) agreed to establish an oversight group for transition planning. High priority countries and those that have not had WPV in over 12 months will be expected to complete their transition plans by the end of 2016.

IMPROVING REPORTING AND FINANCIAL MANAGEMENT

In addition to the GPEI Annual Report, the IMB report and reports to WHO governing bodies, the GPEI has developed a strengthened monitoring framework that tracks progress against the objectives of the PEESP in its six-monthly Status Report – *Progress Against the Polio Eradication & Endgame Strategic Plan 2013-2018*. These semi-annual reports are available for 2014 and 2015 at **http://www.polioeradication.org**

To complement technical reporting, the GPEI continues to improve its financial reporting as well as its financial management. The FAC sits within the POB and has direct oversight of the GPEI's financing. The FAC and the Finance Management Team work together to ensure more rapid, comprehensive and transparent financing information for all stakeholders. In addition to the detailed budget requirements outlined in this document, the GPEI has produced annual expenditure reports for 2013, 2014 and 2015. The GPEI also provides current and historical contribution information. All financial information, updated twice per year, is available under the "Financing" section at **http://www.polioeradication.org/Financing.aspx**

TABLE 1 | EXTERNAL RESOURCE REQUIREMENTS BY BUDGET CATEGORY AND OBJECTIVE, 2016-2019
(All figures in US$ millions)

Objective	Objective Area	Element	2016	2017	2018	2019	Grand Total
Objective 1: Poliovirus detection and interruption	Campaigns - Supplementary Immunization Activities	Oral polio vaccine procurement	166.29	127.78	67.07	52.48	413.62
		Campaign operational costs	397.15	273.06	140.26	113.68	924.15
		Campaign social mobilization	55.91	35.52	19.42	13.01	123.86
	Campaigns - Supplementary Immunization Activities Total		619.35	436.36	226.75	179.17	1 461.63
	Other Immunization Activities	Health camps	9.68	8.87	4.68	3.65	26.87
		Other	26.16	0	0	0	26.16
	Other Immunization Activities Total		35.84	8.87	4.68	3.65	53.03
	Surveillance	Laboratory	13.19	13.30	13.91	14.32	54.72
		Surveillance and running costs	90.59	89.88	91.10	93.77	365.34
	Surveillance Total		103.78	103.18	105.01	108.09	420.06
	Core Functions and Infrastructure	Communications, engagement, social mobilization	88.93	60.88	53.02	32.96	235.80
		Ongoing quality improvements	0	0	0	0	0
		Technical assistance	273.47	234.65	206.06	177.74	891.92
	Core Functions and Infrastructure Total		362.40	295.53	259.08	210.70	1 127.72
Objective 1 Total			**1 121.37**	**843.94**	**595.52**	**501.61**	**3 062.44**
Objective 2: Immunization systems strengthening and oral polio vaccine withdrawal	Inactivated Polio Vaccine Introduction	Inactivated polio vaccine in routine immunization (vaccine procurement)	66.64	80.10	63.10	23.20	233.04
		Inactivated polio vaccine intro grants	4.39	0	0	0	4.39
	Inactivated Polio Vaccine Introduction Total		71.03	80.10	63.10	23.20	237.43
	Oral Polio Vaccine Withdrawal - Switch	Oral polio vaccine withdrawal and switch activities	29.74	1.00	22.79	5.33	58.86
		Research and product development	10.00	10.00	10.00	10.00	40.00
		Stockpiles for emergency response (OPV2)	6.00	0	0	0	6.00
	Oral Polio Vaccine Withdrawal - Switch Total		45.74	11.00	32.79	15.33	104.86
	Technical Assistance	Inactivated polio vaccine introduction	7.20	5.30	5.10	0	17.60
		Oral polio vaccine withdrawal - Switch	19.38	18.25	17.43	16.02	71.08
	Technical Assistance Total		26.58	23.55	22.53	16.02	88.68
Objective 2 Total			**143.35**	**114.65**	**118.42**	**54.55**	**430.97**

CONTINUED →

Objective	Objective Area	Element	2016	2017	2018	2019	Grand Total
Objective 3: Containment and certification	Polio Virus Containment and Certification	Certification	4.00	4.00	4.50	4.50	17.00
		Containment	5.00	5.00	4.50	4.50	19.00
		Technical assistance	6.75	6.72	5.71	4.86	24.05
	Polio Virus Containment and Certification Total		15.75	15.72	14.71	13.86	60.05
Objective 3 Total			**15.75**	**15.72**	**14.71**	**13.86**	**60.05**
Objective 4: Transition planning	Transition Planning	Advocacy, coordination	2.01	0.27	0.05	0.05	2.38
		Guidelines, tools	1.51	0.12	0.05	0.05	1.73
		Oversight	0.97	0.97	0.92	0.92	3.80
		Technical assistance	7.08	5.34	2.85	2.42	17.69
	Transition Planning Total		11.57	6.70	3.87	3.45	25.60
Objective 4 Total			**11.58**	**6.70**	**3.87**	**3.45**	**25.60**
Other	Contingency	Contingency	5.06	8.55	3.03	2.05	18.69
	Contingency Total		5.06	8.55	3.03	2.05	18.69
	Indirect Costs	Indirect costs	95.99	73.23	54.43	42.59	266.23
	Indirect Costs Total		95.99	73.23	54.43	42 .59	266.23
Other Total			**101.04**	**81.78**	**57 .46**	**44.64**	**284.92**
Grand Total			**1 393.10**	**1 062 .80**	**790.00**	**618.10**	**3 864.00**

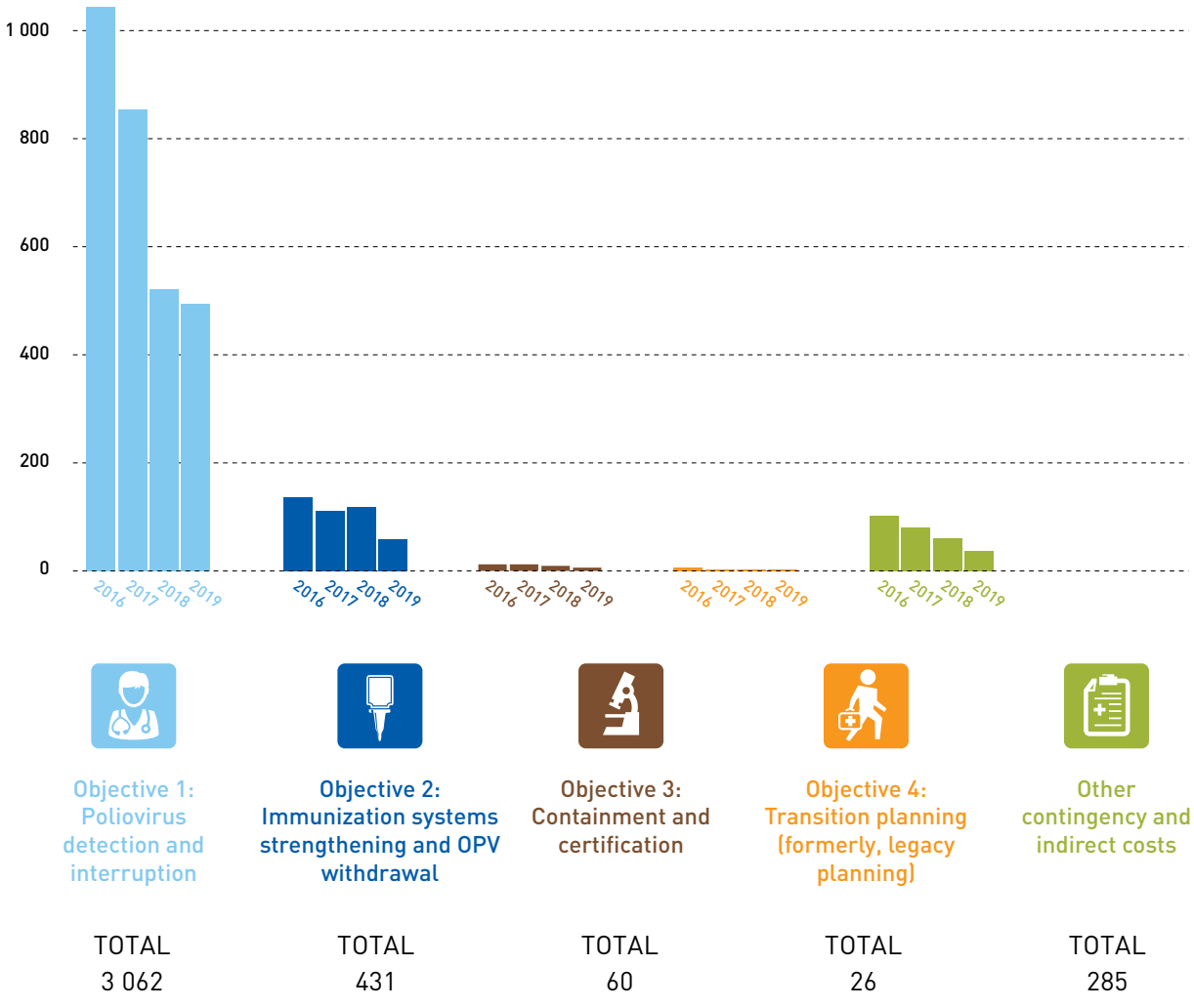
1. BUDGET CATEGORIES BY OBJECTIVE

The GPEI conducted a thorough cost analysis during the second half of 2012, resulting in the establishment of the original US$ 5.5 billion budget to achieve the PEESP's objectives from 2013 through 2018. Based on evolving epidemiology and risk within the context of the overall objectives, four budget scenarios were outlined in the July 2015 MTR. These scenarios, based on stopping transmission in Pakistan and Afghanistan, were reviewed and one endorsed by the POB during its September 2015 meeting. The resulting additional US$ 1.5 billion required the GPEI to undertake an extensive re-budgeting exercise for the 2016-2019 period.

The revised budget was approved by the POB during its April 2016 meeting and reviewed by the FAC in February. The overall budget for the 2013-2019 period now stands at US$ 7.0 billion.

The revised budget has 13 major cost categories grouped under the four PEESP objectives **(Figure 2)**. While the interruption of WPV 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 2019.

