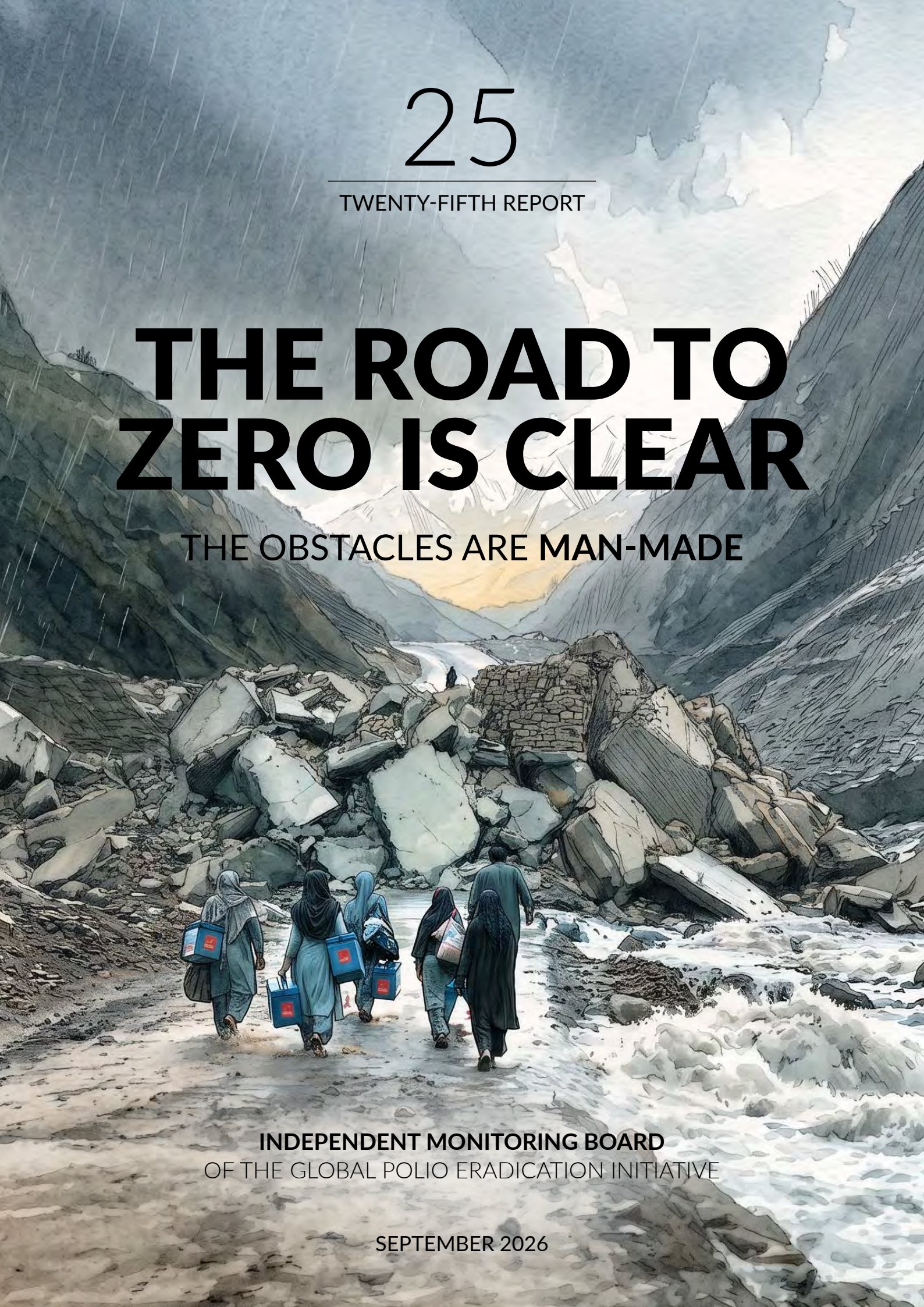


An artistic illustration of a mountainous landscape. In the foreground, a group of people, including women in blue and black headscarves, are walking away from the viewer along a muddy path. They are carrying blue and red medical supply boxes. The path leads towards a large, jagged rock formation that appears to be a landslide or a natural barrier. In the background, a river flows through a valley, and a bright, hazy light suggests a sunrise or sunset. The sky is filled with soft, white clouds, and rain is depicted as thin, vertical lines falling across the scene.

25

TWENTY-FIFTH REPORT

THE ROAD TO ZERO IS CLEAR

THE OBSTACLES ARE MAN-MADE

INDEPENDENT MONITORING BOARD
OF THE GLOBAL POLIO ERADICATION INITIATIVE

SEPTEMBER 2026

INDEPENDENT MONITORING BOARD

The Independent Monitoring Board (IMB) provides an independent assessment of the progress being made by the Global Polio Eradication Initiative (GPEI) in the detection and interruption of poliomyelitis (polio) transmission globally.

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Previous Director SAMRC Centre for Health Economics and Decision Science, School of Public Health, University of Witwatersrand, South Africa.

GRATITUDE FOR DEDICATED SERVICE

The IMB wishes to express its deepest gratitude and respect to three of the Polio Programme's longest serving and influential leaders. They are stepping down from their posts this year, with a distinguished record of service and achievement. Each will be greatly missed right across the Polio Programme and more widely in global health. We wish them the very best for the future.

Arshad Qudus, WHO.

Melissa Corkum, UNICEF.

Jean-Marc Olivé, TAG Chair.

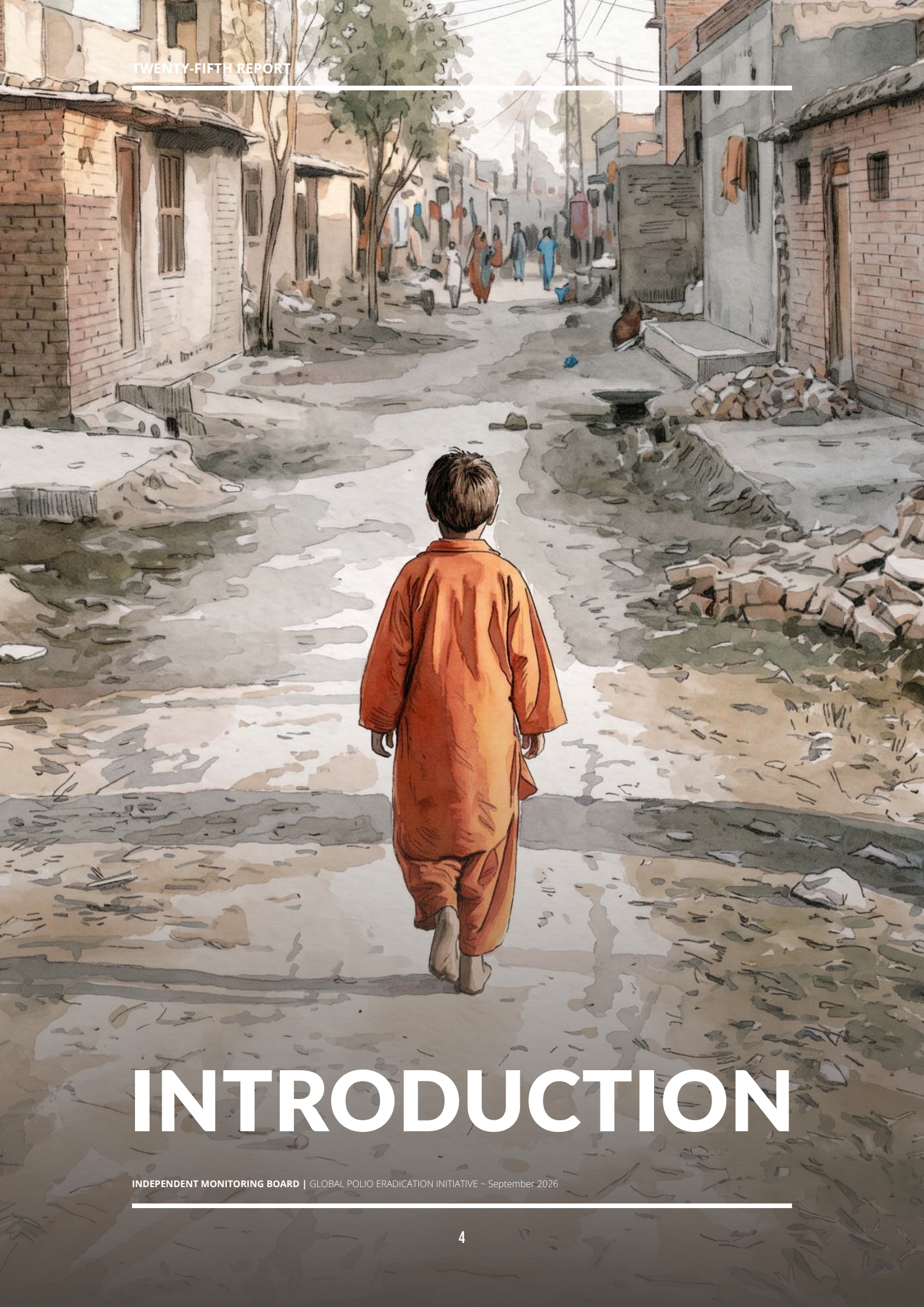
TECHNICAL NOTE

To reduce the density of the text for the general reader, abbreviations and acronyms are kept to a minimum. They are shown in places in the text, however, so that there is a key to understanding the legends and tables in the charts and tables. The latter would be unwieldy if all technical terms were spelled out.

The IMB's reports are entirely independent. No drafts are shared with the Polio Programme prior to finalisation. Although many of the data are derived from the GPEI, the IMB develops its own analyses and presentations.

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INTRODUCTION

INDEPENDENT MONITORING BOARD | GLOBAL POLIO ERADICATION INITIATIVE ~ September 2026

INTRODUCTION

This is the 25th report of the Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative (GPEI). It is also the first produced under the IMB's enlarged mandate following the decision to bring the monitoring previously undertaken by the Transition Independent Monitoring Board (TIMB) into a single independent body.

The report therefore examines both the work to interrupt the remaining poliovirus transmission and the coordinated activities required to ensure that a polio-free world can be sustained after interruption has been achieved.

Polio eradication and polio transition have often been treated as sequential tasks: first stop the poliovirus, then hand over the Polio Programme's functions and assets to those who must finish the job. This separation is artificial. Weak routine immunisation creates the immunity gaps in which outbreaks emerge. Surveillance that is reduced or transferred before the receiving system is ready allows transmission to

continue unseen. An outbreak can reverse years of transition in a matter of weeks, sometimes even returning responsibility to the eradication programme. Containment, vaccine stockpiles, laboratory capacity and capability, as well as the eventual withdrawal of oral poliovirus vaccine, will require global stewardship long after the last case.

The Polio Programme must now pursue interruption and permanence at the same time.

Over the years, the IMB has consistently asked the GPEI some very simple questions including whether the Polio Programme can: identify and

reach the specific children and communities sustaining transmission; demonstrate that its interventions have produced the required immunity; detect poliovirus wherever it survives, and preserve those capabilities whilst exceptional polio financing and infrastructure contract.

The IMB examines performance, too, at the level where eradication will be decided: the insecure district, the mobile settlement, the household that teams do not enter, the specimen that never reaches a laboratory and the essential public health function for which no credible or durable owner and budget yet exists.

The IMB's previous report described a programme that had reached a glass mountain: close

enough to see the summit, but unable to complete the climb through further repetition of the methods that had brought it there. The final TIMB report described the accompanying failure to future-proof the achievement, with transition plans moving ahead while the systems expected to inherit polio functions signalled fragility.

The present report uses these multiple perspectives and loci of performance to assess what has changed, where the Polio Programme has learned, and where existing arrangements succeed only in producing the same result.

The 25th IMB meeting was held in Geneva, Switzerland over four days in July 2026 and drew on more than 30 hours of discussion

with country government programmes, GPEI partners, donors, technical specialists and others involved in delivering and sustaining polio functions. Key areas of Pakistan, Afghanistan, Nigeria and the Democratic Republic of the Congo were examined in particular depth because of their vital importance to the remaining poliovirus circulation and the achievement of the Polio Programme's core goals and objectives.

The IMB also considered the essential functions that cut across countries, including routine immunisation, surveillance and laboratories, outbreak response, community engagement, gender, water and sanitation, containment and the preparations required to sustain a polio-free world.

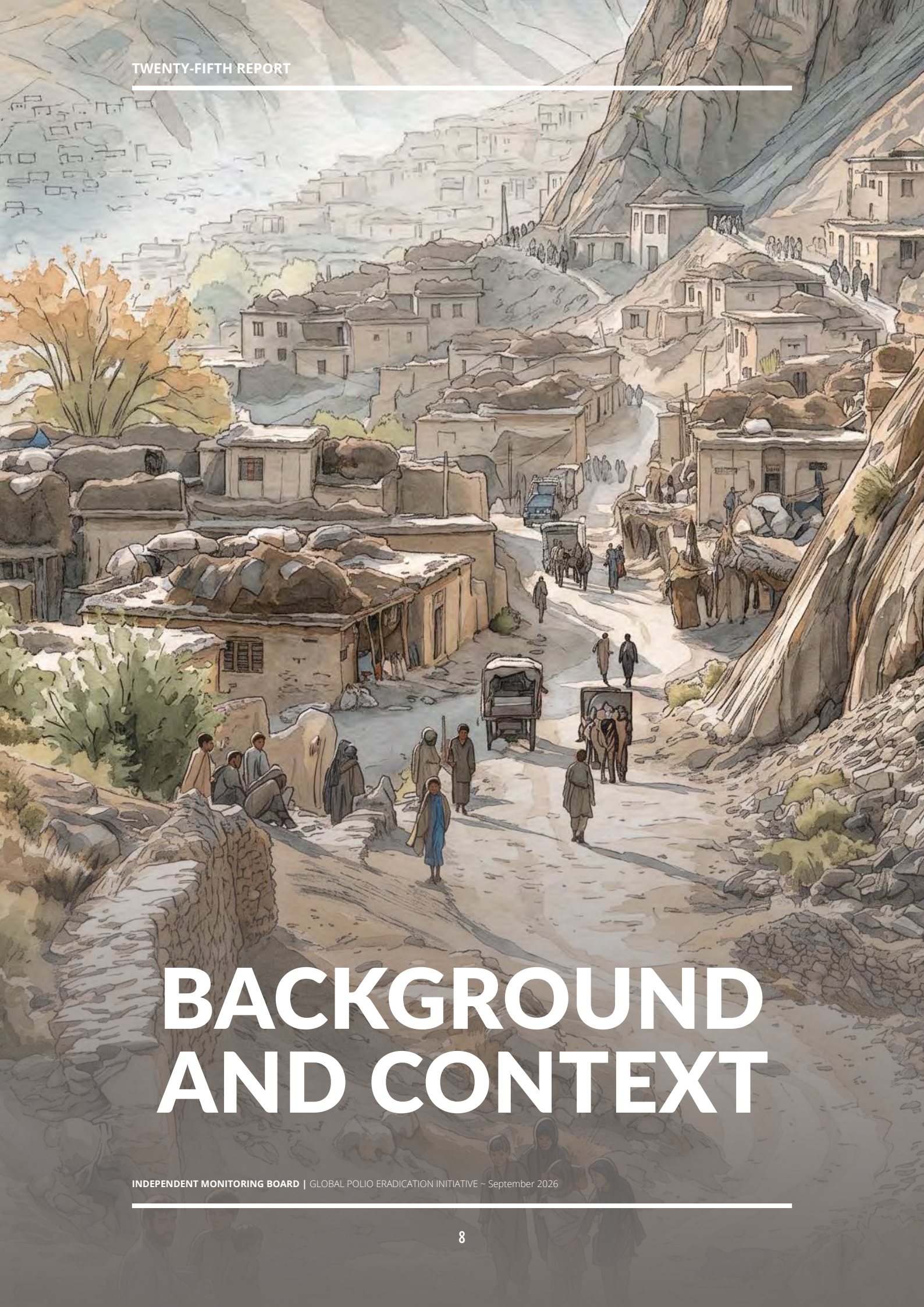


The IMB closes its scrutiny when the meeting ends. It does not subsequently reopen country evidence or invite programmes to extend the discussion while the report is drafted. The world in which this programme operates does, however, continue to change. Important epidemiological, geopolitical, environmental or policy developments arising between the meeting and publication are mentioned where they materially affect understanding of the polio context.

This IMB report is organised in three parts. First, an examination of the essential functions on which eradication depends across every geography. Then, the endemic epidemiological bloc and the countries driving, or remaining vulnerable to, vaccine-derived poliovirus transmission. Finally, a judgement on the capabilities and governance needed to defend a polio-free world, including transition and containment.

The conclusions draw the strands together and the recommended action identifies the changes that the IMB considers most important and most urgent.





BACKGROUND AND CONTEXT

BACKGROUND AND CONTEXT

GPEI RESPONSE TO THE LAST IMB AND TIMB RECOMMENDATIONS

The IMB attaches considerable importance to how the Polio Programme responds to its recommendations. The response is a measure not only of what the GPEI intends to do, but of how the polio partnership, as an entity, receives independent challenge.

The response to the 24th IMB report on polio eradication is competently assembled, courteous in tone but, in many places, the dominant pattern is the substitution of description for action.

The response to the IMB's first recommendation, the regional member states more direct involvement, has been very encouraging. For example, Ministers of Saudi Arabia and the United Arab Emirates and their in-country embassies, have been actively engaging, particularly,

with the Afghanistan administration, working closely alongside the WHO Regional Director. A frank and robust engagement in the endemic countries based on an expectation of peer-based responsiveness and accountability is a vital current strategy.

The response to other 24th IMB report recommendations is more disappointing. Too many are answered with an account of structures that already exist, meetings that have already been held and plans that have already been written. If the current arrangements were sufficient, the problems that prompted the need for recommendations would not exist, nor be so persistent.

The response to the recommendation on performance-based funding is particularly puzzling. It illustrates a recurring habit of engaging with the least favourable interpretation of a recommendation. In its response, the GPEI embarks on a thought experiment in which an imaginary poorly performing campaign has its



next budget cut by 10 per cent. It explains why such a model would be perverse in an emergency programme, and then asks the IMB to specify what it meant. The IMB's concern was never a formula. It was the near-total absence of consequence anywhere in the Programme when publicly made commitments are missed. Does the GPEI not want to find a way out of a situation that is eroding its credibility as a steward of the Programme's scarce funds entrusted to it?

Some responses are almost too brief. The recommendation on delayed outbreak funding receives two lines stating that an analysis has been conducted and resolution is "underway", with no indication of what the analysis found, which outbreaks were involved or what has changed.

The IMB does not expect essays. It does expect evidence.

The IMB has not referred here to every GPEI response to its recommendations so as to avoid a "tennis match"-style dialogue. It is encouraged that, following adoption of the governance review recommendations, there will be an opportunity to debate future IMB recommendations in post-report Polio Oversight Board (POB) meetings.

This section of the report also examines how WHO's Polio Transition Steering Committee and the GPEI Strategy Committee responded to the TIMB's eighth and final report.

In the latter years of the TIMB, when the WHO took responsibility for polio transition, formal responses

to the recommendations were usually prompt and thorough. Latterly, these responses have been graded: "fully agree", "agree in principle", "partially agree", followed by named leads and, in most cases, dated actions. This is the welcome grammar of accountability.

The candour, in places, is also striking. For example, the response conceded openly that no dedicated financing mechanism exists for the pre-cessation vaccination campaigns on which safe withdrawal of oral polio vaccine entirely depends, and that partner alignment remains insufficient. The official response also accepts that there is a persistent gap between the design of the polio transition framework and its implementation. These are important admissions.

Yet, several responses open with concurrence and then seem to withdraw the substance of what was recommended.

In other cases also, the analytical premise is accepted and the operational consequence is declined. This is particularly so with recommendations concerning precisely the durable capacities that polio transition is supposed to protect.

GPEI CURRENT PLANNING DOCUMENTS

The Global Polio Eradication Initiative entered the current period with a strategy that it regarded as sound. The *Polio Eradication Strategy 2022–2026: delivering on a promise*, set two goals.

The first was to interrupt and eradicate type 1 wild poliovirus (WPV1) in the last endemic countries.

The second was to stop and prevent outbreaks of type 2 vaccine-derived poliovirus.

Both rested on a single timetable. Transmission of each virus was to be interrupted by the end of 2023, and eradication of wild poliovirus and elimination of type 2 vaccine-derived poliovirus were both to be certified by the end of 2026.

Neither interruption date was met.

In October 2024, the Polio Oversight Board approved an extension of the strategy, published in the following year as *The Polio Eradication Strategy 2022–2026: delivering on a promise, extension to 2029*.

Under the extension, interruption of wild poliovirus transmission moved to the end of 2025 and certification to the end of 2027. Interruption of type 2 vaccine-derived poliovirus moved to the end of 2026 and certification to the end of 2029. These remain the formal strategic commitments, although subsequent operational plans adopted later dates after the interruption targets had become unattainable.

The extension presented its changes as adjustments of timing rather than of direction. Its diagnosis located the failure in delivery rather than in design. The strategy was declared robust, and the shortfall attributed to how it had been put into effect.

Obstacles were sorted into those within the Polio Programme's control and those outside it. Within its control were inconsistent vaccination of mobile and hard-to-reach populations, weak cross-border coordination, poor microplanning, delay in outbreak

response and in moving money to pay vaccinators, difficulty coordinating multiple partners in a single response, and persistent gaps in surveillance. Outside it were the loss of routine immunisation coverage during the COVID-19 pandemic and the slow recovery since, rising conflict and political instability, climate-related disasters concentrated in the places at highest risk of polio, economic collapse and humanitarian emergency in Afghanistan, conservative gender norms limiting who could be reached and by whom, and vaccine hesitancy fuelled by misinformation.

To these were added consequences of the Polio Programme's own earlier decisions. Outbreaks of type 2 vaccine-derived poliovirus following the 2016 switch from trivalent to bivalent oral polio vaccine proved larger than had been anticipated, and supply of novel type 2 oral polio vaccine was disrupted in late 2023 and early 2024.

Against these obstacles the extension set out what it termed "tactical shifts".

A new action plan for 2026

The *GPEI Action Plan 2026* was then published as the operational companion to the strategy and its extension.

For Goal One, both endemic programmes adopted an operational ambition of stopping wild poliovirus transmission no later than June 2026. Afghanistan's approach was organised around a four-part reset: push, pull, routine immunisation and advocacy. Pakistan developed a three-phase *Roadmap to Zero Polio*.

By the time of the July 2026 IMB meeting, the June ambition had also been missed.

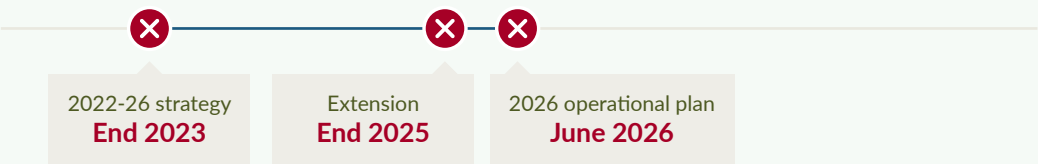
For Goal Two, the Action Plan replaced the extension's single end-2026 interruption date with a phased operational timetable: Southern and Central Africa by the end of 2026, the Horn of Africa by the end of 2027, West and North Africa and the Lake Chad Basin by the middle of 2028, and all type 2 vaccine-derived poliovirus transmission by the end of 2028. The report therefore distinguishes throughout between the strategy extension's formal commitments and the later dates now guiding operations.



EVERY ERADICATION DEADLINE HAS MOVED

Interruption and certification targets, original strategy and subsequent revisions; status as at 21 July 2026

WPV1 TRANSMISSION INTERRUPTION



WPV1 ERADICATION CERTIFIED



cVDPV2 TRANSMISSION INTERRUPTION



cVDPV2 ELIMINATION CERTIFIED



Source: GPEI 2026 Action Plan (operational). GPEI Strategy 2022-2026, Extension to 2029.

PERFORMANCE AGAINST PLANS

As the 25th IMB meeting ended in July 2026, the official weekly data showed that wild poliovirus survived the low transmission season for a second consecutive year. The Polio Programme's own action plan for this year identified the low season as the priority moment for interrupting what remained. It was not interrupted.

The composition of the endemic caseload has inverted, and this is another significant epidemiological feature of the year. In the equivalent period of 2025, Pakistan accounted for 19 of the 22 cases and Afghanistan for three. At the time of the IMB meeting, in July 2026, Afghanistan accounted for 15 of the 18 cases and Pakistan for three. The same

inversion appears in poliovirus detections from environmental and other sources.

Of the 90 vaccine-derived cases reported by 21 July 2026, 62 were caused by type 2 poliovirus. They occurred in nine countries, with onsets extending into June 2026. Nigeria accounted for 30; close to half the type 2 total. The Democratic Republic of the Congo (DRC) made 11 reports. Cases in Chad, Somalia, the Central African Republic, Togo, Sudan, Angola and Mali made up the remainder.

The type 2 vaccine-derived poliovirus trajectory is improving. The comparison, though, must distinguish complete years from the part-year figure for 2026. Cases rose from 396 in 2023 to 448 in 2024, before falling to 228 in 2025 and to 62 by the time of the July 2026 IMB meeting.

There is a central caveat to all of these numbers, and one which is too-often ignored when discussing polio status. In the pre-vaccine era, there were an estimated 200-2000 infections per acute flaccid paralysis (AFP) case (ranging from approximately 1:200 for Type 1, 1:1000 for Type 3, and 1:2000 for Type 2). Among vaccinated children these ratios may be at least 10-fold higher, particularly in children vaccinated with inactivated polio vaccine. Israel's type 1 2013 outbreak is estimated to have infected 24,000 such children without a single paralytic case. Therefore, the focus on case numbers obscures the actual status, which is tens or hundreds of thousands of infections, widely disseminated, in multiple countries.

Despite real progress, continuing case onsets are not consistent



with global interruption within the remaining five months of the formal timetable. The end-2026 target will not be met.

Types 1 and 3 vaccine-derived poliovirus

The GPEI strategy treats the elimination of type 1 and type 3 vaccine-derived polioviruses as a task for the period after 2029. The epidemiology indicates that this task should not be postponed.

Type 1 vaccine-derived poliovirus caused 20 cases of paralysis in the first half of 2026, against three in the whole of 2025. Ethiopia, South Sudan, Lao People's Democratic Republic and Madagascar were the countries affected.

Type 3 vaccine-derived poliovirus caused eight cases this year, concentrated in Nigeria and Chad, against 15 across the whole of 2025.

Types 1 and 3 together therefore account for nearly a third of the 90 vaccine-derived poliovirus cases reported globally. This included countries with no recent history of them.

This matters for reasons beyond the case count. Type 1 and type 3 vaccine-derived poliovirus emergencies are a consequence of weak routine immunisation rather than of type 2 vaccine withdrawal, so they are not addressed by the type 2 strategy. Each round mounted against them consumes outbreak capacity and budget that the type 2 goal

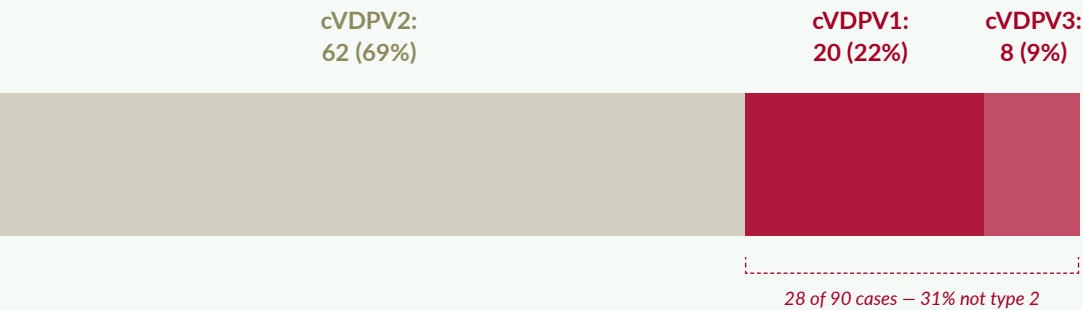
requires. They are appearing while the Programme's attention, structure and deadlines are directed at type 2 vaccine-derived poliovirus.

The performance bottom line

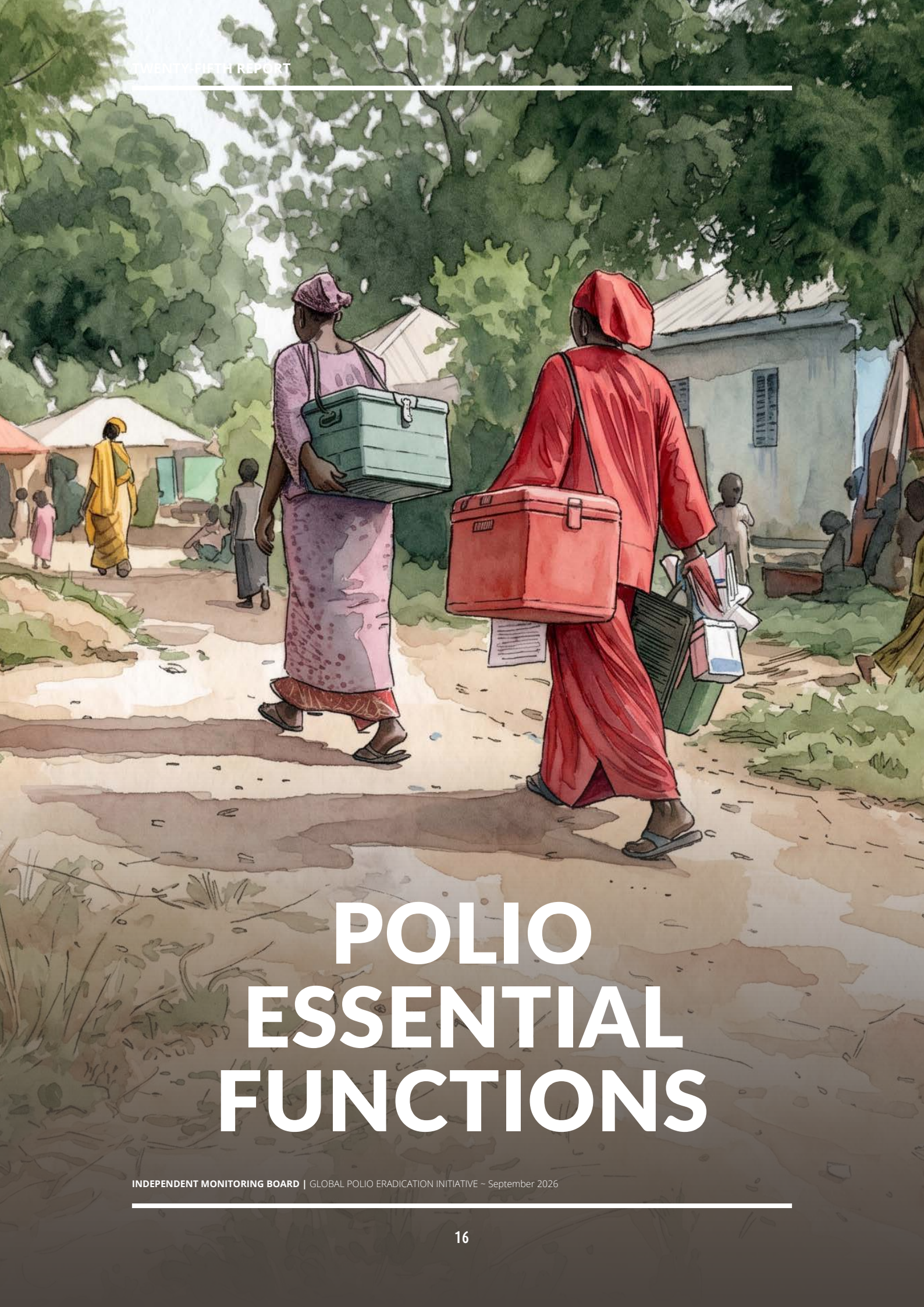
The performance conclusion is clear. Wild poliovirus transmission did not stop by the end of 2025; certification at the end of 2027 cannot follow from cases in 2026; and global interruption of type 2 vaccine-derived poliovirus will not be achieved by December 2026. Certification of type 2 elimination by the end of 2029 depends on achieving interruption first. The Programme is therefore no longer operating to a credible global timetable.

NEARLY ONE-THIRD OF 2026 cVDPV CASES ARE NOT TYPE 2

Circulating vaccine-derived poliovirus (cVDPV) paralytic cases by type, 1 January to 21 July 2026



Source: WHO Polio Weekly Global Updates, July 2026.



POLIO ESSENTIAL FUNCTIONS

INDEPENDENT MONITORING BOARD | GLOBAL POLIO ERADICATION INITIATIVE ~ September 2026

POLIO ESSENTIAL FUNCTIONS

ROUTINE IMMUNISATION

A great deal now rests on routine (essential) immunisation.

The Polio Programme's two remaining technical goals both depend on countries' routine services delivering bivalent oral polio vaccine and inactivated polio vaccine (IPV), whether standalone or within a hexavalent product.

Beyond those goals, sit the two enablers of everything that follows: preparing for the withdrawal of oral polio vaccine, and holding the immunity gains afterwards so that a polio-free world can endure.

Five distinct tasks are being asked of country immunisation programmes.

- They must establish the foundation of population immunity that allows oral polio vaccination campaigns to work and reduces the risk of re-emergence.

- They must achieve high coverage with inactivated polio vaccine, not merely a first dose but the completed series.
- They must reach children who have already been missed, through catch-up doses, outreach and the fixed service.
- They must support integrated delivery, linking polio activity to other vaccines and other health interventions wherever that is feasible.
- They must anchor all of it in lasting improvement to the countries' own public health systems.

The last of these is the one that matters most. It receives the least attention.

These expectations are being placed on systems under mounting strain. That strain is worst precisely where the expectations are highest. That is not an incidental difficulty. It should be central to the Polio Programme's thinking.

Taking wild and vaccine-derived paralytic polio cases together, the world recorded 298 cases in 2025 and 108 in the first part of 2026. Those are the numbers of the early 2010s, and the 2025 total was more than seven times higher than the 2016 low.

On this measure the Polio Programme stands no better than where it stood just over a decade ago. The reason is not wild poliovirus, which accounted for 52 of those 298 cases. It is the malign emergence and spread of vaccine-derived poliovirus. The origin of that reversal lies in the 2016 withdrawal of type 2 oral polio vaccine, the so-called “switch”. Since then,

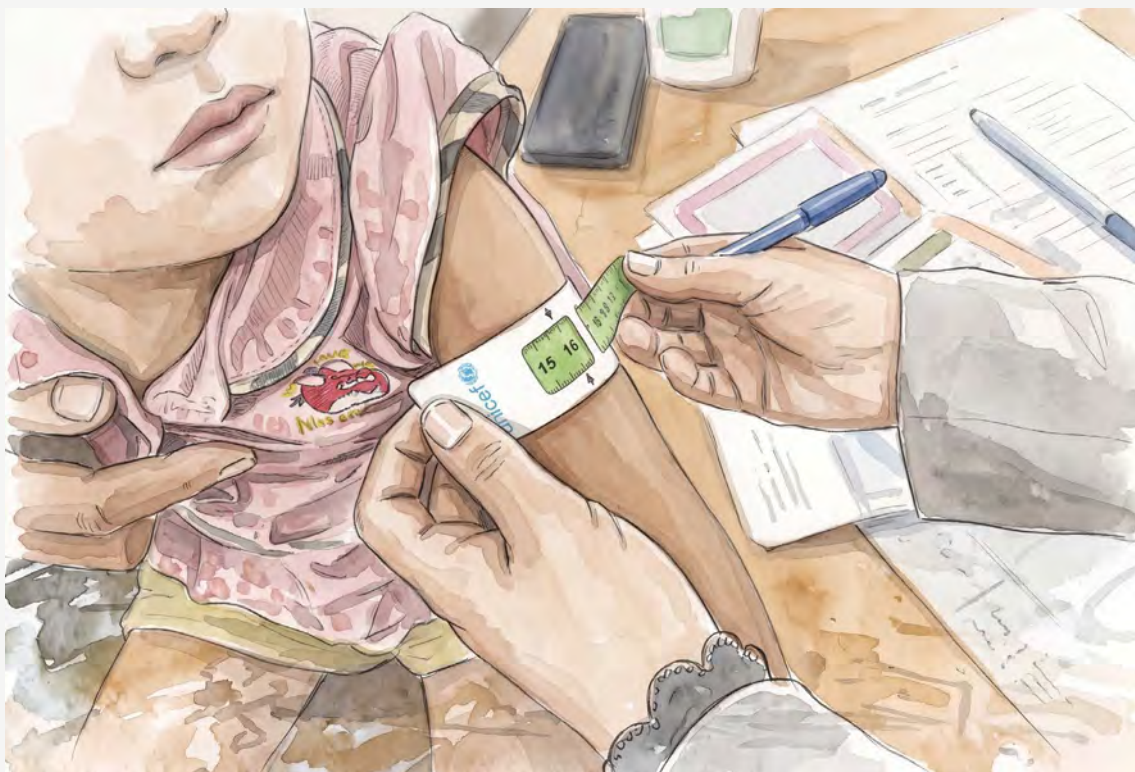
and outside outbreak response with monovalent, or novel type 2, oral polio vaccine, the sole route by which a child in the community acquires protection against type 2 poliovirus has been inactivated polio vaccine. It has been delivered through routine services. A decade has now passed, and the accumulated cohort of children without type 2 immunity is the fuel by which every subsequent outbreak has been powered.

