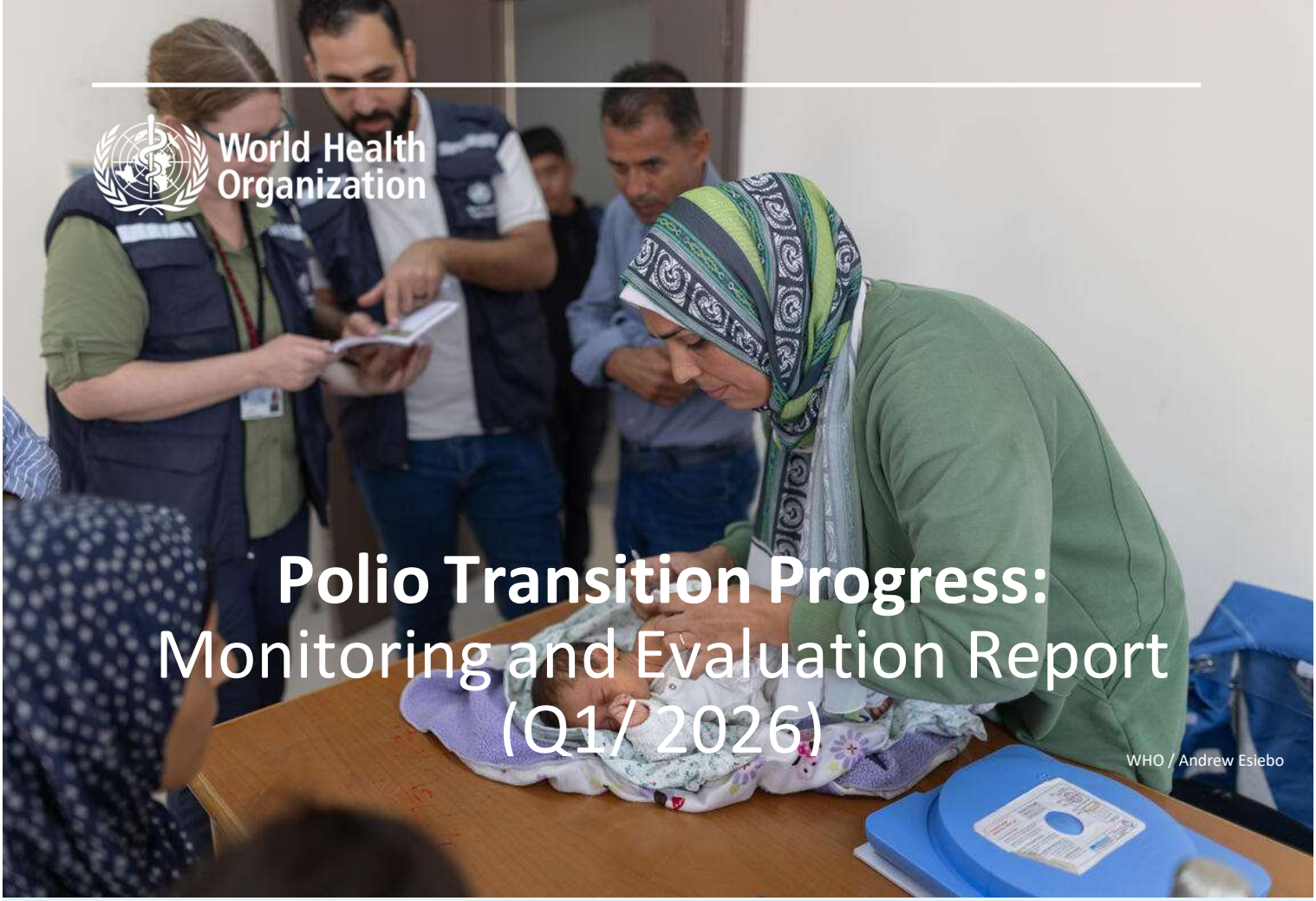


World Health Organization

Polio Transition Progress: Monitoring and Evaluation Report (Q1/ 2026)

WHO / Andrew Esiebo

The Polio Transition Monitoring and Evaluation Report provides an overview of the progress made as of Q1 2026 in priority countries[1] and in countries in the watch list[2] towards the goals and strategic outcomes of the Polio Transition Strategic Framework. The priority list comprises a total of 21 countries: 14 from the African Region, six from the Eastern Mediterranean Region and one from the South-East Asia Region. Countries that have exited the priority list are placed on a 'watch list' and monitored for a minimum of three years to ensure there is no backsliding of functions. The present report provides updated data for the year 2025 of the indicators on surveillance, outbreak response, International Health Regulations (IHR) capacity scores, containment and an update on milestone indicators where available. Time series data are available in the online dashboard: https://www.who.int/teams/polio-transition-programme/monitoring-and-evaluation-dashboard

Key highlights:

Immunization coverage is low: Almost half of the priority countries report coverage for IPV1 and DTP3 below 70%, with limited gradual progress over the last two years.

Countries report high dependence on external partners: Most of the priority countries rely on external partners for managing and financing surveillance, outbreak response and immunization functions.

Surveillance quality and sensitivity show gaps: Environmental surveillance and timeliness of reporting is sub-optimal in almost half of the priority countries and in some of the watchlist countries.

Clear progress is reported on integration of programmes: Majority of priority countries and all watch list countries report achievement of the milestone of integrated polio essential functions.

1 In 2024-25, the list of 21 priority countries comprises Angola, Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Ethiopia, Guinea, Madagascar, Mali, Mozambique, Niger, Nigeria and South Sudan in the African Region; Afghanistan, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen in the Eastern Mediterranean Region; and Myanmar in the South-East Asia Region.

2 The 'watch list' comprises Kenya* in the African Region; Iraq and Libya in the Eastern Mediterranean Region; Bangladesh, India and Nepal in the South-East Asia Region; Indonesia in the Western Pacific Region. *Kenya is considered a priority country by the WHO Regional Office for Africa.

Introduction and policy context:

The eighth report of the Transition Independent Monitoring Board (TIMB), published in October 2025, warned that transition will be judged not by the absence of poliovirus alone, but by the strength of the health systems left in its wake. As the present report shows, the context for polio transition remains challenging as of Q1 2026. Afghanistan and Pakistan continue to be endemic for wild poliovirus, and several priority countries reported circulating vaccine-derived poliovirus (cVDPV) outbreaks in 2025. Efforts to sustain polio essential functions compete with the immediate demands of outbreak response. Across almost all priority countries, immunization coverage remains sub-optimal, surveillance shows gaps in timeliness and sensitivity, and poliovirus containment indicators show also potential risks, with progresses remaining uneven across countries. These are functions that must be sustained through and beyond certification.

