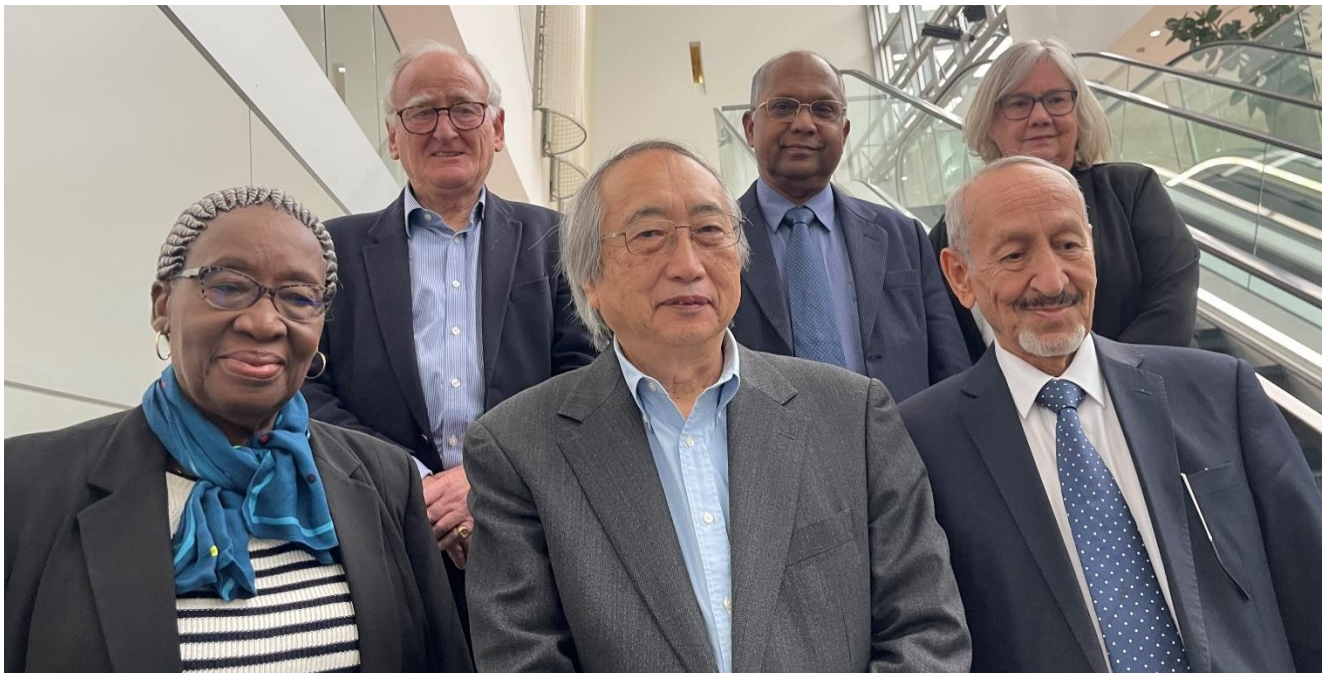
Summary Report from the Twenty-seventh Meeting of the Global Commission for Certification of Poliomyelitis Eradication

Geneva, Switzerland, 26 - 27 November 2025

World Health Organization

Members of the Global Commission for Certification of Poliomyelitis Eradication



Left to right,
Top row: Professor David Salisbury, Professor Mahmudur Rahman, Dr Arlene King
Lower row: Professor Rose Leke, Dr Nobuhiko Okabe, Professor Yagoub Al Mazrou

Abbreviations

Abbreviation	Definition
AFP	Acute Flaccid Paralysis
CC	Certificate of Containment
CCS	Containment Certification Scheme
CP	Certification of Participation
CWG	Containment Working Group of the GCC
ES	Environmental Surveillance
GAPIV	Global Action Plan for Poliovirus Containment Version IV
GCC	Global Commission for Certification of Poliomyelitis Eradication
GPEI	Global Polio Eradication Initiative
IPV	Inactivated Poliomyelitis Vaccine
NAC	National Authority for Containment
NCC	National Certification Committee
oPt	occupied Palestinian territory
OPV	Oral Poliomyelitis Vaccine
PEF	Poliovirus-Essential Facility
PID	Primary Immunodeficiency Disorders
PV	Poliovirus (PV1 is PV type 1, etc.)
RCC	Regional Commission for Certification of Poliomyelitis Eradication
SAGE	Strategic Advisory Group of Experts on Immunization
TAG	Technical Advisory Group
VDPV	Vaccine Derived Poliovirus
WHO	World Health Organization
WPV	Wild poliovirus (WPV1 is type 1, etc.)

Contents

Introduction

The 27th meeting of the Global Commission for Certification of Poliomyelitis Eradication (GCC) took place in Geneva on 26-27 November 2025, chaired by Professor David Salisbury. Commission Members are chairs of their respective Regional Commissions for Certification of Poliomyelitis Eradication (RCC):

- Professor David Salisbury – Chair Global Certification Commission and Chair European Regional Certification Commission
- Dr Arlene King - Chair Regional Certification Commission for Region of the Americas and Chair GCC Containment Working Group
- Dr Nobuhiko Okabe - Chair Western Pacific Regional Certification Commission
- Professor Mahmudur Rahman - Chair Southeast Asia Regional Certification Commission
- Dr Yagoub Al Mazrou - Chair Eastern Mediterranean Regional Certification Commission
- Professor Rose Leke - Chair Africa Regional Certification Commission

Objectives

- Provide GCC with an update on the implementation of the GPEI strategy and Action Plan, particularly in the context of optimizing resource utilization, with a focus on poliovirus surveillance,
- Report to the GCC on surveillance in polio endemic countries and seek inputs,
- Present to the GCC the reports from the Regional Certification Commissions (RCCs),
- Update the GCC on the implementation of poliovirus containment plans and highlight any issues requiring its input and guidance, and
- Provide the GCC with an update on bOPV cessation planning, as well as the outcomes of the Strategic Advisory Group of Experts on Immunization (SAGE) meeting.

The agenda is included in the Annex.

Session 1: Global Update on GPEI Strategy Implementation and Programme Status in the WHO Eastern Mediterranean region

Update on GPEI Strategy

Despite notable gains, the program continues to face significant challenges in WPV1 endemic countries, as well as countries affected by polio outbreaks. These include humanitarian emergencies, insecurity, lack of full access and increasing financial constraints, putting the gains achieved at risk. Globally, an estimated 14 million zero-dose children remain unreached, largely concentrated in fragile and conflict-affected settings, including Afghanistan, Pakistan, northern Nigeria, Somalia, Yemen, Sudan, and Gaza, where insecurity and health system disruptions continue to impede vaccination and surveillance. While the supply of novel oral polio vaccine type 2 (nOPV2) has stabilized, resource limitations and campaign quality challenges continue to limit the full impact of outbreak response activities. The GPEI Strategy Committee emphasized a critical 6 to 12 month window of opportunity to substantially advance polio eradication, noting that ending WPV1 in Afghanistan and Pakistan remains the most cost-efficient way to protect all countries globally against WPV1.

Goal 1: Interrupting Wild Poliovirus (WPV1) Transmission

Under Goal 1, GPEI continues to prioritize interruption of WPV1 transmission in the two remaining endemic countries, Afghanistan and Pakistan, where cases declined from 99 in 2024 (25 in Afghanistan, 74 in Pakistan) to 39 cases in 2025 (9 in Afghanistan, 30 in Pakistan, as of end October), although environmental surveillance indicates ongoing circulation in core reservoirs. Transmission mostly remains concentrated in South Khyber Pakhtunkhwa, Karachi, and the Quetta-Kandahar corridor, driven by access constraints, insecurity, population movement, and inconsistent campaign quality. In Afghanistan, the “Strategic Reset”, informed by February 2025 TAG recommendations, aims to maximize reach under current access constraints by optimizing site-to-site delivery, improving micro-census accuracy, strengthening routine immunization in high-risk urban centers such as Kandahar and Lashkargah, and sustaining advocacy to enable improved access through house-to-house campaigns. In Pakistan, the “Roadmap to Zero”, aligned with July 2025 TAG guidance, focuses on gaining access in South KP, emergency EPI scale-up in South KP and the Quetta Bloc, prioritizing mobile and missed populations, expanding community vaccination initiatives (ComVI) in inaccessible areas, and strengthening monitoring and accountability in historic reservoirs, including Karachi.

