POLIO GLOBAL ERADICATION INITIATIVE

GPEI ACTION PLAN

2026

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EVERY LAST CHILD

Contents

Acronyms and abbreviations

BCU	Big Catch-Up (global immunization initiative)
bOPV	bivalent oral polio vaccine
CBO	community-based organization
CE	community engagement
ComVI	community vaccination initiative
CSO	civil society organization
cVDPV	circulating vaccine-derived poliovirus
cVDPV1	circulating vaccine-derived poliovirus type 1
cVDPV2	circulating vaccine-derived poliovirus type 2
cVDPV3	circulating vaccine-derived poliovirus type 3
DRC	Democratic Republic of the Congo
EPI	Essential Programme on Immunization
fIPV	fractional dose of inactivated polio vaccine
FLW	frontline worker
FRR	financial resource requirements
GPEI	Global Polio Eradication Initiative
H2H	house-to-house (campaign modality)
HR	human resources
IBRA	in-between round activities
IPV	inactivated polio vaccine
IPV1	first dose of inactivated polio vaccine
IPV2	second dose of inactivated polio vaccine
ISD	integrated service delivery
KPI	key performance indicator
M&E	monitoring and evaluation
MMP	migrant and mobile population
NEOC	National Emergency Operations Centre
NGO	nongovernmental organization
NID	National Immunization Day
non-FRR	non-financial resource requirements
nOPV2	novel oral polio vaccine type 2
ODA	official development assistance
OPV	oral polio vaccine
S2S	site-to-site (campaign modality)
SAGE	Strategic Advisory Group of Experts on Immunization
SBC	social and behavioural change
SIA	supplementary immunization activity
SNID	Subnational Immunization Day
SOPs	standard operating procedures
South KP	South Khyber Pakhtunkhwa
TAG	Technical Advisory Group
VfM	Value for Money (project)
VPD	vaccine-preventable disease
WASH	water, sanitation and hygiene
WHO	World Health Organization
WPV1	wild poliovirus type 1

Introducing the GPEI Action Plan

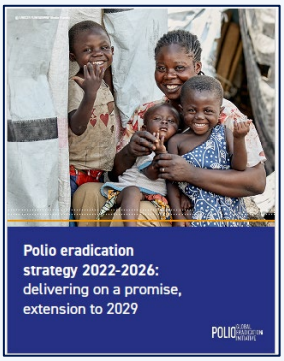
The Global Polio Eradication Initiative (GPEI) introduces a new tool to support annual planning and implementation efforts to achieve the eradication of wild poliovirus type 1 (WPV1), or Goal One, and the elimination of circulating vaccine-derived poliovirus type 2 (cVDPV2), or Goal Two, as outlined in its Polio Eradication Strategy.

The GPEI Action Plan represents an operational companion to the GPEI Eradication Strategy and the strategy's extension, approved by the Polio Oversight Board in October 2024. The Action Plan builds upon these guiding documents by defining the concrete actions needed to meet the final challenges and achieve eradication.

As the GPEI approaches its final milestones, alignment and coordination across its vast partnership is even more critical. The development of the GPEI Action Plan through direct engagement of country, regional and global teams has provided a platform to advance planning dynamically within and across national governments, global agencies and partners. Through this broad, whole-of-programme engagement, the Action Plan identifies necessary shifts given the current epidemiology and the current geopolitical, operational and financial realities faced by polio-affected countries and regions.

Country-level plans, which have been a cornerstone to the success of the polio eradication effort, underpin the GPEI Action Plan. Subnational plans that correspond to and draw upon national emergency action plans appear as a separate annex that will be updated as the GPEI continues to respond to challenges at a local level.

The GPEI Action Plan will function as a living document, reviewed quarterly and updated annually, to ensure the plan is fit for purpose in meeting the programme's most critical challenges.



In addition to translating the GPEI Eradication Strategy into action, the GPEI Action Plan provides an update on shifts proposed under the 2024 strategy extension.

Whole-of-programme planning

The GPEI Action Plan is developed in collaboration with: national governments; National Emergency Operations Centres (NEOCs); country and regional offices of the World Health Organization (WHO) and United Nations Children's Fund (UNICEF); the U.S. Centers for Disease Control and Prevention (CDC), the Gates Foundation, Rotary International and Gavi, the Vaccine Alliance; GPEI global programme support groups and decision-making bodies; the Essential Programme on Immunization (EPI); key technical advisory groups and donors. It is directed to internal audiences, including country programmes and NEOCs, WHO and UNICEF regional focal points for polio eradication, and GPEI partners and consultants. The GPEI Action Plan will be disseminated widely to promote its implementation.

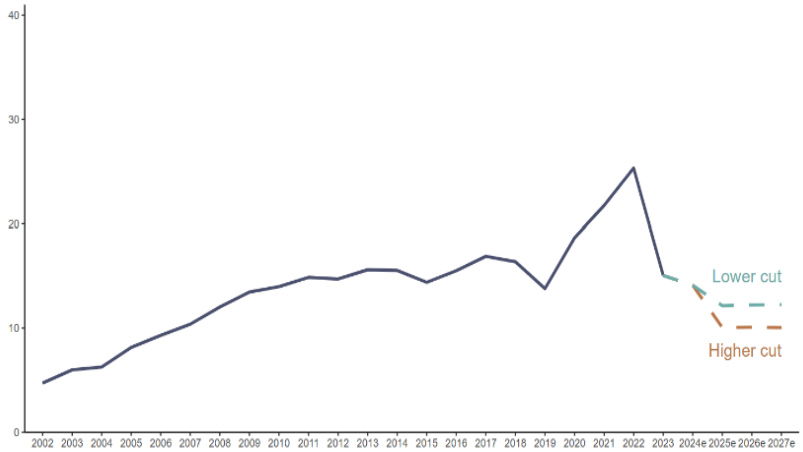
An overview on the GPEI Action Plan is available for external audiences that include: donors; other immunization, health emergency and humanitarian programmes; nongovernmental organizations (NGOs), civil society organizations (CSOs), community-based organizations (CBOs) and other partners whose missions overlap with the critical geographies and public health priorities that are the focus of the polio eradication effort.

GPEI Action Plan 2026

Context

The global health and development landscape has experienced profound shifts within the last few years. Escalating geopolitical tensions, regional instability, humanitarian emergencies and economic constraints are reshaping global health priorities and funding environments. Traditional funding sources for global health are under pressure as national security and other domestic needs have taken on new priority among donor countries. Unstable coalitions within and across governments have further fractured support to global health. In a 2025 report on the current state of official development assistance (ODA), the Organisation for Economic Cooperation and Development (OECD) notes a sharp decline in aid over the past three years, with ODA for health and population services in 2025 and 2026 expected to reach levels not seen for nearly two decades (**Fig. 1**). These trends will affect the delivery of immunization and disease surveillance in regions and countries most in need of support – even as many are still recovering from COVID-19.

Fig. 1. Net bilateral ODA for health from DAC countries



DAC = Development Assistance Committee; ODA = official development assistance.
Note: Data based on official data for 2010–2023 and projections for 2024–2027.

Source: OECD.

This evolving context also carries significant financial and operational risks for the polio eradication effort. The GPEI is now planning for an adjusted 2026 budget of US$786M – 30% less than what was originally laid out within its multi-year budget ($1.132B). As financial uncertainties impact the programme's ability to sustain comprehensive support across all geographies and partners, the GPEI has defined an Action Plan to sharpen operations and deploy resources more strategically by targeting investments toward areas of active poliovirus transmission and toward populations at greatest risk.

The 2026 GPEI Action Plan

To adapt to changes within the global health landscape, the 2026 Action Plan sets a course that centers integration with immunization and health partners, reinforces community-driven approaches to better meet local realities, and above all maintains momentum toward eradication through a greater push toward whole-of-programme planning, coordinated implementation and rigorous operational accountability.

The GPEI Action Plan for 2026 includes:

- planning for Afghanistan and Pakistan in 2026 that maintains investments in a campaign schedule needed to achieve WPV1 interruption (**Goal One**) and prioritizes innovative strategic approaches for the highest risk areas;
- a new phased approach to cVDPV2 elimination (**Goal Two**) that leverages efficiencies, workforce transformations and dedicated cross-regional strategies to target activities and achieve the greatest impact;

- an overview of how efficiency measures were identified and will be implemented, alongside detailed assessments of key risks, trade-offs and critical mitigation measures for both goals;
- a revised budget based on materially lower contributions to the programme;
- operational accountability to support the success of the GPEI Action Plan; and
- detailed subnational plans for areas where progress in 2026 is critical to GPEI eradication goals.

The milestones provided in the 2026 Action Plan for Goal One and Goal Two may impact the strategy timeline as defined in the 2024 extension. The GPEI Eradication Strategy timeline and multi-year budget will be revised in review of progress in 2026 and in consultation with the Polio Oversight Board.

Eradication depends on effectively finding every trace of polio and immunizing every child, powered by sustained political and financial commitment. Working together, countries, agencies, donors and partners must ensure that hard-won gains are preserved and that the collective efforts of all remain tightly focused on the goal: a world free of all forms of poliovirus.

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Operational focus for 2026

Goal One

Assessment

Wild poliovirus type 1 (WPV1) persists in Afghanistan and Pakistan with widespread detections across the two endemic countries. Although transmission may have peaked based on declining detections in recent months, access is still limited in south Afghanistan and south Khyber Pakhtunkhwa (South KP) in Pakistan. WPV1 transmission also continues in the region's largest urban reservoir of Karachi and in the moving reservoir among migrant and mobile populations (**Annex A: Current epidemiology**).

Strong global and regional commitments to eradication remain critical as the two countries navigate complex political, operational and technical landscapes that have contributed to missed milestones for stopping WPV1 transmission. Both programmes established plans based on recommendations provided in February and June 2025 by the Technical Advisory Group (TAG), with early 2025 TAG benchmarks not met. Amid these challenges, both countries face an 18% reduction in funding which has largely been absorbed through efficiency measures so the countries can bring clear and urgent focus to the activities and interventions critical to WPV1 eradication.

Achieving Goal One hinges on addressing shared and distinct challenges in Afghanistan and Pakistan to simultaneously interrupt WPV1 transmission across all subnational areas within this single epidemiological block (**Table 1**).

Tactical shifts implemented for Goal One under the 2024 strategy extension

- ✓ Redefine, remap and vaccinate mobile and migrant populations.
- ✓ Improve microplanning, coordination to reach cross-border communities.
- ✓ Ensure vaccination campaigns better align with local gender norms.
- ✓ Prioritize integration between the GPEI and essential immunization programmes.

Afghanistan

- ✓ Advocate for the resumption of house-to-house campaigns.
- ✓ Optimize quality of site-to-site campaigns.

Pakistan

- ✓ Tailor campaigns with innovations and added security measures to reach all children in South KP.
- ✓ Enhance campaign preparations.
- ✓ Tighten accountability to prevent underreporting, refusals or fake finger-marking.
- ✓ Apply solutions co-designed with frontline workers, including the female frontline listening initiative.

Table 1. Challenges in Afghanistan and Pakistan

Afghanistan	Pakistan
• Limited ownership by provincial authorities in the south region contributed to incomplete implementation of the 'Reset Strategy.'	• Persistent inaccessibility in South KP contributes to a significant number of unreached children.
• Weak political commitment hampered implementation, resulting in poor quality supplementary immunization activities (SIAs) in the south region.	• The programme struggles with ensuring consistent high-quality vaccination campaigns in historic reservoir areas.
• A ban on female community-based workers, particularly in the south, remains a significant barrier.	• SIA quality and coverage are also compromised by vaccine hesitancy.
Common across the epidemiological block	
• Polio-affected areas have low routine immunization coverage.	
• Intense population movement in-country and across borders, including returnees from Pakistan to Afghanistan, requires constant mapping and flexible and targeted strategies to ensure consistent vaccination of all children among mobile and migrant populations (MMPs).	
• Misinformation about polio and polio vaccination is commonplace, creating distrust and a loss of confidence in eradication efforts.	

MMP = mobile and migrant population; SIA = supplementary immunization activity; South KP = South Khyber Pakhtunkhwa.

Plan for 2026

The next low season, ending in mid-2026, represents a window of opportunity for interrupting WPV1 transmission. Both country programmes have developed plans to create the necessary momentum to deliver Goal One. In recognition of the challenges that elevate risks to the global polio eradication timeline, both country programmes have set a clear target: to stop WPV1 transmission no later than June 2026.

The plans outlined below will guide implementation through the rest of 2025 and into 2026. To ensure both programmes operate within a leaner financial environment, a risk-based approach will bring clear focus to enhancing campaign quality in all high-risk areas and closing immunity gaps among vulnerable populations. Routine immunization is a central pillar of polio eradication, and both country programmes will assume greater ownership in working with the EPI and Gavi, the Vaccine Alliance, to increase routine immunization coverage in the major urban centres of south Afghanistan and South KP. These efforts will be reinforced by improving monitoring, aligning human resource (HR) capacity, synchronizing cross-border coordination, advocating for strong political leadership, and ensuring effective oversight at all levels of the programme to drive robust accountability.

Implementation will be guided by the latest data to ensure both programmes remain agile and can adapt as needed to the epidemiology and to changes within the larger operating environment. Each programme has conducted prioritization exercises to focus programme efforts on key subnational geographies as determined by the current epidemiology (**Annex A**). Implementation of subnational plans will be monitored with national, regional and global oversight (**Annex B**).

Afghanistan

In February 2025, the TAG endorsed the Afghanistan programme's 'Strategic Reset' to overcome barriers to WPV1 interruption in the country, most notably a ban on house-to-house vaccination.

The Strategic Reset aims to reach a maximum number of children with polio vaccines through SIAs in a site-to-site campaign modality, while also working to rapidly improve EPI delivery in key areas.

The Strategic Reset draws on four pillars:

1. **'maximize push'** by placing vaccination services as close to beneficiaries as possible and enabling the programme to track and quantify missed children by sex and age;
2. '**maximize pull'** by conducting community engagement and adding strategically designed 'pluses' to encourage beneficiaries to access vaccination sites without a knock at the door;
3. **strengthen routine immunization** by providing operational support to EPI in critical geographies and rapidly improving routine immunization coverage in epidemiologically prioritized areas, notably major urban centres in Helmand and Kandahar; and
4. **leverage advocacy**, including at the highest levels of national and provincial leadership, to improve ownership at all levels and ensure full implementation of the Strategic Reset in priority geographies.

The Strategic Reset and subnational planning

As part of the Strategic Reset, each subnational area has a tailored action plan focused on high-risk populations and areas that include urban and peri-urban centres with dense populations, recently infected geographies, and border districts. These plans are also adapted to each region's unique epidemiology, priorities, political dynamics and contextual realities (see **Annex B**).