FIGURE 2 | POLIO ERADICATION & ENDGAME STRATEGIC PLAN BUDGET BY OBJECTIVE, 2016-2019
(All figures in US$ millions)



DEFINITION OF BUDGET CATEGORIES AND KEY COST DRIVERS

The major budget categories under each of the PEESP's objectives include the cost of reaching and vaccinating more than 450 million children multiple times every year; implementing monitoring and surveillance activities in more than 70 countries; ensuring the full application of relevant poliovirus containment requirements globally; fulfilling national, regional and global certification requirements; and supporting core functions, including securing the infrastructure required for polio eradication, which could potentially benefit other health and development programmes.

OBJECTIVE 1: POLIOVIRUS DETECTION AND INTERRUPTION

The PEESP proposed five major activities under Objective 1 to detect and interrupt transmission of all polioviruses. The costs for Objective 1 represent 80% of the 2016-2019 budget. The budget categories linked to those activities are supplementary immunization activities/campaigns (planned and emergency response), core functions and infrastructure, other immunization activities, and surveillance.

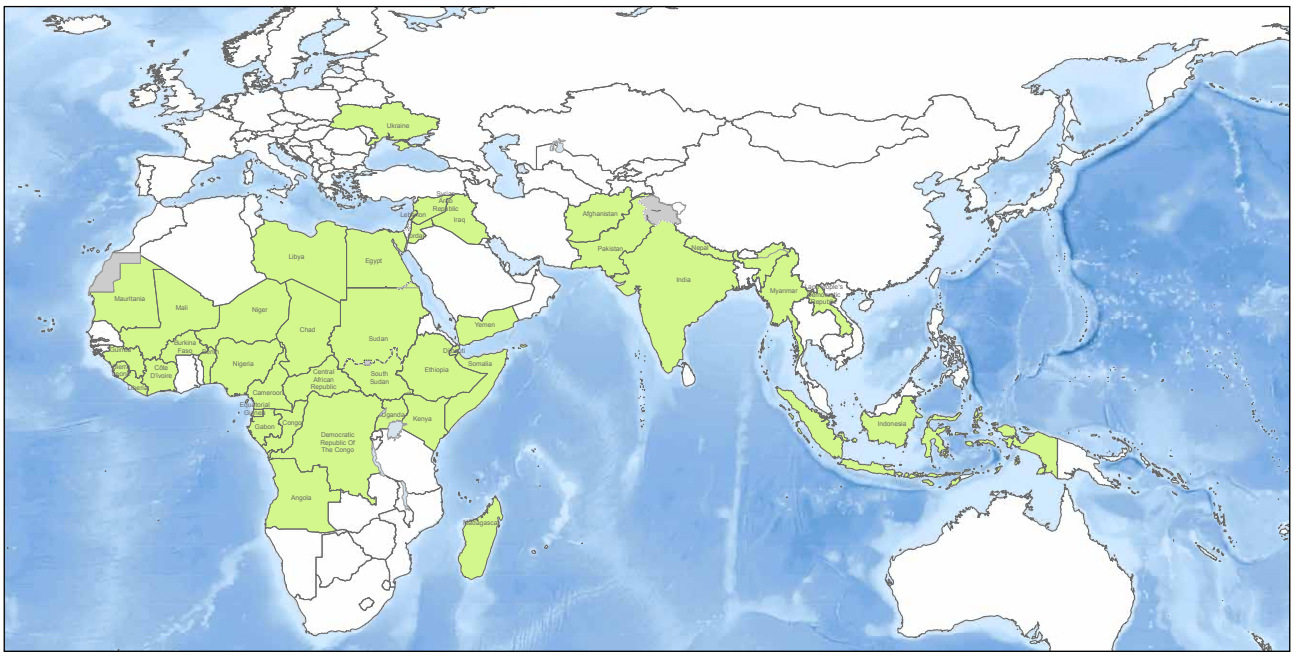
Annex A provides the cost details for endemic, recently-endemic and highest-risk countries.

SUPPLEMENTARY IMMUNIZATION ACTIVITIES/ CAMPAIGNS

The interruption of transmission of both WPV and VDPVs requires raising the population's immunity in the two remaining endemic countries, Nigeria and high-risk areas prone to outbreaks and importations, to levels sufficient to stop transmission. This is achieved by vaccinating children with polio vaccines, through routine immunization (RI) and supplementary immunization activities (SIAs) or campaigns, both planned and emergency. **Figure 3** and **Annex B** provide an overview of the countries where SIAs are planned in 2016.

This major budget category represents nearly 51% of the total requirements for the 2016-2019 period under Objective 1. The key cost drivers in this area are the date of interruption of transmission, and the number and quality of vaccination campaigns. The sub-budget categories for SIAs (both planned and emergency) are OPV costs, operational costs and campaign-related social mobilization costs. (See the text box on page 15 for additional information on outbreak response and emergencies.)

FIGURE 3 | COUNTRIES WHERE SIA ACTIVITIES WILL BE CONDUCTED, 2016



POLIO VACCINE COSTS

This sub-budget category represents the cost of procuring OPV for use in both planned and emergency SIAs, including the vaccine itself plus shipping and freight. UNICEF is the agency that procures vaccines 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 2015, more than 1.3 billion doses of OPV were procured by the UNICEF Supply Division for use in 75 countries. The weighted average price of each OPV dose in 2015 was US$ 0.13. For the 2013-2019 period, the assumed average cost is US$ 0.15. After the switch to bivalent oral polio vaccine (bOPV) in April 2016, the GPEI will only procure bOPV and inactivated polio vaccine (IPV) for campaigns and for use in routine immunization. A global stockpile of monovalent oral polio vaccine type 2 (mOPV2) will be maintained to appropriately respond to VDPV type 2 outbreaks. WHO has developed a protocol for the use and distribution of mOPV2 post-switch (see also Objective 2).

OPERATIONAL COSTS

This sub-budget category represents the cost of delivering vaccines during planned and emergency SIAs, including microplanning, 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 cost for social mobilization and communication activities during campaigns. These activities ensure high levels of community demand and acceptance for the vaccine. They include the production and dissemination of communication and educational materials, the production of mass media campaigns aired on television and radio, the engagement of local leaders and influencers, the training of health workers and social mobilizers, and the mobilization of civil society. See **Annex C** for additional details.

CORE FUNCTIONS AND INFRASTRUCTURE

National authorities are ultimately responsible for developing immunization plans and budgets and for implementing activities. WHO and UNICEF play an important supplementary and catalytic role in supporting countries by providing core functions and infrastructure, including technical assistance planned and surge support and community engagement.

ONGOING SOCIAL MOBILIZATION

Data show that in communities where full-time social mobilization networks are deployed, there is greater social commitment to polio eradication, higher demand for vaccines and fewer children missed during campaigns. Demand and trust are strengthened when communities are engaged with tailored, culturally appropriate communication approaches. It is critical to ensure all vaccination campaigns incorporate supply- and demand-based tactics to ensure every parent accepts OPV for their children once vaccination teams reach them. **Annex C** details both ongoing and campaign-related social mobilization costs.

TECHNICAL ASSISTANCE

GPEI funded technical assistance (staff and consultants) is deployed to fill capacity gaps when relevant skills are not available within the national health system, to build capacity and to facilitate international information exchange. The priorities for technical assistance are driven by the relative strength of the health systems in countries as well as how critical the country is to global polio eradication. During the last couple of years, WHO and UNICEF have deployed significant new technical assistance, "surge", to boost capacity in the highest-risk areas to more effectively support endemic, recently endemic and highest-risk countries. The scale-up of technical capacity is to ensure the highest quality of activities to have an impact on epidemiology as quickly as possible. **Annex E** details both surge support and planned technical assistance costs.

OTHER IMMUNIZATION ACTIVITIES

Limited accessibility to children in conflict-affected areas has increasingly presented an intermittent but major barrier to conducting SIAs. Special approaches have been developed in Nigeria and Pakistan to reach children in these areas and simultaneously minimize the risk to vaccinators. Additionally, PolioPlus activities may be conducted to ensure all children are reached with the polio vaccine, e.g. conducting health camps, integrating polio vaccine into other vaccination campaigns and providing other services during polio vaccination campaigns.

SURVEILLANCE

The detection and investigation of acute flaccid paralysis (AFP) remains the core strategy for detecting all polioviruses. As the number of WPV cases declines, greater attention will need to be placed on closing subnational surveillance gaps, especially in endemic, recently endemic and highest-risk countries. Environmental surveillance will continue to be scaled up as a critical complement to AFP surveillance activities. Efforts are under way to increase the number of countries with environmental sites to include at least 11 more countries at high risk of WPV importation or VDPV emergence.

A major focus of increasing surveillance capacity and quality over the next few years will be on training national staff and expanding management capacity to increase performance and accountability.

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 around 200 000 stool specimens and over 7 000 sewage specimens as well as sustaining the Global Polio Laboratory Network of 146 laboratories in 92 countries.

EMERGENCY RESPONSE TO OUTBREAKS

New guidelines for the management of polio outbreaks and type 2 transmission, and standards on the reporting and classification of VDPVs, were introduced in 2015 and 2016. They propose a more proactive and robust approach to manage both WPV and VDPV outbreaks and events, which was necessary to fulfil the PEESP objective of stopping polio outbreaks within 120 days of the first case and reducing risks associated with transmission of VDPV type 2. Based on modelling data, the Eradication and Outbreak Management Group estimates that up to 15 polio outbreaks and 17 VDPV type 2 events may occur within the four years following the switch. These estimates, along with the parameters articulated in the new guidelines, informed the development of the budget for emergency response to outbreaks.

The GPEI FRRs include budget lines for emergency response under Objective 1 within campaigns/SIAs, surveillance and technical assistance budget categories. These budget lines are implemented by WHO and UNICEF. For 2016, the annual combined budget is US$ 115.0 million. WHO and UNICEF maintain funding against these budget lines 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 time.

To ensure a 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 headquarter offices review the availability of funding and vaccine based on estimated requirements to quickly confirm support. The GPEI management groups responsible for outbreak management and resource mobilization are currently working to establish an updated resource mobilization strategy to ensure rapid and adequate resources for outbreak response.

In addition, WHO and UNICEF country offices are encouraged to apply to in-country humanitarian financing mechanisms for outbreak response. Mobilizing funds from humanitarian mechanisms enables the rapid release of funding and complements global resources, which ensures that the limited funding available at the global level for outbreak response is not completely depleted.