Goal 2: Phased Approach to cVDPV2 Elimination

Under Goal 2, the GPEI reported substantial progress in reducing the global circulating vaccine-derived poliovirus (cVDPV2) burden. As of mid-November 2025, a total of 161 cVDPV2 cases had been reported during the year, compared to 448 cVDPV2 cases in 2024. Progress in 2025 has been the most notable in Southern Africa and the DR Congo, while persistent transmission in the Lake

Chad Basin and the Horn of Africa continues to pose a challenge to the GPEI. Nigeria in the Lake Chad Basin, together with Ethiopia and Yemen in the Horn of Africa, accounted for more than 60% of global cVDPV2 cases in 2025, so far.

GPEI Action Plan Development Process

To operationalize the GPEI Strategy 2022–2029 efficiently in the context of current financial constraints, the GPEI Strategy Committee, in close consultation with national governments, national emergency operations centers, regional and national advisory groups, WHO, UNICEF, Gavi, Rotary, donors, and independent advisory bodies, developed an Action Plan for 2026. The Action Plan defines sub-national plans for core transmission areas and sets out resource allocation, efficiency measures, risk mitigation, and accountability frameworks, including provisions on gender, integration, and special interventions, with the overall aim of accelerating progress towards Goals 1 and 2 of the GPEI Strategy. The Action Plan is aligned with the revised financial outlook, including a 2026 budget target of approximately US$780 million within a US$6.9 billion envelope for 2025–2029, and reflects a continued commitment to efficient resource utilization, stopping endemic WPV1 transmission in 2026, phased cVDPV2 elimination, and sustained political and donor engagement. The Action Plan has been endorsed by the Polio Oversight Board and is currently under implementation. The GPEI Strategy Committee is providing direct oversight through close engagement with regional and country programs and by advising on mid-course corrections as implementation progresses.

Afghanistan Polio Eradication update

Afghanistan reported 9 WPV1 cases in 2025 (as of late October), compared to 25 cases in all of 2024, reflecting a decline. It is important to note that due to the land border closure between Afghanistan and Pakistan, stool specimens from AFP cases and contacts, as well as environmental samples, could not be shipped to the Regional Reference Laboratory in Islamabad, Pakistan, since 12 October 2025, resulting in a substantial backlog of untested samples. Efforts are ongoing to resume the laboratory testing of the AFP and environmental samples. WPV1 transmission has significantly declined in the East Region in 2025, following improved quality of vaccination campaigns. However, the southern region of Afghanistan continues to report WPV1 cases and positive environmental samples, indicating ongoing intense transmission.

While transmission outside the southern region has declined, sporadic environmental detections in the eastern and other regions highlight ongoing vulnerability and the risk of resurgence if access and campaigns do not improve.

Since October 2024, Afghanistan has not been able to conduct house-to-house vaccination, and all campaigns since then have been implemented through the site-to-site modality, constraining reach, particularly to younger children. In response, the program launched a “Strategic Reset” in early 2025, aimed at maximizing reach under restricted access conditions. The Afghanistan polio program is making concerted efforts to optimize operational and communication strategies to maximize reach to target children through site-to-site campaigns. Key components include improved micro-census and settlement mapping, optimization of operational and communication strategies to maximize reach through the site-to-site modality, acceleration of routine immunization in priority urban centers, and intensified advocacy to expand access opportunities. The strategy emphasizes

maximizing reach, strengthening EPI–PEI integration, and maintaining eradication-level surveillance. The quality of site-to-site campaigns has been reasonably good in the Eastern Region but low in the Southern Region of the country. AFP surveillance in Afghanistan continues to demonstrate high quality, as reflected in key surveillance indicators at both national and sub-national levels. Community reporting volunteers remain a critical component of the surveillance system. Afghanistan's environmental surveillance network currently comprises 45 collection sites across key epidemiological geographies, complementing AFP surveillance.

Pakistan Polio Eradication update

Pakistan reported 51 WPV1 cases in 2025 (as of late October), compared to 73 cases in all of 2024. WPV1 continues to be detected in environmental samples across all four major provinces. Transmission remains most intense in South Khyber Pakhtunkhwa (KP), as indicated by continued reporting of WPV1 cases and positive environmental isolates. Although Karachi in Sindh Province has not reported any WPV1 cases in 2025, ongoing detections in environmental samples, which are mostly genetically linked, indicate continued transmission within the city. A decline in both WPV1 cases and environmental detections has been observed in 2025 in the Quetta and Peshawar blocs. Active WPV1 transmission is also being detected in 2025 in Lahore, Punjab Province, and several districts within the Central Pakistan epidemiological block.

Despite overall improvements in the quality of vaccination campaigns in 2025, as reflected by national and provincial indicators, gaps in full access and operational performance remain the primary challenges to interrupting WPV1 transmission. Insecurity resulting in limited access in southern KP and inconsistent campaign quality in Karachi constitute the main challenges at this juncture.

The Pakistan program is implementing a three-phase "Roadmap to Zero Polio": Phase 1 (July–September 2025) focused on adjusting to lessons from the 2024–25 experience, optimization and simplification, and strengthening campaign quality; Phase 2 (August 2025–April 2026) focuses on optimizing campaign quality in high-risk geographies and implementing targeted additional interventions; and Phase 3 (April–June 2026) focuses on maintaining high-quality surveillance for eradication, mapping residual risks, and interrupting the final chains of transmission.

AFP surveillance performance remains strong at both national and sub-national levels, with all districts meeting the non-polio AFP rate target. Stool adequacy at the sub-national level improved in 2025, with 147 districts meeting the 80% target, compared with 128 districts in 2024. Further analyses indicate that surveillance generally provides good coverage of migrant populations and is equitable by gender. AFP surveillance is being further strengthened in border and security-compromised districts, including through engagement of community informants. Robust systems are in place at both national and provincial levels to monitor AFP surveillance quality and to identify and address emerging gaps in a timely manner. AFP surveillance is complemented by 127 environmental surveillance sites across 87 districts nationwide, which play an important role in monitoring epidemiological trends and informing program strategies. In addition, there are 81 sentinel sites for poliovirus surveillance among patients with primary immunodeficiency disorders (PID).

Regarding molecular epidemiology in Afghanistan-Pakistan epidemiological block, there has been an overall decrease in genetic biodiversity between 2020 and 2023. However, an increase in genetic biodiversity was observed in 2024, necessitating a split of two genetic clusters into eight genetic clusters, three of which are active in 2025. The remaining chains of transmission continue to circulate in populations and geographies with persistently low immunization coverage, including the bordering districts of the southern and northern epidemiological corridors across the two endemic countries.

Eastern Mediterranean Regional Update (other than WPV1 endemic countries)

As per the regional risk assessment, Yemen continues to be at high overall risk, while Somalia, Sudan, Syria, and Iraq are classified as medium-risk countries. From a surveillance perspective, Morocco is classified as a high-risk country, while Libya and Sudan are classified as medium-risk countries.

A total of 40 cVDPV2 cases have been reported from the Region in 2025 (as of end October), compared to 196 in 2024. The cVDPV2 cases in 2025 were reported from Djibouti, Somalia, Sudan, and Yemen. Northern Yemen has reported the most intense transmission in the Region, with 30 cVDPV2 cases in 2025, as no immunization response was conducted due to insecurity and lack of functional access for vaccination campaigns in Northern Yemen. In addition, cVDPV2 was detected through environmental surveillance in Gaza and Sudan, with the last detections reported in March and April 2025, respectively.