Afghanistan's subnational plans place consistent focus on special strategies to enhance cross-border coordination at all levels and reach migrant and mobile populations, including returnees from Pakistan and other neighbouring countries.

While the programme continues to advocate for restoring house-to-house vaccination campaigns, site-to-site vaccination will be optimized through these four pillars (**Table 2**). In the country's south region, efforts to engage key stakeholders are ongoing to optimize site-to-site vaccination.

Table 2. Four strategic pillars and interventions to optimize site-to-site vaccination

Strategy	Interventions
Maximize push	• Maintain the same level of vaccination teams for site-to-site (S2S) campaigns as the house-to-house (H2H) campaign modality. • Fine-tune microplanning: one (1) site for no more than five (5) households. Rationalize workload, if needed. • Reassess team composition to ensure teams are culturally acceptable and community-supported. • Adjust timing to maximize mobilization of children to sites. • In a culturally acceptable manner, record the numbers of children available (girls and boys) and children missed in houses to ascertain coverage and plan to revisit. • Plan for a fourth day to cover missed children. • Work with EPI and nutrition programmes to track and maintain a list of newborns by sex to ensure correct SIA and EPI doses.

Maximize pull	• Systematically engage provincial and district governors so they identify enablers for mobilization before and during every SIA and include enablers in microplanning.
	• Conduct gender-responsive community engagement through enablers/community elders in advance of the campaign.
	• Review the role and effectiveness of current 'social mobilizers' who appear to be functioning only as announcers and are not influential.
	• Identify appropriate 'pluses' – context-specific incentives or services – that help to attract caregivers with younger children and infants to the vaccination site.
	• Establish cross-partnership 'Pluses Committees' at the national and provincial levels in priority provinces to ensure adequate planning and implementation.
	• Identify and leverage opportunities with humanitarian services, particularly nutrition.
	• Implement a six-month plan for the deployment of pluses that includes:
	  ○ clear identification of populations for pluses (highest-risk districts);
	  ○ timely procurement, distribution and accountability; and
	  ○ integration into microplans.
	• Provide strong supervision and monitoring to assess impact.

Improve EPI	**Prioritize interventions in Kandahar, Lashkargah and their peri-urban areas.** • Cross-match polio microplans with EPI to identify 'white areas' (areas that don't fall under the catchment of any health facility) or possible overlaps. Lead work with EPI, Gavi and other stakeholders to re-plan for the remaining white areas. • Rationalize and redistribute gender-responsive EPI services in white areas. • Engage humanitarian partners to maximize services. • Reassess and redistribute female mobilizers to white areas in urban and peri-urban areas of high-risk provinces. • Provide support in planning, implementation and monitoring of EPI sessions. • Ministry of Health to reassess denominator for EPI in these areas.
Prioritize advocacy	• Advocate for the support of all relevant departments (Propagation of Virtue and Prevention of Vice, Religious, Interior, Health and others), administrative, police and military leadership. • Obtain the support of nationally and internationally respected religious scholars. • Leadership to communicate directly with communities and confer their full support to health workers and the priority they give to eradicating polio. • Community enablers, influencers, elders and local authorities to participate in the microplanning exercise.

EPI = Essential Programme on Immunization; H2H = house-to-house; S2S = site-to-site; SIA = supplementary immunization activity.

As part of the Action Plan, the Afghanistan programme will also strengthen coordination and management structures to ensure it is 'fit for purpose' in delivering on polio eradication. Before the end of 2025, the GPEI will work with authorities to conduct a joint review of programme quality in south Afghanistan. The objectives of this review will be to:

1) understand the barriers to better quality S2S vaccination campaigns;
2) identify strategies to reach all children with vaccination;
3) ensure the current strategies are programmatically, socially and politically acceptable; and
4) identify the most effective mechanisms for programme coordination with provincial authorities in the south region.

Gender in polio endemic country contexts

The GPEI advocates for a contextual understanding of gender, age, ethnicity and other social determinants of health in polio-affected communities. Programme data on missed and zero-dose children provide insights into barriers to WPV1 interruption when such data is disaggregated by sex and age. Immunization outcomes for girls and boys can support smarter strategies. As the choice for polio vaccination is mediated through caregivers, culturally nuanced appeals ensure boys and girls are equally protected from disease. Such gender-responsive strategies aim to engage mothers and fathers differently based on not only gender norms but also social and interpersonal customs, daily habits and the sources of local information available to women and men — which work together to shape each response to a knock at the door.

Adding a gender lens to community engagement helps to deepen the programme's understanding of local culture and to create new ways to increase vaccine acceptance. This deeper understanding can be leveraged to cultivate a workforce that is more effective because it reflects a team composition that engenders trust among local families. Gender-balanced teams with both men and women offer distinct advantages, including flexibility with frontline encounters shaped by norms and customs.

Under the 2026 GPEI Action Plan

The Afghanistan programme will build upon past successes with gender-balanced teams in areas where they are culturally acceptable. The country's "pull" strategy, which aims to mobilize fathers and mothers to bring eligible children to vaccination sites, presents opportunities to add gender-responsive strategies to community engagement — for example, through working with male elders and grandmother committees to shape public opinion on polio vaccination and to inform site-to-site vaccination strategies.

The Pakistan programme will build upon its 2025 national gender action plan to develop a comprehensive gender policy, communication tools on the value of female frontline workers (FLWs), changes to standard operating procedures (SOPs) to better support female FLWs, and new participatory mechanisms to incorporate female FLW experiences into campaign planning.

The Pakistan programme will also:

- strengthen implementation of the programme's anti-harassment guidelines, including improved reporting and redressal mechanisms;
- upgrade and monitor conditions in team support centres to ensure that they meet the needs of female FLWs by providing amenities like women-only bathrooms, sufficient seating, drinking water;
- strengthen the skills, supportive supervision and performance management of Pakistan's 8 000+ community health workers/area supervisors in core reservoirs (which are 85% female);
- establish provincial-level hotlines to address questions and complaints from FLWs, including those related to payment, operational challenges and harassment;
- institutionalize listening sessions with FLWs as part of post-campaign review and create capacity within programme staff for facilitating co-design sessions on key campaign challenges; and
- pilot and scale a digital skills training for high-performing community mobilizers and frontline managers that will focus on building content related to polio and the value of women's engagement in campaigns.

Pakistan

In response to TAG review and mid-2025 recommendations (**Table 3**), the Pakistan programme developed tailored approaches to achieve WPV1 interruption in each subnational geography: South KP, the only part of Pakistan where the intensity of transmission is increasing; the Karachi block where WPV1 transmission has not yet declined significantly and where the extent of migrant and mobile populations pose unique challenges; followed by Peshawar and Quetta blocks, Lahore and Central Pakistan districts.

Table 3. June 2025 TAG recommendations, Pakistan

Maximize immunization in South KP	Audit SIA quality in Karachi
Deliver locally adapted approaches to reach all children and ensure higher-quality SIAs.	Assess and validate SIA quality to identify gaps and build confidence in campaign improvements.
Achieve high-quality SIAs	**Use expanded age IPV**
Further improve campaign quality through microplans, community engagement, capacity-building and clear accountability.	Administer a single dose of full or fractional IPV in children (four months to 15 years) in areas with persistent transmission.
Optimize campaign monitoring	**Intensify EPI strengthening**
Refine campaign monitoring by including campaign preparations, skills assessments, other inputs.	Leverage initiatives to improve coverage among zero-dose and under-immunized children.

EPI = Essential Programme on Immunization; IPV = inactivated polio vaccine; SIA = supplementary immunization activity. South KP = south Khyber Pakhtunkhwa; TAG = Technical Advisory Group.

Meeting challenges across these geographies requires sustained focus on strategic priorities (**Table 4**). Along with key interventions and targeted subnational plans, the programme will implement an intensive 2025 SIA schedule, with large-scale Subnational Immunization Days (SNIDs) and National Immunization Days (NIDs). In the first half of 2026, from January to June, the programme will conduct three mop-up campaigns followed by two NIDs to close remaining immunity gaps. Administration of bivalent oral polio vaccine (bOPV) is also planned for the measles-rubella (MR) mass campaign in collaboration with EPI and Gavi for November 2025, which presents an opportunity to leverage demand for measles vaccination to boost population immunity for polio.

Table 4. Strategic priorities and interventions for 2026 in Pakistan

Strategic priorities	Interventions
Gain access in South KP	• Engage local government through advocacy efforts to improve access. • Develop and optimize context-driven approaches to improve SIA quality and reach. • Continue to assess opportunities for *community vaccination initiatives (ComVI)*, where vaccination activities are conducted by community members.

Improve EPI coverage in South KP and Quetta block	• Accelerate Gavi joint planning to strengthen routine immunization, especially in high-risk areas and major urban centres.
	  ○ Build on the polio-EPI synergy framework to co-develop gender-responsive SOPs to vaccinate zero-dose children.
	  ○ Integrate EPI strengthening into programme monitoring.
	• Prioritize the recruitment of female vaccinators and nutrition staff.
	• *South KP:* Develop and implement an emergency plan for routine immunization strengthening, prioritizing high-risk and inaccessible Union Councils. Expand efforts to build EPI coverage by linking with integrated service delivery (ISD) of nutrition services for children.
	• *Quetta block:* Support emergency EPI implementation in Balochistan.

Prioritize high-risk mobile populations	• Engage humanitarian organizations (UNHCR, IOM) to track MMPs; consider conducting all polio eradication activities among MMPs. • Tailor approaches to reach children among MMPs. Training and microplanning should focus on effective social mobilization among MMPs.

ComVI = community vaccination initiative; EPI = Essential Programme on Immunization; IOM = International Organization for Migration; ISD = integrated service delivery; MMP = migrant and mobile population; SIA = supplementary immunization activity; SOPs = standard operating procedures; South KP = south Khyber Pakhtunkhwa; UNHCR = United Nations High Commissioner for Refugees.

Table 4 (continued)

Strategic priorities	Interventions
Strengthen monitoring in historic reservoirs, including Karachi	• Review M&E strategies to simplify tools (e.g. tally sheets) and develop approaches to strengthen oversight, primarily through independent intra-campaign monitoring and through the use of real-time data. • Expand monitoring through process indicators and other operational inputs to assess programme delivery and support more timely course corrections.

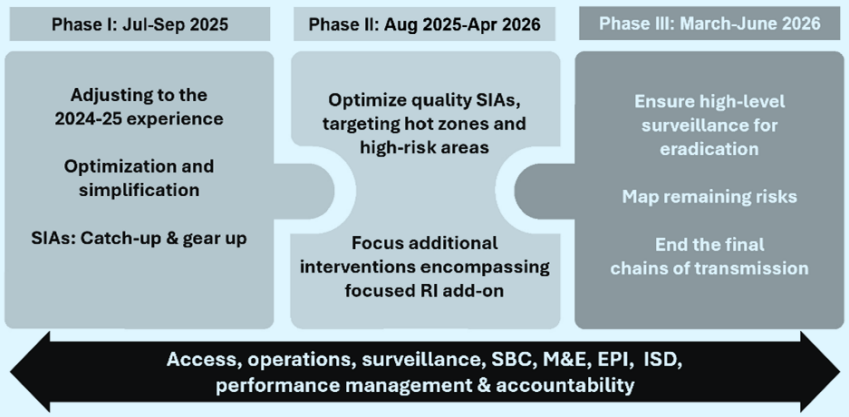
M&E = monitoring and evaluation.

The Roadmap to Zero Polio and subnational planning

To clear a path to eradication, the Pakistan programme developed a 'Roadmap to Zero Polio' with three phases that drive progress toward stopping transmission by mid-2026 (**Fig. 2**).

The roadmap incorporates TAG recommendations, aligns the programme on strategic priorities and targets activities within the subnational geographies that are most critical to success.

Fig. 2: Pakistan's Roadmap to Zero Polio



Source: Pakistan Polio Eradication Initiative.

South KP poses the greatest risk to progress given access constraints and suboptimal campaign quality that contribute to an expanding cohort of susceptible children. In this critical geography**,** the team will implement locally adapted approaches based on programme access in high-risk areas.

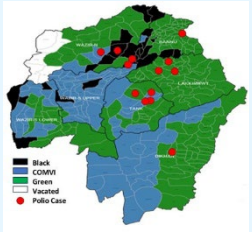
- *For high-risk areas with compromised access,* the programme will assess opportunities to use ComVI (*see right panel*). Integration with nutrition and the delivery of other expanded services will further help to increase demand for vaccines. The programme will also conduct joint planning with EPI to rapidly improve routine immunization coverage.
- *For high-risk areas with full access,* tailored approaches will enhance SIA quality and improve monitoring to resolve the root causes for missed children.

The process for determining whether to use tailored SIAs or ComVI is dynamically driven by changes in the operating environment. It requires constant review and assessment of conditions on the ground to determine which set of programme approaches will be responsive to access, effective in achieving high coverage, and efficient it its use of programme resources.

ComVI: A new approach for inaccessible areas

The community vaccination initiative, or ComVI, is leveraged by engaging local community members to conduct vaccination activities. The selection of community members varies by area to reflect local norms and customs. As a unique approach, ComVI can help to increase community acceptance while also minimizing the need for security. In 2026, the Pakistan programme will explore an independent mechanism to identify areas for ComVI and to monitor delivery where it is in use.

Determining whether to use ComVI or tailored SIAs requires regular review and adjustment, as seen below in the quarterly categorization of South KP Union Councils.



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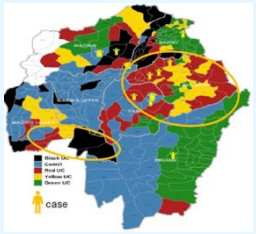


September 2025

In the Karachi block, an independent external field review will guide corrective measures and build confidence in the programme's capability to meet challenges. In areas with persistent transmission, the programme will conduct targeted campaigns with fractional dose administration of the inactivated polio vaccine (fIPV) in older children up to 15 years of age.

Additional planning is also under development for other high-risk areas in Pakistan:

- **In Peshawar and Lahore,** the programme will conduct fIPV campaigns among children up to 15 years of age. Peshawar will additionally focus on quality improvement plans for low-performing areas, strengthened performance management to sustain motivation amid changes to FLW contracts, and the establishment of a FLW hotline to build trust and aid in identifying fake finger marking. Lahore will develop a strategic engagement plan to reach zero-dose children within migrant and mobile populations and build upon joint planning with EPI to strengthen delivery in priority areas.
- **In Quetta block,** recent gains will be sustained through improvements in campaign quality and through strengthening routine immunization. The government has dedicated significant funding to support the implementation of an EPI emergency plan across all four districts of Quetta block and three surrounding districts. Other initiatives include strengthening community listening, increasing the number of female staff and influencers and registering defaulters to reach them between SIAs.
- **In central Pakistan and the border districts,** the programme will continue to improve campaign quality, strengthen monitoring and increase routine immunization coverage, particularly among migrant and mobile populations.

