Joint Meeting of the Gavi Board and GPEI Polio Oversight Board

Strengthening collaboration and commitment to reach zero-dose children, eradicate polio and sustain a polio-free world

19 June 2025

Polio vaccination, Pakistan
Credit: Gavi/2023/Asad Zaidi

Introduction

Agenda for today's meeting

Topic	Lead	Time
Introduction	• Prof José Manuel Barroso, *Chair, Gavi Board* • Dr Chris Elias, *Chair, Polio Oversight Board*	5 min
Progress on our shared goals	• Dr Jamal Ahmed, *Director, Polio Eradication, WHO* • An Vermeersch, *Chief Vaccine Programmes and Markets Officer, Gavi Secretariat*	15 min
Opportunities for enhanced collaboration	• Dr Kate O'Brien, *Director, Department of Immunization, Vaccines and Biologicals, WHO* • Steven Lauwerier, *Director, Polio Eradication, UNICEF*	15 min
Commitment and accountability	• Dr Ephrem Tekle Lemango, *Associate Director, Immunization, UNICEF*	5 min
Country interventions	• *Nigeria Ministry of Health and Social Welfare* • *Pakistan Ministry of National Health Services, Regulation & Coordination*	15 min
Discussion – Q&A		60 min
Closing and next steps	• Prof José Manuel Barroso, *Chair, Gavi Board* • Dr Chris Elias, *Chair, Polio Oversight Board*	5 min

Vaccine champion Uwase Rose Uwajeneza, Kigali, Rwanda Gavi/2023/Isaac Rudakubana

POLIO GLOBAL ERADICATION INITIATIVE

Gavi The Vaccine Alliance

Progress on our shared goals

The Global Polio Eradication Initiative (GPEI) launched in 1988

GPEI is a public-private partnership led by national governments with **six core partners** with the goal to eradicate polio worldwide

World Health Organization

Rotary

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

unicef

Gates Foundation

Gavi The Vaccine Alliance

GPEI's Operating Model

Funding Cycle

- Raises funds on a **continuous basis**
- Target of raising US$6.9bn for **current strategy, covering 2022-2029**

Allocation Cycle

- Annual funding cycle within a multi-year budget framework
- Quarterly performance adjustments made to remain agile

2024 by the numbers

926 MILLION USD spent

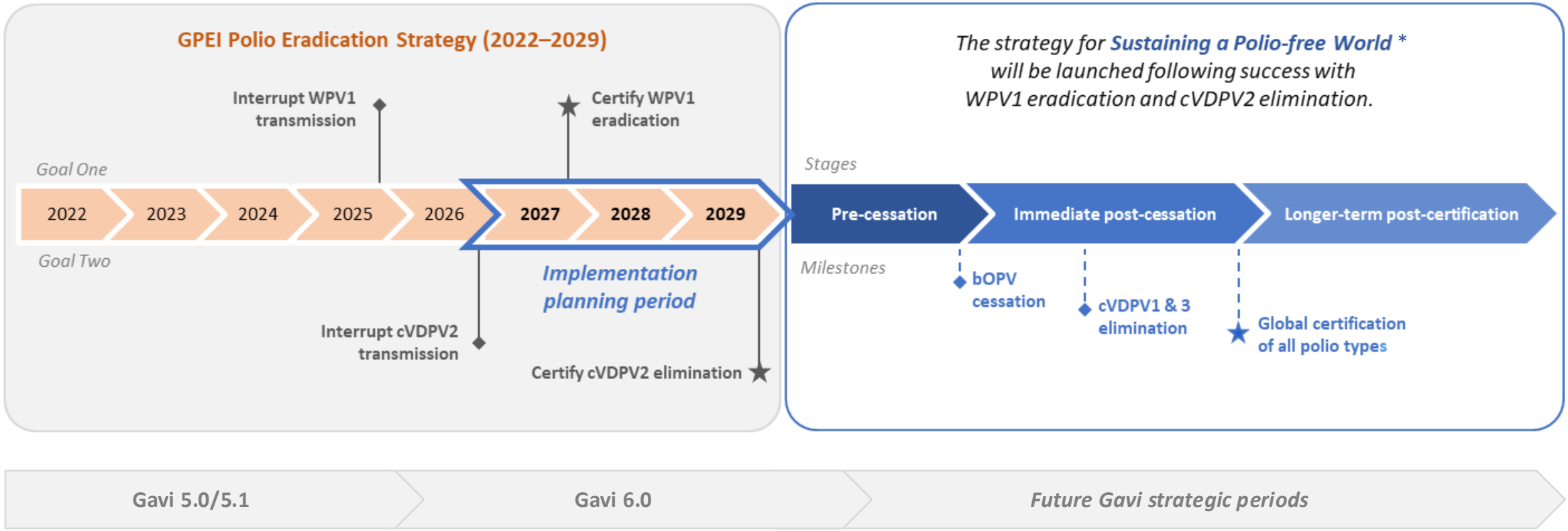
129 campaigns conducted

912 MILLION vaccinations

Source: GPEI website; GPEI 2024 KPIs

We face increased urgency to reach and sustain eradication

Key milestones remain to achieve our goals amidst funding constraints and persistent challenges



Gavi 5.0/5.1 | Gavi 6.0 | *Future Gavi strategic periods*

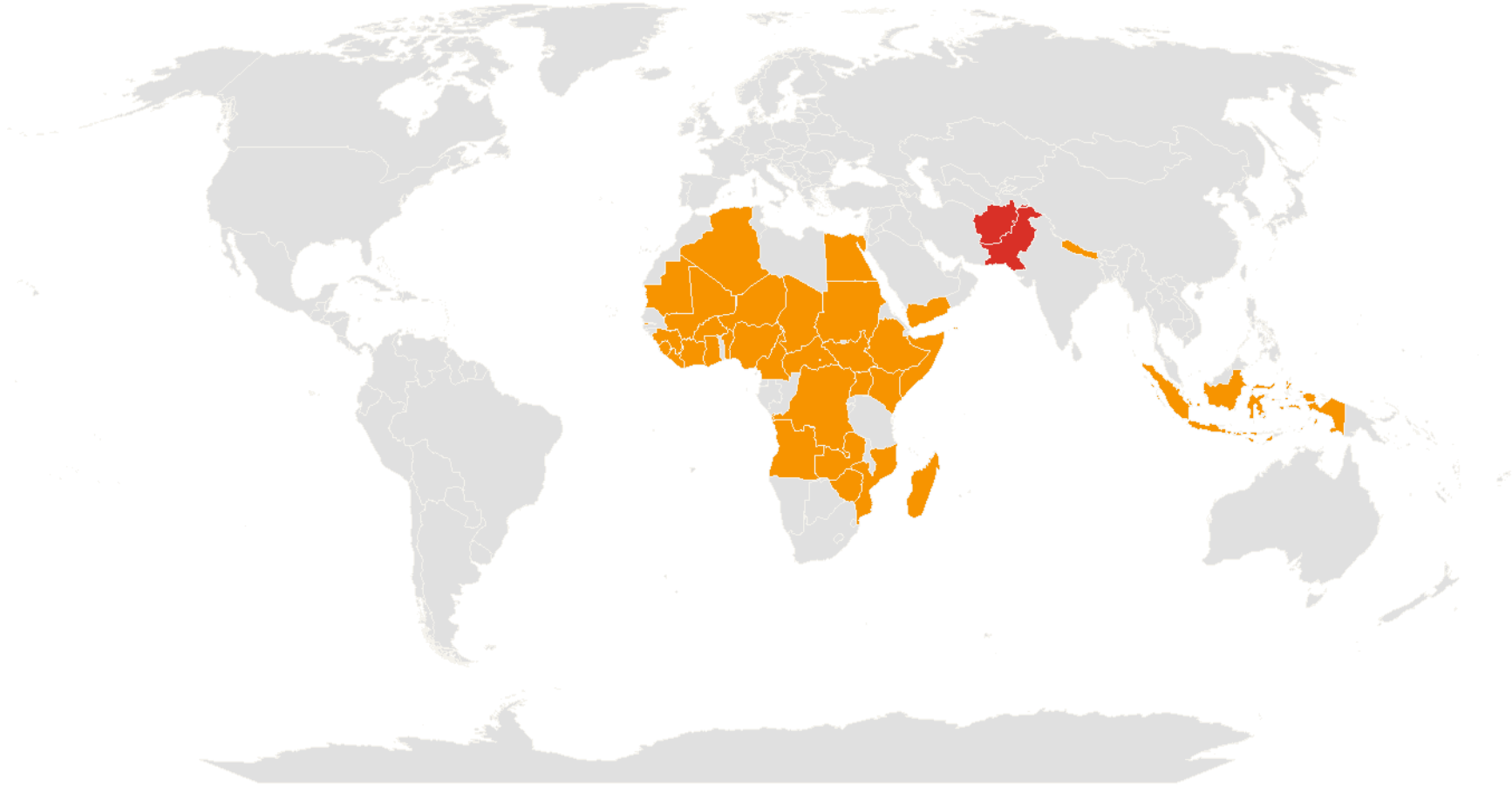
* formerly known as the *Post-Certification Strategy*; a draft of the strategy is currently being consulted with key stakeholders and Member States ahead of finalization in 2026.

Today we focus on clearing the areas of remaining polio transmission

GPEI response

2 **endemic countries**
(WPV1)

34 **outbreak countries**
(variant poliovirus)

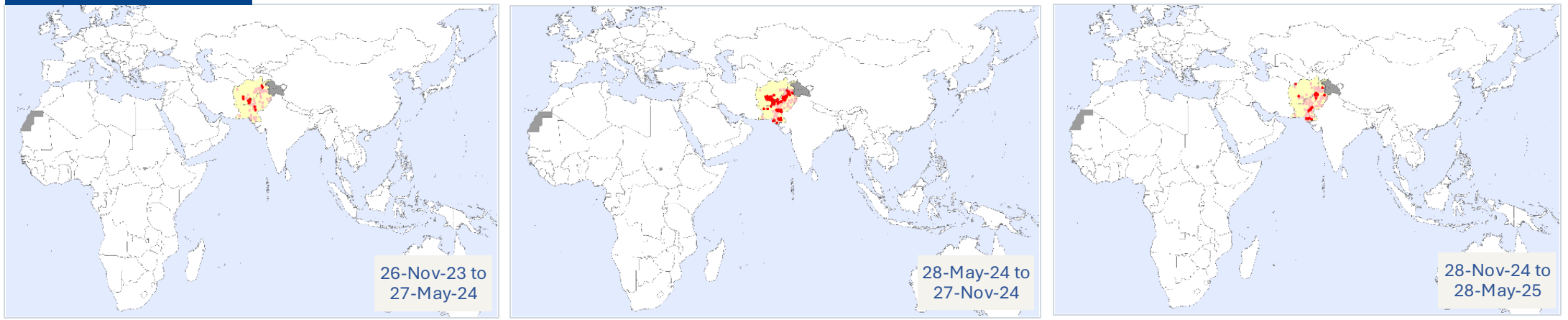


Source: GPEI response in countries in 2024

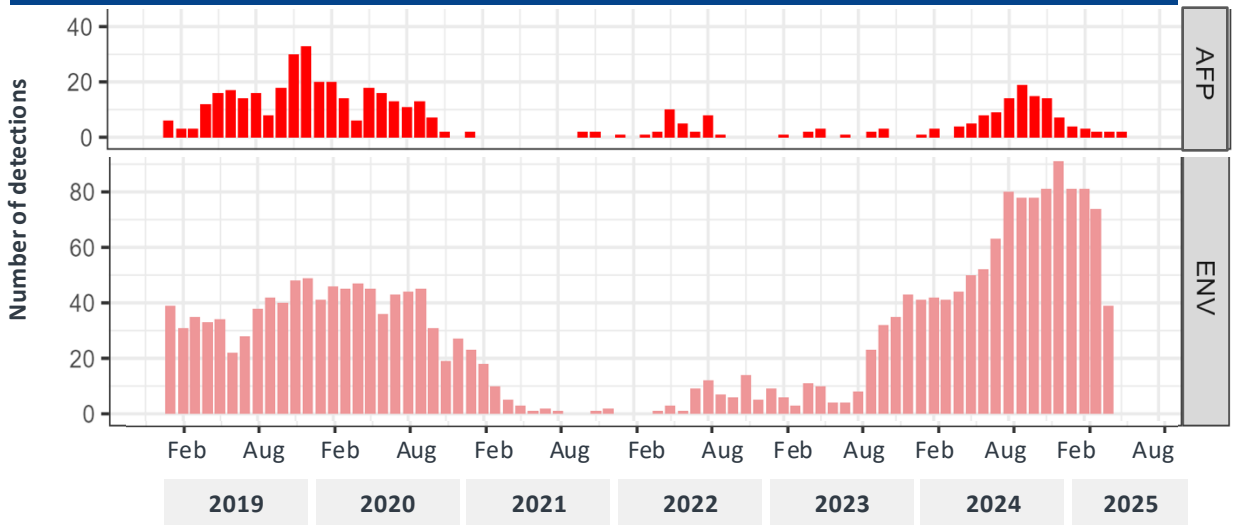
GPEI Goal 1: Ending wild polio in Afghanistan and Pakistan