OBJECTIVE 2: IMMUNIZATION SYSTEMS STRENGTHENING AND OPV WITHDRAWAL

Objective 2 calls on countries to introduce at least one dose of IPV in routine immunization and to withdraw OPV in a phased manner, starting with type 2 in April 2016. Objective 2 also includes efforts to strengthen routine immunization in 10 focus countries with significant polio assets. Finally, the establishment of a mOPV2 stockpile to respond to any VDPV type 2 outbreaks after the switch, as well as research on new tools and approaches to maximize the impact of eradication efforts and to inform long-term policy for the post-eradication phase are also included within this objective.

IPV INTRODUCTION IN ROUTINE IMMUNIZATION[1]

Starting in 2014, the GPEI budget included support for the introduction of IPV into routine immunization programmes in 126 OPV-only using countries.

In addition to funding technical assistance to countries, the GPEI provided direct funding to countries:

1. **Low-income countries** received GPEI funds channelled through Gavi, the Vaccine Alliance [GPEI donors provided the necessary funding to Gavi, which in turn managed the process of dispersing the support to countries. Gavi's own funds were not used to support Objective 2 activities – see **Annex F** for additional details]. Support included a vaccine introduction grant to offset the operational costs of IPV introduction, as well as 100% funding for IPV procurement for at least the 2014-2018 period.

2. **Twenty-five middle-income countries** received financial support directly through WHO and UNICEF, using GPEI funds. Support included a vaccine introduction grant to contribute towards the operational costs of IPV introduction, as well as one year of catalytic funding for IPV procurement.

Significant progress has been made towards the introduction of IPV in the 126 OPV-only using countries since 2013. As of April 2016, 165 of 194 Member States and territories globally have introduced at least one dose of IPV in their routine immunization programmes. Unfortunately, the IPV supply situation is constrained and thus there is insufficient IPV available globally to support further introductions at this point. As a consequence, approximately 20 low-risk countries have to delay their planned IPV introductions until 2017 when additional supply is expected to become available.

The total budget for the IPV introduction component of the FRRs is approximately US$ 255.0 million for vaccine procurement, introduction grants and technical assistance.

WITHDRAWAL OF OPV2: THE TRIVALENT OPV TO BIVALENT OPV SWITCH

In 2015, through the World Health Assembly, Member States and the WHO Strategic Advisory Group of Experts on immunization reviewed global readiness for proceeding with the withdrawal of OPV2 through a globally synchronized switch from trivalent OPV (tOPV) to bivalent OPV (bOPV).

Following the Global Certification Commission's confirmation of eradication of WPV2 in September 2015, and based on its assessment of global readiness, OPV2 will be withdrawn in 2016. This historic achievement sets the GPEI on the path to full OPV withdrawal.

In preparation for the switch, GPEI partners worked to ensure that bOPV is available and registered in all countries currently using tOPV, that guidance on the disposal of tOPV has been developed and that technical assistance is available to support countries in implementing the switch – from training materials to the deployment of experts, as appropriate to the needs of each country. Additionally, select countries that were unable to fund the switch activities from their national budgets benefited from direct financial support for switch implementation – logistics, transport, training, waste disposal, etc. The GPEI requirements for switch support is approximately US$ 129.0 million.

Between 17 April and 1 May 2016, 155 countries and territories will withdraw tOPV and introduce bOPV into their routine immunization programmes in the largest coordinated vaccine introduction scheme ever seen. Documenting lessons learned from the switch is a priority in 2016 to ensure they can be applied to full OPV withdrawal.

As part of the preparation for OPV2 withdrawal, a globally managed stockpile of mOPV2 has been created to allow rapid response to any VDPV type

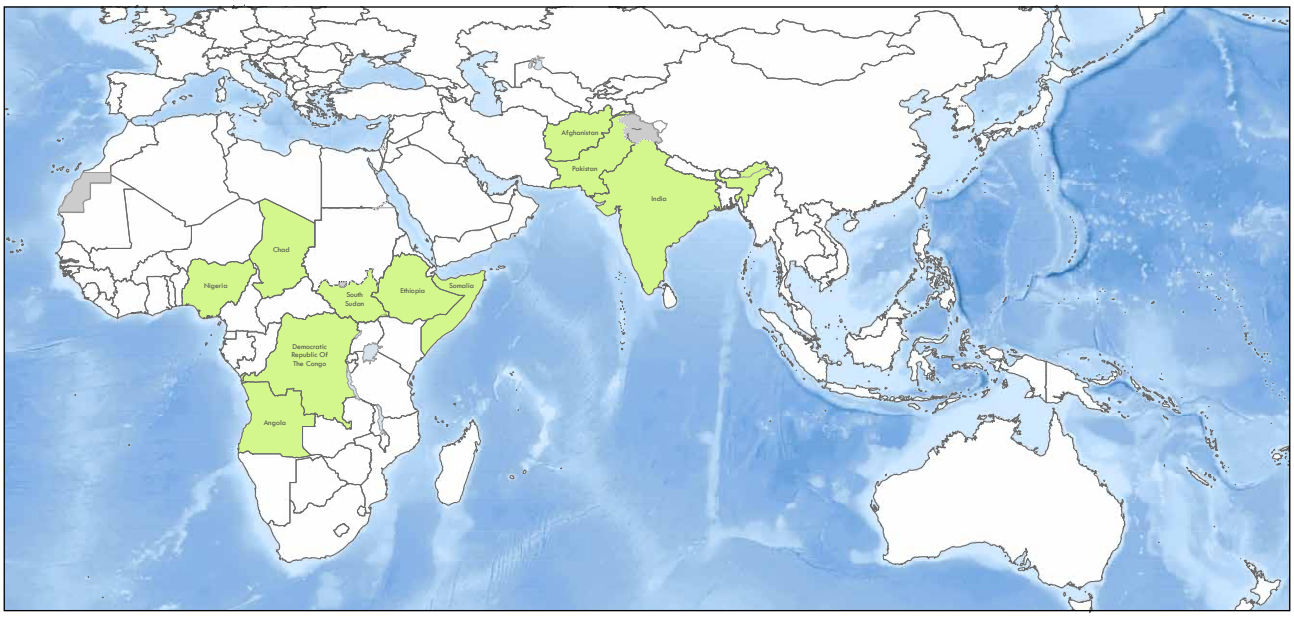
[1] This budget category does not include direct costs associated with routine immunization strengthening.

2 outbreaks that may occur. This global stockpile has adequate vaccine supply to respond to potential outbreaks. As is the case for other eradicated diseases whose vaccines contain live virus, such as smallpox, the mOPV2 stockpile can only be released with the approval of the WHO Director-General. An advisory group has been established to oversee and manage this stockpile, contracts have been negotiated with manufacturers, and regulatory pathways are being clarified with all Member States to ensure the rapid deployment of mOPV2 is possible in case of an outbreak. In addition, a reserve stock of IPV has been put aside for use as a complementary measure when responding to VDPV type 2 outbreaks as needed. The budget for the stockpile in 2016 is US$ 6.0 million.

ROUTINE IMMUNIZATION STRENGTHENING

Since 2013, the GPEI, through Objective 2, has worked on strengthening routine immunization in 10 priority countries that have significant polio-funded personnel and assets **(Figure 4)**.

FIGURE 4 | PRIORITY COUNTRIES FOR IMMUNIZATION STRENGTHENING



In these countries, the GPEI provided catalytic support to critical activities, such as the development of annual Expanded Programme on Immunization plans and the implementation of comprehensive strategies that would enable an annual reduction in unimmunized children. WHO and UNICEF, along with GPEI partners and Gavi, the vaccine alliance, initiated a joint programme of work in the priority countries. The joint approach seeks to capitalize on Gavi's investments in health systems strengthening while also fully exploiting the substantial polio-funded technical assistance deployed through the GPEI.

Through these efforts, the focus countries have begun to regularly develop comprehensive Expanded Programme on Immunization plans. In addition, polio-funded staff have been asked to dedicate at least 50% of their time to non-polio activities, such as support to routine immunization, measles campaigns, etc.

A survey conducted by the GPEI shows that this target has been met with polio staff spending 46% of their time on routine immunization activities and 7% on other activities. In 2016, the GPEI will continue to work with the priority countries to increase immunization coverage as well as to look at ways to support other countries with weak routine immunization systems that may be at risk for VDPVs and WPVs.

The GPEI's catalytic support to this area of work will end in 2016, although efforts to ensure polio assets transition to support routine immunization as appropriate will continue as part of the Objective 4 workplan for these priority countries.

For the latest updates on Objective 2, see **www.who.int/immunization/diseases/poliomyelitis/endgame_objective2/en/**

RESEARCH AND DEVELOPMENT

Research is a vital component of the GPEI's work, providing the necessary evidence to guide the final steps to a lasting polio-free world and beyond. The GPEI coordinates and supports an extensive programme of research from a wide range of core scientific disciplines. The research programme has two broad objectives: to identify, develop and evaluate new tools and tailored approaches to maximize the impact of eradication efforts, and to inform long-term policy for the post-eradication era. Current research areas include optimizing OPV efficacy; optimizing OPV delivery; developing affordable IPV; managing risks associated with VDPV and vaccine-associated paralytic polio (including OPV cessation); antivirals; polio diagnostics.

For further information, see
http://www.polioeradication.org/Research.aspx

OBJECTIVE 3: CONTAINMENT AND CERTIFICATION

The global certification of WPV eradication necessitates fully applying relevant poliovirus containment requirements throughout the world and ensuring highly sensitive poliovirus surveillance.

CONTAINMENT

The *Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use* (GAPIII) was endorsed by the World Health Assembly in May 2015. It describes the global activities and timeline required to achieve appropriate containment of all polioviruses, beginning with a focus on any type 2 poliovirus in any product (vaccine, stool samples, etc.). The plan has three phases. As part of Phase I, all WHO Member States are requested to destroy or safely contain all OPV2 and Sabin2 materials by the end of July 2016. This deadline is set three months after the switch in April 2016, assuming that by then shedding will have stopped. In Phase II, the national authorities for containment of the countries hosting facilities planning to retain type 2 polioviruses will have to certify them against the implementation of containment requirements described in GAPIII.

To ensure the appropriate containment of any type 2 poliovirus, WHO is organizing training sessions on GAPIII implementation and certification for stakeholders, including national authorities for containment, poliovirus-essential facilities, and the Global Commission for the Certification of the Eradication of Poliomyelitis, the global oversight body for poliovirus containment.

WHO has developed a GAPIII containment certification scheme to allow countries to implement a robust, transparent and equitable mechanism for facility certification. WHO will start containment certification training workshops to qualify a pool of auditors in support of countries' containment certification efforts.