Detailed plans for each subnational area are available in **Annex B**.

Cross-border coordination

As a regional initiative to support both country programmes, cross-border coordination aims to mitigate the heightened risk of poliovirus transmission in the corridors between Afghanistan and Pakistan. Border areas represent a unique risk to WPV1 eradication due to the frequent movement of people, as well as contextual and programmatic challenges that arise in each corridor.

As country programmes develop their SIA schedules, regional offices work with NEOCs to synchronize SIA planning, harmonize timelines and align strategic approaches to local challenges. Priorities for further cross-border coordination include: regular updating of national and provincial frameworks; timely field investigation and information sharing of surveillance data, particularly for orphan viruses; joint mapping; identification of migrant and mobile populations and missed communities; mobilization of religious leaders and influencers in bordering areas to support communication efforts; and general coordination to enhance M&E in the bordering districts.

Cost-efficiency measures

In review of the 2026 budget, the GPEI committed to maintaining a campaign schedule comparable to 2025, which will be needed to interrupt WPV1 in the next 12 months, as stopping endemic transmission in Afghanistan and Pakistan is the most cost-effective way to protect all countries from WPV1. To plan for operating with leaner resources, the country programmes integrated substantial efficiency measures that reduced their budgets to US$90.1M in Afghanistan and $171.6M in Pakistan (**Annex C**).

These efficiency measures include streamlined campaigns and sustained support for essential activities. Surveillance, for example, will be sustained with a minor reduction (2%) achieved through cost-efficiency reviews to guide allocations. Both countries will realize efficiencies through risk-based planning, specifically by preserving cost-intensive, innovative approaches in areas at the highest risk and with the populations most vulnerable to polio. Afghanistan will prioritize continuous vaccination activities among high-risk mobile

populations, social mobilization in high-risk districts, and pluses and water, sanitation and hygiene (WASH) interventions in select areas based on risk assessments. Pakistan will prioritize ComVI in high-risk, inaccessible areas where it can make the greatest impact. Pakistan will also streamline their SIA campaign approach outside of the core reservoirs by reducing the number of campaign days while increasing the daily targets for vaccinators. Technical assistance from WHO and UNICEF will be optimized to align with current needs. Pakistan will also re-evaluate opportunities for further efficiencies in mid-2026 following the low season.

Potential risks and mitigating activities are outlined in **Table 5** below.

Risks and risk mitigation

Table 5. Risks and risk mitigation for Goal One

Risk	Impact	Mitigation approach	Activities
AFGHANISTAN			
Authorities introduce a ban on all vaccination activities	• Children miss vaccinations. • Polio outbreak increases in scale. • High disability and deaths from vaccine-preventable diseases (VPDs).	• Advocate for immediate resumption of vaccinations and for the prioritization of immunization as a health agenda. • Leverage other platforms to reduce vulnerabilities (nutrition, WASH etc.).	• Identify interlocutors. • Map high-risk localities for targeted alternative interventions (health, nutrition, WASH). • Develop pre-emptive messages for tailored audiences to address misinformation / disinformation.
Ineffective implementation of enhanced S2S strategy, particularly in the south	• Critical mass of children miss vaccinations. • Resurgence of polio outbreaks. • Children debilitated, maimed by polio.	• Advocate with provincial authorities for high-quality S2S SIAs. • Conduct proper microplanning, implementation and monitoring of S2S SIAs. • Improve reach and uptake of routine immunization services. • Ensure awareness through effective community engagement (CE).	• Conduct microplanning. • Train FLWs on quality S2S SIAs. • Ensure adequate social mobilization and CE activities prior to campaigns. • Conduct pre-campaign mapping of S2S areas by community health workers (CHWs). • Conduct intra-campaign and post-campaign monitoring. • Engage non-traditional polio partners in the planning, implementation and monitoring of S2S SIAs.
Ineffective implementation of the Strategic Reset due to management issues	• Children will miss vaccinations. • Polio resurgence. • Crippling of children.	• Advocate for access and implementation of plans. • Mobilize resources, including HR. • Develop and share strategies and plans with the authorities in advance. • Regularly scope the environment for potential management bottlenecks (regular SWOT analysis).	• Develop and share costed plans. • Dialogue with stakeholders on action plans to address concerns. • Forecast and procure supplies well in advance. • Conduct transparent FLW recruitment.

CE = community engagement; CHW = community health worker; FLW = frontline worker; HR = human resources; S2S = site-to-site (campaign modality); SIA = supplementary immunization activity; SWOT analysis = Strengths, Weaknesses, Opportunities, Threats (strategic planning tool); VPD = vaccine-preventable disease; WASH = water, sanitation and hygiene.

Table 5 (continued)

Risk	Impact	Mitigation approach	Activities
AFGHANISTAN			
Low-level transmission in the east	• Virus moves to other parts of the country in a widespread outbreak. • Loss of faith in the programme. • Donor fatigue, leading to no funding for the programme.	• Sustained vaccinations in high-risk areas, including fIPV. • Increase age of vaccinations in and around areas of persistent transmission. • Advocate for H2H campaign so that no child is left unvaccinated. • Mobilize resources to sustain efforts. • Raise public awareness and educate on the dangers of sustained transmission and need for vaccinations.	• Re-plan and reprioritize localities for vaccinations. • Develop and review resource mobilization plans. • Improve and sustain the quality of routine immunization services. • Conduct rigorous monitoring of response activities including case response campaigns and intensified routine immunization sessions. • Plan and implement CE and awareness sessions through various platforms.
PAKISTAN			
Continued lack of access in South KP and continued transmission	• Accumulation of a large cohort of unvaccinated children.	• Ensure monitoring is a pre-requisite for any future campaigns using ComVI. • Identify better influencers by using all available sources and applying a gender lens. • Work with Chief Secretary, law enforcement agencies (LEAs) to define milestones for achieving access in inaccessible areas by year-end. • Implement ISD interventions.	• Continue to assess opportunities to implement standard SIAs or ComVI to gain access, expand reach. • Expand existing ISD services. • Tightly link immunization services for polio and EPI with nutrition services for children to create demand.
Inability to sustain the current level of political will	• Weak political ownership.	• Build political commitment to ensure an enabling environment for polio.	• Conduct cross-ministerial provincial task force meetings. • Arrange more than 12 inaugurations.
Lack of political will at subnational level	• Poor quality campaigns leave children vulnerable to polio.	• Conduct post-campaign review, to be chaired by Health Minister or Chief Minister. • Hold public meet-and-greet sessions in every campaign.	• Conduct post-campaign review, chaired by Minister of Health or Chief Minister to review progress, lend support with challenges. • Hold periodic meet-and-greet sessions of the political leadership in different areas of the city.

CE = community engagement; ComVI = community vaccination initiative; EPI = Essential Programme on Immunization; fIPV = fractional-dose inactivated polio vaccine; H2H = house-to-house (campaign modality); ISD = integrated service delivery; LEA = law enforcement agency; SIA = supplementary immunization activity; South KP = south Khyber Pakhtunkhwa.

Accelerating integration through joint planning
in support of Goal One and Goal Two

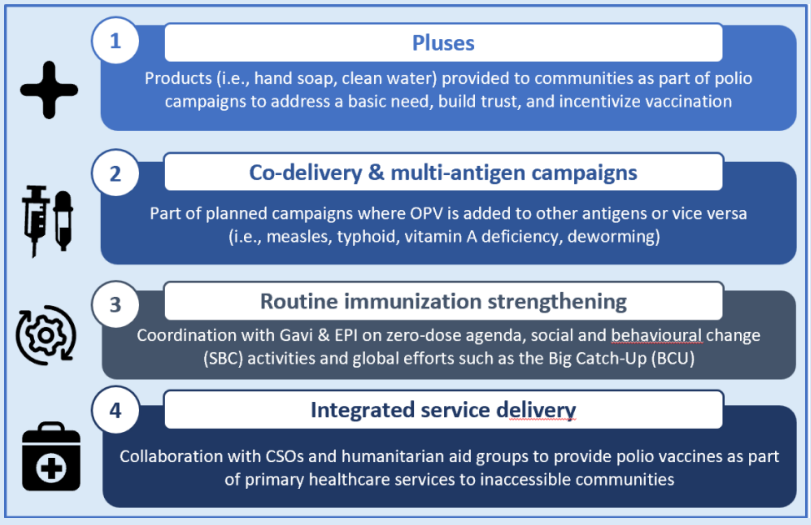
Since its establishment in 2023 as a dedicated programmatic function, integration efforts have aimed to improve polio vaccination coverage and reduce missed opportunities to reach more zero-dose children by delivering polio vaccines alongside expanded services that respond to broader health concerns. The design, development and implementation of integration efforts begin as country programmes and national governments work together to identify government-driven integration priorities that can be leveraged to increase community demand for polio vaccines. While such country-led integration priorities cover a range of activities, they are generally pursued through four areas (**Fig. 3** below).

The GPEI is working closer than ever with Gavi, the Vaccine Alliance, and EPI. The maturity of this collaboration can be seen in the GPEI Action Plan and subnational plans through expanded efforts to improve coverage in routine immunization, plan and implement more integrated outreach, and co-deliver multi-antigen campaigns.

In June 2025, the first ever joint meeting of the Gavi Board and the Polio Oversight Board agreed to further push collaboration across the programmes. At the request of the joint board, the partnerships are working together to improve the targeting and coverage of routine vaccines (bOPV and IPV/hexavalent) in key geographies, and implement a more systematic, comprehensive approach to integration during and outside of campaigns in select geographies of the WHO African and Eastern Mediterranean regions. Gavi has also included a headline indicator on IPV coverage in its measurement framework for Gavi 6.0.

Through this expanded collaboration, the GPEI will play an enhanced role to lead on accelerating routine immunization strengthening in polio-affected countries. GPEI ownership of EPI strengthening will be most critical in areas at the highest risk, particularly major urban centres in south Afghanistan, south KP in Pakistan and Sokoto, Nigeria. Country-level subnational plans will reflect joint polio-EPI collaboration, and operational accountability for the GPEI Action Plan will include routine immunization strengthening as a central pillar for polio eradication.

Fig. 3. Primary areas for integration



BCU = Big Catch-Up; CSO = civil society organizations; EPI = Essential Programme on Immunization; OPV = oral polio vaccine; SBC = social and behavioural change.

Source: GPEI.

Goal Two

Assessment

Since a peak in 2020, the number of children paralyzed by circulating vaccine-derived poliovirus (cVDPV) has reduced significantly (**Annex A: Current epidemiology**).

In 2025, the GPEI invested in bigger responses through robust SIAs and wider NIDs. A shift to regionally-led epidemiological blocks improved campaign operations through joint risk assessments and synchronized response efforts. Improved supply of the novel oral polio vaccine type 2 (nOPV2) enabled the programme to respond at-scale to the most prevalent form of cVDPV (type 2). Strengthened regional lab capacity allowed for more rapid testing and deeper analysis of sequencing results, leading to a better understanding of transmission that then enabled more targeted responses. Integration efforts were also strengthened through more intentional planning and tracking, with more than 40% of 2024 campaigns delivering 'pluses,' other antigens and/or other health interventions.

Tactical shifts implemented for Goal Two under the 2024 strategy extension

- ✓ Deliver faster, bigger campaigns that consistently reach every child.
- ✓ Improve campaign quality through gender and social and behavioural change (SBC).
- ✓ Leverage opportunities for integrated delivery, including multi-antigen campaigns.
- ✓ Strengthen essential immunization through collaboration, including with the Big Catch-Up (BCU) initiative, Gavi.
- ✓ Establish regional action plans.
- ✓ Stabilize oral polio vaccine (OPV) stockpiles.

However, cVDPVs continue to circulate due to shared challenges across countries and regions.

- **Inaccessibility**: Countries with polio outbreaks are often affected by humanitarian crises, conflict or disasters, leading to large-scale displacements, insecurity and access constraints. As a result, historically high routine immunization coverage rates reversed in some geographies, such as Darfur and Gaza. Protracted crises in Somalia, northern Nigeria and northern Yemen continue to limit the programme's ability to implement responses, with vast hard-to-reach areas and large pockets of un- or under-vaccinated children. Inaccessibility remains a challenge despite concerted efforts ranging from negotiation to integrated approaches.

- **Poor quality response**: While responses with two to four large-scale rounds are usually sufficient to stop transmission in most geographies, they are insufficient wherever coverage is low (below the 90% needed to stop circulation) and where children are persistently missed. Response quality can diminish due to a range of challenges: from poor microplanning and a lack of supervision to logistical issues like HR recruitment and payment that create delays in response. Quality improvement initiatives are sometimes needed to address systemic issues. Responses in the most complex geographies also require tailored strategies – and even with preparation, the quality of response may not achieve high coverage. Insufficient campaign quality under these conditions has created reservoirs for the disease, such as in northern Nigeria and Chad.

- **Resource constraints:** From 2021 to 2024, nOPV2 supply constraints led to significant delays and/or reductions in campaign scope which contributed to the spread of the virus in geographies that historically have not been polio reservoirs, such as Ethiopia. While supply has improved dramatically in 2025 with a stockpile now of 200 million doses, the current global health funding outlook presents new risks. Amid declining aid, polio-affected countries may encounter steep challenges in maintaining routine immunization coverage levels (including for bOPV and IPV) and difficulties in prioritizing polio outbreak response. With a 26% reduction in its outbreak budget for 2026 (**Annex C**), the GPEI will also need to mitigate the impact of fewer or smaller campaigns to ensure that the programme's core focus is maintained in the most critical areas.

Plan for 2026

The GPEI is at a critical juncture where it must build upon progress and implement new approaches to stop cVDPVs amid reduced global health funding.

Strategically leveraging resources to maintain progress

In careful analysis of the epidemiology, modelling and programmatic insights to date, and in consideration of funding allocations for 2026, the GPEI has charted a new way forward for Goal Two through a phased approach to cVDPV2 elimination (*see panel at right*). This new approach aims to maintain hard-won gains and sequentially target epidemiological blocks where interventions can generate the highest impact toward stopping all transmission.

