Global Polio Eradication Initiative

Annual report 2025



World Health Organization · unicef · Rotary · CDC Centers for Disease Control and Prevention · Gates Foundation · Gavi The Vaccine Alliance

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Global Polio Eradication Initiative: annual report 2025

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Cover photo: Fractional Inactivated Polio Vaccine (fIPV) campaign, Afghanistan - October 2025
© WHO / Khesraw Omid Farooq

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Acronyms

AFP	Acute flaccid paralysis
bOPV	Bivalent oral polio vaccine
cVDPV2	Circulating variant poliovirus type 2
DTP	Diphtheria–tetanus–pertussis
EPI	Expanded Programme on Immunization
ES	Environmental surveillance
ES+	Positive environmental sample
fIPV	Fractional-dose inactivated poliovirus vaccine
FRR	Financial resource requirement
GCC	Global Certification Commission
GPEI	Global Polio Eradication Initiative
IPV	Inactivated poliovirus vaccine
LQAS	Lot quality assurance sampling
nOPV2	Novel oral polio vaccine type 2
OPV	Oral polio vaccine
POB	Polio Oversight Board
SAGE	Strategic Advisory Group of Experts on Immunization
SIA	Supplementary immunization activity
SOP	Standard operating procedure
VDPV	Variant poliovirus
WPV	Wild poliovirus

A POLIO-FREE WORLD IS WITHIN REACH

Amid conflict, shifting geopolitics and a constrained financing environment, the programme is holding the line: wild poliovirus transmission remains endemic in only two countries and is confined to a limited number of subnational geographies.

OUR IMPACT SINCE 1988



>99%
REDUCTION
in polio cases globally



20+
MILLION
people are walking today who would otherwise have been paralysed



1.5
MILLION
childhood deaths averted through vitamin A during polio activities



STRONGER HEALTH SYSTEMS
Polio-funded infrastructure continues to support disease surveillance, outbreak response and service delivery

Executive summary

In 2025, the Global Polio Eradication Initiative (GPEI) persevered in its mission to protect children from poliomyelitis (polio) and secure a polio-free world. Thirty-seven years after the World Health Assembly set the goal of eradication, the global context has changed significantly. Amid conflict, shifting geopolitics and a constrained financing environment, the programme is holding the line: wild poliovirus transmission remains endemic in only two countries and is confined to a limited number of subnational geographies.

2025 PROGRESS



WILD POLIOVIRUS
Transmission remains endemic in just **two countries**



CIRCULATING VARIANT POLIOVIRUS (cVDPV)
Outbreaks detected in **17** countries / territories



HIGH-QUALITY SURVEILLANCE
>150 countries with sensitive polio surveillance

This progress reflects one of the most extensive public health efforts in history. Since 1988, polio cases have declined by over 99%. More than 20 million people are walking today who would otherwise have been paralysed, and an estimated 1.5 million childhood deaths have been averted through the systematic administration of vitamin A during polio immunization activities (1). At the same time, polio-funded infrastructure continues to support broader health priorities, including disease surveillance, outbreak response and service delivery in underserved communities.

The year was marked by significant external pressures. Declining development assistance, protracted conflicts and operational challenges affected programme delivery in multiple settings. Despite this, governments and partners maintained their commitment to eradication. This was reaffirmed at the pledging moment hosted by the Mohamed bin Zayed Foundation for Humanity, where longstanding partners, including Rotary International and the United Arab Emirates underscored their shared commitment to completing eradication.

In response to this dynamic environment, the programme developed the GPEI Action Plan 2026 (2) (Box 1) to align programme priorities with available resources, with a focus on interrupting endemic transmission, stopping outbreaks and improving the efficiency and accountability of operations.

The tools to eradicate polio remain effective. Progress depends on ensuring that proven interventions reach the communities that are currently missed, particularly in areas affected by insecurity, population movement and limited access to services.

In the remaining endemic countries, Pakistan and Afghanistan, wild poliovirus type 1 transmission is concentrated in defined geographical areas, including southern Afghanistan and parts of Khyber Pakhtunkhwa, Karachi and Quetta in Pakistan. Programme strategies include sustaining highly sensitive poliovirus surveillance (including environmental surveillance), supplementary immunization campaigns and additional targeted vaccination for high-risk geographies, alongside continued cross-border coordination.

Several areas made progress in reducing circulating variant poliovirus outbreaks, with a declining trajectory in cases in most countries. Significant progress was noted in countries including Angola, the Democratic Republic of the Congo, Djibouti, Ethiopia, Guinea, Indonesia and Papua New Guinea, as well as in the Gaza Strip. Remaining transmission is concentrated in a limited number of high-risk areas, notably in northern Nigeria, the lake Chad basin and Yemen. Experience across diverse settings—including humanitarian pauses enabling vaccination in the Gaza Strip and tailored outreach in Papua New Guinea—continues to demonstrate that outbreaks can be interrupted when interventions are implemented at scale.

WHAT'S WORKING



TARGETED IMMUNIZATION
Tailored campaigns reaching the most underserved and highest-risk communities



STRONG SURVEILLANCE
Early detection through AFP and environmental surveillance



RAPID OUTBREAK RESPONSE
Risk-based, data-driven response to stop outbreaks quickly



COMMUNITY TRUST & PARTNERSHIPS
Working with communities and partners to deliver and protect every child

Recent detections of poliovirus in environmental samples, including in Europe, reinforce that polio remains a global risk until eradication is achieved. As such, international spread of poliovirus continues to be classified as a Public Health Emergency of International Concern in accordance with the International Health Regulations (2005).

At the same time, preparations for a post-eradication world continued. The Sustaining a polio-free world: a strategy for long-term success (3) was finalized through consultation with Member States and partners, outlining how critical functions such as surveillance, outbreak response and containment will be maintained following eradication. Transition efforts continued at the country level, with a focus on updating and implementing national transition plans to reflect changes in operational context. The first three global containment certificates were awarded in 2025 to facilities in Belgium, Denmark and the Republic of Korea, reflecting country commitment to long-term risk reduction.

Polio eradication remains a collective effort. The task ahead is to ensure that all children are reached, that transmission is interrupted, and that the systems built through eradication continue to deliver broader health benefits. The outcome is within reach, but sustained commitment is required to achieve and maintain a polio-free world.

In 2025, more than 350 million children were vaccinated multiple times, with more than 924 million doses of polio vaccine, during 117 supplementary immunization activities (SIAs) in 28 countries[a].

[a] Data in 2025, WHO/HQ

01 Permanently interrupt wild poliovirus transmission in endemic countries and stop circulating variant poliovirus and prevent outbreaks

1.1 Overview of current epidemiological situation

In 2025, both endemic wild poliovirus type 1 (WPV1) transmission and circulating variant poliovirus type 2 (cVDPV2) transmission declined in both geographical spread and number of cases. In 2025, 52 cases of WPV1 were reported (31 from Pakistan and 21 from Afghanistan); three cases of cVDPV1 from three countries; 228 cases of cVDPV2 from 16 countries; and 15 cases of cVDPV3 from four countries[b]. Transmission is now concentrated in a limited number of core areas:

WPV1

Key epidemiological corridors, spanning:

- Southern Afghanistan;
- Key districts of southern Khyber Pakhtunkhwa, Karachi and Quetta in Pakistan.

cVDPV2

- Lake Chad basin, particularly northern Nigeria;
- Northern Yemen and south-central Somalia in Horn of Africa.

Programme response

Response strategies have become ever-more targeted and risk-based, focusing on:

- rapid detection and genetic sequencing;
- prioritization of the highest-risk areas;
- tailored operational approaches;
- stronger performance monitoring.

For cVDPV2 response, expanded use of novel oral polio vaccine type 2 (nOPV2), integration with routine immunization and improved campaign execution have contributed to faster outbreak control.