Most priority countries still rely on GPEI and other external partners to manage and finance immunization, surveillance and outbreak response, and only few countries have a dedicated national budget line for surveillance. In 2025, GPEI continued to provide substantial financial support to surveillance activities in most priority countries, also in one watchlist country. This dependence has become more acute as a sharp contraction in official development assistance, including reduced funding for WHO and other partners, affects health programmes broadly and transition countries in particular, widening the gap between the cost of sustaining essential functions and the resources available. These pressures are not unique to polio: the same contraction has placed the wider global health architecture under strain, prompting a Member State-led reform process aimed at greater efficiency, stronger country ownership of health financing, and more sustainable and predictable financing for essential functions. Sustaining polio essential functions through transition is both part of, and dependent on, this wider repositioning.

At the same time, the present report points to areas of progress on which a sustainable transition can be built. The majority of priority and watchlist countries have completed or updated country transition plans and conducted structured capacity building to sustain the quality of essential functions, and several have advanced further in 2025: India has moved to the next stage of its transition plan, with functions managed and funded nationally; the Syrian Arab Republic has fully transitioned out of GPEI financial support; and countries such as South Sudan are updating their transition plans. Regional governance for transition continues to evolve: the Eastern Mediterranean Region's integrated Department of Polio Eradication and Vaccine-Preventable Diseases became operational in January 2026, the African Region's regional framework for transition and sustainability (2026–2035) is in final review ahead of the Seventy-sixth session of the WHO Regional Committee for Africa, and in the South-East Asia Region polio transition is now overseen by the Regional Certification Commission.

However, significant liabilities remain, especially in conflict-affected and fragile countries such as Chad, the Democratic Republic of the Congo, Myanmar, Sudan, Somalia and Yemen. The Sustaining a Polio-free World (SPW) strategy, presented to the Seventy-ninth World Health Assembly, estimates global resource needs of US$ 6.9–8.7 billion over the coming decade to maintain polio essential functions. Set against the current reliance on external funding, this points to three areas for policy attention during the SPW implementation planning period: (1) strengthening delivery of polio essential functions through integration into national health systems and keeping country transition plans current and government-owned; (2) securing predictable, increasingly domestic financing in countries able to assume these functions; and (3) sustaining support for countries in fragile settings entering an intermediate transition phase, which will require short to medium-term technical, operational and financial support while building national capacity.

1. Progress Towards Impact Goals

GOAL 1: All countries remain polio free

Afghanistan and Pakistan continue to be endemic for wild polio virus. In 2025, 14 polio transition priority countries reported circulating vaccine derived poliovirus (cVDPV) outbreaks. Inactivated polio vaccine first dose (IPV1) coverage remains sub-optimal (less than 90%) in all priority countries, except one, contributing to delays in reaching the eradication goal and requiring resources for outbreak control. In many transition priority countries, work to achieve long-term sustainability remains challenged by the immediate necessity of outbreak response, whereas in others, other disease areas take priority.

GOAL 2: Minimize the burden of and eliminate vaccine-preventable diseases (VPDs)

Fourteen countries remain below the benchmark for the third dose of diphtheria tetanus pertussis vaccine (DTP3) coverage at the sub-national level, indicating significant challenges in achieving equitable baseline immunity against vaccine preventable diseases. Further, data from the WHO/UNICEF estimates of national immunization coverage (WUENIC) demonstrates the third dose of polio vaccine (POL3) coverage globally in 2024 was 84%, still below pre-pandemic coverage of 86% in both 2018 and 2019. Whilst the 'Big Catch Up' has enabled integrated delivery of polio vaccine, this is not yet systematic, and significant gaps remain in delivery of integrated services.

GOAL 3: Rapidly detect and control disease outbreaks

Despite progress toward strengthening preparedness, detection, and timely response to public health emergencies, there are still challenges of timeliness and sensitivity of surveillance systems and timely response to outbreaks. Most of the priority countries reported significantly lower scores than the regional average on the International Health Regulations (IHR) core capacity indicators for laboratory capacity and health emergency management. Repeated outbreaks of polio underscore health system fragility and inhibit the ability of countries to focus attention on planning for the future, thus acting as a barrier to effective transition planning and implementation.

2 Progress Towards the Strategic Outcomes

The indicators for strategic outcomes (SO) measure health systems performance and resilience related to the essential functions: immunization surveillance, health emergency preparedness and response, and poliovirus containment.

SO 1: National immunization programmes systematically reach and immunize everyone with polio and other vaccines

Priority countries:

Most of the priority countries reported IPV1 and DTP3 coverage gradually increasing or stable over the period 2023-24*. However, 10 priority countries reported coverages of both IPV1 and DTP3 below 70% in 2024: Afghanistan, Angola, Central African Republic, Chad, Democratic Republic of Congo, Guinea, Madagascar, Nigeria, Sudan and Yemen. Equity remains also a challenge with only six priority countries reporting over 80% of districts with DTP3 coverage above 80% level.
** 2025 data will be released in July 2026.*

Watchlist countries:

Among watchlist countries, five countries are on track for IPV1 and DTP3 coverage, two countries have IPV1 coverages lower than 90%: Indonesia and Kenya, 81% and 88% respectively, and two countries have DTP3 coverage lower than 90%: Indonesia and Libya, 78% and 86%, respectively; Indonesia and Kenya reported a low percentage (32% and 55% respectively) of districts with DTP3 coverage greater than or equal to 80%.

	Priority countries			Watchlist countries		
SO1 Indicators	On Track	At Risk	Off Track	On Track	At Risk	Off Track
1.1.National coverage of IPV1 provided through routine service	1	9	11	5	2	0
1.2.National coverage of DPT3 provided through routine services	1	10	10	5	2	0
1.3.Percentage of districts with DTP3 coverage greater than or equal to 80%	6	5	9	3	1	2
Total 2024	**8**	**24**	**30**	**13**	**5**	**2**
Total 2023	*11*	*20*	*30*	*13*	*9*	*1*

SO 2: National surveillance systems rapidly detect and report poliovirus and other diseases

Priority countries:

Surveillance indicators in priority countries show that 13 countries are on track for the non-polio Acute Flaccid Paralysis (AFP) detection rate, while two countries, Burkina Faso and Myanmar, are off track with the percentage of districts with rate of non-polio AFP detected annually ≥ 2 per 100 000 population aged less than 15 years of 48% and 20%, respectively. Ten countries are on track for the timeliness of reporting while eight countries are off-track: Burkina Faso, Democratic Republic of Congo, Ethiopia, Niger, Pakistan, Somalia, Sudan and Yemen. Only four countries reported meeting the sensitivity threshold for environmental surveillance (ES), and most countries reported a relatively low percentage of ES sites complying with the sensitivity threshold. Rates of discarded non-measles non-rubella cases are above the threshold in 14 countries. Five countries reported an IHR capacity score related to laboratory higher than the regional average, whereas eleven countries reported scores lower than the regional average.