The introduction of inactivated polio vaccine, alongside the withdrawal of type 2 oral polio vaccine, was understood as protection against exactly this eventuality. It was not achieved at a sufficient level

of coverage, and the paralysed children of the last 10 years are the consequence.

An important distinction bears directly on what is now being asked of the programme. The failure to achieve high inactivated polio vaccine coverage explains the volume of paralysis that followed. It does not explain the emergencies themselves or their onward transmission. They have separate causes and require different remedies.

Inactivated polio vaccine given by injection produces strong systemic protection and, where oral polio vaccine has preceded it against the same



serotype, enhances mucosal immunity. It is not a substitute for oral vaccine as a means of interrupting transmission. It never was. There is a persistent temptation to present higher inactivated vaccine coverage as the answer to circulation. It is the answer to paralysis, and it is the precondition for withdrawing oral vaccine.

The same caution applies to hexavalent vaccine. Its arrival at an affordable price is a genuine advance. It will make delivery through routine services considerably easier. It is a means of getting inactivated polio vaccine into more children more reliably. It is not a solution to the problems that keep children unreached. So, it should not be allowed to become one in the Programme's rhetoric.

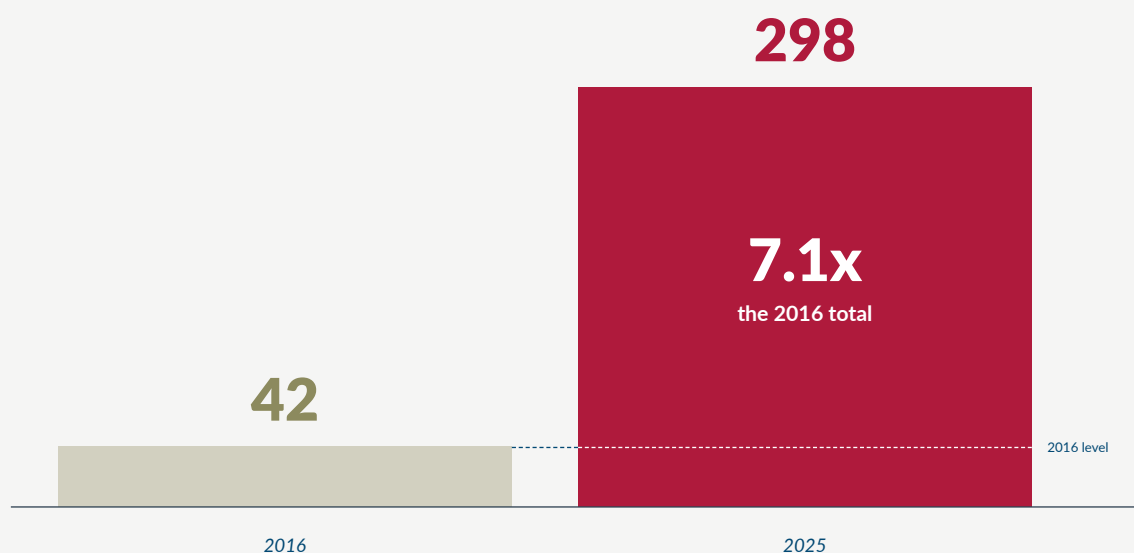
The global pattern of unreached children

Global vaccine coverage has not recovered from the COVID-19 pandemic.

Coverage with a first dose of diphtheria-tetanus-pertussis (DTP1) vaccine stands at 90 per cent against 91 per cent before the pandemic; third-dose coverage with that vaccine stands at 85 per cent against 86 per cent. Those percentages conceal what matters.

POLIO BURDEN IS MORE THAN SEVEN TIMES THE 2016 LOW

Paralytic cases of wild and circulating vaccine-derived poliovirus



Paralytic polio cases, end of year total.
Source: GPEI Polio Information System (POLIS), 2026.



In absolute terms, 13.5 million children received nothing at all in 2025. That is an improvement on the 14.2 million of 2024, but it remains above the 12.8 million of pre-pandemic 2019. A further group of children is known to the system, having received a first dose but not a third. Taken together, 19.6 million children were un- or under-immunised in 2025, some 1.4 million more than in 2019.

The children who drop out after a first contact need particular attention. They have been found, registered and reached once. Whatever prevented their return is a different problem from them never having been reached at all. Indeed, it should be a considerably more tractable one.

Countries with fragile, conflict-affected or vulnerable settings hold a third of the world's birth cohort. They account for 54 per cent of all zero-dose children; amounting to 7.3 million children compared to 6.2 million in the rest of the world. Of the eight countries that matter most for polio, the two with endemic wild poliovirus transmission and the six holding consequential geographies for vaccine-derived poliovirus, all but Angola fall within that fragile and conflict-affected group. The overlap is close to total.

Essential immunisation is being asked to fill the immunity gaps in exactly those places where access is most constrained, where the health workforce

is most inadequate, where financing is least secure and where continuity of service is least achievable.

The concentration is starker for polio than for other diseases: the majority of confirmed polio cases occur in fragile or extremely fragile states, a share higher than the equivalent figures for malaria or for communicable disease deaths generally.

In short, polio is the disease that has retreated furthest into the hardest-to-reach places, and the tools being asked to finish the work are weakest in precisely those areas.

Progress is real, but not fast enough

It would be wrong to present a picture of stagnation. Coverage with a first dose of inactivated polio vaccine has improved measurably in two years, with the number of countries above 90 per cent rising from 118 to 122 and the number below 80 per cent falling from 39 to 33. Completion of the inactivated polio vaccine series has improved rather more: the number of countries above 90 per cent rose from 78 to 85, and those below 50 per cent fell from 61 to 38. That last movement represents a substantial number of national programmes that have introduced a second dose and made it work.

Two things nonetheless stand out.

Eighty-one countries still report completed inactivated polio vaccine coverage below 80 per cent. Eighteen countries still have only a single dose in the schedule. Thirteen of those are supported by Gavi (the Vaccine Alliance): five have been approved for, or are moving towards, a second dose or a hexavalent product, and eight have not applied at all. The remaining five are middle-income, or self-procuring, countries outside that support.

Since withdrawal of oral polio vaccine is predicated on adequate inactivated polio vaccine coverage everywhere, the eight countries that have

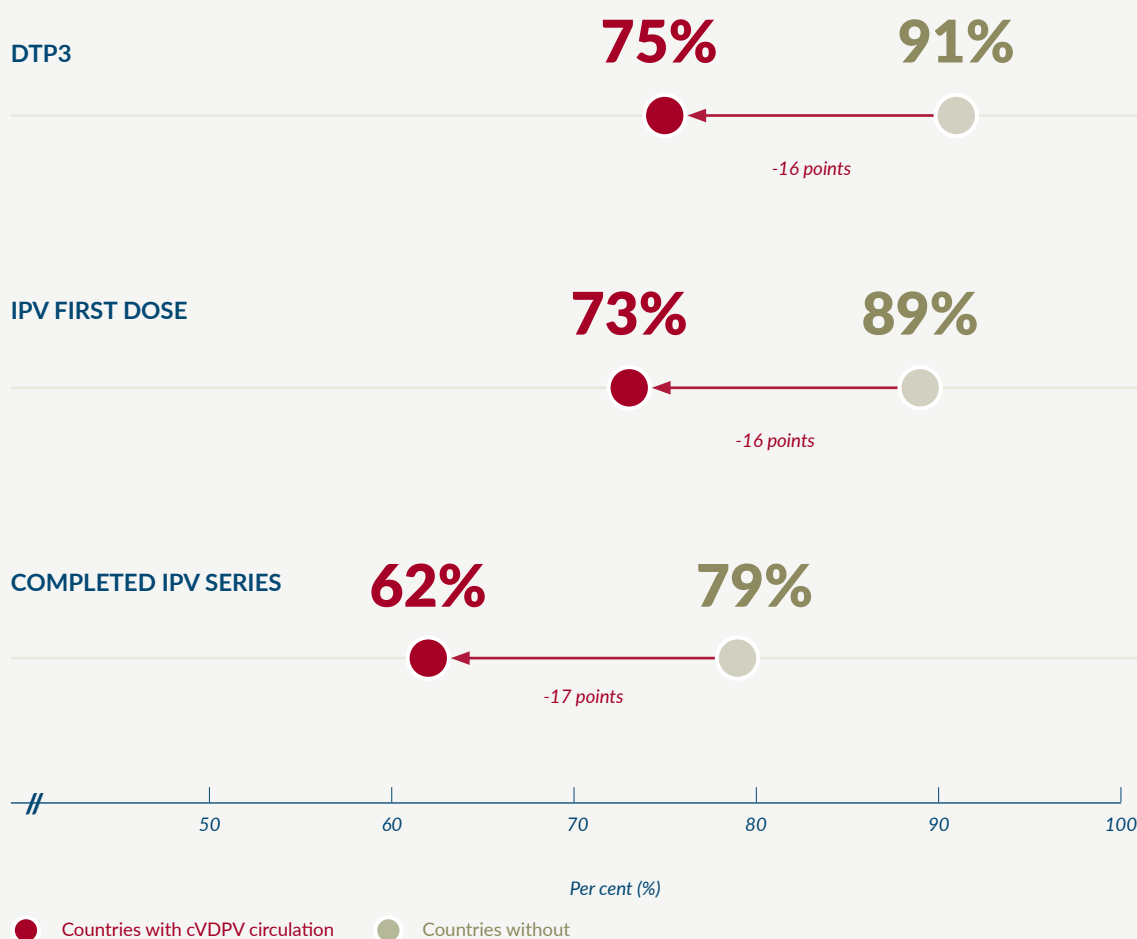
not begun the process are far from a marginal administrative matter. They are a significant constraint on the date at which the polio endgame can unfold.

The relationship between routine coverage and outbreak risk is visible and worrisome. Among oral polio vaccine-using countries, those experiencing circulation of vaccine-derived poliovirus in 2025 had 75 per cent third-dose diphtheria-tetanus-pertussis (DTP3) coverage, 73 per cent first-dose inactivated polio vaccine coverage and 62 per cent completion of the inactivated polio vaccine series. Those without vaccine-derived poliovirus circulation recorded, for the same categories, 91, 89 and 79 per cent respectively.



COUNTRIES WITH cVDPV CIRCULATION HAVE LOWER IMMUNITY AT EVERY STEP

Routine immunisation coverage, countries with and without cVDPV circulation



Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), 2026. Groupings per WHO.

From this it could be argued that completion, not introduction, is where the greatest remaining risk sits.

There is a further reason to press on completion in the hardest places specifically. Oral polio vaccine performs less well where sanitation is poor and the burden of enteric infection is high. That is to say that it works least well exactly where it is most needed. Injectable vaccine does not share that limitation and

performs consistently across settings. The countries carrying the largest immunity gaps are therefore the countries in which the injectable schedule earns most, and they are the countries in which it is least often completed.

Why national strengthening cannot be the answer on this timetable

Over the past decade, and setting aside the rises in inactivated polio vaccine coverage that follow introduction rather than programme improvement, the diphtheria-tetanus-pertussis vaccine coverage trajectories diverge.

Afghanistan has drifted downwards. The Democratic Republic of the Congo has been broadly flat. Nigeria has climbed roughly 20 points from a low base and Pakistan has reached the low 90s percentages.

The conclusion is not that these programmes are static but rather that none is improving fast enough nationally to shift the polio risk. Moreover, the national figures are themselves too unreliable to carry the judgement. For example, Nigeria's 92 per cent administrative coverage level contrasts with the 62 per cent WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) figure.

No plausible programme of national system strengthening will bend those lines sharply within two or three years.

A great deal of language about strengthening routine immunisation carries an implicit promise of national transformation. The evidence does not support this at all. Generic routine immunisation strengthening is necessary, valuable but slow. The polio eradication timetable is not slow. At most national levels, the two cannot presently be reconciled.

If national averages will not move fast enough to alter polio risk, then the work must be done at subnational level, in the consequential geographies and the areas surrounding them, where transmission actually persists.



“No plausible programme of national system strengthening will bend those lines sharply within two or three years.”

Six countries currently have, within their national borders, consequential geographies. In them, some chronic outbreaks are running beyond a year, combined with repeated emergences, regular exportations or a heavy paralytic burden. Between them, these jurisdictions account for roughly four-fifths of paralytic polio cases in the last 12 months. Targeting them is a programmatic precondition, not a preference.

Major coverage uncertainties

It has long been clear that targeted action in the immunisation programme is seriously impaired by unreliable vaccination coverage data. It takes a number of different forms.

Officially reported coverage in some settings runs at 80 per cent or higher while field surveillance estimates suggest 20 or 30 per cent.

Accurate denominators are vital to metrics assessing performance. Coverage is a fraction, and its lower half depends on knowing how many children there are. Several of the countries central to polio eradication have not conducted a population census for many years. Census-taking is expensive and often politically difficult but every coverage figure, every microplan and every calculation of missed children in those countries rests upon reliable population estimates. Improvements in vital registration systems are slow,

and, although they could result in near-complete denominator data, are not currently on track to be useful for this purpose in the coming years.

A birth dose of novel type 2 oral polio vaccine (nOPV2), followed by inactivated polio vaccine (IPV1) at six weeks, is being examined for early protection and mucosal boosting. Its programmatic value may prove greater still. A contact at birth is a registration event. Registration is one of the few practical routes to knowing how many children exist. It enables parents to be reached before unofficial sources shape their view of vaccination. Above all, registration and follow-through vaccination prevents a child from entering the zero-dose pool.

This has a direct bearing on the question of targets. What subnational coverage threshold is required before transmission can be considered stopped?

Polio does not require the very high thresholds that measles demands, and the relevant range may be nearer 80 to 85 per cent than 95 per cent. However, a threshold means little when most subnational areas have no reliable idea what their coverage is, and no plan exists that would let them find out.

The Polio Programme should stop treating better subnational data as an enabling condition to be worked on alongside everything else, and start treating it as one of the actions that is mission-critical.



What is known to work

Three bodies of experience show that essential immunisation does produce gains that matter for polio, provided the work is planned, paid for and monitored.

The first is the global catch-up effort mounted after the pandemic: two and a half years, some US\$ 280 million of alliance resources, 36 participating countries, and over 100 million supplementary doses delivered to children who had missed out. Among them were 25.3 million catch-up doses of inactivated polio vaccine and 28.9 million doses of bivalent oral polio vaccine, reaching children aged 12 to 59 months. In immunisation terms, these are “older” children whom routine services no longer target and campaigns often bypass. That polio antigens were included at all is worth noting, since previous catch-up efforts have not always included them.

The lesson, however, is not that this should be repeated. It is that it should not need to be. The initiative succeeded because it was exceptionally resourced, intensively monitored and supported by a coalition assembled for the purpose. None of those conditions is normally available. The learning lies in converting catch-up from a periodic rescue into an ordinary function of the routine programme.

Second, periodic intensification of routine immunisation is another key adaptation for polio. It is an approach, in a number of forms, already part of many national routine immunisation programmes. Pilots in the Democratic Republic of the Congo tested whether such intensification could be made more deliberate, and the results are striking. In under a year, coverage of first-dose measles vaccine rose by nearly 36 per cent, first-dose pentavalent vaccine by around 35 per cent and third-dose pentavalent vaccine by around 33 per cent. The pentavalent measures are the ones usually used as the marker for polio protection.

The operational finding beneath those numbers is the more important one. During intensification, a volume gain of roughly a third was achieved with only 7.6 per cent more sessions; annualised, that becomes a nine to 10 per cent increase in priority antigen volume for two per cent more sessions. On both measures, the programme returns roughly four and a half times the output for the additional effort. This was not achieved by doing more but by mobilising better within what was already being done.

Third, the value of the Coalition on Health Campaign Effectiveness is clear. It is now seven years old. The Polio Programme has helped to lead it, bringing together an unusually wide range of funders, agencies and country representatives.

For example, its collaborative strategy was piloted in Ethiopia and Nigeria. Ethiopia integrated measles, zero-dose routine immunisation, COVID-19 vaccine, vitamin A, deworming, nutrition screening and maternal and child health services. Onchocerciasis treatment, malaria nets and non-communicable disease screening were added in a second initiative. A different bundling of vaccines, treatment and other amenities was successfully delivered in Nigeria.

A key lesson is the importance of leveraging enabling conditions including political commitment, national coordinating structures and formal national plans for integrated campaigns. Persistent obstacles are related to weak subnational coordination, fragmented financing and conflicting denominator data.

What essential immunisation cannot do

Essential immunisation cannot rapidly interrupt active transmission. Where poliovirus is circulating, high-quality outbreak response and supplementary oral polio vaccination campaigns remain the only instruments capable of shutting it down quickly. No amount of routine strengthening can be a substitute.

It cannot remove the barriers created by insecurity and lack of access. Conflict, population movement and refusal call for political, operational



and community strategies at a higher governmental or international level.

It cannot make up for campaigns that are poorly run. Children whom a round fails to find will not be picked up by routine services quickly enough to change the epidemiology.

It cannot fix subnational data quality in the near term. Triangulation helps, but building data systems and local intelligence takes years,

and the international coverage estimates on which the world relies are national, retrospective and published annually. These are three properties that make them ineffective for managing subnational outbreak risk with the speed that polio eradication demands.

Neither can essential immunisation sustain gains without resources and clear ownership. Catch-up, intensification, outreach, completion of the inactivated

polio vaccine series and post-campaign follow-through all require dedicated ring-fenced financing, workforce and an accountable owner. None of them will happen by exhortation alone.

The IMB draws attention to this list because the Polio Programme has a long habit of requiring “a little help from its friends”. Too often this has meant transferring its unsolved problems to whichever partner has most recently been

described as essential. Routine or essential immunisation is indispensable to bringing a durable end to polio. It is not a place to channel the things nobody else has managed to do.

The Gavi–GPEI joint programme

That warning bears directly on the partnership now being constructed between the polio eradication programme and Gavi, the Vaccine Alliance. It is a principal mechanism through which the expectations set out so far are meant to be met.

Gavi's commitment to polio is framed mainly as part of the polio eradication endgame. Its contribution includes financing inactivated polio vaccine within routine immunisation systems and supporting hexavalent schedules in eligible countries.

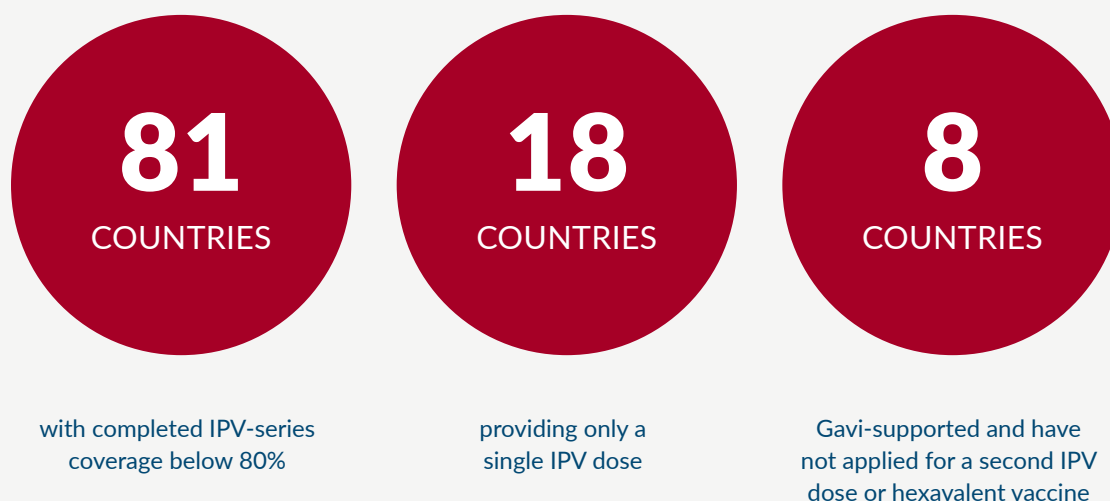
Gavi's role is set out in its own co-financing policy rather than being a subset of the polio eradication strategy.

Inactivated polio vaccine is exempt from the country co-financing rule. This is one

of a set of policy exceptions the Gavi Board agreed when it approved support for the vaccine's introduction across the 72 eligible countries. The commitment to sustain that support will last until global oral polio vaccine cessation. Countries switching to the hexavalent vaccine will co-finance this under Gavi's standard policy but will retain the inactivated vaccine exemption within it. Bivalent oral polio vaccine stays in routine schedules until cessation but this remains outside Gavi's vaccine support system.

THE POST-OPV ENDGAME IS NOT YET OPERATIONALLY READY

Prerequisites for withdrawal of oral polio vaccine, by number of countries



Source: Department of Immunization, Vaccines and Biologicals (IVB), WHO, 2026.

GPEI and Gavi have arrived at the same problem from opposite directions. Gavi's concern is with children who have received no vaccine at all and with the subnational areas where routine immunisation is weakest. The polio eradication programme's concern is with the places where poliovirus will not stop circulating. These are very largely the same places, and often the most fragile and least accessible of them.

The joint meetings of the Polio Oversight Board and the Gavi Board in June and December 2025 endorsed two priority objectives: to improve the targeting and coverage of essential vaccines

through routine programmes, including inactivated polio vaccine and the hexavalent product that carries it; and to make integration during and outside campaigns systematic rather than occasional.

A joint Gavi–GPEI leadership team was created to oversee this, supported by a task team, with joint action plans required first in Afghanistan, Pakistan, Nigeria and the Democratic Republic of the Congo.

This is not a general integration agenda from which polio benefits incidentally. Its objective is polio eradication. By the Polio Programme's own account, roughly seven in 10

polio outbreaks are closed within three or four rounds; the population is then handed back to a routine system that was not reaching those children before the outbreak and will largely not reach them afterwards. That is the sequence the joint programme exists to break.

Progress in the Gavi–GPEI collaboration is real. It has made a promising start, including meeting the four priority countries regarding their integration plans, but it is not yet keeping pace with the ambition the two boards set for it. That judgement was put to the IMB by the partnership representatives themselves.



The larger opportunity is the Gavi 6.0 funding period, which began in 2026 and whose design deliberately created points at which polio requirements can be written into country programmes.

Inactivated polio vaccine and hexavalent vaccine sit inside the guaranteed vaccine budget, which malaria vaccine, for example, does not; that is a welcome prioritisation. Country cash and health system strengthening budgets can fund the reduction of missed opportunities for vaccination in health facilities, integrated outreach and catch-up activity.

A co-financing waiver agreed by the Gavi Board halves a country's funding requirement within its scope; that is a substantial financial incentive.

Gavi's multilateral development bank multiplier, which draws development banks and finance institutions into joint health financing, offers a route to embed a subnational inactivated polio vaccine coverage indicator among the disbursement triggers in the performance-based agreements of polio-risk countries.

When the coverage indicator for Gavi 6.0 was designed, the technical proposal was that at least half of Gavi's 56 implementing countries should reach 80 per cent completed inactivated polio vaccine coverage by 2030. The polio

eradication programme pointed out the obvious weakness: half of 56 countries could be reached without including any of the countries that determine whether polio is eradicated. It therefore asked that the 13 high-risk countries be counted within that 50 per cent. After examination, Gavi concluded it could not commit to that and declined. The compromise reached was disaggregated transparency: the 13 will be reported separately to the Gavi Board as part of routine performance reporting, without a commitment attached.

Three constraints now govern what the GPEI-Gavi joint programme can achieve.

The first is that the polio eradication programme must arrive at Gavi's country processes with a specific, costed and prioritised request rather than with a general interest in the outcome. Guidance to regional and country teams setting out what polio eradication requires from routine immunisation, country by country, was described to the IMB as in preparation; its completion is urgent.

The second is the calendar. Countries are now developing holistic applications or reprogramming existing grants for the whole of the sixth Gavi strategic period. What is not costed into those documents before they are finalised cannot readily be spent afterwards.

The window in which the joint programme can influence five years of country programming is measured in months, and for two of the four priority countries it is already closing.

The third is the least tractable. Beneath the governance and programmatic barriers lies one that country teams reportedly raise more frequently than others: the cultural difference between polio and essential immunisation, and between the two partnerships themselves.

The Gavi-GPEI collaboration has moved further in 12 months than in the preceding decade. It is not yet moving fast enough to change the epidemiology within the period that matters. A year has been spent connecting the two partnerships to one another. Whether anything really transformative travels along that connection will be decided in the grant applications now being drafted, in health ministries, over the next nine months.

Essential and indispensable: what has to lie ahead

Essential immunisation is indispensable to ending polio enduringly, and it cannot end polio by itself. Sustaining momentum will require several key actions.

The work must be organised around geography rather than nations. The consequential geographies and the areas around them are where support must land.

Subnational data must be treated as the first deliverable rather than an accompanying ambition. Until districts know their own coverage well enough to tell which way they are moving, targets are decorative and the Polio Programme is managing a problem it cannot see.

Catch-up must become regular practice rather than periodic rescue. Every child found by a campaign must be linked onward to routine services, and the reason that child was missed must be fully understood and used to change what happens in the next round. The test of success is a smaller cohort of zero-dose children in the following birth year, not a larger number caught up in this one.

There must be realism about inactivated polio vaccine. It is what protects a child against type 2 vaccine-derived poliovirus in the absence of an outbreak response, and it is the only protection of any kind once oral vaccine has gone. Withdrawal cannot happen without it. It is not, however, the instrument that stops transmission.



“

“Catch-up must become regular practice rather than periodic rescue.”

The 18 countries still on a single-dose schedule are a constraint on the endgame timetable.

Finally, accountability must be measurable and jointly held, with milestones and benchmarks at global, national and subnational level. A short list of indicators is needed, capable of showing whether support has landed where it was meant to and whether anything changed; and the routine programme needs ring-fenced resources in its own right.

held steady or improved. However, the direction of travel is not universally positive; composite markers can be misleading and consequences lag behind changes in activity.

Across the countries that the Polio Programme treats as its highest priority, three of the four global surveillance indicators moved backwards over the 12 months to May 2026. The proportion of those countries in which districts met the non-

polio acute flaccid paralysis rate target fell from 78 per cent to 58 per cent. Stool adequacy at subnational level fell from 70 per cent to 62 per cent. Timeliness of final laboratory results for wild and vaccine-derived polioviruses fell from 35 per cent to 12 per cent. Only environmental surveillance sensitivity improved, and for reasons set out later in this section the IMB does not regard that improvement as straightforwardly reassuring.

SURVEILLANCE AND VIRUS IDENTIFICATION

Surveillance is the business of knowing the truth. Excellent surveillance will not by itself produce a polio-free world, but there will be no polio-free world without it. Everything else the Polio Programme does – where it vaccinates, how quickly it responds, when it declares an outbreak over, and ultimately whether it can certify that a poliovirus has gone – rests on being able to see where the virus is.

The Polio Programme entered the funding disruption of 2025 without eradication-level surveillance in place. Matters have generally worsened since. The aggregate trend conceals real variability: some countries improved, some technologies improved, and some environmental surveillance



SURVEILLANCE PERFORMANCE FELL ON THREE OF FOUR CORE MEASURES

Highest-priority countries, 12 months to May 2025 compared with 12 months to May 2026

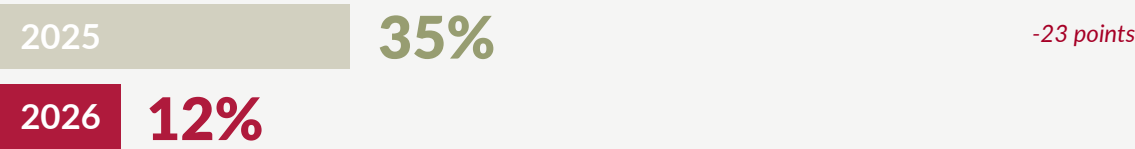
COUNTRIES MEETING NON-POLIO AFP DISTRICT RATE TARGET



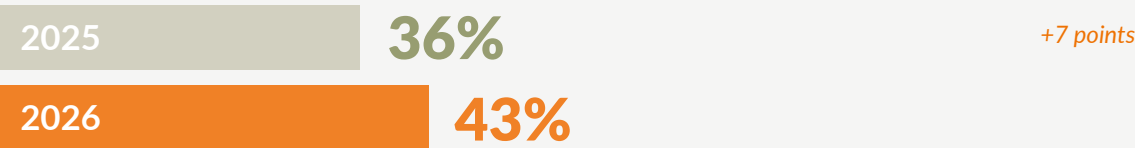
STOOL ADEQUACY



COUNTRIES MEETING FINAL-RESULT TIMELINESS STANDARD



ENVIRONMENTAL SURVEILLANCE SENSITIVITY



Source: GPEI Polio Information System (POLIS), 2026. Centers for Disease Control and Prevention.

Where the decline is worst

The pattern beneath the headline is more troubling than the headline. It is not the highest-priority countries that have deteriorated fastest. It is the tier immediately below them. Among medium-priority countries, the proportion meeting the district-level acute flaccid paralysis rate target fell from one in three to one in seven. The proportion meeting stool adequacy targets fell from 45 per cent to 32 per cent. Watch-list countries fell from 54 per cent to 31 per cent on the first measure.

The Polio Programme's attention, and its reduced money, has been concentrated where the poliovirus is currently known to be. The consequence is a widening group of countries in which the capability to find out whether the poliovirus has arrived is now materially weaker than it was a year ago. These are precisely the sort of geographies in which the last decade's new emergences have appeared. A programme that looks hardest where it has already found something will keep finding things there, and will be hit by surprises elsewhere.

In the WHO Africa Region, the number of countries meeting the acute flaccid paralysis rate fell from 22 of 38 to 13 of 40. In the WHO Eastern Mediterranean Region, it fell from 13 of 22 to 8 of 22. On stool adequacy, the Africa figures moved from 25 of 37 countries to 20 of 35, and the Eastern Mediterranean figures from 16 of 22 to 11 of 20 countries.

Two features of this trend matter.



The first is that a majority of countries in both regions now fail the most basic test of whether their surveillance is sensitive enough to find polio.

The second is that the denominators themselves are unstable, shifting between periods as countries drop out of the analysis for want of data, or of districts large enough to assess. An indicator whose base is shrinking will understate the very decline it is meant to measure. This is a recurring feature of the surveillance measures discussed in this section, and it should be borne in mind wherever a percentage is quoted.

Surveillance systems not fully restored after funding cuts

The withdrawal of United States support in early 2025 dealt the surveillance system a heavy blow. The IMB was given an informed estimate that active surveillance funding fell by something between 30 and 50 per cent across a substantial group of affected countries. The IMB treats that figure as an approximation rather than a measurement.

What happened next is the more important part of the story, and it was a matter of choice. When the external money was withdrawn, the Polio Programme did not reprioritise what remained in order to protect surveillance. It continued down a path it had already chosen: funding outbreak

responses where outbreaks were visible, and withdrawing that funding once they appeared to stop. The active search for the poliovirus, the laborious business of looking in places where no cases are presently identified, was not maintained when funding decreased.

The surveillance system therefore moved from trying to confirm that the poliovirus was absent to waiting for it to announce itself. That approach may just be adequate for disease control. It is not adequate for eradication, and the distinction is central to the Polio Programme's purpose.

The consequences are already visible in places where the Polio Programme believed it had beaten the poliovirus. Countries that had cleared their vaccine-derived polioviruses

are seeing them return, and the returning viruses carry a genetic distance from known strains that indicates long undetected circulation rather than fresh importation. The poliovirus did not come back – it had never left, and nobody was looking.

What this looks like on the ground

The two polio endemic countries are maintaining sensitive surveillance and have shown no significant declines even at subnational level. More significant than the indicator values is their demonstrated capacity to identify their own gaps and close them promptly. Both networks are extensive and engage all sectors, including private, informal and community-based reporting routes.



“Surveillance is the business of knowing the truth.”



The collapse of the global timeliness indicator has been attributed partly to political and transport difficulties in Afghanistan and Yemen. This does not contradict the finding that the endemic countries retain sensitive field surveillance: the country-level global indicator is a demanding pass-or-fail measure, while later regional laboratory analysis describes the distribution of individual sample turnaround times. In Afghanistan, no samples reached the regional reference laboratory for almost three months in the final quarter of 2025. When shipments resumed, the Pakistan laboratory processed nearly 5,000 environmental and case specimens in about six weeks. Regular air shipment

has since been established, although it requires samples to be accumulated and batched.

A warning from civil society partners working at the front line of the system points to an anticipated reduction of a quarter to a third in surveillance work in the areas where they operate. A workaround is being used to stretch community-based surveillance to cover facility-based active surveillance that is no longer being sustained.

There is a related doubt about Pakistan, where access to certain areas depends on community volunteers. Independent evaluation sometimes confirms the reported numbers and

sometimes does not, and, in places, it is said to be “just reporting on paper”. This is an illustration of the same problem: a reported figure is only as good as the verification behind it, and verification is precisely what has become harder to afford.

One polio partner organisation reported to the IMB a signal that no global forum would ever have picked up. It has begun receiving small, episodic requests for laboratory reagents and other supplies. Individually these are trivial. Collectively they indicate that basic consumables are no longer being reliably provided through the channels that should provide them. In this account, a partner

is being used to fill gaps that should have been closed by transition arrangements or absorbed by national budgets.

Two conclusions can be drawn.

First, declining surveillance sensitivity does not only mean later detection; it destroys the cost-effectiveness of the entire response, because a system that detects late is responding to a larger and more dispersed problem with the same resources.

Second, community-based surveillance is undervalued and under-accounted for, particularly in fragile and conflict-affected settings, where it is precisely the mechanism picking up detections in the most remote places.

The one indicator that rose

Environmental surveillance is the single positive element of the field picture. The proportion of sites meeting the enterovirus detection threshold rose at every risk tier: from 36 to 43 per cent among high-priority countries, from 53 to 61 per cent among medium-priority countries, and from 82 to 100 per cent among watch-list countries. Several countries recorded real gains.

One large central African country went from having no adequately performing site at all to having half its sites above threshold. One Pacific country restarted collection after several

years and now meets the threshold at every site. Regional teams have worked hard at site selection, sampling practice and catchment definition. That work has produced results.

The gains are real but the indicator is not a sufficient account of them. This is because the measure counts only sites that have been operating for at least 12 months and have submitted at least 10 samples in that period. Closing a poorly performing site does not depress the score; it removes the site from the denominator and raises it. The metric shows improvement every time the weakest member is excluded.

Over the same period, 13 of 56 priority countries reduced their environmental surveillance footprint by a quarter or

more. Two countries, Eritrea and Guinea-Bissau, closed every site they had. One West African country went from 14 sites to three. The watch-list tier that achieved a perfect score did so on nine countries, where a year earlier it had reported on 11 countries.

Rationalising a network by shutting sites that never detect anything may seem defensible. However, the Polio Programme has ended the year with a measure that cannot distinguish between a network that has become more sensitive and a network that has simply become smaller.