Surveillance and laboratory strengthening

Despite challenges, surveillance capacity continued to expand:

- environmental surveillance systems are now operating in nearly all countries in the WHO African Region;
- over 600 000 active surveillance visits were conducted in 2025[c];
- laboratory sequencing capacity increased, reducing turnaround times and improving response speed.

These systems enable earlier detection and faster response to emerging outbreaks.

[b] Weekly, updated case data is available at www.polioeradication.org/about-polio/polio-this-week/
[c] Data in 2025, WHO/HQ

Operational challenges

Remaining transmission is concentrated in fragile settings with:

- low routine immunization coverage;
- insecurity and access constraints;
- high population movement.

These factors require sustained, high-quality implementation to interrupt transmission.

Outlook

The concentration of transmission in a limited number of areas provides a clear operational focus. Strengthening results and interrupting transmission in these core zones will significantly reduce global risk.

Box 1. GPEI Action Plan

The 2026 GPEI Action Plan (2) marks a decisive step to strengthen the programme's ability to deliver results, in the context of broader political and financial upheavals in global health and with a 30% budget reduction. The Action Plan translates strategic priorities set out in the 2022-2029 GPEI Strategy (4, 5) into a streamlined set of high-impact actions. It reflects extensive analysis of epidemiological trends, operational performance, and financial realities, and represents a collective commitment by partners to sharpen focus, improve efficiency and protect core eradication functions while sustaining momentum towards a polio-free world.

Key elements of the plan comprise:

- Endemics: Resources are being directed to continue intensive nationwide campaigns and surveillance in the last two endemic countries - Pakistan and Afghanistan. The most effective innovations to address local challenges are being focused in five subnational areas in Pakistan and two in Afghanistan that drive transmission. Stronger engagement with the Expanded Program on Immunization (EPI) and Gavi, the Vaccine Alliance to reach children who have received no vaccines of any kind ('zero-dose') and stronger cross-border coordination will remain essential.
- Variant polioviruses: Outbreak response and surveillance resources are being focused on countries and subregions where they can have the most impact in 2026. These regions include southern and central Africa, where outbreaks can be most quickly stopped, and the Horn of Africa and lake Chad basin, where the virus is most persistent and children remain at the greatest risk of encountering and spreading it. Operations are being streamlined at every level and local teams are being equipped to respond to outbreaks more effectively—not only for polio, but for other health challenges too.

02 Permanently interrupt wild poliovirus transmission in endemic countries

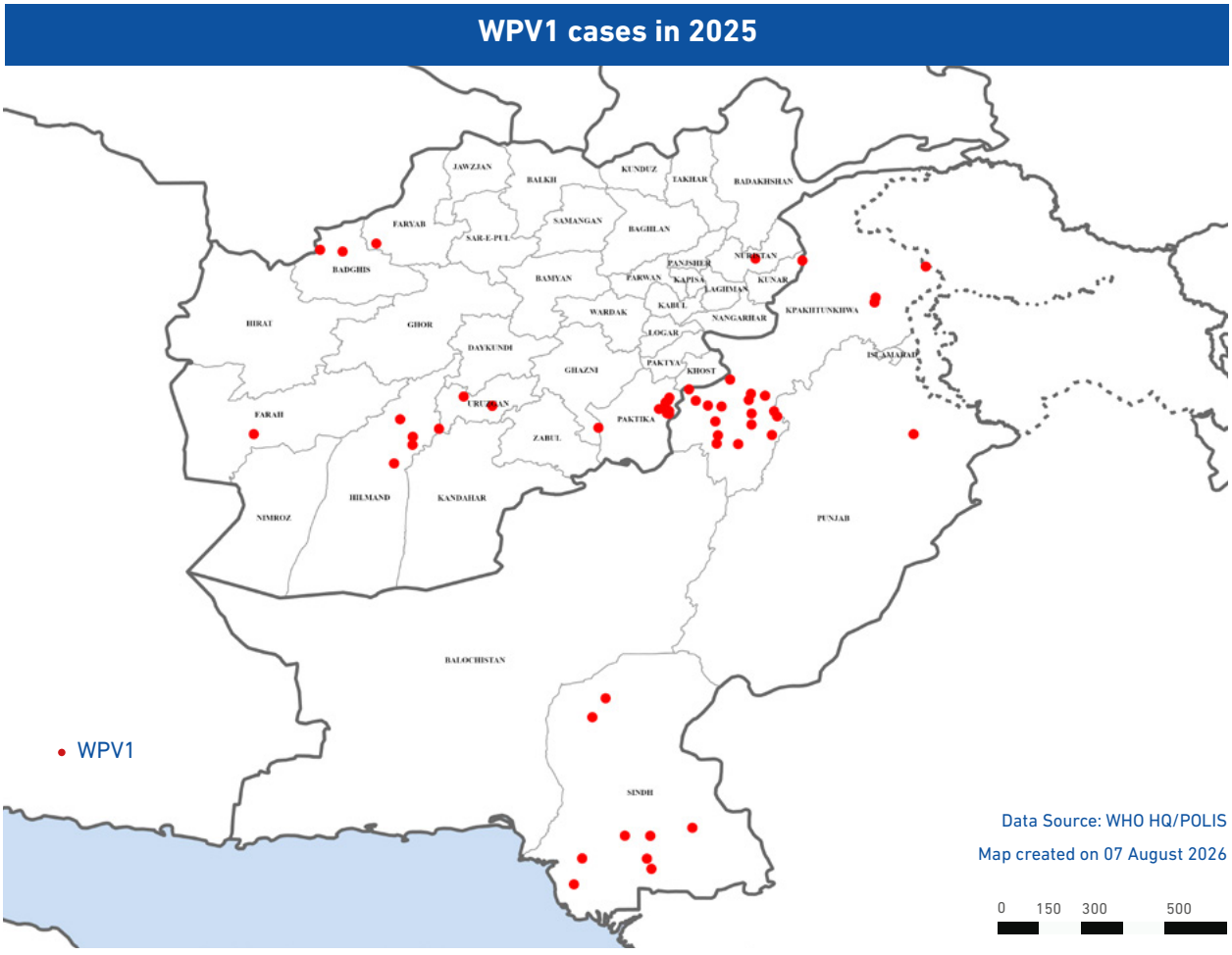
2.1 Pakistan and Afghanistan: narrowing the final reservoirs

Transmission of WPV1 in the last two endemic countries has shrunk to a few epidemiological corridors, primarily spanning southern Afghanistan and key districts of southern Khyber Pakhtunkhwa, Karachi and Quetta in Pakistan (Fig 1).

While environmental surveillance continues to detect virus beyond these areas, genetic sequencing suggests that such detections reflect population movement rather than the establishment of new reservoirs.

Today, both countries operate among the most sensitive poliovirus surveillance systems in the world. Environmental sampling has expanded significantly in reach, frequency and laboratory sensitivity, putting in place the infrastructure that can enable detection of virus earlier and more precisely than ever before. New detections increasingly reflect the strength of surveillance, not expanding transmission.

Fig.1. Wild poliovirus type 1 (WPV1) cases reported in 2025



2.2 Why the final reservoirs remain complex



WHO supported a Subnational Polio Vaccination Campaign launched across 19 provinces in Afghanistan - July 2025
© WHO / Khesraw Omid Farooq

Interrupting transmission in the remaining endemic areas is fundamentally different from eradicating polio in high-income settings. The final reservoirs combine multiple overlapping risk factors that create an epidemiological "perfect storm":

- Dense, urban settings, where even small gaps in vaccination coverage translate into hundreds of thousands of missed children;
- Challenging environmental conditions, including poor sanitation and flooding, both of which facilitate faecal–oral transmission;
- Malnutrition and recurrent diarrhoeal disease, which can reduce vaccine effectiveness and require repeated doses to achieve protection;
- High population mobility, including seasonal labour migration and cross-border movement between Pakistan and Afghanistan;
- Gender-specific barriers, including unequal household access when vaccinators or monitors are male, and gendered caregiving and decision-making, where women provide care but men decide on whether to accept vaccination for their children;
- Operational constraints, including insecurity, remote terrain, cold chain limitations and infrastructure gaps.