Global WPV1 isolates[1]

Detections: ● WPV1 Case ■ WPV1 ES



Global WPV1 Acute Flaccid Paralysis (AFP) cases and environmental samples (ENV)

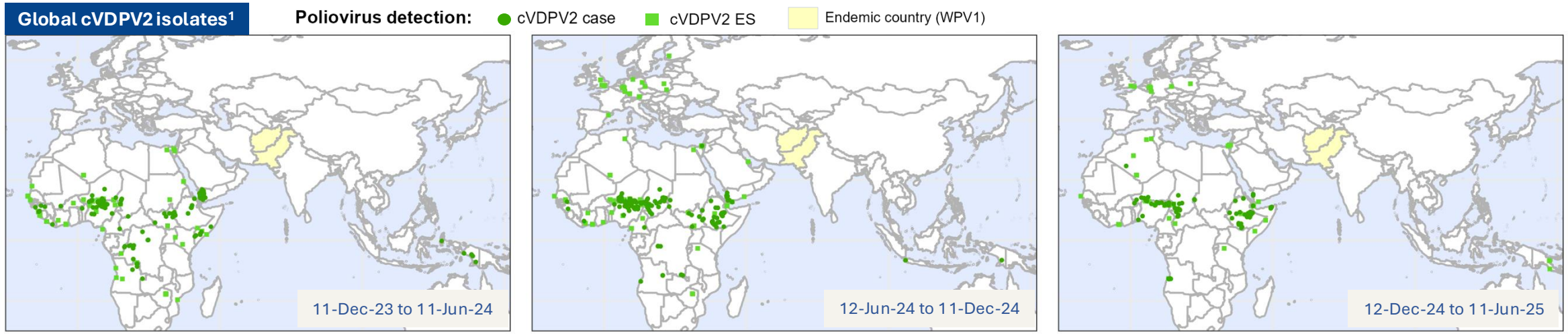


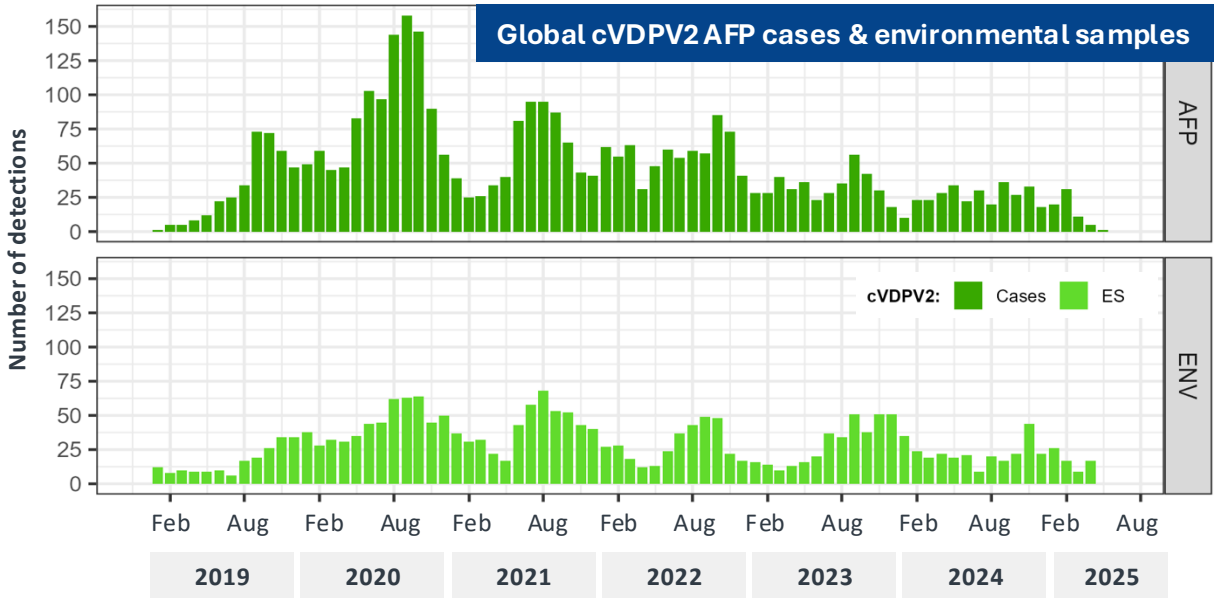
- **99 cases in 2024:** 25 in Afghanistan, 74 in Pakistan
  - *Compared to only 12 cases in 2023: 6 in Afghanistan, 6 in Pakistan*
- **13 cases reported to date in 2025** (as of 10 Jun): 2 in Afghanistan, 11 in Pakistan
- Surge in detections from wastewater environmental samples since September 2023

Produced by: CDC-GHC-GID-PEB Source: WHO HQ; Data as of 11 June 2025.

[1]includes viruses detected from AFP (onset date) and environmental surveillance (collection date)

GPEI Goal 2: Stopping variant polio type 2 outbreaks





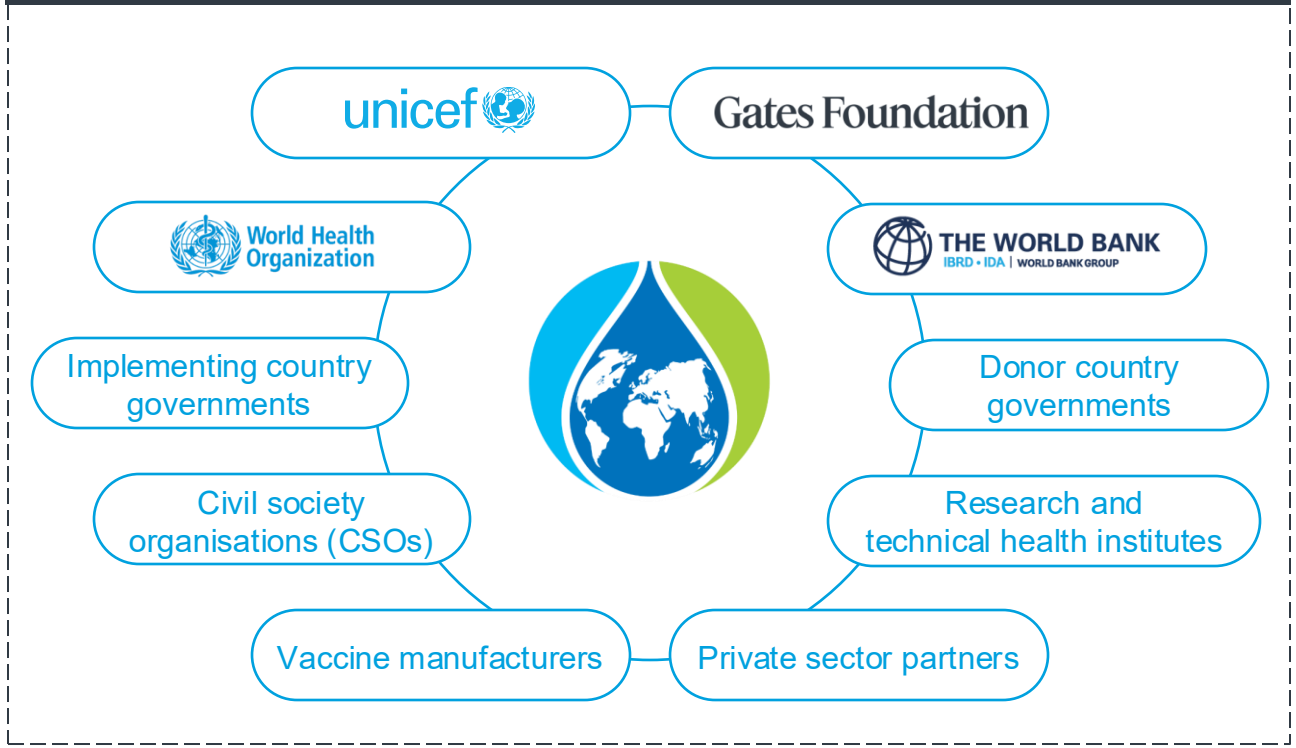
- 53 cVDPV2 cases reported in 2025 (as of 27 May), in line with **overall downward trend in cases since 2020**
  - *688 in 2022; 395 in 2023; 301 in 2024*
- Type 2 detections from wastewater environmental samples from **multiple countries of European Region**
- **Progress in the DRC and Southern Africa**, operational challenges in Lake Chad Basin

Produced by: CDC-GHC-GID-PEB Source: WHO HQ; Data as of 11 June 2025.

[1]includes viruses detected from AFP (onset date) and environmental surveillance (collection date)

Gavi, the Vaccine Alliance was founded in 2000

Gavi, the Vaccine Alliance is a **public-private partnership** that helps vaccinate more than half the world's children against some of the world's deadliest diseases



Gavi's operating model

Funding cycle

- Raises funds in **five-year cycles**
- US$8.8bn raised for **current Gavi 5.0/5.1 strategic period** (2021-2025)

"Country first" funding model

- **New holistic application** to minimise country transaction costs, admin burden
- Delivery support allocated on **five-year grant cycles**