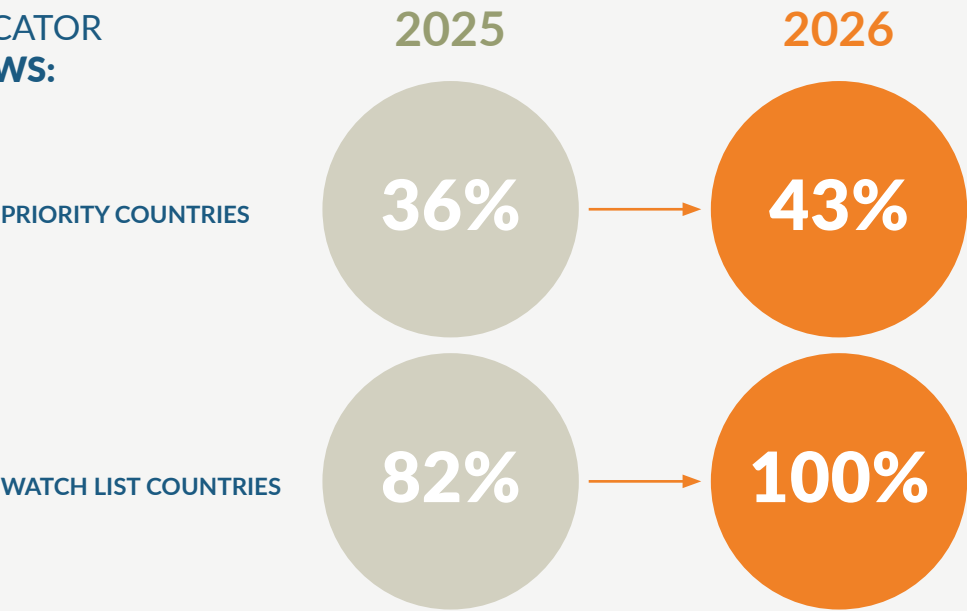
This is not an academic point. Where a country has closed all of its sites, its environmental surveillance sensitivity is not poor. It is undefined.



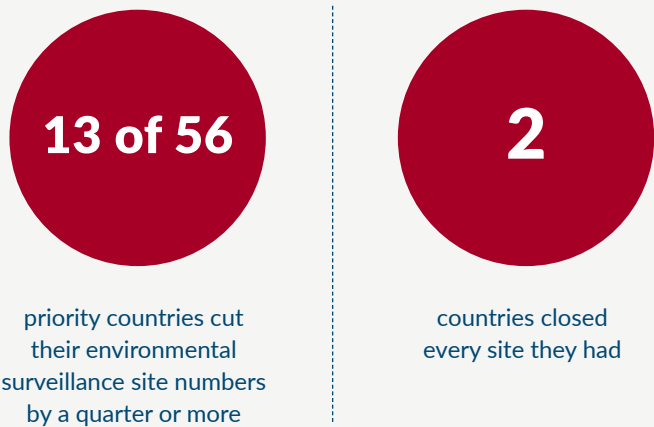
A BETTER ENVIRONMENTAL SURVEILLANCE SCORE CAN CONCEAL A SMALLER NETWORK

Environmental surveillance sites meeting enterovirus sensitivity threshold

WHAT THE INDICATOR SHOWS:



WHAT IT DOES NOT SHOW:



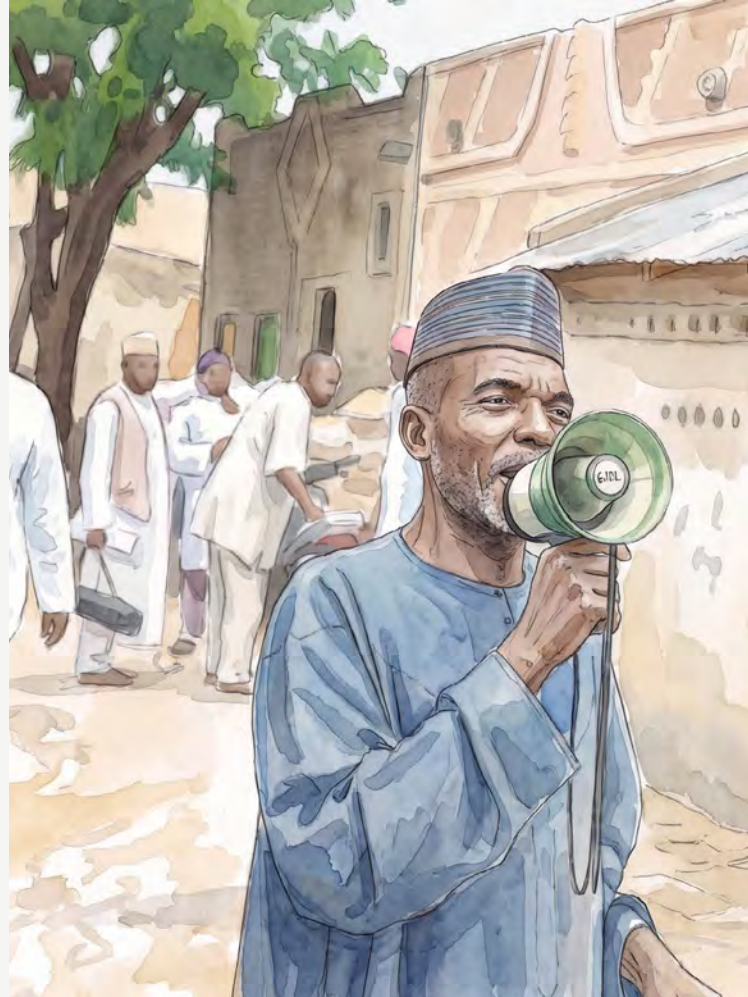
12 months to May 2025 versus 12 months to May 2026.
Source: GPEI Polio Information System (POLIS), 2026, Centers for Disease Control and Prevention.

Measurements that see the problem sooner

The Polio Programme has recognised that annual indicators are too slow to manage a system deteriorating month by month, and has built shorter-interval instruments to sit beneath them. This is sensible work and should be consolidated rather than treated as a temporary expedient.

The first such indicator compares each country's monthly acute flaccid paralysis reporting with its own three-year average for that month. Nearly a third of priority countries in the African and Eastern Mediterranean Regions had two or more months in 2026 in which reporting fell more than half below its historic level. A country can fail this test while still meeting the annual rate target. In other words, it detects the onset of a problem rather than waiting for the annual indicator to confirm that the decline is established. The countries appearing on the list are overwhelmingly in the medium-priority and watch-list tiers.

The second is the deliberate strengthening of surveillance assessment within outbreak response reviews. Eight of nine countries reviewed showed reduced case detection, with a median fall of about 30 per cent. National teams cited three common findings: no money to move specimens, no money to



train or sensitise reporting sites, and no money to make the visits.

The use of “batching” should be closely monitored. It illustrates how a financial decision becomes an epidemiological concern. It saves transport costs by accepting delay. For example, extending the interval between collection and laboratory arrival from about nine to 35 days implicitly accepts roughly four additional weeks

of undetected transmission. This epidemiological price is rarely made explicit.

What the poliovirus's own genome shows

There is one source of evidence about surveillance quality that does not depend on the Polio Programme's own reporting. Every poliovirus carries in its genome an approximate record of how long it has

been circulating unobserved. It is the most objective check available of whether a detection system is working.

Traditionally the judgement of poliovirus genetic profiles has been binary: a virus detected has either been an orphan or it has not.

Today's analysis uses a scale, running from isolates that link tightly to known chains, through those separated by a shorter unsampled interval, to a newly defined "intermediate" category representing roughly a year of unseen transmission, and finally to orphans.

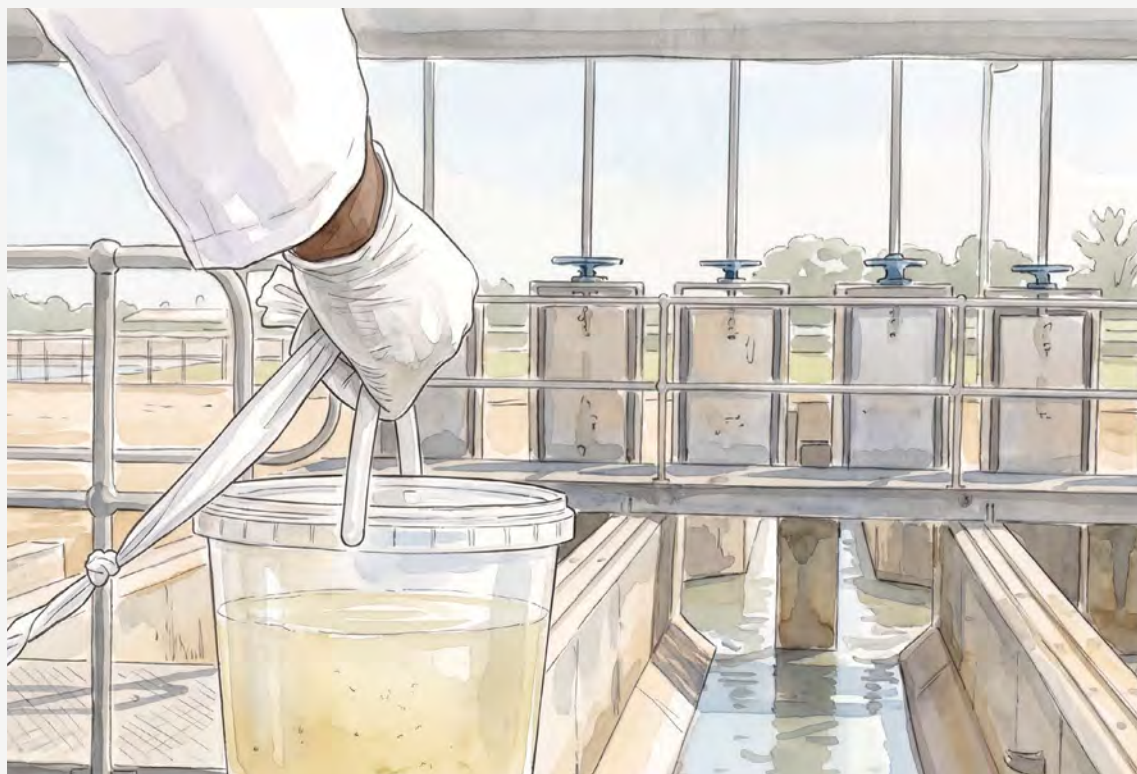
The value of the intermediate category is that it shows before orphans do, giving a programme the chance to act on a surveillance gap that is one year old rather than waiting until the two-year point.

Across some 5,500 detections from 56 countries, between 2023 and 2026, the detection system found most polioviruses close to the point of emergence. However, nine per cent of detections fell into the intermediate category and a further 5.6 per cent were orphans. This gave a reduced-sensitivity fraction of nearly 15 per cent for the period as a whole. That

fraction is rising. It stood at around 14 per cent in 2023 and reached roughly a quarter in 2026, the year for which reporting is least complete.

The burden is not evenly spread. The largest absolute contributions come from the countries with the most detections, which is unsurprising.

Circulating type 2 vaccine-derived poliovirus (cVDPV2) carries the heaviest reduced-sensitivity burden of any poliovirus group. It is getting worse, amounting to over a fifth of detections across 2023-2026.



The Polio Programme is therefore least able to “see” type 2 vaccine-derived poliovirus, the strain that it is least well equipped to stop. The gap between those two capabilities is widening rather than closing.

Ambiguous vaccine-derived polioviruses (single detections not assigned to any established emergence) show a marked rise in the orphan fraction over the period. Seventeen of the 19 orphans among them occurred in high-priority countries. These are, by definition, polioviruses whose history the Polio Programme cannot account for, appearing in the very places where it is looking hardest.

Laboratories: the part of the system that improved

The laboratory network has had a better year than the field, and in one respect a very much better one.

In over 5000 polioviruses reported in the Africa Region since 2023, the proportion of samples reaching a final sequencing result within the applicable standard rose from 15 per cent in 2023 to 44 per cent, then 51 per cent, and then 74 per cent in the part-year to mid-2026.

Over the same period, the median interval from paralysis

onset or sample collection to final sequencing result fell from 67 days to 34. That is a near-halving, and it reflects the value of putting sequencing capacity closer to where samples are generated instead of shipping isolates between continents.

Set beside the global timeliness indicator, which fell from 35 per cent to 12 per cent of countries, the two findings are not in contradiction. They measure different things.

The global indicator asks whether at least four-fifths of a country's detections met the standard, and returns a pass or a fail.



The regional analysis describes the whole distribution. A country whose median has improved substantially can still fail, and several have.

The headline timeliness indicator is registering the deterioration in the field while concealing a genuine and substantial improvement in the laboratory.

Behind the timeliness gain sits an infrastructure programme of real substance.

There is accredited sequencing capacity in four countries of the Africa Region with expansion planned to cover five more.

Nanopore sequencing is established in three countries and extending to a fourth. Direct detection techniques are being introduced across both polio

and non-polio laboratories. A regional laboratory information system is moving to full transition, and an inventory management system is being piloted across 18 laboratories.

In the Eastern Mediterranean Region, work has continued to strengthen laboratories and reduce turnaround times against a background of considerable regional disruption.

A global sequence database launched in late 2025 has established a single unified record of poliovirus sequences after the fracture of the previous year, and is now in use by sequencing laboratories across four regions.

The governance around this has also been amended. A laboratory strategy coordination

group established in March 2026 now reports directly to the GPEI Strategy Committee, giving laboratory questions a formal route into the Polio Programme's strategy, resource allocation and outbreak response for the first time.

What is holding the laboratories back

There are a number of barriers to greater efficiency in the polio laboratories' role.

The first is a simple mismatch between two intervals. Sequencing reagents have a shelf life of around three months. In several high-priority countries of the Africa Region, the IMB was told that importing them requires a clearance process that has been known to take four to five months. A consumable can therefore expire before permission to use it arrives. So, laboratories that have been equipped, staffed and accredited at considerable expense are prevented from working by a bureaucratic document, and a country may possess a sequencing laboratory and still be obliged to send its samples abroad.

Second, a sequencing machine is the smallest part of a sequencing capability. Each new method brings with it information systems, inventory management, quality assurance, proficiency testing, accreditation and, above all, retained human expertise. Each of these must



be funded continuously rather than once. The proposal that the network should move towards an adaptive testing algorithm, in which the sequence of tests applied is matched to what a given setting can actually sustain, rather than to a single global standard, is the right instinct. There has been some frustration based on the assumption that a sequencer can be installed and sequences immediately produced and interpreted. This is wrong. Standing up a sequencing laboratory takes time. Becoming a molecular epidemiology laboratory takes considerably longer, because such a laboratory is a first-line interpreter of genetic data rather than a machine producing sequences for someone else to interpret.

Third, concerning direct detection, which offers the single largest available reduction in the detection interval, the evaluation timetable is now firm. Dossiers from method developers were available at the end of July 2026, triggering up to three months of structured review. Technical recommendations will be made by December 2026, with possible acceptance during 2027.

The IMB supports both the ambition and the rigour, and endorses without qualification the principle that faster reporting is worth having only if confidence in detection is

preserved. However, the costing and budgeting work for what acceptance would require is only now beginning. A method may be approved in 2027 and unaffordable in the same year. An indicative costing should accompany the technical recommendation in December 2026 rather than follow it.

The IMB also notes that the pressure for in-country capacity is not always technical in origin. In Afghanistan, the wish to establish domestic laboratory capacity is bound up with a longstanding unwillingness to have specimens tested across the border, and with doubt

expressed at senior level about results produced there. The IMB does not comment on that doubt. It observes only that in-country capacity in this instance would serve a purpose beyond speed, and that the Polio Programme should say plainly, when it makes its case for investment, that confidence in the result is part of what is being bought.

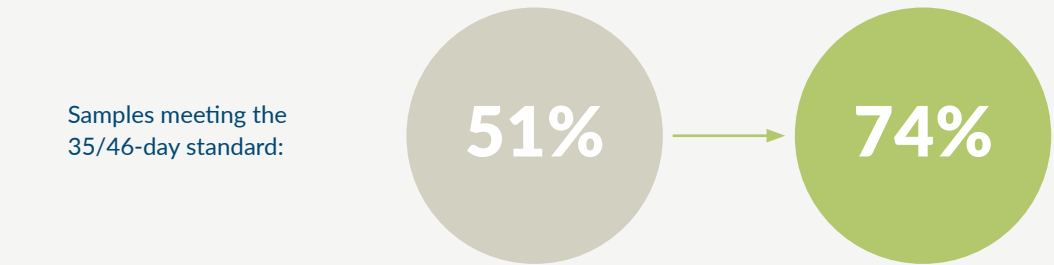
There is no single solution to improving poliovirus detection, and progress will depend on several complementary approaches pursued together.



LABORATORY PERFORMANCE IMPROVED WHILE FIELD DETECTION WEAKENED

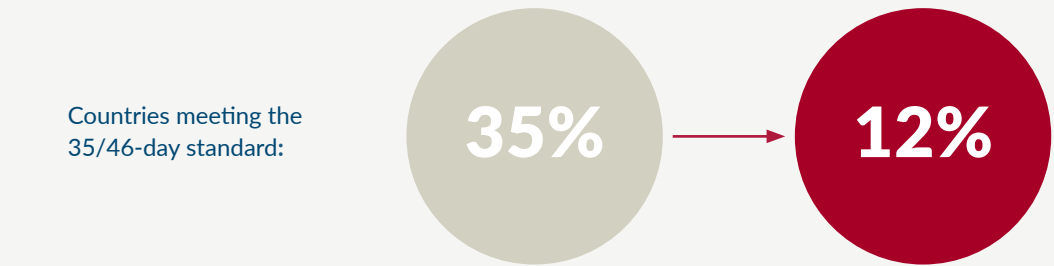
The programme has a real laboratory success, but it has not overcome the deterioration in field and transport systems

AFRO REGION: WHERE SEQUENCING CAPACITY EXPANDED



WHO Africa region • VDPV and Sabin • End 2025 vs data to June 2026

HIGH-PRIORITY COUNTRIES: WHERE SPECIMEN TRANSPORT FAILED



High-priority countries • WPV and VDPV • 12 months to May 2025 vs 12 months to May 2026

Sources: WHO AFRO Region Polio Laboratory Network. Centers for Disease Control and Prevention. GPEI Polio Information System (POLIS), 2026.

OUTBREAK RESPONSE AND CLOSURE

During 2026, the Polio Programme issued a substantially revised version of its outbreak response guidance: *Standard operating procedures: Global guidance for responding to a poliovirus event or outbreak, Version 5.0*, superseding the version of March 2022 and its 2025 addendum.

The standard vaccination response is now three large-scale campaigns rather than two. Outbreaks are classified

by poliovirus type rather than by emergence group, and divided between new outbreaks, running to 180 days from Day 0, and persistent outbreaks beyond. Within the persistent category, a chronic outbreak runs beyond a year.

A consequential geography is a country already in chronic outbreak that has additionally generated three or more new emergences, exported poliovirus to 10 or more countries, or accumulated a hundred or more paralytic cases. Those thresholds count damage done rather than damage forecast, and each is a count only surveillance can produce.

Three named categories of failure are introduced: a failure to respond, a failure of scope and a failure of response, more than one of which may operate at once.

They force a diagnosis of why an outbreak has not stopped rather than merely a record that it has not. The previous binary judgement of whether a target was met has been replaced by a four-level scheme distinguishing optimal performance, a caution zone, failure and critical failure. The document is also now to be reviewed every six months rather than revised occasionally. Each of these steps is a move towards sharper accountability.



The timetable is admirably clear. An investigation must begin within 24 hours. A risk assessment must be submitted, at least in part, and the outbreak graded within 72 hours. The government must declare a public health emergency within seven days. A rapid response round may be conducted within 14 days.

The first large-scale campaign must be launched within 28 days. Two campaigns should be complete within 56 days and three within 84 days. Transmission must be stopped within 120 days.

Every one of those intervals is counted from Day 0, which the procedures define as the date on which the World Health Organization receives notification of a laboratory-confirmed poliovirus together with its sequencing result.

The inference is obvious and uncomfortable. All the time consumed between a child's paralysis and that notification – the delay in the case being reported, the wait for transport, the days added by batching, the journey to the laboratory, culture, intratypic differentiation, sequencing, and any reagent clearance problem along the way – falls outside every indicator by which response is judged.

The procedures do not ignore surveillance, but no response indicator begins before Day 0, so the interval most likely to be lengthening is judged only in

aggregate and never attached to any outbreak. A country whose median interval from paralysis to notification is 34 days begins its response more than a month after the poliovirus was already injuring children. The paralysed child who starts the sequence is a late and improbable signal, standing for a much larger number of infections that produced no symptoms at all.

The IMB is not proposing that Day 0 be redefined. There are good operational reasons for anchoring the response to the moment at which a response can begin. It is proposing that the Polio Programme stops reporting the two halves of the interval as though they belonged to different subjects. Detection time and response time are one continuous quantity, and only the second is ever judged outbreak by outbreak.

There is a second and less obvious reason why this document matters. It makes surveillance quality a direct determinant of the response. Orphan viruses are named among the factors signalling high virologic risk, and the procedures state plainly that they indicate undetected transmission and gaps in surveillance sensitivity. The contextual risk assessment requires a detailed review of all surveillance indicators at subnational level. A vaccination response is recommended, even without confirmed local transmission, if surveillance gaps are serious enough for a detection to represent only the visible part of a larger problem.

The Polio Programme has thus given surveillance quality more weight in its response decisions at exactly the moment when surveillance quality has



“Detection time and response time are one continuous quantity, and only the second is ever judged outbreak by outbreak.”

fallen. It guards against the obvious circularity by listing the sensitivity of the acute flaccid paralysis system among the contextual risk factors, but that guard works only where the weakness is recognised. The orphan poliovirus is the standing proof that it is not always recognised. Weaker surveillance does not merely delay a response; where the weakness is itself unseen, it degrades the risk assessment on which that response is scoped.

Finally, a point of connection. The procedures adopt the orphan virus definition used in the genetic analysis set out earlier. Response framework and genetic surveillance now share a technical vocabulary. That makes the absence of any mechanism linking a genetic finding to a corrective examination of the surveillance system even more surprising. A detection obliges a country to investigate where the virus came from and how far it has travelled. Nothing obliges anyone to ask why nobody saw it sooner. The two systems already speak the same language. Nothing apparently yet requires them to speak to each other.

COMMUNITY ENGAGEMENT

Since its earliest reports, the IMB has argued that social data are indispensable to polio eradication. The Polio Programme has never seriously disputed this. Despite the pioneering work of UNICEF in this area, it has simply never given such data the standing it gives to epidemiology.

Laboratory results, environmental sampling, case counts and coverage estimates are the currency in which the Polio Programme thinks, plans, argues and reports.

Everything learned about permission, authority, fear, obligation and grievance is gathered in quantity, discussed, but not truly mainstreamed in the strategic management of the Polio Programme.

It is different at country and provincial level, in some cases, where it has become fully recognised that the barriers to eradication are strongly linked to human factors, and that the Programme's work absolutely must be shaped accordingly.

Extensive study has shown that, in the places where poliovirus still circulates, a household does not assess a vaccination visit on its own terms. It reads the



visit through everything else it knows about institutions and power. Is the family treated with respect? Is it safe to open the door? Who has asked for entry, what is their gender and who has given permission for it? The decision that follows is not principally a judgement about a vaccine. It is a judgement about the people offering it and the system standing behind them.

The consequence is that delivery is no longer the binding constraint. Getting vaccine to a settlement has often been solved, unless there are serious security problems. What has not been solved is whether the relationships surrounding a household make acceptance possible when the vaccine arrives. Every remaining reservoir of poliovirus is, in this sense, a place where the Programme does not hold its own access. It is granted access, round by round, by people who are not accountable to it, on terms it does not set and frequently cannot discover.

This is not a soft observation offered for balance. It is a claim about what determines the outcome. If access is produced by relationships, then relationships are operational variables. They should be mapped, measured, tested and managed with the same rigour the Programme applies to the poliovirus itself. They are not, at least not consistently and comprehensively.

The single most reliable indicator of quality in this domain – the degree to which community engagement and operations are planned and implemented together rather than in parallel – remains unmet in many places.

Mistrust is a verdict on the health system, not an opinion about a vaccine

Southern Afghanistan, the Pakistan districts along its border and northern Nigeria differ in many particulars. Yet, the forces generating mistrust in them are strikingly alike: insecurity and restricted access, norms governing who may speak to whom, contested political relationships within and across borders, weak routine health services, layered deprivation and populations that move.

These are also, precisely, the conditions in which the poliovirus survives. The same variables drive transmission and drive suspicion, which is why the two cannot be addressed by separate teams working from separate evidence.

Provincial sources in Baluchistan report that households routinely say the programme comes only for polio, knocking on the same doors again and again for one thing while many health and economic needs go unmet. Refusing families regularly provide this rationale. Rumours about concealed purposes take hold, not because they are intrinsically plausible but

because they answer a question that genuinely demands an answer. The Polio Programme's own prominence is therefore among the raw materials of the suspicion directed at it.

There are two main sources of that suspicion. One is misconception, which concerns the vaccine itself: its contents, its purposes, its effects. The other is fear, which concerns exposure, safety and the consequences of being seen to cooperate with an external party in a contested environment.

These require entirely different responses. A programme that answers a security fear with theological or scientific reassurance has misheard the question, however accurate its answer. Distinguishing them is precisely the work that social listening and the mapping of local influence exist to do. It cannot be done by any epidemiological instrument. Perhaps too much effort continues to focus on vaccine hesitancy when the dominant obstacles lie well beyond it. No amount of skilled communication will move an obstacle that fear is holding in place.

Acceptance is largely conditional, and the conditions are held by others

Where the programme enjoys acceptance in communities, it is for the most part based upon one of two conditions.

In the first, a caregiver accepts the vaccine because a trusted local figure has endorsed the campaign. The confidence runs to that person and reaches the programme only by association. In the second, a caregiver accepts because the vaccine arrives alongside something the household values more highly: nutrition commodities, hygiene items, a wider package of services. Here the underlying position is that polio is not the family's priority, but the visit is worth admitting to the home for what accompanies it.

Both are genuine acceptance but both are contingent. The first can be revoked by the person who granted it, without warning and without reference to the programme. The second expires with the commodity. High acceptance figures in these settings should therefore not be read as evidence of confidence in the programme going forward, because in many households the Polio Programme is not the party being trusted at all.

Trust of this kind is borrowed rather than transferred, and a borrowed asset can be recalled. This is a materially different position from the one the Polio Programme's reporting implies, and it explains how apparently strong performance can reverse within a single round.

The IMB heard how much a modest addition can achieve.

In four districts of Baluchistan, long regarded as among the more rigid in their views, a bar of soap given to every vaccinated child accompanied coverage that exceeded expectations and, more significantly, changed the direction of the encounter. Families came forward with children of their own accord, including children they had not previously presented, and pointed out those still due. Teams reported finding hidden children as a direct result.

This should be read carefully in both directions. It is a well-judged and inexpensive response to a grievance. It is also a demonstration that a meaningful part of what the programme has been recording as refusal, concealment or inaccessibility was in fact a negotiation about reciprocity.

The household's price for participation was, in these districts, very low indeed.

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“Trust of this kind is borrowed rather than transferred, and a borrowed asset can be recalled.”



In the Polio Programme's long and largely successful engagement with religious authority, faith leaders possess something the programme structurally lacks: continuous presence. They remain when the campaign vehicles have gone, through the intervals in which questions, rumours and grievances circulate and attitudes harden or soften. However, influence of this kind is relational, conditional and brittle. A national scholar may hold status without persuasive power at a doorway; a local imam may command deep respect within a few streets and none beyond them; female religious teachers may reach

mothers whom senior male scholars will never address, while holding little public authority.

Recruiting people with religious titles is not the same as understanding the actual geography of influence, and a standard training package cannot substitute for knowing why one particular family will not have its child vaccinated.

One programme has moved from mapping influencers to mapping networks, on the reasoning that an influencer has influencers of their own. What matters is the hierarchy: who is suited to advocacy, and who will walk a street to bring children to

a vaccination point. Mapping it exposes the leverage within it.

Boycotts are not spontaneous; they are preceded by discontent circulating in tea houses, religious places and community gatherings. What was missing was never the signal but the capacity to convert it into intelligence quickly enough to act. The IMB heard that this capacity has been built deliberately and used to prevent boycotts rather than explain them afterwards. Misinformation is now answered continuously rather than in the fortnight before a round.



Refusal among the educated, and what happens when the programme explains itself

The assumption beneath most refusal programming is that refusal is an information deficit concentrated among the poor, the uneducated and the remote. Two accounts given to the IMB show that areas of deprivation are not the sole source of rejection of the programme's approaches.

The first is that refusal continues to climb the social scale. Last year the IMB noted non-compliance spreading among educated and affluent communities in Nigeria, and hesitancy among intellectual elites and clinicians in the Democratic Republic of the Congo.

In northern Nigeria that trend has reached its endpoint: doctors and nurses declining vaccination for their own children in accommodation built for health staff. These are not people who dispute the value of a vaccine. They distrust the system delivering it. This cannot be attributed to illiteracy, to susceptibility to rumour or to lack of access.

Last year, the IMB asked the Polio Programme to understand why people refuse rather than merely record that they do. This is part of the answer: a considered withdrawal of confidence by the people best placed to judge. A community

that watches its own clinicians refuse will not be persuaded by anybody else. The operational response – composing resolution teams from the refusers' professional peers rather than deploying standard personnel – extends the logic of last year's Fathers for Good Health initiative and is positive.

The same phenomenon appears institutionally in Karachi, where private schools and religious schools have refused entry to vaccination teams, and where police lines have generated a notable share of the refusal caseload. These are not marginal households. They are organisations run by educated people with professional obligations to the children in their care, and their refusal has consequences far beyond a single doorstep.

What the Sindh provincial polio programme then did with that problem is an instructive piece of practice, and it rests on a single decision of framing. Provincial leadership concluded that where institutions deny access, the fault is more likely to lie at the programme's end than in the conservatism or hostility of the population; these barriers exist because of something the programme has failed to do, and can therefore be ameliorated.

The method followed from that. The team worked out what the other side's concerns were actually likely to be, rather than what the programme

assumed them to be or wished them to be. For the private schools these turned out to be entirely reasonable and entirely unanswered: whether vaccinators are properly trained, since the programme had never told them that training takes place or how; whether the cold chain is maintained, given that the same families trust the identical vaccine when it is given privately; whether this is in fact the same vaccine as the one obtained from a private clinic; why the campaigns come round so often; and what religious authority says about it. A presentation was built to answer precisely those questions and delivered to several hundred principals, managers and owners.

The result is a better measure of engagement quality than any activity count. Before the campaign, schools had required a consent letter, leaving each parent to decide and to refuse without explanation. Afterwards, one school issued a letter of intimation instead: notifying parents that vaccination would take place on a stated day, that it was expected for children of the relevant ages, and asking for their support. The gatekeeper had moved from neutral permission to active advocacy. The schools then admitted the programme to their parent-teacher meetings, which is access of a kind the programme could not have obtained by any other route. The owner of a chain of schools said afterwards that he had

understood the programme for the first time and would write to his principals in support.

The same preparation was applied to the municipal authorities, and it was the first time the programme had approached them. A separate presentation was prepared for the metropolitan council, on the reasoning that elected representatives would have different concerns from school proprietors and so they did. They asked why campaigns are so frequent and whether that is safe; whether the vaccine has been tested and whether certification could be shown; how it differs from what the private sector gives; and, inevitably, about water and sanitation, with the mayor present. Where councillors were Pashto speakers, a team member addressed them in that language, and the effect was immediate. The mayor was vaccinated. So, following a comparable meeting, was a senior police officer.

Three things follow from this that the IMB considers generalisable. Institutional refusal is frequently a failure of explanation and respectful engagement rather than a failure of belief, and the programme has been slow to consider that possibility; the concerns raised were legitimate, answerable and unanswered for years, which means the deficit of information

ran from the Polio Programme outwards rather than towards it. Different gatekeepers hold different concerns, so a single message prepared centrally would have failed with at least one of these audiences. The real objective is not permission but advocacy: the movement from a consent letter to a letter of intimation is exactly the shift from conditional acceptance to institutional ownership, and it happened because somebody listened, learned and prepared properly for a meeting.

This required no new resource, no new platform and no new evidence. It required the programme to find out what people wanted to know and to tell them.

Where locality substitutes for protection

The Polio Programme's principal asset in the most violent districts is not security provision. It is the fact that its workers live there.

Provincial leadership in some parts of Pakistan uses an operating model in which teams are drawn from the union councils in which they work, speak the local language and are known as belonging to the area, and can therefore move where outsiders cannot. Access to households is maintained on that basis. In the hardest environments the programme can often best reach children because its workers are neighbours.



It also produces an inversion. Two distinct armed threats can operate in the same territory, and they select different targets. One targets vaccination workers directly. The other targets police and security forces. A team travelling under security escort can be therefore more exposed than a team travelling without one, because the escort attracts the second threat while the team already attracts the first. Some workers have accordingly indicated that they prefer to move through their own neighbourhoods unaccompanied, and campaigns have proceeded on that basis, by decision taken at the highest level of the province against the advice of the security authorities.

A programme whose workforce is safer without protection than with it is operating at the outer edge of what can reasonably be asked of anyone, and the calculation was made by the people who bear the consequences. This arrangement is available only because the workforce is local, which makes the recruitment, retention and safety of local workers a security question and not only a staffing one. Extremely carefully considered judgements are required in designing operations in such settings.

Violence remains a present danger

Between 1998 and 2024, immunisation activities were associated with more than 700 reported violent incidents, causing 359 deaths, 358 non-fatal injuries and 179 kidnappings; 85 per cent of those killed or injured were in the two endemic countries. These published cumulative figures end in 2024 and do not include the more recent incidents described below. They also represent only reported events and can create the misleading impression that violence is an accumulated historical burden rather than a current operating condition.

In the days immediately before the July 2026 IMB meeting, attacks in Baluchistan killed and injured police officers in a village on the outskirts of Quetta and in Ziarat nearby, prompting public protest and widespread alarm among residents. During the campaign then in progress, teams in two separate districts reported being followed and questioned by masked individuals about whether they were working on polio and where they were going.

Some months earlier, coordinated attacks struck 10 districts of the province simultaneously on a Saturday, days before a synchronised campaign was due to begin on the Monday. The campaign began on time in most

districts; in two or three it was delayed, in one it started and was suspended for two days after further threats, and in a single district a continuing security operation prevented it altogether. On another occasion a campaign in a border town was halted for a day by cross-border exchanges of fire and resumed only after negotiation with the district administration.

Set against that, the ordinary difficulties of a campaign look different. When security incidents occur, the district administration's attention necessarily moves to them, and the programme falls down the order of priority at precisely the moment it most needs support. This account describes only one province in one country over a few months.

Missed children will not be found by a gender-blind programme

Gender is often treated within polio eradication as a workforce issue: where men cannot enter a household, recruit more women. That is necessary in many settings, but it is not gender mainstreaming.

A true gender lens asks a wider set of operational questions. Who is permitted to cross the threshold? Who knows how many children are inside? Who is present when a team visits? Who decides whether vaccination can proceed? Who influences decision-

making? And what conditions enable or prevent the worker from completing the task safely and effectively?

These questions go directly to the programme's central problem, because the remaining children are not missed for one reason. Some are absent and recorded as such. Others are inside a household but never disclosed to the team. Some cannot be reached because an unrelated male worker is not allowed to enter or speak with the caregiver. Others are withheld because the person at home lacks authority to consent. A further group is missed when the caregiver is working, collecting water, caring for other family members or otherwise unavailable at the time of the visit. These are operational failures shaped by gender roles, even when no explicit refusal is recorded.

The distinction between visible and invisible missed children is especially important. Campaign data usually capture a child who is known to exist but was absent or refused. They are much less reliable when an infant is never included in the household denominator, a sleeping or sick child is not presented, or the team cannot see beyond the entrance. A household can therefore be marked as visited while one or more eligible children remain biologically unprotected and

statistically invisible. Gender-sensitive access is not a matter of social correctness; it is part of denominator accuracy.