Snapshot of supplementary immunization activities – Afghanistan and Pakistan, 2025

During 2025, 57.4 million children were immunized multiple times, using 317.2 million doses of bivalent OPV, during 17 supplementary immunization campaigns across Afghanistan and Pakistan. To reach interruption of virus, the two countries are focusing on areas including improvements to cross-border coordination, increased integration with measles and rubella, and increased use of fractional-dose IPV.

In Afghanistan, intensified site-to-site vaccination, strengthened transit vaccination and sustained gender-responsive community engagement have improved campaign quality, particularly in eastern provinces. Continued advocacy supports access and acceptance in more complex southern areas.

In Pakistan, implementation of the National Emergency Action Plan is strengthening political oversight, supervision and accountability mechanisms. Campaign quality has improved overall, though sub-provincial variation remains in key transmission zones.

Both countries are applying increasingly sophisticated risk-based approaches to identify and reach persistently missed children, including migrants and mobile populations. Core strategies include:

- detailed household-level microplanning;
- expansion of women vaccinators and locally recruited outreach workers;
- community-led vaccination initiative and Integrated Service Delivery approach for security-compromised areas or for underserved, highly vulnerable populations;
- targeted use of fractional-dose inactivated poliovirus vaccine (fIPV) in under-protected populations;
- vaccination of older age groups in specific hotspots;
- strengthened subnational surveillance;
- integration with nutrition, diarrhoeal disease management and basic health services to improve community trust;
- Gender-responsive community engagement;
- safeguarding of women vaccinators.

Through these tailored approaches, endemic transmission has become more geographically restricted than ever before.

03 Stopping circulating variant poliovirus and preventing new outbreaks

In 2025, the programme continued to reduce the geographical spread and intensity of circulating variant poliovirus type 2 (cVDPV2) transmission. While outbreaks persist, transmission is increasingly concentrated in a limited number of core geographies rather than widespread across multiple regions.

Today, the majority of cVDPV2 transmission is driven by three primary zones:

- Northern Nigeria and the Lake Chad basin (Fig 2);
- the Horn of Africa (Fig 3);
- Yemen (Fig 3).

From these areas, most other detections in surrounding countries can be directly or indirectly linked through population movement and immunity gaps. This epidemiological concentration underscores a critical reality: stopping transmission in these core zones will significantly reduce global risk.

At the same time, there has been notable progress. Transmission in Indonesia was interrupted. In the Democratic Republic of the Congo, cases declined dramatically, with transmission now largely contained to localized areas after years of intense response efforts.

Fig.2. Circulating variant poliovirus type 2 (cVDPV2) and circulating variant poliovirus type 3 (cVDPV3) cases reported in 2025 in northern Nigeria and the lake Chad basin

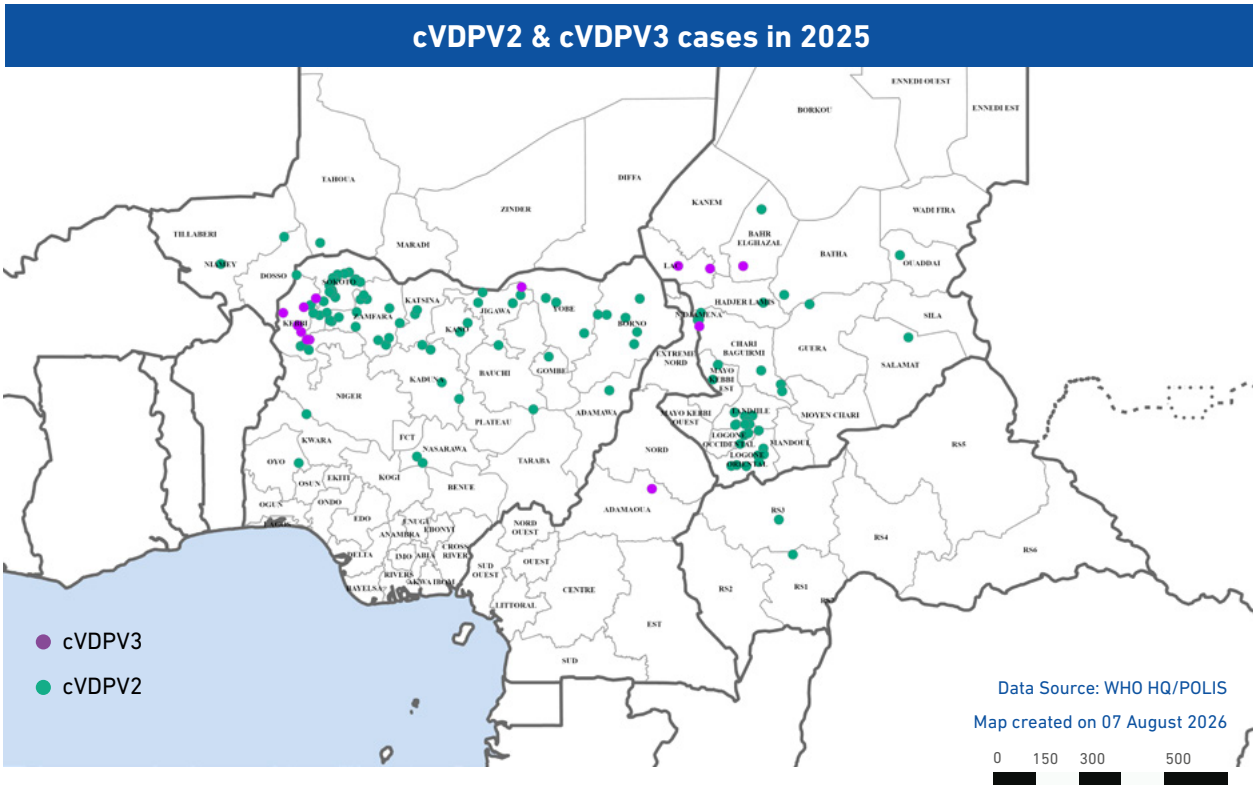
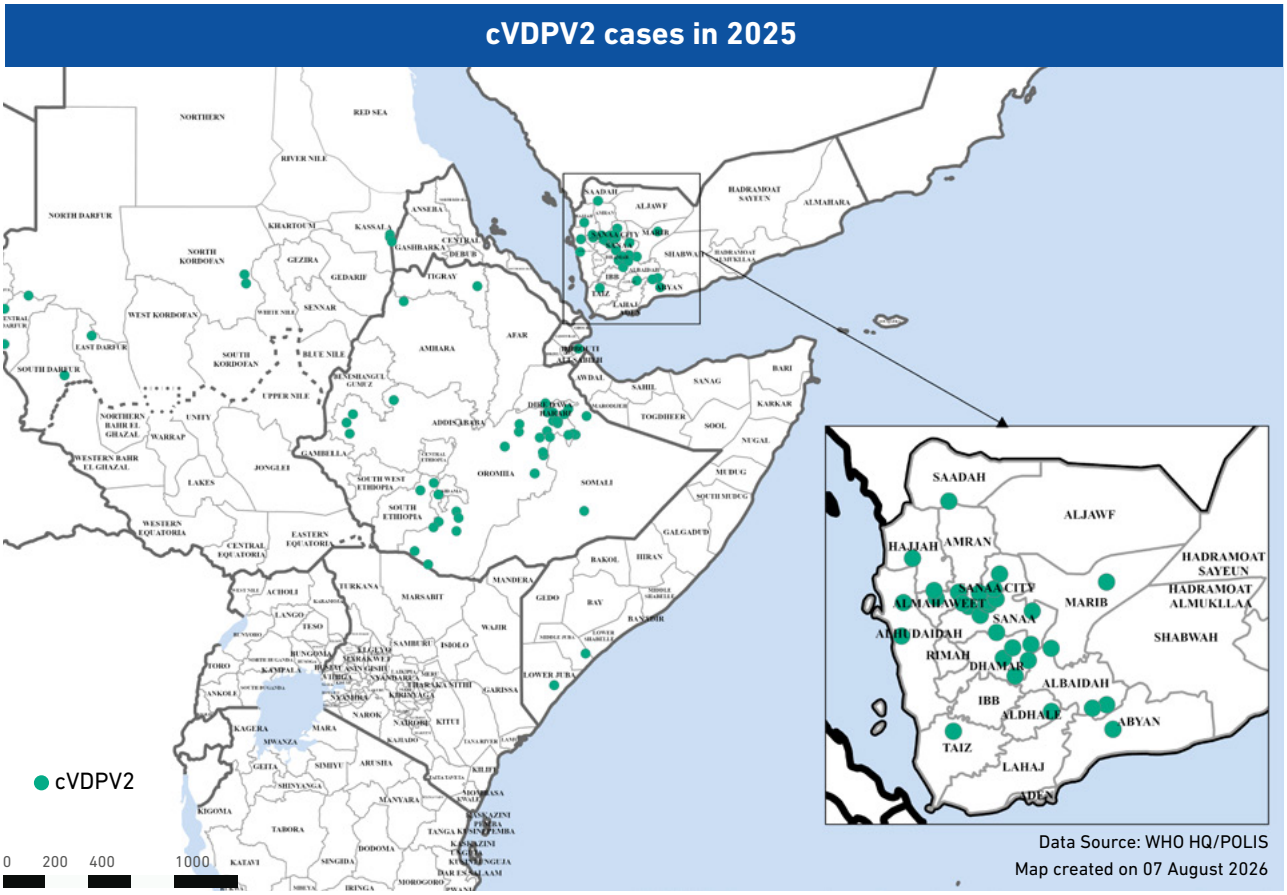