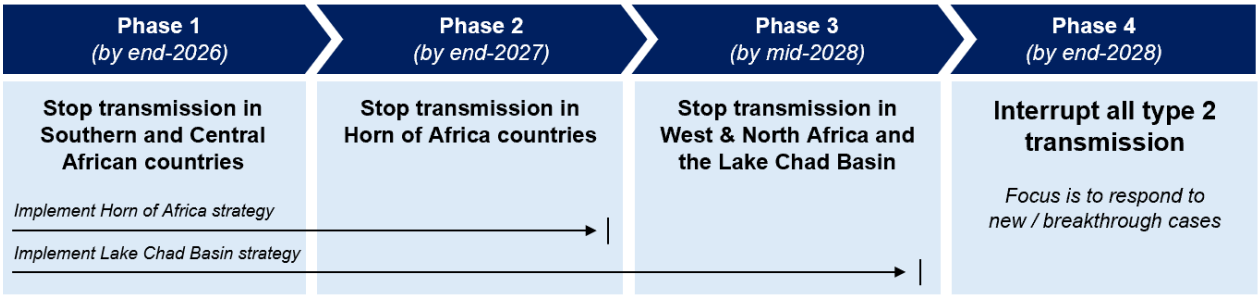
Pillars for phased elimination of cVDPVs*

1. Maintain the gains through active, aggressive responses to any cVDPV detections, including circulating vaccine-derived poliovirus type 1 or 3 (cVDPV1 or cVDPV3), to ensure that certified regions remain polio-free.
2. Stop cVDPV transmission in areas with persistent transmission by sequentially targeting transmission across epidemiological blocks and ensuring circulation is controlled globally.

* The elimination of all three cVDPV types, starting with type 2, is a necessary step toward the eradication of all polio.

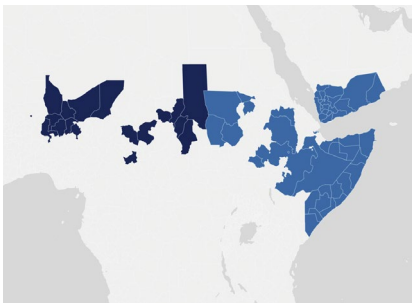
Phased cVDPV2 elimination will proceed through a progressive, intensive focus on epidemiological blocks, one after another, to clear the map of all cVDPVs – starting with Southern and Central Africa (Phase 1), followed by the Horn of Africa (Phase 2) and the Lake Chad Basin (Phase 3), where new approaches will need more time to interrupt the most persistent transmission (**Fig. 4**). This approach will provide a concrete framework by which to assess and monitor progress. It will also help to strategically align resources, with additional funds becoming available for the most challenging geographies as the number of infected countries shrinks. To make the most efficient use of resources, the GPEI will also deploy a mix of cost efficiencies and workforce transformations to enable outbreak response under a reduced budget which will require trade-offs on campaign sequencing and scale. This approach is not without its risks, including the risk of not meeting the milestones for phased elimination. (See **Table 7, p. 21**, for more on risks and risk mitigation.)

Fig. 4. Phased elimination of cVDPV2 transmission



Note: Progress against the timelines will be assessed annually as part of the Action Plan's regular performance monitoring.

Programmatic review, epidemiological analysis and modelling have also shown that the success of a phased approach to cVDPV2 elimination requires dedicated strategies and locally driven solutions within critical geographies where circulation is entrenched and neighbouring areas are at high risk of importation. In addition to high-quality, rapid outbreak response, new vaccination strategies will play a critical role in stopping transmission in these regions. Pre-planned campaigns will allow more time for preparation and enable better integration with other antigens, greater alignment with in-country planning and increased opportunities for cross-border synchronization which has been critical to driving down transmission in 2025. Additionally, in-between round activities (IBRAs) in complex settings with the most persistent transmission will support delivering nOPV2 to populations often missed by regular campaigns, for example through integrated outreach, transit point vaccination or vaccination at health centres.



Dedicated strategies for cVDPV2 elimination

Region	**Lake Chad Basin**	**Horn of Africa**
Core focus	Northern Nigeria	South-central Somalia
Includes	Niger, Chad, West Sudan	Ethiopia, Yemen, East Sudan

Based on country experiences in eliminating WPV1 transmission, the GPEI recognizes that stopping cVDPV2 transmission within the Lake Chad Basin and Horn of Africa will likely require a longer runway and significant funding. These regional areas share common challenges: weak health systems, low routine immunization coverage, inaccessibility, insecurity and large population movement. Despite shared challenges, however, each area requires solutions that meaningfully reflect the local context and that go beyond traditional campaign approaches (**Annex B**).

Dedicated strategies for each block run across all phases of the new approach, with a more significant push to the finish line occurring in 2027 in the Horn of Africa and 2028 in the Lake Chad Basin. These milestones clear the path needed to increase campaign quality, improve routine immunization coverage and overcome access challenges. Furthermore, increases in available funds through a reduction in need from other cleared epidemiological blocks will progressively enable full implementation of activities essential for maintaining population immunity and protecting against exportation.

Making every dollar count

To direct resources toward high-impact, cost-saving initiatives, the GPEI has also identified ways to streamline outbreak response operations (see ***Efficiencies in outbreak contexts***).

These efficiencies will be joined with broad efforts to restructure the field workforce (or surge) and reduce the overall budget space for outbreak response.

Under the 2026 Action Plan, the GPEI will pursue workforce transformations to realign capacities across the global, regional and country levels and create a more agile surge structure. Rosters of international experts will be routinely updated to ensure technical assistance across key areas. In countries with strong capacity, positions will be transitioned to national consultants to build in-country expertise closer to the ground. Across GPEI partner agencies, new flexible contracting modalities and changes to surge duration will help to ensure response efforts are both cost-effective and capable of maintaining the quality of technical assistance. WHO will consider shifting international staff to the remuneration and budgeting framework used for consultants in the Stop Transmission of Polio (STOP) programme, as these individuals provide an equivalent level of in-country expertise. In parallel, both WHO and UNICEF will explore distributing national staff across newly proposed dynamic pay bands to better align compensation with roles and responsibilities. These transformations of the surge workforce are expected to generate ~US$23–26M in savings for the 2026 outbreak response budget.

Efficiencies in outbreak contexts

The GPEI conducted an analysis of over 300 outbreak campaign budgets from 2022 to 2024. This analysis identified 10-15% reductions in outbreak costs that could be achieved while minimizing impact to campaign quality, with the following changes driving the savings:

1. rationalize the daily team target.
2. rationalize the number of supervisor deployment days.
3. rationalize the number of social mobilizer deployment days.
4. rationalize the number of supervisors per level.
5. diversify social mobilizer functions to cover multiple activities and minimize overlap.
6. reduce training frequency when rounds are close and limit training/planning meetings to a single day; and
7. optimize resources by budgeting for the destruction & safe disposal of used vials at the end of all rounds per campaign and limit deployment days for counting / destruction agents.

These efficiencies are expected to generate ~US$30–35M in savings for the 2026 outbreak response budget. To incorporate these efficiency measures, current outbreak budget templates will be updated for 2026.

Close monitoring of surge support will be a critical facet of Goal Two tracking. As part of GPEI Action Plan performance monitoring, quarterly reviews (at minimum) and annual updates will help to identify emerging risks and assess opportunities to maintain progress toward cVDPV2 interruption (see **Annex B**).

Leveraging cost-efficiencies and workforce transformations will help to position the GPEI to operate in a leaner financial environment (**Annex C**). The decline in outbreak response funding, however, will also result in scaled-back operations with a shift from larger-scale NIDs to an increased use of SNIDs. New SOPs are being developed to help guide GPEI's outbreak response efforts in this new context. Fewer campaigns will be implemented in some geographies and slower progress may be seen in some areas, as the GPEI may not be able to respond at-scale to all outbreaks. The GPEI will continue to expand its efforts to encourage countries to fund their own outbreak responses where possible.

Risks related to these shifts and their mitigating activities are detailed below and in **Table 7 (p. 21)**.

Maintaining timely detection

The repercussion of changes to the global health architecture and development aid will be pronounced for field and laboratory surveillance. In response to reductions in support, the programme has taken the difficult decision to make a sharp reduction in the 2026 surveillance budget for outbreak regions (**Annex C**).

To preserve surveillance quality and sensitivity, functions and activities that are crucial for ensuring an effective surveillance system will be maintained. These include laboratory processing, stool kits and samples shipment, limited active surveillance, case investigation, environmental surveillance collection, and surveillance and lab coordinator networks. Other activities, such as more extensive active surveillance, supervision and training, will need to be reduced in lower-risk areas. Additional cost-savings measures, such as reducing the number of coordination meetings, will be pursued as needed.

Updated surveillance guidance

Interim technical guidance will be made available to countries on how to operate polio surveillance systems with more limited funding. Recommendations will include areas for potential savings and approaches to preserve quality, such as changing the frequency of visits for active surveillance or batching some specimens for shipment to reduce costs.

To effectively leverage global resources, new budgetary controls and performance assessments will be used to ensure a measured, equitable and risk-based approach to resource allocation.

- A limited reserve of funds will be established at the global level. This reserve will provide flexibility in responding to unexpected challenges and urgent demands.
- In WHO African and Eastern Mediterranean regions, a 34% budget reduction will be made to the surveillance budget.
    - For 15 countries directly supported by the GPEI, allocations will be determined through a quarterly, country-by-country budget review. Funds will be disbursed following each review.
- Non-GPEI-supported countries—previously funded primarily by donors or through self-financing and occasionally receiving ad hoc GPEI support for field activities—will not receive funding from GPEI. As these countries will need to rely on national resources or support through other programmes moving forward, they face the greatest risk for surveillance gaps that may lead to missed transmission and delayed outbreak response.

To further mitigate risks and inform decision-making around resource allocation, a structured monitoring system will be implemented at the global level through monthly and quarterly tracking of country-level surveillance performance and periodic desk reviews. Regular feedback will be provided to regional offices to support planning efforts and to address any surveillance quality issues that arise. Focused field review

will also be implemented in countries where major gaps in surveillance are suspected. In the African and Eastern Mediterranean regions, the activities affected by the reduction will be monitored to ensure that any major risk is documented and mitigated.

Fig. 5. Surveillance accountability under the GPEI Action Plan

GPEI = Global Polio Eradication Initiative.
Source: GPEI.

By upholding the responsibilities summarized in **Fig. 5** (above), the GPEI will navigate the impact of reduced funding on polio surveillance, ensuring that critical operations are sustained and risks are monitored to preserve a sensitive surveillance system. The polio surveillance programme will continue to collaborate with a range of partners to integrate surveillance activities to ensure the long-term, sustainable transition of polio functions to other health programmes and national health systems. However, it is anticipated that not all risks can be mitigated, with a potential decline in surveillance sensitivity for other VPDs due to a reduction in active surveillance and supportive surveillance. Certain key performance indicators—such as the speed of detection and surveillance sensitivity in non-GPEI supported countries—may be affected over the next 12 to 24 months with a potential delay in timely responses. To limit these effects in the long run, the programme will need to re-invest in formal training and strengthen supervision of surveillance as soon as possible.

Optimizing response to stop transmission

Under the 2026 GPEI Action Plan, country-level planning will be most critical in programmatic areas and subnational geographies with persistent transmission, where achieving interruption is most complex – such as in south-central Somalia and northern Nigeria.

Focused planning for subnational areas

With the support of WHO and UNICEF regional offices, countries have developed subnational plans to target the root causes of persistent cVDPV transmission. These subnational plans, collected in **Annex B**, draw upon a mix of time-tested tools and new interventions. Their aim is to strike a balance of getting the basics right while implementing innovations to more effectively target local barriers to interruption.

Some planned activities represent shifts that will be adopted by many countries. These include:

- expanded, systematic and high-impact IBRAs with nOPV2 administration through health facilities and integrated routine immunization outreach and intensification activities;
- pre-planned campaign schedules that help to expand integration opportunities and support a scale-up of integrated responses with other antigens, especially measles and cholera;
- maximized OPV coverage and coverage with a first and second dose of IPV (IPV1 and IPV2) through strengthened routine immunizations, targeting the highest-risk areas;
- greater cross-border synchronization within and across countries to reach more high-risk mobile and displaced populations; and
- innovative strategies for access-compromised areas that may include integrated services to leverage opportunities to reach more children.

The use of nOPV2 in outbreak response

Consistent with guidance from the Strategic Advisory Group of Experts on Immunization (SAGE), nOPV2 is co-administered with bOPV in areas with co-circulation of cVDPV2 and cVDPV1 or 3. Future recommendations from SAGE and revised SOPs to guide country teams are expected to support nOPV2 delivery in non-campaign settings (see ***Forecast: Expanding nOPV2 use***).

Many activities are rooted in local context and draw on lessons learned to optimize response. **Table 6** highlights examples of key interventions. **Annex B** provides detailed subnational plans that will be assessed quarterly and adjusted as needed.

Table 6. Goal Two primary challenges and examples of interventions

Challenges	Interventions
Inaccessibility and insecurity	• Review, map and engage gatekeepers in insecure settlements to increase access. • Develop innovative plans through bottom-up community engagement. • Collaborate with local NGOs, CSOs, CBOs, humanitarian actors and/or other organizations to negotiate access. • Ensure cooperation across all levels of government through interministerial coordination (administrative, health, education, religious, agriculture, security). • Include polio immunization in an integrated service delivery package to maximize impact. • Identify alternative transport for sample shipment within remote, insecure areas.
Poor-quality response	• Disaggregate data by high-risk areas and populations to drive prioritization and planning. • Adapt dashboards for campaign planning, implementation and monitoring. • Strengthen incident management system leadership to improve accountability. • Digitize the implementation of demand-generation activities to support monitoring. • Hold regular bilateral meetings and joint planning across epidemiological blocks. • Sustain advocacy efforts to ensure polio outbreak response remains a priority.
Resource constraints	• Reduce the scope of campaigns with an overall shift from larger-scale NIDS to targeted, high-quality SNIDs, in careful review of epidemiology. • Implement the cost-saving efficiencies through a modified SIA budget template and transformations in surge processes. • Co-administer bOPV and nOPV2 in areas with co-circulation, including older age groups. • Integrate routine immunization and EPI strengthening with polio activities. • Ensure advocacy at the highest level to increase government funding and accountability. • Simplify the funds release process; monitor the deployment of funds to the lowest level.

bOPV = bivalent oral polio vaccine; CBO = community-based organization; CSO = civil society organization; EPI = Essential Programme on Immunization; NGO = nongovernmental organization; NID = National Immunization Day; nOPV2 = novel oral polio vaccine type 2; SIA = supplementary immunization activity; SNID = Subnational Immunization Day.

A *deeper commitment to community engagement to increase vaccine acceptance*

While community engagement has been a key objective of the GPEI Eradication Strategy, approaches to social and behavioural change (SBC) will take on both new importance and an expanded scope through a commitment to fully integrate SBC into operational planning.