Most countries in the Region are meeting the targets for the key surveillance indicators. Polio endemic, outbreak-affected, and high-risk countries are maintaining high non-polio AFP rates in 2025 at the national level, except Libya and Morocco. The target for the stool adequacy rate was met by all countries in 2025 at the national level, except Morocco and Qatar. There are sub-national variations in the key surveillance indicators in some countries, and national programmes are making efforts to address these gaps with support from the regional team. The Shipment of AFP and environmental samples from Northern Yemen remains challenging due to insecurity and logistical constraints, resulting in a significant backlog for the second half of 2025. There is significant sub-national variability in surveillance quality in Sudan in 2025 due to the prevailing conflict situation, with several silent districts and districts reporting a low non-polio AFP rate. There have also been challenges in Sudan in regularly collecting environmental samples in 2025. Since the outbreak notification in Gaza, surveillance has significantly improved despite the ongoing conflict and humanitarian emergency, with environmental and community-based surveillance complementing AFP surveillance. An outbreak response assessment is planned in Gaza during the first quarter of 2026. Sub-national gaps in surveillance quality persist in Morocco, Libya, and Tunisia, mainly due to operational constraints. A surveillance review was conducted in Tunisia in September 2025, and a review is planned in Libya during the first half of 2026.

Session 1 - Conclusions

Overall conclusions

WPV1

1. Based on the current WPV1 epidemiology in late 2025, with extensive WPV1 transmission throughout Pakistan and in Southern Afghanistan, the GCC considers that interruption of transmission by the end of 2026 is highly unlikely.
2. As a consequence, even if transmission were interrupted at the end of 2026, certification of WPV1 eradication could not be completed before 2029 at the earliest.
3. The GCC will review the WPV1 situation at the end of the next low-transmission season (May–June 2026) and will update its position on certification of eradication to the programme.
4. The GCC proposes to develop guidance for RCCs to outline the requirements from already certified Regions so that they can start planning for provision of national data to support the RCCs' conclusions that their respective Regions are indeed free of WPV1 and would have detected WPV1 circulation, had that occurred.

cVDPV

1. The GCC notes the GPEI's approach to stopping cVDPV2 outbreaks in the African Region. The GCC, in collaboration with the African Regional Certification Commission (RCC), will continue to review the situation from the certification perspective.

Overarching / Global

1. The GCC acknowledged the GPEI action planning, including the sub-national planning for endemic and outbreak countries, and urges that the implementation of these plans be closely tracked and supported, as this will be critical to determining success.
2. The GCC is concerned about the significantly declining GPEI resources. The GCC appreciates the ongoing commitment of the GPEI and all partners supporting eradication, recalling that polio is an eradicable disease and that significant progress has been made. Further coordinated efforts must continue until the eradication goal is achieved.
3. The GCC appreciates the steps taken to maintain surveillance and laboratory capacity, particularly in the African Region, despite the reduction in resources. Surveillance remains a lynchpin of the programme for the timely detection and response to polioviruses, as well as for informing programme strategies and tactics.
4. The GCC noted the WPV1 importation into Germany, which reinforces the continued risk of international spread and underlines that poliovirus anywhere represents a risk everywhere. The GCC further noted that environmental surveillance can facilitate the early detection of poliovirus importation.

Endemic Countries

1. The GCC appreciates the resolve and commitment of the Afghanistan and Pakistan polio eradication teams, especially the frontline workers, and expresses its sympathy for the families and friends of the health workers who have lost their lives in the line of duty.

2. The GCC acknowledged the high-level political commitment in Pakistan. However, the GCC remains concerned about the effectiveness of this commitment at the operational level, particularly with respect to performance management.
3. The GCC is concerned that the Afghanistan programme has not been able to implement house-to-house campaigns for more than a year now. In this context, achieving campaign quality to achieve eradication is very challenging.
4. The GCC noted that the two of the three cross-border epidemiological corridors (southern and central) continue to have active WPV1 transmission. The GCC further noted with appreciation the progress in the northern corridor, particularly the eastern region of Afghanistan, despite regression from house-based campaigns to 'site-to-site' campaigns.
5. The GCC notes that the Pakistan Government's 2/4/6 strategy of 2024 has not been successful and the 2026 approach needs to be more effective.
6. The GCC is concerned that the south region (AFG) continues to have intense WPV1 transmission, due to continuing low campaign and routine immunization quality.
7. Karachi (Pakistan) continues to be critical to WPV1 eradication in Pakistan, as well as the Afghanistan-Pakistan epidemiological block. This populous cosmopolitan city, with extensive population movement has the potential to sustain, amplify and export WPV1 to the entire epidemiological block, and beyond.
8. South KP remains an impediment for the Pakistan polio programme, having led to slippage in 2021-2022, and continues to pose a significant risk to eradication efforts.
9. Surveillance quality, both in Afghanistan and Pakistan, is high, continues to provide a good epidemiological picture and provides useful information for programme planning.
10. The GCC noted with concern the suspension of shipment of AFP and environmental samples to the WHO Regional Reference Laboratory in Islamabad, and the resulting accumulation of backlog.
11. The GCC noted the ongoing low routine immunization coverage, including in the key polio hotspots of the endemic countries, mainly due to governance and performance management issues. This compounds the challenge of stopping endemic WPV1 transmission.

Eastern Mediterranean Regional update

1. The GCC noted with concern the ongoing intense cVDPV2 transmission in northern Yemen. This situation poses a risk of further spread to other countries within the Eastern Mediterranean Region and beyond, given the continued population movement.
2. The GCC noted declining cVDPV2 detections in Somalia; however, risks still exist due to lack of full access in south-central Somalia for vaccination campaigns.
3. The GCC noted the co-circulation of cVDPV1 and cVDPV2 in Djibouti, requiring urgent attention and implementation of high-quality responses.
4. The GCC acknowledges the support that WHO EMRO is providing to the Member States on outbreak response preparedness through simulation exercises.

Session 1 – Recommendations

Overarching

1. The GCC recommends that the accountability part of the GPEI Action Plan should be reviewed regularly, particularly aiming to improve programme performance and

implementation quality.
2. It is not clear what the process for accountability reviews will be and how this will differ from previous processes.
3. The GCC reinforces its previous recommendation to continue to optimize environmental surveillance in all the WHO regions, based on risk of importation.

Endemic Countries

4. The GCC urges that both endemic country programmes focus on effective performance management under their accountability frameworks.
5. The GCC recommends that comprehensive support be provided to frontline health workers, including supervision and full security and protection, using an all-of-government approach.
6. The GCC emphasized that the gains made in the eastern region of Afghanistan and adjoining Peshawar Block of Pakistan must be sustained, by ensuring high-quality vaccination in future campaigns, as well as by improving routine immunization.
7. The GCC recommends reviewing the strategies in southern Afghanistan, which have not yet yielded desired results. The GCC encourages local dialogue and recommends that GPEI partners support the Afghanistan programme through advocacy and new operational and innovative approaches.
8. Strategic and operational tactics in South KP (Pakistan) have not worked, as indicated by the ongoing intense WPV1 transmission. The GCC, while acknowledging the difficulties, recommends that the programme review and tailor its approaches to the local context in South KP.
9. While noting the recently completed independent programme audit in Karachi, the GCC recommends the urgent development of an action plan to implement the audit's recommendations.
10. The GCC recommends maintaining cross-border programme coordination between Afghanistan and Pakistan, especially on programme implementation in the bordering areas and successfully vaccinating populations on the move.
11. The GCC recommends that all necessary measures be urgently taken to restore and sustain the timely shipment and testing of AFP and environmental samples to a WHO-accredited laboratory, and to ensure rapid clearance of any accumulated backlog, in order to maintain surveillance sensitivity and timeliness of detection.
12. The GCC recommends that both endemic countries engage women in the frontline eradication activities as much as possible, as well as in management roles.