Fig.3. Circulating variant poliovirus type 2 (cVDPV2) cases reported in 2025 in the Horn of Africa and Yemen



3.1 Why outbreaks persist: immunity gaps in fragile settings

Variant poliovirus outbreaks occur where population immunity is low, mainly due to persistently low routine immunization coverage. Additionally, transmission zones are characterized by complex humanitarian conditions, insecurity, large-scale population movement and access constraints.

These settings create conditions in which the virus can circulate for prolonged periods if routine vaccination coverage or outbreak response is suboptimal. As with wild poliovirus, the final chains of variant transmission are not driven by biological barriers but by operational and geopolitical realities.

3.2 What is working: targeted, risk-based outbreak response

In response, the GPEI has refined its outbreak strategy to become more targeted, risk-based and operationally precise. Updated outbreak response Standard Operating Procedures (SOPs) (6) (Box 2), aligned with the 2026 Action Plan, emphasize:

- Rapid detection and genetic analysis to pinpoint transmission pathways;
- Prioritization of the highest-risk geographies rather than diffuse responses;
- Tailored approaches adapted to local realities;
- Stronger accountability and implementation tracking to ensure campaign quality.

Recent experiences demonstrate that these targeted approaches work when fully implemented:

- In the Gaza Strip, despite active conflict and displacement, negotiated humanitarian pauses enabled rapid vaccination and strengthened surveillance, successfully bringing the outbreak under control.
- In Papua New Guinea, innovative approaches to reach children in extremely remote terrain have contained transmission in challenging geographic conditions.

The expanded use of nOPV2, use of fIPV strategies where pertinent, and improved integration with routine immunization continue to strengthen both rapid outbreak control and longer-term immunity. Of polio campaigns undertaken in 2025, seven included "plusses" such as soap or diapers, and 52 included other antigens / health interventions, often focused on routine immunization or Vitamin A delivery[d]. This represents around 50% of all campaigns undertaken.

Global risk remains until transmission is stopped everywhere

Despite progress, all countries remain at risk until variant poliovirus transmission is fully interrupted. Recent detections in countries outside the main transmission zones — including in European wastewater surveillance systems — reinforce a central truth of eradication: poliovirus anywhere remains a risk everywhere.

A key challenge remains the timely detection of viruses from every source. In 2025, existing geopolitical challenges, particularly in areas of conflict, led to delays in timely detection of viruses, although overall reporting of AFP cases and collection of environmental samples remains high (Fig 4; Fig 5). In the endemics, interim solutions were found, in particular in eastern Afghanistan, for timely shipment of samples to laboratories. Additionally, the programme is continuing to explore and develop measures to help rapidly identify subnational surveillance and detection gaps. Such measures include increased roll-out of environmental surveillance, retrospective searches for AFP cases in health centres, sampling of older age groups, evaluating new direct detection techniques, and scaling up capacity within the Global Polio Laboratory Network. In outbreak contexts, strengthened disease surveillance measures now form an integrated aspect of updated poliovirus outbreak response SOPs, launched in early 2026 (6) (Box 2). Collectively, these measures have led to significant improvements in timely detection of polioviruses in some areas in the early part of 2026. However, further efforts will be required to mitigate surveillance gaps in other areas, including countries with limited access, such as Yemen.

[d] Data in 2025, WHO/HQ

Box 2. New outbreak response standards to stop polio faster

As the world moves closer to polio eradication, stopping outbreaks quickly and decisively has never been more important. To reflect evolving epidemiology, new scientific evidence and years of operational experience, the Global Polio Eradication Initiative has updated its poliovirus outbreak response SOPs (6).

The updated SOPs sharpen how countries detect, assess and respond to poliovirus outbreaks — with a particular focus on the type 2 outbreaks that now account for most global transmission. They introduce clearer outbreak definitions, stronger risk assessment and more tailored response strategies, helping programmes close immunity gaps faster and prevent outbreaks from becoming prolonged.

At the heart of the updated guidance is a simple goal: protect children more rapidly and interrupt transmission more reliably, even in the most challenging settings. The SOPs also strengthen implementation tracking, making it easier to identify and address operational gaps before outbreaks become entrenched.

While these updated standards provide clearer direction and better tools, their impact ultimately depends on strong national ownership and high-quality implementation. Used well, they will help countries respond smarter, faster and more effectively — bringing the world closer to a lasting polio-free future.