The core partners are implementing a new communications and advocacy strategy to raise awareness of the importance of poliovirus containment to the global community.

WHO is also convening a formal Containment Advisory Group to advise on policy, programme and technical issues related to the implementation of GAPIII.

The GPEI has formed a Containment Management Group, made up of staff from the core GPEI partners, to report to the GPEI Strategic Committee on gaps, needs and progress with poliovirus containment activities.

The associated cost of boosting capacity, training, technical guidance for facilities and countries, and coordination are included in the FRRs.

CERTIFICATION

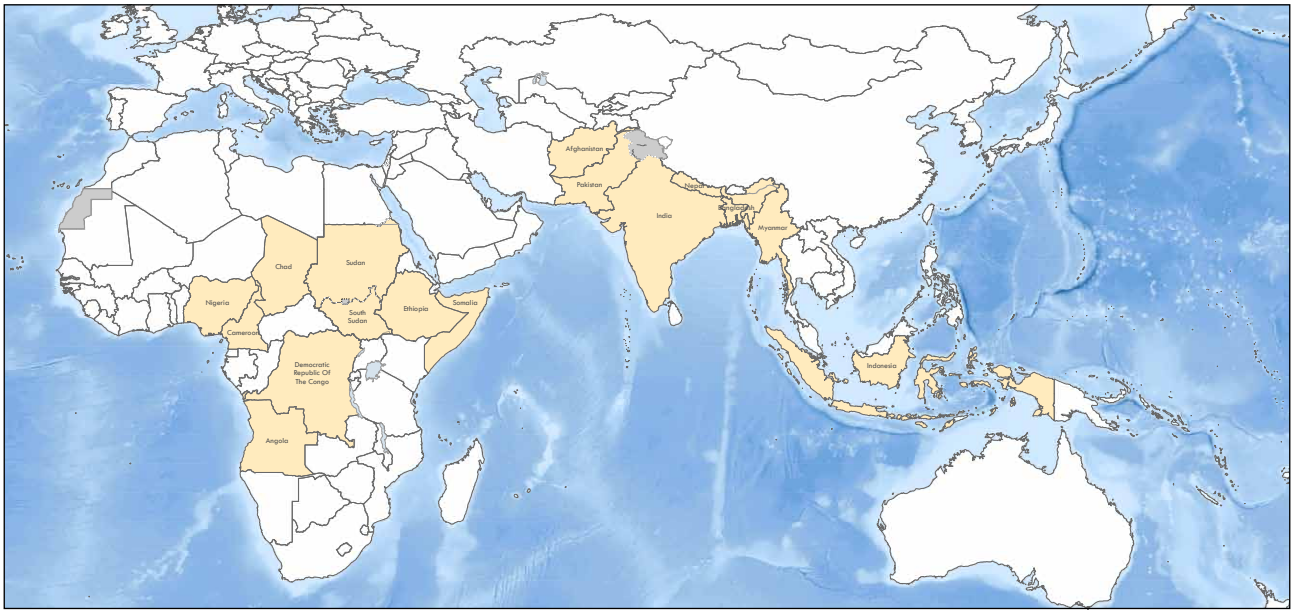
The certification of polio eradication, that is the certification of the interruption of transmission of WPV, is conducted by WHO regions. Each region can consider certification only when all countries in the area demonstrate the absence of WPV transmission for at least three consecutive years in the presence of certification standard surveillance. For the two regions not yet certified as polio-free – the African and Eastern Mediterranean Regions – the priority will be to close the remaining gaps in the quality and sensitivity of AFP surveillance *(budgeted under the surveillance category)* and then to sustain certification-standard surveillance performance at the national and subnational levels through regional and global certification. The priority for the four regions already certified polio-free – the Region of the Americas and the European, South-East Asia and Western Pacific Regions – will be to achieve or maintain surveillance at certification-standard levels. The certification costs represent an annual provision for regional- and country-level activities in preparation for certification, such as the large annual

multi-country meetings of the Regional Certification Commissions, activities of the National Certification Committees, or visits of Regional Certification Commission members and WHO technical staff to countries in need of support for preparing their national documentation on certification.

OBJECTIVE 4: TRANSITION PLANNING (FORMERLY, LEGACY PLANNING)

After polio eradication is certified, the GPEI will cease to exist. The aim of the transition planning process is for the GPEI to advocate for and support stakeholders such as ministries of health, GPEI and non-GPEI partners and recipients of polio services and other programmes to plan for the transition of polio assets. By the end of 2016, 14 of the 16 priority countries and their respective regions are expected to have completed their transition plans. The implementation of these plans should take place between 2017 and 2019 as GPEI funding begins to ramp down. Afghanistan and Pakistan will begin transition planning within 12 months after interruption of WPV.

FIGURE 5 | PRIORITY COUNTRIES FOR TRANSITION PLANNING



While the country governments in the 16 priority countries **(Figure 5)** are expected to drive the process, the GPEI will support the development of transition plans. The GPEI Transition Management Group is developing a workplan, complemented by an advocacy and communications plan. Ensuring that all stakeholders have a common vision of the transition planning process is critical. The cost of US$ 26 million covers the activities required to support the 16 priority countries in undertaking their transition planning processes. This support includes in-country technical assistance, advocacy and communication with governments and other stakeholders, facilitation of critical meetings, and expertise commissioned at the headquarters/regional office level to optimize this complex process.

BUDGETING FOR THE POST-2019 PERIOD

As part of the polio legacy transition process, the GPEI will work with partners to develop policy and plans for the continuation and funding of critical polio functions (such as containment, surveillance and outbreak response capacity) after 2019. Much of this will occur at the country level, but some global and regional capacity will need to continue. The US$ 26 million budgeted for transition planning will cover policy development and planning activities, but not the costs of transition or post-2019 activity.

2. BUDGET PROCESS

BUDGETING PROCESS, FUNDS ALLOCATION AND PRIORITY SETTING

For the 2016-2019 budgeting process, the GPEI developed a cost model that looked at different epidemiological scenarios, driven by dates of ending transmission in Afghanistan and Pakistan. Based on the model and the recommendations of the MTR, the GPEI conducted a top-down/bottom-up approach to finalize global budget figures for the period. (See the text box on page 21 on the budget process.) The budgets for each objective are overseen by the GPEI's various oversight and management groups.

The budgets that underpin the FRR are prepared by WHO, UNICEF and the national governments that undertake polio eradication activities. The funds to finance the activities flow from multiple channels, primarily through these stakeholders. Both United Nations agencies support the governments in the preparation and implementation of activities.

For immunization activities under Objective 1, in particular, the schedule is developed based on the guidance of national and regional Technical Advisory Groups, the ministries of health and the WHO and UNICEF country offices. 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 that take into consideration local costs for all elements of the activities, as described in the "Budget Categories by Objective" section above.

Developing the GPEI country budgets is paired with a regular, interactive process of reviewing and reprioritizing activities in light of evolving epidemiology and available resources by the Eradication and Outbreak Management Group. The in-depth weekly epidemiological and SIA review is complemented by weekly and biweekly 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 operational funds for SIAs include the submission of the final activity budget, which is reviewed and validated at the regional office and headquarter 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 the full budget review is pending. For staff and surveillance, funds are disbursed on a quarterly or semi-annual basis, depending on the GPEI cash flow, against long-term human resource 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.

In the event that sufficient funds are not available to fully support the GPEI budget in a given year, available resources are 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 the global level) and Community engagement activities (quarterly)
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 accordingly to reflect the new priority activities of the PEESP's four objectives, and global progress towards those objectives.[2]

[2] This prioritization does not include funding from the GPEI to Gavi for IPV. All funding required for IPV introduction through Gavi was fully financed in advance to ensure stable vaccine supply.

THE 2016-2019 BUDGET PROCESS: THREE PHASES

The GPEI undertook a revamped budget process to develop the 2016-2019 requirements. It included intensified consultations with the countries through the various GPEI management groups, which has facilitated the introduction of risk identification/management approaches as well as iterative quality checks.

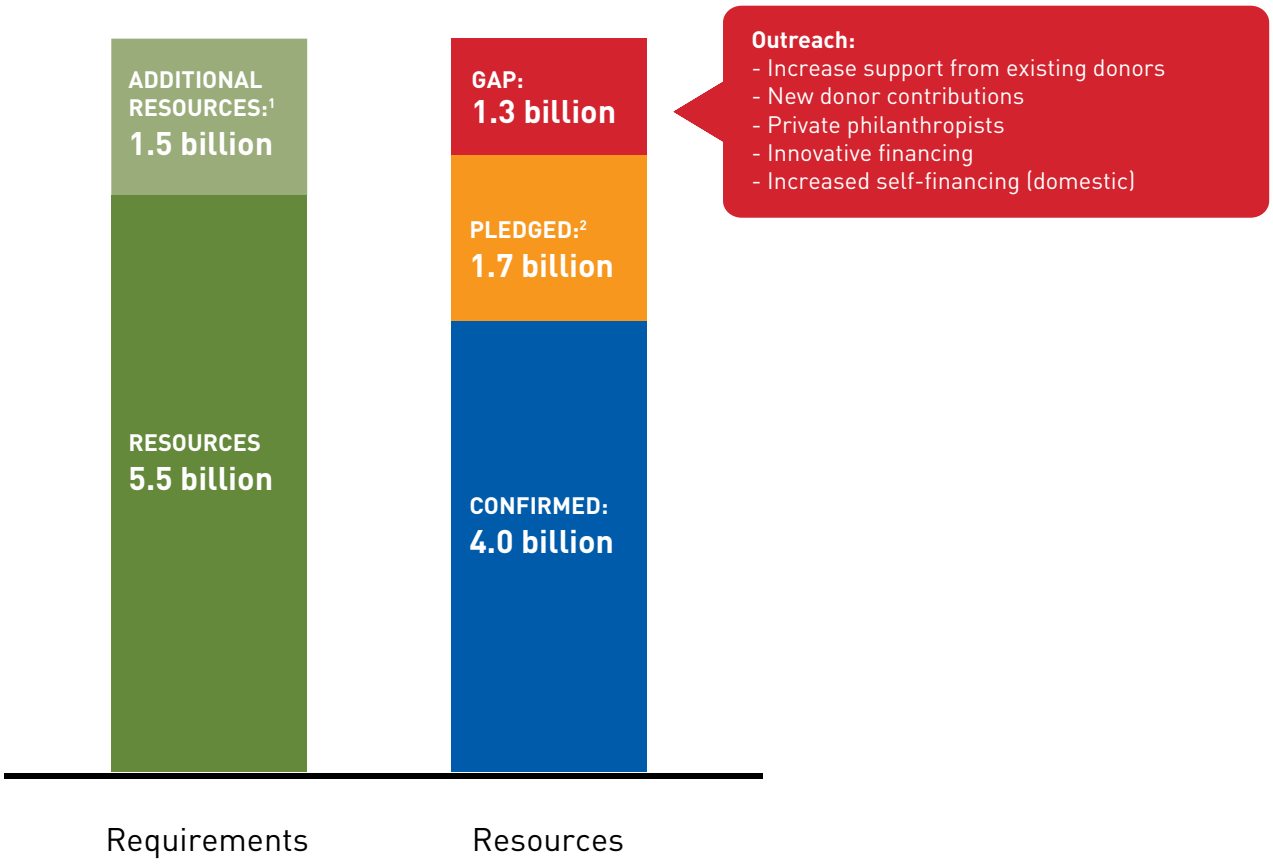
- **Phase I:** The top-down process started from the MTR recommendations, the associated financial model and the 2015 historical budget to provide details on the budget envelopes available for the strategic and risk-based adjustments. This allowed alignment of the budget categories of the FRR within the PEESP's four objectives.
- **Phase II:** The bottom-up process involved partners and regional and country offices to build up a budget estimate based on national contexts and requirements. For example, security and access constraints were discussed in detail and the necessary updates in operational costs included. This phase represents an innovation in the budget process and has helped generate greater input from the countries through the GPEI management groups.
- **Phase III:** The budget consolidation and review process of the top-down and bottom-up estimates was conducted. This phase required (1) developing the outbreak response budget in light of the inclusion of vaccine-derived outbreaks in the revised definition of outbreaks ahead of the OPV switch to mitigate the risks of vaccine-derived outbreaks; and (2) finalizing the SIA calendar with a more standardized quantitative model for endemic and non-endemic countries, in addition to intensified consultations with the country and the Technical Advisory Groups in endemic countries.