Women frontline workers are indispensable in communities where household entry and communication with mothers are restricted by social norms. Experience in Afghanistan indicates that expanding the female workforce and enabling women to work inside

households was accompanied by a large decline in the proportion of children reported missed.

The correct conclusion is not that a particular staffing ratio automatically produces coverage. It is that access to women and children inside the household is a critical programme capability, and that removing it is likely to increase the number of unseen and zero dose children.



Gender also shapes decision-making. The mother or grandmother present during a campaign may support vaccination but lack the authority to accept it. Fathers may be away from home when teams visit but still control the decision. Religious and traditional leaders-most of whom are men in the settings of greatest concern – can legitimise vaccination or reinforce opposition.

A programme that communicates primarily with mothers while the final decision rests elsewhere is engaging the right caregiver but not necessarily the decisive person. Engagement must therefore be designed around these relationships rather than aimed generically at the community.

The examples from Nigeria show the value of bringing men into the solution. Where traditional leaders helped select and support vaccination activity, coverage increased more than in comparable areas without that involvement, and leaders encouraged fathers to authorise vaccination in advance when they expected to be absent. A separate initiative in Bauchi State recruited respected men to discuss immunisation with other men, generating large numbers of referrals into routine services; tens of thousands of children subsequently received birth vaccines, began the pentavalent series or completed later doses.

The significance of this work is wider than male advocacy for a campaign. It recognises fathers as participants in child health rather than obstacles encountered only after a refusal, and it connects polio with essential immunisation. The most useful gender intervention is not one that converts a household for a single round; it is one that changes family behaviour sufficiently for a child to enter and complete the routine schedule.



“Gender-sensitive access is not a matter of social correctness; it is part of denominator accuracy.”

Yemen offers a related lesson in the parts of the country where access is maintained. Engagement with both women and men religious leaders was associated with a substantial reduction in the number of districts characterised by persistent refusal. The combination matters. Male leaders may have formal authority and public reach, while women leaders and networks may have access to mothers and private household concerns. Gender-responsive communication should identify who influences whom, through which channels and at what stage of the decision, rather than assume that one

category of leader can speak for the whole community.

Better data are essential, and sex- and age-disaggregated reporting can reveal patterns hidden by totals. Disaggregation is only the beginning of analysis. Raw counts of missed boys and girls cannot establish inequality unless they are compared with the number of eligible boys and girls in the relevant population. The Pakistan data show that boys accounted for 55% of recorded refusals and girls for 45%. This may indicate a meaningful difference, or it may largely reflect the sex distribution of the children recorded. Rates,

not counts alone, are needed. The Nigerian data similarly show that the sex composition of missed children varies greatly by state and campaign, with more boys recorded as non-compliant in some places and girls predominating in others. This variation argues against a simple global claim that one sex is consistently disadvantaged and supports a more useful conclusion: gender barriers are local and must be demonstrated at subnational level rather than assumed from national averages.

Age should be analysed alongside sex. The youngest children may be disproportionately hidden because they are sleeping, ill, secluded after birth or considered too young for repeated vaccination. Older children may be absent at school, work or play. A country's programme should therefore examine missed-child rates by sex, narrow age group, reason missed, household structure, whether caregiver present, sex of the vaccinator and monitor, and whether the team entered the household. These variables should be linked to action at team and settlement level rather than collected for a global dashboard alone.

The position of women frontline workers presents a further paradox. The programme depends upon them to gain household access, communicate with mothers and identify



hidden children, yet their own ability to work is constrained by mobility restrictions, insecurity, harassment and opposition to working alongside unrelated men.

A substantial majority of Pakistan's frontline workers are women; in the southern districts of Khyber Pakhtunkhwa the proportion falls to roughly a third, because the culture does not permit otherwise. Women may be assigned to remote or male-dominated areas without sufficient choice, transport or protection, and may face excessive workloads, delayed payment and limited routes for reporting mistreatment. A programme cannot claim to be gender-responsive because women are numerically

present while ignoring the conditions under which those same women work.

Gender analysis should be built into microplanning rather than run as a parallel workstream. Every high-risk area should know who can enter each type of household, who normally presents the child, who makes the decision and which children are most likely to remain unseen, with team composition and visit timing following that analysis.

Gender interventions require the same performance discipline as other eradication strategies, their effect measured through fewer missed children, more accurate household denominators, sustained conversion of refusals,

higher routine immunisation completion, improved workforce retention and the disappearance of poliovirus from the communities concerned.

The final reservoir will survive wherever the programme cannot see inside the household, reaches the caregiver but not the decision-maker, depends on women workers without protecting them, or collects sex-disaggregated data without using it routinely to change what teams do.

A gender-informed polio programme will not simply employ more women. It will use the realities of women's and men's lives to find children whom a gender-blind system continues to miss.

Trust can be made observable

Everything set out in this section of the report rests on evidence that the Polio Programme collects but does not yet weigh. Research now beginning in Afghanistan and Nigeria offers a way out of that impasse: a method of treating trust as an observable property of situations rather than an attitude to be surveyed.

An early analysis of 20 interviews with Afghan women frontline workers, conducted and analysed in Dari and Pashto rather than English, has already produced a finding of practical consequence.

The word "trust" barely appears-in fewer than one occurrence per thousand words. Interpretation of the vocabulary that constitutes trust saturates the interviews: relational credibility, assurance, safety, proof and demonstrated performance. Credibility is confirmed by visible performance, safe conduct and accountable behaviour.

The implication for measurement is considerable. An instrument that asks whether people trust the programme is measuring a word its respondents do not use for a thing they discuss constantly. The productive question is specific rather than general. What exactly is it that must be trusted? Who has to trust it? And what would count, for them, as evidence that it can be trusted?

From this, a diagnostic follows that the IMB considers a most useful operational idea now available to the Polio Programme. Access requires six conditions to hold simultaneously: the household understands what is offered; the visit feels safe; the provider is credible; formal and informal permission agree; concerns can be raised and heard; and the service is seen to deliver something of value.

These conditions do not compensate for one another. Five satisfied and one denied leaves a child unvaccinated. That is why confidence accumulates

slowly and disappears quickly, since credibility is built by repetition while a single interrupted service, a withdrawn permission or an unsafe visit removes it.

The IMB draws a single conclusion from this section. The Polio Programme knows how to ask questions of communities and has been doing so, diligently and at scale, for many years. What it has yet to do consistently is treat the answers as actionable evidence: subject them to the same tests of comparison, denominator and follow-up that it applies without hesitation to a laboratory result, and admit them to the decisions that determine where teams go and what they do when they arrive.

Until that happens, the Polio Programme will continue to be surprised by behaviours of communities that it has assumed it understands on the basis of general principles.

WATER AND SANITATION

Where sanitation is poor, contaminated hands, food, water, drains and soil give the poliovirus many routes between children.

Water, sanitation and hygiene (WASH) cannot substitute for vaccination, and no country has eradicated polio through environmental improvement

alone. They do, however, alter the conditions in which the poliovirus is being asked to survive. Poor enteric health is also associated with a weaker response to oral vaccines, although the causes are complex and no single short-term WASH intervention can be expected automatically to improve vaccine performance. Vaccination remains the means of interruption, while sanitation, safe water, hygiene and nutrition make interruption more attainable and more durable.

The scale of the deficit in polio-affected settings is substantial.

In Afghanistan, fewer than half of people have basic sanitation; coverage is about two-thirds in urban communities but only a little over one-third in rural areas. More than a quarter of rural communities have no sanitary infrastructure.

Yemen presents the problem at still greater humanitarian scale: UNICEF estimated in January 2026 that 17.8 million people lacked sufficient access to safe water, sanitation and hygiene.

Across countries classified as fragile contexts, the WHO–UNICEF Joint Monitoring Programme estimated that only 19 per cent of health facilities had basic sanitation in 2023. National figures should not be mistaken for precise descriptions of a polio reservoir, but they show how limited the surrounding service platform can be.

The problem is not simply the absence of infrastructure. In dense urban settlements, intermittent water, leaking pipes, open drainage, unmanaged



faecal sludge and overcrowding can keep exposure high even where a household nominally has a tap or a toilet.

In conflict and displacement settings, an existing service can disappear within days. Goma, a major city in eastern Democratic Republic of the Congo, fell under the control of the M23 rebel group during an offensive in January 2025. This disrupted water, sanitation and power in the city of two million people, requiring UNICEF and partners to provide clean water to about 700,000 people each day.

In Somalia, water provision expanded during 2025 but sanitation lagged: UNICEF reported at mid-year that its sanitation response had achieved only six per cent of the annual target, largely because of funding gaps.

These examples show why a count of facilities built is not enough. Reliability, water quality, drainage, waste management and the ability to keep services operating through conflict, flood and displacement matter at least as much.

Pakistan now has WASH investment on a scale that the polio budget could never provide. The World Bank's 10-year country framework aims to expand water and sanitation access to 60 million people by 2035. Current

programmes include a second Karachi water and sewerage project expected to benefit more than six million people, work intended to reach nearly six million rural residents and four million people in Punjab's secondary cities. In rural Punjab, 218,000 people in 180 villages had gained safe water by mid-2025, with wastewater treatment operating in 80 villages. This is development investment rather than polio expenditure, which is precisely the point: improvements on the necessary scale must come from national and development-bank programmes, with polio risk used to influence where investment is directed.

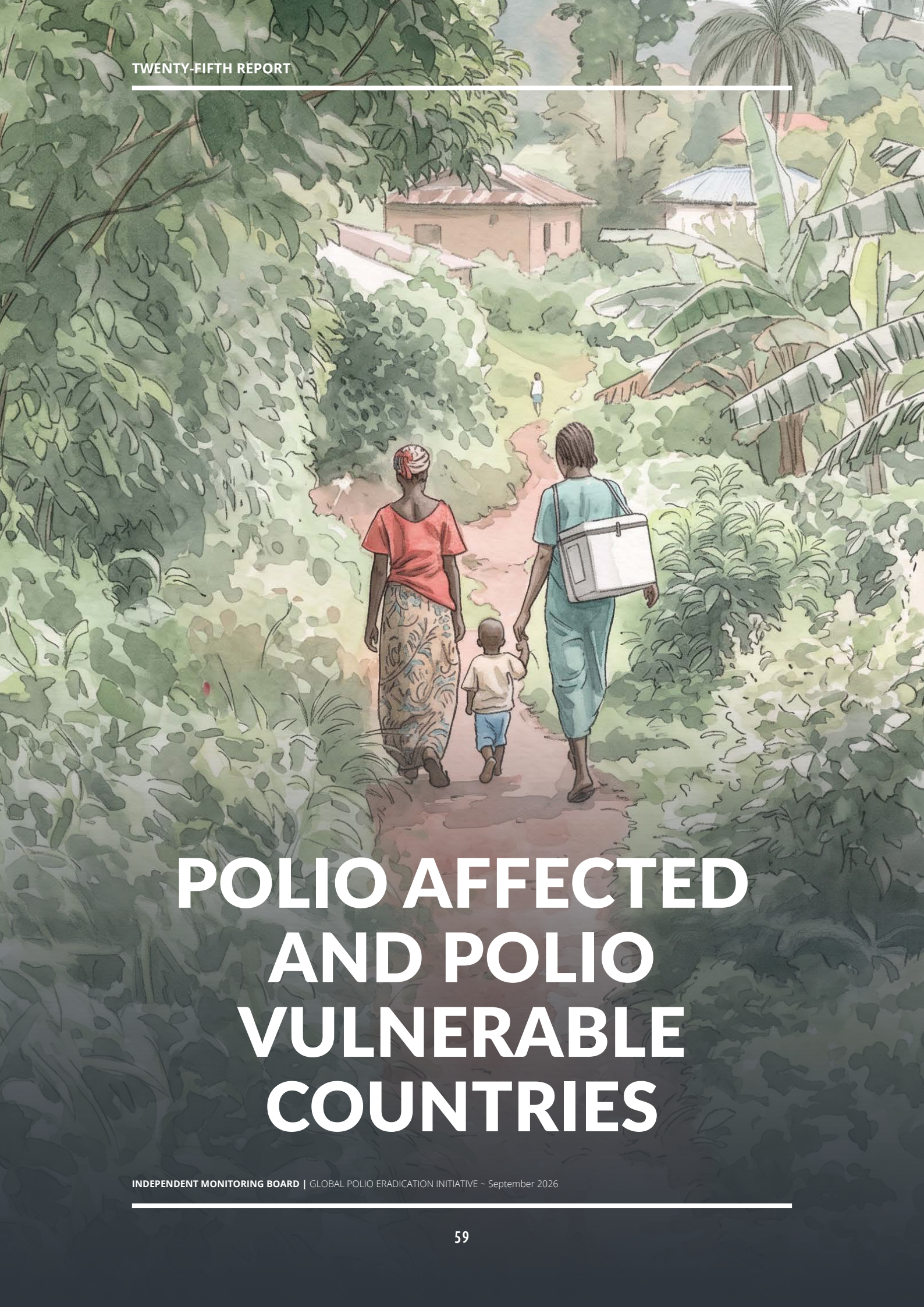
Further provincial action is being taken elsewhere in Pakistan as well.

The role of the Polio Programme should therefore be to identify the communities in which sanitation and environmental exposure are most closely aligned with persistent transmission, bring that evidence into national and development-bank decisions, and ensure that new infrastructure reaches those communities rather than stopping at an administrative boundary nearby.

Progress is also visible in the polio outbreak countries, although it remains far below need.

WASH is neither an optional embellishment to eradication nor a plausible substitute for vaccination. It is part of the environment that determines how readily poliovirus moves and how communities judge a programme that repeatedly visits them.

The highest return will come from disciplined geographic targeting.



POLIO AFFECTED AND POLIO VULNERABLE COUNTRIES

INDEPENDENT MONITORING BOARD | GLOBAL POLIO ERADICATION INITIATIVE ~ September 2026

POLIO AFFECTED AND POLIO VULNERABLE COUNTRIES

THE WILD POLIOVIRUS ENDEMIC BLOC

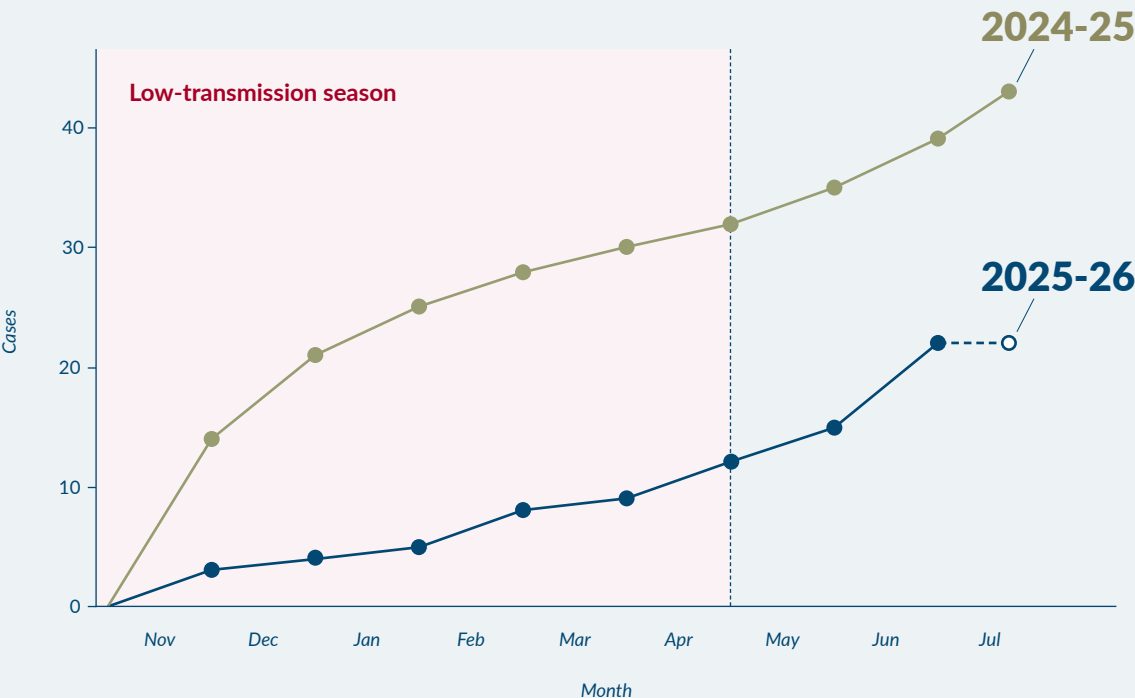
The border between Afghanistan and Pakistan exists on maps, at official crossing points and in the machinery of two governments. It is much less visible in the daily life of the communities that straddle it, and entirely meaningless to the poliovirus. Families, tribes, trading networks, religious influence and channels of information all extend across the frontier, and the genetic history of the poliovirus shows movement in both directions along the southern, central and northern corridors connecting the remaining reservoirs.

For polio eradication this is not the meeting point of two national programmes. It is a single epidemiological space managed through two operational systems, whose ability to work together rises and falls with the political relationship between their governments. The two countries are therefore described separately in what follows, as the programmes are separately run and separately accountable, but the sections should be read as an account of one problem.

The IMB returns, later in this section, to the border itself, the more recent impact of forced repatriation and what the division loses.

WILD POLIOVIRUS SPREAD IN EVERY MONTH OF LOW-TRANSMISSION SEASON

Cumulative paralytic WPV1 cases by month of onset, Afghanistan and Pakistan



Paralytic polio cases notified by 21 July of each season.
Source: GPEI Polio Information System (POLIS), 2026.

PAKISTAN

Pakistan came to the IMB's 25th meeting with an exceptionally senior delegation. The Minister of State for National Health Services, Regulations and Coordination led it. With him were: the Prime Minister's focal person for polio eradication, who this year also holds the GPEI gender champion role; the coordinator of the National Emergency Operations Centre,

newly appointed as joint secretary for immunisation in the Ministry of Health; the chief secretaries of all four provinces; provincial coordinators, surveillance and laboratory leads. The country representatives of the main partner agencies were also present.

Pakistan's chief secretaries are the permanent administrative heads of the provinces, and the programme's position is that

no other single event in the country's calendar takes all four of them out of their provinces on the same day. Convening power of this order is real, it has been built deliberately, and few programmes anywhere command it.

The case those officials came to make was that Pakistan has entered the final phase and can now see the end of it.



Wild poliovirus cases had fallen from 74 in 2024 to 31 in 2025, with three reported in 2026 by the time of the IMB meeting. Environmental positivity had fallen steeply since the autumn. The number of infected districts had roughly halved.

Two of the four historic reservoirs, Lahore and the Quetta Bloc, had gone more than a year without a case, and a third, Karachi, where a low case count had masked two years of sustained transmission visible only in sewage, was down to a single positive environmental sample in June 2026. On this reading, the Pakistan Polio Programme's remaining problem is geographically

small, technically understood, and bounded in time. Its prediction: everything except southern Khyber Pakhtunkhwa cleared by December 2026, and southern Khyber Pakhtunkhwa itself cleared by the middle of 2027.

The IMB's assessment is that the first half of that account is a reasonable expectation and the second half is not yet supported by anything the programme currently controls.

The decline in polio in Pakistan is real. Independent surveillance data confirm the case totals, and the reduction in the poliovirus's geographical footprint is not an artefact of reduced looking:

the non-polio acute flaccid paralysis rate stands at 16.5 per 100,000 nationally against a certification benchmark of three. Every province exceeds the benchmark by a wide margin, and the proportion of districts meeting the standard for specimen adequacy has risen from 80.5 per cent in 2024 to 93 per cent in 2026, with notification within seven days rising from 77 to 86 per cent over the same period. The system is looking harder than it was, and finding less.

The shape of the decline nonetheless matters more than its size.

Three features of it should be held in view.

The first is that the turn is young. Pakistan's environmental surveillance produced 369 positive samples in the first half of 2025 and 282 in the second, a total marginally higher than the 628 recorded in the whole of 2024. The programme's own framing dates the improvement to October 2025. What has happened since is therefore three quarters of good data following two years of bad.

The country entered the 2026 high season with roughly 100 positive environmental samples already accumulated in the first six months.

The second is that 2025 offers a precedent for reading a mid-year figure too positively. At this point in 2025 Pakistan had recorded 19 cases and was describing a comparable trajectory. The year closed at 31, with the additional cases concentrated in the monsoon months. The programme is right to say that three cases at mid-2026 is a materially different position from 19 at mid-2025. It is not yet a different position from the one the programme believed itself to be in a year ago.

The third feature of the decline is that the residual poliovirus is not evenly distributed and is not behaving as a set of

independent local problems. Southern Khyber Pakhtunkhwa sustains two genetic clusters, and within them seven distinct lineages, several of which have persisted for more than a year. The programme describes the area as a major source of genetic diversification. Peshawar shows low-grade circulation fed by repeated introductions from southern Khyber Pakhtunkhwa, with cross-border importation a second route. In the Quetta Bloc, case-free since November 2024, environmental samples regularly demonstrate poliovirus genetically linked to circulation in southern Afghanistan.



The IMB has said before that the silence of the reservoirs cannot be trusted, and the phrase is worth restating here for a specific reason. By the time of the July 2026 IMB meeting, Punjab had no case since February 2025 and no positive environmental sample in the previous two months. The Quetta Bloc had no case since November 2024. Karachi's positivity fell from every sample site to a single detection in Sindh-wide testing in the most recent month.

These gains require verification through the next transmission season.

The programme's own presentation of the last five years shows this pattern plainly enough. The question the IMB puts is not whether these areas have improved, but whether the programme is confident it would know quickly if they had not.

Southern Khyber Pakhtunkhwa

Southern Khyber Pakhtunkhwa has produced 44 per cent of Pakistan's cases over five years, 17 of the 31 cases in 2025, and two of the three cases in 2026. Three of the four cases since October 2025 came from there. It sustains two clusters and multiple lineages simultaneously.

The virology settles what that means. Seven distinct combinations of genetic cluster and district, spanning both circulating clusters, have been found in Bannu and North and South Waziristan, with intervals between first and last detection running from eight to 15 months. The longest was first detected in February 2025 and was still appearing in April 2026. Another was still being detected in May 2026.

This is the signature of a well-established reservoir rather than an outbreak, and it is the clearest available statement that the Polio Programme has not yet reached the standard required in this part of the



province. The programme's own position is that its remaining challenge is implementation rather than strategy design.

Access is the binding constraint, and it is a security constraint rather than, principally, a community one. Union councils are classified as “Green” where standard house-to-house campaigns run with monitoring; “COMVI” where vaccination proceeds at low visibility through community influencers; or “Black” where no campaign runs at all.

The number of black union councils was 26 in May 2025 and 62 by October. Sustained work through the low season brought it to 18 by December and five by April 2026, before insecurity returned it to 19 in May. The May 2026 campaign could not be conducted in South Waziristan Upper. Over the six months before the IMB meeting, campaigns did not run in 26 union councils, leaving more than 136,000 children with no campaign vaccination opportunity during that period.

Access in southern Khyber Pakhtunkhwa is almost like the weather: the programme can forecast it, prepare for it and take advantage of good spells, but it does not control it. A favourable month is never a trend.

Delivering through the Pakistan government's roadmap depends on access improving and remaining improved. The stated aim is for every union council here to reach green status by September 2026. On the evidence of the last three rounds, that would require the most favourable security conditions of the past two years to arrive. It would then have to hold through the high season, in a region where recorded security incidents at divisional level rose roughly threefold between 2023 and 2025, where 2026 is on course to set a further record, and where a single district accounts for about a quarter across that period.



“A favourable month in southern KP is never a trend.”

The distribution within the remaining figures is the more important part, and it points somewhere the access numbers do not.

The most recent polio vaccination round left 75,430 security-excluded children across the south of the province.

The 151 green union councils accounted for 4,014 of them, the 95 COMVI union councils for 42,227, and the 19 black union councils for 29,189.

More than half the shortfall therefore sits in areas where the programme is running

campaigns but cannot fully verify them. Almost all the remainder sits in areas where it is running nothing at all. Within the accessible fraction the position is no more comfortable: five per cent of children were missed in green union councils in the May 2026 round against 13 per cent in those opened by community volunteers, with independent monitoring recall of 89 per cent and 85 per cent respectively. Neither figure is adequate to interrupt transmission.

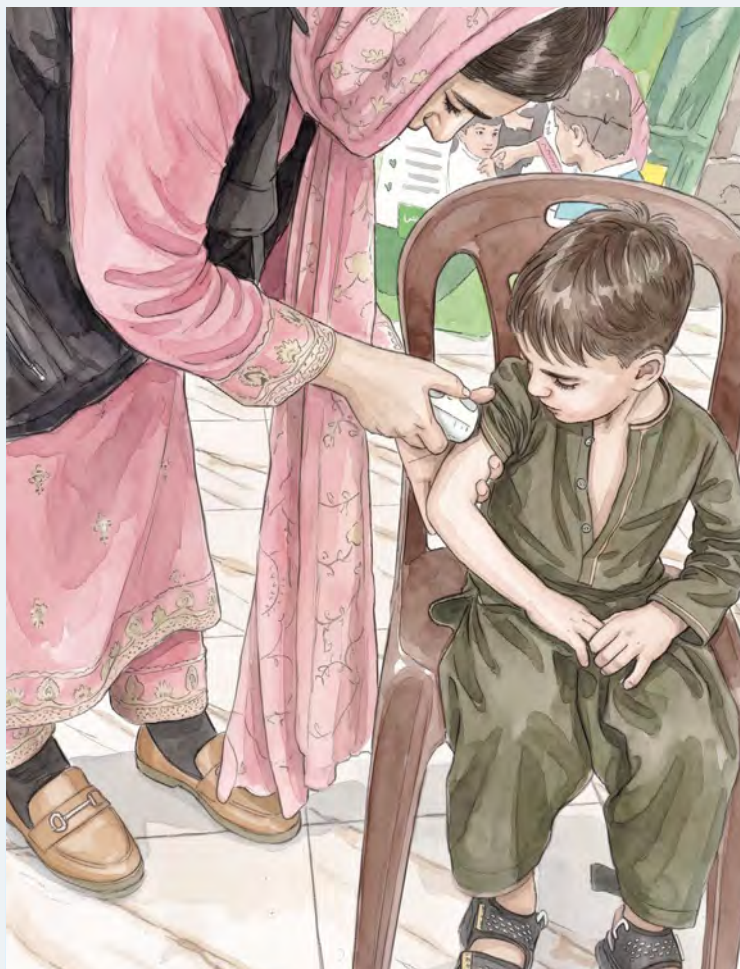
As inaccessibility recedes, the constraint transfers from whether the programme can reach a community to whether

it performs to a high standard when it arrives. Access gains must now be matched by verified delivery quality.

The COMVI model has produced the Pakistan polio programme's most striking numbers of the year. Coverage in these union councils rose from 67.7 per cent in September 2025 to 87.7 per cent in April 2026. The number of such councils expanded from 46 to 108 by April 2026, before 13 reverted to Black status in May, and children left over after each round fell from 20.6 per cent of target to 5.5 per cent. The IMB has no reason to doubt that community-led vaccination has reached children who would otherwise have been unreachable. The model is one of the more important operational innovations of the period.

It is nonetheless the case that the programme's fastest-improving figures come from the places where independent verification is weakest. Its assurance system is therefore concentrated where assurance is easiest to obtain. This is a combination that has misled polio programmes before, in Pakistan and elsewhere.

Independent third-party lot quality assurance sampling covers about a quarter of the country's union councils and reports a 95 per cent pass rate in them. In the May 2026 oral polio vaccination round in southern Khyber



Pakhtunkhwa, lot quality assurance sampling reached 38 Green, six COMVI, and none of the 19 Black union councils.

Assessment coverage therefore falls away precisely as access becomes harder: a quarter of green union councils were sampled, against six per cent of COMVI and none at all where teams operate under negotiated or denied access. Within that small sample, some union councils in Tank and South Waziristan Lower

were assessed repeatedly and returned 100% lot quality assurance sampling passes that sit uneasily alongside weaker readings on microplan quality, intra-campaign monitoring and still-missed children in the same districts.

These pass rates cannot, on their own, establish field quality. The right response is not to distrust the campaigns but to widen independent monitoring fastest in precisely the places where



the gap between official and independent figures is likely to be largest, rather than in the places where it is easiest to deploy monitors. That is a decision about where to spend a shrinking monitoring budget, and it should be taken deliberately rather than by default.

The Pakistan polio programme's response is substantial and, in the IMB's judgement, correctly aimed. A dedicated support unit established by the national and provincial emergency operations centres now covers these areas exclusively. Partners delivering integrated services have been assigned discrete geographies so that

responsibility for any given union council is unambiguous. Every unreached child is assigned to a named individual responsible for reaching them, and children missed on two or more occasions are being re-checked. A go versus no-go access assessment precedes any deployment, and teams return on an approximately three-weekly cycle where access allows.

The targeting is finer than in previous cycles. Seventy-eight of the 265 union councils have been designated for intensified mop-up covering roughly 165,000 under-five year olds. A separate hamlet-by-hamlet rolling strategy applies where deploying a full

union council team would itself create exposure to hostility.

Hamlets missed in two of the last six campaigns are flagged, ultra-local teams vaccinate about 25 children in a day, and the aim is three contacts per child at 21-day intervals, with no deployment permitted without confirmed access, a microplan, a vaccine handover point and same-day reporting. In the largest districts this work proceeds without accompanying security, on the assessment that an escorted team is a more conspicuous target than an unescorted one.

Mop-up rounds in July 2026 reached, on the province's account, more than 90 per

cent of the target in the four black union councils and seven partially inaccessible councils of North Waziristan, 92 per cent in eight union councils of Tank, and 84 per cent of a 91,000-child target across 25 union councils of Bannu.

This is a genuinely different operational posture from the one the IMB reviewed a year ago.

Almost every element depends on a security environment that the health programme does not set, negotiated at the highest levels of civil and military authority: the programme reports four senior civil-military meetings in little more than a week, two of them chaired by the Prime Minister, devoted to access in these seven districts. That level of attention is necessary. It is not, on the evidence of the last two years, yet sufficient.

On boycotts, the picture is better than it was and better than it is sometimes reported. The boycotts' causes are almost entirely unrelated to vaccination, for example: mineral royalties, roads, water, electricity, employment.

Since the last IMB meeting, 159 boycotts were recorded across 16 districts of Khyber Pakhtunkhwa, of which 148 were resolved, and the children left unvaccinated by boycott range from 300 to nearly 1,900 per round.

Karachi

Karachi presented the Pakistan polio programme with a specific analytical problem. Paralytic cases were few, population immunity indicators looked reasonable, and yet environmental surveillance showed sustained local transmission across multiple sites, seeding reinfection elsewhere.

In November 2025 an external audit of Karachi and the linked city of Hyderabad was commissioned to explain the divergence. It combined a full quantitative review of campaign data with field validation in eight districts across the pre-campaign, intra-campaign and post-campaign phases, tally sheet analysis, visits to 105 union councils and interviews with stakeholders.

Its findings were unambiguous. The data available to managers did not give a sufficiently accurate picture of campaign quality to identify problems or guide decisions. More children were being missed than the data indicated. Preparation for campaign rounds was inadequate and too little time was allocated to it, and the basic elements of a quality campaign were compromised in consequence. Social and behavioural change time was disproportionately spent converting individual refusals rather than building engagement before a round began.

Also, the management framework rewarded a narrow set of indicators in a punitive way, which is a reliable method of degrading the honesty of the numbers it rewards. A post-campaign cluster survey found that fewer than half of union councils surveyed, 48 per cent, achieved 95 per cent finger-marked coverage, with 30 union councils in the Karachi bloc below 90 per cent.

The importance of the audit does not lie in any individual finding. It lies in the demonstration that a programme can appear adequate to itself. Every one of these weaknesses was invisible in the reporting that management was receiving, and several were being actively concealed by it.

Karachi is therefore the clearest example in this cycle of a programme finding something out about itself and acting on it. The audit's recommendations became the Karachi Action Plan, and the plan has been implemented rather than filed.

Alongside this sits social profiling of children recorded as not available, refusal conversion committees and mayoral and ministerial engagement in the worst performing union councils, a team-building module across seven districts, joint operations and communications training within frontline worker training, follow-up of zero-

dose children through routine immunisation, and a further field-based external audit commissioned before the next national round.

The May 2026 campaign shows what the changed approach can do. A combined fractional inactivated, and bivalent oral, polio vaccine round across the city's highest-risk union councils reached an expanded age range. It was presented to communities as a booster dose rather than a repeat of something they had already refused.

The campaign administered fractional inactivated polio vaccine to 2,580,847 children and oral vaccine to around 2.7 million. The original registered target for the fractional dose had been 1.8 million, but almost a third of the children reached were found in schools, outside registered households or visiting from other areas. The reported 96.8 per cent coverage figure relates to fractional inactivated polio vaccine and rests on an expanded operational denominator. These figures demonstrate the inadequacy

of the original register as much as the reach of the campaign, and future reporting should identify the denominator attached to each coverage measure.

The epidemiological results are visible. Karachi has reported no case in 2026, and environmental positivity has fallen from every site sampled to a single detection in June 2026. One positive was found from 11 samples in the city and it was the only positive among 29 tested across Sindh that month.



The IMB draws two conclusions.

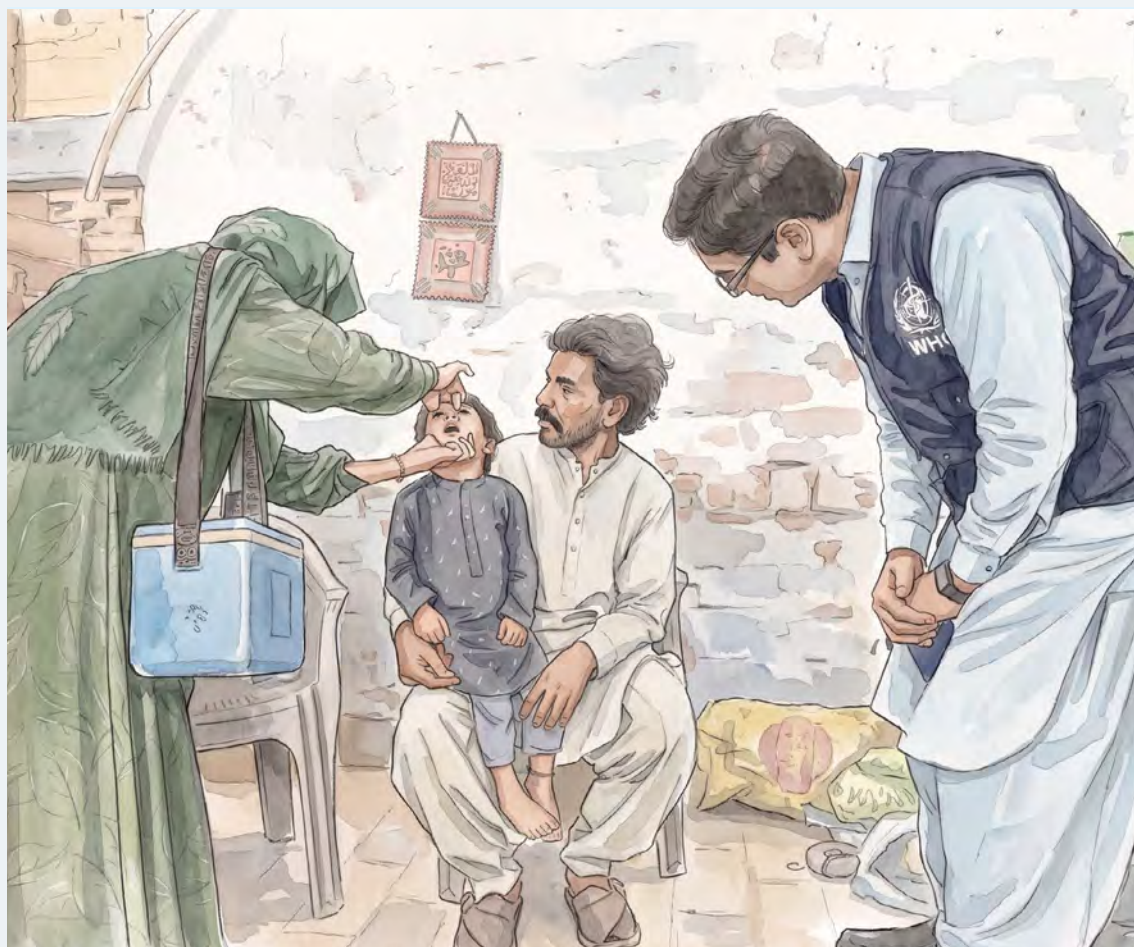
The first is that the audit model works and should be applied elsewhere without waiting for a plateau to force it. The programme is already repeating the exercise in Peshawar, which is the right instinct.