Fig.4. Acute Flaccid Paralysis cases reported in 2025

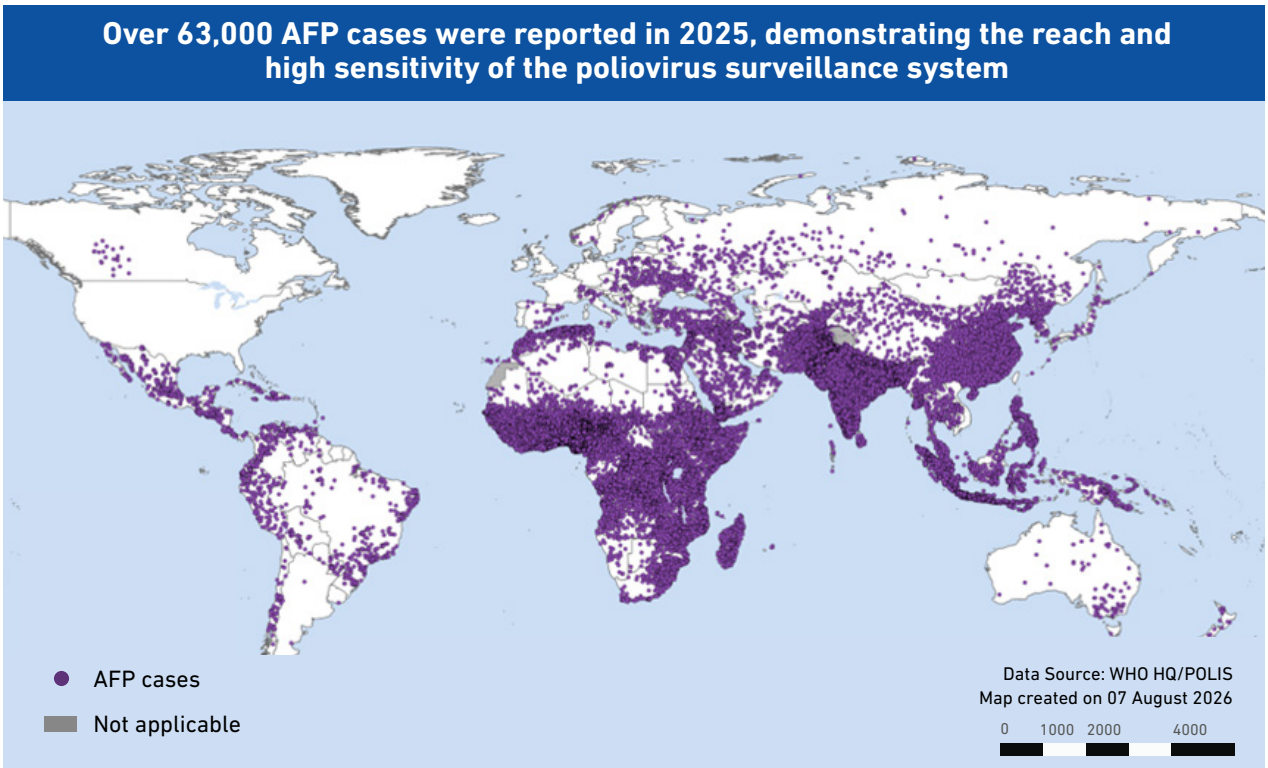
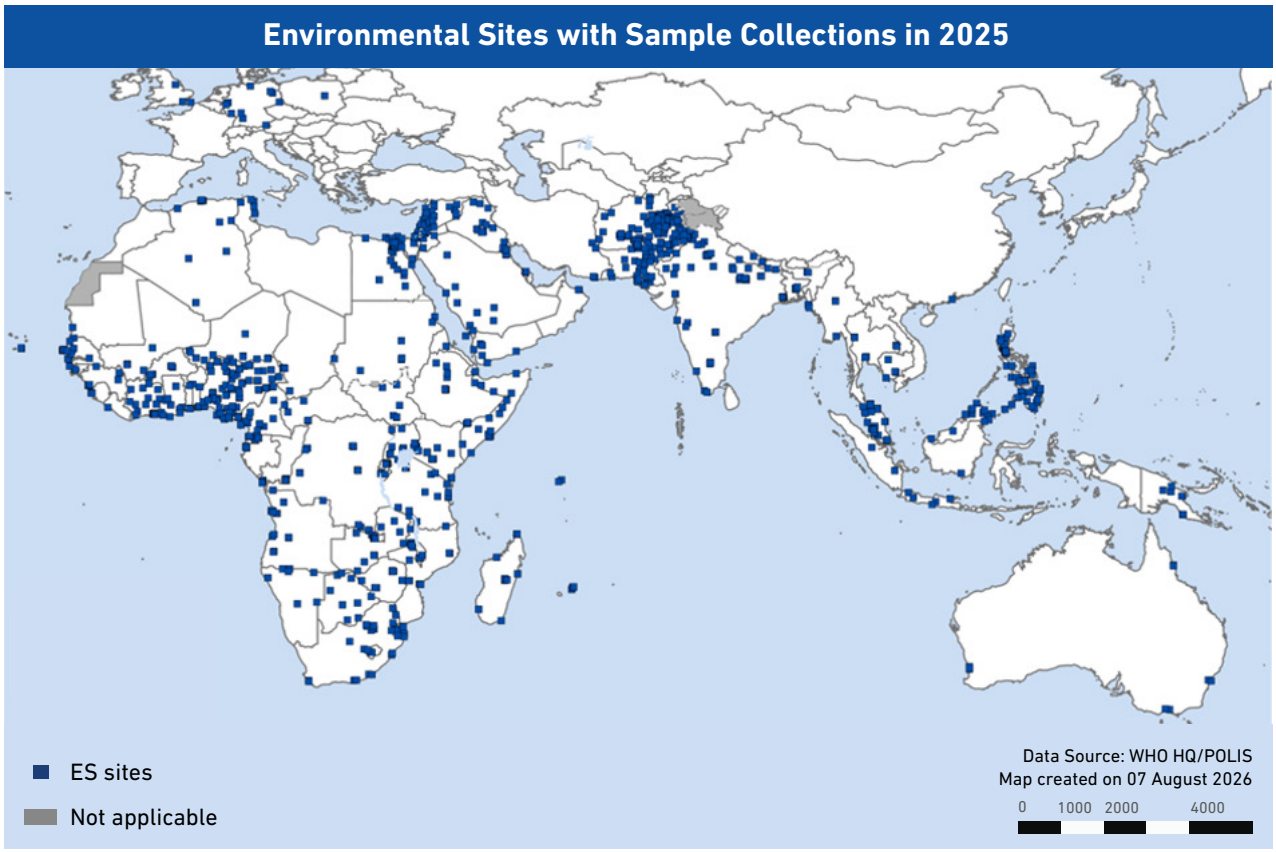


Fig.5. Environmental Sites with Sample Collections in 2025





WHO, UNICEF and MoPHP launch a second round of polio vaccination in Government of Yemen-controlled areas © WHO

04 Enabling areas

4.1 Gender

Key progress made against the GPEI Gender Equality Strategy (7) during 2025 is summarized below (Box 3; Table 1).

Box 3. Progress against the GPEI Gender Equality Strategy in 2025

Result	Progress in 2025
Result 1: The GPEI designs and implements gender-responsive programming and applies a gender perspective into its interventions	• Tangible progress demonstrated by countries in integrating gender considerations informed by gender analysis and operational evidence into campaign design, microplanning, supervision and social and behaviour change strategies in Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Djibouti, Mozambique and Yemen. These approaches directly addressed restrictive gender norms, unequal household decision-making and provider bias through tailored community engagement, peer-based outreach, men and youth engagement. • In Mozambique and Yemen, gender responsive community engagement strengthened acceptance and follow through, contributing to increased coverage and districts passing LQAS assessments. • In Cameroon and the Democratic Republic of the Congo, institutionalized gender integration through youth engagement and EPI training systems improved access, provider attitudes and caregiver trust, helping reduce missed and zero-dose children. • In Chad and Djibouti gender-informed microplanning enhanced identification of hard-to-reach children and improved campaign quality. • Across Djibouti and Sudan, women leaders including women religious leaders and community volunteers were engaged as trusted advocates, expanding acceptance and demand for immunization. • In Burundi, comprehensive gender reforms contributed to a dramatic decline in zero-dose children from nearly 36 000 in 2023 to 53 in 2025 supported by measurable improvements in gender equitable attitudes and fathers' engagement.
Result 2: GPEI leadership, structures and systems support gender-responsive programming and gender-sensitive approaches	• Structural reforms, such as the rollout of anti-harassment guidelines and inquiry committees in Pakistan, advanced retention and safety of women frontline workers. • Expanded participation of women frontline workers in the East Region of Afghanistan, enabling access to households otherwise unreachable by male teams, contributed to a sharp reduction in missed children. • In Cameroon and Chad, women were strengthened as gender champions and focal points within EPI systems, reinforcing leadership and coaching roles. • The Prime Minister's Focal Point for the Polio Eradication Programme in Pakistan, and the WHO Regional Director for the Eastern Mediterranean became gender champions.
Result 3: The GPEI is closer to gender parity and increases women's meaningful participation and agency at all levels of the partnership	• National-level Emergency Operations Centers in Pakistan and Afghanistan show a gradual increase in women's meaningful participation in decision-making forums, reaching 29% and 19%, respectively. In outbreak-affected countries, particularly in the WHO African Region, there has also been a steady increase in women's representation in surge deployments, with women comprising 24% of international surge staff and 32% of national surge deployments. • In Nigeria, gender-responsive supervision models increased women's representation as team supervisors and independent cluster monitors, strengthening accountability, reach and vaccination coverage.