The 2026 GPEI Action Plan recognizes an urgent need to shift away from reactive, campaign-centric models toward more anticipatory, conflict-sensitive and context-driven approaches to SBC. In settings across the Lake Chad Basin and the Horn of Africa, chronic insecurity, protracted conflict, community displacement and fractured health systems severely constrain last-mile delivery. Even in accessible areas, low perceived risk, a lack of trust in health authorities and the prioritization of life-sustaining needs over immunization contribute to vaccine hesitancy and parental refusals. In northern Yemen, a surge in misinformation and anti-vaccine sentiment complicates efforts to build trust and generate demand for vaccination. Broadly, wherever access to caregivers is mediated through power structures, traditional approaches are no longer sufficient – and a reliance on them as part of community engagement often results with entire communities missed.

Gender as a tool in resolving refusals

Designing effective gender-responsive interventions requires a clear understanding of power structures, including cultural norms that are embedded in the larger social dynamics of communities vulnerable to polio. To reach unvaccinated children, a rapid gender analysis can help teams gain greater insight into whether gender creates barriers to vaccination (who decides between mothers and fathers and other members of the families and who oversees taking the children to vaccination). Gender-responsive strategies can increase uptake and generate vaccine demand among local families and communities by:

- empowering more mothers about vaccination;
- increasing the engagement of fathers to take children for vaccination;
- collecting sex-disaggregated data on a regular basis to ensure there is no discrimination between boys and girls on who is vaccinated or who is missed during a campaign;
- ensuring the safety and security of FLWs, especially the female FLWs through regular training and mechanisms to report and redress PRSEAH; and
- advocating for more women to hold leadership positions within polio eradication programmes.

FLW = frontline worker; PRSEAH = preventing and responding to sexual exploitation, abuse and harassment.

New approaches aim to make SBC a frontline strategy, not an add-on. They cover a range of interventions: settlement-level ACSM (advocacy, communication and social mobilization) microplanning, interpersonal communication training for the frontline workforce, sub-district non-compliance resolution teams, and sustained engagement with religious leaders, traditional influencers and grassroots civil society actors. Partnerships with local CSOs and CBOs remain critical to build community ownership and expand reach into insecure or inaccessible areas. New digital tools for these efforts will produce real-time social data that can empower trusted local actors as they engage families in complex and dynamic contexts. Deploying open-source mobile technology, these tools will also help to align polio campaigns with broader humanitarian and social service delivery.

By integrating SBC more deliberately and systematically into the heart of programme operations, the GPEI aims to ensure that, even in the most challenging environments, no child is left behind.

Intensified advocacy to drive country ownership

When implemented effectively, advocacy generates political will, commitment and urgent action on the part of key decision-makers and stakeholders. It drives accountability for activities toward cVDPV interruption, notably timely and effective outbreak response (including cross-border coordination and synchronization), surveillance strengthening and routine immunization efforts that are essential to sustain the hard-won gains of the polio eradication programme.

Under the 2026 GPEI Action Plan, advocacy will be pursued through context-sensitive and adaptive ways:

- In countries where sustained political will for polio outbreak response is lacking, the GPEI will deploy a variety of tactics from country-level closed-door meetings to engagements at regional and global events and platforms. Political advocacy with heads of state and key ministries will help to unblock operational and technical challenges.
- In countries where conflict and insecurity create pockets of vulnerable communities – and distinct challenges for programme delivery – advocacy will be conducted with a range of stakeholders to facilitate access. Polio thrives in these fragile settings, and the GPEI recognizes that bold, innovative approaches are needed to protect communities from polio. Holistic approaches through the delivery of integrated health services that include polio immunization will be key, alongside active engagement with local authorities at all levels, to build the momentum needed for quality response efforts.

Country-level advocacy efforts detailed in **Annex B** include:

- integrated health advocacy through a Governor's Immunization Forum in the Democratic Republic of the Congo (DRC);
- interministerial committee meetings chaired by high-level country leadership in Niger;
- cross-ministerial meetings held quarterly in Somalia, Ethiopia, Djibouti and Kenya; and
- dedicated meetings of WHO, UNICEF representatives with health ministers in northern Yemen.

Such advocacy efforts encourage countries to renew their commitments to eradicating all forms of polio.

Risks and risk mitigation

The shift to phased cVDPV2 elimination comes with risks and trade-offs that will need to be addressed as part of the 2026 GPEI Action Plan (**Table 7**). Some risks are more general but will also require mitigating activities to sustain progress and stop transmission.

Table 7. Risks and risk mitigation for Goal Two

Risk	Impact	Mitigation approach	Activities
Insufficient resources to respond to all outbreaks (either the number of countries or the required scope/scale)	• Longer-term, low-level endemic transmission in some geographies. • Additional countries declare outbreaks. • Increasing numbers of cases.	• Monitor risks and seek efficiencies in outbreak response to maximize the number of detections that can be responded to at-scale.	• Fully implement VfM efficiencies via a new campaign budget template for rollout and enhanced reviews. • Implement new modalities for staff recruitment based on market rates. • Continue resource mobilization efforts.
The quality of outbreak responses is not at the required level to stop transmission in key geographies	• Despite implementing multiple rounds, circulation persists with an increasing potential for exportation.	• Develop targeted subnational plans for areas of persistent transmission to improve campaign performance in core areas.	• Develop and regularly update subnational plans with clear roles and responsibilities. • Conduct an analysis of bottlenecks; develop and implement emergency response plans.
A perceived de-prioritization of outbreak response efforts jeopardizes political momentum and disrupts ongoing efforts as governments juggle competing priorities	• Countries no longer prioritize responding to polio or are no longer willing to financially support responding to polio outbreaks.	• Increase efforts to integrate polio responses with other activities. • Advocate with Member States to mobilize domestic funding to support routine immunization and potential outbreaks through existing emergency mechanisms. • Implement high-level advocacy to increase awareness of risks from not responding to polio outbreaks.	• Leverage integration opportunities for nOPV2 delivery with other antigens through pre-planned campaigns. • Include ISD as a core component of subnational plans. • Continue high-level advocacy missions and include polio in WHO Member State forums (e.g. the World Health Assembly, regional committee meetings)
The GPEI's approach to phased cVDPV2 elimination leads to countries thinking they can 'ease off' polio eradication for now.	• Gains are lost and progress reverses, making timelines unattainable.	• Strong messaging and engagement with national governments on what phased elimination means and the importance of continuing efforts both before and after milestones are met to sustain gains.	• Ensure high-level and technical level engagement with countries in later phases • Develop clear materials and messaging on phased elimination. • Consider incentives for elimination of cVDPV2s ahead of schedule in geographies.

cVDPV2 = circulating vaccine-derived poliovirus type 2; GPEI = Global Polio Eradication Initiative; ISD = integrated service delivery; nOPV2 = novel oral polio vaccine type 2; VfM = Value for Money (project); WHO = World Health Organization.

Table 7 (continued)

Risk	Impact	Mitigation approach	Activities
Increasing conflict and disasters reduce access for polio campaigns in countries	• An inability to respond to detections leads to continued transmission, increasing cases and exportation to neighbouring countries. • This is a particular challenge for the Horn of Africa given inaccessibility in northern Yemen and south-central Somalia.	• Expand the range of polio outbreak response implementation approaches, learning from humanitarian efforts, to enable better access / acceptability of polio outbreak response. • Engage in high-level advocacy efforts and local negotiations to improve access.	• Seek integration opportunities to deliver polio together with other antigens and life-saving services (e.g. HEER in northern Yemen) • Use GPEI partnership to effectively engage in high-level discussions to enable access for vaccination (e.g. Gaza).
A sharp decline in humanitarian assistance contributes to a rise in humanitarian crises	• Polio cases increase as humanitarian crises and other disease outbreaks worsen.	• Identify opportunities to integrate polio and humanitarian efforts, leveraging the funding across both for maximum impact.	• Strengthen coordination and advocacy with on-the-ground humanitarian partners. • Scale-up integration with other public health emergency responses such as cholera and measles.
bOPV & IPV coverage doesn't improve and/or planned hexavalent or IPV2 introductions are delayed	• Rising cases of polio across all types.	• Implementation of the joint GPEI/Gavi workplan to increase IPV/hexavalent and bOPV/nOPV2 rates in geographies key for polio interruption.	• Identify subnational geographies most crucial to interruption. • Conduct joint GPEI/EPI/Gavi activities (e.g. IBRA, integrated outreach) to reach under-immunized and zero-dose children.

bOPV = bivalent oral polio vaccine; EPI = Essential Programme on Immunization; GPEI = Global Polio Eradication Initiative; HEER = Health Emergency and Early Recovery (Yemen plan); IBRA = in-between round activity; IPV = inactivated polio vaccine; IPV2 = second dose of the inactivated polio vaccine; nOPV2 = novel oral polio vaccine type 2.

Special interventions for targeted geographies

To support targeted efforts aimed at resolving the root causes for persistent transmission, the GPEI will set aside funding for special interventions in priority subnational geographies for both WPV1 eradication (Goal One) and cVDPV elimination (Goal Two).

Polio-affected countries are encouraged to propose time-bound, high-impact activities tailored to local context and need. Interventions selected for support may include activities that need greater support to scale up and produce results or pilot projects that explore alternative approaches to programme challenges. Through this effort, the GPEI aims to expand the use of proven approaches and identify new approaches that can be evaluated and rolled out in support of global polio eradication goals.

Many special interventions are planned in some countries (**Annex B**). These include:

- local strategies to address inaccessibility, poor campaign quality and country ownership, such as ComVI in Pakistan and mobile rapid response teams in Sudan;
- use of the nOPV2 outside of campaigns, for example through IBRA activities in Nigeria, border vaccination in Chad and Sudan, and integrated outreach in Somalia and southern Yemen;
- accelerated routine immunization integration initiatives for children under five years of age in collaboration with EPI and Gavi, as proposed in the major urban centres of Helmand and Kandahar (Afghanistan), South KP (Pakistan) and Sokoto (Nigeria);
- fIPV campaigns as planned for Pakistan's Karachi Block, Peshawar and Lahore;
- expanded age range campaigns where the epidemiology points to transmission in older children or where large cohorts of children older than five years of age are under-immunized;
- integrated service delivery that builds on experience, such as in Afghanistan, Pakistan and Somalia; and
- M&E improvements in conflict-affected and inaccessible areas, for example through third-party monitoring.

Process for submission and review

The GPEI will work with country programmes to identify opportunities for introducing special interventions. Proposed activities should be costed and should include an evaluation component. Proposals will be rigorously reviewed to ensure effectiveness and suitability for rollout to other geographies.

Financial response

The GPEI prepared this Action Plan to operate under a historically reduced budget. The budgeting process that assessed the funding requirements for the GPEI Eradication Strategy extension period set out a budget of US$1.1 billion for 2026. However, materially lower contribution assumptions that suggest lower financial support for 2026 and beyond prompted a multi-stepped approach to define a new budget.

To realign to this funding context while mitigating impact, the GPEI leveraged a mix of efficiency measures and targeted reductions to achieve a final budget of **US$786M for 2026** — a reduction of US$314M, or close to 30% when compared to the previously outlined requirements for 2026 (**Annex C**). In collaboration with external technical experts, the GPEI Finance Management Group led the analysis of budget scenarios with the GPEI Strategy Committee. The smaller budget introduces important programmatic risks that are addressed under the Action Plan's ***Operational focus*** (above) for **Goal One** and **Goal Two**.

Value for Money: A drive for efficiencies

In 2025, the GPEI Financial Accountability Committee sponsored a comprehensive *Value for Money* (VfM) project to identify efficiencies that offered the potential to diminish costs without compromising programme quality. The 12-week project included interviews with more than 60 GPEI stakeholders across global, regional and country levels. Lead investigators participated in a rapid review mission to Pakistan, a coordinator retreat in Nigeria and an in-person meeting of the SC. The VfM analysis also drew from desk reviews of strategic and operational materials, programmatic data and GPEI financials, including three years of outbreak campaign budgets. Through this process, the VfM project identified potential cost savings of roughly US$100M based on the feasibility and complexity of specific initiatives.

Building on the VfM assessment, GPEI technical teams evaluated and recommended efficiencies that were adapted to local contexts while maintaining global standards. These country-level adaptations of efficiency measures were then integrated into the 2026 budget. Some of the most impactful VfM efficiencies include:

- in Pakistan, a leaner staffing structure, harmonization of the number of days required for campaigns, and reorganization of WHO and UNICEF field footprints are projected to save ~$38.8M;
- in Afghanistan, a similar approach to campaign planning and operations is expected to generate ~$19.5M in savings; and
- in outbreak settings, the application of VfM parameters—such as rationalized vaccination team targets, streamlined supervisor and social mobilizer deployment and reduced training frequency—is expected to generate ~$30–35M in annual savings. An additional ~$23–26M will be realized through restructured personnel contracts and rightsized non-HR costs.

Savings related to VfM efficiencies may take time to actualize as teams plan for their implementation. Each quarter, the Finance Management Group will report to the Financial Accountability Committee and Strategy Committee on the implementation of VfM recommendations to track efficiencies across the programme and to support accountability of the GPEI Action Plan.

Dynamic budgeting for agility

The GPEI uses dynamic budgeting to optimize resource allocation. Overseen by the Finance Management Group as part of expenditure and variance analyses, dynamic budgeting involves:

- quarterly reviews to identify underutilized budget areas;
- consultations with operational and technical teams to collaborate on reallocation decisions; and
- contingency management where savings from underspent areas are reallocated to a contingency budget line, enabling the Strategy Committee to redirect resources to urgent, underfunded priorities.

In 2024, dynamic budgeting identified US$63.6M in budget savings that were reallocated to areas of need. Given that the GPEI will be operating in 2026 under a historically reduced budget, the potential for budget savings is expected to be lower than in previous years.

Aligning financial resources to end polio

The GPEI Action Plan emphasizes the importance of aligning core contributions (referred to as financial resource requirements, or FRR) and complementary, partner-managed funds (non-FRR) to maximize impact. FRR resources maintain core infrastructure by sustaining essential capacities across WHO and UNICEF, while non-FRR funds provide flexibility to fill critical gaps, drive innovation and adapt to epidemiological shifts. Aligning these two funding streams allows for coordinated planning, avoids duplication and ensures that complementary investments strengthen rather than substitute core functions.

In 2026, the programme will leverage the existing annual non-FRR reporting process through which partners detail their non-FRR investments to ensure that non-FRR investments are aligned with the GPEI's strategic priorities. By systematically reviewing this portfolio alongside FRR allocations, the Strategy Committee and agency partners can reinforce complementarities and prioritize resources to urgent epidemiological and operational needs.

Innovative financing

To adapt to changes within the global health and development landscape – including increased calls for greater country ownership, localized health service delivery and coordinated action among global health initiatives – the GPEI will explore a range of new financing solutions rooted in innovation, sustainability, and shared responsibility.