3. MOBILIZING THE FUNDING: CURRENT STATUS

At the April 2013 Global Vaccine Summit in Abu Dhabi, global leaders, donor nations and polio-affected countries signalled their confidence in the PEESP by pledging over US$ 4.0 billion towards its projected US$ 5.5 billion cost. Since then, the GPEI has continued to work to convert pledges into signed agreements and to secure the required funding needed to implement PEESP. **Table 3** provides an update on the status of the funds pledged at the Global Vaccine Summit, as well as additional contributions received.

As of 1 April 2016, with the inclusion of all confirmed and pledged funding, the overall best-case funding gap for the 2013-2019 period is US$ 1.3 billion **(Figure 6)** against the US$ 7.0 billion budget. The pledged funding represents donor commitments for which no signed agreement or cash payments have been received. The confirmed funding constitutes funds that have been received and are available for programme use.

FIGURE 6 | MEETING THE POLIO ERADICATION & ENDGAME STRATEGIC PLAN FUNDING REQUIREMENTS, 2013-2019 (All figures in US$)



[1] Based on the 2015 MTR and the 2015/2016 GPEI budget review process.
[2] Based on the breakdown of pledges made to the GPEI at the April 2013 Vaccine Summit as well as additional pledges made since the Vaccine Summit; includes carry-forward.

TABLE 3 | SUMMARY OF CONFIRMED FUNDING AGAINST GLOBAL VACCINE SUMMIT COMMITMENTS
(All figures in US$ millions)

	Committed funding at the April 2013 Vaccine Summit*	Confirmed funding against the GPEI FRRs, as of 1 April 2016
G7 & European Commission		
Canada[1]	243.53	216.77
European Commission	6.50	27.06
Germany[2]	151.70	111.67
Japan[3]	9.70	43.50
United Kingdom[4]	457.00	480.67
USA[5]	90.60	401.84
Non-G7 OECD Countries		
Australia[6]	34.55	55.24
Finland	0.53	0.53
Ireland	6.50	6.36
Luxembourg	0.70	3.21
Norway[7]	252.45	211.93
Other Donor Countries		
Brunei Darussalam	0.05	0.05
Isle of Man	0.14	0.05
Liechtenstein	0.02	0.08
Monaco	0.35	0.95
Saudi Arabia	15.00	12.35
Private Sector/Non-Governmental Donors		
Al Ansari Exchange	1.00	1.00
Abu Dhabi-Crown Prince[8]	120.00	53.49
Bill & Melinda Gates Foundation[9]	1 800.00	1 108.39
Korean Foundation for International Healthcare/Community Chest of Korea	1.00	3.00
Private Philanthropists/High Net Worth Individuals	335.00	89.68
Rotary International[9]	76.81	344.53
UN Foundation	0.75	0.80
Multilateral Sector		
Gavi/IFFIm	24.00	25.21
Islamic Development Bank/Government of Pakistan	227.00	225.46
UNICEF	64.50	56.08
World Bank (Grant to Afghanistan)	10.00	11.00
World Bank Investment Partnership, Bank Portion	50.00	50.00
World Health Organization	4.27	12.77
Domestic Resources		
Angola	7.30	6.54
Bangladesh	10.00	10.00
Nepal	0.90	0.67
Nigeria[10]	40.00	239.37
TOTAL	4 041.85	3 810.25

* Only includes donors who pledged funds at the Vaccine Summit. See www.polioeradication.org/financing.aspx for additional information on contributions, including those that are not against the GPEI budget (non-FRR report).

[1] Canada pledged Can$ 250 million for the 2013-2018 period. Canada also provided an additional Can$ 3 million for the 2013-2014 Horn of Africa outbreak. Contributions include approximately US$ 8.15 million for activities in Pakistan during 2013-2015 that were outside of the GPEI budget, but supported the overall goal of polio eradication. Additionally, Canada provided US$ 9.8 million for activities in Nigeria and Ukraine for routine immunization activities outside of the GPEI budget.

[2] Germany also provided over €13 million in 2013-2014 for the Middle East outbreak in addition to current disbursements under its €105 million 2013-2017 pledge.

[3] Since 2011, Japan has supplemented its traditional grant financing with innovative financing in partnership with the Bill & Melinda Gates Foundation. Under this loan conversion model, Japan has provided development assistance loans to Nigeria (approximately US$ 70 million, 2015-2016) for vaccine and operational costs. If performance criteria are met, the BMGF will repay the loan credit to the Japan International Cooperation Agency on behalf of the Nigerian government, in effect converting the loan to a grant.

[4] The UK committed £300 million to polio eradication for the 2013-2018 period, comprised of "core" and "match" funds. The figures for 2016-2018 include £28 million in "match" funds as well as £27 million to Gavi for IPV procurement. The UK also provided an additional £13.8 million for the 2013-2014 Horn of Africa and Middle East outbreaks.

[5] US figures reflect the actual amount received directly by the two implementing agencies, consistent with the UN revenue recognition policy. The fiscal year 2016 Congressional allocation is US$ 228 million. The 2016 figure represents disbursements to WHO and UNICEF from the US Centers for Disease Control and Prevention and USAID against the GPEI's 2016 budget to date.

[6] Australia's figures include funding received for the 2013-2015 period under two commitments: 2011-2015 (Aus$ 50 million) and 2015-2019 (Aus$ 36 million).

[7] Norway's figures reflect all confirmed funding to Gavi (2013-2019) and funding to WHO (2013-2015).

[8] Abu Dhabi-Crown Prince figures include funds via the UAE Pakistan Assistance Programme.

[9] In 2013, Rotary pledged up to US$ 175 million for the 2013-2018 period, which will be matched by the Bill & Melinda Gates Foundation. Contributions under this scheme are recognized under Rotary's figures as and when confirmed by Rotary. Rotary's contributions to the GPEI are through the Rotary Foundation.

[10] Nigeria's figures include domestic resources from loans from the World Bank (US$ 85.6 million) and the Japan International Cooperation Agency loan conversion (US$ 70.3 million).

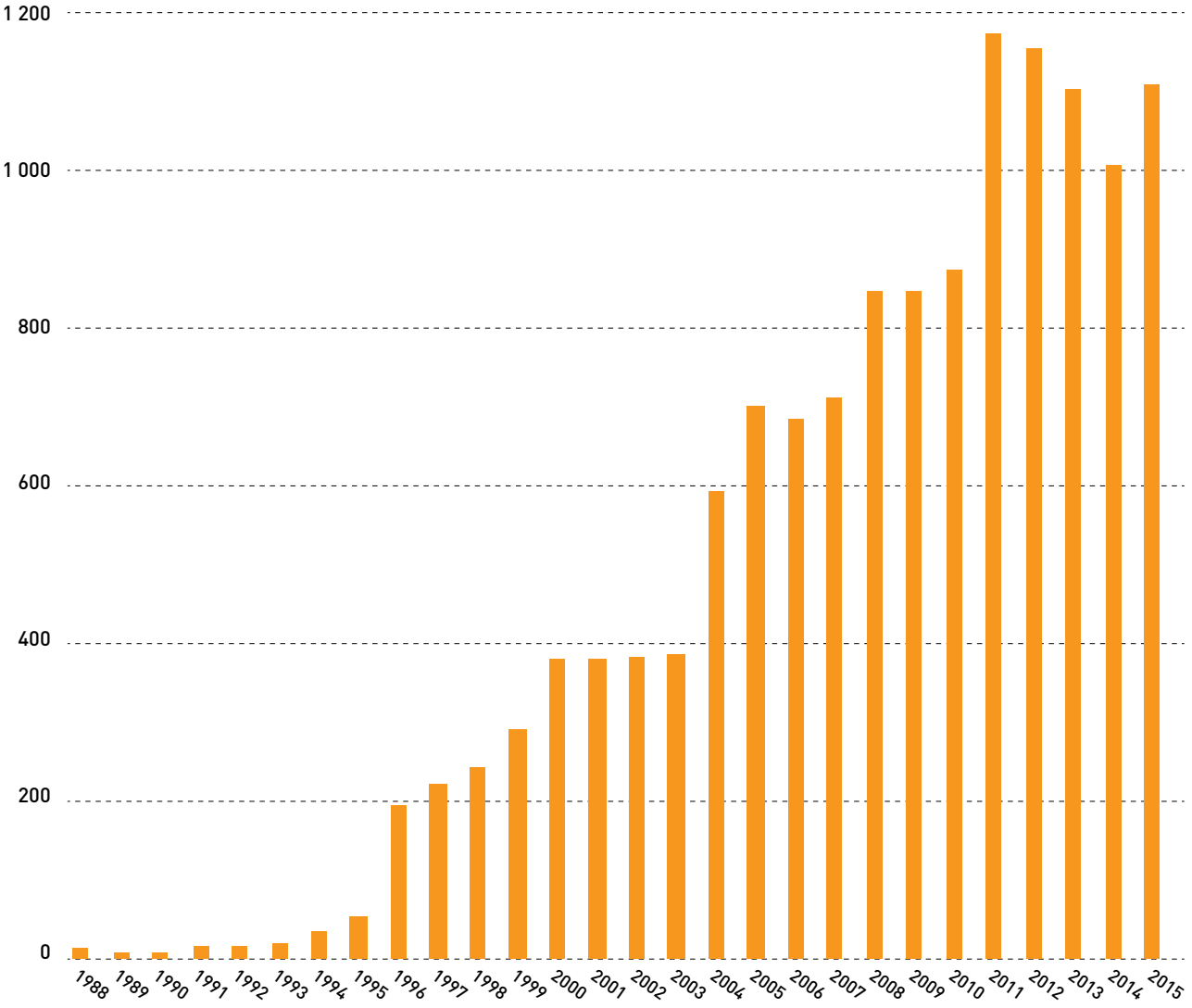
Delays in the operationalization of pledges can lead to significant cash flow problems and the postponement or cancellation of activities. The MTR identified this as one of the major risks to the programme.