Table 1. An overview of GPEI performance on gender mainstreaming key performance indicators

Gender Specific KPI	Target	Applicability	Pakistan	Afghanistan	WHO African Region
% polio vaccination missed girls	2% or less	Endemics	2.16%	9%	5%
% of polio vaccination missed boys	2% or less	Endemics	1.88%	9%	4%
Polio vaccination coverage of girls	90%+	Endemics	97.87%	92%	95%
Polio vaccination coverage of boys	90%+	Endemics	98.11%	92%	96%
Stool adequacy targets in girls, acute flaccid paralysis (AFP)	90%+	Endemics	88%	95%	91%
Stool adequacy targets in boys AFP	90%+	Endemics	89%	95%	92%
Percentage of women frontline health workers	Afg: 50% Pak: 90%	Endemics Optional for Outbreak	59%	22%	53%
Percentage of women in National Emergency Operations Centre	50%	Endemics	29%	19%	N/A
Percentage of women in National Surge Deployment	50%	Outbreak	N/A	N/A	32%
Percentage of women in International Surge Deployment	50%	Outbreak	N/A	N/A	24%

4.2 Climate change



Health workers during a polio vaccination campaign in Kenya
© WHO / Genna Print

Extreme weather events linked to climate change continue to impact polio eradication activities. Operations are continuously adapted as much as possible to ensure that vaccination campaigns and surveillance activities can proceed. The GPEI is incorporating climate-change risk into its risk and performance monitoring. Additionally, GPEI published a technical brief with concrete recommendations on how to build a climate-resilient GPEI, some of which are being implemented by the programme (8).

05 Transition and legacy

Governments continue to prepare for a polio-free world, guided by the Polio Transition Strategic Framework and insights from the Transition Independent Monitoring Board. During 2025, the first set of results against the 2024 baseline were received from the Polio Transition Monitoring and Evaluation Framework (9). This framework tracks progress against strategic and milestone indicators to measure health system strength and ability for countries to transition polio functions to national health systems. Results from the first quarter of 2026 reporting show that the greatest challenges remain in the WHO African Region, where most priority countries will require additional support to take on and sustain functions as we approach eradication. Routine immunization coverage remains low, with coverage of inactivated poliovirus vaccine (IPV) and the third dose of diphtheria–tetanus–pertussis (DTP) on average 70% in priority countries in 2024, far from the 90% target (9, 10). Acute flaccid paralysis (AFP) surveillance sensitivity is relatively high, with 85% of priority countries on or near the target. However, timeliness and sensitivity of environmental surveillance show gaps in several countries. Gaps also remain in health emergency management capacities, with 52% of priority countries reporting indicators below the respective regional averages.



Polio vaccination Campaign Djibouti - 13 April 2025
© WHO / Hamza Awaleh

Overall, most of the priority countries still rely on external partners for managing and financing essential functions, such as immunization, surveillance and outbreak response. However, during 2025, countries in the WHO African Region, such as South Sudan, began updating their national transition plans to reflect operational and contextual changes. In South-East Asia, transition progress is overseen by the Regional Certification Commission. Last year, India progressed to the next stage of their transition plan, with functions managed and funded by the national government. In the WHO Eastern Mediterranean Region, steps forward are also being made. During 2025, the Syrian Arab Republic fully transitioned out of GPEI financial support for sustaining essential functions. However, liabilities remain in all three regions, especially in conflict-affected and fragile countries such as Chad, the Democratic Republic of the Congo, Myanmar, Somalia, Sudan and Yemen. Most countries with fragile health systems are expected to enter an intermediate transition phase, in which they continue to receive time-limited mid- or long-term technical, operational and financial support from external partners while progressively building national capacity and ownership.

5.1 Sustaining a polio-free world

A major undertaking in 2025 was the finalization of the Sustaining a polio-free world: A strategy for long-term success (3). This strategy updates the Polio Post-Certification Strategy (11) and outlines the long-term actions required to safeguard eradication once achieved, including efforts to vaccinate against polio in routine immunization systems, monitor for polio in wider disease surveillance, prepare for and respond to any outbreaks, and contain polioviruses in laboratories. During 2025, an extensive consultation was undertaken with Member States, GPEI partners and other stakeholders to ensure that the final strategy reflects national priorities and is fully aligned with the latest approaches and research guiding the programme. Significantly, the strategy elaborates on possible options and outlines considerations for new governance and accountability structures that will be required as GPEI evolves during the period following certification of eradication, principally to oversee the cessation of bivalent oral polio vaccine (bOPV) in routine immunization, and certification of the elimination of variant poliovirus types 1 and 3 as well as the global certification of all poliovirus types. Costing has also been included to enable long-term strategic planning. Following the presentation of the strategy to the World Health Assembly in 2026, initial implementation planning will begin through the second half of 2026, aligned with transition activities and eradication timelines, as well as the joint WHO-GPEI response to the recommendations of the eighth report of the Transition Independent Monitoring Board.

5.2 OPV cessation

A critical component of preparations for a polio-free world is the successful withdrawal of OPV from routine immunization globally. In 2025, a policy framework for OPV cessation was finalized and endorsed by the Strategic Advisory Group of Experts on Immunization (SAGE) (12,13). The framework outlines guiding principles, defines triggers—non-negotiable conditions that must be met—and identifies enabling factors that will minimize the risk of failure during cessation. In April 2025, WHO regional offices initiated consultations on preparations for OPV cessation, and these discussions will continue into 2026. In the event that eradication of wild poliovirus type 1 or elimination of circulating variant poliovirus type 2 is delayed, contingency measures for a delayed cessation scenario will be developed during 2026.

GPEI continued to support research with the objective to provide tools and data to help accelerate and sustain poliovirus eradication. In 2025, significant progress was made in development of novel OPV and IPV-like vaccines such as virus-like particle vaccines. Clinical data from several trials supported policy decisions of SAGE on optimization of routine immunization and outbreak response strategies.

06 Containment

Member States continued to advance implementation of poliovirus containment during 2025, and while progress remained uneven, an encouraging acceleration was observed in the latter part of the year, with three certificates of containment awarded by the Global Certification Commission Containment Working Group in late 2025. Following the deadline set by the Global Certification Commission of the Eradication of Poliomyelitis[e] in November 2023 and reconfirmed in October 2025, all facilities retaining poliovirus materials are expected to achieve full containment certification by the end of 2026 through the issuance of a certificate of containment. By end 2025, 22 Member States reported retaining infectious poliovirus materials across 72 designated poliovirus-essential facilities. The three facilities in three countries (Belgium, Denmark and the Republic of Korea) that obtained certificates of containment in 2025 demonstrated leadership and compliance with the WHO Global Action Plan for Poliovirus Containment (GAPIV) (14), highlighting that certification is attainable with sustained national commitment and strong regulatory oversight.

Building on the progress achieved in 2025, 2026 represents a critical opportunity to reinvigorate country momentum and accelerate progress towards full poliovirus containment certification. With the end-2026 deadline for achieving full containment certification set by the Global Certification Commission fast approaching, sustained, targeted and well-coordinated efforts will be essential to support Member States in overcoming remaining technical, operational and policy-level barriers.