2023 by the numbers

>1.9 BILLION US$ disbursed*

19 antigens supported**

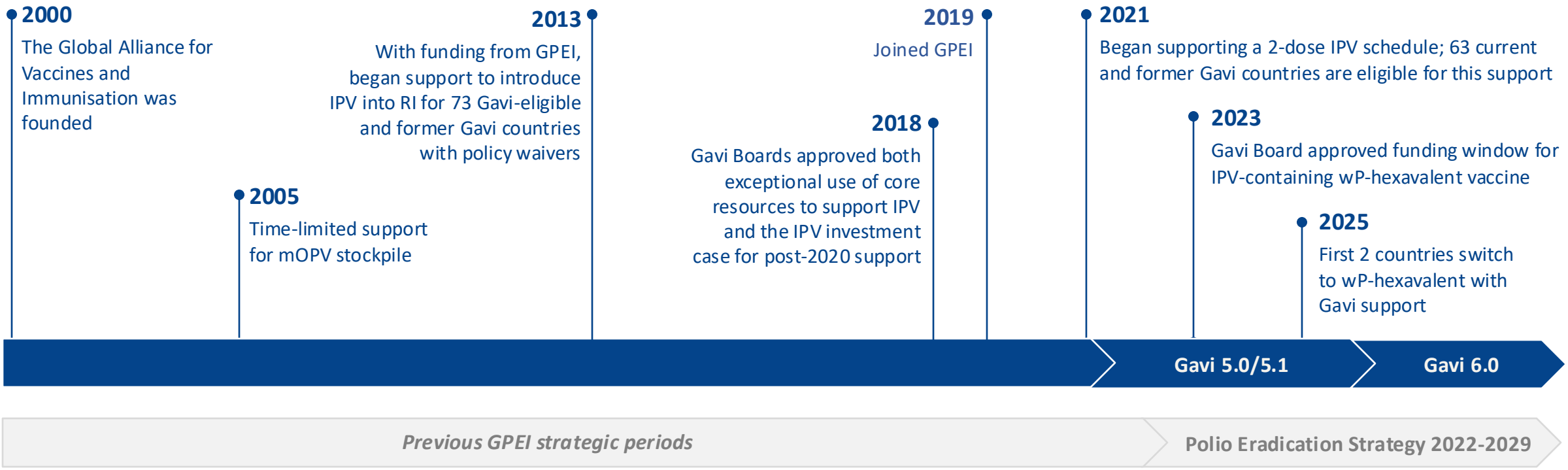
>69 MILLION children reached through RI

Source: Gavi, the Vaccine Alliance

** >US$1bn to vaccine programmes; ** full 2025 Gavi portfolio supports 21 antigens, including rabies & mpox.*

Gavi's engagement in polio eradication has grown over nearly 20 years

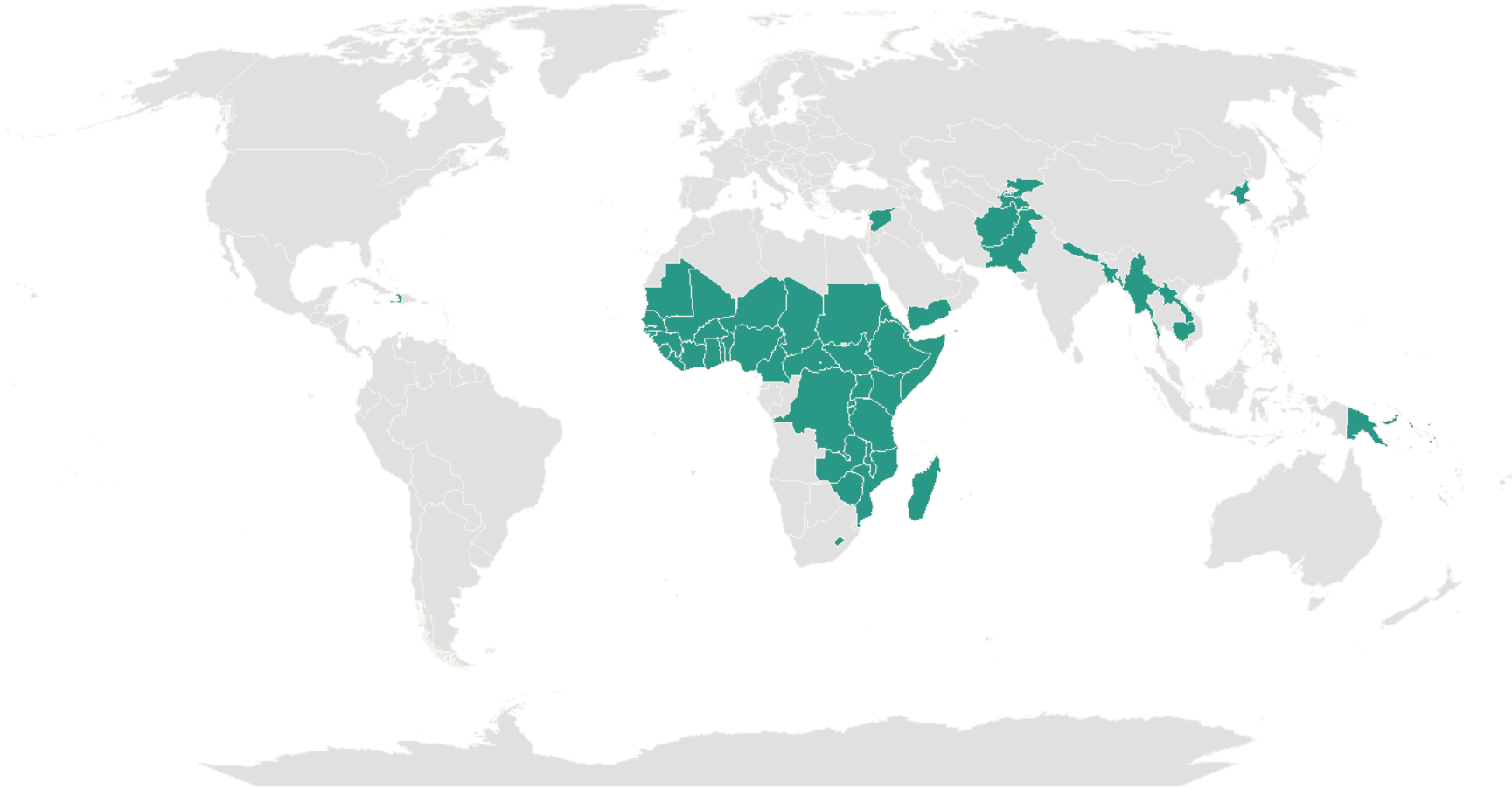
Amidst broad contributions to childhood immunisation protecting against 19 diseases and averting 18.8 million deaths



Gavi focuses support on the world's lowest income countries

Gavi footprint

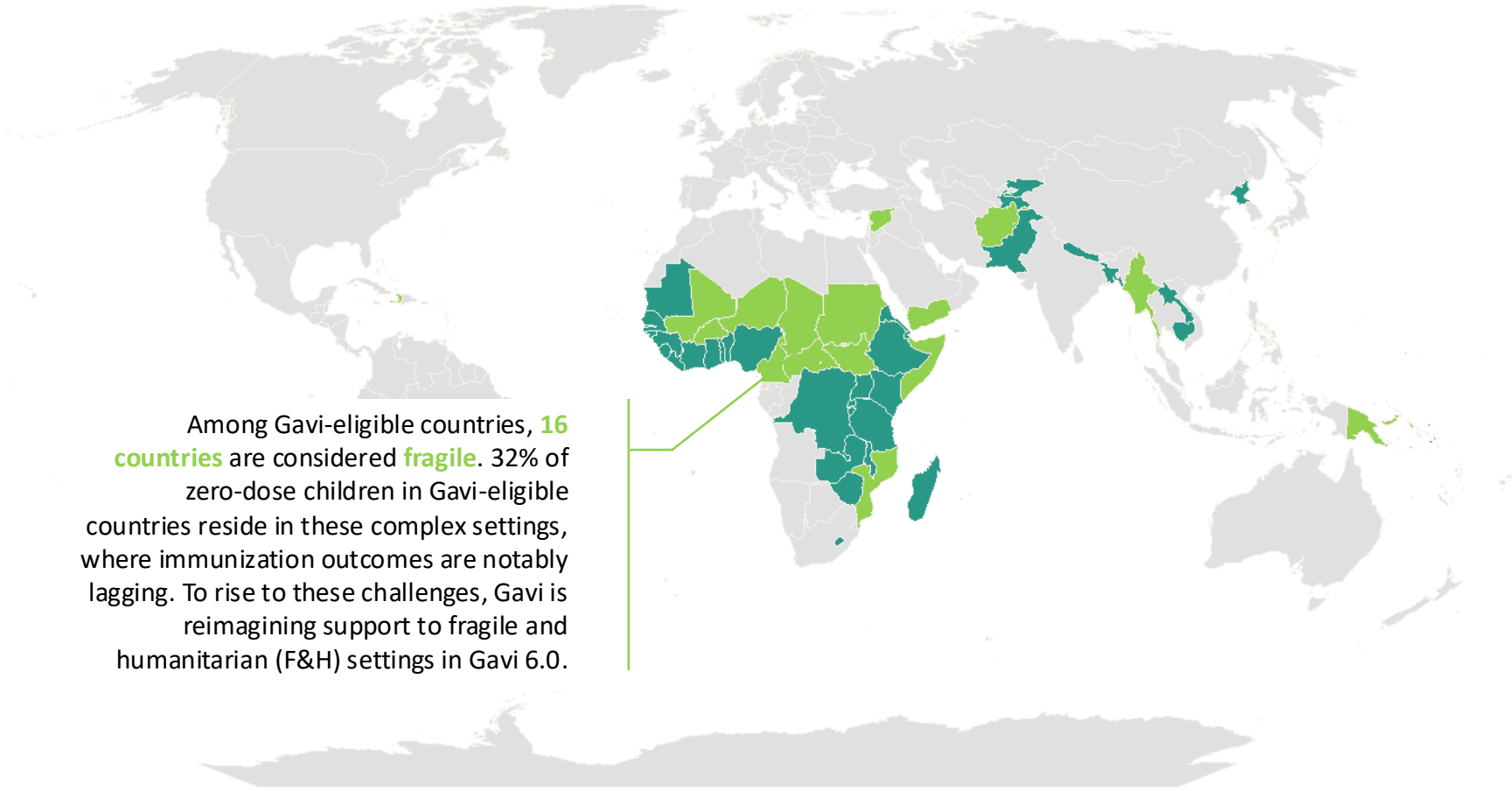
54 **eligible countries**



Gavi focuses support on the world's lowest income countries

Gavi footprint

54 eligible countries



Among Gavi-eligible countries, **16 countries** are considered **fragile**. 32% of zero-dose children in Gavi-eligible countries reside in these complex settings, where immunization outcomes are notably lagging. To rise to these challenges, Gavi is reimagining support to fragile and humanitarian (F&H) settings in Gavi 6.0.

Source: "Update on Gavi 6.0 and Gavi's Fragile & Humanitarian approach" presentation to the GPEI Strategy Committee, Jan 2025

Our joint footprint spans the most complex geographies

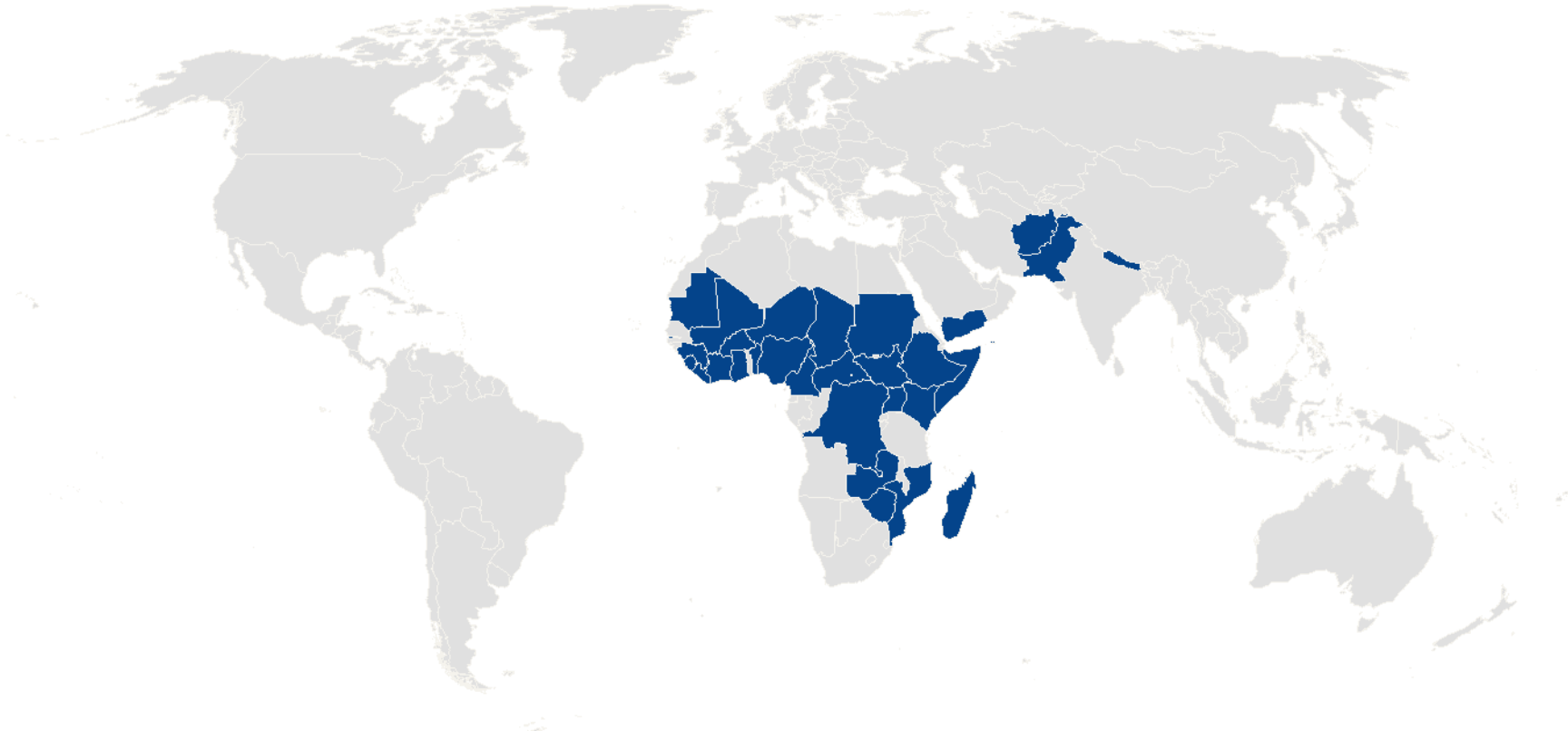
Gavi footprint

54 eligible countries

GPEI response

2 endemic countries

34 outbreak countries



Together we work across 31 common countries*

Afghanistan, Benin, Burkina Faso, Cameroon, CAR, Chad, Congo, CIV, DRC, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Pakistan, Sierra Leone, Somalia, South Sudan, Sudan, Uganda, Yemen, Zambia, Zimbabwe