SO2 Indicators	**Priority: 21 countries**			**Watchlist: 7 countries**		
Surveillance	On Track	At Risk	Off Track	On Track	At Risk	Off Track
2.1.Percentage of districts with rate of non-polio AFP detected annually ≥ 2 per 100 000 population aged less than 15 years.	13	6	2	3	2	2
2.2 Percentage of reporting AFP cases and ES sample final results within 35 days of onset of AFP cases or ES sample	10	3	8	5	1	1
2.3 Percentage of active ES sites meeting sensitivity threshold of at least 50% samples positive for enterovirus	8	6	7	3	3	0
2.4 Rate of discarded non-measles non-rubella cases annually per 100,000 population (provisional data)	14	0	6	7	0	0
2.5 Country average IHR capacity score related to laboratory compared to regional average	5	5	11	2	2	3
Total 2025	**50**	**20**	**34**	**20**	**8**	**6**
Total 2024	*49*	*21*	*34*	*18*	*7*	*9*

Watchlist countries:

Surveillance indicators show that three countries in the watchlist are on track for the non-polio AFP detection rate, whereas two countries are off-track: India and Nepal. Libya and Kenya moved back on track since the Q3 2025 M&E report. Five countries are on track for timely reporting. Three countries in the watchlist reached the sensitivity threshold of environment surveillance; seven countries met the criteria for measles surveillance. Two countries reported an IHR capacity score related to laboratory higher than the regional average.

SO 3: National health emergency systems prepare for and respond to polio and other disease outbreaks

Priority countries:

Indicators on outbreak preparedness and response present a mixed performance. Three countries – Cameroon, Madagascar, and Yemen – remained below the benchmark of 120 days for the timely control of polio outbreaks between Q1 2023 and Q4 2025. Eight countries met the timeline for implementing the first large scale campaign, whereas four countries had outbreak response Supplementary Immunization Activities (SIAs) delayed or cancelled due to ruptures of vaccine supply during the period 2023-25: Guinea, Madagascar, Niger and Yemen. Three countries reported delayed detection and response to measles outbreaks (*2024 provisional data)*: Ethiopia, South Sudan and Pakistan. Five countries reported an IHR capacity score related to health emergency management of 10 scores higher than the regional average, these are positive self-assessments of strong capacity: Burkina Faso, Ethiopia, Guinea, Nigeria and Sudan.

SO3 Indicators	**Priority: 21 countries**			**Watchlist: 7 countries**		
Health Emergency	On Track	At Risk	Off Track	On Track	At Risk	Off Track
3.1.Percentage of polio (WPV and cVDPV) outbreaks stopped within 120 days of outbreak confirmation in the last 3 years	8	3	3	1	0	0
3.2.Percentage of the first large-scale campaign (R1) implemented within 28 days of outbreak confirmation in the last 3 years	8	4	2	0	0	0
3.3 Percentage of polio (WPV and cVDPV) of outbreak response SIAs delayed or cancelled due to ruptures of vaccine supply in the last 3 years	9	6	4	2	1	0
3.4 Percentage of Measles outbreaks with timely detection and response - provisional data (in brackets average number of days)	0	0	3	0	0	1
3.5.Country average IHR capacity score related to Health Emergency management compared to regional average	5	7	9	2	3	2
Total 2025	**30**	**20**	**21**	**5**	**4**	**3**
Total 2024	*27*	*27*	*21*	*6*	*5*	*2*

Watchlist countries:

Among the watchlist countries, Kenya was reported to be off track for timeliness of measles outbreak response. India and Indonesia were reported as on track, with an IHR capacity score related to health emergency management higher than the regional average.

SO 4: Poliovirus infectious materials are either destroyed or safely and securely contained in line with the established bio risk management standard

Priority countries:

Seven countries reached the benchmark on the percentage of novel oral polio vaccine type 2 (nOPV2) vials due for destruction – opened, used during SIAs, and unusable vials – that were destroyed during the period January to December 2025, while two countries remained not fully complaint with the containment policy and six countries were off track. Pakistan has one facility retaining poliovirus infectious materials for long-term use.

Watchlist countries:

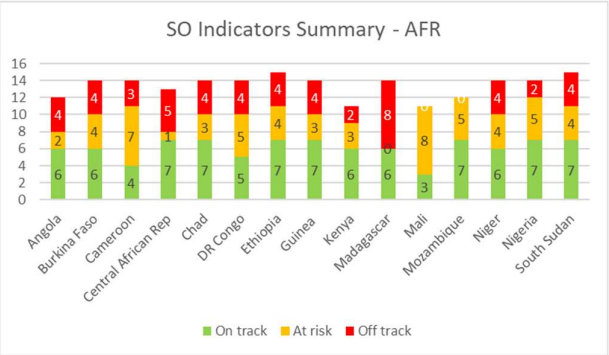
Among the watchlist countries, Kenya destroyed a low percentage of used nOPV2 vials. Indonesia did not report any destruction of nOPV2 vials, this is planned for Q2-Q4 2026. In the watchlist group, India has three facilities, and Indonesia has one facility retaining poliovirus in the long term, that obtained a Certificate of Containment on 13 March 2026.

Number of biomedical facilities retaining poliovirus

Region	Country	Facility
EMRO	Pakistan	1
SEAR	India	3
WPR	Indonesia	1

Regional Summary on Strategic Outcomes

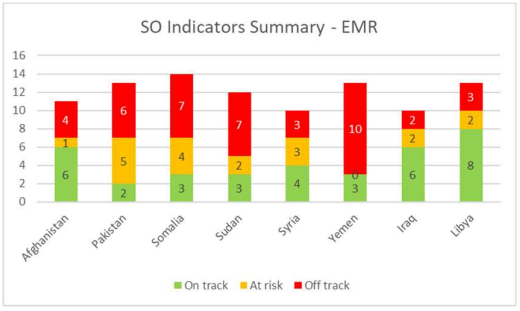
Summary update on the African Region (AFR):



Among the 14 priority countries, eight countries (Angola, Central African Republic, Chad, Democratic Republic of Congo, Guinea, Madagascar, Nigeria and South Sudan) are off-track for the IPV1 and DTP3 immunization indicators. Surveillance indicators are on track in most of the countries, except five (Burkina Faso, Cameroon, Democratic Republic of Congo, Ethiopia and Niger). Only two countries (Ethiopia and Nigeria) report all three indicators for outbreak preparedness and response as on track. Six countries reported destruction of 100% of unusable novel oral polio vaccine type 2 (nOPV2) vials.