Nationwide polio vaccination campaign of 2025, Pakistan - February 2025 © WHO

[e] Global Commission for Certification of the Eradication of Poliomyelitis (GCC) is an independent body that oversees the process for certifying the world as polio-free.

07 International commitment: sustaining momentum in a challenging financial landscape

The financing of the GPEI in 2025 reaffirmed continued global commitment to ending polio, even as the broader landscape for overseas development assistance becomes increasingly constrained. Governments, philanthropic partners and communities continue to support the eradication effort, while the programme is adapting to ensure maximum impact, efficiency and accountability in the use of resources (Table 2).

Declining development assistance and competing global priorities require a more focused, strategic and results-driven approach. The GPEI Action Plan 2026 (2) reflects this shift, prioritizing the highest-risk geographies, strengthening performance management and ensuring that investments translate into measurable epidemiological impact.

7.1 A milestone year for resource mobilization

In December 2025, the Investing in Humanity: Uniting to End Polio pledging event in Abu Dhabi marked a major milestone for the eradication effort. Convened by the Mohamed bin Zayed Foundation for Humanity in partnership with GPEI, the event mobilized US$ 1.9 billion in support of polio eradication, including US$ 1.2 billion in new pledges.

Contributions came from a broad coalition of partners, including national governments, philanthropic organizations and long-standing supporters such as Rotary International and the Gates Foundation. This collective effort demonstrated strong global alignment behind the goal of eradication.

In the current financing environment, translating pledges into disbursements remains a critical priority. Ensuring that announced commitments are fully realized will require sustained engagement, continued demonstration of programme impact and close collaboration with donors.

Sustained leadership from partners

Rotary International and the Gates Foundation continued to play a central leadership role in 2025, including through a renewed commitment to raise up to US$ 450 million over three years. Rotary's global network remains a cornerstone of the eradication effort, mobilizing political support, financial resources and public awareness in countries around the world. To this end, Rotary International's Mike McGovern has recently taken over as Chair of the GPEI Polio Oversight Board.

World Polio Day 2025 once again demonstrated the strength and reach of this global movement, with activities ranging from community-level engagement to high-level national advocacy, reinforcing polio eradication as a shared global priority.

Expanding regional leadership and solidarity

The year also highlighted growing leadership from countries in the WHO Eastern Mediterranean Region. The Polio Legacy Challenge[f], led by the Governments of Qatar, Saudi Arabia and the United Arab Emirates, demonstrated strong regional commitment to supporting Afghanistan's health system and advancing eradication efforts.

Regional and cross-border collaboration continues to play a critical role in both endemic and outbreak settings. From synchronized vaccination campaigns to coordinated surveillance and outbreak response, these partnerships reinforce the principle that poliovirus transmission can only be stopped through collective action.

Impact of contributions

Contributions in 2025 supported large-scale immunization and surveillance activities across more than 40 countries, enabling the programme to:

- reach more than 350 million children with polio vaccines;
- maintain some of the most sensitive disease surveillance systems globally (~248 000 samples processed in 2025 across the Global Polio Laboratory Network);
- respond rapidly to outbreaks in fragile and conflict-affected settings (88 outbreak response campaigns conducted across 22 countries in 2025).

These investments not only protect children from paralysis but also strengthen broader health systems and global health security capacities. The GPEI is grateful for the generous contributions from donors and partners in 2025, which helped to immunize more than 350 million children against polio and strengthen the health emergency and pandemic preparedness response systems needed to tackle future health threats. Their long-standing support is critical to achieving a polio-free world.

7.2 Adapting to a changing financing landscape

In response to evolving global conditions, the GPEI is strengthening its approach to resource mobilization and financing. This includes:

- broadening the donor base and engaging new partners;
- exploring innovative financing approaches;
- aligning more closely with routine immunization and health system strengthening efforts;
- contributing to broader global health reform discussions.

These efforts aim to ensure that eradication is achieved efficiently and that progress can be sustained over the long term.

Looking beyond eradication: sustaining a polio-free world

As the world moves closer to interrupting transmission, planning for the post-eradication phase is accelerating. The Sustaining a polio-free world strategy (3) estimates global resource needs of US$ 6.9–8.7 billion over the coming decade to maintain essential functions, including surveillance, outbreak preparedness and vaccine stockpiles.

Ensuring sustainable financing for these functions will be critical to protect the gains achieved and prevent resurgence.

[f] The Polio Legacy Challenge is a results-based financing initiative to support polio eradication and strengthen health systems in Afghanistan.

08 Contributions in 2025

Table 2. Contributions to the GPEI, 2025

Donors	Amount in USD
G7 countries & European Commission	
European Commission[a]	US$ 69 665 000
United States of America[b]	US$ 68 190 000
Canada	US$ 38 075 000
Germany	US$ 34 339 000
United Kingdom of Great Britain and Northern Ireland	US$ 13 515 000
Japan	US$ 6 055 000
Sub-total	US$ **229 837 000**
Non-G7 OECD countries	
Australia	US$ 8 618 000
Republic of Korea	US$ 1 000 000
Luxembourg	US$ 781 000
Spain	US$ 115 000
Austria	US$ 59 000
Türkiye	US$ 20 000
Sub-total	US$ **10 591 000**
Other donor countries	
Saudi Arabia	US$ 100 000 000
Brazil[c]	US$ 500 000
Monaco	US$ 110 000
Sub-total	US$ **100 610 000**
Private sector / non-governmental donors	
Gates Foundation[a,d]	US$ 341 283 000
Rotary International[d]	US$ 150 467 000
Mohamed bin Zayed Foundation for Humanity	US$ 33 089 000
Gates Philanthropy Partners (High Networth Individuals)	US$ 33 500 000
Islamic Food and Nutrition Council of America	US$ 600 000
United Nations Foundation	US$ 50 000
Sub-total	US$ **458 642 000**
Multilateral sector	
European Investment Bank[a]	US$ 139 330 000
Islamic Development Bank / Government of Pakistan[e]	US$ 40 000 000
Sub-total	US$ **40 000 000**
Domestic resources	
Algeria[f]	US$ 8 301 000
Nigeria[f]	US$ 12 693 000
Sub-total	US$ **20 993 000**
Grand Total	**US$ 860 673 000**

[a] In October 2023, the European Commission (EC), European Investment Bank (EIB) and the Gates Foundation announced a groundbreaking financing partnership to provide € 500 million in upfront funding to the GPEI for the period 2024-2026. This innovative mechanism leverages private and public sector financing, enabling the EIB to front-load the €500 million to the GPEI. The financing is backed by the EC and the Gates Foundation, with repayment split between the two donors based on performance against pre-agreed indicators. The contributions are included in totals of the EIB, EC and the Gates Foundation, but are not included in the subtotals nor in the bottom line grand totals. Contributions from the EC and Gates Foundation will be updated following repayment to the EIB.

[b] For Fiscal Year 2025, Congress appropriated US$ 180 million for the polio eradication activities of the CDC and US$ 85 million for USAID. For more information, please see https://polioeradication.org/financing/donors/historical-contributions/. Funds received by WHO were terminated (USAID) or suspended (CDC) in the first quarter of 2025. No new funding is expected for WHO from either USAID or CDC under the new Administration, following the notification by the United States of its intent to withdraw from WHO and its freeze on foreign aid. Funds recorded for 2025 include funding from the United States to WHO that may be subject to recovery. As of April 2026, funding from these agencies was still flowing to UNICEF. USAID was dissolved on 1 July 2025. Foreign assistance funding from the United States for polio eradication is now administered through the State Department. US CDC and the State Department also provide support for polio eradication activities outside of the FRR. For more information, please see https://polioeradication.org/resource-hub/?rh_policy_and_report_types=non-frr-reports.