*This list does not include Algeria, Angola, Egypt, Gaza, and Indonesia, which were GPEI response geographies in 2024 but not Gavi-eligible

Our joint footprint spans the most complex geographies

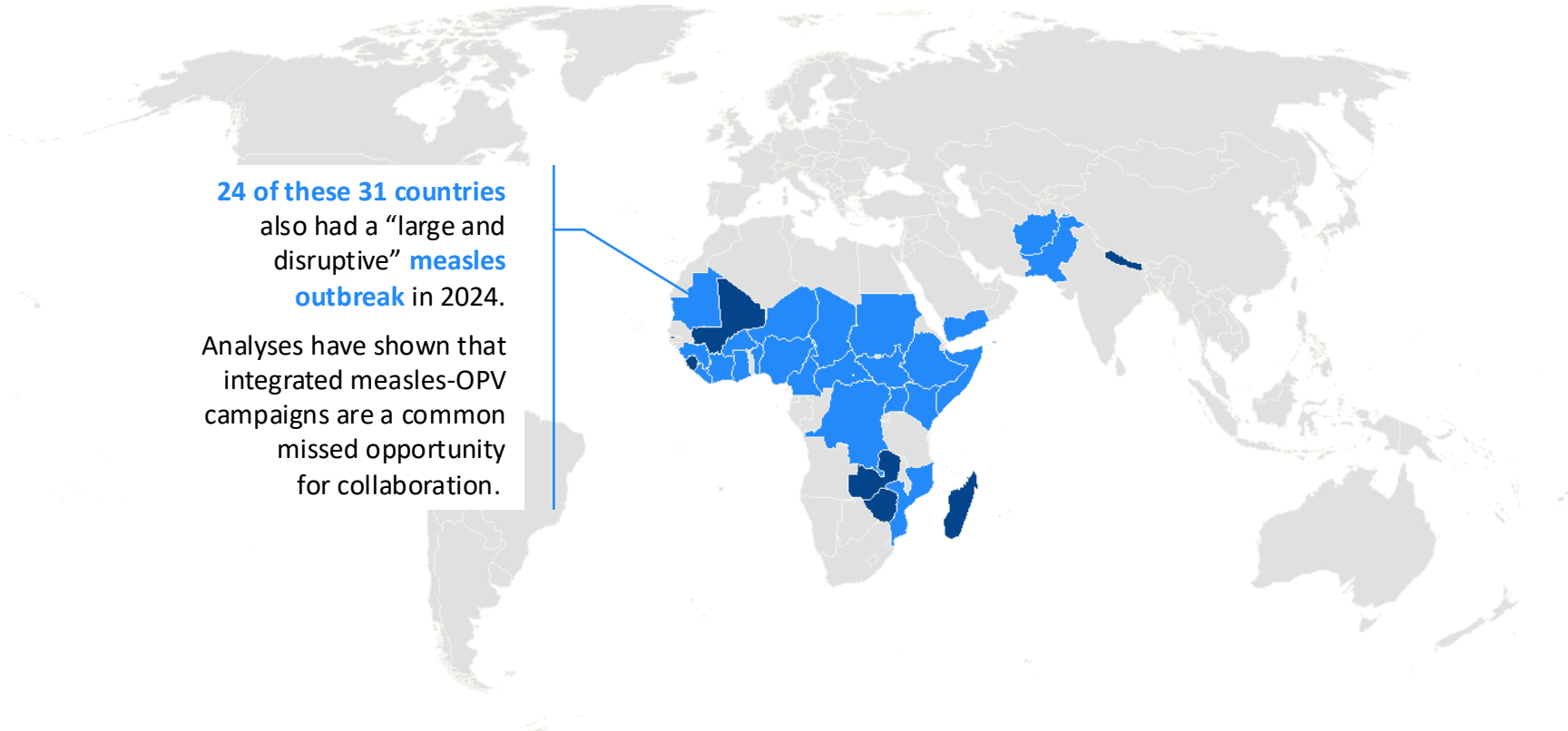
Gavi footprint

54 eligible countries

GPEI response

2 endemic countries

34 outbreak countries



24 of these 31 countries also had a "large and disruptive" **measles outbreak** in 2024.

Analyses have shown that integrated measles-OPV campaigns are a common missed opportunity for collaboration.

Together we work across 31 common countries

Afghanistan, Benin, Burkina Faso, Cameroon, CAR, Chad, Congo, CIV, DRC, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Pakistan, Sierra Leone, Somalia, South Sudan, Sudan, Uganda, Yemen, Zambia, Zimbabwe

Source: WHO IVB "Measles and Rubella Global Update May 2025"; countries provisionally meeting the large and disruptive outbreaks definition, data from 2024-01 to 2024-12 included

Yellow fever and polio vaccination session, Uganda
Gavi/2023/Were Brian

POLIO GLOBAL ERADICATION INITIATIVE

Gavi The Vaccine Alliance

Opportunities for enhanced collaboration

We rely on complementary polio vaccines to reach and protect every child

	IPV/hexa protects against paralysis	OPV protects and stops transmission

Vaccine	• **Inactivated polio vaccine (IPV):** inactivated poliovirus type 1, 2, and 3
	• **Hexavalent vaccine (hexa)** is a 6-in-1 combination vaccine that includes IPV + (DTP, Hib and HepB)
		• **Oral polio vaccine (OPV):** live, weakened poliovirus
		• Multiple products, with **one or more types**
		  • bOPV = type 1 & 3
		  • nOPV2 = type 2

Protection	• **Prevents paralytic disease** • **Only sources** of **type-2** immunity through RI schedule • **2 doses**, minimum	• **Prevents paralytic disease,** and • **Reduces the risk of transmission,** by mucosal immunity • **No type 2**, in RI schedule • **3 doses**, minimum (2 for sequential schedules)
Delivery	• Administered through **injection**, delivered at RI clinic sites • Some countries use IPV/hexa alone to protect against polio, while other countries use both IPV and bOPV in RI	• Administered as **oral drops**, delivered at RI clinic sites and **house-to-house (H2H)** outbreak response and preventive campaigns • **126 countries** use bOPV in RI schedule
Financing	• IPV **fully financed by Gavi (70 countries)** until bOPV cessation • Hexa **co-financed by Gavi**, with a 2-dose IPV subsidy	• bOPV in RI is **financed by countries** • OPVs for **outbreak responses** are **financed by GPEI**

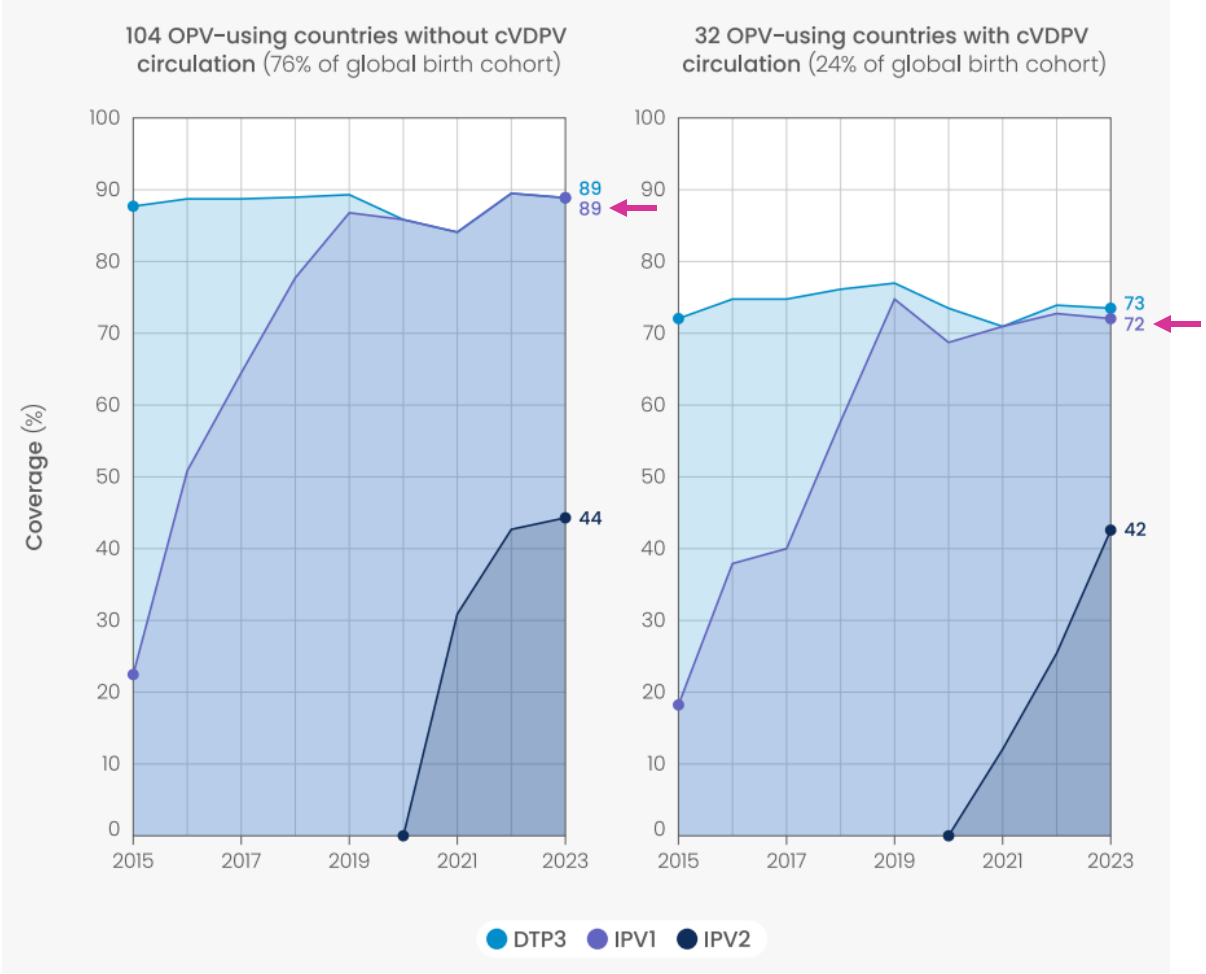
Low IPV coverage leaves children susceptible to paralytic polio

As the only source of type 2 immunity in RI, IPV is also crucial for mitigating risks in the final stages of polio eradication

IPV plays a critical role in preventing paralytic polio and enabling successful OPV cessation to protect populations and sustain a polio-free world. But **coverage remains insufficient**, particularly in high-risk polio areas.