Kenya, in the watch list, is at risk for national IPV1 coverage and off-track for the percentage of districts with DTP3 coverage above 80%. The country does not meet the benchmark for measles surveillance, whereas it reports IHR capacity scores for laboratory functions and health emergency management above the regional averages.

Summary update on the Eastern Mediterranean Region (EMR):

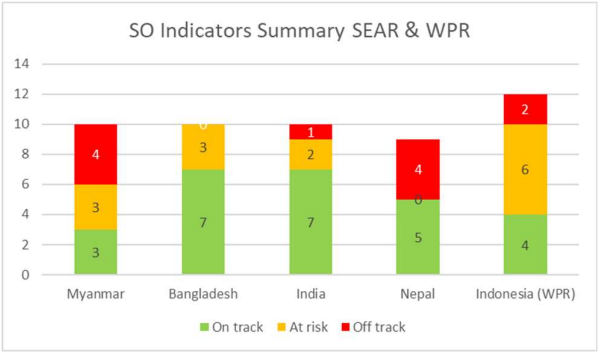


Out of the six priority countries in the region, three (Afghanistan, Sudan, and Yemen) are not on track for the immunization indicators. Afghanistan and Syrian Arab Republic are on track for most surveillance indicators, except for the IHR capacity score for laboratory functions, which falls below the regional average. Pakistan reports low percentage of reporting AFP cases and ES sample final results within 35 days of onset of AFP cases or ES samples.

All priority countries in the region reported IHR capacity scores for health emergency management below the regional average, apart from Sudan. In Somalia and Sudan, the conflict and humanitarian context continue to have a considerable impact on health outcomes, potentially impacting any applicable indicators aside from timely outbreak control and the IHR capacity score for health emergency management in Sudan.

Iraq and Libya, in the watch list, report relatively high immunization coverage but face some challenges in surveillance indicators. In addition, both countries report laboratory and health emergency management IHR capacity scores below the regional average.

Summary update on the South-East Asia Region (SEAR) and Western Pacific Region (WPR):



Myanmar, the only priority country in the South-East Asia Region, continues to fall short of the benchmark for the three immunization indicators. While surveillance data are only available for about half the country due to the security situation, the available data suggests progress on most surveillance indicators, except for the percentage of district reporting on AFP surveillance. In addition, the IHR capacity score for health emergency management remains below the regional average.

Among the watchlist countries, India and Bangladesh are on track for most indicators, except for Bangladesh IHR capacity scores for laboratory functions and health emergency management, both of which are below the regional average. Nepal is on track for the indicators on immunization, whereas it reports weaknesses on surveillance and IHR capacity scores for both laboratory functions and health emergency management. Indonesia faces challenges in immunization coverage across districts and in the containment indicator, however destruction of nOPV2 vials that are opened, used during SIAs, and unusable vials is planned for Q2-Q4 2026.

3. Update on Milestones

M1: Polio essential functions are safeguarded by WHO with support from partners ("intermediate transition"):

The share of workforce in the WHO country office funded by the Global Polio Eradication Initiative (GPEI) is reported relatively low (below 10%) in seven priority countries. It is reported high (above 25%) in Angola, Cameroon, Ethiopia, Mali, Niger, Nigeria, South Sudan and Somalia.

Fifteen priority countries and six watchlist countries have developed integration plans and have integrated polio essential functions into recipient programmes. Three priority countries report not having developed a plan to integrate polio essential functions.

The level of non-GPEI funding secured to sustained polio essential functions was reported low in all priority countries of the African region and in Somalia. It was reported medium-high in the other EMR countries and in the watchlist countries (see Tables A3 and A4).

M2: Action Plan jointly developed:

Seventeen countries reported having developed transition plans, of which two do not have full endorsement or ownership by government: Yemen and Myanmar.

Most of the existing plans, however, have not been formally updated since their development, with efforts instead focused on implementing relevant components from the original version.

Six countries in the watchlist have updated or completed polio transition plans (see Table A4).

M3: National government is managing polio essential functions as a part of the national health system:

All priority countries continue to rely heavily or partially on external partners for managing key programmatic areas: surveillance, immunization and outbreak response functions. Among the watch list countries Kenya and Nepal report high dependence on external partners for managing surveillance and outbreak response. Some degree of dependency is reported also by Bangladesh, India and Indonesia.

Only five priority countries held polio transition management meetings in 2025. Sixteen priority countries and six watchlist countries have structured capacity building systematically conducted to sustain the quality of polio essential functions (see Tables A3 and A4)

M4: Polio essential functions are predictably and sustainably funded through national budgets:

Priority countries report varied levels of reliance on GPEI and other funding sources for immunization and surveillance. Angola, Cameroon, Guinea, Madagascar, Nigeria, Sudan, Syrian Arab Republic, Yemen and Myanmar report low dependence on GPEI. Overall, all priority countries remain significantly dependent on external funding. Among the watchlist countries, Kenya and Nepal show the highest degrees of dependency. Iraq, Libya and Indonesia report low external dependence, operating entirely with locally sourced funds.

Six countries in the watch list have a dedicated budget line for surveillance, whereas only seven priority countries have such a budget line, indicating lower priority given to surveillance during the budget allocation process (see Table A3 and A4).

Surveillance systems

Polio surveillance systems, built over decades with support from the GPEI, are designed to detect poliovirus in near real-time, through rigorous case detection of acute flaccid paralysis, environmental monitoring of wastewater, and the genetic sequencing of every virus found. These systems are not only protecting the world from polio—they are also detecting and responding to other health threats, including measles, cholera, and emerging zoonotic diseases.

Looking ahead, surveillance will remain essential in the post-eradication era. Poliovirus can re-emerge if vigilance wanes, and continued monitoring will be vital to prevent resurgence, manage bio-containment risks, and maintain global confidence in eradication. At the same time, the transition of polio-funded surveillance assets offers a rare opportunity: to embed high-quality disease detection system into national health architectures, leaving a legacy that strengthens public health far beyond polio.

Strategic objective indicators show relatively strong performance in terms of surveillance sensitivity and, to a lesser extent, timeliness across priority countries. However, milestone indicators demonstrate continued reliance on external partners for management and financing. In 2025, the GPEI remained a major contributor to surveillance activities in 15 priority countries and one watchlist country. While transition of these functions to national ownership remains a core objective of the polio transition agenda, this highlights the need to identify sustainable long-term financing arrangements to ensure continuity of polio essential functions and protect investments in disease detection and response capacities.