The second is that Karachi's improvement is thinner than the headline suggests. In the April 2026 round, 80 union councils reported more than five per cent of children still

missed, and 58 union councils have been persistently above that level across three rounds. In Karachi, routine-immunisation follow-up of children identified as zero-dose reached 67 per cent overall, but only 31 per cent in Karachi East and 48 per cent in Kemari, compared with 88 to 91 per cent in Karachi West and Central. Coverage of mobile and migrant populations was 91 per cent, with nine union councils persistently below 90 per cent.

A city of more than 20 million people with internal variation of that magnitude has not yet removed the conditions that allowed it to seed national outbreaks in the past. Persistent missed-child, zero-dose and mobile-population gaps mean that the conditions for renewed transmission remain.

Karachi is a reservoir in remission, not a reservoir cured.



CONCERNS IN THE REST OF THE COUNTRY

Three linked matters concern the IMB in the rest of Pakistan.

The first is what the genetic data are saying about detection. Roughly 30 per cent of environmental samples from Afghanistan are genetically linked to Baluchistan, principally the Quetta Bloc, and around 60 per cent of those are either orphan viruses without an identified source or members of long, previously undetected chains.

In a system with Pakistan's surveillance sensitivity, that combination points to transmission occurring in populations the system is not sampling. The analysis of these detections does not yet seem to be consolidated in one place, at a point when it should be one of the two or three questions the programme keeps permanently open.

A second concern is the persistence and re-establishment of transmission in parts of Central Pakistan beyond the principal reservoirs. The Technical Advisory Group identifies prolonged circulation in Larkana and Qambar, sustained transmission in Kashmore, and re-established transmission in Dera Bugti; it also flags persistent chains in Mirpurkhas and Badin.

The programme's own current-risk analysis adds Usta Muhammad, Dera Ghazi Khan and Rahim Yar Khan.

Baluchistan's own account of Dera Bugti is candid: attention had been directed elsewhere across a province of 347,000 square kilometres, and the reassurance offered is that the affected area is small and that tribal fragmentation limits movement between districts. The IMB notes that the same reasoning has been used about small, isolated pockets before, and that the signal has persisted for a year.

These two things are connected to a third by geography. The community network at union council level has been reduced to zero in central Pakistan and northern Sindh, and to zero across the rest of the country outside priority areas, with provincial-level positions cut from 98 to 22. Southern Khyber Pakhtunkhwa has been fully protected. The protection was the right choice. However, the map of where the network was withdrawn and the map of where new transmission signals and surveillance blind spots are now appearing are substantially the same map.

Set against this, the Quetta Bloc shows what targeted work can do: union councils with more than three per cent of children missed fell from 86 in April 2026 to seven in

May 2026; joint operations and communications work has identified around 20,000 previously unrecorded children, some two per cent of the bloc's target population; and a door-to-door sweep in Quetta and Killa Abdullah found 313 unvaccinated children. That last figure is the one to hold on to. It is small, and it was found only because someone went looking in a way the routine system does not.

AFGHANISTAN

Afghanistan's Minister of Public Health and the Director of the National Emergency Operations Centre were expected to attend the IMB's 25th meeting in person. Travel approval was withheld at the last moment. The IMB instead spoke separately by video link with the Emergency Operations Centre Director and the Minister. Country representatives of the partner agencies were in attendance in Geneva. Consecutive translation inevitably reduced nuance, but the main positions were clear and consistent with those presented last year.

The case Afghanistan put

Afghanistan's account of polio eradication progress rests on five propositions.

The first is that political commitment is not the constraint: from the Prime Minister through the

ministry to provincial and district governors, the Programme is described as supported at every level.

The second is that site-to-site delivery is now close enough to house-to-house to be equivalent: sites separated by no more than two or three houses, teams remaining 15 to 20 minutes at each. The country points to measurable improvement in campaign indicators: around 80% of lot quality assurance sampling passing nationally, post-campaign coverage above 90%, and a rise in

south region pass rates from near zero to around 50%.

The third is that what remains is refusal and awareness rather than modality. Decades of conflict have left communities with almost no health services and very little information; vaccine acceptance is filtered through religious judgement; and the visible concentration of international investment in polio while other needs go unmet has itself become a reason for community suspicion. The Afghanistan administration's proposed remedy is religious: a national

Islamic advisory group expanded from about 10 members to 40 or 50, and a proposal for a gathering of 400 to 500 scholars drawn from Saudi Arabia, Indonesia, India and elsewhere to settle questions in the light of Islam.

The fourth is that frontline workers are underpaid for what is asked of them. The country asks that incentive rates and transport costs be reviewed, with an assurance that this would deliver more than the modality debate does.





The fifth, put by the minister, concerns the cases themselves. He recounted visiting a district in Badghis where a child recorded as a polio case was found on inspection to be walking and running with no paralysis. He said there were other such instances, and asked that genuine and false cases be distinguished. This seems to be a misunderstanding of the nature of an acute flaccid paralysis case. A child who is walking when visited some months after onset may have recovered function; polio paralysis is not always permanent and complete, and only a proportion produces paralysis at all. So, the case count has never been a count of infections. Understanding this is the foundation of every

polio eradication programme that has succeeded.

What the epidemiology means

As summarised in an earlier section of this report, the balance of wild poliovirus transmission within the Afghanistan–Pakistan epidemiological bloc has reversed. At the time of the IMB meeting in July 2026, Afghanistan had reported five times as many paralytic cases as Pakistan. Two years earlier, it had carried about one quarter of the bloc's burden. The reversal does not mean that Pakistan is safe or that all Afghanistan's transmission is newly generated. It means that the bloc's principal source of detected disease

has moved decisively into Afghanistan while cross-border movement continues to connect the two countries.

The epidemiology continued to develop after the meeting. By the WHO bulletin of 25 August 2026, Afghanistan had reported 19 cases during 2026, close to the 21 recorded during the whole of 2025. In the same reporting week, 18 wild-poliovirus-positive environmental samples were added from specimens collected in July in Helmand, Kandahar, Herat, Kabul, Laghman and Nangarhar. Some of those infections and samples pre-dated the IMB meeting and were confirmed later. They do not reopen the country's evidence to the

THE ENDEMIC CASELOAD HAS SHIFTED FROM PAKISTAN TO AFGHANISTAN

Type 1 wild poliovirus cases notified to WHO, 1 January to 21 July



Paralytic polio cases notified by 21 July of each year.
Source: GPEI Polio Information System (POLIS), 2026.

IMB, but they reinforce the conclusion that the apparent quiet around the meeting was not a change in transmission.

The geography is best understood as one persistent source, two vulnerable receiving regions and several warning detections elsewhere. The South Region – principally Kandahar and Helmand, with Zabul, Uruzgan and Nimroz – remains Afghanistan’s endemic

reservoir and the main source of spread inside the country and across the border. Nine lineages had been active there during the previous six months, environmental positivity remained high and campaign quality remained furthest below the level required for eradication.

Kandahar City and Lashkargah are not isolated problem points; they sit inside

a connected southern transmission system.

The Southeast Region is vulnerable in a different way. Barmal district in Paktika reported eight cases between September and November 2025. By May 2026 there had been no further detected case for several months, but the campaign evidence remained poor across parts of Paktika and Ghazni. Ten of the 31

districts classified nationally as most critical were in those two provinces. Quiet in such a setting should be read as an interval of risk, not proof of durable interruption. A new introduction can move rapidly through cohorts accumulated during repeated low-quality campaigns.

The east region had shown real progress. Indigenous transmission had not been detected after mid-2025, campaign quality was stronger and women participated in delivery. It was nevertheless exposed to importation from the South, and an environmental detection in early 2026 was genetically linked to southern transmission. The later cases and environmental positives in Nangarhar, Kunar and Laghman show that improvement was not the same as insulation. The east can clear transmission when programme quality is high; it cannot protect itself indefinitely from a reservoir that remains active elsewhere in the same country.

Detections in Kabul and Herat matter for the same reason. A polio case or poliovirus-positive sewage sample outside the core reservoir may represent importation rather than a new enduring chain. That distinction can be made only retrospectively, through sequencing and sensitive follow-up. In a year of extensive population

movement, such detections should be treated as evidence of the reservoir's reach and of the receiving area's susceptibility, not dismissed at the outset as sporadic.

Cases and environmental samples answer different questions. A positive sewage sample demonstrates that infected people are shedding virus in the catchment. A paralytic case requires transmission, a susceptible child and the uncommon outcome of paralysis. Fewer cases than positive sewage samples do not therefore show that a campaign modality is working. Nor does a case in one region and only sewage detection in another establish that the first performed worse. The programme must interpret both through virus genetics, population immunity and the quality and reach of surveillance.

What the performance measures show

Afghanistan has made measurable national progress in campaign execution. An external assessment examined all 400 districts across 15 supplementary immunisation activities between January 2025 and May 2026.

It combined three independent sources rather than relying on reported administrative coverage. Lot quality assurance sampling classifies a defined

area as accepted or rejected against a coverage standard. Out-of-house surveys check finger marks among children encountered in places such as markets and transport points. Post-campaign assessment visits households and checks the finger marks of children found there. Each sees a different part of performance; none is a complete census of eligible children.

Across the country, the proportion of assessed lots failing the quality standard fell from 68.2 per cent in January 2025 to 19.6 per cent in May 2026. The proportion of districts failing the out-of-house measure fell from 55.2 to 13.5 per cent, and those failing post-campaign household assessment from 51.2 to 4.6 per cent. A total of 162 districts did not fail any of the three measures during the assessment period. These are substantial improvements.

The national averages also conceal the exact geography that determines eradication. The assessment classified 31 districts as Tier 1 critical and 34 as Tier 2 high risk. These 65 districts represent about one sixth of the country but accounted for 38 of the 50 wild poliovirus cases included in a three-year analysis. All 16 assessed districts in Kandahar fell into the two highest-risk tiers. The equivalent proportions were 92 per cent in Helmand and 82 per cent

in Zabul. Critical districts also clustered in Paktika and Ghazni. The programme has improved most where the poliovirus is not entrenched and remains weakest where transmission has to be stopped.

That is the simple meaning of the tier analysis. Three quarters of recent cases arose in the districts that repeatedly failed the independent campaign measures. Transmission is not persisting mysteriously despite uniformly good campaigns. It is concentrated in a relatively small group of districts where the programme repeatedly fails to achieve or demonstrate eradication-level

reach. Cases also occurred in some districts classified as performing, reminding the programme that a tier constructed from campaign indicators is a guide to risk, not a guarantee that no susceptible subpopulation remains.

The south region illustrates the difference between improvement and adequacy. Its Lot Quality Assurance Sampling pass rate rose from almost zero in parts of 2025 to approximately half of lots in April 2026. Moving from near-total failure to one lot in two passing is progress but it is not close to eradication performance. Averages from

post-campaign assessment above 90 per cent cannot cancel the Lot Quality Assurance Sampling result, particularly when the post-campaign measure checks only children present in households that monitors can identify and visit. The correct conclusion is that performance has improved while remaining insufficient and uncertain in the reservoir.

The programme should also resist using the most favourable measure as the headline. A district can appear strong in post-campaign household checks and weak in Lot Quality Assurance Sampling or out-of-house



surveys because each method samples different children and places. Disagreement is not a nuisance to be averaged away. It is information about who the programme may be missing. Where the three measures diverge, the district should be investigated at cluster level and the microplan corrected before the next round.

Orphan and long-chain polioviruses in the south show that some transmission has continued without being sampled. Nomadic populations present a particular blind spot: their non-polio acute flaccid paralysis rate is low even though their movement follows the same corridors used by the poliovirus. High national sensitivity cannot compensate for weak detection in the mobile population most capable of carrying infection between reservoirs and receiving areas.

The central limitation of site-to-site vaccination

Afghanistan's case is that the site-to-site modality has been heavily optimised. Sites are placed close together, teams remain at them for longer, local leaders mobilise families and national campaign indicators have improved. These activities have consumed substantial resources. The question is not whether site-to-site can be improved. It is whether the modality can establish that virtually every eligible

child in the reservoir was identified and vaccinated. The evidence says that it cannot.

A site-to-site campaign counts children who are brought to a vaccination point. It does not naturally generate a list of children who never arrive. Teams may have workload estimates, previous-round records and locally revised targets, but these are not an independently validated denominator. The external campaign assessment found that microplanning was used primarily to allocate people and supplies, with no common minimum standard or systematic validation capable of telling a monitor whether every settlement, household and child had been included. A campaign cannot demonstrate eradication-level reach if it cannot state credibly how many eligible children existed and which ones it failed to see.

There is also an unresolved inconsistency in verification. Post-campaign assessment is permitted to visit homes and inspect children's finger marks after a round, while vaccination teams are not permitted to use the same household access to administer vaccine. Whatever the rationale for restricting delivery, the programme should use the permitted household monitoring to produce named, geolocated missed-child lists and rapid revisits through an acceptable mechanism. Monitoring that proves a child was missed but cannot trigger vaccination of that child has limited operational value.

The immunity gap is older than the current round

Almost one third of recent cases were in children aged five years or older. These children were infants during the periods from 2019 to



“Monitoring that proves a child was missed but cannot trigger vaccination of that child has limited operational value.”

2022 when access and campaign quality were at their worst and the reported number of missed children rose towards 1.8 million. An older paralysed child is therefore not necessarily evidence that recent rounds failed or that the vaccine did not work. The child may be expressing an immunity deficit acquired several years earlier. Persistent transmission allows yesterday's missed infants to appear as today's older cases.

Routine immunisation is the deeper and more widespread immunity weakness. Among 9,099 non-polio acute flaccid paralysis cases investigated between 2024 and 2026, 14.3 per cent had received no routine dose, compared with 1.1 per cent with no supplementary dose alone; a further 1.4 per cent had received neither. These proportions should not be presented as national coverage but their relative pattern is nonetheless clear: absence of routine vaccination is much more common than complete absence from campaigns, and the children missed by both systems are concentrated in the south.

This matters for the proposed use of fractional inactivated polio vaccine and expanded age groups. Inactivated polio vaccine protects individual children against paralysis but does not generally provide the intestinal immunity needed to



stop transmission as effectively as oral vaccine. The Technical Advisory Group therefore advised that the south should first deliver at least two highest-quality oral vaccine campaigns before adding a targeted fractional inactivated polio vaccine campaign.

Vaccinating older children can reduce the legacy burden of susceptibility, but it cannot compensate for continuing failure to find infants and

toddlers. The programme should not add age groups to a weak delivery platform and mistake a larger target for a stronger response.

The need to urgently align with the global operating standard for eradication

The absence of women from programme delivery in the south is a fundamental operating weakness. More than 20,000 frontline workers

may be deployed there during a campaign without a single woman among them. In the east, female workers help to list children, speak directly with mothers, enter households where appropriate and identify newborns and toddlers. In the south and parts of the southeast, the same functions are restricted. The close overlap between male-only delivery and the districts of chronic campaign failure is not coincidental. A male-only site-to-site system is least able to discover the children who are not brought forward.

The programme should distinguish cultural acceptability from the exclusion of capability. If women cannot work as vaccinators in particular locations, the operating model still needs an acceptable way for women to contribute to enumeration, communication with caregivers, newborn tracking and independent monitoring. These are not representational objectives. They are functions without which the programme cannot know who is inside the household or why a child was not presented.

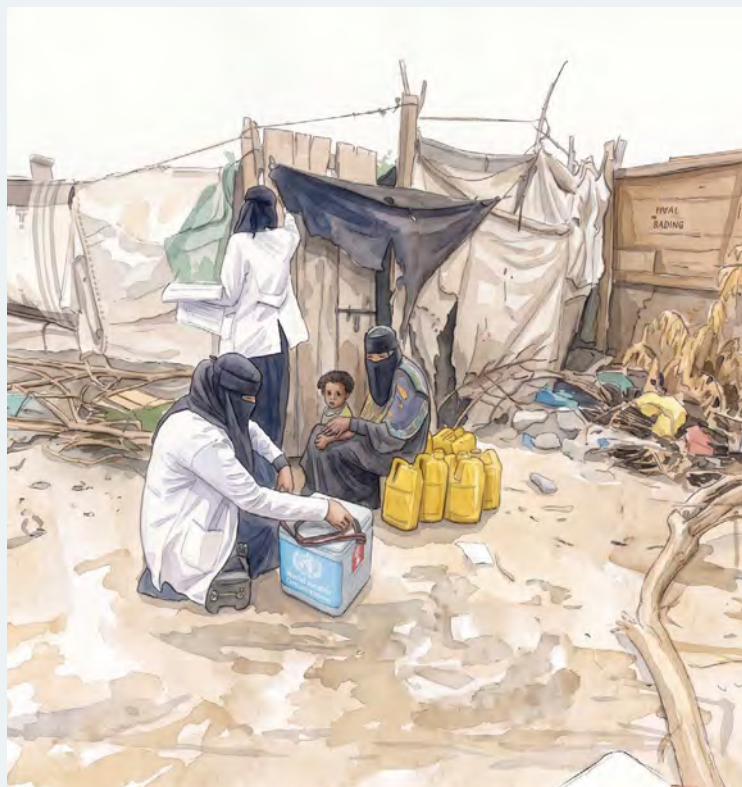
Afghanistan's programme has knowledge, experienced staff and evidence of improvement across much of the country. Its strongest analysis – the nationwide tiering of campaign performance – also shows why it remains off the eradication trajectory.

The principal reservoir and most of the critical districts occupy the same geography. The present modality has improved but cannot produce a complete denominator or eradication-level assurance there. Routine immunity is weakest, women's operational contribution is most restricted, and accumulated susceptibility extends into older children.

House-to-house vaccination with women able to perform the functions needed to reach households would remove the largest structural barrier. It would not by itself repair weak microplans, low routine coverage, unreliable dose

histories, poorly measured community interventions or mobile-population surveillance. All of those require action too, but without a delivery model that identifies and vaccinates children at their homes – or can credibly demonstrate equivalent reach – the south region will continue to sustain transmission and export it to the rest of Afghanistan and Pakistan.

The immediate test is not whether Afghanistan can report another improvement in a national percentage. It is whether the programme can move the same 65 districts out of chronic failure, show



that the southern lineages are contracting, and demonstrate that every newborn, mobile child and repeatedly missed household is visible across successive rounds. Until those measures change together, progress elsewhere will remain vulnerable to the reservoir that the programme has not yet been able to close.

Afghanistan's government claims that it wants to eradicate polio. Its health ministry and its programme leadership understand what eradication requires and have said so; its partners have optimised a deeply flawed modality about as far as it can be optimised.

The country will not eradicate polio, and neither will the world, until children are once again vaccinated in their homes by teams that include women.

Everything else in this section is preparation for the day that becomes possible, and worth doing on that basis.

The decision does not belong to any of the very committed people that the IMB spoke to, and has heard of in the country.

The international community has not yet found a way to reach the people to whom this decision does belong. Finding that way is now the central task of polio eradication, and it is not a technical issue.

Meantime, Afghanistan is denying itself the praise and credit that would come from it cutting through the present impasse to become a success story for global health and for its children – the future of its country.

THE BORDER AND THE VITAL PART IT PLAYS IN POLIO'S PERSISTENCE

Four principal crossing areas identified by the Afghanistan programme – Torkham, Ghulam Khan, Angor Ada and Spin Boldak – are not simply vaccination posts. They are pressure points at which population movement, political tension, insecurity, misinformation, gender restrictions and weak programme coordination converge.

The endemic bloc polio programmes are working together about as well as they can when the governments above them are not. Bilateral relations are effectively suspended: there are no negotiations and no talks.



“The country will not eradicate polio, and neither will the world, until children are once again vaccinated in their homes by teams that include women.”



Beneath that, the national coordinators are in direct and frequent contact, a face-to-face joint programme review was held in Istanbul, and two national immunisation days this year were synchronised. Joint improvement planning has reduced low-performing union councils in border districts by around a third, and Pakistan attended Afghanistan's Technical Advisory Group meeting in Kabul. This is a considerable achievement given the wider geopolitics.

It is also, in the IMB's view, close to the ceiling of what technical goodwill can deliver without a political floor beneath it.

Three limits are already visible.

The first is that formal borders have been closed and movement has not stopped. The continuing mass repatriation of Afghans from Pakistan and Iran, an estimated six million since 2023, adds a big additional layer of complexity to polio eradication.

Recent monthly data show sharp surges rather than a predictable flow. This is not a marginal mobile population but a major demographic event unfolding across precisely the areas where population immunity is most consequential to global eradication. Repatriation continues through the official crossings along routes that reflect four centuries of economic integration. Pakistan's remapping exercise added some two million

mobile and migrant people to microplans and its returnee strategy has reached 116,000 individuals since April 2026.

The origin data show substantial flows from Kabul, Nangarhar, Kandahar, Kunduz and Kunar into precisely the districts that carry Pakistan's remaining transmission. Sealing is not a strategy that is available. Nor can the border response operate continuously while political and military tensions repeatedly close or restrict the formal crossings.

The second limit is that information does not cross the border even where people do. That kind of information sharing belongs to an advanced stage of bilateral relations that does not currently exist.

Southern Afghanistan's failure to conduct house-to-house campaigns means that Pakistan's own programme may interrupt indigenous transmission, but remain exposed to repeated importation from a reservoir using a modality that has not stopped circulation.

What follows from this is that the border must be managed as a continuous epidemiological and social system rather than as a series of transactions at crossing points. Vaccination at recognised crossing points is necessary, but it cannot compensate for children passing through informal routes, for weak follow-up after arrival, for missing counterparts on the other side, or for communities in border clusters that remain repeatedly underserved.

THE VACCINE-DERIVED POLIOVIRUS COUNTRIES

NIGERIA

Nigeria is not simply one outbreak country among many.

It is the principal remaining engine of circulating type 2 vaccine-derived poliovirus in the Africa Region and the largest test of whether the polio eradication partnership can convert money,



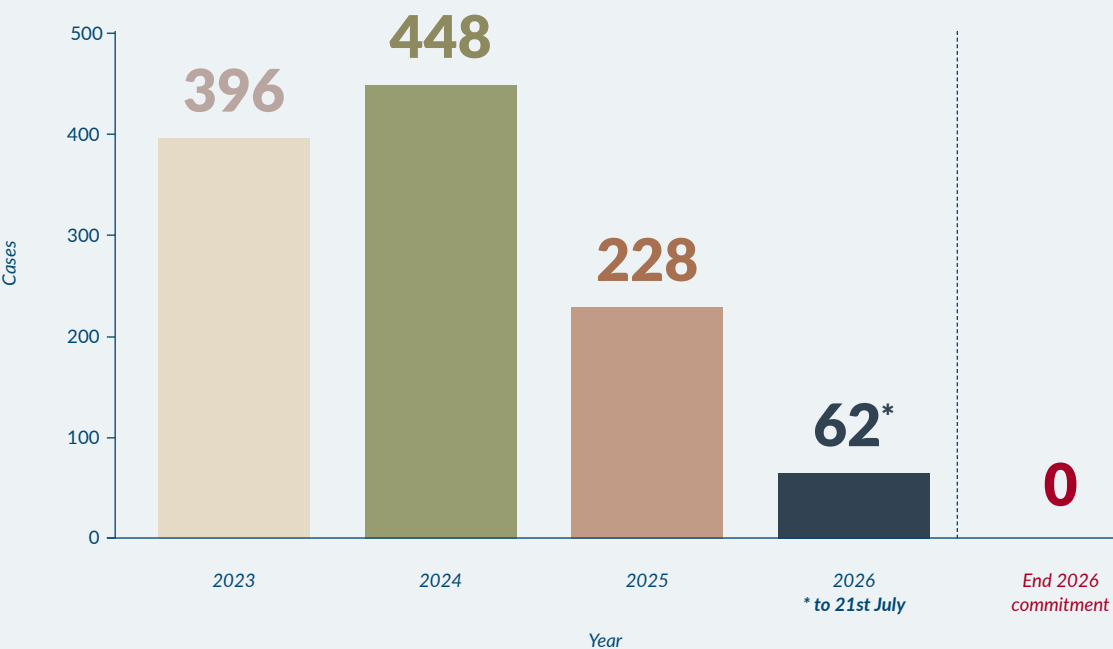
technical sophistication and institutional memory into vaccination in the household.

By mid-July 2026, Nigeria accounted for around two-fifths of the Region's poliovirus detections. Fourteen northern states were infected, essentially the same geography as in previous years. Around 70 per cent of detections were concentrated in Zamfara, Sokoto and Kebbi.

The dominant Zamfara emergence has persisted for approximately eight years and through more than 40 campaigns. Of the 1,032 children reported to have been paralysed by circulating type 2 vaccine-derived poliovirus in the Region since 2023, around four-fifths were linked to this single emergence.

cVDPV2 IS DECLINING, BUT IT HAS NOT REACHED ZERO

Type 2 circulating vaccine-derived poliovirus paralytic cases reported



Source: WHO Polio Weekly Global Updates; July 2026. GPEI 2026 Action Plan (operational).

Global progress against the type 2 poliovirus now depends substantially on whether northern Nigeria stops transmitting it. The comparison with Nigeria’s achievement against wild poliovirus is unavoidable. The country stopped wild poliovirus in an operating environment that was, in several respects, more insecure and less well-resourced than it is today. Many of the people who led that earlier programme remain available,

the technical tools are better, and northern Nigeria has received exceptional financial, political and partner attention over many years.

Nigeria’s continued position as an epicentre therefore cannot be explained by lack of knowledge, vaccine or external investment.

The programme is caught in a damaging cycle. Poor execution reduces donor and partner confidence.

Reduced confidence constrains investment and campaign frequency. Lower resources weaken supervision, readiness, surveillance and response speed, which further damages quality. Nigeria is attempting to break this cycle through better measurement and accountability.

The Nigeria government representatives met with the IMB on 20 July 2026. The delegation was led by the Executive Director of

the National Primary Health Care Development Agency, supported by a senior member of his staff. The principal international partners working at country and regional level were in attendance.

The Nigeria government team's central case was that reforms introduced during 2026 have changed what the programme can see, who can be held responsible and how missed children can be identified. They hold the view that epidemiological improvement will follow after a lag and that transmission can be interrupted during 2027.

They openly acknowledge low household reach, rising orphan-poliovirus detection, poor coverage for routine immunisation, extensive data-quality problems and continuing execution failure. This candour is important. For several years, the programme defended aggregate indicators that were inconsistent with continuing transmission. It has now begun to expose the weaknesses concealed by those indicators.

The headline epidemiology does not yet show a turning point. Nigeria had recorded 36 paralytic poliovirus detections at mid-July 2025. That figure when the IMB met at the same time in 2026 was also 36. The composition shifted: type 2 vaccine-derived poliovirus detections fell from 35 to

30, while circulating type 3 vaccine-derived poliovirus (cVDPV3) detections rose from one to six.

The year-to-date movement from 35 circulating type 2 vaccine-derived poliovirus detections to 30 is too small to distinguish epidemiological improvement from variation in detection.

The Nigeria polio programme knows the three states, the local government areas, the settlement types and the dominant genetic chain. Yet, the same reservoir continues to seed infection. The appearance of type 3 vaccine-derived poliovirus in overlapping geographies is not a secondary complication. It is evidence of a broader failure of intestinal immunity and requires a second vaccine strategy, additional antigens and further operational attention. It should also be seen as a warning of what could happen if type 1 wild poliovirus were imported into the same immunity landscape. Nigeria has remained free of wild poliovirus since certification; the conditions for sustaining that achievement are nevertheless being allowed to erode.

The outbreak must also be understood as a Lake Chad basin problem rather than a line drawn around Nigeria. Orphan viruses are repeatedly detected across bordering

areas of Nigeria, Niger, Chad and Cameroon. The great majority of the Region's orphan detections now arise in the Lake Chad epidemiological bloc. Nigeria's scale makes it the dominant source of risk, but a Nigerian response disconnected from Chad and the wider basin will repeatedly leave routes for reintroduction and undetected circulation.

A programme that has begun to see the missed child

The strongest part of Nigeria's self-assessment is the set of reforms intended to replace aggregate claims of coverage with evidence about actual households and named children.

An important governance reform has been made that addresses IMB concerns about dysfunctional arrangements in the National Emergency Operations Centre. Its staffing has been reduced from more than 80 members representing 17 institutions to 37 core members. One lead implementing partner now has responsibility for each local government area; this covers control over team selection and supervision. Performance will be judged against a small number of thresholds. Partners are required to revisit missed areas without additional payment. The intention of these changes is to replace fragmented responsibility with identifiable ownership.

More consequentially, Nigeria has digitally enumerated 24.9 million children under five years across 14 high-risk states. That total is around 20 per cent higher than some standard population estimates, while still being materially lower than figures previously used for vaccine forecasting. Nigeria has coupled that enumeration with geolocated household tracking and with daily analysis intended to direct supervision and mop-up while a campaign is still underway. The Nigeria polio programme is trying to demonstrate that better denominators will both improve reach and provide better value for money.

The country has used multiple data sources to classify local government areas by household entry and reported vaccination. This is instead of treating every low-performing area as having the same problem. These are technically sound changes, and they matter because they have made the programme look worse rather than better. A reform that reveals failure which the previous system concealed has immediate credibility.

What the new system revealed is stark. Across the November 2025 and March and April 2026 responses, reported settlement reach and vaccination coverage remained close to 90 per cent. However, when household entry was



measured, figures of only 30 to 50 per cent were achieved. In April 2026, the Nigeria Polio Programme child list indicated that approximately 79 per cent of enumerated children had been reached.

More than 20,000 settlements were missed or only partially reached across the March and April 2026 polio vaccination rounds. Household coverage in the three states carrying most transmission was reported

at 59 per cent in Kebbi, 58 per cent in Sokoto and 52 per cent in Zamfara. These are not marginal gaps at the edge of an otherwise effective response. They are failure at the centre of the outbreak.

Lot quality assurance sampling for the same period suggested that about 88 per cent of assessed local government areas passed at the 90 per cent threshold. That is irreconcilable with the household findings.

Nigeria's historical campaign series cannot therefore be used uncritically as a record of population immunity. The programme has repeatedly measured settlement presence, administrative output or a selected sample and called it coverage. Poliovirus supplied the external quality check and contradicted the programme's conclusion.

The Nigeria polio programme has conducted a "quadrant analysis" to make the problem more specific. Among 58 local government areas examined in the three highest-burden states, only nine combined high household reach with high reported vaccination. Twenty-six showed households being entered but too few children vaccinated, requiring work on absence, refusal, poor use of the child list or inadequate mop-up. Nine were low on both measures. Fourteen showed high reported vaccination despite low household entry.

The Nigeria team's own interpretation is that this last troubling group requires investigation. Causes are likely to include data falsification, street vaccination and security constraints.

This willingness to focus data into insights that challenge reported performance is welcome. It should have begun years ago.

Consequences have started to follow. Parts of payments have been withheld. The worst-performing teams have been replaced. Those that appointed weak teams have been sanctioned. Accountability becomes real only when poor performance changes who works, who is paid and who remains responsible.

There are, however, three important cautions.

First, the Nigeria polio programme's threshold of 70 per cent household coverage may be a useful initial accountability floor, but it is not an epidemiological standard for interruption.

Second, geolocation tracking and enumeration must not become another reporting layer placed on top of unchanged field practice. The value lies in teams returning to named missed children, not in producing a more sophisticated dashboard describing them.

Third, a measure that exposes politically inconvenient failure is vulnerable to dilution or quiet retirement. Household and child-level reporting should be made non-negotiable in campaign approval and partner contracts.

The new implementing-partner model also concentrates functions that should be separated. A lead partner may select teams, supervise them, manage performance and

report the result. It cannot also be allowed to judge whether it has succeeded. Given the volume of public and philanthropic money invested in Nigeria, independent verification cannot be optional.

The Nigeria polio programme reviewed children paralysed by type 2 vaccine-derived poliovirus over the preceding year. Ninety-three per cent of the total of 121 children were under five years of age. Eighty-three per cent had received no routine oral poliovirus vaccine. Eighty-eight per cent had not been given any inactivated polio vaccine through routine systems. Ninety-six per cent lived within five kilometres of a nomadic settlement, almost half were linked to insecure areas, and more than nine in ten had a recent connection to family movement, travel or visitors.

These findings strongly point to the need for concentrated work with nomadic and mobile populations.

The most disturbing finding of the review of the 121 childhood cases related to their campaign-dose histories. In 76 per cent of reviewed cases, caregivers reported more campaign doses than the number of campaign visits made to the settlement. Caregiver recall is imperfect, but an error of this scale cannot be treated as harmless noise. It means that recalled doses, finger marks and



reported vaccination histories cannot be accepted as proof of vaccine administration without corroboration.

Insecurity remains a major operational constraint. Nearly half of the reviewed 2026 cases were linked to insecure areas, and the geography of risk has become more diffuse than during the final wild poliovirus years. Some locations are under effective alternative authority and require military-supported access. Elsewhere, banditry and kidnapping create shifting windows in which an area may be reachable one day and closed the next. The military is overstretched and civil defence and police are increasingly

required. These are genuine constraints, and frontline workers should not be asked to take unacceptable risks.

However, security has become a blanket explanation larger than the evidence supports. More than half of reviewed cases were not classified as linked to insecure areas. Major execution failures are also being found in state capitals and other accessible urban settings. Where specimens can be transported, other government activities delivered and populations mobilised for political or commercial purposes, the programme is entitled to ask whether vaccination is impossible or simply not prioritised. Security

can explain why a named child was unreachable on a named day. It cannot explain false coverage, late planning, weak supervision or failure to revisit accessible missed settlements.

A surveillance system not doing its job

Nigeria's surveillance system presents the sharpest internal contradiction in the programme. Conventional indicators are reported as strong. The non-polio acute flaccid paralysis rate is high, stool adequacy is high and enterovirus isolation is good.

Laboratory speed has improved substantially, with 84 per cent of relevant samples reaching

a final sequencing result within the 35-day standard in 2026, compared with nine per cent in 2023. Nigeria is increasingly fast at processing what reaches its laboratories.

At the same time, 43 per cent of polioviruses detected in 2026 were genetic orphans. The proportion has risen almost linearly from negligible levels five years ago and is far above the Africa average.

About half of Africa's orphan viruses are being found in Nigeria. An orphan virus is evidence of a transmission history that surveillance did not observe. The obvious conclusion is that the programme does not know the scale or distribution of current transmission with sufficient confidence.

Surveillance may perform intensively in accessible facilities and communities while remaining weak in insecure, mobile, peripheral or administratively silent places. Aggregating those experiences produces a national rate that passes quality checks, while the poliovirus circulates beyond the system's field of view.

The three-month interruption to surveillance and specimen movement in Sokoto is especially serious. Sokoto is not a peripheral low-risk state; it is one of the three centres of transmission. An

epicentre cannot disappear from the surveillance system for a quarter of a year and then have a decline in detections presented without qualification.

An external surveillance review has been agreed. The IMB supports it, but the terms matter. It must be independent of the structures whose performance it examines.

It must investigate why standard indicators remained reassuring while genetic evidence deteriorated, rather than merely confirming that forms were completed and thresholds reported. It should assess geographic representativeness, community informant networks, specimen origin and verification, environmental surveillance, mobile and insecure populations, silent wards, supervisory incentives and the implications of integrating functions with the Nigeria Centre for Disease Control.

Questions raised by states about isolates should be answered transparently and scientifically, not allowed either to undermine confidence in laboratories or to suppress inconvenient results.