- **Global IPV1 coverage estimates have been stagnating around 83%** since 2019
- **Adequate protection against polio requires two doses of IPV, but roll-out of IPV2 has been slow** (23 countries have yet to introduce IPV2)

*Average IPV1 coverage is **17 percentage points lower** in OPV-using countries with cVDPV circulation.*



Source: 2023 WEUNIC estimates; from the 15 July 2024 WHO and UNICEF technical document "Progress and Challenges with Achieving Universal Immunization Coverage"

Gavi's ZD agenda and GPEI's eradication goals are inextricably linked

Persistent and reinforcing challenges jointly impede our work

1 in 7 children in Gavi-supported countries are zero-dose. Global RI coverage has not fully recovered from pandemic disruptions

Preventing onward transmission requires timely and high-quality outbreak response with OPV

New birth cohorts *continue to rebuild the population of susceptible children*

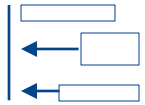
Importation of poliovirus or undetected transmission **can infect and paralyze unimmunized children**

Under-resourced health systems, inaccessible populations in fragile & humanitarian settings*, and* ***low political commitment*** *affect our ability to operate*

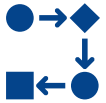
Despite many successes, barriers remain to systematising integration

Guidance and incentives are needed at all levels to foster more impactful collaboration among GPEI, Gavi Alliance, and EPI

Inconsistent strategic and programmatic incentives provided at the global level: Programs designed and managed to serve different yet complementary roles on the path to polio eradication and reaching zero-dose children



Misaligned funding and operational models: Sporadic opportunities and entry points to routinely foster collaboration and joint programming



Weak coordination and accountability processes between global level and regions/countries: Without global, regional and country focal points **with institutional mandates and authority**, integration is often ad hoc and opportunistic rather than planned

Limited alignment on and prioritization of integration: Limited consensus on the value and scope of integration and siloed tendencies of both partnerships at the global, regional and country levels

Enhanced collaboration is needed to address these challenges

Two priority areas are critical for achieving our goals and maximizing our joint impact; today's commitments will help us get there

Priority collaboration area	*Anticipated impact*
1 Improve **targeting and coverage of routine vaccines including bOPV, IPV/hexa**	**Improved use of campaign data and technical support enables targeting of vaccination** to interrupt polio transmission and close immunity gaps **Increased high immunity prevents future cases of paralytic polio** in areas with continued transmission and reduces VPDs in underserved communities
2 Implement a **more systematic and comprehensive approach to integration** during and outside of campaigns	**Co-delivery of multiple vaccines and other health interventions** improves service efficiency, reach and uptake, reducing missed opportunities **Targeted RI strengthening activities** build off lessons from the Big Catch-Up, maintain population immunity in the post-campaign period, and extend reach of RI services to ZD children

Geographic Focus	Countries and sub-national areas with **persistent polio outbreaks** and **zero-dose children**; **Fragile & Humanitarian settings**
Enabling Environment	Improved **coordination and planning** among Gavi, GPEI, EPI teams and other disease-specific initiatives (e.g., MRP) at all levels Improved **commitment and accountability** for shared goals and new ways of working, including stronger incentives to collaborate

Accelerating IPV2 and hexa introductions in high-risk polio countries

IPV will continue to be a critical tool for preventing paralytic polio; demand for hexa offers new opportunities to close immunity gaps

Since Dec. 2023, Gavi-eligible countries can apply to switch to whole-cell pertussis (wP) **hexavalent vaccine (hexa).**

- This 6-in-1 combination vaccine is important to Gavi and GPEI goals by **increasing IPV coverage (in some contexts), reducing delivery costs**, and **meeting community and country demand** through fewer injections.
- High-income countries have long had access to aP-hexa. Switching to hexa is key to **sustaining immunity in the long term** and **closing the vaccine and immunity gaps**.

1 Political advocacy in high-risk polio countries yet to introduce IPV2

- **Provide technical assistance/guidance** to countries about the WHO recommendation and support with planning and applications

2 Prioritize hexa rollout in countries with highest incidence of polio

- **Provide technical assistance/ guidance** to countries considering introducing hexa (e.g., NITAG briefings, cost modeling, IPV immunity modeling)

Modeling can help determine **how and where to prioritize**

GPEI can **model high-impact opportunities to boost IPV coverage** – e.g., targeting subnational geographies, optimal IPV schedules, and impact of switch to hexa.

By combining IPV with pentavalent, **hexa increases access to IPV for under-immunized children,** especially in geographies where penta coverage exceeds IPV coverage

Hexa's potential to increase protection is especially important in polio priority countries. For example:

- **Chad** and **Madagascar** have applied for hexa but will need support to prepare and implement.
  - *In Chad, DTP3 coverage is 67% vs 32% IPV2 coverage. In Madagascar, DTP3 coverage is 65% vs 43% IPV2 coverage. (WUENIC, 2023)*
- **Mauritania and Burundi**, both without IPV2, are approved for hexa introduction.

⚠ *Expanding coverage is dependent on full, continued Gavi funding for IPV/hexa procurement.*

Improving IPV/hexa coverage in high-risk polio geographies

We can build on lessons learned from past integration efforts to increase and maintain high coverage for IPV and other RI antigens

1 Extend targeting and reach of RI services in geographies most crucial to polio

- Explore opportunities for improving access to RI **at fixed sites** and **for hard-to-reach populations**

2 Leverage existing and new data to improve identification of missed children and monitor progress

- Conduct **modeling** to help quantify high-impact opportunities to boost IPV coverage
- Use **polio enumeration data and microplans** to support the identification of missed children

Prior to immunization activities

- Use **polio H2H and monitoring teams** for systematic, direct referral to EPI
- Utilize **polio social mobilizers** to share information on BCU/RI activities with communities

During immunization activities

- Leverage **polio campaign quality data (LQAS/IM)**

Following immunization activities

Our shared commitment to improving IPV coverage and measurement

Gavi Programme and Policy Committee aligned on the need for a Gavi 6.0 indicator on a completed series of IPV coverage, which is currently measured with IPV2. The measurement will be refined with Alliance stakeholders following this meeting.

⚠ *Expanding coverage is dependent on full, continued Gavi funding for IPV/hexa procurement.*

More systematic planning of multi-antigen campaigns

GPEI, Gavi Alliance, and EPI should capitalize on the increasing momentum for integration through tighter collaboration and stronger incentives for joint planning

Co-delivering multiple vaccines and/or health interventions simultaneously can help to:

- **Maximize resources (efficiencies):** By co-delivering vaccines for different diseases, healthcare workers can cover more ground with fewer campaigns
- **Improve coverage:** Families and communities may be more likely to agree to be vaccinated if they receive protection against multiple diseases in one visit
- **Strengthen health systems:** Delivering multiple vaccines and/or health interventions together helps strengthen the relationship between communities and health systems

⚠ There are important **operational constraints** to integrating with polio that can disincentivize joint planning:

- **Different delivery modalities:** GPEI delivers OPV via H2H campaigns, while most other vaccines are delivered at fixed sites or through outreach
- **Different timelines:** GPEI aims to respond to a polio outbreak within 56 days, while preventive campaigns, such as for measles, are ideally planned 12 months in advance*
- **Different funding mechanisms:** Disparate costs, including different per diem rates

Guidance on multi-antigen campaigns

Prioritize integration when it can achieve maximum impact:

- **Measles, meningitis and yellow fever vaccines, vitamin A**, and **deworming medications** are best suited to integrate with polio
- Administer as part of **planned or preventive campaigns**

To increase likelihood of success, ensure GPEI, Gavi Alliance, and EPI:

- **Improve information sharing**
- **Strengthen in-country coordination**
- **Improve agility**

**Recent example in Somalia shows that integrated polio and measles campaigns can be planned and implemented on a much shorter time horizon; lessons learned should be leveraged*

A suite of complementary activities to more broadly strengthen RI

As countries approach polio interruption, the focus of GPEI integration efforts will increasingly shift to supporting RI strengthening

Priority areas for polio and RI strengthening activities

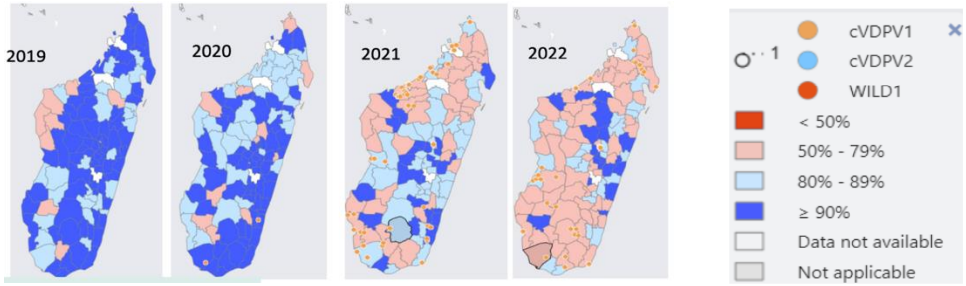
- *Countries where polio has been interrupted (or is close to being interrupted)*, for example, Madagascar and DRC

A **differentiated approach** to RI strengthening – tailored to epidemiological needs and health system capacity at **subnational levels** – is needed to ensure resources are used most effectively.

- *In areas where RI is ineffective and polio vaccination rates are low:*
  - ➢ **Continue campaign-based and outreach activities** to generate demand and fill immunity gaps
- *In areas where RI system is present but not functioning optimally:*
  - ➢ **Collaborate to improve RI system**
    - **GPEI** can facilitate improved surveillance, microplanning, data analytics, and community awareness
    - **Gavi** can invest in infrastructure, health worker training and management, and outreach and catch-up activities

What does this look like in practice?: ***Joint RI strengthening in Madagascar***

- **Context:** Declining district-level IPV1 coverage since 2019; a cVDPV1 outbreak that began in 2021 (since closed); fragile RI situation, but political will and funding to improve RI



- **Progress:** GPEI and Gavi/EPI are implementing several integration activities that support both RI strengthening and polio eradication.
  - Implemented 4 BCU campaigns via PIRIs, with all RI antigens and bOPV
  - Leveraging polio data to target zero-dose children
  - Using LQAS and GTS to better inform microplanning and performance tracking
  - H2H campaign teams referring children to health centers

Enhanced collaboration will build off ongoing country-level progress

A snapshot of 2025 integration plans in priority countries; activities range from campaign-based to health systems strengthening

Country	Plusses	Multi-Antigens	RI Strengthening	Integrated Service Delivery	Other
Afghanistan	• WASH & nutrition • Soaps & diapers in Kandahar (Jan. & Feb.'25 SNIDs, Apr. & May. '25 NIDs)	• NID + Vit A (Apr. '25) • NID + Deworming (May '25) • *TBC: OPV + Measles (Sept. & Nov. '25)*	• Big Catch Up (underway) • Mobility-sensitive service delivery to reach ZD migrant/nomadic populations • Polio & RI pilots in East & South – ISD with RI • Microplanning revision workshops • SBC activities	• **Humanitarian engagement (health camps)**	• **Returnees response (OPV + measles)** • Ongoing emergency response
Pakistan		• NID + Vit A (May '25) • *TBC: OPV + Measles (Sept. or Nov. '25)*	• **Big Catch Up** (underway) • **Renewed EPI/PEI coordination; implementation of synergy framework** • QR-coded vaccine card pilot to target ZD children (Apr. & May '25 NIDs) • High-risk/vulnerable UCs supported for RI • SBC activities	• RI strengthening through fixed sites (Balochistan & SKP) (GF) • ISD services in 110 UCs (UNICEF) • Experimental dispensaries	
Nigeria	• DOPV in select LGAs • Noodles (Katsina), milk sachets & candies (other states in 8 districts) (Apr. '25 SNID)	• ***TBC:* OPV + Measles (Oct. '25)**	• **Big Catch Up** (underway, includes bOPV – Step 2 only) • RI antigens in May. '25 NID • **Reaching chronically missed children (RES, RIC)** • Boosting immunity through RI outreach (13 states with < 60% IPV coverage) • SBC activities	• IBRA activities using the Identify Enumerate & Vaccinate (IEV) strategy (Apr. '25 SNID) • Child & maternal health events	• Collaborative Action Strategy (CAS) focus country • cVDPV2 OBR
DRC		• *TBC:* OPV + Measles (Nov. '25)	• **RI intensification with all polio campaigns** (Jan., Apr., May, Jun., Jul., Aug. '25) • Big Catch Up (underway) • SBC activities • Training of teachers in Kinshasa & Tanganika to raise awareness (Apr. '25)		
Madagascar		• *TBC:* OPV + Mass drug distribution	• **Big Catch Up (PIRIs)** (underway) • Cascade training on vaccination SBC (5 targeted regions)	• Health convoy providing PHC and other health services (Mar. '25, Western corridor, 3 regions)	• Transition planning
Somalia		• **nOPV2 + Measles + PCV (May '25)**	• **Big Catch Up** (underway, includes bOPV – Step 1 only) • SOMNET / SBC activities • Zero dose revamp activities	• **FARID**	
Yemen		• nOPV2 + Vit A (S. Governorates) (Aug. '25)	• **Big Catch Up** (underway, includes bOPV, S. Governorates) • SBC activities (S. Governorates)	• **HEER – RI strengthening, outbreak response, health system rehab (N. Governorates)**	

Note: **Blue = highest priority activity;** *Source:* All information sourced from country implementation plans, inventories, campaign tracking, M&RP tracker and BCU team (as of June 2025). There may be differing viewpoints on activities within countries, which may impact documentation of key activities.