The majority of contributions from donors to the GPEI are specified, usually by geographical area or activity, and often both. This presents a significant challenge to programme planning, as the donors' allocation of resources may not be known in advance or arrive in time to implement programme activities. It restricts the programme's capacity to react swiftly to programmatic changes.

The high earmarking of contributions also means that the cash gap is unevenly spread across the programme, with critical funding gaps in particular budget lines or countries.

Since the 1988 World Health Assembly resolution to eradicate polio, 76 public- and private-sector donors have contributed over US$ 14.0 billion to the GPEI **(Figure 7)**. 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 7 | ANNUAL CONTRIBUTIONS TO THE GPEI, 1988-2015 (All figures in US$ millions)

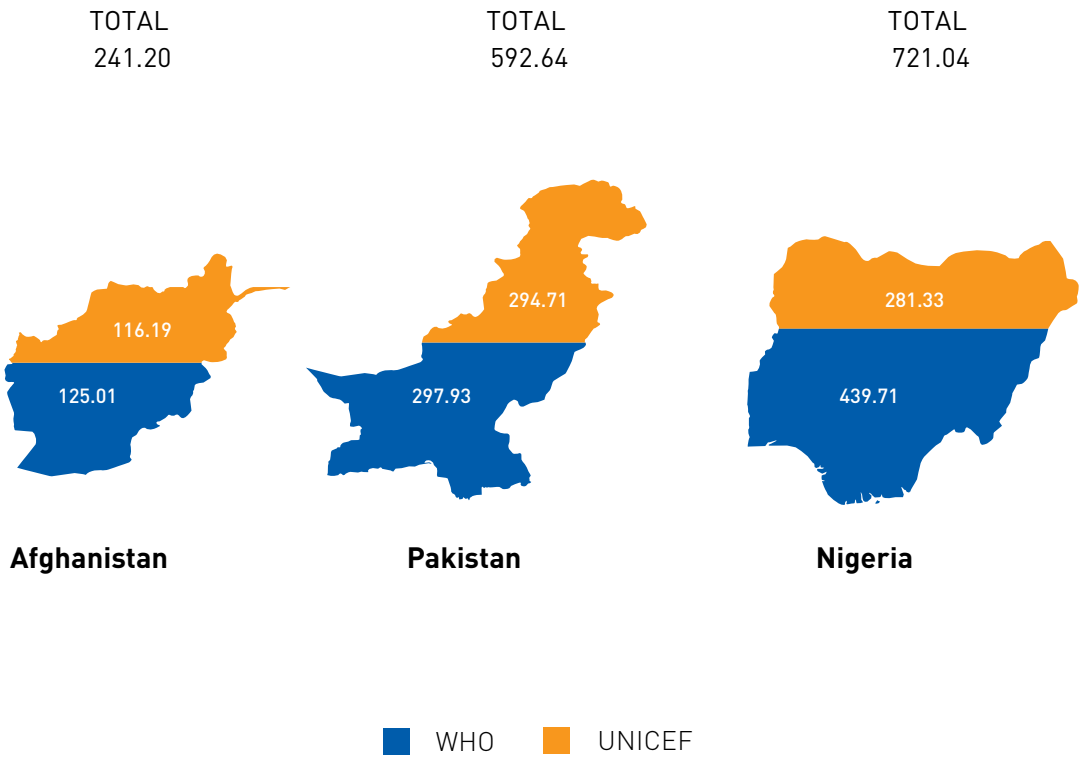


4. FUNDING REQUIREMENTS FOR AFGHANISTAN, PAKISTAN AND NIGERIA, 2016-2019

When the PEESP was developed and launched, three countries were endemic – Afghanistan, Pakistan and Nigeria. As of April 2016, only Afghanistan and Pakistan remain endemic for WPV transmission. Although Nigeria was removed from the list of endemic countries in 2015, the country still has two more years of intense activities before it is certified WPV-free. In these three 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.

The estimated total cost for the three countries is approximately US$ 1.55 billion*, representing 41% of the US$ 3.86 billion budget for the 2016-2019 period **(Figure 8)**. **Annex G**, provided in the online version, shows the requirements and funding details for Afghanistan, Pakistan and Nigeria.

FIGURE 8 | ESTIMATED COSTS FOR AFGHANISTAN, PAKISTAN AND NIGERIA, 2016-2019*
(All figures in US$ millions)



* Does not include Gavi costs for IPV introduction as those costs are held at global level.

ANNEXES A-G: COST DETAILS

ANNEX A | EXTERNAL FUNDING REQUIREMENTS IN POLIO-ENDEMIC, RECENTLY-ENDEMIC AND HIGHEST-RISK COUNTRIES, AREAS AND TERRITORIES, 2016 (All figures in US$ millions)

2016 - Allocation of Financial Requirements Only								
FRR Category	**OPV Campaigns**	**Operational Cost**	**Core Comm. Engagement/ SIA Social Mobilization**	**Technical Assistance**	**Surge Capacity**	**Surveillance and Running Costs (incl. Security)**	**Other Immunization Activity**	**Grand Total**
West/South Asia								
Afghanistan	12.42	17.65	22.39	13.87	5.40	6.42	0.60	78.75
Pakistan	44.07	72.65	31.37	21.19	14.98	5.59	20.21	210.07
India	0	0	9.60	16.16	0	7.20	1.32	34.29
Nepal	0.70	1.10	0	0.93	0	0.49	0.24	3.46
Indonesia	0	14.22	0	0.33	0	0.65	2.43	17.63
Myanmar	0.17	0.19	0.12	0.51	0	0.60	0.57	2.16
Lao People's Democratic Republic	0.34	1.89	0.46	0	0	0	0.07	2.76
West/South Asia Areas Subtotal	57.70	107.70	63.94	52.99	20.38	20.95	25.44	349.12
West/Central Africa								
Nigeria	34.17	77.42	31.86	46.06	24.08	17.00	16.82	247.42
Chad	2.41	4.70	2.25	4.50	2.59	1.50	0.32	18.28
Niger	2.32	3.55	0.57	1.03	0.48	0.61	0.30	8.87
Mali	3.90	4.39	0.39	0.14	0	0.30	0.20	9.32
Burkina Faso	2.30	3.72	0.32	0.26	0	0.32	0.23	7.14
Benin	1.24	1.68	0.24	0.26	0	0.18	0.10	3.70
Cameroon	2.80	3.19	2.21	0.97	0.70	0.55	0.48	10.89
Democratic Republic of the Congo	6.60	16.99	4.06	8.32	2.21	2.70	0.60	41.47
Central African Republic	0.48	0.61	0.78	0.77	0	0.72	0	3.37
Gabon	0.12	0.27	0.20	0.39	0	0.35	0.02	1.35
Equatorial Guinea	0.09	0.53	0.24	0.15	0.50	0.04	0	1.55
Congo	0.34	0.62	0.32	0.33	0.28	0.13	0.06	2.09
Liberia	0.60	1.80	0.80	0.49	0	0.22	0.05	3.97
Sierra Leone	1.00	1.78	0.60	0.43	0	0.24	0.16	4.16
Guinea	2.30	7.31	0.70	0.29	0	0.41	0.06	11.08
Côte d'Ivoire	2.60	2.13	0.32	0.94	0	0.25	0.26	6.50
Mauritania	0.13	0.60	0.21	0.08	0	0.18	0.07	1.28
Senegal	0	0	0	0.16	0	0.27	0.08	0.51
Madagascar	2.40	3.70	1.41	0.63	0.35	0.71	0.44	9.65
Angola	0	0.12	0.10	6.83	2.01	0.90	0.20	10.17
West/Central Africa Subtotal	65.80	135.11	47.58	73.03	33.20	27.60	20.45	402.77

CONTINUED →

2016 - Allocation of Financial Requirements Only								
FRR Category	**OPV Campaigns**	**Operational Cost**	**Core Comm. Engagement/ SIA Social Mobilization**	**Technical Assistance**	**Surge Capacity**	**Surveillance and Running Costs (incl. Security)**	**Other Immunization Activity**	**Grand Total**
Horn of Africa								
Somalia	1.80	9.06	3.75	4.64	2.31	2.83	0.80	25.20
Ethiopia	5.80	25.67	1.57	1.73	0.81	3.20	0.99	39.78
Kenya	2.26	6.44	0.92	1.10	0.71	0.40	0.69	12.51
South Sudan	2.10	10.12	2.13	5.71	0	1.00	0.76	21.81
Sudan	0.72	3.76	0.16	1.02	0	1.65	0.21	7.51
Uganda	2.78	6.63	0.53	0.61	0.04	0.45	0.35	11.40
Djibouti	0.03	0.13	0.08	0.17	0	0.08	0	0.49
Eritrea	0	0	0	0.16	0	0.11	0.13	0.40
Yemen	3.44	13.48	1.00	0.24	0	0.96	0.55	19.68
Horn of Africa Subtotal	18.93	75.29	10.14	15.38	3.87	10.68	4.48	138.78
Middle East								
Syrian Arab Republic	1.85	2.11	0.21	0.89	0	0.48	0	5.56
Egypt	0	2.85	0	0.38	0	0.33	1.45	5.01
Jordan	0.18	0.67	0.20	0.15	0	0.34	0	1.54
Lebanon	0.06	0.10	0.13	0.26	0	0.43	0	0.98
Iraq	3.21	11.39	1.20	0.42	1.18	0.25	0	17.65
Libya	0	1.25	0	0	0	0.61	0	1.86
Middle East Subtotal	5.30	18.37	1.74	2.10	1.18	2.44	1.45	32.60
Europe								
Ukraine	1.05	0.64	0.72	0	0	0.05	0	2.46
Europe Subtotal	1.05	0.64	0.72	0	0	0.05	0	2.46
Grand Total	**148.78**	**337.11**	**124.12**	**143.50**	**58.63**	**61.72**	**51.82**	**925.73**