The surveillance review should also be the first part of a full outbreak response assessment, not a substitute for it. A broader review had been expected earlier in 2026 but

remained under discussion at the time of the IMB meeting.

Nigeria's outbreak response has continued since 2019 without interruption of circulation of the poliovirus.

The northern immunity vacuum

Routine immunisation in northern Nigeria is not simply weak. In the places carrying transmission, it is functionally absent for a large proportion of children.

Third-dose oral poliovirus vaccine coverage is below 50 per cent across most of the north, including approximately 16 per cent in Sokoto, 22 per cent in Kebbi and 38 per cent in Zamfara.

First-dose inactivated polio vaccine coverage was about 13 per cent in Kebbi and Sokoto and 19 per cent in Zamfara, compared with more than 80 per cent in parts of southern Nigeria.

Approximately 1.08 million zero-dose children were forecast in the north-west during 2026, and 591 of Nigeria's 774 local government areas were below the 80 per cent coverage target. A child under two years in the north-west is several times less likely to receive a routine dose than a child elsewhere in the country.

The gap cannot be explained only by poorer facilities or fewer health workers in the north. In parts of the south, the physical supply system is not much better, yet demand and utilisation are substantially higher.

Northern Nigeria has received large investments in immunisation infrastructure, outreach, social mobilisation and partner support without a commensurate rise in verified uptake.

Nigeria has made substantial efforts to integrate polio with services people value. Inactivated Polio Vaccine

delivered through the Big Catch-Up and optimised outreach found more than 770,000 children. Polio vaccine was incorporated into measles campaigns, including an October 2025 campaign reporting 102 million measles-rubella vaccinations alongside 32 million novel oral polio vaccine doses and 12 million bivalent oral polio vaccine doses across 21 states.

Integration, however, should be judged by whether it changes the identity of children reached, not by the total number of doses delivered during a very large campaign.

The federal-state axis

Nigeria is heavily criticised, with justification, for receiving a very large share of polio eradication resources while remaining an epicentre for paralytic disease transmission. The relevant question is not whether money has been spent. It plainly has. The question is what verified immunity the spending purchased.

Northern Nigeria has conducted repeated oral polio vaccine campaigns, been given extensive technical assistance, established large social-mobilisation networks,



introduced geospatial systems technology, created emergency structures and operated with a dense field of implementing organisations.

An over-elaboration of central controls and specifications seems to have disempowered the state-level leadership and mechanisms that operated so effectively during the wild poliovirus period.

Decision-making has become highly centralised, while state and local structures have often been expected to implement plans they did not meaningfully shape. Operational information, targets and resources have sometimes reached states too late for credible preparation.

Polio and routine immunisation are widely treated as federal and external partner responsibilities, while cholera, meningitis and other visible emergencies

play out more directly as state responsibilities.

The states must be given both authority and liability for performance.

Governors respond differently when they believe the political consequence belongs to them.

Moving forwards

Nigeria planned two further large-scale oral polio vaccination rounds for September and October 2026 across high-priority states targeting almost 30 million children, with fractional inactivated polio vaccine also being deployed.

These rounds must respond simultaneously to established type 2 vaccine-derived poliovirus transmission and the emerging type 3 threat, while in-between-round activity must target missed settlements and mobile populations.

Nigeria has taken consequential action over the past year. It has built a child register, introduced household-level evidence, acknowledged that reported coverage was misleading, begun to sanction poor performance, profiled the children being paralysed, recognised demand as a central constraint and accepted the need for external surveillance review. These are meaningful reforms and should be sustained and resourced. They are also a confession of how little the previous system knew about the children it claimed to have vaccinated.

The reforms that matter most were only one or two campaign cycles old at the time of the July 2026 IMB meeting.

Transmission remained geographically extensive, household reach remained close to half, nearly half of detected polioviruses had an unseen recent history,



“A reform that reveals failure which the previous system concealed has immediate credibility.”

routine immunity was profoundly low and a second serotype was expanding.

The country now occupies an uncomfortable position. It is finally measuring the right things while the financial and operational intensity of the global response is contracting. That does not erase responsibility for the years in which abundant attention produced insufficient results.

Nigeria will be judged on: whether named children in known transmission zones swallow vaccine; whether unseen transmission becomes visible; whether states and partners are held to independently verified outcomes; and whether the Zamfara emergence finally contracts genetically and geographically.

The country's government does not need another explanation of why it remains an epicentre. It needs to cease being one. Until the money, leadership and technical capacity concentrated on northern Nigeria produce that result, Nigeria will remain not only a national outbreak concern but one of the principal reasons global eradication remains unfinished.

Nigeria's target of interruption in 2027 is not supported by the evidence available to the IMB. It will become credible only when household

coverage in the transmission zones is independently verified as being high.

DEMOCRATIC REPUBLIC OF THE CONGO

The Democratic Republic of the Congo has achieved one of the largest recent reductions in vaccine-derived poliovirus transmission in the Africa Region.

The country reported 540 poliovirus detections in 2022, 285 in 2023, 29 in 2024, 18 in 2025 and 15 by mid-July 2026. Circulating type 1 vaccine-derived poliovirus (cVDPV1) has not been detected for more than 12 months. Genetic diversity has fallen from approximately 19 groups at the height of the outbreak to two active or newly emerging groups in 2026, while the number of detections has declined by about 98 per cent from the 2022 peak.

These are not figurative achievements. They are transmission chains that were closed and large numbers of children who were not paralysed.

The country has earned recognition for doing this in an operating environment of exceptional scale and complexity. Its 123 million people are distributed across 26 provinces and 519 health

zones. It covers roughly 2.345 million square kilometres, making it the second-largest country in Africa by area and comparable in size to much of Western Europe. It shares borders with nine countries (Angola, the Republic of the Congo, Central African Republic, South Sudan, Uganda, Rwanda, Burundi, Tanzania, and Zambia). Its total terrestrial border length exceeds 10,400 kilometres.

Only a small fraction of the road network is surfaced, and vaccine movement to much of the country depends on aircraft, boats, motorcycles and human carriage. The programme estimates that around 80 per cent of vaccine distribution requires air transport.

No serious assessment of the Democratic Republic of the Congo can treat logistics as background context.

The country government delegation that attended the July 2026 IMB meeting was represented by the director of the national immunisation programme. GPEI regional partners and country representatives were in attendance. The coordinator of the National Emergency Operations Centre was travelling and attempted to join remotely with limited success.

The delegation's self-assessment is that their polio

programme has moved from broad emergency campaigns towards faster and more selective outbreak control. They pointed to: the emphasis on round zero responses, direct detection in the national laboratory, better collaboration with the South African laboratory, vaccine pre-positioning for limited rapid responses, campaign integration, geospatial tracking, province-specific operational plans and deployment of senior staff to villages where performance is weak.

They also reported that environmental enterovirus isolation rose from seven per cent to more than 50 per cent and that health zones silent for acute flaccid paralysis fell from 121 to 31 between June 2025 and June 2026.

The Democratic Republic of the Congo polio programme has become faster, more technically capable and more geographically focused.

The delegation was also frank and direct about its own weaknesses.

Only four of 12 supplementary immunisation activities conducted since the start of 2025 were implemented on time. Frontline workers remain unpaid for past activities in several provinces. Fully vaccinated coverage was only 38 per cent in the 2023 survey, more than one million



children were zero-dose, and 42 per cent were under-immunised. Surveillance and vaccination remain weakest in the populations at greatest epidemiological risk.

The epidemiological improvement has narrowed the problem rather than completed the task. Type 2 vaccine-derived poliovirus detections increased across the most recent comparison windows.

Transmission is concentrated in Maniema, Haut-Lomami and neighbouring areas, with additional concern in Kasai Central and Haut-Katanga.

The widely held external perception that the outbreak is geographically contained to the east is too reassuring. The remaining affected areas extend into the south-eastern and central transmission corridor and include highly mobile populations moving between provinces.

Polioviruses are now located in precisely the communities and health zones that the system is least able to see and repeatedly reach. The Democratic Republic of the Congo has brought past outbreaks close to extinction and then discovered that



poliovirus had survived outside the visible programme. Its own presentation quoted a previous IMB report conclusion accurately: the country has eradicated polio many times, but has found it much harder to sustain nationwide quality. The present moment must be judged against that history.

Kinkondja and the surveillance ceiling

The findings in Kinkondja, Haut-Lomami, are a litmus test of the solidity of national progress.

Two children were infected by genetically independent type 2 vaccine-derived polioviruses. One isolate was eight nucleotide changes from the novel oral polio

vaccine's genetic profile and the other was 13 nucleotides distant, implying at least eight and 13 months of unseen circulation respectively. The more recently paralysed child carried the older virus. This is not one transmission chain detected late. It is evidence that more than one chain was moving through the same health zone without the surveillance system knowing.

Haut-Lomami has experienced repeated phases of type 2 vaccine-derived poliovirus circulation since 2017, with the first poliovirus in each phase already substantially diverged.

Kinkondja also recorded no non-polio enterovirus isolation. The programme therefore cannot treat the event as an

unforeseeable emergence in a previously low-risk locality.

The national laboratory may process specimens quickly, and aggregate acute flaccid paralysis indicators may exceed their thresholds, while local transmission remains invisible for a year. The system has become increasingly efficient after a specimen enters it. Its central weakness is ensuring that the right children, communities and locations generate specimens in the first place.

National surveillance figures are strong on their face. Direct detection and improved laboratory coordination reduced average sequencing time from about 50 days in 2023 to approximately 14 days

during 2026. Only three health zones were reported silent for a full 12 months, down from 12 a year earlier, all in conflict-affected provinces. These are important improvements and should be maintained but the aggregates conceal extreme local variation.

A planned external surveillance review was postponed. The IMB understands the operational reason but is concerned by the consequence. A review is most valuable when the system is under stress, because that is when its blind spots become visible.

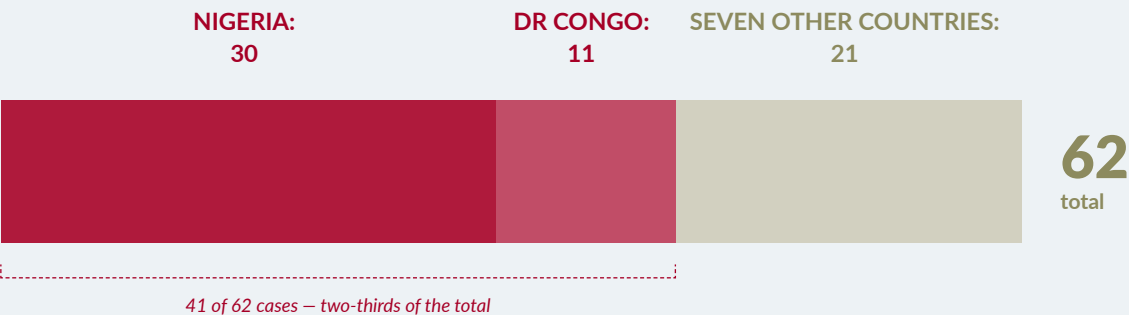
Immunisation activity and quality

The Democratic Republic of the Congo polio programme conducted eight campaigns during 2025 and four completed campaigns, with another under way, during the first half of 2026. National and subnational rounds were synchronised with Angola, and used different combinations of oral polio vaccines where indicated. Integration of inactivated polio vaccine and other routine antigens was built into campaign contacts.

Quality measures (LQAS) were strong but coverage figures cannot be accepted without qualification as one national campaign reported 111 per cent. This suggests inaccurate denominators and population movement; it cannot be interpreted straightforwardly as excellent reach. More importantly, in-process monitoring identified health areas with up to 41 per cent of children unvaccinated while quality indicators were satisfactory in the wider health zone. A sampling quality method that excludes the highest-risk populations can provide a technically correct answer to the wrong question.

NIGERIA AND DRC ACCOUNT FOR TWO-THIRDS OF 2026 cVDPV2 CASES

Type 2 circulating vaccine-derived poliovirus paralytic cases, 1 January to 21 July 2026



Source: WHO Polio Weekly Global Updates, July 2026.

Population reach logistics are very challenging. Examples include: fishing communities on Lakes Mweru and Tanganyika, itinerant mining camps, seasonal farming populations near borders, displaced and refugee communities in the east of the country, islands and settlements accessible only by boat, and health areas cut off during the rains. In particular, fishing and farming communities may be away for an entire campaign. These populations have little or no probability of selection in standard quality sampling frames. They are not simply missed by vaccination teams. Many are missing from the denominator and from the measurement system used to judge whether the campaign succeeded.

In addition, new mining camps appear and disappear before entering a microplan.

The polio programme reported vaccinating large numbers of children at special-population sites. Yet, only a very small proportion of children reached through these activities were zero-dose. That finding requires investigation. Either the special strategies are repeatedly reaching children already known to the programme, the recording of zero-dose status is weak, or the most excluded communities are still not being found.

A special-population strategy should be judged by the previously unreached children it converts into repeatedly vaccinated children, not by the number of contacts made at designated sites.

Geospatial Tracking Systems have improved the programme's ability to see team movement.

The country's 98 per cent reduction in detections has been achieved without the routine immunisation base required to sustain it. Coverage levels suggest that population immunity is weakening while the country attempts to close its final transmission chains.

A range of appropriate actions are ongoing but many remain episodic.

The separation of the routine immunisation and the polio structure, each created through a separate ministerial authority, remains a governance problem. However, integration is now an obligation rather than an option, and polio structures participate in weekly immunisation programme meetings. That is progress in practice without full institutional resolution. Integration cannot depend indefinitely on ad hoc collaboration between parallel structures. Accountability for planning, workforce, finance, surveillance and the immunity of a named health zone must be unambiguous.

Timeliness and financial flows

The Democratic Republic of the Congo polio programme has made response timeliness a central part of its reform. Risk analysis is updated quarterly, epidemiological information is reviewed weekly and vaccines are retained in-country for limited rapid responses. Direct detection enables investigation before final sequencing confirmation. The country's team reported four rapid responses initiated within 14 days of case confirmation. This is impressive in a country where physical distribution alone can take two weeks.

Other data are less reassuring. Only four of 12 supplementary activities conducted since January 2025 were on time. Shipping vaccine from GPEI approval to country arrival often takes 28 to 30 days. This makes the formal 14-day response standard impossible in some cases. The Polio Programme should not impose a timeliness standard whilst maintaining a supply process incapable of meeting it. The country cannot, though, blame all delay on global shipment. Approved funds have moved slowly to the provinces and health zones slowing down implementation.

Payment arrears have led to boycotts in some areas, damaging routine immunisation services and polio vaccination campaigns. About 42 per

cent of payments are now electronic but a full digital solution is unrealistic because of no network coverage and a significant proportion of health care workers who lack smartphones. Cash transport is insecure. Every worker should have a traceable entitlement, payment route, payment date and mechanism for rapid exception resolution. Solutions are being worked on.

The eastern emergency

Eastern Democratic Republic of the Congo is facing two emergencies superimposed on one another: a fragmented armed conflict that repeatedly displaces communities and weakens the reach of the state, and an Ebola epidemic that WHO has designated a Public Health Emergency of International Concern.

For the country's polio programme, this is not simply a more difficult access environment; it is a simultaneous assault on vaccination, disease surveillance, specimen transport, the health workforce and the community relationships on which each of them depends.

The Ebola outbreak was reported from Ituri during April 2026 and was confirmed in May 2026 as a disease caused by the Bundibugyo species of the virus.



By 12 August 2026, it had expanded into 54 health zones. WHO reported 4,665 confirmed cases and 2,184 deaths, making this the largest Ebola outbreak recorded in the country. The reported case fatality ratio approaches 47 per cent, and the continuing geographical expansion showed that the epidemic moved well beyond a localised event around its original mining and trading centre.

Ebola is spreading through many of the same conditions that make poliovirus difficult to find and stop: large-scale displacement, frequent

movement between provinces and across borders, disrupted health services and areas in which response teams cannot operate safely.

WHO recorded at least 12 attacks on health care facilities following the international emergency declaration. Such attacks restrict access, deter sick people from seeking treatment and interrupt surveillance and contact follow-up. They undermine the right of healthcare staff to a safe and secure workplace and also draw scarce health workers, vehicles, laboratories, protective equipment and

management attention away from vaccination and other essential services.

The consequence for polio is cumulative. Campaigns postponed because of Ebola leave susceptible children unvaccinated; interruptions to routine services enlarge the next zero-dose cohort; and surveillance loses sensitivity when its staff, transport and community informants are redirected to the more immediately lethal emergency.

The answer cannot be to suspend polio work until Ebola is controlled. Essential immunisation, acute flaccid paralysis surveillance and specimen movement must be deliberately protected inside the wider emergency response. Otherwise, this risks controlling one highly visible epidemic while allowing another virus to circulate quietly beyond the programme's field of vision.

The conflict in eastern Democratic Republic of the Congo is not a single rebellion with a clearly defined front line. It is a long-running contest over authority in which national forces, foreign-backed movements, community militias, transnational armed groups and local protection networks exercise overlapping control. The result is a complex humanitarian emergency, one of the most complex in today's world.

M23 is currently the most visible military actor, but it sits within a much wider armed landscape extending across North Kivu, South Kivu, Ituri and neighbouring provinces. Territory may change hands while roadblocks, informal taxation, local feuds and insecurity continue behind the apparent front. A political agreement with one movement can therefore reduce major fighting without restoring a functioning state or safe public services.

The conflict draws energy from several unresolved sources at once.

For communities, the result is not one episode of displacement followed by return. Families move repeatedly between villages, towns, informal camps, mining areas and neighbouring countries. Settlements can empty during fighting and

reappear elsewhere with different names and leadership. People may cross one border for treatment or vaccination and return through another route. Health workers are displaced alongside the population, facilities lose staff or equipment, and cold-chain and communication systems become unreliable. Even where a clinic remains open, the surrounding referral, supervision and supply network may have ceased to function.

This is especially damaging to polio eradication because the programme depends on continuity. A microplan may be obsolete before a campaign begins; a denominator may describe a population that has moved; an acute flaccid paralysis informant may no longer be present; and a specimen may have to pass through several areas controlled by different actors before reaching a laboratory.



“The east of DRC cannot wait for a comprehensive peace settlement before restoring immunity.”

Humanitarian organisations and locally accepted health structures can negotiate entry where government teams cannot. That access is indispensable, but it is not equivalent to a normal programme.

Some vaccination occurs in contested territory without being fully observable or verifiable. The absence of a detected poliovirus from such an area is weak reassurance when surveillance and campaign assurance are impaired by the same conditions.

The east of the country cannot wait for a comprehensive peace settlement before restoring immunity. The political and armed order may remain fragmented beyond the eradication timetable. What is required is a permanent emergency operating model that treats mobility, negotiated access and changing control as normal planning variables rather than exceptional disruptions. The programme must be capable of following children and specimens through shifting geography while preserving independent evidence of what was delivered. Otherwise, the east will continue to generate areas in which the programme cannot distinguish interruption of transmission from interruption of sight.

Moving forwards

The Democratic Republic of the Congo has made genuine and impressive progress. It has reduced detections, closed type 1 vaccine-derived poliovirus transmission, improved laboratory speed, expanded environmental surveillance, introduced geographic tools, integrated antigens and shown that it can coordinate activity across an immense country.

However, it has also again discovered old virus in a known high-risk province, while reporting campaign acceptance above 90 per cent and strong national surveillance indicators. Both accounts are true. The programme has become much better, but it is still not reliably reaching or observing its most consequential populations. The latter is its biggest challenge.

SOMALIA

Circulating type 2 vaccine-derived poliovirus has been transmitting continuously in Somalia since 2017. The principal emergence was already genetically orphaned when first identified, implying that it had circulated undetected before discovery. More than one emergence is now present, including newer transmission centred on Banadir.

The setting is exceptionally difficult. Authority is dispersed across a federal system, several million people are displaced, and there is extensive movement across the Horn of Africa and by sea to Yemen. Around 72 per cent of the population lives in areas the programme can access, eight per cent in restricted areas and 20 per cent in areas it cannot enter at all.

Approximately 477,000 children under five years in south-central Somalia remain beyond reach. Negotiations have produced localised openings, but progress has stalled and the negotiating structure is now being rebuilt. Somalia's wider humanitarian situation remains marked by conflict, climatic shocks, displacement, food insecurity and continuing disease outbreaks.

Access, however, is not an adequate explanation for nine years of continuing transmission. In a typical campaign only around half of assessed quality lots pass. Sixteen districts passed no lots during 2025 and seven conducted no assessments. Some fully accessible districts have not passed once in three years. Roughly 60 per cent of children recorded as missed were missed because a vaccination team never visited the household. Field verification found weak microplanning, limited

use or validation of data, inconsistent supervision and poor adherence to operating standards.

Routine immunisation is too thin to compensate. Nationally, only 45 per cent of children under five years live within five kilometres of a functioning immunisation site, with access ranging from 98 per cent in Banadir to none in Middle Juba. Around 234,000 children are zero-dose for inactivated poliovirus vaccine, while the wider backlog to be reached through integrated delivery is estimated at 800,000. These immunity gaps coexist with recurrent drought, flooding, malnutrition and measles and other outbreaks. All compete for depleted staff, transport and funding.

The response is therefore being rebuilt rather than simply intensified. District

personnel have been reset, state coordination cells strengthened and readiness thresholds introduced. Walk-through microplanning supported by geographic information systems has begun in Mogadishu and is intended for other urban centres.

This is strategically important. The major towns connect inaccessible communities to the rest of the country and function as amplifiers of transmission and potential points of exportation. Immunisation is also being combined with nutrition, measles response and primary health care so that scarce access achieves more than a single vaccination contact.

The Polio Programme intends to conduct no more than two large-scale campaigns before January 2027, and only after operational repair.

Somalia's outbreak cannot be treated as geographically contained. Current GPEI planning explicitly links Somalia, Yemen and the wider Horn of Africa because population movement and shared immunity gaps connect their outbreaks.

YEMEN

Circulating type 2 vaccine-derived poliovirus has become entrenched in Yemen. At least 452 children have been paralysed since the outbreak began in 2021, with most infections occurring in the northern governorates. The true burden is certainly greater. Transmission has been sustained by large immunity gaps, population movement and a health system fragmented by more than a decade of conflict.

Yemen cannot be treated as a geographically contained national outbreak. Its connections across the Red Sea and Gulf of Aden, and with the Horn of Africa, make continued northern transmission a threat to neighbouring countries that are themselves struggling with immunity gaps and population displacement.

The epidemiological picture is now dangerously incomplete. Acute flaccid paralysis samples from northern Yemen have not been shipped for laboratory testing since the end of March 2025. More than 400



specimens were reported to be awaiting shipment later that year. Environmental sampling has also been intermittent. The absence of newly confirmed cases therefore cannot be interpreted as an absence of transmission. The Polio Programme is attempting to manage one of the region's principal reservoirs of poliovirus without being able to see its current boundaries, intensity or direction of travel.

Yemen is effectively divided into two different outbreak responses. In the internationally recognised government areas in the south, two large vaccination rounds during July and September 2025 reached approximately 1.3 million children. WHO reports that these rounds interrupted detectable transmission in the south. In the much more heavily populated north, the de facto authorities have continued to withhold permission for mass polio vaccination.

Routine and integrated outreach has resumed to some extent, but it cannot reproduce the rapid, simultaneous population immunity required to stop an established outbreak.

This is not principally a shortage of technical knowledge. The vaccine, operational plans and international support exist. What is missing is a political

agreement that permits repeated high-coverage campaigns, independent monitoring, surveillance throughout the northern governorates and the uninterrupted movement of specimens to an accredited laboratory. Until those conditions are secured, northern Yemen remains an engine of transmission rather than simply another difficult outbreak setting.

The wider humanitarian environment compounds every operational weakness. WHO estimates that 23.1 million people require humanitarian assistance and that only around 60 per cent of health facilities are fully functional. Malnutrition, cholera, measles, dengue and other emergencies compete for depleted staff, transport and funding. Displacement and movement between governorates continually replenish susceptible populations and allow the poliovirus to escape areas in which vaccination has temporarily improved.

The operating space for international agencies has also contracted. Detention of United Nations personnel and restrictions on movement in areas controlled by the de facto authorities led to additional limitations on staff movement in January 2026.

Polio work cannot be insulated from this wider confrontation.

Negotiations over vaccination, surveillance and specimen shipment are taking place within a relationship characterised by insecurity, mistrust and coercion.

Further conflict in September 2026, in the context of developments in the wider Middle-East will impact further on the broader humanitarian situation. Particular added complexity for the polio programme will come from: accelerated internal displacement (intensified airstrikes displace thousands of families into informal settlements; these overcrowded camps lack basic water, sanitation, and hygiene (WASH) infrastructure, amplifying transmission pathways essential to enterovirus spread); critical supply chain and fuel bottlenecks; economic strain and compounding malnutrition; further shrinking of operational space for aid agencies.

POLIOVIRUS DETECTIONS IN HIGH-INCOME COUNTRIES

Poliovirus detections in high-income countries are becoming a recurrent feature of the eradication endgame, but they require careful interpretation. Since September 2024, circulating type 2 vaccine-derived poliovirus has been

identified through wastewater surveillance in Finland, Germany, Israel, Poland, Spain and the United Kingdom.

At the time of the July 2026 IMB meeting, the latest positive sample reported by WHO in this sequence was collected in Germany in September 2025. No associated paralytic cases or sustained community transmission were identified. Environmental circulation of a separate type 1 vaccine-derived virus in Israel, first detected in February 2025, was nevertheless classified as an outbreak.

A different warning followed in November 2025, when type 1 wild poliovirus was found in a wastewater sample from Hamburg. Its genome was closely related to poliovirus circulating in Afghanistan. The finding was unrelated to the type 2 vaccine-derived detections, and no human case was reported.

These events do not mean that endemic transmission has returned to high-income countries.

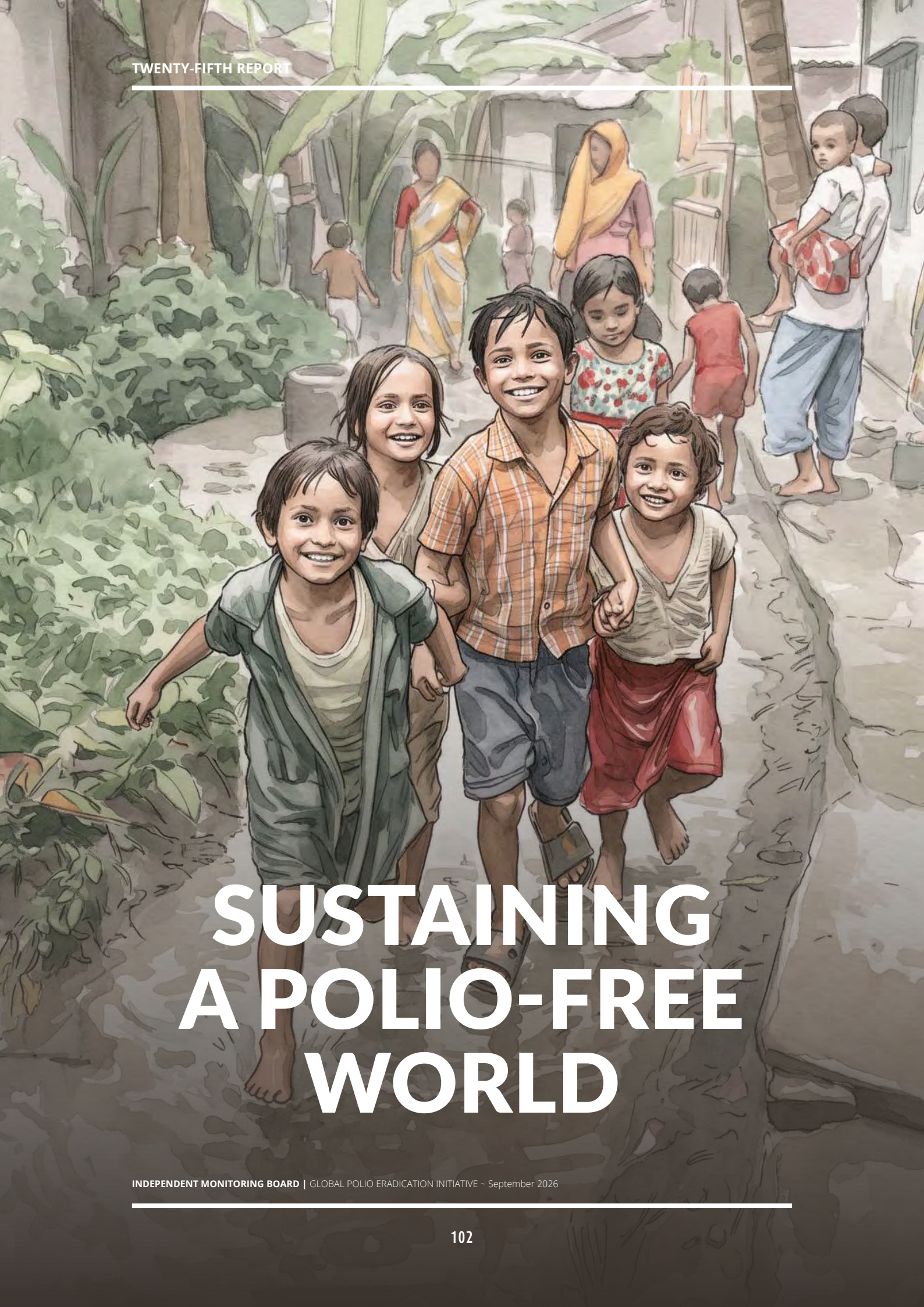
They demonstrate the sensitivity of environmental surveillance and the amount of poliovirus movement that can occur without recognised paralysis. Only a small proportion of infections cause paralytic disease, while high coverage with

inactivated poliovirus vaccine in such countries gives strong individual protection. A poliovirus may therefore be imported, replicated and excreted without producing a clinical case. Wastewater surveillance makes visible what would previously have passed unnoticed.

These detections should not, however, be dismissed as epidemiological curiosities.

European vaccination coverage fell during 2024, leaving more than 450,000 infants unprotected, and national averages conceal communities with substantially lower uptake. An imported poliovirus encountering one of these pockets can move from a surveillance event to an outbreak. The London and New York events of 2022 have already demonstrated that high national income and formal polio-free status do not remove this vulnerability.

The phenomenon therefore fits squarely within the present polio eradication story.



SUSTAINING A POLIO-FREE WORLD

SUSTAINING A POLIO-FREE WORLD

This is the first reporting cycle in which the IMB has held the polio transition brief alongside the polio eradication brief. The merger is not administrative tidying.

Eradication and transition are inseparable in practice: where an outbreak occurs, transition reverses; where routine immunisation cannot maintain immunity, there is nothing ready to transition; and where surveillance remains dependent on external staff and finance, the function is not yet nationally sustained. The three functions considered throughout this report – population protection, surveillance and outbreak response – are also the foundation of a polio-free world.

WHAT THE STRATEGY COMMITS THE WORLD TO

The technical strategy for sustaining a polio-free world is complete and has been presented to the World Health Assembly. It rests on three goals: to protect populations, by withdrawing bivalent oral polio vaccine and providing long-term access to polio vaccines through routine immunisation; to detect and respond, by maintaining sensitive surveillance and



rapid response to any poliovirus; and to contain polioviruses, by securing compliance across laboratories, manufacturers and other facilities holding materials that could reintroduce them.

It carries no dates, and the omission is deliberate. The strategy is triggered not by a calendar but by the completion of the two remaining eradication goals, and runs for 11 to 12 years thereafter. It is costed at roughly US\$ 7 billion to US\$ 9 billion.

Four planning phases are envisaged. The first, defining what functions must be sustained, is complete. The second, defining how they are to be transitioned, is underway. The third, identifying who will own and fund them,

and the fourth, sustaining performance thereafter, have not begun. Three of the four therefore remain ahead, and the second is the one on which the other two depend.

The strategy names its own enabling factors: country ownership, domestic financing, integration, and governance and accountability. Each of those is the subject of the assessment that follows in this section, and on each the current position is weak.

It also names its risks, among them wavering political and financial commitment, inconsistent application of global standards, insufficient supply of bivalent oral vaccine, and destabilising conditions including further reductions in development assistance.

On containment, the intended shift is from establishing systems and processes in individual facilities to a global risk-containment approach resting on oversight, standards and systems. That is the right direction and it is also, precisely, a global function without a country list, which bears on the question of scope considered below.

PLANNING DOCUMENTS ARE NOT THE MEASURE

The polio transition work has produced plans, and by that measure it is doing well. Seventeen of the 21 priority countries have a transition plan; in two of those, Yemen and Myanmar, the plan is

an internal country-office document that the government has not endorsed. Integration planning is the most advanced area of progress.

Against that, only one of the 21 is on track for both first-dose inactivated polio vaccine and third-dose diphtheria-tetanus-pertussis coverage, and that figure has not moved in two years. Many plans have not been formally updated since they were written. Five governments held a polio transition meeting in the past 12 months. Seven of the 21 have a dedicated budget line for surveillance. Across the African priority countries,

non-GPEI funding secured is generally low, and in most of them a quarter or more of the WHO country office workforce is still paid from polio funds.

Plans measure intent. Coverage, surveillance performance, workforce retention, executed budgets and outbreak-response capability measure whether the intended functions can actually be sustained. On those measures, progress is largely flat.

What the TIMB wanted, and what the IMB now requires, is an assessment of three separate conditions in each

country: capacity—the people, systems and resources that exist; capability—the essential functions perform to the required standard; and commitment—political and financial decisions to sustain them. A transition plan by itself establishes none of the three.

Two of the countries that have already exited the priority list illustrate the difficulty. Bangladesh appears on the compliance chart with a completed transition plan, scored low for quality. The polio transition monitoring report published in June 2026 recorded it at 99 per cent coverage for both core





vaccination markers, with every district above the 80 per cent threshold, and therefore described it as “on track”. Those were 2024 figures. The 2025 estimates, released the following month, show third-dose diphtheria-tetanus-pertussis coverage down from 97 to 92 per cent, first-dose measles from 96 to 90 and second-dose measles from 93 to 86.

Every Bangladesh estimate in the series, including the reassuring ones, carries the lowest of the grades of confidence that WHO and UNICEF assign. By the time the polio transition framework

reported Bangladesh as on track, the country was entering its largest measles outbreak since 2005.

India is described as having moved to the next stage of its plan, with functions managed and funded nationally. Yet, the regional certification commission describes surveillance quality indicators falling and funding for the transitioned functions insecure. India's immunisation coverage is meanwhile comprehensively above the global average. The concern is specific: strong coverage is not evidence that a transitioned surveillance function is being sustained.

Commitment is the third element sitting alongside capacity and capability. Political attention is a manifestation of this, determining, for example, whether a budget line is executed, whether a polio transition meeting is held, and whether functions survive the loss of visibility that follows success.

Fourteen of the polio transition priority countries have reported poliovirus outbreaks. The pattern is dealt with elsewhere in this report, but the impact of large, continuing or recurrent vaccine-derived poliovirus outbreaks is a major brake on making progress with transition.

A TRANSITION PLAN IS NOT EVIDENCE THAT A FUNCTION WILL SURVIVE

21 polio transition priority countries



Have a transition plan

BUT ON THE FUNCTIONS THAT MATTER



on track for both IPV1
and DTP3 coverage



have a dedicated
surveillance budget line



held a transition meeting
in the past 12 months

Source: Polio Transition Progress: Monitoring and Evaluation Report (Q1/2026), WHO, 2026.

WHAT THE 21 COUNTRIES ACTUALLY LOOK LIKE

The IMB is not funded by the Polio Programme to make country assessment visits, nor to bring priority countries to its meetings. It has therefore assessed the 21 from published sources and from contacts at strategic, field and political level. It has examined progress through two lenses: the domestic capacity to finance and deliver essential immunisation, surveillance and outbreak control; and the quality of the operating environment (meaning fragility, conflict, humanitarian pressure, environmental hazard and poverty).

Afghanistan, Pakistan, Nigeria and the Democratic Republic of the Congo are assessed in full elsewhere in this report.

What emerges from the remainder is not 17 separate country stories but five recurring conditions, and they are conditions that a transition plan cannot easily address.