4. Regional oversight and integration

	AFR	EMR	SEAR
R1) Is there a Regional Strategic Plan in place?	Yes*	Yes	Yes*
R2) Does the Region have a functional Polio Transition Steering Committee?	Yes	Yes	Yes
R3) Is polio transition on the agenda of regional meetings?	Yes	Yes	Yes
R4) Have polio essential functions been integrated at the regional level?	No	Yes	Yes
R5) Has non-GPEI funding been secured for integrated functions at the regional level?	No	Yes	Yes
* Draft			

In the African Region the regional framework for transition and sustainability 2026-2035 is in its final stages of review and will be presented at the next scheduled Regional Committee (RC76) for endorsement by Member States. However, technical support to countries in 2025 has been limited due to funding issues and the planned subregional partner engagement forum has been put on hold. Also, implementation of country plans has been limited, with many country plans not funded or outdated and needing reviews. Transition planning was an agenda item at the last RC75 in 2025 and included at the 2025 Regional Technical Advisory Group on Immunization (RITAG) meeting. Efforts are ongoing to developing an integration working group between the polio and vaccine preventable diseases (VPDs) departments to coordinate and champion these efforts. Standard Operating Procedures (SOPs) for integrated health campaigns are currently being developed for polio campaigns. There are challenges in funding some essential functions even in the 32 other countries no longer receiving GPEI funding, this is a risk for ensuring surveillance standards remain optimal. The region is considering carrying out an assessment of the impact of US Government funding withdrawal, especially on surveillance in these countries, to better understand the funding gaps and help explore resource mobilization opportunities. The region also continues to support integrated health campaigns with the successful implementation of a large-scale Polio/Measles and Rubella integrated campaign in Nigeria in 2025-26.

The Eastern Mediterranean Region has a Regional Strategic Plan (2024-2026) focusing on moving forward transition in the priority countries and programmatic integration at the Regional Office level to ensure integrated and streamlined support to countries. As part of the broader regional integration agenda outlined in the Regional Strategic Plan (2024–2026), the WHO Regional Office has established a newly integrated Department of Polio Eradication and Vaccine-Preventable Diseases. This strategic merger reflects the Region's commitment to streamlined and enhanced coordinated technical and programmatic support to countries. Beginning in January 2026, polio transition management will be under the leadership of this department. The merging of these two departments is a key component of a wider integration effort aimed at aligning polio eradication and immunization programmes at both regional and country levels, paving the way for a smoother and more sustainable transition. Leadership of the Expanded Programme for Immunization (EPI) and Polio has already been successfully merged across all priority countries in the Region, except in Afghanistan and Pakistan. In Yemen, Libya, Iraq, Syrian Arab Republic, and Sudan, integration has been achieved, with polio and EPI functions operating under a unified structure. These developments build on the foundation laid by the former Polio Transition Steering Committee and respond to the ongoing challenges of poliovirus transmission, conflict, and humanitarian emergencies in a budget constrained environment

The South-East Asia Region has a draft Regional Strategic Plan for Polio Transition, which was presented for input to the RITAG. The plan is for the document to undergo Member State consultation. The WHO Regional Office reinstated its Polio Transition Steering Committee in 2025. The most recent meeting of the Steering Committee was held on 24 March 2026. Polio transition is a standing agenda on relevant regional fora (e.g. RC and ITAG). Polio transition is also now monitored by the Regional Certification Commission for Polio Eradication (RCCPE) and is part of its revised terms of references. The RCCPE receives annual progress reports on Polio transition from priority and watchlist countries and provides feedback accordingly through the respective National Certification Commissions for Polio Eradication (NCCPEs). In 2024, three countries of the region were classified as in the watchlist given their progress towards transition. In an independent evaluation, SEAR has been recognized as the most advanced region in polio transition, attributing the integrated setup of the networks as the key success factor. Despite significant contributions of domestic funding – for instance Nepal has gradually increased its government share of funding for VPD surveillance and institutionalized in the national budget – there is still dependency on external funding.

5. Data sources and limitations

The M&E report includes the set of strategic outcome and milestone indicators.

Strategic outcome indicators are integrated with existing monitoring frameworks and reporting systems, such as the Global Polio Eradication Initiative 2022–2029 strategy key performance indicators, the Immunization Agenda 2030 scorecard, and the e-SPAR (IHR State Party Self-Assessment Annual Report). The milestones indicators, on the other hand, are collected at the country level through a dedicated webtool and validated at regional level.

The data for this report was collected in the first quarter of 2026 cover the following periods:

- Immunization indicators (SO 1.1 - 1.3): year 2024, Jan – Dec 2024
- Surveillance indicators – Acute Flaccid Paralysis, environmental surveillance for Polio and Measles / Rubella surveillance (SO 2.1 - 2.4): 12 months rolling period, 1 Jan – 31 Dec 2025
- Surveillance indicators – IHR capacity (SO 2.5): year 2025, Jan – Dec 2025. e-SPAR online accessed on 5 May 2026.
- Health emergency – polio outbreak indicators (SO 3.1 - 3.3): years 2023-2025, Jan 2023 – Dec 2025
- Health emergency – measles outbreak and IHR indicators (SO 3.4 – 3.5): Jan – Dec 2024; Jan – Dec 2025, respectively.
- Containment indicator (SO 4.1): year 2025, Jan – Dec 2025
- Biomedical facilities with poliovirus infectious material indicator (SO 4.2): year 2025
- Milestone Indicators (M1 – M4): year 2024-25, AFRO countries reported milestones in November 2024 and updates in March 2025 and April 2026; EMRO countries provided updates in April 2025; SEARO countries provided updates in October 2025; and WPRO (Indonesia) provided updates in March 2026.
- Milestone indicator – external health expenditure (M4.2): 2021 or latest available year

SEAR country data is based on the annual updates presented at Regional Certification Commission for Polio Eradication (RCCPE) in addition to updates based on quarterly progress.

The M&E framework presents certain limitations. Strategic outcome indicators rely on existing monitoring systems, which may be constrained by data quality and availability issues. Due to delays in reporting, the most recent data available was used, which may limit the comparability of results. Overall, data availability was 99%, with 836 out of 840 required data points reported across the 28 countries. Additionally, data extracted from existing sources and reporting mechanisms were not subjected to additional quality assurance processes. Proxy indicators—such as DTP3 coverage, measles surveillance/outbreak response, and IHR core capacities—were utilized to provide insights into broader health system performance.