ANNEX B | PLANNED SUPPLEMENTARY IMMUNIZATION ACTIVITY SCHEDULE, 2016
(All activities are expressed in percentages*)

TRANSMISSION ZONE/COUNTRY	2016											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
West/South Asia												
Afghanistan	50	100	100	50	100	40		100		100		50
Pakistan**	100	40	100	40	100		40	40		50	100	
India**	100	100			45				45			
Nepal		80										
West/Central Africa												
Nigeria**	45	100	100		45					45		
Chad		100	100						50	100		
Niger			200						50			
Mali			200							100		
Burkina Faso		100	100									
Benin			100							100		
Cameroon		100		100					50			
Dem. Rep. of the Congo			60	100						60		
Central African Republic	20		130		50					100		
Gabon		100	100									
Equatorial Guinea		100	100							100		
Congo		100	100									
Liberia		100	100					100		100		
Sierra Leone		100	100					100		100		
Guinea	100		200					100		100		
Côte d'Ivoire		100	100									
Mauritania			100							50		
Horn of Africa												
Somalia		100	100		25			25		100	100	
Ethiopia		33	100		33				33		33	
Kenya			33	100								
South Sudan		33		100					100		100	
Sudan			50						50			
Uganda	57		100	57								
Djibouti			100									
Yemen	100		100		100				100			
Middle East												
Syrian Arab Republic		100	100			50				100		
Egypt			100									
Jordan			100									
Lebanon		30	30									
Iraq		100		100		50				50		
Iran (Islamic Republic of)												
Libya			100							100		
Other												
Angola**			100									
Ukraine**			50							100		
Madagascar			100	100						100		
Lao People's Dem. Rep.										100	100	
Myanmar	20											
Indonesia**			100									

Countries with no poliovirus for more than 12 months

Countries with poliovirus within the last 6 months

Countries with poliovirus between 6 and 12 months

Categorization includes cVDPVs
* Percentage of country coverage (100% = national activity; >100% = more than one national activity in the month; and <100% = subnational activity)
** These countries are partially or fully "self-financing".

ANNEX C | SOCIAL MOBILIZATION COSTS, 2016

Social mobilization and communication efforts are essential to ensure high levels of awareness, community demand and continued acceptance of polio vaccines, and to gain trust in the most challenging areas. The activities can be broadly separated into two categories – ongoing and campaign-related.

Ongoing activities

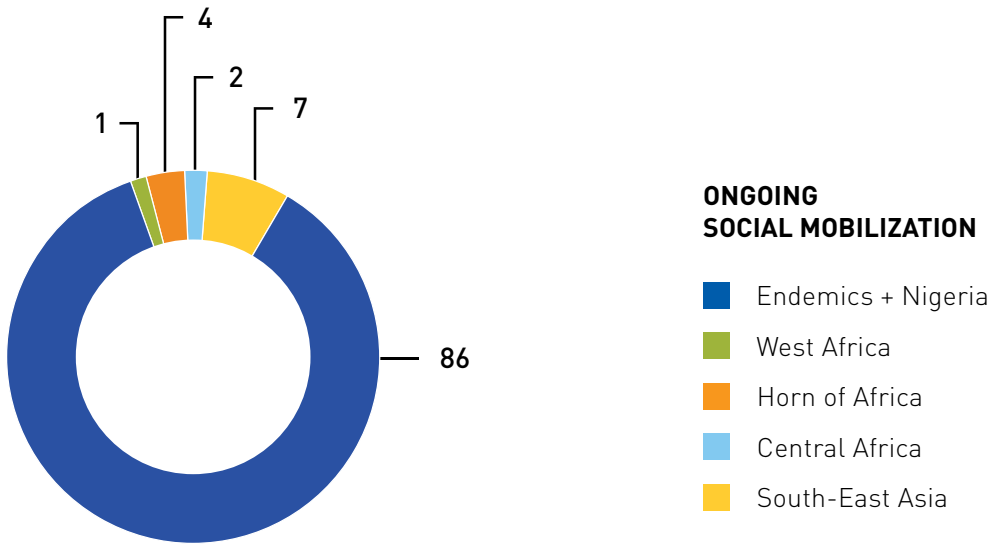
Ongoing activities are those conducted continuously throughout the year in support of the polio eradication programme and the broader Expanded Programme on Immunization, to lay the foundation for campaign work, but also to promote RI and increase families' and communities' understanding and demand for vaccination beyond campaigns and polio vaccines. 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 all types of supplementary immunization activities/campaigns, such as Subnational Immunization Day/National Immunization Day/Short Interval Additional Dose/ 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 front-line workers, the printing of materials to announce campaign dates, the airing of campaign-specific radio or television spots, high-quality and relevant trainings, and operations and logistical costs.

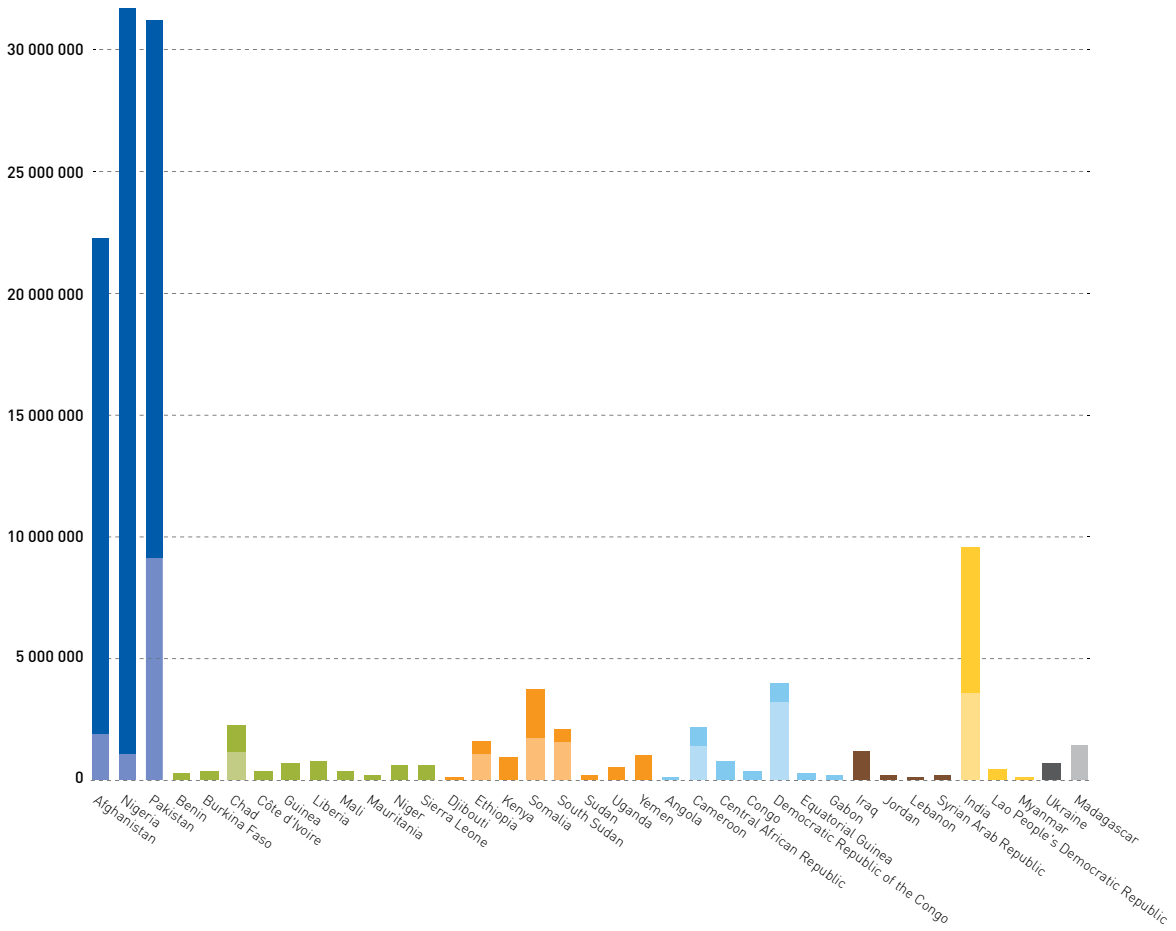
In the majority of countries, the campaign-related budget is larger than the ongoing activity budget. Exceptions are found in Afghanistan, India, Nigeria and Pakistan, where the concentration is to a greater extent on the ongoing activities (see the figures below).

FIGURE C1 | ONGOING SOCIAL MOBILIZATION REQUIREMENTS BY CATEGORY, 2016
(All figures in percentages)*



* Figures reflect "planned" social mobilization requirements.
Total emergency requirements of US$ 16.93 are held globally for allocation as required.
Ongoing social mobilization requirements do not reflect headquarter or regional office requirements.