National governance not reaching the territory that must be covered

Large areas of Burkina Faso remain insecure and beyond reliable administrative reach, despite official claims of

expanding control. In Myanmar, the military controlled only about 30% of territory during the 2025–26 election period, and polio surveillance data covered only about half the country. Mali's September 2025 fuel blockade cut deliveries to Bamako by around 80%; coordinated attacks then struck at least six cities in April 2026. Niger withdrew from the Multinational Joint Task Force in March 2025, while Al-Shabaab reclaimed at least five districts in southern Somalia. Yemen adds a different form of inaccessibility: fragmented authority, movement restrictions and damaged infrastructure that obstruct vaccination and surveillance even where an authority is present.

In such settings, epidemiological data reflect access and territorial control as much as programme quality. For example, a landlocked immunisation programme with interdicted fuel supplies has a cold-chain problem before it has a coverage problem.

Continuity of government ownership broken and its restoration uncertain

Cameroon returned the incumbent president, in office since 1982, to a further term in October 2025. Protests followed in which lives were lost, and with the leading opposition candidate departing the country,

the succession question remains unresolved. An army unit's defection collapsed Madagascar's administration within hours in October 2025, and an interim head of state holds a mandate of 18 to 24 months. Guinea and the Central African Republic each returned incumbents following constitutional changes that removed term limits or extended mandates, with opposition participation curtailed. Syria has a transitional president and an interim constitutional declaration. Government ownership of a polio transition plan presupposes a government whose continuity is settled, and in a substantial minority of the priority countries it is not.

Delivery mechanisms that are not governmental

In South Sudan, humanitarian assistance is largely channelled through non-governmental organisations rather than through government, principally because of corruption concerns. External contraction there removes not merely the financing but the delivery mechanism itself, and there is no national system standing behind it to absorb the function. In the Central African Republic, security in the main towns depends substantially on foreign forces, and the United Nations mission had 63 per cent of its approved annual budget unpaid in

February 2026. Somalia's African Union mission had no funding pledged for 2026 and troops are going long periods unpaid. These fragile and inadequately financed security arrangements threaten humanitarian programmes and public service delivery.

External support contracting

Across Somalia, Sudan, the Democratic Republic of the Congo, Chad and Myanmar, the evidence points not to a funded handover of services, but to contraction of externally supported humanitarian provision. In Somalia, funding shortfalls had led to closure of around 500 primary health-care facilities by mid-2026, while the response plan was about one-fifth funded. Sudan faced the world's

largest humanitarian caseload. Overall, 33.7 million people were in need, while its 2026 response plan was only around 20% funded in April. In the Democratic Republic of the Congo, the response plan narrowed from 332 to 228 health zones; Myanmar reduced its target population by 27%; and eastern Chad had already seen refugee health services, including a maternity ward, close under funding pressure. These contractions are especially concerning in countries that include priority poliovirus outbreak-risk areas.

Environmental hazards posing a major transition risk

Floods, droughts, cyclones and pest infestation destroy the physical infrastructure on which surveillance and

the cold chain depend, displace the populations that immunisation is designed to reach, and consume the domestic budgets that would otherwise absorb transitioned functions. Niger's 2024 floods damaged more than 100 health facilities and over 5,000 classrooms; Mozambique's flooding damaged health facilities and water systems alongside over 30,000 homes; the March 2025 earthquake in Myanmar affected 17 million people and destroyed health infrastructure that conflict had already degraded. Ethiopia has carried drought in the south and east, and exceptional flooding and landslides in the west simultaneously. Somalia declared a drought emergency in November 2025 and its subsequent long rains were again below normal.



Madagascar's exposure to drought, cyclone and locusts is chronic rather than episodic.

What another partnership's transition experience offers

The polio transition process could have done more to learn from other global health organisations and programmes that have deeper experience of moving countries out of dependency on external support.

Gavi is an established polio partner and has a well-developed process for withdrawing its financing from countries.

Eligibility rests on gross national income per head measured against a published threshold, and countries

move through four defined phases: initial self-financing, preparatory transition, accelerated transition, and finally, fully self-financing.

Governments have co-financed a share of their own vaccine doses since 2008, and that share rises as national income rises. Nineteen countries have completed the passage and now fund the immunisation programmes that Gavi support originally established. This is a mechanism with an operating history reaching back to 2000 and a substantial number of countries have passed through it.

Handing over responsibility for delivery and for funding has nonetheless proved more complex than the mechanism assumed. Gavi's own policy

record is the clearest evidence of it. The accelerated transition phase, originally five years, was extended to eight years. The eligibility threshold was raised exceptionally for 2026. Both decisions were taken expressly to reduce the risk of unsuccessful transition.

What makes that experience useful to the Polio Programme is that the same difficulties recur. They appear in different countries, in different regions and across two decades, which suggests they are generic features of donor withdrawal rather than local failures of particular governments.

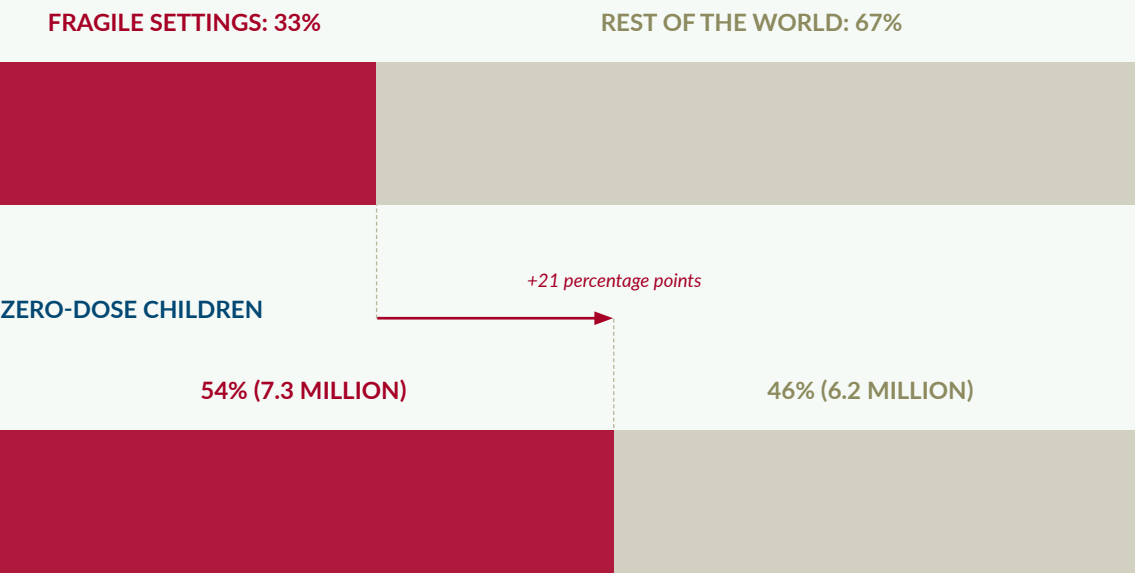
The Polio Programme's circumstances differ in obvious ways: it is not withdrawing on an income rule, and what it hands over



FRAGILE SETTINGS CONTAIN MOST OF THE CHILDREN THE PROGRAMME MUST REACH

Seven of the eight countries that matter most for polio are fragile, conflict-affected or vulnerable

GLOBAL ANNUAL BIRTH COHORT



Source: WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), 2026. Groupings per WHO.

is not vaccine financing responsibility only but wider infrastructure costs including for surveillance, outbreak response, containment and the workforce that carries them.

The underlying sequence is nevertheless the same: an external partner that has financed and largely delivered a function for a generation, a national

system asked to assume it, and a defined moment at which the money stops.

The governing definition is the one the Polio Programme should adopt: sustainability is achieved when essential functions continue to perform after external support changes, not when external support ends. This places the measure of success on the

behaviour of the health system rather than the withdrawal decision of the donor.

The weakness of the model as built is that movement between the phases has been driven by income per head. Income starts the clock. It does not certify capability, and readiness varies markedly between functions within the same country.

For polio, the judgement has to be made function by function – immunity, surveillance, outbreak response, containment and workforce – rather than by a single national status.

Gavi's experience exposes five assumptions that polio transition should not repeat. Economic growth did not necessarily produce delivery capability; governments took longer than expected to absorb externally supported functions; technical plans did not substitute for political leadership and budget execution; transition involved institutions and workforce as much as finance; and ending support was not the same as sustaining performance.

Countries could become able to purchase vaccines while still failing to reach their most vulnerable children. In polio's case, income and vaccine financing should therefore not be treated as proof that surveillance, delivery or outbreak response is sustainable.

For Gavi transition, workforce, governance and institutional capability also took much longer to establish than expected. For polio, surveillance, human resources and outbreak response require longer horizons and explicit backstop arrangements rather than an abrupt transfer at the point a financing threshold is crossed.

For Gavi, political leadership, accountability and the execution of budgets proved more decisive than the completion of technical plans. For polio, risk must therefore remain visible after eradication, when the disappearance of cases would otherwise allow attention and responsibility to dissipate.

Five practical lessons for polio transition follow from the analysis of Gavi's experience: begin before certification; transition functions rather than close programmes; assess readiness separately by country and function; protect the workforce explicitly; and maintain accountability after the visible emergency has gone.



A practical readiness test follows. Routine immunisation must sustain protection and reach missed communities; acute flaccid paralysis, environmental and laboratory surveillance must detect poliovirus rapidly; and the system must mount a timely response without extraordinary mobilisation. Critical staff must be budgeted and institutionally anchored, accountability must remain clear as polio-specific structures reduce, and allocated budgets must be released and executed. Transition should proceed when a function performs under stress, not merely when a plan exists.

There are country experiences that bear directly on the polio transition priority group members. For example, Vietnam had long-standing national immunisation structures, an established institutional history and genuine government ownership. In 2023 it decentralised immunisation financing to provincial governments; severe vaccine stockouts followed, together with the steepest fall in childhood immunisation coverage recorded in more than two decades. The policy was rapidly reversed.

Responsibility for financing had been moved without the authority and management capacity to exercise it. Several of the polio priority countries are large devolved systems in which precisely this error could happen. The lesson is not that devolution is wrong but that some functions require central stewardship even where execution is subnational. The line between them has to be drawn deliberately rather than by default. Further, when a country government takes over responsibility for polio essential functions, the national commitment must carry with it an explicit assurance that it can produce subnational capability.





Experience shows that major transition processes in global health take longer, cost more and require stronger institutions than commonly expected.

The object to be protected is the function, not the structure that currently delivers it. That is a good standard against which to assess the work.

Scope, governance and capacity

On scope, polio transition currently addresses 21 priority and seven watchlist countries. The functions that sustain a polio-free world reach much further: surveillance spans 66 countries, and containment some 20, of which only three fall inside the transition group.

The seven watchlist countries (Kenya, Iraq, Libya, Bangladesh, India, Nepal and Indonesia) have left the priority list and are monitored for three years against slipping back.

Kenya has no completed transition plan, is off track for timeliness of measles outbreak response, reports high dependence on external partners for both surveillance and outbreak response and still draws more than a quarter of its WHO country office workforce from polio funds. On several of those measures it is weaker than priority countries discussed in this report, and the WHO Regional Office for Africa (AFRO) continues to treat it as a priority country while the global list does not.

Syria makes the point from the other direction. It has fully transitioned out of GPEI financial support, while holding a transitional presidency under an interim constitutional declaration. In the same period, it lost six percentage points of first-dose diphtheria-tetanus-pertussis coverage and 12 percentage points of first-dose measles coverage, among the steepest single-year declines recorded anywhere. It reports fewer than two in five districts at 80 per cent third-dose coverage. Leaving the list is not the same as leaving the risk.

The narrow geography made sense for a programme designed to wind down country offices. It does not describe the work of sustaining a polio-free world, which

requires both a finite country transition and an open-ended stewardship of functions that are already global.

The IMB's view is that the second of these has no owner at present, and that continuing to define the task by the priority-country list will leave the majority of the risk outside the frame.

On governance, the arrangement designed in 2024 was narrow and country-focused and sat outside eradication. Those teams have since been folded into eradication across headquarters and the regions, and a revised concept note is under review.

The IMB is not persuaded that a mandate of this breadth can be discharged from

within the Polio Programme's own structure. This is not polio's transition alone; the functions concerned belong to immunisation, primary health care, emergency response and health security, and the bodies that will own them are not all inside the eradication partnership. A planning process convened and led through a polio lens will produce a plan that only polio owns.

On capacity, the position is the reverse of what the widening scope requires. The headquarters function has fallen from a full team with consultants to a core of two or three. The Africa region, which carries the largest caseload, is supported by two staff, both of them consultants. Polio transition in the Eastern Mediterranean, South-East Asia and Western

Pacific regions is run by part-time staff. The scope has widened and the capacity to deliver it has narrowed.

No governance redesign will compensate for that.

What transition is transitioning to

If the poliovirus goes, what will be sought from countries is not polio-specific at all. It is the capacity to deliver a vaccine through routine services, to contain a pathogen securely, to detect a problem early through surveillance, and to respond to an outbreak quickly.

Only the polio vaccine itself is particular to polio. Everything else is a general property of a functioning health system, and a country that builds it will be protected against a



great deal besides poliovirus. Stating the requirement in those terms is more honest than the language of transition, and considerably more likely to attract the domestic and external financing that the language of transition has not. One frequently asked question that has always defeated this work is: transition to what? The answer is now available. It is the strategy for sustaining a polio-free world, and the functions currently described as transition belong inside it.

The TIMB recommended a hard look at whether a separate polio transition programme remained necessary once that strategy existed, on the grounds that the distinction was not intelligible to those being asked to act on it. That recommendation stands, and the case for it is stronger now than when it was made. Polio transition is not a programme. It is part of what the enterprise does.

Within those constraints, the concept of polio transition will face three tests in the coming period, and should report against them rather than against the existence of plans.

Whether the Polio Programme can state, country by country and function by function, what standard of performance would be sufficient to release external support, and whether it will commit to transitioning



“Polio transition is not a programme. It is part of what the enterprise does.”

only when a function can perform under stress rather than when a plan exists.

Six countries – Chad, the Democratic Republic of the Congo, Myanmar, Sudan, Somalia and Yemen – have no visible pathway to exit polio money. Support to them is open-ended and, at present, uncoded. For this group, polio transition means a differentiated and sustained partnership rather than a handover date. It is better to be clear about this, and to cost it, rather than to maintain a timetable that no one involved believes.

Whether the stewardship of the functions that are already global – surveillance across 66 countries, containment, the vaccine stockpile, the withdrawal of bivalent oral vaccine – has an owner, a governance arrangement and a staff complement adequate to it. At present it has none of the three.

POLIOVIRUS CONTAINMENT

Poliovirus containment is the part of eradication that begins where transmission ends. When the last naturally circulating chains have been stopped, live poliovirus will still exist in vaccine factories, research laboratories, diagnostic collections and storage facilities. Unless those materials are destroyed or held under independently certified conditions, eradication will remove the virus from communities while leaving open an institutional route for its return.

Containment is therefore not a specialist biosafety exercise alongside eradication. It is one of the conditions by which eradication becomes permanent.

The new global strategy for sustaining a polio-free world places containment beside vaccination, surveillance and outbreak response as a continuing essential function.

Unlike most polio transition activity, however, certification of facilities does not have to wait for transmission to stop in Afghanistan, Pakistan or the outbreak countries. It can proceed now, largely in countries with advanced scientific, regulatory and financial capacity. Containment remains one of the few parts of the programme capable of delivering a complete and visible result on a timetable not controlled by epidemiology.

Progress has accelerated. The number of designated poliovirus-essential facilities has fallen from 102 in 30 countries in 2018 to 70 in 20 countries by June 2026. This reflects countries destroying material, transferring it or consolidating work into fewer sites. More importantly, full certification has moved from isolated proof of principle to an emerging group of completed facilities.

By April 2026, facilities in Australia, Belgium, Canada, Denmark, France, Hungary, Indonesia and the Republic of Korea had received full Certificates of Containment, with Belgium completing both of its designated facilities. Approximately nine facilities were fully certified, compared with only two when the final TIMB report was published.

This progress deserves more recognition from the polio eradication partnership than it has received. It shows that the certification standard is achievable, that national authorities can work through the audit and corrective-action process, and that countries can finance it from their own resources. The Programme

is overdue successes that demonstrate disciplined delivery rather than another revised forecast. Containment now provides one. WHO and the GPEI should communicate it as a strategic achievement, while avoiding the temptation to portray several compliant facilities as completion of the global task.

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“The Polio Programme is overdue successes that demonstrate disciplined delivery rather than another revised forecast.”



The remaining portfolio is increasingly concentrated in a small number of countries. China, India and the Russian Federation have recently shown renewed engagement. China submitted its outstanding applications after prolonged senior-level advocacy, and India has re-established a practical working relationship between its national authority, facilities and WHO.

Japan and several European countries are progressing, while the United Kingdom expects to complete its process during 2027. The pattern confirms the TIMB's earlier diagnosis: where technical work was stalled, the missing ingredient was often political attention, institutional coordination or clear communication

rather than an inability to meet biosafety standards.

The global end-2026 target will nevertheless not be met in full.

The working expectation has moved towards approximately mid-2027 for most facilities, with several serious outliers. Romania has not completed the national legal and authority arrangements required to regulate its facility, amid continuing political turnover. The Netherlands has faced a breakdown of understanding between the national authority and the certification process, despite its experience of containment incidents. Iran's facility is linked to national vaccine production and is now harder to engage because of geopolitical instability. These

situations require tailored political intervention, not another generic reminder sent through technical channels.

The United States is the largest unresolved problem. In January 2025, it held 20 designated facilities, more than any other country, with national authority sitting within the Centers for Disease Control and Prevention. At that point, the indicated intention was to pursue full containment certification of 11 facilities by the end of 2026. Formal engagement with WHO and the independent containment certification mechanism seems to have effectively ceased, with progress towards the goal unknown.

The United States has been offered routes to work directly with the independent Global Certification Commission and its containment working group, limiting any concern about WHO involvement. These have not yet restored the required cooperation. The world cannot credibly certify global containment while the country holding the largest concentration of facilities remains outside the common assurance process. This is not an administrative exception to be written in a footnote. It is a vital problem requiring engagement at a high political level.



CONTAINMENT HAS BECOME A CREDIBLE NEAR-TERM SUCCESS

Designated poliovirus-essential facilities

DESIGNATED FACILITIES

102 → 70

2018 to June 2026

COUNTRIES

30 → 20

2018 to June 2026

FULLY CERTIFIED FACILITIES

1 → 9

April 2025 to June 2026

PROGRESS UNCERTAIN

11

facilities the United States
indicated it would certify
by the end of 2026

WHO has received no confirmation of progress since January 2025

Source: WHO Poliovirus Containment Team, 2026.



Moving the operational completion date into 2027 may be realistic, but it must not become another quietly rolled deadline. Each remaining country and facility should have a dated route to certification, an identified political owner and a clear escalation point when milestones are missed. The eventual declaration must also be defined now. The Global Certification Commission should state what level of completion is required, how it would treat a non-participating country, and whether global facility certification can be declared with unresolved facilities. Leaving these questions until the final meeting would convert a foreseeable governance problem into a last-minute crisis.

The next containment risk is broader than the 70 designated facilities. Certification deals with locations intentionally retaining poliovirus for essential vaccine, diagnostic or research functions. Inventories must also find infectious or potentially infectious material elsewhere: old stool collections, environmental samples, research archives, vaccine remnants and material stored in laboratories outside the polio laboratory network. Repeated outbreak responses using oral vaccines create new material that may enter clinical laboratories, environmental programmes and cold-chain systems. A country can have no designated essential facility and still hold forgotten samples capable of containing poliovirus.

This makes the revision of guidance on potentially infectious material more than a technical update. The proposed approach moves from a narrow facility inventory towards a system-wide obligation to identify, destroy or appropriately contain material across clinical, environmental and research settings. It is particularly important in the Africa and Eastern Mediterranean regions, where outbreak response remains intensive and attention is naturally concentrated on stopping present transmission. Those regions contain almost no designated essential facilities, but they face the greatest risk that samples or vaccine-related material will be retained unintentionally after an outbreak ends. Regional certification commissions

and national containment coordinators must therefore maintain inventories as a living function, not a one-off exercise completed during the vaccine switch.

A broader search may initially increase the number of facilities or collections requiring action. That should not be mistaken for deterioration. Finding a previously unknown risk is progress if it is followed by destruction, transfer or secure management. The governing principle should remain minimisation. Retention should be justified by an essential public-health purpose, not by scientific habit, institutional prestige or a desire to preserve national capability. Historical collections that can be replaced by inactivated material, extracted nucleic acid or safer alternatives should not remain live indefinitely merely because they have always been kept.

Containment must also acquire a sustainable home. Certification is not the finish line: facilities will require continuing oversight, certificates will expire, inventories will change and breaches must be investigated for as long as poliovirus is retained.

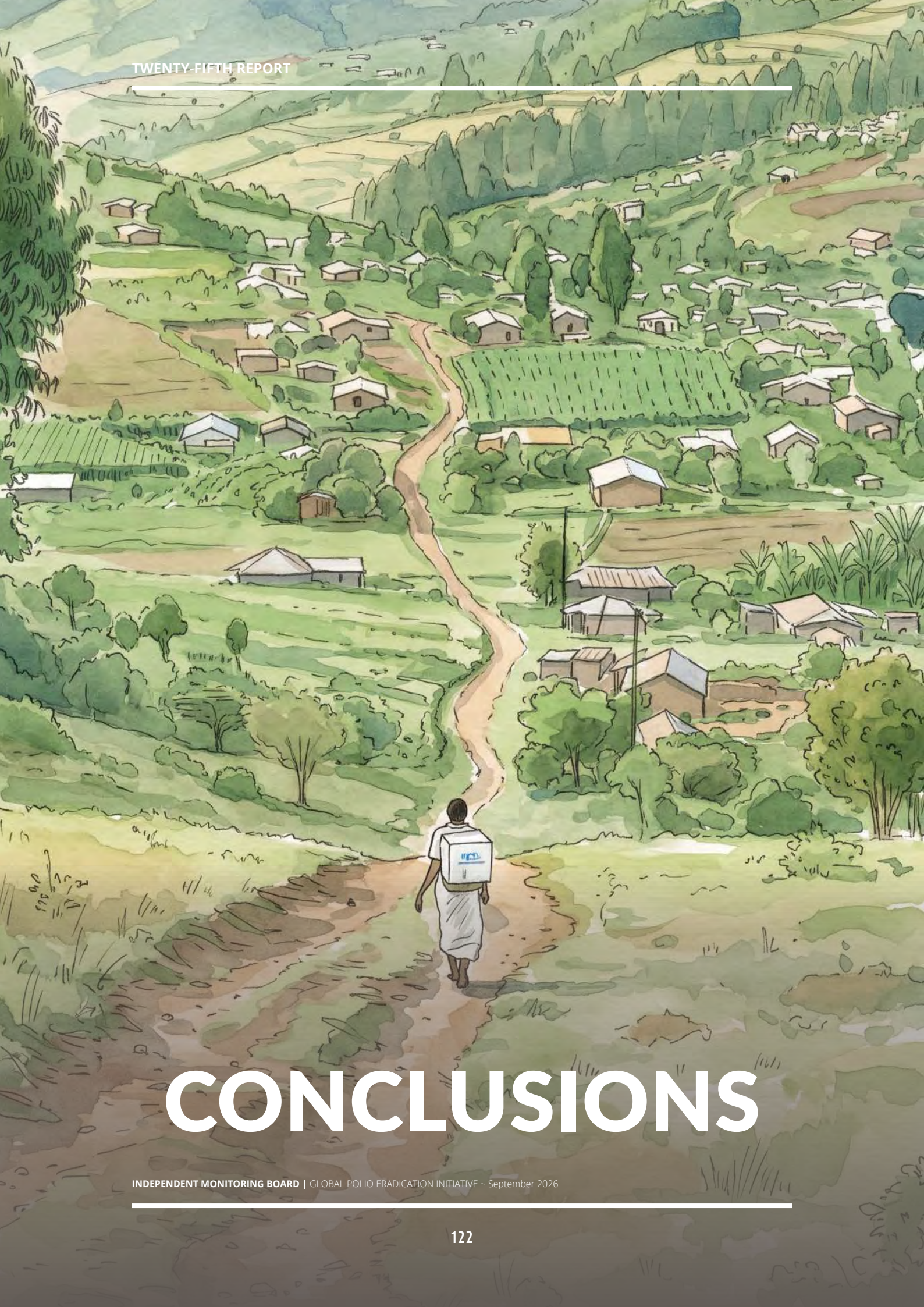
WHO's current containment function cannot remain a small project attached to a programme expected eventually to close. The sustaining-a-polio-free-world arrangements should specify who owns the standards, who supports national authorities, who audits facilities, how regional certification commissions oversee countries without essential facilities, and how the work will be financed after GPEI structures contract. An indefinite public-health obligation needs an institutionally durable system. Containment of poliovirus could provide a blueprint for containment of other laboratory-associated security and safety risks.

The IMB's conclusion is more positive than the TIMB's was a year ago. Containment is no longer almost stationary. Countries have consolidated facilities; certification has accelerated and several former concerns have moved into credible completion pathways. The remaining obstacles are now clearer and more concentrated. That is precisely why the Polio Programme should intensify rather than relax. A near-complete containment system with one major country

outside it, weak political authority in several others and incomplete inventories beyond designated facilities is not a safe system. It is a system whose remaining gaps have become more consequential.

Polio eradication will ultimately be certified not only by showing that the virus has ceased to circulate, but by demonstrating that the viruses intentionally retained by institutions cannot readily return to circulation. Containment offers the programme a near-term victory and the world a long-term safeguard.

The task now is to complete facility certification, bring the United States back into independent assurance, expose and remove material outside designated facilities, and transfer containment from a time-limited eradication workstream into the permanent architecture of global health security.



CONCLUSIONS

CONCLUSIONS

The wild poliovirus has survived another low-transmission season, the principal vaccine-derived poliovirus reservoirs remain active, and some of the functions required to find and reach the last children are being weakened by financial contraction and insecurity.

The remaining barriers now rest with fundamental causal factors: political authority, security, trust, accountability, team culture and management, true country ownership and continuity of public health capacity as much as with vaccine or technical knowledge.

The IMB closed its meeting on 23 July 2026 and has not reopened its scrutiny of the programmes examined. The epidemiology, however, did not stop with the meeting. The WHO update available on 18 August 2026 sharpens the conclusions reached in July. Four additional wild poliovirus cases were reported from Afghanistan in a single week, bringing its 2026 total to 19, against three in Pakistan. The global year-to-date wild poliovirus total was 22, almost unchanged from 23 at the same point in 2025. That near equality conceals

a decisive shift of burden of disease into Afghanistan and the survival of transmission throughout a second low season.

The dates attached to the GPEI's extended strategy have therefore been overtaken. Wild poliovirus transmission did not stop in 2025. Cases in 2026 make certification by the end of 2027 impossible, and global interruption of circulating type 2 vaccine-derived poliovirus will not occur by the end of 2026.

This is not a temporary delay within an otherwise intact plan. The assumptions on access, campaign quality, surveillance, routine immunity and finance on which the dates depended have not held. The answer should not be another timetable moved to the right while the same operating model is preserved. A credible plan must be rebuilt from the conditions required

for interruption, the evidence that will show those conditions exist, and the decisions that follow when they do not.

Afghanistan and Pakistan must be managed as one epidemiological system even while remaining two sovereign programmes. Technical cooperation currently just about survives despite a hostile impasse at wider political level, but these arrangements are approaching their limit. Border vaccination posts cannot substitute for shared understanding of population movement, harmonised mapping of communities and delivery capable of reaching children before and after they cross. Border closures and informal crossings only add to the risk. Neither country will secure the common reservoir alone.

Pakistan has made the strongest progress in the endemic bloc. Its case burden and geographic footprint have fallen sharply. The Minister of State, Prime Minister's focal person, Provincial Secretaries and other leaders have invested substantial time, effort and credibility. The unresolved question is whether their commitment is reaching the frontline consistently enough to interrupt transmission and whether they can reach the remaining inaccessible areas effectively. National intensity cannot compensate for recurrent gaps in a small number of decisive districts. Nor can reported data alone settle the question: it is striking that important gaps are often visible only when experienced reviewers visit implementation areas directly, as with Karachi this year. Field verification is

necessary to determine what is happening on the ground.

The principal concerns in Pakistan remain south Khyber Pakhtunkhwa, Karachi and then the central interprovincial corridor.

In south Khyber Pakhtunkhwa, Bannu and adjacent districts vaccination activities continue to miss children because of insecurity, volatile access and campaign cancellation or modification at short notice. Where access changes so rapidly, the quality of activity is least independently verifiable. The Pakistan polio programme has developed a geographical classification of districts and alternative delivery strategies, but these have not yet produced dependable access to every child. The concern is not lack





of effort; it is that effort is continually disrupted before it creates sustained immunity.

Karachi has improved following candid external expert examination, self-realisation of its programme's fundamental flaws, and immediate follow-through on recommendations. Yet, whilst it urgently needs stronger programmatic performance, Karachi remains vulnerable to underlying conditions that sit outside the vaccination campaigns themselves: substantial, long-established population movement; very high birth rates and persistently low routine immunisation. Campaign refusal may be manageable if most other children are consistently reached, but

low routine immunisation coverage turns every gap into a continuing reservoir. Karachi is a core and vital poliovirus reservoir in remission and, as such, leaves no room for a moment's complacency.

The central Pakistan corridor around Kashmore and Dera Bugti also needs to be highlighted. Persistent monthly detections suggest that the area may require a dedicated, time-limited intervention with teams assigned continuously for several months, rather than reliance on ordinary campaign cycles. The epidemiological space crosses provincial boundaries and needs one coordinated strategy.

Even with all of this addressed, Pakistan may interrupt

indigenous transmission, but cannot indefinitely protect that achievement from repeated importation while poliovirus continues to circulate in Afghanistan across a border traversed by families, workers, traders and displaced and migrant populations.

That makes the position in Afghanistan a matter of profound concern. It has not materially changed in two years. There have been some improvements, but they are not of a kind or a scale that brings the interruption of transmission within reach. It is impossible to generate any sense of anticipation that a breakthrough is imminent.

The Afghanistan polio programme continues to rest on foundations that were judged inadequate at the last two IMB meetings. They are still inadequate. The epidemiology and other performance metrics leave no room for doubt.

The programme appears to be rediscovering, campaign by campaign, the extent of this weakness. The absence of female workers is much more than a workforce statistic. It impedes vaccination, enumeration, communication with mothers and the validity of coverage assessments. Without reliable access to households, denominators cannot be established; without denominators, the microplans rest on guesswork, or “magical thinking” about how many children exist and where they are.

A thorough evaluation of oral polio vaccination campaign activities in the south found that, despite sustained effort to improve campaign quality, between 15 and 20 per cent of children are still being missed. The proximate cause is consistent and well understood: the difficulty of deploying female workers able to reach into households, compounded by the impossibility of confirming how many children a household contains.

The east had been the programme’s one encouraging story, and it now carries a

warning. At the onset of the high season the region has been reinfected after a period of apparent control. The east’s relative strength has rested on something the south lacks: active female participation, which has translated into better campaign quality. That even this region can be reinfected illustrates how little insulation the better-performing geographies enjoy while transmission continues across the border and within the wider reservoir.

Afghanistan is, in principle, the more tractable of the two endemic countries, since its population density is lower than Pakistan’s, and progress there would materially assist Pakistan. Yet, the Polio Programme has been unable to establish the engagement on which success depends. The decisive restriction is a political stranglehold imposed above the level of the technical programme, which is run by many dedicated and competent staff.

Afghanistan will not interrupt transmission under the present modality. Further technical optimisation cannot substitute for the political decision required to permit household access and women’s participation. Regional political and religious engagement is therefore not simply supporting diplomacy around the eradication strategy; it now has to be the heavyweight part of the eradication strategy itself.

Globally, 123 vaccine-derived poliovirus cases had been reported in 2026 by the WHO weekly update of 18 August, compared with 125 at the same point in 2025. The decline has stalled. These later reports include infections whose onset preceded their confirmation and do not retrospectively change the evidence reviewed by the IMB. What they show is that the risks identified in July were not theoretical and, in several places, were already larger than that July picture suggested.

The vaccine-derived poliovirus problem remains unfinished and distant from resolution. Like much else in this report, it is at root a weakness of public health services, particularly the shortfall in routine immunisation. Where such services deliver, the programme does not face the problems that now define it; where they do not, no amount of vaccination campaign machinery substitutes for the absence. It is also becoming apparent that the vaccine-derived poliovirus emergency is increasingly concentrated in countries where conventional performance measures have proved unreliable. Three of them illustrate the point in different ways.

Nigeria has been a massive source of concern, frustration and despair since it failed to build on the impressive success of eradicating wild poliovirus. It has received exceptional investment, huge amounts of

technical support, and help with many special initiatives, but steadfastly remains a principal engine of type 2 vaccine-derived poliovirus transmission for Africa, accounting for two fifths of the region's poliovirus detections, and a source of exported virus to the rest of the world. The Zamfara emergence has survived eight years, 40 vaccination campaigns and has paralysed more than 800 children since 2023. Many conversations about Nigeria's polio performance start with the question: how and why is it this bad?

The Nigeria Polio Programme's most recent reform is not another campaign but a new capacity to see its own underperformance. Household enumeration and geolocation tracking show that earlier measures greatly overstated reach. In the north-western epicentre, conventional indicators described successful campaigns while only about half of households were being entered. Nigeria is beginning to impose consequences. It must now prove that the new measurement system, and its flurry of other initiatives, changes what happens to named children rather than becoming another reporting platform or "work in progress" report.

The Democratic Republic of the Congo has reduced an enormous outbreak under conditions of exceptional logistical, security and humanitarian difficulty caused by multiple

recurrent sources of conflict and the country's largest Ebola outbreak. Its achievement is real. The subsequent increase in Haut-Lomami cases also demonstrates why it is not yet secure. Kinkondja revealed more than one lineage circulating unseen in a known high-risk area, and the latest bulletin shows the outbreak expanding beyond the scale presented at the July 2026 IMB meeting.

The country's central requirement is continuity: surveillance maintained between emergencies, workers paid, vaccines and funds pre-positioned, and technical support retained after detections fall. Repeatedly rebuilding the response after hidden transmission returns is more expensive than sustaining the capacity that would have found it earlier.

Somalia and northern Yemen expose the limits of describing prolonged circulation as just another difficult national outbreak. Somalia has campaigned for years without interrupting circulation of a poliovirus that was already old when first found. In northern Yemen, mass response and the movement of surveillance specimens remain dependent on political permission. In both, the absence of recent confirmation may reflect loss of sight rather than absence of poliovirus. These are regional and global reservoirs sustained inside national emergencies. Their neighbouring countries

cannot be expected to contain the consequences indefinitely.

Moving from specific country programmes, the examination of polio essential functions globally and systemically reveals many important findings and conclusions that are key to successful polio eradication.

The Polio Programme's deepest vulnerability lies beneath the campaigns. Millions of children receive no routine vaccination or fail to complete their schedules, and they are concentrated in the same conflict-affected and politically marginalised populations in which poliovirus survives. National coverage averages obscure them, uncertain denominators miscount them, and administrative results sometimes exceed 100 per cent while transmission continues. The Programme needs registers, household enumeration, birth identification and named missed-child lists wherever these are feasible. At this stage, the child who is never counted is more consequential than the percentage point in a national estimate.

Routine immunisation is therefore the most vital polio essential function, yet the Polio Programme is placing expectations on it that existing systems may not be able to meet at the required speed or scale. Routine services are increasingly expected to compensate for fewer campaigns, prevent the re-emergence of types 1 and 3



poliovirus, protect successive birth cohorts against type 2 vaccine-derived poliovirus paralysis and eventually sustain the withdrawal of oral vaccine. That strategic direction is correct. Its operational basis is not yet secure. In the decisive subnational geographies, routine systems often lack: reliable denominators, staff, vaccine availability, supervision, transport, demand and the capacity to follow an individual child through a complete schedule.