Eastern Mediterranean Region

13. The GCC recommends maintaining high-quality poliovirus surveillance across the region, with particular focus on countries at high risk of WPV1 importation and cVDPV2 emergence, to ensure early detection.
14. Surveillance sensitivity should be closely monitored in high-risk countries to promptly identify and address any emerging gaps in surveillance.
15. The GCC recommends aligning POSE planning with countries' risk classification.

Session 2: Update on Global Polio Surveillance Action Plan (GPSAP)

GPSAP 2025–2026 implementation

Under GPEI Surveillance Group prioritization, 24 high-priority countries are being monitored against the key performance indicators set for 2024–2025, including six in the Eastern Mediterranean Region (Afghanistan, oPt, Pakistan, Somalia, Sudan, Yemen). While the overall performance in the high-priority countries at the national level remained generally satisfactory, there remains variability at the sub-national level. In 2025 (as of mid-October), among the 24 priority countries, 16 had more than 80% of districts meeting the target for non-polio AFP rate, and 17 achieved this target for stool adequacy. Kenya, Angola, Mozambique, Chad, Madagascar, oPt, Sudan, and Somalia did not achieve the sub-national uniformity target of 80% for non-polio AFP rate, while Mozambique, Niger, Central African Republic, Burkina Faso, oPt, Indonesia, and Papua New Guinea did not achieve the same target for stool adequacy rate. Regarding the overall timeliness of detection for WPVs and cVDPVs, three of the 19 priority countries with WPV or cVDPV transmission in 2025 had final results available within the timelines defined by the GPEI strategy (35 days for countries with full laboratory capacity and 46 days for those without, measured from AFP onset and environmental sample collection dates). Both WPV1-endemic countries have maintained high timeliness of detection, supported by well-organized sample handling and shipment mechanisms, and a well-performing Regional Reference Laboratory in Islamabad, Pakistan. It is important to note that since mid-October 2025, the program has faced challenges in regularly shipping AFP and environmental samples from Afghanistan to Pakistan due to land border closures, resulting in a growing backlog. WHO and GPEI are working closely with the country teams to address this challenge, including through the implementation of alternative shipment arrangements and exploration of contingency measures. In general, international shipment of specimens from African countries to laboratories located in other countries remains a major challenge in achieving the target for timeliness of detection. It is important to note that the accreditation of two laboratories in March 2025, in Nigeria and Uganda, has begun to improve detection timeliness in the African Region, as reliance on laboratories outside the region has been reduced.

The program continues to monitor trends in the detection of orphan polioviruses as a complementary measure to assess surveillance quality, particularly in high-risk areas. Nigeria and Chad in the African Region continue to report the highest number of orphan viruses, with nearly a quarter of cVDPV detections in 2025 meeting the criteria for orphan classification as of early October. This suggests that certain populations and geographies in the Lake Chad Basin may not be fully covered by surveillance and immunization activities, highlighting the need for focused efforts to strengthen surveillance overall, particularly in hard-to-reach populations and areas.

GPEI funding constraints pose a significant risk to maintaining high-quality surveillance in 2026. The GPEI Surveillance Group, in close collaboration with WHO Regional Offices, is establishing strengthened monitoring and support mechanisms to enable timely identification and response to emerging challenges in the coming months. The group is also updating global guidance on AFP

surveillance, including guidance on orphan virus analysis, adoption of new laboratory technologies, and approaches to improve efficiency in the context of reduced resources.

Session 2 – Conclusions

1. The GCC appreciates the report from the GPEI Surveillance Group (SG).
2. The GCC noted with concern the continued detection of orphan polioviruses (cVDPV2) in the Lake Chad Basin of Nigeria and Chad, indicating potential gaps in surveillance.

Session 2 – Recommendations

1. The GCC endorses the approach to establish a process for thorough monitoring of surveillance performance to identify and address any emerging gaps in a timely manner. The GCC further proposed to also consider process indicators in this mechanism and not just the outcome indicators.
2. The GCC recommends further analyses of orphan viruses, including field investigations, to inform surveillance strengthening.

Session 3: Regional Updates from WHO European, Western Pacific, and Southeast Asia Regions and Region of the Americas

European Region Update

The WHO European Region remains wild poliovirus free, supported by overall strong surveillance and containment systems. AFP surveillance is operational in 45 countries, environmental surveillance in 27, and enterovirus surveillance in 32 countries, with ongoing efforts to further integrate surveillance strategies to maintain high surveillance sensitivity. Environmental surveillance expanded in 2025, with five additional countries and two pilot initiatives. Surveillance quality remains suboptimal in some settings in the Region, particularly in Kyrgyzstan, Tajikistan, and Ukraine. The composite regional risk assessment for 2024 classifies three countries as high risk, twelve as intermediate risk, and 38 as low risk.

In 2025, as of mid-November, four countries in the Region reported cVDPV2 detections, including the United Kingdom, Germany, Israel, and Poland. The United Kingdom reported two detections, most recently in September; Germany reported 17 detections, most recently in October; Israel reported two detections, most recently in February; and Poland reported one detection in January 2025. These detections represent cVDPV2 importations, and all but one in Israel are genetically linked to the emergence group NIE-ZAS-1, originating in Nigeria. One of the two detections in Israel was linked to the emergence SUD-RED-1, originating from Sudan. No human cVDPV2 cases were reported in the European Region in 2024 or 2025, and risk assessments did not indicate evidence of established local transmission. Countries with cVDPV detections continue to strengthen surveillance and address sub-national population immunity gaps to prevent community transmission. These detections reinforce the ongoing risk of international cVDPV2 spread due to population movement and highlight the need for continued vigilance through high-quality surveillance.

In 2024-2025, program activities focused on desk reviews, integrated disease surveillance refresher trainings and webinars, and laboratory training on direct detection, while most field reviews were postponed to 2026 due to operational and financial constraints. Progress towards IPV-only schedules continues, with 43 Member States now using IPV-only schedules. The European Technical Advisory Group reiterated at its 2025 meeting the need to minimize OPV use and transition to IPV-only schedules ahead of globally coordinated bOPV cessation in line with available global and regional guidance. Population immunity remains uneven at the sub-national level in Ukraine, Kyrgyzstan, Romania, and Bosnia and Herzegovina, requiring targeted catch-up and supplementary immunization activities. Progress on poliovirus containment has been encouraging in 2024 and 2025.

The Region has 29 designated poliovirus-essential facilities across 10 countries; all engaged in the containment certification process. Interim containment certification has been awarded to seven

facilities, while Belgium and Denmark have achieved full containment certification. Romania remains the only country with no progress in implementing containment measures, which remains a significant concern. Seven countries in the region retain poliovirus infectious materials in non-poliovirus-essential facilities, including Austria, Germany, Israel, Norway, Romania, Switzerland, and Kosovo.

The RCC, at its most recent meeting, expressed concern about declining immunization coverage in many countries. The Commission noted improvements in AFP and acute flaccid myelitis (AFM) surveillance, and commended the expansion of environmental surveillance, as well as the laboratory network's contributions in maintaining timeliness of detection and high standards of performance and accreditation, and efforts to strengthen response preparedness in selected countries. The Commission reiterated its recommendation to expedite bOPV cessation in European countries and recognized the need for additional support to Belarus, the Russian Federation, and Serbia to advance progress towards containment certification.