Ripon & Nirjala's ten-month-old son has been vaccinated against polio, Bangladesh
Gavi/2023/Ashraful Arefin

Commitment & accountability

Increasing momentum and urgency for improved collaboration

Joint Gavi Alliance and GPEI commitments are needed today to move forward with operationalizing these priorities

Priority areas for enhanced collaboration

1. **Improve targeting and coverage** of routine vaccines including bOPV, IPV/hexa
2. Implement a more **systematic and comprehensive approach to integration** during and outside campaigns

Initiate enhanced collaboration in 4 initial focus countries, including Nigeria and Pakistan, focused on strengthening on-the-ground collaboration between GPEI, Gavi Alliance, and EPI in support of RI strengthening and polio eradication activities.

Develop a joint global action plan to operationalize closer collaboration on priority areas, with an update to the Gavi Programme and Policy Committee (PPC) and GPEI Strategy Committee (SC) on joint action plan development in October 2025.

Generate a measurement framework as part of the joint action plans to track progress and reinforce accountability, drawing on existing indicators to the extent possible.

Report annually on implementation progress and challenges to the Gavi PPC and Board and the GPEI SC and POB, respectively.

Key milestones for Gavi Alliance and GPEI collaboration

Three-year-old Bhoomika is vaccinated against the most common diseases. Datwas, India
Gavi/2023/Benedikt V. Loebell

Country interventions and Q&A

For discussion and guidance

1. Are we aligned on the **areas** and **level of ambition** for enhanced GPEI-Gavi Alliance collaboration?

2. Are there **additional areas or factors that should be accounted for** as Gavi and GPEI develop an action plan to operationalize these collaboration areas in the coming months?

Back-up slides

Context for enhanced Gavi-GPEI collaboration

Global polio progress and epidemiology update

IPV coverage gaps and hexa potential

Measles update

Context for enhanced Gavi-GPEI collaboration

Context

- Polio eradication targets are repeatedly missed, and the programme remains off track
- Routine immunization rates are stalling, and are off track to meet IA2030 targets
- While there have been many successes, there is a lack of systematic collaboration to date; acceleration needed to reach both GPEI eradication and Gavi/IA2030 zero-dose goals
- Gavi Board approval for the 6.0 Strategy – preparing for recalibration following replenishment
- Global funding and political environment is increasingly challenging and complex; impacts from reduced funding underscore importance of improved synergies

Guiding principles

A **shared commitment to** polio eradication and reaching zero-dose children

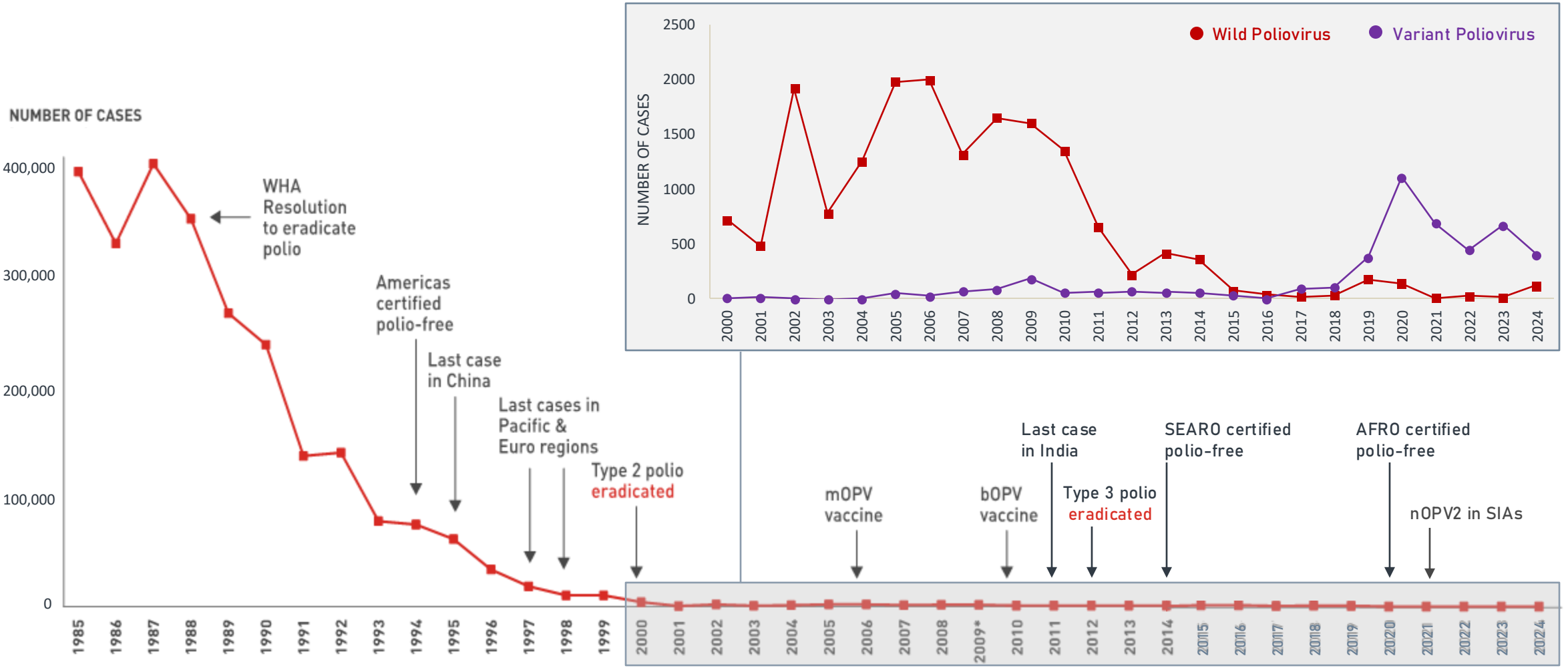
Greater alignment with broader immunization system cooperation to maximize efficiency, impact and sustainability

Joint accountability and streamlined reporting to existing governance structures across partners

Collaboration is **within GPEI's and Gavi's current scopes and budgets** as approved by Polio Oversight Board and Gavi Board, respectively

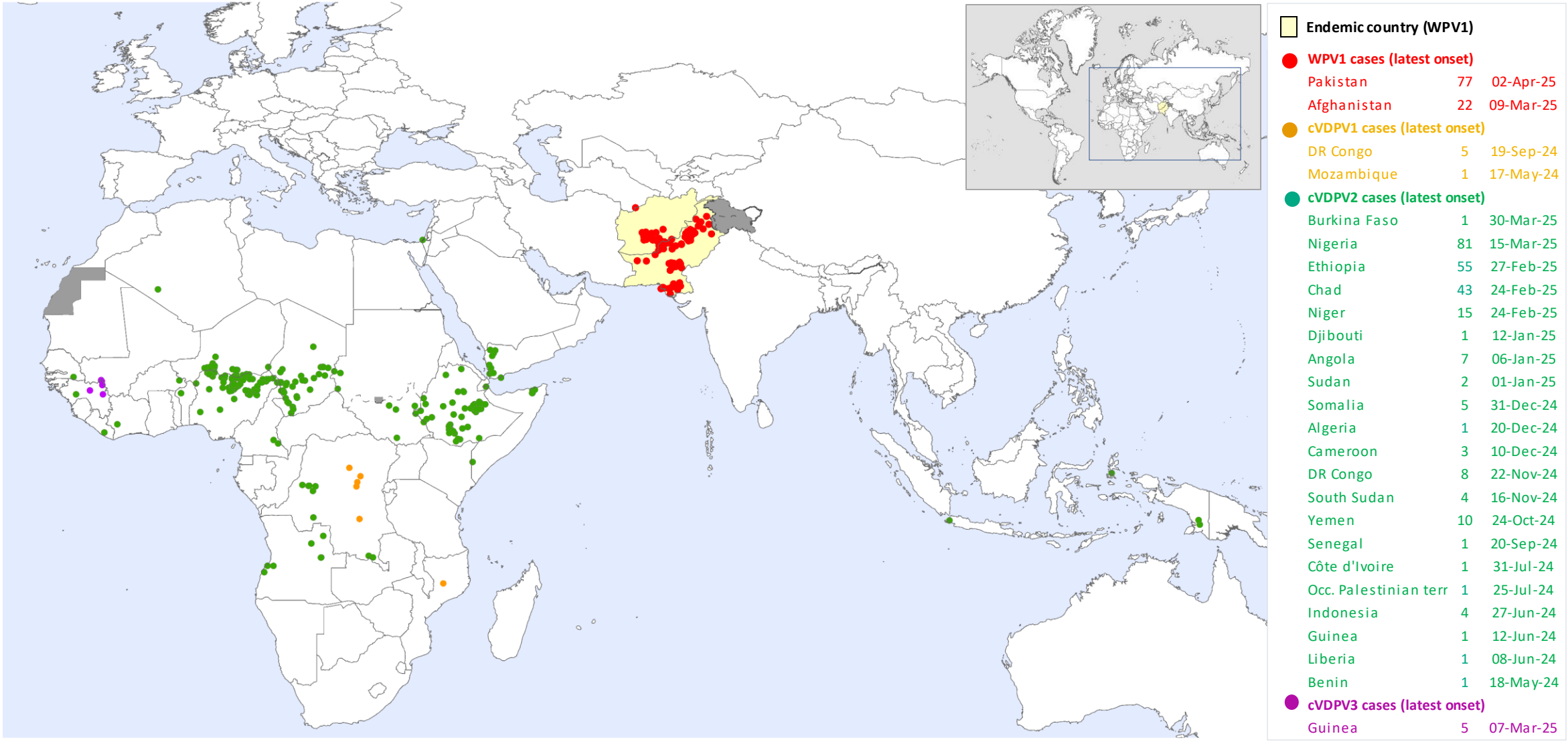
We have made historic strides, reducing global polio incidence by 99%

In 1988, polio paralysed more than 1,000 children every day across 125 countries. Today wild polio remains in just two endemic countries, *but the last mile is the hardest!*



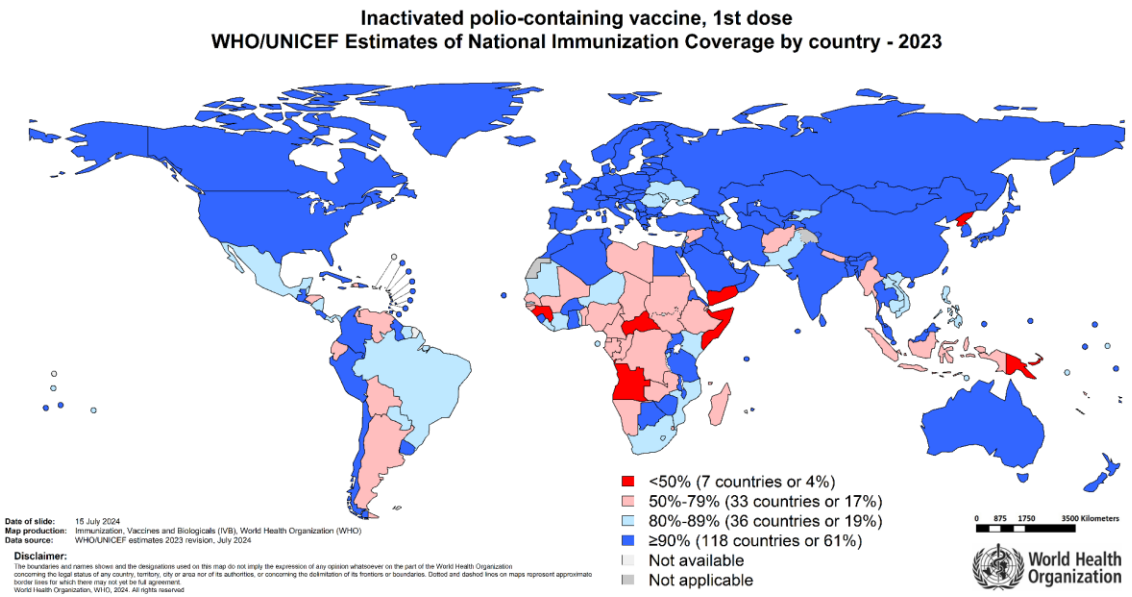
Source: WHO/Polio database; Data updated May 2025