[c] The Government of Brazil donated 1.6 million doses of polio vaccine to Pakistan. The amount reflected is an estimated value.

[d] The Gates Foundation has provided challenge grants to Rotary International since 2008. Every dollar raised by Rotary International is matched with two additional dollars from the Gates Foundation. These amounts are included in totals for both Rotary International and the Gates Foundation, but are not included in the subtotals nor in the bottom-line grand total.

[e] The Government of Pakistan has taken out a US$ 100 million loan from the Islamic Development Bank in support of its polio eradication efforts in collaboration with UNICEF. This loan builds on previous support from the Islamic Development Bank and includes a US$ 35 million principal buy-down from the Gates Foundation. These funds are Pakistan's domestic contribution towards the GPEI budget for 2022-2026.

[f] Only countries for which domestic contribution amounts are known have been included in the table above. These domestic contributions are non-Financial Resource Requirement (FRR) funding and are therefore not gap-reducing. Non-FRR funding supports eradication activities funded through the FRR, as well as funding for emergent supporting activities.

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Annexes

Table A1.1 Key performance indicators

Category	Ref.	Indicator name	Indicators	Baseline (2024)*	2025 result	Target	On/off track
Campaigns	C.1	Number of children vaccinated	Number of children immunized across all GPEI campaigns	930 million	913 million	NA	
Goal One							
Endemics	E.1	Number of cases	Number of cases WPV1 reported in the previous 12 months	99	52	End of 2026	
	E.2	LQAS pass rate	% of total campaigns in the reporting period that achieve the LQAS pass rate of 90%	83%	71%	Annual	
	E.3	WPV districts	Number of districts reporting WPV1 cases and/or ES+ in the previous 12 months	118	102	End of 2026	
Goal Two							
Outbreak	O.1	cVDPV2 cases	Number of cVDPV2 cases reported in the previous 12 months	449	228	End of 2027	
	O.2	Countries reporting cVDPV2 cases	Number of countries reporting cVDPV2 cases and/or ES+ in the previous 12 months	37	28	End of 2027	
	O.3	Effectiveness of the response	% of complete outbreak responses with virus detection after completion	70%	65%	0	
Surveillance							
Surveillance	S.1	Districts >=100 000 children under 15 with non-polio AFP >=2 (%)	Number of districts with >= 100 000 children aged under 15 years that meet the non-polio AFP rate target/number of districts with >= 100 000 children aged under 15 years x 100	91%	87%	90%	
	S.2	ES sites with >=50% enterovirus detection (%)	Number of sites with >=10 samples collected where >=50% enterovirus was detected/ Number of total sites with >=10 samples collected x 100	79%	83%	90%	
	S.3a	AFP and ES: timely detection of WPV (%) (positives)	Number of WPVs with final lab results <=35 days of paralysis onset for AFP cases or collection date for ES samples/Number of WPVs (AFP and ES) x 100	93%	65%	90%	
	S.3b	AFP and ES: timely detection of VDPV (%) (positives)	# of VDPVs with final lab results <=35 days of paralysis onset for AFP cases or collection date for ES samples / # of VDPVs (AFP and ES) x 100	12%	21%	90%	
Vaccine supply							
Vaccine	V.1	bOPV availability	Number of months in which bOPV buffer stock was at or above the buffer stock target	5	9	8	
	V.2	nOPV2 availability	Number of months in which nOPV2 buffer stock was at or above the buffer stock target	N/A	12	8	
Financing							
Resource mobilization	RM.1	Resource mobilization	Available funds for the year as a % of annual budget	99%	97%	100%	
Financial management	FM.1	Resource utilization	Annual expenditure as a % of available funds for the year	86%	84%	90%	
Gender							
Gender	G.1	Achievement of gender parity in management positions	% of GPEI staff and consultants in mid- and senior decision-making management positions that are either gender	45%	44%	45% - 55%	
	G.2	Sex/age-disaggregated data reporting	Number of selected countries (Afghanistan, Nigeria and Pakistan) reporting sex/age disaggregated missed and zero-dose children data	3	3	3	

* Baseline figures have been updated following the consolidation and validation of all data for year 2024.

a The number of children immunized is calculated as the number of administered doses in campaigns. In cases where the number of administered doses is unknown, the target population is considered. Targets do not apply to this indicator.

b The surveillance key performance indicator inclusion criteria are countries with "high" status in the Global Polio Surveillance Action Plan OR countries with positive cases and/or environmental samples of WPV1 or VDPV types 1, 2 or 3 in 2022 and beyond AND included in the Global Polio Surveillance Action Plan 2025–2026 high, medium or low (watch-list) status countries.

AFP = acute flaccid paralysis; cVDPV2 = circulating variant poliovirus type 2; ES = environmental surveillance; ES+ = positive environmental sample; GPEI = Global Polio Eradication Initiative; LQAS: lot quality assurance sampling; N/A = not applicable; VDPV = variant (or vaccine-derived) poliovirus; WPV = wild poliovirus; WPV1 = wild poliovirus type 1, bOPV = bivalent oral polio vaccine; nOPV2 = novel oral polio vaccine type 2.

Table A2. Key surveillance indicators in outbreak countries and territories[a]

Countries and territories	Total number of AFP cases reported	Total WPV1 cases	Total cVDPV1 cases	Total cVDPV2 cases	Total cVDPV3 cases	National NP AFP rate	National stool adequacy rate	Number of env. surveillance sites	Number of env. samples collected
Afghanistan	6871	21	0	0	0	36.7	95.3	42	502
Algeria	489	0	1	0	0	3.3	85.9	10	130
Angola	538	0	0	19	0	2.9	88.5	17	156
Benin	488	0	0	3	0	7.8	94.8	7	90
Burkina Faso	1279	0	0	1	0	12.6	74.3	10	135
Cameroon	875	0	0	0	1	7.0	93.6	20	270
Central African Republic	199	0	0	2	0	7.2	83.9	6	68
Chad	970	0	0	33	4	9.6	84.6	5	110
Côte d'Ivoire	841	0	0	0	0	6.2	76.3	25	273
Democratic Republic of the Congo	4609	0	1	7	0	8.7	88.9	28	282
Djibouti	38	0	0	1	0	10.8	94.7	2	40
Ethiopia	2067	0	0	40	0	3.8	91.8	11	82
Guinea	677	0	0	0	2	10.7	96.0	9	90
Israel	28	0	0	0	0	1.0	37.0	13	63
Lao People's Democratic Republic	37	0	1	0	0	1.5	63.9	0	0
Malawi	321	0	0	1	0	3.6	95.7	11	148
Mali	716	0	0	1	0	6.0	95.0	7	71
Namibia	40	0	0	0	0	3.0	82.4	8	109
Niger	1036	0	0	3	0	8.0	82.2	16	237
Nigeria	15892	0	0	66	8	16.2	98.2	109	1302
occupied Palestinian territory, including east Jerusalem	91	0	0	0	0	4.3	83.5	11	54
Pakistan	21278	31	0	0	0	23.0	85.5	162	1557
Papua New Guinea	285	0	0	5	0	7.6	55.9	10	122
Senegal	286	0	0	0	0	3.9	71.3	15	110
Somalia	485	0	0	2	0	5.3	93.0	25	246
Sudan	666	0	0	13	0	3.1	89.0	8	88
United Republic of Tanzania	1005	0	0	0	0	3.3	98.4	21	183
Yemen	1094	0	0	31	0	6.2	91.3	6	36
Zambia	329	0	0	0	0	3.6	82.8	17	196

a Data in WHO HQ, as at June 2026. In 2025, virus was further detected from environmental samples in Germany, Poland and the United Kingdom, as part of routine national enterovirus surveillance activities. Weekly global poliovirus reporting is available at www.polioeradication.org/about-polio/polio-this/week/.

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