Western Pacific Region Update

The Western Pacific Region has remained free of indigenous and imported wild poliovirus; however, circulating vaccine-derived polioviruses (cVDPVs) remain a challenge. The Indonesia cVDPV2 outbreak, reported in 2022, was closed in late 2023. However, a related cVDPV2 outbreak was reported in Papua New Guinea in 2025, with virus detections showing substantial divergence and indicating prolonged circulation due to immunity gaps. In Lao PDR, a cVDPV1 outbreak was reported in 2025 following detections through acute flaccid paralysis surveillance and community healthy-child sampling. These events highlight the ongoing risk of cVDPV emergences and spread in settings with suboptimal population immunity in the Region. The Region also detected ambiguous and immunodeficiency-associated vaccine-derived polioviruses in 2024 and 2025, including ambiguous vaccine-derived poliovirus (aVDPV2) in Australia through environmental surveillance and immunodeficiency-associated vaccine-derived poliovirus (iVDPV) in China and Mongolia, with investigation and response actions initiated. While overall surveillance quality at the regional level and in most countries remains adequate, uneven performance persists in several high-risk countries, including Lao PDR, Papua New Guinea, Cambodia, Viet Nam, and the Philippines. Environmental surveillance continues to expand in the Region, with more than 210 sites currently functioning across 11 countries. Environmental surveillance resumed in Papua New Guinea in 2025. Performance indicators for environmental surveillance are not meeting targets in Lao PDR, Cambodia, and the Philippines. Viet Nam is currently not regularly sharing the surveillance data with WHO. Financial constraints, including reduced regional human resource capacity, are leading to additional challenges in maintaining high-quality operations and technical support to the Member States.

Population immunity gaps in some countries, driven by uneven routine immunization coverage, continue to contribute to regional risk. The Region made progress in 2025 towards introducing a second dose of IPV in routine immunization in Lao PDR and several Pacific Island countries, while Cambodia and Mongolia continue with a single-dose schedule.

Poliovirus containment is advancing in the Region, with 13 designated poliovirus-essential facilities across five countries and continued progress towards certification, including full containment certification achieved by the Republic of Korea. China has yet to demonstrate

sufficient progress on containment certification for its seven poliovirus-essential facilities, in view of the timeline to achieve full certification by the end of 2026. A new regional web-based platform, the Poliovirus Containment Information Management System, is planned for launch in 2026 to strengthen inventories and oversight of containment-related activities.

The RCC, during its 2025 meeting, reaffirmed the Region's wild polio-free status. The meeting marked Indonesia's participation as a Member State of the Western Pacific Region in the RCC process, following its reassignment from the WHO South-East Asia Region. The meeting coincided with the 25th anniversary of the Western Pacific Region's wild polio-free certification, hosted by the Government of Japan in Tokyo and supported by the Japan Institute for Health Security. Participants included chairs of national certification committees, leaders from across the WHO Western Pacific Region, and global experts and partners from the United Nations Children's Fund, Rotary International, Gavi, the Vaccine Alliance, the United States Centers for Disease Control and Prevention, and the Gates Foundation. They participated in a dedicated session to mark this milestone and reaffirmed that maintaining a polio-free Region requires constant vigilance, sustained financing, and unwavering political commitment.

The RCC noted that ongoing outbreaks, surveillance and immunity gaps, and funding constraints pose significant risks in the Western Pacific Region. The Commission recommended accelerated introduction of IPV2 in remaining bOPV-using countries, strengthening surveillance quality, optimization of environmental surveillance, and increased domestic financing for essential polio functions.

Southeast Asia Region Update

The WHO South-East Asia Region has remained free of wild poliovirus detection since 2011; however, variant polioviruses continue to occur and require sustained vigilance and response. Prior to its reassignment from the WHO South-East Asia Region to the WHO Western Pacific Region, Indonesia implemented a biphasic response to the cVDPV2 outbreak, with regular independent assessments to monitor response quality. Following a third independent outbreak response assessment, it was recommended that the cVDPV2 outbreak in Indonesia be closed. The assessment team, however, highlighted the risk of cVDPV2 re-introduction into Indonesia from the ongoing outbreak in Papua New Guinea, which was originally linked to transmission in Indonesia.

In 2025, as of October, the Region reported one aVDPV1 case from Myanmar, one aVDPV3 and one iVDPV3 case from India. In addition, an aVDPV3 detection was reported through environmental surveillance in Nepal. Myanmar implemented two bOPV vaccination rounds across seven townships, administering approximately 35,000 doses, and also conducted an outbreak response simulation exercise. Primary immunodeficiency surveillance is expanding in India, with 340 PID cases notified since January 2024 and four iVDPV detections, all currently non-excreters.

Immunization performance remains generally high in the Region, with most countries reporting high national coverage; however, sub-national gaps persist. Seven countries provide at least two IPV doses in routine immunization, while DPR Korea, Maldives, Myanmar, and Timor-Leste

continue to provide a single IPV dose. Surveillance quality is broadly maintained at the national level; however, Timor-Leste in 2024 and 2025 (as of October), as well as Maldives and Sri Lanka in 2025, remained below the non-polio AFP rate of one. Regarding stool adequacy, Bhutan, Maldives, Sri Lanka, Thailand, and Timor-Leste did not achieve the target of 80% in 2024 and 2025 (as of October). Sub-national variations also persist in countries with otherwise strong national performance. Environmental surveillance is being conducted through 93 sites across five countries and is generally performing well. However, Thailand reported non-polio enterovirus isolation below 50% in 2024 and 2025 (as of October). There is a need to review and optimize surveillance sites where enterovirus isolation is low, particularly in hard-to-reach areas, including parts of Myanmar affected by security and access challenges.

The 2025 regional risk assessment highlights an increased risk of missed poliovirus transmission in several settings and continues to guide the prioritization of outbreak preparedness and response, cross-border coordination, including between Nepal and India, Thailand and Myanmar, and in Cox's Bazar, as well as targeted surveillance reviews and strengthening.

Poliovirus containment is progressing, with two poliovirus-essential facilities in the Region, both in India. Most countries have completed surveys and inventories, with destruction or transfer of identified infectious materials, and certification processes are ongoing for India’s facilities. Transition planning is also advancing, including phased transition of NPSN in India and the development of a regional strategy to sustain essential functions.

The RCC for Polio Eradication, at its 2025 meeting, reaffirmed that the Region remains free of wild poliovirus and that variant polioviruses were detected and responded to in a timely manner. The Commission emphasized the need for continued vigilance, preparedness, cross-border coordination, and sustained resources to manage the risk of importation and new emergences.

Region of the Americas Update

The Region of the Americas marked 30 years without endemic wild poliovirus transmission. In 2024, regional coverage was 90% for IPV1, 89% for IPV2 (up from 87% in 2023), and 85% for Polio3 (down from 87% in 2023). Acute flaccid paralysis (AFP) surveillance meets the regional certification benchmark, with a regional AFP rate of 1.07 per 100,000 children aged less than 15 years over the last 52 weeks. However, persistent national and sub-national gaps in some countries continue to pose a risk of delayed detection. Outbreak and event risk management remain a priority. The cVDPV2 outbreaks in the USA and Canada were officially closed in 2024, with the last detection in the USA in February 2023 and in Canada in August 2022. The Region reported a VDPV1 detection in Peru in 2023, and cVDPV3 was detected through environmental surveillance in French Guiana, an overseas territory of France, in 2024, raising concerns for neighbouring areas with immunity and surveillance vulnerabilities. In 2025, a high-risk event in Honduras involved an 8-year-old child with paralysis; sequencing confirmed a Sabin-like type 1 virus with nine nucleotide differences, phenotypically neurovirulent and with no known genetic linkages. A risk assessment was conducted, and the response included two vaccination campaigns in high-risk districts of Honduras and Nicaragua.

Regional risk assessment highlights heterogeneity in surveillance and population immunity in some countries. Countries classified as high risk for missed poliovirus transmission include the Bahamas, Belize, Haiti, Jamaica, Suriname, and Uruguay. High-risk immunity profiles are observed across multiple countries and territories, reflecting suboptimal routine immunization coverage and uneven district-level performance. The mitigation actions include follow-up on RCC recommendations, including strengthening surveillance in Bolivia, Argentina, the Dominican Republic, Nicaragua and Haiti; targeted regional workshops in Mexico, Honduras, and the Dominican Republic to strengthen detection and investigation capacity; and strengthening national laboratory sequencing and analysis to improve confidence in virus characterization and response.