Global polio cases by type: *Previous 12 months*

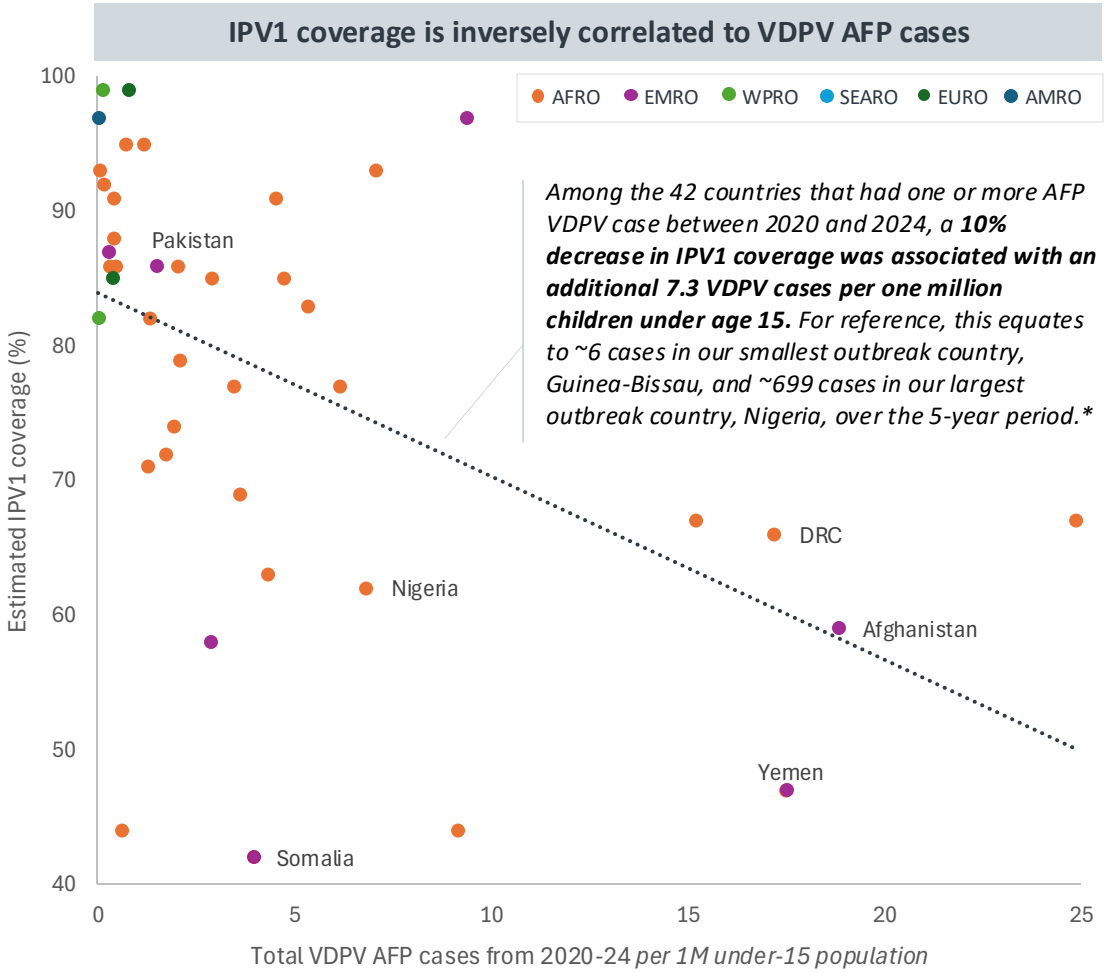


Source: WHO HQ; Data as of 13 May 2025; Excludes viruses detected from environmental surveillance; Onset of paralysis: 14 May 2024 to 13 May 2025

Global IPV1 coverage estimates and relationship with polio cases



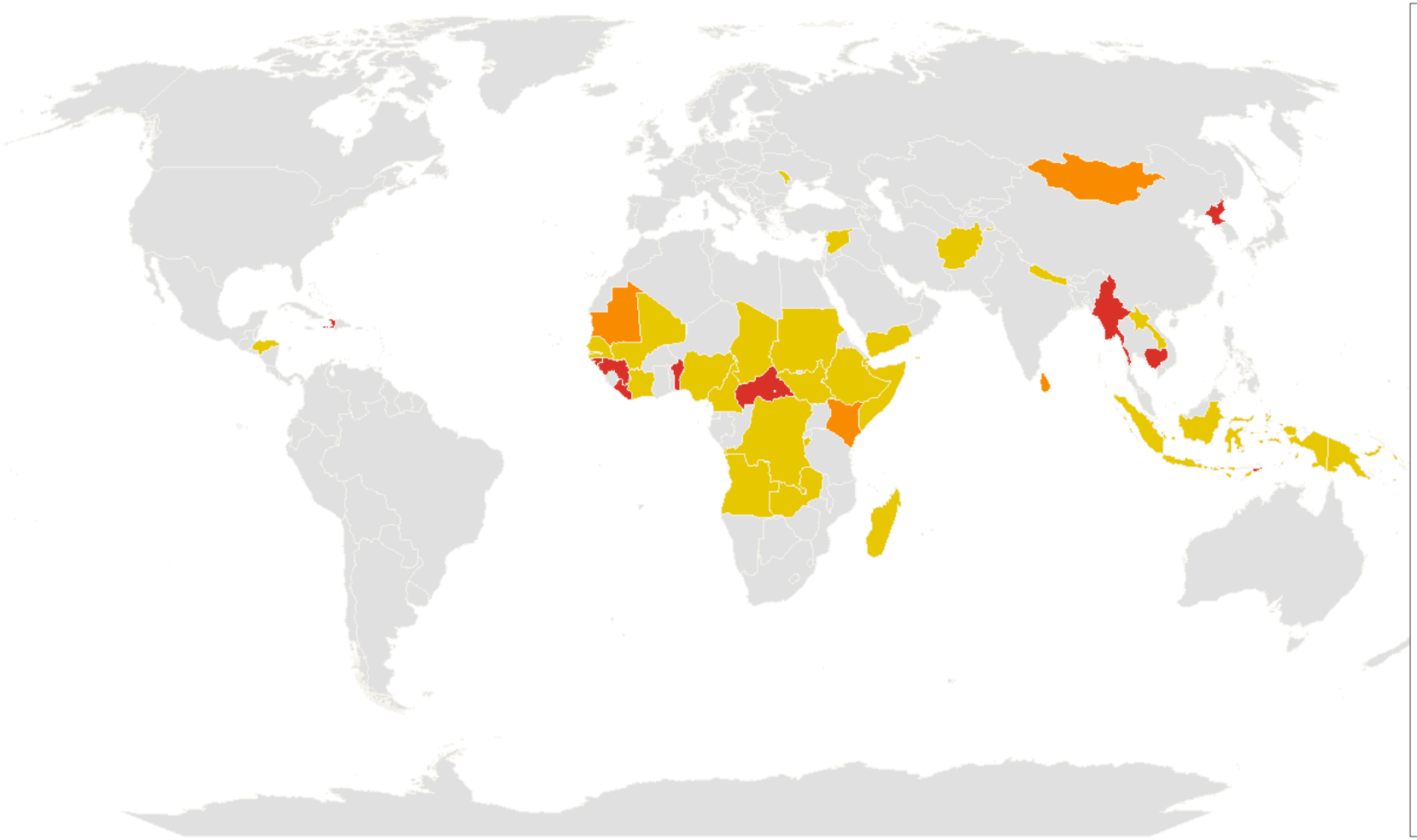
- Global IPV1 estimated coverage for 2023 is 83% (from 84% in 2022)
- 7 countries below 50% coverage (Angola, CAR, DPRK, Guinea, PNG, Somalia and Yemen)
- Many African countries continue to have low IPV1 coverage
- A number of PAHO countries have dropped in coverage



Source: IPV1 coverage estimates from 2023 (WEUNIC), AFP cases from POLIS (2020-24), u15 data from UN Population Div (2024)

*This should not be interpreted as causality, as IPV1 coverage and VDPV case incidence vary considerably at the subnational level and are also correlated with other factors like IPV2 coverage, OPV coverage, strength of health systems, etc.

Gavi73 countries with low IPV1 coverage and/or no IPV2 intro



Gavi-73 country with *IPV1 coverage <85%*

- **Afghanistan, *Angola*,** Bolivia, **Cameroon, Chad, Congo,** Comoros, **CIV, DRC, Djibouti, Ethiopia, Gambia,** Honduras, **Indonesia,** Lao, **Madagascar, Mali, Nepal, Nigeria, *Papua New Guinea*,** Moldova, **Senegal**, ***Somalia*, South Sudan, Sudan, Syria**, ***Yemen*, Zambia**

Gavi73 country with *no IPV2 introduction*

- **Burundi, Kenya, Mauritania,** Mongolia

Gavi73 country with *IPV1 coverage <85%* AND *no IPV2 introduction*

- **Benin,** Cambodia, ***CAR***, *DPR Korea*, ***Guinea***, **Guinea-Bissau,** Haiti, **Liberia**, Myanmar, Sao Tome and Principe, Solomon Islands, Timor-Leste

Bolded countries *= polio transmission detected (2022 to date)*

**Starred countries* = <50% IPV1 coverage*

Source: 2023 WEUNIC estimates (updated July 2024); WHO Immunization Data portal

IPV coverage gaps: *Gavi73 countries yet to introduce IPV2*

Country	pen-1	IPV-1	gap Δ	pen-3	Notes
Benin	79%	69%	10 ppt	69%	Plans to introduce hexa in 2027; *high risk for polio*
Burundi	89%	86%	3 ppt	89%	Plans to introduce hexa in Q3-25 and can expect a 3 ppt increase in IPV-1 coverage and IPV-3 coverage of 89% based on 2023 penta coverage; *high risk for polio given shared border with DRC*
Cambodia	93%	83%	10 ppt	85%	
CAR	54%	44%	10 ppt	42%	*high risk for polio*
DPRK	41%			16%	Has withdrawn bOPV. Has indicated plans to introduce IPV2
Guinea	62%	47%	15 ppt	47%	Plans to introduce hexa in 2027/28; *high risk for polio*
Guinea-Bissau	80%	77%	3 ppt	74%	Plans to introduce hexa in 2027; *medium risk for polio*
Haiti	75%	75%	0 ppt	51%	
Kenya	97%	87%	10 ppt	93%	Plans to introduce IPV-2 in 2025; *high risk for polio given shared borders with Somalia and Ethiopia*
Liberia	99%	82%	17 ppt	82%	Plans to introduce hexa in 2026; *high risk for polio*
Mauritania	96%	88%	8 ppt	90%	Plans to introduce hexa in Q3-25 and can expect 8 ppt gain in IPV-1 coverage and 90% gain in IPV-2/3 coverage from the switch to hexa; *high risk for polio*
Mongolia	98%	96%	2 ppt	96%	
Myanmar	80%	78%	2 ppt	76%	
Sao Tome	86%	81%	4 ppt	86%	
Solomon Is.	92%	80%	12 ppt	84%	
Timor-Leste	89%	80%	9 ppt	83%	Plans to introduce IPV-2 in 2025