FIGURE C2 | SOCIAL MOBILIZATION REQUIREMENTS BY COUNTRY AND CATEGORY (ONGOING AND CAMPAIGN-RELATED), 2016 (All figures in US$)



ONGOING SOCIAL MOBILIZATION

- Endemics + Nigeria
- West Africa
- Horn of Africa
- Central Africa
- South-East Asia
- Middle East
- Europe
- Other

CAMPAIGN-RELATED SOCIAL MOBILIZATION

- Endemics + Nigeria
- West Africa
- Horn of Africa
- Central Africa
- South-East Asia
- Middle East
- Europe
- Other

ANNEX D | LABORATORY, SURVEILLANCE (INCLUDING SECURITY) AND RUNNING COSTS BY COUNTRY AND REGION, EXCLUDING INDIRECT COSTS, 2016 (All figures in US$ millions)

WHO African Region	**2016**
Algeria	0.03
Angola	0.90
Benin	0.18
Botswana	0.09
Burkina Faso	0.32
Burundi	0.06
Cameroon	0.55
Cape Verde	0.02
Central African Republic	0.73
Chad	1.50
Comoros	0.03
Congo	0.14
Côte d'Ivoire	0.25
Democratic Republic of the Congo	2.70
Equatorial Guinea	0.04
Eritrea	0.11
Ethiopia	3.20
Gabon	0.35
Gambia	0.05
Ghana	0.30
Guinea	0.41
Guinea-Bissau	0.06
Kenya	0.40
Lesotho	0.04
Liberia	0.22
Madagascar	0.71
Malawi	0.18
Mali	0.30
Mauritania	0.18
Mauritius	0.02
Mozambique	0.24
Namibia	0.14
Niger	0.61
Nigeria	17.00
Rwanda	0.11
Sao Tome and Principe	0.02
Senegal	0.28
Seychelles	0.01
Sierra Leone	0.24
South Africa	0.20
South Sudan	1.00
Swaziland	0.07
Togo	0.14
Uganda	0.45
United Republic of Tanzania	0.40
Zambia	0.30
Zimbabwe	0.25
Regional surveillance and laboratory	5.03
Subtotal	40.54
WHO Region of the Americas	**2016**
Regional surveillance and laboratory	1.00

WHO Western Pacific Region	**2016**
Regional surveillance and laboratory	1.35
WHO Eastern Mediterranean Region	**2016**
Afghanistan	6.42
Djibouti	0.09
Egypt	0.33
Iran (Islamic Republic of)	0.00
Iraq	0.25
Jordan	0.35
Lebanon	0.43
Libya	0.61
Pakistan	5.59
Somalia	2.83
Sudan	1.65
Syrian Arab Republic	0.49
Tunisia	0.02
West Bank and Gaza Strip	0.24
Yemen	0.97
Regional surveillance and laboratory	2.15
Subtotal	**22.40**
WHO South-East Asia Region	**2016**
Bangladesh	0.85
India	7.20
Indonesia	0.65
Myanmar	0.60
Nepal	0.49
Regional surveillance and laboratory	4.78
Subtotal	**14.57**
WHO European Region	**2016**
Armenia	0.01
Azerbaijan	0.01
Bosnia and Herzegovina	0.01
Georgia	0.01
Kazakhstan	0.01
Kyrgyzstan	0.01
Republic of Moldova	0.02
Tajikistan	0.03
Turkey	0.05
Turkmenistan	0.02
Ukraine	0.05
Uzbekistan	0.03
Regional surveillance and laboratory	1.55
Subtotal	**1.80**
WHO/HQ Global	2016
Laboratory	2.74
Infrastructure and security	3.23
Environmental	6.25
Emergency	9.90
Subtotal	**22.12**

Global	**2016**
Total	**103.78**

ANNEX E | TECHNICAL ASSISTANCE, INCLUDING SURGE CAPACITY BY COUNTRY AND REGION, EXCLUDING INDIRECT COSTS, 2016 (All figures in US$ millions)

WHO African Region	2016
Angola	6.83
Benin	0.26
Botswana	0.15
Burkina Faso	0.26
Burundi	0.12
Cameroon	0.97
Central African Republic	0.78
Chad	2.26
Congo	0.33
Côte d'Ivoire	0.94
Democratic Republic of the Congo	5.98
Equatorial Guinea	0.15
Eritrea	0.16
Ethiopia	1.47
Gabon	0.39
Gambia	0.07
Ghana	0.12
Guinea	0.29
Guinea-Bissau	0.16
Kenya	0.89
Lesotho	0.09
Liberia	0.49
Madagascar	0.63
Malawi	0.09
Mali	0.14
Mauritania	0.08
Mozambique	0.41
Namibia	0.25
Niger	1.03
Nigeria	35.73
Rwanda	0.22
Senegal	0.16
Sierra Leone	0.44
South Africa	0.56
South Sudan	3.68
Swaziland	0.15
Togo	0.13
Uganda	0.39
United Republic of Tanzania	0.45
Zambia	0.56
Zimbabwe	0.19
IST (Central block)	1.55
IST (South/East block)	1.99
IST (West block)	1.32
Regional Office for Africa	2.96
Subtotal	**76.23**

*** IST= Intercountry Support Team**

WHO Eastern Mediterranean Region	2016
Afghanistan	8.26
Djibouti	0.17
Egypt	0.38
Iraq	0.42
Lebanon	0.26
Jordan	0.15
Pakistan	15.21
Somalia	2.29
Syrian Arab Republic	0.90
Sudan	0.93
Yemen	0.24
Regional Office for the Eastern Mediterranean	4.61
Subtotal	**33.80**

WHO Western Pacific Region	2016
Regional Office for the Western Pacific	0.90
Subtotal	**0.90**
WHO South-East Asia Region	**2016**
Bangladesh	1.45
India	14.64
Indonesia	0.33
Myanmar	0.51
Nepal	0.93
Regional Office for South-East Asia	1.37
Subtotal	**19.23**
WHO European Region	**2016**
Regional Office for Europe/Countries	0.68
Subtotal	**0.68**
WHO	**2016**
WHO/HQ	28.03
Short-term technical assistance	31.63
Emergency surge	10.72
Subtotal	**70.38**
UNICEF	**2016**
UNICEF HQ/Regional offices	10.78
Afghanistan	5.61
Chad	2.25
Democratic Republic of the Congo	2.34
Ethiopia	0.26
India	1.52
Kenya	0.21
Nigeria	10.33
Pakistan	5.99
Somalia	2.35
South Sudan	2.03
Sudan	0.08
Uganda	0.22
Subtotal	**43.96**
WHO Surge Capacity	**2016**
Afghanistan	5.40
Angola	2.02
Chad	2.59
Democratic Republic of the Congo	2.21
Ethiopia	0.81
Iraq	1.18
Jordan	0.00
Kenya	0.71
Niger	0.49
Nigeria	24.08
Pakistan	14.46
Somalia	2.31
Uganda	0.04
IST Central - Regional Office for Africa	0.20
Regional Office for the Eastern Mediterranean	2.27
Regional Office for Africa	0.90
Subtotal	**59.66**
UNICEF Surge Capacity	**2016**
Cameroon	0.70
Congo	0.28
Equatorial Guinea	0.50
Madagascar	0.35
Pakistan	0.53
Subtotal	**2.36**

Global WHO-UNICEF	2016
Total	**307.20**

ANNEX F | GAVI, THE VACCINE ALLIANCE, SUPPORT FOR THE INTRODUCTION OF IPV

In November 2013, the Gavi Board agreed to support the introduction of IPV in routine immunization programmes in the world's 73 poorest countries, on the condition that the GPEI provide the necessary funding. This decision allowed Gavi to play a complementary role in helping the GPEI to eradicate polio under Objective 2 of the PEESP, leveraging its existing systems and processes to assist countries with new vaccine introductions. The Board endorsed support for all Gavi-eligible countries and those graduating from Gavi support. Given polio eradication is a global health priority, the Board also agreed to a number of policy exceptions for IPV, such as encouraging but not requiring countries to cofinance IPV introduction.

While Gavi donors were engaged in discussions around its role in supporting IPV introduction, the cost of introduction through Gavi was not included in its 2014 "replenishment ask". To ensure adequate vaccine supply and country preparedness for introduction, the GPEI donors (the Bill & Melinda Gates Foundation, Norway and the United Kingdom) committed all required funding up front to cover Gavi's requirements. **Table F1** represents Gavi's requirements for the 2016-2019 period*.

TABLE F1 | GAVI REQUIREMENTS, 2016-2019* (All figures in US$ millions)

	2016	2017	2018	2019	Grand Total
Objective 2: Immunization Systems Strengthening and Oral Polio Vaccine Withdrawal					
Inactivated Polio Vaccine Introduction	**66.29**	**80.10**	**63.10**	**23.20**	**232.69**
Inactivated Polio Vaccine in Routine Immunization (vaccine procurement)	65.80	80.10	63.10	23.20	232.20
Inactivated Polio Vaccine Intro Grants	0.49	0	0	0	0.49
Technical Assistance	**6.70**	**5.30**	**5.10**		**17.10**
Inactivated Polio Vaccine Introduction	6.70	5.30	5.10	0	17.10
Grand Total	**72.99**	**85.40**	**68.20**	**23.20**	**249.79**

* The requirements for 2019 are from 2017 to 2018 due to the constrained global IPV supply and the resulting delay of IPV introduction. The GPEI and Gavi are currently reviewing requirements post-2016.

ANNEX G | REQUIREMENTS AND FUNDING DETAILS FOR AFGHANISTAN, PAKISTAN AND NIGERIA

These requirements and funding details will appear in the online version
http://www.polioeradication.org/Financing.aspx

GLOSSARY: ACRONYMS AND ABBREVIATIONS

AFP	Acute flaccid paralysis
BMGF	Bill & Melinda Gates Foundation
bOPV	Bivalent oral polio vaccine
CDC	US Centers for Disease Control and Prevention
cVDPV	Circulating vaccine-derived poliovirus
FAC	Finance and Accountability Committee
FRR	Financial Resource Requirement
Gavi	Gavi, the Vaccine Alliance
GPEI	Global Polio Eradication Initiative
HQ	World Health Organization headquarters
IFFIm	Innovative Financing Facility for Immunization
IHR	International Health Regulation
IMB	Independent Monitoring Board
IPV	Inactivated polio vaccine
JICA	Japan International Cooperation Agency
mOPV2	Monovalent oral polio vaccine type 2
MTR	Midterm review
OPV	Oral polio vaccine
OPV2	Oral polio vaccine type 2
PEESP	Polio Eradication & Endgame Strategic Plan 2013-2018
POB	Polio Oversight Board
RI	Routine immunization
SIA	Supplementary immunization activity
tOPV	Trivalent oral polio vaccine
UNICEF	United Nations Children's Fund
VDPV	Vaccine-derived poliovirus
WHO	World Health Organization
WPV	Wild poliovirus
WPV2	Wild poliovirus type 2

www.polioeradication.org

EVERY LAST CHILD