Progress towards IPV-only routine immunization schedules continues; however, the transition itself represents a risk marker. Countries that switched to IPV-only schedules between 2020 and 2025 are predominantly classified as high or very high risk, underscoring the need for strengthened immunity monitoring and surveillance during and after transition. Poliovirus containment work is advancing, with countries reporting inventories and disposal or transfer of poliovirus materials. The Regional Office continues to monitor the updating of inventories for facilities retaining poliovirus materials, destruction or transfer of unneeded materials, implementation of GAP-IV, and sustained national oversight. Capacity-building efforts have supported this agenda, including a virtual course on risk-based containment strategies, which enrolled 1,892 participants, of whom 940 (49%) were certified.

Session 3 - Conclusions

European Region:

1. The GCC noted the cVDPV2 detections in the European countries in 2024 and 2025, as well as the recent WPV1 detection in Germany through environmental surveillance. This reinforces the ongoing risk of international spread, for both WPV1 and cVDPVs.
2. The GCC noted that it has been more than 12 months since the last cVDPV3 detection in French Guiana.
3. The GCC commends the ongoing efforts in the European Region to enhance poliovirus surveillance, including AFP surveillance and optimization of environmental surveillance.

Western Pacific Region:

4. The GCC noted with concern the reporting of two new cVDPV outbreaks in the Western Pacific Region since its last meeting: cVDPV2 in Papua New Guinea (PNG) and cVDPV1 in Lao PDR, both with persistently low population immunity due to weak routine immunization. The GCC further noted sub-optimal surveillance quality in both PNG and Lao PDR.

5. The GCC appreciates the ongoing outbreak response to cVDPV2 in PNG, and that the response planning is underway at the sub-regional level to the cVDPV1 in Lao PDR.

Southeast Asia Region:

6. The GCC remains concerned about the situation in Myanmar, regarding population immunity as well as surveillance quality.
7. The GCC noted the ongoing transition of poliovirus surveillance in India to Integrated Disease Surveillance Programme (IDSP), planned to be completed by March 2027.
8. The GCC noted the risk to Thailand, associated with the cVDPV1 outbreak in Lao PDR.

Region of the Americas

9. The GCC noted that regional IPV coverage has improved in 2024; however, it remains concerned about the persistent sub-national disparity in IPV coverage.
10. Some countries continue to show lack of meaningful progress in routine immunization coverage at the district level, particularly Suriname, Haiti, Argentina, Mexico, Ecuador, and Bolivia.
11. The GCC noted the very high risk related to sub-optimal surveillance quality and low population immunity in Haiti, Suriname and Argentina. These countries continue to have some risk of missed poliovirus transmission and need urgent attention.
12. The GCC noted the high-risk event in Honduras, related to isolation of a Sabin 1-like poliovirus, a possible pre-VDPV from an AFP case. This event is a reminder of the risk associated with low-immunity population pockets in the Region.

Session 3 – Recommendations

European Region:

1. The GCC recommends continuing the focus on institutionalizing AFP surveillance and enhancing environmental surveillance based on the regional risk assessment.
2. The GCC recommends maintaining the focus on population immunity assessment and prioritizing catch up vaccination initiatives, as needed.

Western Pacific Region:

3. Noting that the quality of response campaigns in PNG was not uniformly optimal, the GCC recommends a thorough performance review to inform planning of further vaccination rounds in PNG.
4. The GCC recommends immediate steps to scale up poliovirus surveillance in PNG and Lao PDR, as well as in Viet Nam, which will help fully understand the extent and patterns of cVDPV transmission in the region.

Southeast Asia Region:

5. WHO and other health partners should continue monitoring the situation in high-risk countries of the Region, particularly Myanmar, and provide technical and financial support, as needed.
6. The GCC emphasizes the importance of maintaining high quality poliovirus surveillance following the transition in India, which is critical to sustaining the gains in the country.
7. The GCC recommends full implementation of the recommendations from the recent surveillance review conducted in Thailand.

Region of the Americas

8. The GCC notes and reinforces the RCC recommendation on ES expansion in the region, based on risk assessment. AFP surveillance, as the primary surveillance strategy, should also be improved, especially in the 'very high-risk' countries identified by the RCC.
9. The GCC recommends tailored vaccination plans to enhance population immunity in the countries with significant sub-national level disparity in immunization coverage.
10. The GCC recommends systematically including containment related risk in the overall national risk assessment process.
11. The NAC in the USA should immediately make available information on poliovirus containment to the GCC's Containment Working Group (CWG) and take urgent steps to align the containment processes to the GCC defined timelines.

Session 4: WHO African Regional Update (GPEI Goal 2)

African Regional Update and Progress on Responding to cVDPV2 Outbreaks

There has been an overall decline in the number of cVDPV cases reported from the African Region since 2022. The wild poliovirus outbreak in southern Africa, resulting from importation from Pakistan, was closed in 2024. In 2025, a total of 147 cVDPV2 cases were reported from nine countries in the Region, with transmission largely driven by countries in the Lake Chad Basin, particularly Nigeria. The cVDPV2 emergences designated "NIE-ZAS-1 (originating from Nigeria)" and "SOM-BAN-1 (originating from Somalia)" together accounted for 73% of all cases reported in the Region. Angola and Tanzania experienced intensifying cVDPV2 transmission during the second half of 2025.

There has been a significant reduction in the number of cVDPV1 cases in the Region, with one case each reported from the DR Congo and Algeria. The cVDPV1 case in Algeria, with paralysis onset in January 2025, was genetically linked to an iVDPV1 spillover from a primary immunodeficiency disorder (PID) patient. Algeria also reported a positive environmental sample genetically linked to the same cVDPV1 emergence. This represents the first documented instance of a cVDPV1 emergence of presumed iVDPV origin. Further risk assessment, field investigations, and surveillance strengthening measures are under way to determine the geographical extent of transmission and to closely monitor the situation, particularly in eastern Algeria and neighbouring areas of Tunisia.

Three countries, Cameroon, Chad, and Guinea, reported cVDPV3 in 2025. Cameroon and Chad experienced co-circulation of cVDPV types 2 and 3 during the year. Notably, the same cVDPV3 emergence caused outbreaks in both countries, indicating cross-border transmission, with one case reported in Cameroon and five cases in Chad.

Between January and November 2025, the Region conducted 40 vaccination campaigns across 16 countries, reaching approximately 200 million children, including co-administration of bOPV with nOPV2 in Nigeria and Chad.

While overall surveillance indicators meet targets at the national level, sub-national surveillance sensitivity remains variable. The Region maintains a comprehensive environmental surveillance network comprising 528 sites across 360 districts in 236 provinces, covering an estimated 789 million people (56% of the population). Of these, 62 sites achieved the benchmark of at least 50% enterovirus isolation rate in 2025. Between 2022 and week 45 of 2025, 204 orphan polioviruses were detected, predominantly in Nigeria and Chad, highlighting the ongoing risk that some populations and geographies, particularly in the Lake Chad Basin and Sahel epidemiological blocks, may not be fully covered by the surveillance networks.

Routine immunization remains uneven across the Region, with approximately 75% OPV3, 77% IPV1, and 48% IPV2 coverage in 2024 at the regional level, and several countries have yet to introduce

IPV2. Containment has advanced, supported by ODK-based inventories, with 27 Member States fully implementing ODK. South Africa eliminated the Region's only poliovirus-essential facility (PEF) through destruction of infectious materials, leaving AFRO without a PEF. However, slow uptake of containment tools in some countries and limited domestic financing remain key challenges.

Strategic regional priorities include sustaining co-administration approaches (bOPV and nOPV2) where warranted by epidemiology, strengthening cross-border coordination, strengthening sub-national AFP and environmental surveillance quality, accelerating IPV2 introduction and routine immunization improvement, and maintaining robust containment compliance. There remains significant scope for improvement in the timeliness of detection, particularly in high-risk countries. Risks to surveillance quality associated with reduced GPEI funding in 2026 are further exacerbated by limited political commitment and insufficient domestic financing.

Session 4 – Conclusions

1. The GCC noted, and is encouraged by, the overall decrease in the number of cVDPV2 cases in the African Region.

2. However, the ongoing intense transmission in the Lake Chad Basin and the Horn of Africa remains a concern and places the progress achieved in 2025 at risk.