The GPEI has a longstanding history of developing and implementing innovative financing mechanisms. To identify new financing options within the current environment, the programme established an Innovative Finance Working Group, supported by external expertise. The working group will help to define GPEI's future financing through additional engagement with private and non-traditional donors. Future financing solutions will draw upon diverse financing models, including domestic financing mechanisms, blended finance, impact investments, in-kind contributions and public-private partnerships. The aim will be to link funding to performance, which will require co-designing financing mechanisms with donors and national governments, thereby increasing country ownership and accountability. Recommendations brought forward by the working group will also explore financing mechanisms for potential piloting and/or scale-up to help the GPEI assess the feasibility of solutions for delivering on eradication goals while closing funding gaps.

This is a critical phase of the polio eradication effort, and GPEI's resource mobilization strategy emphasizes the return on investment that extends far beyond polio to include infrastructure and assets that are critical to health service delivery and to stronger, more resilient health systems.

Forecast

As the 2026 GPEI Action Plan is reviewed to set a course for 2027, a clear view on anticipated milestones and activities with a longer horizon will support future planning.

Goal One

In Afghanistan and Pakistan, 2027 planning will be based on a rigorous review of progress achieved by mid-2026, alongside assessments of the broader epidemiological and operational outlook. The GPEI foresees three scenarios that may inform future planning.

- ***Scenario one:*** WPV1 transmission is stopped simultaneously in Afghanistan and Pakistan by June 2026. Under this scenario, from mid-2026 through 2027, focused efforts will be needed to maintain population immunity, with strong surveillance to provide confidence that interruption has been achieved. Certification of WPV1 eradication could be achieved in 2028 based on a flexible period of at least two years of non-detection as defined by the latest guidance of the Global Commission for the Certification of the Eradication of Poliomyelitis (GCC). By 2029, polio efforts would be fully integrated into routine immunization.
- ***Scenario two:*** WPV1 transmission is stopped in all areas of both countries except South KP, Pakistan, and south Afghanistan by June 2026. Under this scenario, the programme will have demonstrated that the current strategy is successful in maintaining high immunity in all areas except the last remaining core reservoirs, but a review of the strategic approach in South KP and South Afghanistan will be needed to address the final barriers to extinguishing all WPV1 transmission. While this review and new strategic approaches or special interventions are underway, a strong surveillance system and high immunity levels will be critical in the rest of the epidemiological block to protect against exportation.
- ***Scenario three:*** Widespread WPV1 transmission continues across Afghanistan and Pakistan. Under this scenario, the programme's long-term gains may be placed at risk. Depending on the scale of continued WPV1 transmission, an independent and comprehensive review and re-evaluation may be needed to define a new strategy to address the social, political and systemic factors contributing to persistent WPV1 transmission.

Goal Two

With the full implementation of the 2025 outbreak campaign calendar, the GPEI expects to see improved population immunity and progress across many geographies in 2026. Under the phased approach to cVDPV2 elimination, stopping transmission in Southern and Central Africa is targeted for end-2026. By mid-2026 significant progress toward this milestone should be clear in the epidemiological data and in delivery of key activities outlined in the subnational plans for DRC (**Annex B**). Based on the planned quarterly performance review, any necessary intensification of response efforts in South and Central Africa will be identified and prioritized. Aligned with country planning, Q3 2026 will also provide an opportunity for review of progress in the other epidemiological blocks, with any necessary shifts in plans and budget requirements factored into planning for 2027.

Across the longer horizon for the GPEI Action Plan, dedicated regional strategies will target stopping cVDPV transmission in the Horn of Africa by end-2027 and in the Lake Chad Basin and West and North Africa by mid-2028. As the GPEI works to interrupt all type 2 transmission by end-2028, efforts will increasingly shift to partnering on routine immunization and building population immunity to help sustain a polio-free world.

As milestones within the GPEI Action Plan will impact the GPEI Eradication Strategy timeline, a plan to revise the strategy timeline and multi-year budget will be developed in review of progress in 2026 and in consultation with the Polio Oversight Board.

Future planning

Additional global-level activities will be critical to successful planning in 2027 and beyond.

Expanding nOPV use

The Polio Research and Analytics Group is currently investigating the use of nOPV2 beyond conventional delivery in outbreak response campaigns to provide countries with expanded options.

A critical tool, nOPV2 is effective in stopping most cVDPV2 outbreaks. However, alternative approaches to stopping outbreaks are needed in geographies with persistent transmission. Expanding nOPV2 use beyond SIAs has the potential to improve population mucosal immunity and increase the likelihood of interrupting transmission.

Expanded use of nOPV2 is intended to provide countries with an additional tool to complement campaigns. This could include continuous and/or opportunistic use of nOPV2 through supplemental interventions such as IBRAs, mobile or outreach platforms, administration at health care centres wherever children present for care, targeted use alongside routine immunization or other integrated services such as nutrition or WASH. Such approaches are already being used with IBRAs in Nigeria and border vaccination in Somalia. This approach is not expected to require label change for the vaccine, but alignment will be sought with policymakers and programme leadership. Revised SOPs will include additional guidance for teams.

Current guidance from the Strategic Advisory Group of Experts on Immunization (SAGE) covers the use of nOPV2 during outbreak response, and a proposal to clarify this position to more specifically include non-campaign use will be considered by SAGE in September 2025. Any future change in nOPV2 policy will be pursued in close coordination and communication with key stakeholders.

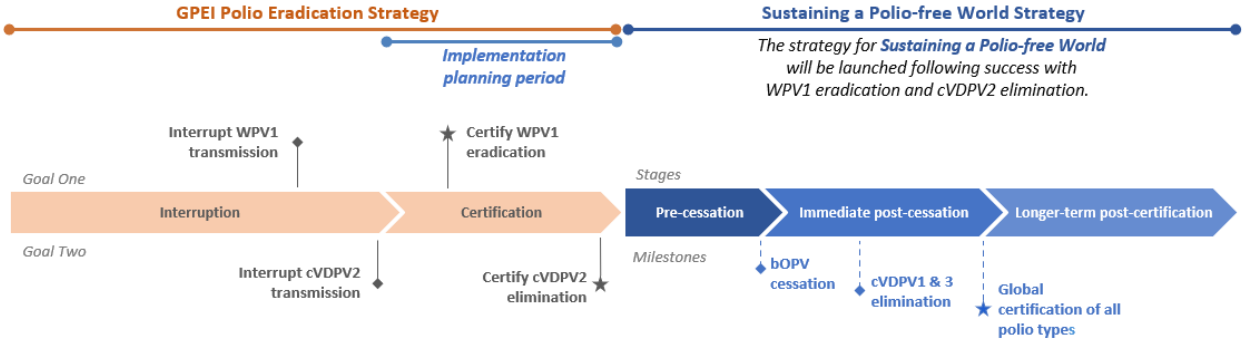
Preparing for a polio-free world

Planning efforts are also underway to lay the groundwork for preserving the gains of the GPEI.

Sustaining a Polio-free World: A strategy for long-term success (SPW) defines the technical standards that will be needed as the functions required to sustain polio eradication become integrated into national health programmes and other health and immunization initiatives. The SPW builds on the GPEI Eradication Strategy: it starts after certification of WPV1 eradication and certification of cVDPV2 elimination and extends for 10 years after the withdrawal of bOPV from routine immunization programmes.

The GPEI envisions a three-year period of overlap between the two strategies (**Fig. 6**). During this time, some global activities related to SPW goals and objectives will already be in progress, notably planning for bOPV cessation and establishing vaccine stockpiles, as well as poliovirus containment activities. Additionally, a high-level phased planning process has been developed so national governments, relevant partners and agencies work together to define how polio-essential functions should be transitioned and who is best positioned for long-term ownership through a well-defined governance structure. The SPW strategy will be presented to the 79th World Health Assembly in May 2026.

Fig. 6. The GPEI Polio Eradication Strategy and the strategy for Sustaining a Polio-free World



cVDPV1 = circulating vaccine-derived poliovirus type 1; cVDPV2 = circulating vaccine-derived poliovirus type 2; cVDPV3 = circulating vaccine-derived poliovirus type 3; WPV1 = wild poliovirus type 1.

The work of transitioning polio-essential functions to national governments ownership has already begun in many countries and regions, initially guided by the Strategic Action Plan on Polio Transition (2018–2023) and now continuing under the Polio Transition Strategic Framework. The Framework provides a flexible, risk-based approach for transitioning polio-essential functions from GPEI to national ownership, facilitated by WHO in collaboration with key stakeholders. It comprises a Global Vision, Regional Strategic Plans, country action plans and an M&E framework. The latter includes indicators to measure both health system performance related to polio-essential functions and the progress and readiness of countries in the transition process.

Polio transition aims to support countries to build strong, resilient and equitable health systems, with a focus on ensuring that countries are well-prepared to take on full responsibility for sustaining polio-essential functions in longevity. Not all countries, however, will be ready to do so in the short- to medium-term, particularly fragile and conflict-affected countries. In these contexts, longer-term support is likely to be required into the SPW era to ensure that polio eradication gains are not reversed.

The transition workstream is becoming increasingly vital as the GPEI focuses limited resources on the last remaining geographies with transmission. During 2026, work by national governments to fully integrate and take ownership of polio-essential functions is expected to accelerate as outbreaks are closed and countries move towards sustaining the gains of polio eradication.

Operational accountability

The GPEI Action Plan provides a whole-of-programme view of annual operational plans in key subnational geographies (**Annex B**). Performance monitoring for the Action Plan will thus focus on the delivery of these subnational plans, their expected outcomes and progress over the coming year.

The GPEI already employs a range of mechanisms that form a pillar of accountability for programme oversight and performance management (**Fig. 7**, next page).

To effectively monitor performance of the GPEI Action Plan, the programme will utilize these existing mechanisms – and strengthen them, where necessary. Performance management challenges within the GPEI are often related to delayed course corrections to underlying issues, particularly through missed opportunities to escalate issues for resolution. Operational accountability within the GPEI Action Plan will seek to address this weakness by clarifying and reinforcing accountabilities at all levels of the partnership and across agencies, as performance management is dependent on the effective use of agency management and reporting structures.

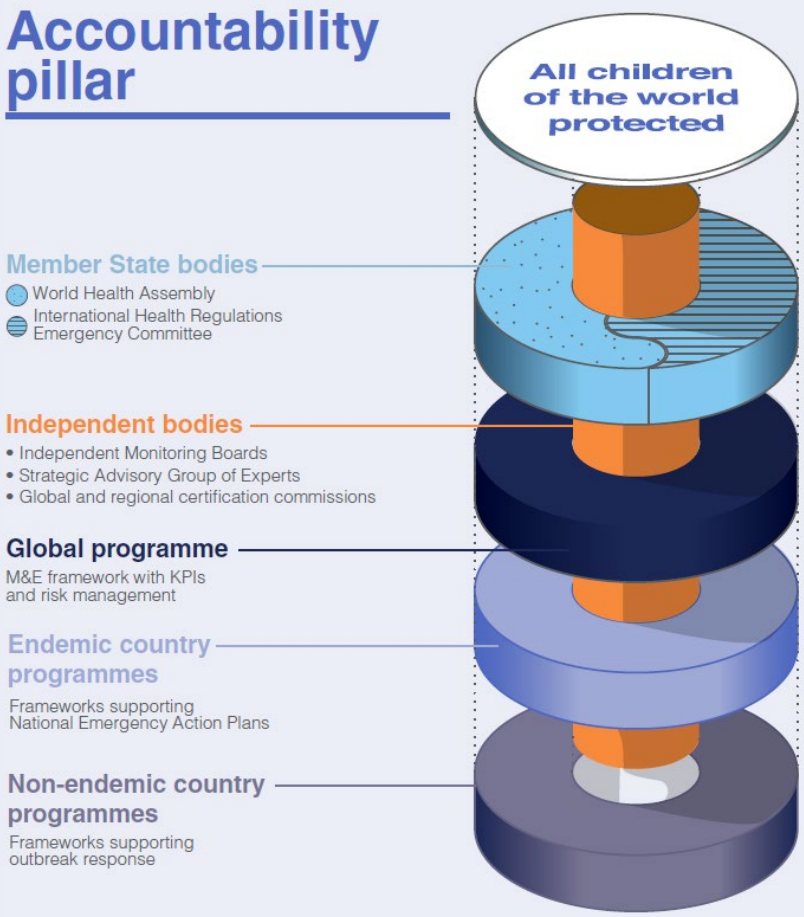
Levels of performance monitoring

- The first line of performance monitoring will draw upon mechanisms that exist at the national and subnational levels, with additional support to enhance these national mechanisms provided, where necessary. National and subnational performance monitoring will be complemented by independent advisory bodies that fulfill a core function for GPEI accountability. Such bodies include the TAGs and Expert Review Committees (ERCs).
- Second-level monitoring will take place at the regional level through regular engagement by the Regional Operations Groups with country operations teams.
- The Outbreak Response and Preparedness Group will provide a third level of review that will include the semi-annual regional ‘deep dive’ programme review meetings, which provide an opportunity for engagement between countries and regional and global partners with in-depth discussion to resolve intractable problems.
- The GPEI Strategy Committee will track progress of the GPEI Action Plan on a quarterly basis to ensure the Outbreak Response and Preparedness Group, Regional Operations Groups and country teams are held accountable for programme delivery. Furthermore, in-country missions of the Strategy Committee will help to reinforce oversight and accountability and to improve programme delivery in geographies that are off track. Past missions have provided an important view on progress by senior leadership that can help to overcome blockages at the national and regional levels. National and regional partners will continue to play an important role in identifying where and when these missions can benefit and improve programme implementation.

Upholding operational accountability for success

The success of the GPEI Action Plan relies upon strong operational accountability over the subnational plans that identify local challenges and propose mitigations with clear responsibilities and timelines (**Annex B**). These subnational plans will be supported through the GPEI's pillar of accountability to ensure that planned actions are executed on time and with impact and that any underlying issues, barriers or bottlenecks are quickly resolved or escalated for resolution. Key performance indicators (KPIs) will continue to be leveraged to measure overall progress toward eradication milestones.

Fig. 7. Accountability pillar for the GPEI Eradication Strategy



KPI = key performance indicator; M&E = monitoring and evaluation.
Source: WHO.

Global: Responsible for allocating resources to support implementation of national / subnational plans and holding regions accountable for delivery of the GPEI Action Plan outcomes and progress towards eradication milestones. Held accountable by Member State bodies, including the World Health Assembly, and by independent oversight bodies, such as the Independent Monitoring Board.

Regional: Responsible for supporting country-led planning and holding countries accountable for progress on national and subnational plan implementation. Responsible for escalating implementation barriers that require global action.