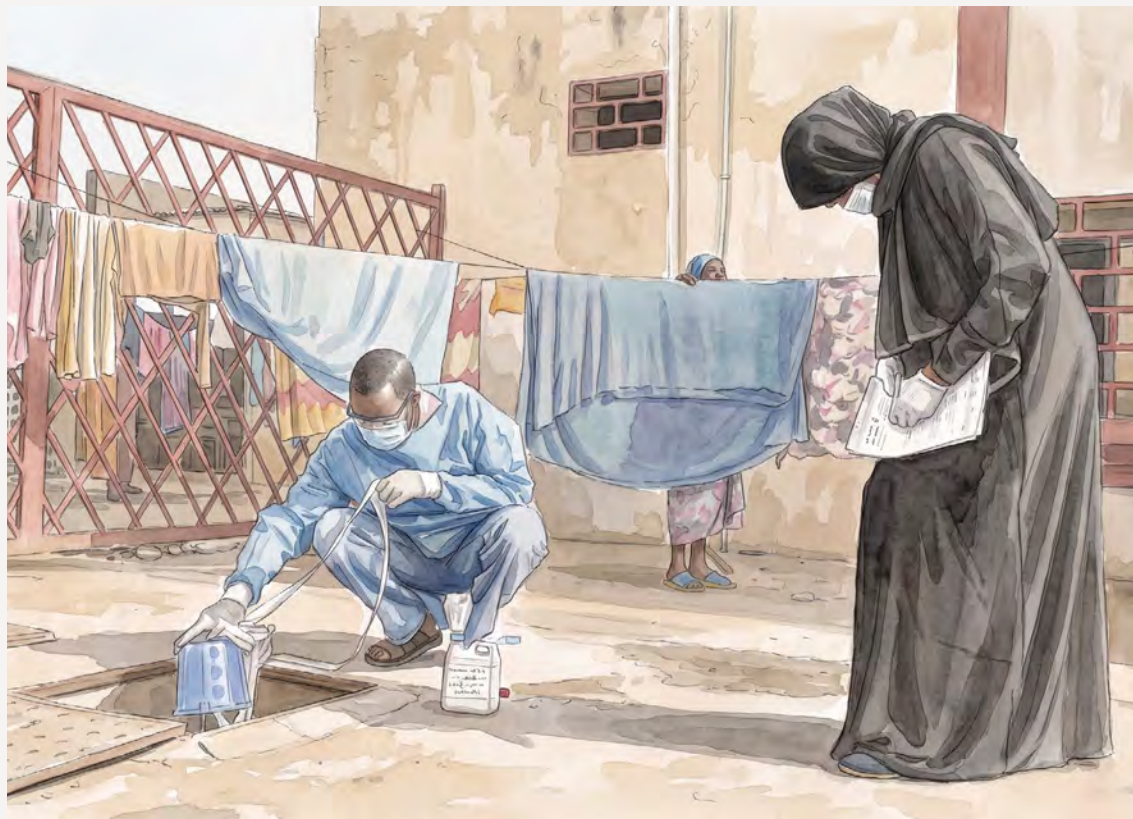
The GPEI must recognise the implications. If essential immunisation cannot be transformed rapidly in polio-affected and polio-vulnerable settings, it is not a background health-system weakness; it is a potential showstopper

for eradication. Integration cannot mean transferring an expectation to routine services without transferring the authority, finance and delivery capacity needed to fulfil it. For every priority geography, the Polio Programme should state what immunity routine services must produce, by when, whether the local system can realistically produce it and what interim campaign protection will remain necessary if it cannot. A strategy that depends on routine immunisation improving faster than the system is capable of improving contains an unacknowledged failure point.

Surveillance, the second vital polio essential function, is being weakened at exactly the stage when eradication requires it to prove absence.

Laboratory sequencing has become faster and more widely distributed, but field detection, specimen transport, active visits and community networks are deteriorating. Orphan viruses in Nigeria, Kinkondja (in the Democratic Republic of the Congo), and elsewhere, are the genome's record of what surveillance failed to observe. A response clock that begins only when a laboratory confirms the virus excludes the weeks or months during which a child was not identified or a specimen did not move. Detection and response must be measured as one continuous interval, with named accountability for every delay.

Financial contraction is falling on the Polio Programme's least visible, but most essential,



functions. Campaigns have been protected more successfully than independent monitoring, community engagement, active surveillance, specimen movement and the support and payment of frontline workers. This is a false economy. Those functions determine whether campaign numbers are true, whether access can be sustained and whether the next outbreak is found before paralysis. Payment is not administrative housekeeping. Trust is not a communications accessory. Independent monitoring is not optional assurance. Each is part of vaccine delivery.

The same is true of communities. In the remaining reservoirs, communities are part of the delivery system. They determine whether a vaccinator can enter, whether a child is brought forward, whether a woman worker can operate safely, whether a rumour is corrected and whether access is granted again at the next round. Understanding the role of gender in family decision-making and permission-giving is vital.

Trust, permission, safety, reciprocity and the perceived value of the encounter are therefore operational conditions, not soft additions to campaign design. Social

evidence must carry the same authority as epidemiological evidence and must be capable of changing who delivers, what is offered, when teams visit and how success is measured. If this thinking remains confined to communications specialists while operational plans continue unchanged, the Polio Programme will continue to keep arriving with vaccine at places where it has not secured a relationship capable of delivering it.

Polio transition cannot be separated from polio eradication. A national transition plan does not demonstrate that surveillance, immunisation,

outbreak response or the workforce can perform under stress. These functions must be assessed separately and supported for as long as their performance requires. Some fragile countries do not have a credible path to complete financial independence from polio support, and maintaining a fictional exit timetable is less responsible than agreeing a differentiated and costed long-term arrangement.

Containment offers a different and more encouraging transition story. Facility consolidation and certification accelerated during 2026, showing that a core part of the post-eradication architecture can be completed even while transmission continues. It is a genuine programme success, though it remains incomplete for now.

All of this sits within a broader environment: a world growing less secure, more disconnected, with weaker global institutions and sea-changes in development assistance.

The prospects for the kind of sustained, fully committed action that polio eradication requires are narrowing rather than widening. The concern that a major opportunity may have been missed is not defeatism. It is a sober reading of a programme that has the tools, the knowledge and, for now, the resources to succeed, and has nonetheless been unable to establish the necessary commitment across country governments dealing with multiple health emergencies, civil unrest and conflict as well as economic and environmental challenges.

There is an important counterweight. Burundi, Ghana, Guinea-Bissau, the Republic of the Congo and Uganda have independently demonstrated interruption of their outbreaks. The Polio Programme still knows how to stop poliovirus when surveillance is sufficiently sensitive, campaigns are timely and well-executed, political ownership is clear and the affected population can be reached.

The global difficulty is not that eradication methods have ceased to work. It is that the conditions under which they work are absent or unstable, particularly in a small number of consequential geographies, and the Polio Programme has too often responded to that difference by repeating standard activity rather than changing the conditions.

The evidence in this report shows that programmes improve when they stop defending reassuring averages and examine the places where their systems fail: Karachi after external audit, Nigeria after household tracking, the Democratic Republic of the Congo after genomic evidence exposed blind spots, and countries that closed outbreaks through disciplined execution.

The Polio Programme should now reset its targets around verified conditions rather than desired dates and state openly what must change in each remaining reservoir. Its measure is no longer the global campaign total or the national coverage



“Trust is not a communications accessory.”

headline. It is whether the specific children sustaining transmission are known, reached and protected, and whether the system can prove that the poliovirus is gone after the emergency attention has moved elsewhere.

The last mile is not a shorter version of the road already travelled. It is a different road, indeed a road less travelled. The road to zero is clear; the obstacles are man-made. With goodwill, courage, pride in excellence, unwavering commitment and total solidarity, those obstacles can be lifted out of the way, and children everywhere can walk unaided into the light of a polio-free world.



RECOMMENDED ACTION

RECOMMENDED ACTION

This IMB report follows the governance review requirements, and, for each recommended action, states why action is needed and from what starting position, what must change, who is accountable and who must contribute, by when, and how delivery will be judged.

Where an accountable owner does not control the decision on which delivery depends, that dependency is set out.

1. ACTIONS TO REBUILD A CREDIBLE PLAN AND MAKE ACCOUNTABILITY CONSEQUENTIAL

The Polio Programme keeps missing public commitments without any consequent change in authority, finance or method.

1.1 Replace competing timetables with one conditional results framework

Why: Three sets of dates are in circulation, from the strategy extension, the 2026 action plan and the country roadmaps, and none has survived contact with the epidemiology. Publishing overtaken dates alongside live ones costs operational discipline and credibility.

Action: The Polio Oversight Board should withdraw the overtaken dates formally and put one framework in their place. It should list each milestone missed or superseded, keep interruption and certification distinct, and attach to every remaining date the assumptions behind it, the evidence that would confirm them, and the decision that follows if one fails. Targets should be conditional: the operating conditions required, the proof needed, and the earliest date that the epidemiology then allows.

Accountable owner: Polio Oversight Board.

Contributing: GPEI Strategy Committee, the Global Certification Commission and the regional certification commissions.

By when: Framework published within 50 days of publication of this report, then reviewed and reissued every six months.

How delivery will be judged: One framework used throughout global and country reporting; the superseded dates publicly withdrawn; and each reissue naming the assumption that failed.

1.2 Bring types 1 and 3 vaccine-derived poliovirus inside the current strategy period

Why: Type 1 vaccine-derived poliovirus paralysed 20 children in the first half of 2026 against three in all of 2025, and type 3 caused eight. Together they approach a third of the global vaccine-derived poliovirus burden. Because they arise from weak routine immunisation rather than the type 2 oral polio vaccine withdrawal, the type 2 poliovirus elimination strategy does nothing for them while their responses draw on the same capacity and money.

Action: The Polio Oversight Board should commission an assessment and publish its position inside the framework at recommended action 1.1, rather than leaving these polioviruses to a period after 2029.

Accountable owner: Polio Oversight Board.

Contributing: GPEI Strategy Committee, WHO regional offices, affected national programmes, and the Strategic Advisory Group of Experts on Immunization.

By when: Assessment to the Polio Oversight Board within 50 days of publication.

How delivery will be judged: A dated position on types 1 and 3 vaccine-derived poliovirus inside the results framework; their cost and capacity use reported separately; and routine immunisation plans addressing type 1 and type 3 poliovirus immunity rather than type 2 alone.

1.3 Make the operating conditions in Afghanistan a high-level regional political task

Why: Afghanistan now carries the greatest wild poliovirus endemic burden. Its highest-risk districts, covering one sixth of the country, produced 76 per cent of cases in a three-year analysis. The reservoir will not close through further refinement of an operating model that is not able to produce a validated denominator, and it will not be secured through technical advocacy. Regional political engagement has moved more than anything else this year, and its remit is narrower than the problem.

Action: The WHO Regional Director for the Eastern Mediterranean should extend the remit of the group of ministers and trusted figures from the region, so that its objects become household-level vaccination in the south and southeast, women performing the functions needed to find and reach children, and authorisation for a validated microcensus with missed-child follow-up.

Accountable owner: WHO Regional Director for the Eastern Mediterranean.

Contributing: Participating regional member state health ministers, the Polio Oversight Board, Afghanistan's health leadership, and the WHO Director-General where escalation is required.

By when: Extended remit and named engagement plan within 30 days of publication.

Dependency: Household access and women's participation turn on a decision taken above the level of the health programme. Afghanistan's technical staff should not be held accountable for this policy.

How delivery will be judged: Permissions carried into campaign practice; women performing agreed functions in the south; defensible household denominators; independent evidence of improving reach across the 65 high-risk districts; and the southern poliovirus lineages contracting.

1.4 Manage Afghanistan and Pakistan as one epidemiological system

Why: Bilateral government political relations are suspended, and cooperation between the two polio programmes has reached about the limit of what technical goodwill can carry: people cross the border and information does not.

Action: The GPEI should build one shared evidence base for the bloc: common case and environmental line lists, harmonised genetic reporting, a single map of crossings, corridors and the communities using them, and agreed follow-up of children moving each way. Corridor campaigns should be synchronised from that picture rather than negotiated round by round, and whatever the two programmes cannot settle should be escalated through IMB recommended action 1.3 rather than accepted as a technical limitation.

Accountable owner: WHO Regional Director for the Eastern Mediterranean, who should appoint one named coordinator for the bloc accountable for the shared evidence base.

Contributing: The two National Emergency Operations Centre coordinators, the GPEI Strategy Committee, and the regional member states supporting the engagement at recommended action three.

By when: Shared evidence base specified within 50 days of publication and operating before the 2027 low transmission season.

How delivery will be judged: One line list and one genetic picture used by both polio programmes; synchronised corridor campaigns; documented follow-up of returnee cohorts on both sides; and a falling orphan and long-chain poliovirus share.

is also unowned: sustaining a polio-free world is costed at US\$ 7 billion to US\$ 9 billion over 11 to 12 years, and the phases that would establish who owns and funds each function have not begun. Overall funding for global health is declining and polio may not naturally be where countries want to focus their efforts. Building the commitment of a coalition of polio-committed member states is especially important with the present state of Middle Eastern and global politics and solidarity for sustaining the conditions for a polio-free world must not be allowed to dissipate; there is poor awareness that interrupting circulation of wild poliovirus is not the end or even the beginning of the end.

Polio has been a Public Health Emergency of International Concern since 5 May 2014, renewed at every review since, and is the longest such emergency in the history of the International Health Regulations. The General Assembly has nonetheless never adopted a resolution on it or held a high-level meeting about it, though it has done so for HIV and AIDS, non-communicable diseases, antimicrobial resistance, tuberculosis, universal health coverage, Ebola, pandemic preparedness and road safety. The polio gatherings at United Nations headquarters in 2012 and 2025 sat beside the Assembly rather than within it, and left nothing negotiated behind them.

Action: Member states should table a General Assembly resolution on polio eradication and sustaining a polio-free world, which itself would convene a high-level meeting, with a negotiated political declaration as its outcome. The precedent is the 2016 meeting on antimicrobial resistance, which left standing machinery rather than a statement; the IMB is not asking for another commemorative event.

Accountable owner: Polio Oversight Board, for sponsorship and substantive content, and partner agencies (particularly Rotary) to facilitate the creation of a coalition of member states. The WHO Director-General for the route through the United Nations system.

1.5 Take polio to the United Nations General Assembly

Why: A big part of what now decides eradication is political. The obligation beyond eradication

Contributing: A wide coalition of member states including polio-affected and polio-vulnerable countries, major donor governments, and the partners holding consultative status at the United Nations.

Dependency: Only member states can decide to convene. What the partnership controls is whether a sponsoring group exists and has something worth adopting.

By when: Sponsoring group of member states identified within 60 days of publication; decision resolution tabled during the 82nd session of the General Assembly; further actions following through according to appropriate procedures.

How delivery will be judged: A resolution tabled and adopted; a meeting held with a negotiated declaration rather than a chair's summary; commitments included concerning access, worker protection, post-eradication financing and containment; and the reporting route used, before the end of 2028.

2. ACTIONS TO MAKE PERFORMANCE IN THE DECISIVE GEOGRAPHIES VISIBLE AND OF ERADICATION QUALITY

The poliovirus now sits where national averages, administrative coverage and routine monitoring are least worth trusting. The unit of performance has to become the child, the household and the transmission cluster, and the strongest independent assurance has to go where information is weakest.

2.1 Apply reservoir-level independent assurance in Pakistan's remaining transmission zones

Why: Pakistan's progress is real. Evidence from the most intractable reservoir is the country's weakest. Assurance is heaviest where it is easiest to obtain. Transmission has also been re-established along the central corridor, where the union council community network has been cut back.

Action: Pakistan should run an assurance plan reporting Green, Community-led and Black union councils separately. It should disclose how much of the child population cannot be independently verified. Monitoring should be moved towards the least-assessed places, testing whether access classifications hold between rounds and triangulating campaign findings against surveillance, healthy-child sampling and named repeatedly-missed children.

Accountable owner: Coordinator of Pakistan's National Emergency Operations Centre.

Contributing: The Khyber Pakhtunkhwa, Sindh, Punjab and Baluchistan provincial polio programmes; independent monitors appointed through the GPEI; and the Prime Minister's focal person where civil and military authority is required.

By when: Assurance plan in operation before the next full campaign cycle and maintained through to at least June 2027; corridor deployment beginning before the 2026–27 low transmission season.

How delivery will be judged: Reporting representative of the whole reservoir, including: union councils never previously sampled; the unverifiable child population quantified; proportion of children left over reduced in Green and Community-led councils. Corridor detections should cease through a full low season.

2.2 Make Nigeria's household evidence the governing measure, and give states authority with liability

Why: Nigeria's new systems have exposed how far the old figures overstated reach. Decision-making has meanwhile concentrated at the centre, and the state-level leadership that delivered against wild poliovirus seems to have been disempowered.

Action: Nigeria should publish, for each local government area, the share of enumerated children reached, households entered, settlements only partly reached and records found unreliable. Dose histories, finger marks and caregiver recall should not stand as evidence without corroboration. Implementing partners should attend to missed areas, but delivery, measurement, financial assurance and final judgement must sit with different parties. States should receive authority and liability, together with an agreed set of operational decisions returned to them and their performance published. The surveillance review should be followed by a fully independent review of the whole outbreak response.

Accountable owner: Executive Director of the National Primary Health Care Development Agency.

Contributing: The National Emergency Operations Centre, state governments and state primary health care agencies, GPEI partners, and an independent expert review team drawn from outside the structures being examined.

By when: Household and child reporting from the next round and every round thereafter. Full outbreak-response review completed by 31 December 2026.

How delivery will be judged: The child register still in use after two rounds that produce unwelcome findings; verification independent of the implementing partners; the wider review completed; and household reach in Zamfara, Sokoto and Kebbi materially above the present baseline.

2.3 Establish continuity compacts for the Democratic Republic of the Congo, Somalia and northern Yemen

Why: What fails in these three places is continuity: surveillance, specimen movement, worker payment and technical support shrink between episodes or must be renegotiated in each emergency.

Action: The GPEI should agree a compact for each geography protecting a minimum surveillance network, specimen transport, essential staff, prompt worker payment, vaccine availability and technical support between rounds. In the Democratic Republic of the Congo, a zero enterovirus isolation rate in any historically high-risk health zone should force corrective action, the postponed external surveillance review should proceed, and essential immunisation, surveillance and specimen movement should be protected explicitly inside the eastern emergency. In Somalia, further large-scale rounds should await independently verified improvement in microplanning, household visitation and supervision. For northern Yemen, senior political engagement should pursue one indivisible agreement covering mass vaccination, independent monitoring, surveillance access and specimen shipment.

Accountable owner: GPEI Strategy Committee.

Contributing: WHO Regional Directors for Africa and the Eastern Mediterranean, the three national polio programmes, humanitarian partners, and political leadership where an agreement is required.

By when: Compacts agreed within 50 days of publication; quarterly public reporting thereafter.

How delivery will be judged: Funding and staffing continuous between outbreaks; specimen routes unbroken, including resumed shipment from northern Yemen; workers paid on time; and surveillance visible again in Haut-Lomami, south-central Somalia and the northern governorates.

2.4 Build one programme of work for mobile, nomadic, displaced and cross-border populations

Why: People who move are absent from the denominator and from the frame used to sample campaign quality, so they are missed twice.

Action: The GPEI should handle mobile, nomadic, displaced and cross-border populations as one programme of work rather than a local complication solved separately in each country. Every consequential geography should hold a mapped account, refreshed periodically, of the mobile populations within it and the routes they use, and those populations should appear in the campaign denominator and in the quality sampling frame. A special-population activity should be judged on previously unreached children converted into repeatedly vaccinated ones, not on contacts made.

Accountable owner: GPEI Strategy Committee, with one named lead representing the WHO Regional Director for Africa and for the Eastern Mediterranean geographies.

Contributing: The national polio programmes of Nigeria, Niger, Chad and Cameroon, the Democratic Republic of the Congo, Somalia, Yemen, Pakistan and Afghanistan, with the humanitarian and displacement agencies working in them.

By when: Mapped accounts in every consequential geography in the Eastern Mediterranean and Africa regions before the next campaign cycle.

How delivery will be judged: Mobile populations present in denominators and sampling frames, with the method stated; the previously zero-dose share of children reached at special-population sites, reported by round; and a falling orphan poliovirus fraction in the Lake Chad bloc.

2.5 Create a standard audit trigger for persistent transmission and contradictory data

Why: Karachi improved only after an external audit found what routine reporting had hidden. A similar approach should be taken in other key geographies.

Action: The GPEI should require an independent, rapid, time-limited diagnostic expert audit whenever transmission persists for 12 months through repeated campaigns, campaign assurance and epidemiology remain at odds, long-chain or orphan polioviruses recur, or the same geography fails across three rounds. Audits should examine field practice, denominators, social and gender barriers, partner roles, data reliability and the management response, and should produce a corrective plan tracked monthly.

Accountable owner: GPEI Strategy Committee, drawing on a standing independent expert audit roster held outside the country and regional structures being examined.

Contributing: WHO and UNICEF regional offices and the affected national polio programmes.

By when: Protocol agreed within 40 days of publication; audits initiated within 10 days of a trigger being met.

How delivery will be judged: Every qualifying trigger producing an audit or a published reason why none was commissioned; corrective decisions published; and measurable change within two campaign cycles.

3. ACTIONS TO PROTECT THE COMPLETE CHAIN FROM DETECTION TO EFFECTIVE RESPONSE

Eradication requires proof of absence. Laboratory science has been improving while field surveillance, specimen transport and laboratory logistics have weakened. Every break in the sequence buys the poliovirus more time, and the chain must be managed and funded as one system. All key sources of failure should trigger mandatory rapid investigations.

3.1 Define, fund and protect an eradication-standard minimum surveillance network

Why: Three of the four global surveillance indicators went backwards in the highest-priority countries over the 12 months to May 2026. Active surveillance funding fell by an estimated 30 to 50 per cent, and what remained was not reprioritised to protect it.

Action: Polio surveillance should be designated as a protected function. The GPEI should publish the minimum active surveillance, environmental and community network each priority and watch-list country requires, with geographic coverage, specimen frequency, transport routes, workforce and cost. Environmental performance should never be reported without the number and distribution of operating sites, and a country closing all its sites should be recorded as having lost the function rather than as missing data. The monthly measure comparing acute flaccid paralysis reporting against a country's own three-year average should become a standing instrument.

Accountable owner: The WHO officer accountable for polio surveillance and the laboratory network, overseen by the Polio Oversight Board.

Contributing: Regional offices, national polio programmes, and the civil society partners carrying community-based surveillance.

By when: Costed network standard by 31 December 2026; critical gaps funded or restored by 31 March 2027.

How delivery will be judged: Country network maps published; site losses reported rather than removed from denominators; community surveillance financed rather than assumed; and the lower tiers no longer falling faster than the highest-priority tier.

3.2 Make genetic evidence an automatic trigger for investigating surveillance failure

Why: Intermediate divergence and orphan polioviruses record how long transmission went unseen. The standard operating procedures treat orphan polioviruses as a marker of high virologic risk, yet no rule obliges anyone to ask why one was not found sooner.

Action: A documented surveillance failure investigation should follow every orphan poliovirus, every defined intermediate divergence poliovirus, every detection after formal outbreak closure, and every detection in a country with no recent history of that poliovirus, including wastewater detections in polio-free countries. Closure should not proceed where surveillance cannot show it could have found continuing transmission.

Accountable owner: GPEI Strategy Committee.

Contributing: The Outbreak Preparedness and Response Team, regional certification commissions and national polio programmes.

By when: Standard protocol within 60 days of publication; investigations initiated within 10 days of a qualifying sequencing result.

How delivery will be judged: An investigation attached to every qualifying detection; closure

decisions explicitly incorporating genetic and surveillance evidence; and the reduced sensitivity share falling from its 2026 level of roughly a quarter.

3.3 Assess every outbreak response against the Polio Programme's own timeliness targets, with the clock beginning at paralysis onset

Why: The Polio Programme sets onset-based targets for surveillance and confirmation-based targets for response, and joins neither to the other nor either to a specific outbreak.

The Programme's existing surveillance and response targets, joined and counted from onset of paralysis, reach the following points, as a

Milestone	Day from onset – full laboratory capacity	Day from onset – without full laboratory capacity
AFP case notified	7	7
Poliovirus identified and sequenced	35	46
Round zero complete	49	60
Three large-scale campaigns complete	119	130

possible framework based on GPEI documents.

Timeliness metrics must be unambiguous so that each response can be measured against them.

Action: The GPEI should publish one set of timeliness targets covering the whole interval from onset of paralysis or environmental sample

collection to completion of the response, extending across the response phase the onset-based targets it already sets for surveillance. It should state whether that combined standard is consistent with its 120-day interruption goal, and if not, which segment it will shorten. It should then assess every outbreak against those targets: met or not met overall. Every target missed should trigger a structured review, conducted without blame, identifying the bottleneck, the fixes, the authority responsible and the date by which the fix applies, and recording the enablers where a step succeeded so that what works is preserved and spreads. The Polio Programme should apply the assessment retrospectively to every outbreak response of the past 12 months and prospectively thereafter, and should test it first in the Democratic Republic of the Congo and Pakistan and/or other willing countries. WHO should establish a small cross-agency logistics cell to review scheduled specimen routes, monitor critical consumables and negotiate accelerated national approvals for reagents. An indicative costing of direct detection should be published with the December 2026 technical recommendation.

Accountable owner: GPEI Strategy Committee.

Contributing: UNICEF Supply Division, regional offices, national regulatory authorities and GPEI finance.

By when: Combined targets and the position on the 120-day goal published by 31 December 2026; retrospective assessment of 2026 responses published by 31 March 2027; every subsequent outbreak assessed within 30 days of its final response round; reagent and shipment fast-track arrangements in all high-priority countries by 1 May 2027.

How delivery will be judged: Every outbreak assessed and results reported outbreak by outbreak rather than as country averages; named bottlenecks, fixes and authority for missed targets; confirmation that no reagent expired before import clearance; and measurable shortening of the intervals.

4. ACTIONS TO CLOSE IMMUNITY GAPS THROUGH SYSTEMS THAT COMMUNITIES CAN AND WILL USE

The Polio Programme is putting increasing weight on essential immunisation, integrated delivery and community acceptance. The direction is right but rests on an untested assumption: that weak local systems can produce the immunity required at eradication speed. Communities and gender are a major deciding factor in whether the model can find the child.

4.1 Treat the transformation of routine immunisation as a condition of the eradication timetable

Why: Routine services are expected to build the immunity that lets campaigns work, complete inactivated vaccine series rather than start them, recover children already missed, carry integrated delivery, and leave stronger national systems behind. They cannot do this at the speed the polio timetable assumes. Generic strengthening is necessary, valuable and slow; the eradication timetable is none of those things.

Action: The Polio Oversight Board should state, for each consequential geography, what immunity routine services must produce, by when, whether the local system can realistically produce it, and what campaign protection stays necessary if it cannot. Any shortfall should be recorded as a risk to the eradication timetable rather than folded into an integration ambition. Work should follow those geographies rather than national averages, since the six countries holding them account for roughly four-fifths of paralytic polio cases in the preceding 12 months. The routine programme needs ring-fenced financing, a named owner and a short indicator set. The Polio Programme should not pass to

essential immunisation the problems it has been unable to solve itself.

Accountable owner: Polio Oversight Board.

Contributing: GPEI Strategy Committee, the Joint Gavi–GPEI Leadership Team, WHO and UNICEF immunisation programmes, national immunisation and polio programmes, subnational health authorities, polio donors.

By when: Statement of required immunity, present capacity and residual campaign protection for every consequential geography by 31 December 2026; ring-fenced financing and named owners in place for the 2027 budget year.

How delivery will be judged: A published requirement and capacity assessment for each consequential geography, with an explicit contingency wherever routine services cannot meet it in time; catch-up reported as a routine function; a smaller zero-dose cohort in the following birth year; and completed inactivated polio vaccine series rising in the communities that carry polio risk.

4.2 Settle the scope of the Gavi–GPEI joint programme and act inside the Gavi 6.0 window

Why: The joint programme is a principal mechanism for meeting the expectations placed on routine immunisation, and it is a year old with its scope not fully settled. Asked whether it is an added-value activity around inactivated polio vaccine delivery or the core transformation of routine immunisation on which eradication depends, the polio partnership gave the IMB no clear answer.

Action: The Joint Gavi–GPEI Leadership Team should issue immediately the country-by-country guidance on what eradication requires from routine immunisation, so that costed requests reach Gavi processes while applications are still being drafted.

Accountable owner: Joint Gavi–GPEI Leadership Team, with the scope decision owned jointly by the Chairs of the Polio Oversight Board and the Gavi Board.

Contributing: Gavi Secretariat, national immunisation and polio programmes, and subnational health authorities.

By when: Scope statement at the next joint meeting of the two boards; country guidance issued within 30 days of publication; costed polio requirements submitted into every open Gavi 6.0 country application before it is finalised; district-level delivery tests for the 13 countries by 31 March 2027, with quarterly joint review.

How delivery will be judged: A published scope statement with resourcing that matches it; polio requirements costed and visible in the Gavi 6.0 grant documents of the four priority countries; applications lodged by the eight countries outside the second-dose process; and completed-series coverage rising where polio risk sits.

4.3 Make essential immunisation a full member of the GPEI Strategy Committee

Why: The IMB made this recommendation in its last report and it was not accepted. Nothing has changed and the case has grown stronger. Integrated delivery rests on four parties: the GPEI, Gavi, UNICEF and the WHO department responsible for essential immunisation. Three of the four sit on the body through which the Polio Oversight Board's directives are implemented across the partner organisations. The fourth does not.

Action: The Polio Oversight Board should appoint the WHO Director of Immunization, Vaccines and Biologicals (IVB) a full member of the GPEI Strategy Committee, on the same footing as other members.

Accountable owner: Polio Oversight Board.

Contributing: WHO Director-General, the Chair of the GPEI Strategy Committee, Gavi and UNICEF.

By when: Decided at the first Polio Oversight Board meeting following publication, and in effect at the next Strategy Committee meeting after that decision.

How delivery will be judged: Full membership recorded in the Strategy Committee's terms of reference and published membership list.

4.4 Make subnational denominators and child registration a deliverable in their own right

Why: Coverage is a fraction whose lower half is often unknown, and several countries central to eradication have not held a census in many years. High reported coverage sits against low, or very low, field estimates.

Action: The GPEI should treat subnational denominators as a deliverable rather than a condition worked on alongside everything else. Every consequential geography should have an enumerated child population with a named source and date, revalidated periodically; every coverage figure should be published with its denominator attached; and every campaign contact should serve as a registration event. The novel type 2 oral polio vaccine birth dose should be assessed for its registration value alongside its immunological value, since a contact at birth keeps a child out of the zero-dose pool.

Accountable owner: GPEI Strategy Committee.

Contributing: WHO and UNICEF immunisation data teams, national polio programmes and national statistical authorities.

By when: Denominator source and date attached to all campaign reporting from the first round of 2027; enumerated populations established in every consequential geography by 30 June 2027.

How delivery will be judged: No coverage figure published without its denominator; a stated and dated enumeration for every consequential geography; and reported coverage above 100 per cent disappearing.

4.5 Put community evidence inside operational decisions and stop funding what cannot show effect

Why: The Polio Programme gathers a great deal of social information but changes the campaign model insufficiently. Access in every remaining reservoir is granted round by round by people and families who answer to nobody in the Polio Programme, and acceptance is usually borrowed rather than held.

Action: Every consequential geography should use a cluster-level community diagnosis to settle who delivers, what is offered, when teams visit and which local authority or provider must be engaged. The six conditions on which access depends: that the household understands what is offered; that the visit feels safe; that the provider is credible; that formal and informal permission agree; that concerns can be heard; and that the service visibly delivers value, should be assessed cluster by cluster and reported as a set that cannot be averaged. Institutional and professional refusal should be met by answering and resolving each gatekeeper's actual concerns. Social mobilisation, religious engagement and integrated-service activity should be judged on household access, newborn registration, refusals that stay converted and routine completion, and what cannot show a contribution should be redesigned or stopped.

Accountable owner: GPEI Strategy Committee.

Contributing: UNICEF, WHO, national polio programmes, implementing partners, and the development and water and sanitation agencies working in the same geographies.

By when: Revised microplans and outcome measures before the next campaign cycle in

every reservoir; portfolio review of community engagement activity within 60 days of publication.

How delivery will be judged: Operational plans changed by community evidence, with the change recorded; the six access conditions assessed cluster by cluster; and sustained improvement in household access and in refusals that stay converted.

4.6 Require context-specific gender diagnostics and minimum conditions for the frontline workforce

Why: Children go unfound through gendered patterns of household entry, disclosure, consent, caregiver availability and worker safety. More than 20,000 frontline workers may deploy in southern Afghanistan during a campaign without one woman among them, and the districts of chronic campaign failure and of male-only delivery are largely the same.

Action: Every priority microplan should establish who may enter each type of household, who knows which children are inside, who can consent, when caregivers are present and which children are likely to remain invisible, with team composition, visit timing and revisits following from that. Where women cannot vaccinate, programmes must negotiate acceptable roles for them in enumeration, communication, newborn tracking and monitoring.

Accountable owner: The National Emergency Operations Centre coordinator in each priority country.

Contributing: Subnational managers, GPEI gender and workforce leads, and the partner agencies employing frontline workers.

By when: Incorporated into all high-risk microplans from the first campaign of 2027.

How delivery will be judged: Gender analysis and small area gender access profiles that visibly

changed deployment; fewer children recorded as unavailable or never disclosed; age and sex disaggregated data collection, analysis and use mandatory.

5. ACTIONS TO SECURE THE FUNCTIONS THAT MUST KEEP THE WORLD POLIO-FREE

Transition is finished not when a plan exists or a budget line moves, but when each essential function performs under stress. Several countries will need long-term support, while surveillance, containment, stockpiles and oral vaccine withdrawal need permanent global ownership.

5.1 Replace country transition status with function-by-function readiness decisions

Why: Income thresholds and transition plans give no clear answer as to whether immunity, surveillance, outbreak response, laboratories or the workforce can perform.

Action: WHO should assess each function separately against a stress test, with defined authority, workforce and a budget executed rather than merely allocated, and should state when an outbreak pauses or reverses transition. For Chad, the Democratic Republic of the Congo, Myanmar, Sudan, Somalia and Yemen, WHO and partners should agree differentiated, costed long-term arrangements instead of assumptions of full financial exit that nobody believes.

Accountable owner: WHO Polio Transition Steering Committee.

Contributing: The relevant governments, WHO regional directors, Gavi and GPEI partners.

By when: Staffing statement within 60 days of publication; revised readiness framework by the 2027 World Health Assembly; long-term country arrangements by 30 June 2027.

How delivery will be judged: Function-specific readiness decisions replacing country status; explicit outbreak reversal rules; funded arrangements for the six countries with no credible near-term exit path.

5.2 Assign permanent ownership of global polio functions and complete containment

Why: Surveillance beyond the transition countries spans 66 countries, containment covers some 20, of which only three sit inside the transition group, and the stockpile and eventual withdrawal of bivalent oral vaccine stand alongside them. None has a clear long-term owner, staffing model or source of finance.

Action: Bring forward a permanent governance proposal assigning decision rights, staff and finance to each global function. The containment plan should carry a dated facility-by-facility route to certification with a named political owner and escalation point for each; high-level engagement to bring the United States back into independent assurance; political intervention tailored to Romania, the Netherlands and Iran rather than further technical correspondence; and a system-wide process to find, destroy or contain potentially infectious material, governed by minimisation. The Global Certification Commission should settle now what level of completion permits a declaration of global containment, and how a non-participating country would be treated.

Accountable owner: WHO Director-General for the governance proposal; Chair of the Global Certification Commission for the declaration pathway.

Contributing: Polio Oversight Board, national containment authorities and the regional certification commissions.

By when: Containment pathway, named escalation owners and United States engagement plan within 60 days of publication; governance proposal to the 2027 World Health Assembly.

How delivery will be judged: Permanent ownership and budgets assigned for each global function; dated certification plans with named political owners; every facility-retaining country back inside independent assurance; and verified inventories beyond essential facilities.