3. The GCC is also concerned about the continuing transmission in Angola and the recent cVDPV2 detection in Namibia, which represents a newly infected country. There is continued risk of further spread of cVDPV2 in the African Region, especially to the countries with low routine immunization coverage.

4. The GCC noted that the reach and quality of the outbreak response campaigns have not yet achieved uniformly high standards in critical geographies and populations within the region.

5. While noting generally good surveillance quality at the national level in most African countries, the GCC is concerned that surveillance quality remains variable at the sub-national level. The GCC noted persistent detection of orphan polioviruses in Nigeria and Chad in the Lake Chad Basin, indicating potential gaps in surveillance.

6. Routine immunization coverage, including IPV1 and IPV2, remains low in most of the infected areas of the region, resulting in continued risk of transmission.

7. The GCC is concerned that nine countries in the African Region have not yet introduced a second dose of IPV into routine immunization schedules, as recommended by SAGE.

8. Whilst WPV transmission has been interrupted throughout the African Region, validated by the ability to detect cVDPVs, the burden of paralysis caused by vaccine derived polioviruses is unacceptable. In effect, WPVs have been replaced with VDPVs and the same urgency that was previously applied to interruption of WPV transmission needs to be applied to VDPV transmission. One critical aspect will be the improvement of population immunity through routine immunization.

Session 4 – Recommendations

1. The GCC recommends increased focus on strengthening sub-national surveillance quality, particularly in high-risk countries. Monitoring surveillance performance at sub-national level has become increasingly important in the context of the current resource-constrained environment.
2. The GCC further recommends close monitoring of surveillance quality and of the system's ability to detect any WPV1 importation or cVDPV emergence or importation, with particular attention to currently non-infected countries and those with limited or no GPEI support.
3. The GCC urges countries that have not yet introduced IPV2 to do so without delay. The GCC also encourages the introduction of hexavalent vaccines whenever feasible. However, if hexavalent vaccine introduction is not imminent, IPV2 introduction should proceed without delay.
4. The GCC recommends strengthening routine immunization to rapidly improve population immunity and close immunity gaps, as a critical requirement to interrupt vaccine derived poliovirus transmission.

Session 5: iVDPV Surveillance, bOPV Cessation Planning

Update on iVDPV Surveillance and bOPV Cessation Planning

iVDPV surveillance

Immunodeficiency-associated vaccine-derived polioviruses (iVDPVs) remain a recognized risk to eradication, arising when individuals with certain primary immunodeficiencies (PID) develop chronic poliovirus infection with prolonged virus excretion. The programme focuses on two key components: detection of iVDPV excretors through surveillance, coordinated by the iVDPV Working Group, and interruption of virus excretion through development of therapeutics under the Polio Antiviral Initiative.

Under GPSAP 2025–2026 (Objective 3), the programme is scaling up iVDPV surveillance to sustain eradication by detecting poliovirus among prolonged excretors and minimizing post-certification risk. Implementation is guided by two approaches: establishing sentinel site surveillance to identify and screen eligible cases for poliovirus in countries at risk of iVDPV and sensitizing relevant societies and healthcare networks to identify additional excretors in other settings. Key tools to support implementation are in place, including training modules (nine modules in English and French), guidelines, standardized forms, a data management approach, WebIFA, and options for integration into POLIS. The iVDPV Working Group continues to work closely with WHO regional offices on supporting the iVDPV surveillance enhancement. The development of therapeutics under the Polio Antiviral Initiative is continuing. Currently, pocapavir is the only antiviral available for compassionate use, while combination antivirals and monoclonal antibodies remain under clinical development.

The cVDPV1 detection in Algeria, linked to community spillover from a prolonged iVDPV1 excretor, represents an important lesson learned and reinforces the critical importance of early detection and rapid containment. The iVDPV Working Group will continue to provide regular updates to the GCC to ensure alignment with its guidance and to seek further direction as needed.

bOPV Cessation Planning

The work of the bOPV Cessation Team (BoCeT) is progressing as per its workplan. Phase I has been completed with a bOPV cessation policy framework developed and endorsed by the SAGE. Under Phase II, regional consultations have been initiated by the BoCET and UNICEF Supply Division has started communication with manufacturers on supply needs for pre-cessation SIAs.

If the current timelines for GPEI goals to interrupt endemic WPV1 transmission and stop cVDPV2 outbreaks are met and additional triggers and enablers for bOPV cessation are achieved, pre-cessation campaigns may begin in 2028, assuming bOPV cessation in 2031, across 46 countries

identified through data analysis and risk modelling. BoCeT will continue to monitor progress against the triggers and enablers recommended by the SAGE, support regional and country level planning, and develop contingency options if timelines are not met or the triggers and enablers are not achieved.

Session 5 – Conclusions

1. The GCC appreciates the regular updates from the PID Surveillance Working Group, which are valuable to its deliberations of the long-term considerations of risks to cessation of polio vaccination.
2. PID surveillance is an important element in the certification of the eradication of VDPVs. The GCC will continue to review this topic. The recent cVDPV1 detection in Algeria, which represents potential spillover of iVDPV1 from a PID patient, reinforces the importance of this consideration.
3. The GCC commends the programme for making available the necessary tools and guidance for PID surveillance.
4. The GCC noted the progress on bOPV cessation planning, including the development of the policy framework, initial estimation about pre-cessation SIAs, and the coordination with vaccine manufacturers.

Session 5 – Recommendations

1. The GCC recommends that efforts to incorporate PID surveillance within the programme be maintained, and requests receipt of regular updates from the iVDPV Working Group.

2. The GCC recommends that WHO ethical considerations be maintained when following up with PID patients who are shedding iVDPV.

3. The GCC, as noted previously, reiterates its preparedness to provide support regarding the triggers endorsed by SAGE, namely: ‘certification of eradication of WPV1’, ‘certification of elimination of cVDPV2’, and ‘no persistent (circulation >6 months) cVDPV1/3 outbreaks in the previous 24-month period at the time of the decision to proceed with bOPV cessation’.

Session 6: a) Poliovirus Containment; b) GCC and RCCs Functioning and Meetings

Update on Poliovirus Containment

Poliovirus containment is anchored in a solid framework of policies, resolutions, and validated standards, but progress towards full certification remains uneven. WHO headquarters containment functions have been integrated within broader surveillance, laboratory, and certification work, while regional technical assistance arrangements remain unchanged for 2025–2026; however, reduced funding is expected to constrain support. Containment remains one of the core pillars of eradication and needs to remain visible in the broader eradication narrative.

Global Action Plan for Poliovirus Containment Edition IV (GAPIV) remains the current audit standard and is considered technically finalized and endorsed; WHO final clearance, editing, and translations is in process. The Containment Certification Scheme version 2 (CCS 2.0) is in final revision, with GCC consultation planned for endorsement in the third quarter of 2026; meanwhile, the current verification process remains in place through the Containment Working Group (CWG) and National Authorities for Containment (NAC). Guidance on potentially infectious materials (PIM) is also moving towards a revision. Strengthening national containment capacity remains a priority, with continued GAPIV trainings since 2023 for poliovirus-essential facility countries, regular orientations for national committees/focal points supporting inventories, and steps to standardize auditor qualifications and improve audit quality and global harmonization.

Progress on Implementation of the Global Containment Action Plan

There is continued reduction in the number of countries and facilities retaining polioviruses. The number of poliovirus-essential facilities declined from 102 in 30 countries (2018) to 71 in 21 countries as of October 2025, reflecting ongoing efforts to minimize retention to only critical functions. Establishment of National Authorities for Containment (NAC) is largely in place across designated countries, though gaps remain, most notably in Romania. The session also highlighted that certification activities are underway, but advancement toward full certification is not yet sufficient to meet upcoming December 2026 milestones.