Country: Responsible for developing and implementing national and subnational plans to achieve interruption. Responsible for identifying, resolving and escalating barriers to effective implementation. Accountable for overall national implementation and oversight of subnational plans to ensure timely and effective implementation. Responsible for escalating barriers that require regional or global action.

Operational accountability is complemented by strategic accountability to assess how subnational, national, regional and global planning and implementation contribute to the broader goals outlined in the GPEI Eradication Strategy. As flexible, transparent and well-coordinated efforts across the partnership are supported by robust accountability, the GPEI can deliver an historic victory that strengthens global health security while protecting children everywhere and securing a polio-free world for generations to come.

Annexes

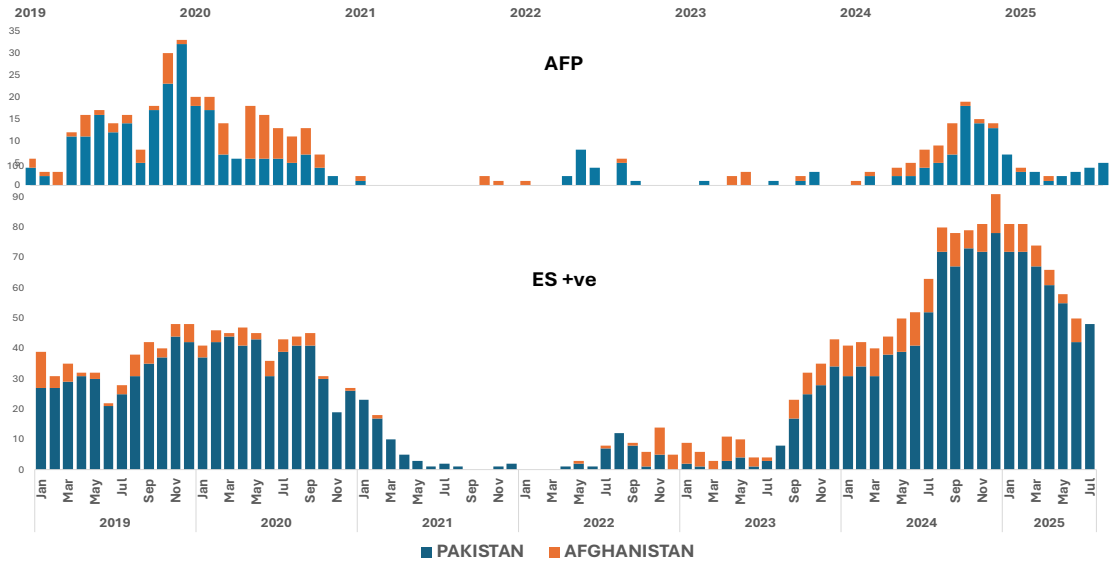
Annex A. Current epidemiology

Goal One

Low-level transmission of wild poliovirus type 1 (WPV1) was seen in the endemic countries from 2021 to 2023 with an increase in cases after the end of the 2024 low season (**Fig. A1**). An increase in environmental detections since 2023 (which appear at a higher rate than previous periods of WPV1 circulation) can be partly attributed to an expansion of wastewater surveillance in September 2023.

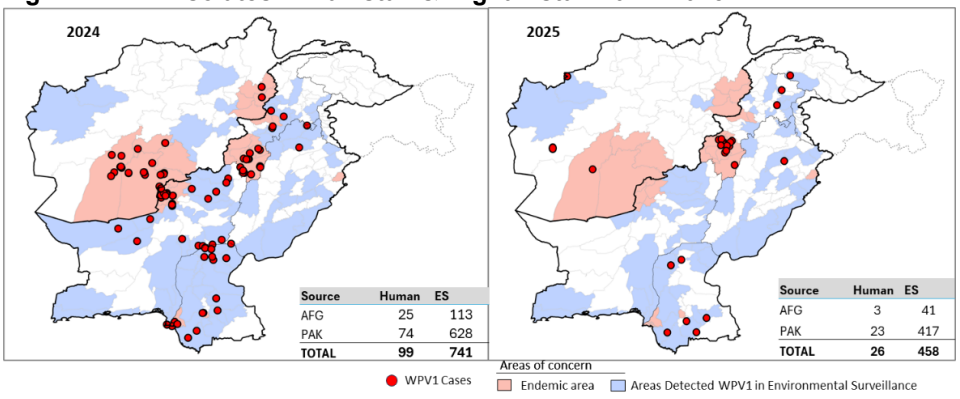
As of 31 August 2025, Pakistan reported 24 WPV1 cases in 2025 and 417 WPV1 positive environmental samples. WPV1 has been detected in either human or environmental samples in 79 of 159 districts. During the same time period, Afghanistan reported four WPV1 cases in 2025 and 41 WPV1 positive environmental samples from ten provinces.

Fig. A1. WPV1 AFP cases and positive samples in Pakistan and Afghanistan since 2019



AFP = acute flaccid paralysis; ES+ve = positive environmental sample.
Note: 2025 data are current as of 31 August 2025.

Fig. A2. WPV1 isolates in Pakistan & Afghanistan 2024–2025



ES = environmental surveillance; WPV1 = wild poliovirus type 1.
Note: 2025 data are current as of 31 August 2025.

Fig. A2 (above) maps WPV1 transmission in both countries. WPV1 is actively circulating in Afghanistan's Kandahar and Helmand provinces with low-level circulation in the eastern region and sporadic detections in the west and central regions. Several provinces in Pakistan also have active circulation of WPV1. South Khyber Pakhtunkhwa (South KP) has the highest number of transmission chains (7) in 2025 to date, with one chain shared across the neighbouring area of Zhob Division in Balochistan. Quetta block has five (5) different chains of continued transmission. Transmission in the Karachi block continues, which points to persistent immunity gaps in this area. The Peshawar block has the lowest frequency of WPV1 detections and the least intensity of transmission.

Review of cross-border detections reflect ongoing active circulation in the southern corridor that connects south Afghanistan and Quetta block, Pakistan. Transmission in the northern corridor that connects Peshawar block, Pakistan, and eastern Afghanistan has slowed down, with a significant reduction in the frequency of WPV1 detections; however, the risk of cross-border transmission in this corridor remains high. Epidemiological data underscores a need for cross-border coordination between Afghanistan and Pakistan.

Epidemiological categorization of districts

The categorization of districts and provinces for Pakistan and Afghanistan was updated during the February and June meetings of the Technical Advisory Group (TAG) (**Table A1** and **Table A2**). Lahore was added under the endemic transmission category for having sustained virus transmission for more than 12 months. Six districts in Pakistan came off the list of re-established transmission in June 2025: Kohat, Zhob, Dukki, Killa Saifullah, Rawalpindi and Islamabad.

Table A1. Districts with endemic and re-established WPV1 transmission

Country	Province / region	Endemic transmission (>12 months) 2025	Re-established transmission (6-12 months) 2025
Pakistan	Khyber Pakhtunkhwa	Peshawar	Lakki Marwat
			Tank
			Dera Ismail Khan
			Bannu
	Sindh	Karachi districts	Mirpur Khas
		Hyderabad	Kambar
			Jacobabad
		Quetta	Usta Muhammad
	Balochistan	Chaman	Dera Bugti
		Pishin	Loralai
		Killa Abdullah	
	Punjab	Lahore	Dera Ghazi Khan
Afghanistan	East region	Nangarhar	Laghman
		Kunar	
	South region	Kandahar and Helmand	

WPV1 = wild poliovirus type 1.

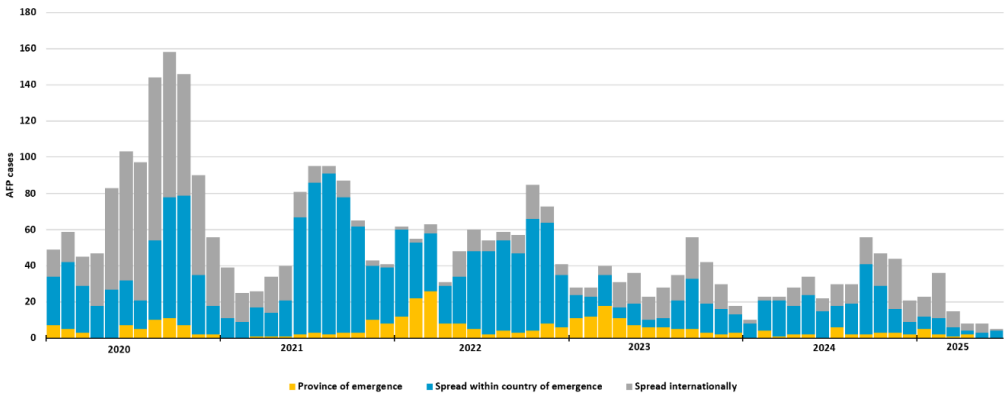
Table A2. Prioritization of provinces and districts, Afghanistan and Pakistan, 2025

Priority	Afghanistan (region/province)	Pakistan (province/district)
Priority 1	South (Kandahar, Helmand and Nangarhar)	South Khyber Pakhtunkhwa
Priority 2	Rest of South and East	Karachi, Quetta Block, Peshawar & Lahore
Priority 3	Southeast, Northeast & West regions and Kabul City	Central Pakistan, Bordering districts
Priority 4	Rest of the country	Rest of the country

Goal Two

Overall, cases of circulating vaccine-derived poliovirus type 2 (cVDPV2) have shown a downward trend since 2020 (**Fig. A3**). Currently, the Lake Chad Basin and Horn of Africa are driving cVDPV2 transmission. A backlog of samples from northern Yemen, where shipments were blocked for nine months, has resulted in an increase in reported cases: 448 (2024) compared to 395 (2023). Wastewater surveillance in multiple countries of the WHO European Region (Finland, Germany, Poland, UK, Spain) detected cVDPVs linked to the genetic strain circulating in Nigeria and the broader West African region.

Fig. A3. cVDPV2 cases by area of emergence, 2020–2025



cVDPV2 = circulating vaccine-derived poliovirus type 2.
Note: 2025 data are current as of 31 August 2025.

Fig. A4 and **Fig. A5** present the geographical spread of cVDPVs, primarily cVDPV2.

Fig. A4. Provinces and districts with cVDPVs, 2020–2025

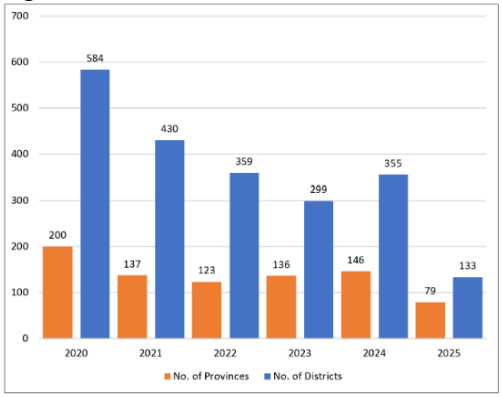
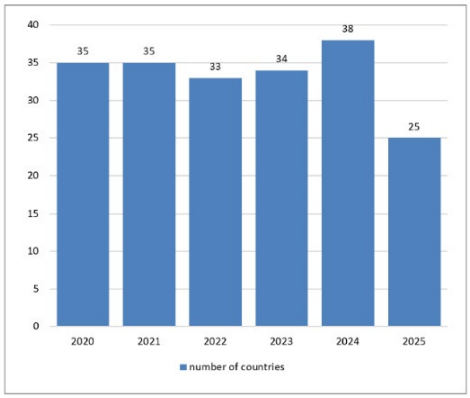


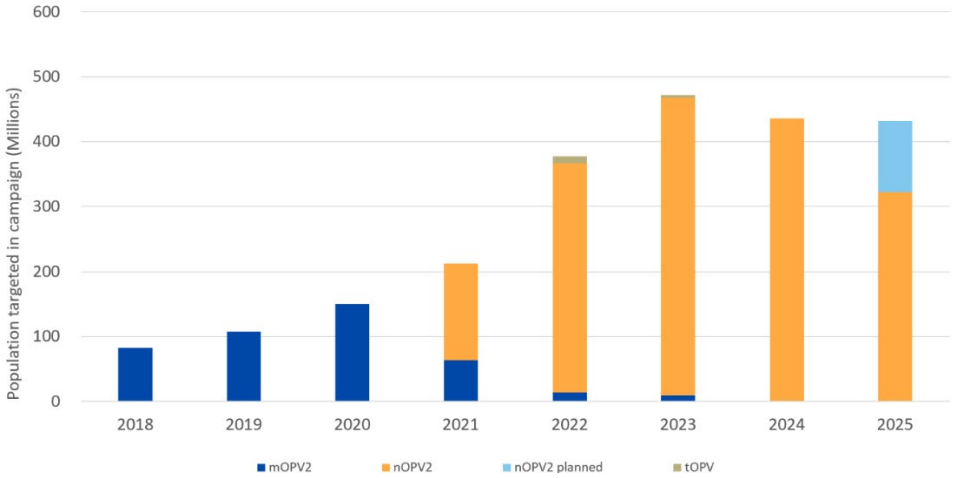
Fig. A5. Countries with cVDPVs, 2020–2025



cVDPV = circulating vaccine-derived poliovirus.
Note: 2025 data are current as of 31 August 2025.

Since its rollout in 2021, the GPEI has administered almost two billion doses of the novel oral polio vaccine type 2 (nOPV2) (**Fig. A6**).

Fig. A6. Size of campaigns and type 2 vaccine utilized in non-endemic outbreak response



mOPV2 = monovalent oral polio vaccine type 2; nOPV2 = novel oral polio vaccine type 2; tOPV = trivalent oral polio vaccine.
Note: 2025 data are current as of 31 August 2025.

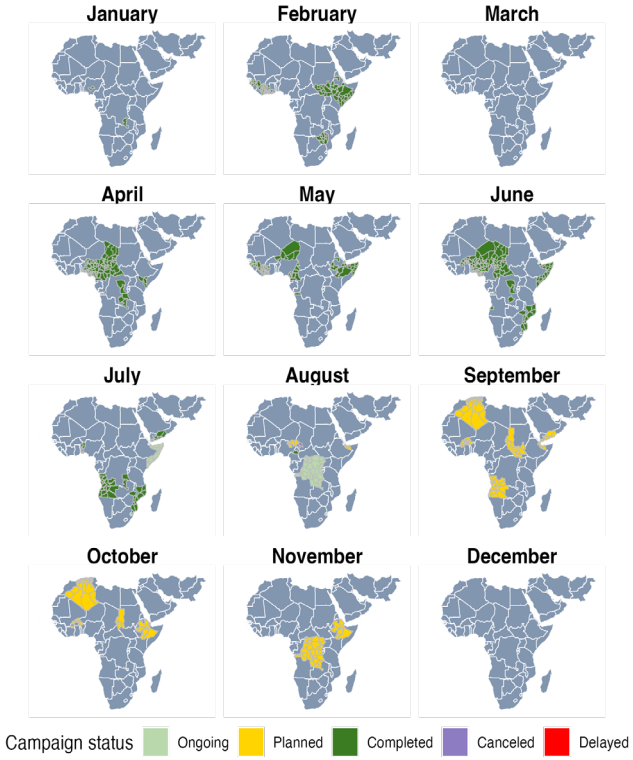
A summary of approved campaigns for 2025 is provided (**Table A3**) with an update on status (**Fig. A7**).