Links to data sources:

- GPEI POLIS: https://extranet.who.int/polis/Account/Login
- Immunization Dashboard: https://immunizationdata.who.int/
- IHR States Parties Self-Assessment Annual Reporting Tool: https://extranet.who.int/e-spar
- Webtool for collecting milestone indicators: polio-transition-monitoring (arcgis.com)

List of Abbreviations:

AFG	Afghanistan
AGO	Angola
BGD	Bangladesh
BFA	Burkina Faso
CMR	Cameroon
CAR	Central African Republic
TCD	Chad
COD	Democratic Republic of the Congo
ETH	Ethiopia
GIN	Guinea
IND	India
IDN	Indonesia
IRQ	Iraq
KEN	Kenya
LBY	Libya
MDG	Madagascar
MLI	Mali
MOZ	Mozambique
MMR	Myanmar
NPL	Nepal
NER	Niger (the)
NGA	Nigeria
PAK	Pakistan
SOM	Somalia
SSD	South Sudan
SDN	Sudan
SYR	Syrian Arab Republic
YEM	Yemen
AFP	Acute Flaccid Paralysis
bOPV	Bivalent oral polio vaccine
cVDPV	circulating vaccine derived poliovirus
DTP	Diphtheria tetanus pertussis vaccine
EPI	Expanded Programme for Immunization
ES	Environmental Surveillance
e-SPAR	IHR State Party Self-Assessment Annual Report
GPEI	Global Polio Eradication Initiative
IHR	International Health Regulations
IPV	Inactivated polio vaccine
ITAG	Immunization Technical Advisory Group
NCCPE	National Certification Commission for Polio Eradication
nOPV2	novel oral polio vaccine type 2
POL3	Third dose of polio vaccine
RC	Regional Committee
RCCPE	Regional Certification Commission for Polio Eradication
RITAG	Regional Technical Advisory Group on Immunization
SIA	Supplementary immunization activity
SO	Strategic Outcome
SOP	Standard Operating Procedure
VPDs	Vaccine preventable diseases
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

Table A1: Strategic Outcomes – Priority Countries

	AGO	BFA	CMR	CAF	TCD	COD	ETH	GIN	MDG	MLI	MOZ	NER	NGA	SSD	AFG	PAK	SOM	SDN	SYR	YEM	MMR
	AFRO														*EMRO*						*SEARO*
SO1: National immunization programmes systematically reach and immunize everyone with polio and other vaccines.																					
1.1.National coverage of IPV1 provided through routine service	58	91	75	42	67	69	73	63	63	76	86	86	67	67	59	87	70	50	81	45	73
1.2.National coverage of DPT3 provided through routine services	64	91	77	42	68	65	73	63	60	82	70	86	67	73	59	87	70	39	73	42	71
1.3.Percentage of districts with DTP3 coverage greater than or equal to 80%	37	79	54	83	90	92	79	84	61	79	86	94	71	62	74	68	50	NR	38	38	53
SO2: National surveillance systems rapidly detect and report poliovirus and other diseases.																					
2.1.Percentage of districts with rate of non-polio AFP detected annually ≥ 2 per 100,000 population aged less than 15 years.	100	48	96	93	100	89	89	91	100	78	100	71	94	100	96	88	97	97	76	92	20
2.2 Percentage of reporting AFP cases and ES sample final results within 35 days of onset of AFP cases or ES sample	91	54	83	95	91	59	77	89	99	90	94	41	83	99	94	77	77	77	92	10	99
2.3 Percentage of active ES sites meeting sensitivity threshold of at least 50% samples positive for enterovirus	100	40	50	100	50	80	14	100	100	85	71	45	56	94	99	52	14	14	100	33	100
2.4 Rate of discarded non-measles non-rubella cases annually per 100,000 population (provisional data)	11.00	1.97	2.16	2.2	3.7	4.2	2.4	1.98	3.46	3.54	1.72	5.87	2.18	2.41	11.36	7.14	0.16	0.16	4.98	5.41	0.53
2.5 Country average IHR capacity score related to laboratory compared to regional average	60 (59)	56 (59)	28 (59)	36 (59)	52 (59)	60 (59)	80 (59)	68 (59)	40 (59)	64 (59)	64 (59)	72 (59)	60 (59)	48 (59)	48 (71)	64 (71)	40 (75)	40 (75)	48 (75)	36 (75)	76 (73)
SO3: National health emergency systems prepare for and respond to polio and other disease outbreaks.																					
3.1.Percentage of polio (WPV and cVDPV) outbreaks stopped within 120 days of outbreak confirmation - in the last 3 years	NA	71%	0%	100%	100%	100%	78%	60%	0%	NA	NA	100%	100%	50%	NA	NA	50%	50%	NA	0%	NA
3.2.Percentage of the first large-scale campaign (R1) implemented within 28 days of outbreak confirmation (in brackets avg number of days) - in the last 3 years	NA	40% (36)	100% (11)	33% (67)	60% (35)	0% (39)	89% (0)	50% (17)	0% (31)	NA	NA	100% (0)	100% (0)	67% (17)	NA	NA	75% (0)	75% (0)	NA	100% (0)	NA
3.3 Percentage of polio (WPV and cVDPV) of outbreak response SIAs delayed or cancelled due to ruptures of vaccine supply - in the last 3 years	0%	50%	56%	24%	45%	18%	26%	71%	70%	43%	29%	91%	25%	25%	0%	26%	50%	50%	NA	83%	NA
3.4 Percentage of Measles outbreaks with timely detection and response - provisional 2024 data (in brackets average number of days)	NA	NA	NA	NA	NA	NA	0% (575)	NA	NA	NA	NA	NA	NA	0% (634)	NA	0% (509)	NA	NA	NA	NA	NA
3.5.Country average IHR capacity score related to Health Emergency management compared to regional average	67 (60)	73 (60)	60 (60)	40 (60)	47 (60)	53 (60)	80 (60)	87 (60)	40 (60)	60 (60)	67 (60)	60 (60)	73 (60)	53 (60)	33 (69)	60 (69)	40 (76)	87 (76)	53 (76)	47 (76)	67 (81)
SO4: Poliovirus infectious materials are either destroyed or safely and securely contained in line with the established biorisk management standard																					
4.1 Percentage of nOPV2 vials that are received by the country and are opened, used during SIAs, and unusable vials that are subsequently destroyed	NA	100%	97%	100%	100%	72%	0%	100%	NA	84%	0%	100%	100%	0%	NA	NA	28%	28%	NA	6%	NA
4.2 Number of biomedical facilities retaining poliovirus infectious material (PV IM) in the long term	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0

Grey boxes represent missing data (NR) or not applicable (NA)