Reviewing the Containment Milestones Timelines and discussion on the way to accelerate

While reduction of infectious materials is broadly on track, full certification of facilities is not: only three of the 57 facilities were described as compliant towards the end-2026 milestone that all facilities should be awarded a Certificate of Containment (CC). Updated certification progress (as of early November 2025) grouped countries by pace and risk of delay, highlighting “concerning” or delayed trajectories in several settings (including larger portfolios). Three facilities in three countries have achieved full CC, demonstrating political commitment, legal readiness, technical process maturity, and generation of required resources in those places. This also demonstrates that achieving CC is feasible, provided that coordinated efforts are implemented in line with the recommended strategies and approaches.

To accelerate the certification of containment of the remaining facilities, it is important to focus on

key feasible approaches, including supporting remaining Member States on realistic application plans; pursuing targeted advocacy approaches with high-level visibility for countries with slow progress; coordinating with partners to align solutions; maintaining regular communication with National Authorities for Containment (NAC); promoting approaches that can safely reduce the number of facilities requiring certification; and increasing the throughput of application and audit review processes (including more frequent reviews and structured, periodic in-person meetings). Poliovirus containment is likely to miss 2026 milestones unless progress is significantly accelerated through sustained national and global commitment, and enhanced advocacy.

GCC and RCCs Functioning and Meetings

It is important to maintain the current mechanism of the periodic program reviews by the Global and Regional Certification Commissions, adequately supported by the WHO secretariat. This is critical to ensure preparedness for evidence based timely certification of WPV1 eradication and cVDPV elimination in future. The in-person meetings of the GCC and RCCs should be held at least annually, with additional meetings (in-person or virtual, as feasible), as needed.

Session 6 - Conclusion

Containment

1. The GCC appreciates the progress made on poliovirus containment, particularly appreciating Belgium, Denmark, and the Republic of Korea for accomplishing the full certificate of containment. This achievement highlights that progressing against containment timelines is possible, if adequate mechanisms are in place.
2. Poliovirus containment is directly linked to global health security, and any shortcoming in poliovirus containment constitutes a serious risk.
3. The GCC notes with deep concern:
    a. The lack of information on the state of poliovirus containment in the United States, which has 22 designated PEFs.
    b. That the NAC has not been established in Romania and hence there is no oversight mechanism in the country for the status of poliovirus containment at the designated PEF.
    c. That none of the seven designated PEFs in China have CP, and the NAC, despite its efforts, is unable to move forward.
4. The GCC appreciates the ongoing support of the WHO secretariat for poliovirus containment and proposes that this support be effectively maintained.

Session 6 – Recommendations on poliovirus containment

1. The GCC recommends fast-tracking the containment processes in all the countries that retain polioviruses, aiming to meet the timeline to achieve CC by the end of 2026.
2. The GCC urges USA, Romania, and China to urgently address its concerns over poliovirus containment by fully operationalizing the respective NACs and accelerating progress in line with the guidance provided by the GCC. The GCC, through its Containment Working Group (CWG), will continue to monitor progress.

3. WHO should continue advocating and supporting Member States and National Authorities for Containment (NAC). The opportunities of the upcoming Executive Board meeting and the World Health Assembly may be utilized to facilitate support.
4. All countries that have made progress on poliovirus containment must not lose the gains.
5. The GCC recommends that CWG and the WHO secretariat prepare a clear position paper, outlining the progress, key issues, and requests to the GCC in advance of its next meeting.
6. The Global Action Plan for Poliovirus Containment IV (GAP IV) should be urgently finalized and formally published by WHO.
7. The GCC, while noting the ongoing work on CCS and PIM guidance, asks the CWG and secretariat to finalize these documents as soon as possible during the first half of 2026.

GCC and RCCs Functioning and Meetings

1. The GCC discussed the current differing mechanisms of the program reviews by the RCCs.
2. The GCC noted with appreciation the ongoing work by the RCCs, supported by the WHO regional offices.
3. The GCC proposes that all RCCs should plan for one in-person or hybrid meeting annually, with one additional virtual/online RCC briefing. Based on the needs, the RCCs can hold additional meetings. The GCC will also plan to follow the same scheme.
4. The WHO secretariat should continue to support GCC and RCCs for meetings and any additional activities.
5. The GCC proposed to standardize the information presented by the Regional Programs during the future GCC meetings. The WHO secretariat should facilitate this process.
6. The GCC commends the RCCs and WHO regional offices that have successfully transitioned from a manual to an electronic annual progress report (APR) review mechanism.
7. The RCCs may consider the WHO European Region's approach to reviewing NCC reports and adapt it, as appropriate, to their regional context and needs. The GCC also recommends the development of an electronic annual progress report (APR) review mechanism, where not yet established.

Annex:

Meeting Agenda

Twenty Seventh Meeting of the Global Certification Commission (GCC) for Certification of Poliomyelitis Eradication

Agenda

Day – 1; 26 November 2025

Session 1: Updates on GPEI Strategy, & Polio Eradication Status in the WHO Eastern Mediterranean Region		
08:30	Registration	All participants
08:45	Welcome / Opening Remarks	David Salisbury, GCC Chair
09:30	- Opening remarks by the WHO Director Polio - Update on GPEI Strategy and GPEI Action Plan	Jamal Ahmed, Director POL/WHO
10:30	**Break**	
10:45	Afghanistan Polio eradication update (epidemiology, surveillance, progress, challenges, way forward)	Afghanistan polio team (virtual)
11:35	Pakistan Polio eradication update (epidemiology, surveillance, progress, challenges, way forward)	Pakistan polio team (virtual)
12:30	Comments of the Chairs, • Eastern Mediterranean Regional Certification Commission • Technical Advisory Group (TAG) on poliomyelitis eradication in Afghanistan & Pakistan	Chair EM-RCC Chair TAG
12:45	Eastern Mediterranean Regional Update (except the WPV1 endemic countries)	WHO EMRO Comments from Chair EM-RCC
13:15	**Lunch**	
Session 2: Update on Global Polio Surveillance Action Plan (GPSAP)		
14:15	GPSAP 2025 – 2026 implementation	GPEI Surveillance Group
Session 3: Regional Updates from WHO European, Western Pacific, Southeast Asian, and American Regions		
14:45	European Regional Update	WHO EURO Comments from Chair EU-RCC
15:15	Western Pacific Regional Update	WHO WPRO Comments from Chair WP-RCC
15:45	**Break**	
16:00	WHO Southeast Asian Regional Update	WHO SEARO Comments from Chair RCCPE-SEAR
16:30	Region of Americas Update	WHO / PAHO Comments from Chair RCC, Region of Americas
17:00	Wrap up / concluding remarks	David Salisbury, GCC Chair / Secretariat
17:30	End of day 1	

Twenty Seventh Meeting of the Global Certification Commission (GCC) for Certification of Poliomyelitis Eradication

Provisional Agenda

Day – 2; 27 November 2025

09:00	Summary day-1 and review of draft recommendations	GCC Chair & Secretariat
Session 4: African Regional Update (GPEI Goal 2)		
09:30	African Regional Update / progress on stopping cVDPV2 outbreaks	WHO AFRO Comments from Chair, ARCC
Session 5: iVDPV surveillance, bOPV Cessation Planning		
10:15	Update on iVDPV surveillance and bOPV cessation planning	WHO HQ PRD / SAGE Secretariat
11:00	**Break**	
Session 6: Poliovirus Containment		
11:15	Update on Poliovirus Containment (including progress on regional inventories and global containment certification, and related KPIs)	WHO HQ - Containment
11:45	Progress on implementation of the Global Containment Action plan 2022-2024	WHO HQ Containment, GCC
12:15	For GCC's guidance: Reviewing containment milestones, progress against those milestones and discussion on ways to accelerate	WHO HQ Containment, GCC
13:15	**Lunch**	
14:15	Next steps / way forward	WHO HQ Containment, GCC
14:45	Concluding Remarks/wrap up	GCC Chair and Secretariat
15:00	End of Day – 2	

15:00 – 16:00	Closed Discussion	GCC, WHO Secretariat

World Health Organization