Source: WEUNIC 2023; WHO Immunization Data portal

Top-15 hexa potential: *Gavi countries with IPV2 coverage data*

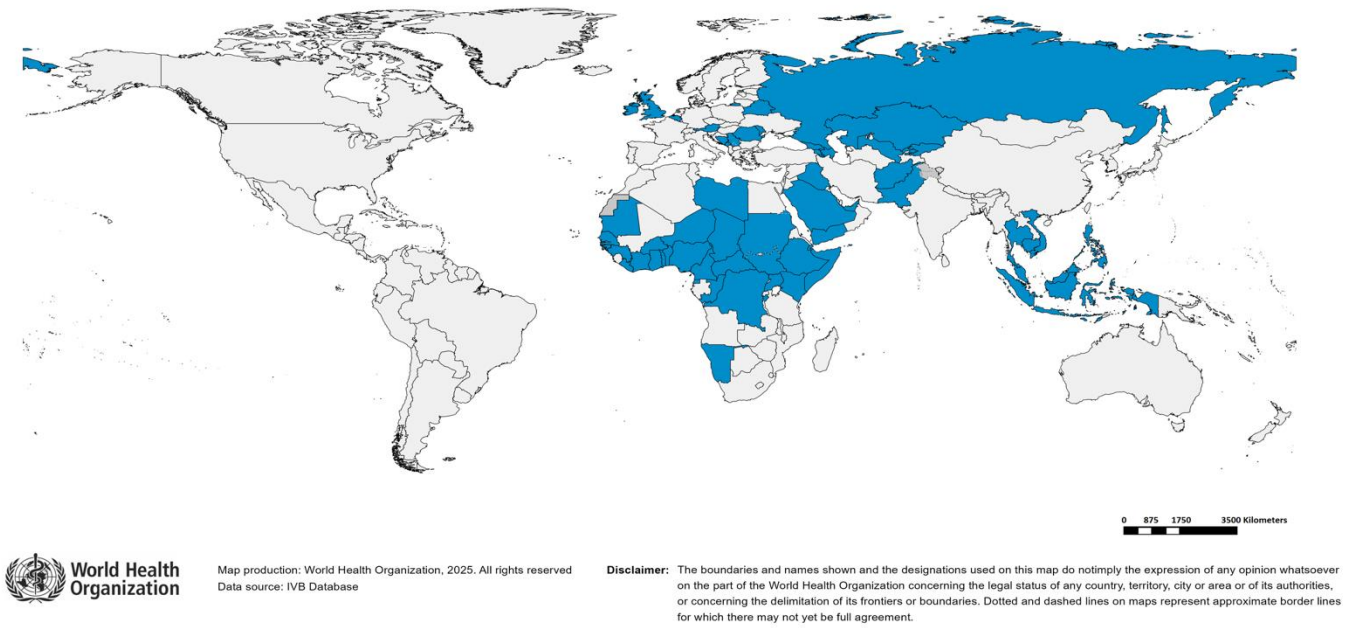
The largest expected gains in coverage for the last doses of IPV would come from a switch to hexa in countries that have substantially lower IPV2 coverage than IPV1 and penta3

Country	pen-1	IPV-1	gap Δ	pen-3	IPV-2	gap Δ	Notes
Uganda	95%	96%	-1 ppt	91%	41%	**50 ppt**	Introduced IPV-2 in 2022 and the gap btwn pen-3 and OPV-2 is expected to close in 2024
Chad	81%	67%	14 ppt	75%	32%	**43 ppt**	Introduced IPV-2 in 2021
South Sudan	76%	67%	9 ppt	73%	34%	**39 ppt**	Introduced IPV-2 in 2021
DRC	80%	66%	14 ppt	60%	23%	**37 ppt**	Introduced IPV-2 in 2022
Mali	78%	77%	1 ppt	77%	52%	**23 ppt**	Introduced IPV-2 in 2021
Madagascar	74%	63%	11 ppt	65%	43%	**22 ppt**	Introduced IPV-2 in 2021
Cameroon	81%	71%	10 ppt	75%	55%	**20 ppt**	Introduced IPV-2 in 2023. Although the gap between pen-3 and IPV-2 is likely to narrow in 2024, it is unlikely to close 10 ppt given the gap btw pen-1 and IPV-1.
Kyrgyzstan	91%	86%	5 ppt	86%	66%	**20 ppt**	Introduced IPV-2 in 2022
Côte d'Ivoire	83%	83%	0 ppt	79%	60%	**19 ppt**	Introduced IPV-2 in 2023 and the 19 ppt gap btw pen-2 and IPV-2 likely to close in 2024
Nigeria	70%	62%	8 ppt	62%	44%	**18 ppt**	Introduced IPV-2 in 2021
Sierra Leone	92%	91%	1 ppt	91%	75%	**16 ppt**	Introduced IPV-2 in 2021
Somalia	52%	42%	10 ppt	42%	26%	**16 ppt**	Introduced IPV-2 in 2022
Togo	92%	85%	7 ppt	85%	69%	**16 ppt**	Introduced IPV-2 in 2022
Afghanistan	67%	59%	8 ppt	60%	45%	**15 ppt**	Introduced IPV-2 in 2020 and WUENIC coverage has since been in the 30-45% range since
Yemen	57%	47%	10 ppt	46%	33%	**13 ppt**	Introduced IPV-2 in 2021

Source: WEUNIC 2023; WHO Immunization Data portal

Immunization Agenda 2030 – Impact Goal 1.3

59 countries provisionally meet the large and disruptive measles outbreaks definition



Country	Cases	Rate/M	Clinical*
Kyrgyzstan	13,651	1,871.27	45%
Romania	27,993	1,480.43	3%
Kazakhstan	18,805	902.19	3%
Azerbaijan	8,586	825.76	75%
Yemen	24,155	578.23	94%
Iraq	25,256	537.12	85%
Bosnia and Herzegovina	1,588	505.72	80%
Liberia	2,040	355.95	11%
Burkina Faso	6,769	281.17	76%
Equatorial Guinea	474	244.53	60%
Afghanistan	10,503	239.55	0%
South Sudan	2,542	208.55	70%
Ethiopia	25,462	187.95	0%
Côte d'Ivoire	5,981	182.84	0%
Armenia	501	169.69	0%
Burundi	2,300	159.83	2%
Serbia	954	142.62	35%
Russian Federation	19,218	133.46	0%
Thailand	8,318	116.14	35%
Ghana	3,890	110.94	4%
Pakistan	23,591	92.43	10%
Malaysia	3,197	88.86	6%
Georgia	333	87.48	7%
Republic of Moldova	223	74.43	1%
Somalia	1,454	73.98	0%
Niger	1,950	69.85	32%
Montenegro	40	63.22	0%
Austria	545	59.80	0%
San Marino	2	59.57	0%

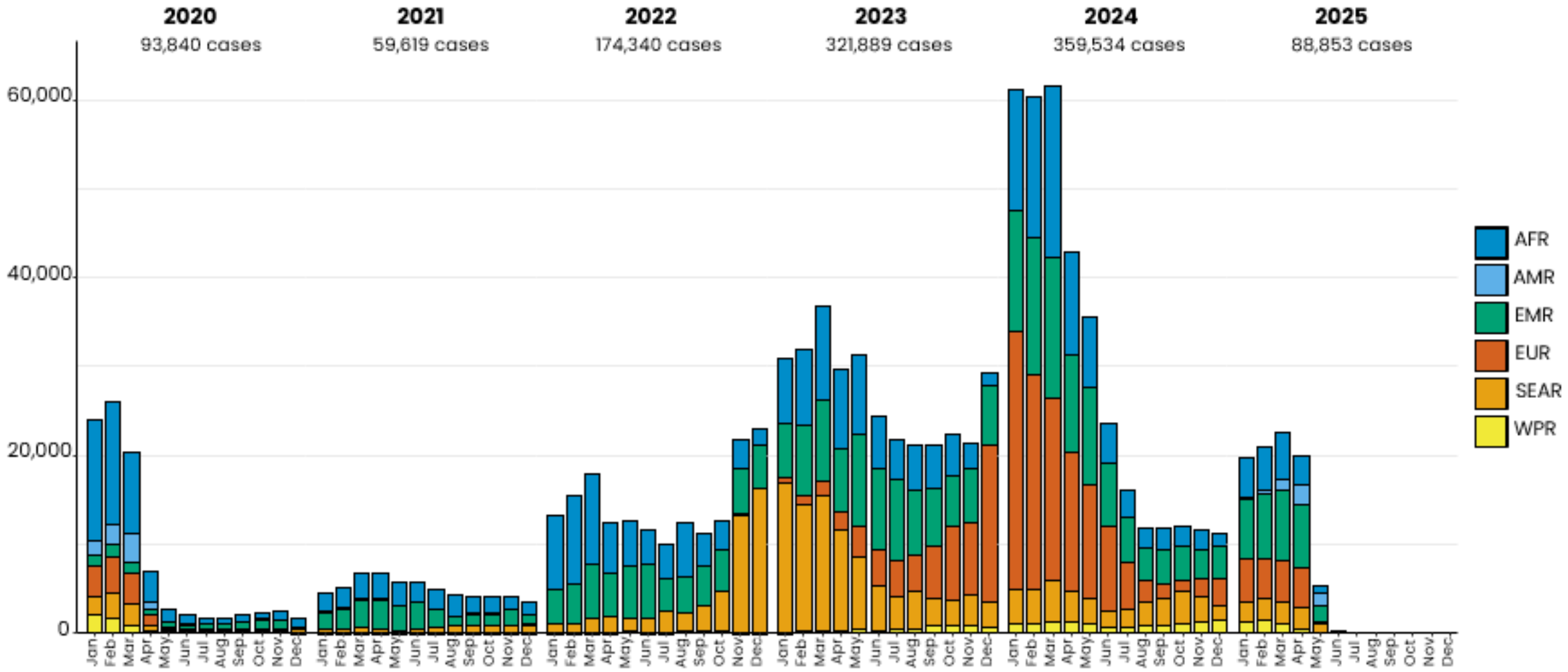
Country	Cases	Rate/M	Clinical*
Benin	880	59.40	21%
Cambodia	989	55.41	0%
Monaco	2	52.16	0%
Mauritania	269	50.61	0%
Djibouti	59	49.83	0%
Guinea	742	49.14	13%
Chad	989	47.09	7%
Belgium	551	46.86	7%
United Arab Emirates	516	45.48	10%
Belarus	402	44.68	0%
Ireland	236	44.46	1%
Togo	428	44.03	11%
DR Congo	4,704	41.69	2%
Nigeria	9,443	39.76	59%
United Kingdom of Great Britain and Northern Ireland	2,738	39.37	0%
Philippines	4,064	34.80	83%
Uzbekistan	1,264	34.11	2%
Saudi Arabia	1,170	33.85	0%
Sudan	1,557	30.14	5%
Cameroon	877	29.35	12%
Namibia	86	27.81	72%
Congo	179	27.60	8%
Libya	193	25.88	0%
Senegal	480	25.35	8%
Guinea-Bissau	56	24.89	100%
Indonesia	6,964	24.37	56%
Kenya	1,369	23.80	5%
Central African Republic	125	22.67	4%
Viet Nam	2,233	21.98	9%
Uganda	1,064	20.71	6%

In the frame of tracking progress towards the goals of Immunization Agenda 2030 (IA2030), an indicator has been developed by a working group in order to represent large and disruptive measles outbreaks. This indicator is defined as an incidence equal or greater than 20 reported measles cases per million population over a period of 12 months. It is important to note that measles outbreak definitions vary between countries and regions according to local context and level of progress towards regional elimination goals. This definition of large and disruptive outbreaks aims to complement and not replace the national and regional definitions, while also providing a degree of global standardization and permitting tracking of progress against a common metric.

Notes: Based on data received 2025-06 and covering the period between 2024-02 and 2025-01 - Incidence: Number of cases / 1M population - Population Data: World population prospects, 2019 revision - A high proportion of clinical cases indicates a high level of uncertainty associated with the incidence rates and the inclusion of countries in this list.

Source: WHO IVB "Measles and Rubella Global Update June 2025"

Measles case distribution by month and WHO region (2020-2025)



Source: WHO IVB "Measles and Rubella Global Update June 2025"; based on data received 2025-05 from IVB Database – This is surveillance data, hence for the last month(s), the data may be incomplete