Table A2: Strategic Outcomes – Watchlist Countries

		KEN	IRQ	LBY	BGD	IND	NPL	IDN
		AFR	*EMR*		*SEAR*			*WPRO*
SO1: National immunization programmes systematically reach and immunize everyone with polio and other vaccines.								
	1.1.National coverage of IPV1 provided through routine service	88	95	90	99	93	96	81
	1.2.National coverage of DPT3 provided through routine services	91	90	86	99	94	97	78
	1.3.Percentage of districts with DTP3 coverage greater than or equal to 80%	55	79	NR	100	92	82	32
SO2: National surveillance systems rapidly detect and report poliovirus and other diseases.								
	2.1.Percentage of districts with rate of non-polio AFP detected annually ≥ 2 per 100,000 population aged less than 15 years.	100	85	91	73	40	25	100
	2.2 Percentage of reporting AFP cases and ES sample final results within 35 days of onset of AFP cases or ES sample	100	95	100	90	91	69	85
	2.3 Percentage of active ES sites meeting sensitivity threshold of at least 50% samples positive for enterovirus	100	98	60	100	75	NR	89
	2.4 Rate of discarded non-measles non-rubella cases annually per 100,000 population (provisional data)	3.20	5.17	12.16	2.10	2.30	3.98	8.69
	2.5 Country average IHR capacity score related to laboratory compared to regional average	72 (59)	68 (75)	56 (75)	72 (73)	80 (73)	48 (73)	80 (78)
SO3: National health emergency systems prepare for and respond to polio and other disease outbreaks.								
	3.1.Percentage of polio (WPV and cVDPV) outbreaks stopped within 120 days of outbreak confirmation - in the last 3 years	NA	NA	NA	NA	NA	NA	NA
	3.2.Percentage of the first large-scale campaign (R1) implemented within 28 days of outbreak confirmation (in brackets average number of days) - in the last 3 years	NA	NA	NA	NA	NA	NA	NA
	3.3 Percentage of polio (WPV and cVDPV) of outbreak response SIAs delayed or cancelled due to ruptures of vaccine supply - in the last 3 years	NA	NA	NA	NA	31%	NA	0%
	3.4 Percentage of Measles outbreaks with timely detection and response - provisional 2024 data (in brackets average number of days)	0% (794)	NA	NA	NA	NA	NA	NA
	3.5.Country average IHR capacity score related to Health Emergency management compared to regional average	67 (60)	53 (76)	20 (76)	73 (81)	93 (81)	67 (81)	87 (78)
SO4: Poliovirus infectious materials are either destroyed or safely and securely contained in line with the established biorisk management								
	4.1 Percentage of nOPV2 vials that are received by the country and are opened, used during SIAs, and unusable vials that are subsequently destroyed	27%	NA	NA	NA	NA	NA	0%
	4.2 Number of biomedical facilities retaining poliovirus infectious material (PV IM) in the long term	0	0	0	0	3	0	1

Grey boxes represent missing data (NR) or not applicable (NA)

Legend: Strategic Outcome Indicators

LEGEND - Strategic Outcome Indicators	Off Track	At Risk	On Track
SO1: National immunization programmes systematically reach and immunize everyone with polio and other vaccines.			
1.1.National coverage of IPV1 provided through routine service	<70	70 - 90	≥ 90
1.2.National coverage of DPT3 provided through routine services	<70	70 - 90	≥ 90
1.3.Percentage of districts with DTP3 coverage greater than or equal to 80%	<70	70 - 80	≥ 80
SO2: National surveillance systems rapidly detect and report poliovirus and other diseases.			
2.1.Percentage of districts with rate of non-polio AFP detected annually ≥ 2 per 100,000 population aged less than 15 years.	<70%	70 - 90%	≥ 90%
2.2 Percentage of reporting AFP cases and ES sample final results within 35 days of onset of AFP cases or ES sample	<80%	80 - 90%	≥ 90%
2.3 Percentage of active ES sites meeting sensitivity threshold of at least 50% samples positive for enterovirus	< 50%	50 - 90%	≥ 90%
2.4 Rate of discarded non-measles non-rubella cases annually per 100,000 population	< 2		≥ 2
2.5 Country average IHR capacity score related to laboratory compared to regional average	≤ reg. avg. - 5	=reg. avg +/- 5	≥ reg. avg +5
SO3: National health emergency systems prepare for and respond to polio and other disease			
3.1.Percentage of polio (WPV and cVDPV) outbreaks stopped within 120 days of outbreak confirmation	< 30%	30 - 60%	> 60 %
3.2.Percentage of the first large-scale campaign (R1) implemented within 28 days of outbreak confirmation (in brackets average number of days)	< 30%	30 - 60%	> 60 %
3.3 Percentage of polio (WPV and cVDPV) of outbreak response SIAs delayed or cancelled due to ruptures of vaccine supply	> 60%	30 - 60%	< 30%
3.4 Percentage of Measles outbreaks with timely detection and response - provisional data	< 30%	30 - 60%	> 60 %
3.5.Country average IHR capacity score related to Health Emergency management compared to regional average	< -10 reg. avg	+/- 10 reg. avg	> + 10 reg. avg
SO4: Poliovirus infectious materials are either destroyed or safely and securely contained in line with the established biorisk management standard			
4.1 Percentage of nOPV2 vials that are received by the country and are opened, used during SIAs, and unusable vials that are subsequently destroyed	<50	50 - 90	≥ 90
4.2 Number of biomedical facilities retaining poliovirus infectious material (PV IM)	> number of PEF	> 0 and = number of PEF	= 0