Table A3. Approved campaigns by month, 2025

Month	Countries
January	DRC, Nigeria
February	Cote d'Ivoire, Ethiopia, Ghana, Guinea, Kenya, OPT, Somalia, South Sudan, Zimbabwe
March	No campaigns planned.
April	Cameroon, CAR, Chad, Djibouti, DRC, Kenya, Nigeria, OPT
May	Cameroon, Cote d'Ivoire, Djibouti, DRC, Ethiopia, Guinea, Niger, Somalia
June	Angola, Benin, Burkina Faso, CAR, Chad, DRC, Mozambique, Niger, Nigeria, Somalia
July	Angola, Benin, DRC, Mozambique, Somalia, Yemen
August	Cameroon, Chad, DRC, Nigeria, Papua New Guinea, Somalia
September	Algeria, Angola, Burkina Faso, Djibouti, Papua New Guinea, Somalia, South Sudan, Sudan, Yemen
October	Algeria, Burkina Faso, Djibouti, Ethiopia, Sudan
November	DRC, Ethiopia
December	No campaigns planned.

CAR = Central African Republic; DRC = Democratic Republic of the Congo; OPT = Occupied Palestinian territory.

Fig. A7. Campaign status, 2025



Continued low-level coverage of a first dose of inactivated polio vaccine (IPV1) persists in the countries most critical to stopping polio transmission (**Fig. A8**). Furthermore, 22 countries do not have a second dose of IPV (IPV2) in their routine immunization schedules (**Fig. A9**). Due to low routine immunization coverage, one case of circulating vaccine-derived poliovirus type 1 (cVDPV1) has been reported in 2025 in DRC, with environment sample detections in Djibouti and Isreal. Four cases of circulating vaccine-derived poliovirus type 3 (cVDPV3) have been reported in 2025 in Guinea, Cameroon and Chad.

Fig. A8. WHO/UNICEF estimates of national immunization coverage for the inactivated polio-containing vaccine, 1st dose (2024)

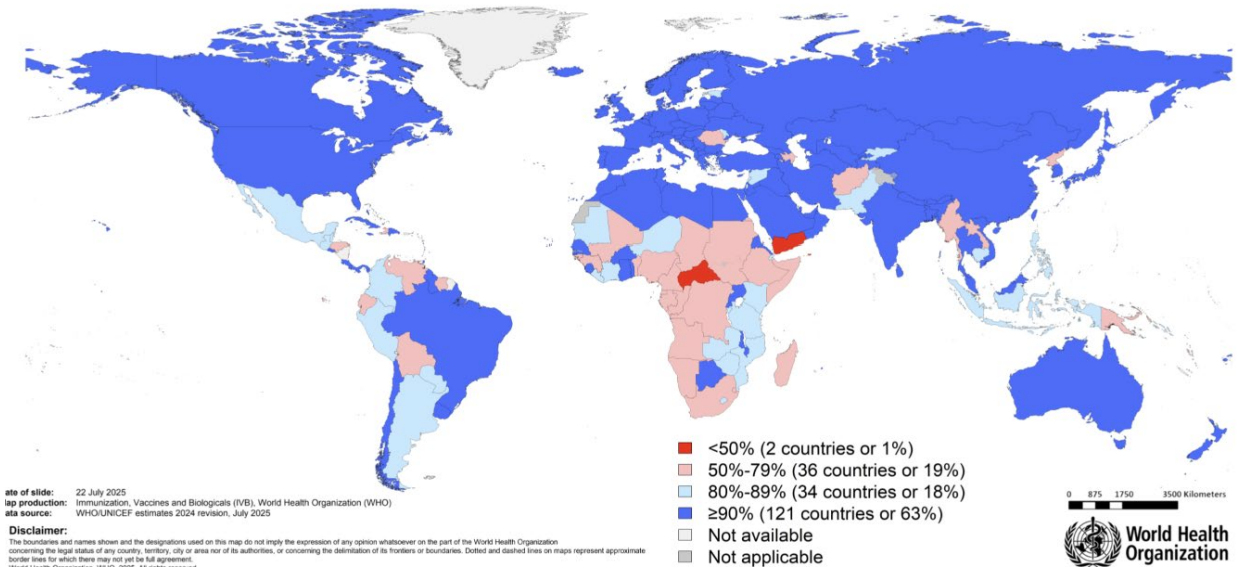
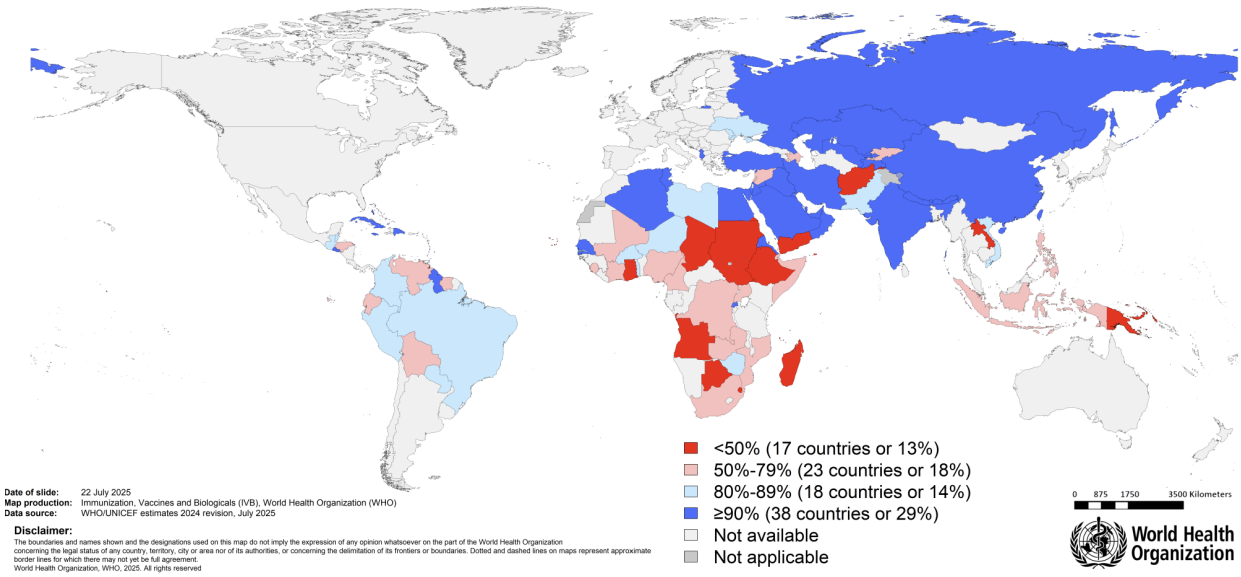


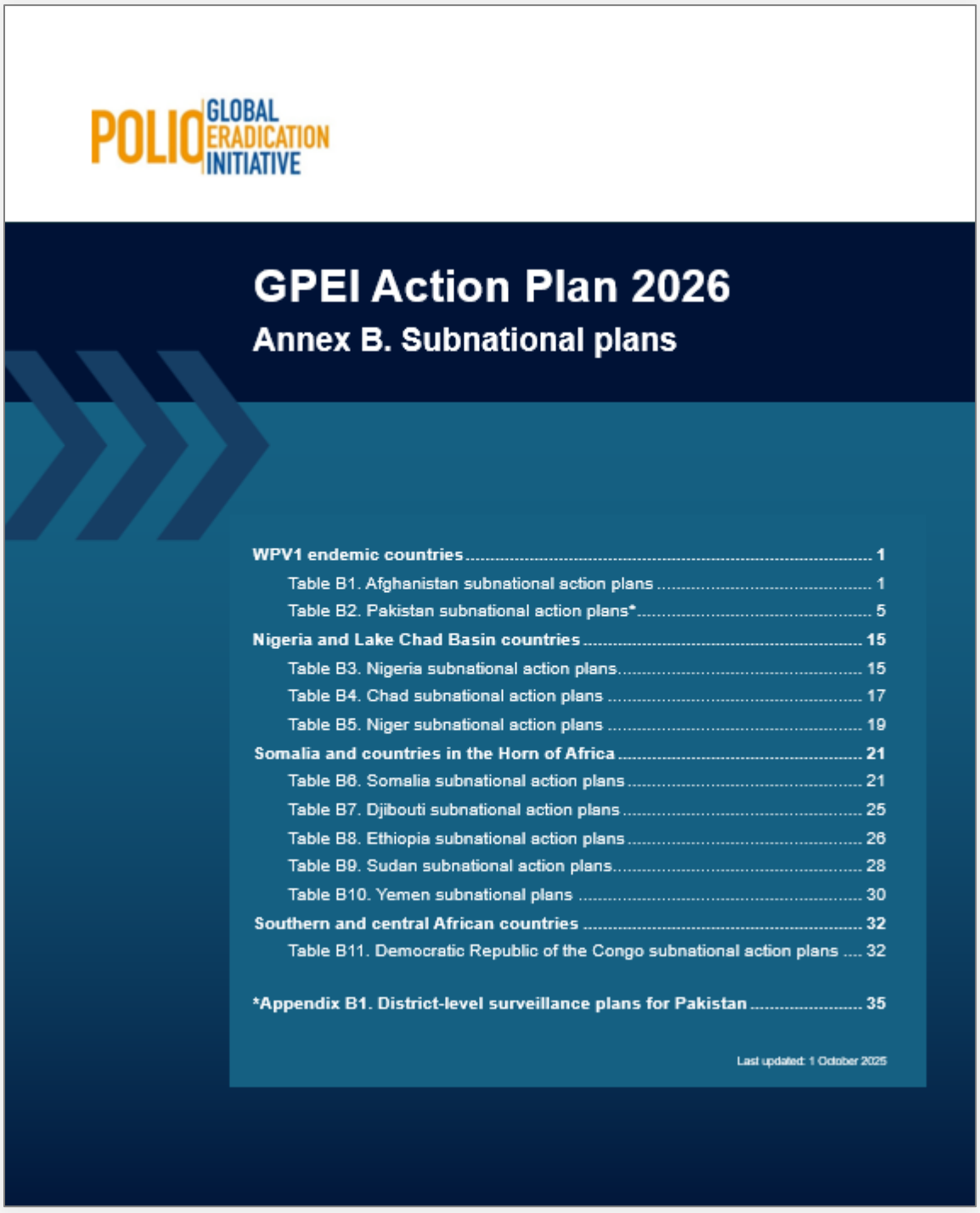
Fig. A9. WHO/UNICEF estimates of national immunization coverage for the inactivated polio-containing vaccine, 2nd dose (2024)



Note: 2025 data are current as of 31 August 2025.

Annex B. Subnational plans

Subnational plans have been published as a separate document on the GPEI website.



POLIO GLOBAL ERADICATION INITIATIVE

GPEI Action Plan 2026

Annex B. Subnational plans

Last updated: 1 October 2025

Annex C. GPEI 2026 budget

The 2026 budget for the Global Polio Eradication Initiative (GPEI) reflects financial resource requirements (FRR) funding for core infrastructure and essential capacities across the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) (**Table C1**). Some management lines, such as research, are additionally resourced through complementary partner-managed funds referred to as non-financial resource requirements, or non-FRR.

Table C1. GPEI 2026 budget and variance analysis

Management lines		2025 budget	2026 budget	Variance from 2025	% reduction
Endemic countries	Afghanistan	$ 109,679,000	$ 90,132,000	$ -19,547,000	-18%
	Pakistan	$ 210,516,000	$ 171,672,000	$ -38,844,000	-18%
Outbreak response*		$ 408,000,000	$ 300,000,000	$ -108,000,000	-26%
Vaccine supply**		$ 124,000,000	$ 70,000,000	$ -54,000,000	-44%
Non-endemic surveillance		$ 98,555,000	$ 64,753,000	$ -33,802,000	-34%
Non-endemic core functions		$ 40,245,000	$ 27,345,000	$ -12,900,000	-32%
Certification		$ 900,000	$ 536,000	$ -364,000	-40%
Containment		$ 2,000,000	$ 1,192,000	$ -808,000	
Research		$ 4,225,000	$ 2,518,000	$ -1,707,000	
Gender		$ 4,366,000	$ 2,620,000	$ -1,746,000	
Population immunity boosting†		$ 30,874,000	$ -	$ -30,874,000	-100%
Special interventions in targeted geographies		$	$ 1,500,000	$ 1,500,000	
Indirect cost		$ 76,879,000	$ 54,188,000	$ -22,691,000	-30%
TOTAL		$ 1,110,239,000	$ 786,456,000	$ -323,783,000	-29%

Note: The budget analysis in the GPEI Action Plan reflects allocated budget space and not funded budget lines. When the 2025 funded budget is considered, some reductions have a different degree of variance.

* The funded budget for outbreak response was increased in mid-2025 to US$ 438M, which suggests a slightly larger variance (31%) when compared to the 2026 allocated budget space.

** The allocated budget for vaccine supply reflects the impact of reduced outbreak response campaign planning. While the 2026 budget space looks like a steep reduction, vaccine supply is healthy due to past investments that supported an nOPV2 buffer of 200 million doses and will fully cover anticipated needs in 2026 and half of 2027.

† In previous budgets (including 2025), the GPEI costed management lines based on the technical requirements for all activities. Consequently, some areas (such as preventative campaigns) were included in the budget but were never funded due to resource-driven prioritizations. For 2026, the GPEI has outlined an operational budget aligned to resources. Due to this change of approach, preventative campaigns under 'population immunity boosting' are no longer listed under a nominal budget space.

References

Global Polio Eradication Initiative (GPEI) strategy and other global resources

- GPEI Polio Eradication Strategy 2022–2026: delivering on a promise
- GPEI Polio Eradication Strategy 2022–2026: delivering on a promise, extension to 2029
- GPEI Global Polio Surveillance Action Plan 2025–2026
- GPEI Standard Operating Procedures for responding to a poliovirus event or outbreak
- GPEI Strategy for Global Poliovirus Containment
- GPEI Gender Equality Strategy
- GPEI Multi-Year Budget Explainer 2022–2029

Regional resources

- The road to zero polio in Africa: Polio eradication action plan for the WHO African Region, 2024–2025