reg. avg. = regional average

Table A3: Milestones – Priority Countries

		AGO	BFA	CAR	CMR	TCD	COD	ETH	GIN	MDG	MLI	MOZ	NER	NGA	SSD	SOM	SDN	SYR	YEM	MMR
		AFR														*EMRO*				*SEAR*
M1. Polio essential functions are safeguarded by WHO with support from partners ("intermediate transition")																				
	1.1 Share of workforce in WHO Country Office funded by GPEI over the last 12 months.	H	L	M	H	M	H	H	L	L	H	L	H	H	H	H	L	L	L	L
	1.2 Integration plans have been developed by polio and recipient programmes.	P	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	1.3 Recipient programmes have integrated polio essential functions.	Yes	P	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	P	Yes
	1.4 Level of non-GPEI funding secured for integrated polio essential functions in the current WHO programme budget period.	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	H	H	M	H
M2. Action Plan jointly developed																				
	2.1 Country Action Plan completed (including ownership by government)	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*
	2.2 Country Action Plan quality score.	H	L	H	H	H	H	H	H	H	H	L	H	H	H	H	H	H	H	H
	2.3 Country Action Plan is up to date or still remains relevant	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	No	No	No
M3. National government is managing polio essential functions as a part of the national health system																				
	3.1 Extent of dependence on external partners for managing the surveillance function within the national health system.	M	H	M	M	M	H	H	H	H	M	H	M	H	H	H	H	H	H	H
	3.2 Extent of dependence on external partners for managing the immunization function within the national health system.	M	H	M	M	M	H	H	M	M	M	M	M	M	H	H	H	H	H	L
	3.3 Extent of dependence on external partners for managing the outbreak response function within the national health system.	H	H	M	H	M	H	H	H	H	H	H	M	H	H	H	H	H	H	L
	3.4 A polio transition management meeting has been conducted by the government in the last 12 months.	No	No	Yes	No	No	No	No	Yes	No	Yes	No	No	No	Yes	No	No	Yes	No	No
	3.5 Structured capacity building is systematically conducted to sustain the quality of polio essential functions.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
M4. Polio essential functions are predictably and sustainably funded through national budgets																				
	4.1 Level of health system dependence on GPEI funding.	L	H	M	L	H	H	M	L	L	H	H	M	L	H	H	L	L	L	L
	4.2 Level of health system dependence on external funding sources.	L	H	M	H	H	H	H	L	M	H	H	H	L	H	H	H	H	H	H
	4.3 Level of funding generated from national or sub-national budget (domestic or other non-GPEI sources) for polio essential functions.	M	L	M	L	M	L	M	M	M	NR	L	M	M	L	L	L	M	L	H
	4.4 A line item has been included in the national and/or sub-national budget on surveillance.	No	Yes	Yes	Yes	No	No	No	Yes	No	No	No	No	Yes	No	No	No	Yes	No	Yes

** Action Plan developed as WCO internal plan or Action Plan not endorsed by the government*

- Pakistan and Afghanistan are endemic, they do not report Milestones

Table A4: Milestones – Watchlist Countries

		KEN	IRQ	LBY	BGD	IND	NPL	IDN
		AFR	*EMR*		*SEAR*			*WPR*
M1. Polio essential functions are safeguarded by WHO with support from partners ("intermediate transition")								
	1.1 Share of workforce in WHO Country Office funded by GPEI over the last 12 months.	H	L	L	M	L	L	L
	1.2 Integration plans have been developed by polio and recipient programmes.	No	Yes	Yes	Yes	Yes	Yes	Yes
	1.3 Recipient programmes have integrated polio essential functions.	M	Yes	Yes	Yes	Yes	Yes	Yes
	1.4 Level of non-GPEI funding secured for integrated polio essential functions in the current WHO Programme Budget period.	NR	NA	NA	M	H	H	H
M2. Action Plan jointly developed								
	2.1 Country Action Plan completed (including ownership by government)	No	Yes	Yes	Yes	Yes	Yes	Yes
	2.2 Country Action Plan quality score.	NA	H	H	L	H	H	H
	2.3 Country Action Plan is up to date or still remains relevant	NA	NA*	NA*	Yes	Yes	Yes	Yes
M3. National government is managing polio essential functions as a part of the national health system								
	3.1 Extent of dependence on external partners for managing the surveillance function within the national health system.	H	L	L	M	M	H	L
	3.2 Extent of dependence on external partners for managing the immunization function within the national health system.	M	L	L	M	L	L	L
	3.3 Extent of dependence on external partners for managing the outbreak response function within the national health system.	H	L	L	M	M	H	M
	3.4 A polio transition management meeting has been conducted by the government in the last 12 months.	No	Yes	Yes	No	No	Yes	No
	3.5 Structured capacity building is systematically conducted to sustain the quality of polio essential functions.	No	Yes	Yes	Yes	Yes	Yes	Yes
M4. Polio essential functions are predictably and sustainably funded through national budgets								
	4.1 Level of health system dependence on GPEI funding.	H	L	L	L	L	L	L
	4.2 Level of health system dependence on external funding sources.	H	L	L	L	L	H	L
	4.3 Level of funding generated from national or sub-national budget (domestic or other non-GPEI sources) for polio essential functions.	L	H	H	L	NR	L	H
	4.4 A line item has been included in the national and/or sub-national budget on surveillance.	No	Yes	Yes	Yes	Yes	Yes	Yes

** Because It has already been completed.*

Legend of Milestones

LEGEND - Milestones Indicators	Not Achieved	Partially Achieved	Achieved
M1. Polio essential functions are safeguarded by WHO with support from partners ("intermediate transition")?			
1.1 Share of workforce in WHO Country Office funded by GPEI over the last 12 months. Measured by percentage of WHO workforce related financial resources funded by GPEI over the last 12 months?	High > 25%	Medium 10-25%	Low <10%
1.2 Integration plans have been developed by polio and recipient programmes.	No	Partially	Yes
1.3 Recipient programmes have integrated polio essential functions.	No	Partially	Yes
1.4 Level of non-GPEI funding secured for integrated polio essential functions in the current WHO Programme Budget period.	Low 0-50%	Medium 50-80%	High ?80%
M2. Action Plan jointly developed?			
2.1 Country Action Plan completed.	No	Yes*	Yes
2.2 Country Action Plan quality score.	Low (0-3)	Medium (4-6)	High (7-9)
2.3 Country Action Plan is up to date.	No	-	Yes
M3. National government is managing polio essential functions as a part of the national health system ?			
3.1 Extent of dependence on external partners for managing the surveillance function within the national health system.	High	Medium	Low
3.2 Extent of dependence on external partners for managing the immunization function within the national health system.	High	Medium	Low
3.3 Extent of dependence on external partners for managing the outbreak response function within the national health system.	High	Medium	Low
3.4 A polio transition management meeting has been conducted by the government in the last 12 months.	No	-	Yes
3.5 Structured capacity building is systematically conducted to sustain the quality of polio essential functions.	No	-	Yes
M4. Polio essential functions are predictably and sustainably funded through national budgets ?			
4.1 Level of health system dependence on GPEI funding. Measured by GPEI funding as percentage of the domestic general government health expenditure?	High >10%	Medium 2-10%	Low <2%
4.2 Level of health system dependence on external funding sources. Measured by health expenditure from external sources as percentage of current health expenditure?	High >10%	Medium 5-10%	Low <5%
4.3 Level of funding generated from national or sub-national budget (domestic or other non-GPEI sources) for polio essential functions.	Low 0-40%	Medium 40-80%	High ?80%
4.4 A line item has been included in the national and/or sub-national budget on surveillance.	No	-	Yes