

Update on the ongoing public health emergencies of international concern

Poliomyelitis

Report by the Director-General

1. Securing a world free from poliomyelitis depends upon reaching the remaining zero-dose children (children who are either unvaccinated or undervaccinated) in subnational parts of the most critical geographical areas,¹ which serve as engines for poliovirus transmission. A number of these areas continue to be affected by insecurity as well as different complex humanitarian emergencies, requiring the polio programme to adapt its operations to deliver polio vaccines within a broader humanitarian context.
2. In 2025, cases of poliomyelitis due to wild poliovirus type 1 continued to be reported in Afghanistan and Pakistan, the last two countries where the poliovirus remains endemic. As at 31 December 2025, a total of 39 cases due to wild poliovirus type 1 have been reported, nine from Afghanistan and 30 from Pakistan. A total of 709 positive environmental samples for wild poliovirus type 1 have also been reported to date in 2025, 54 from Afghanistan and 654 from Pakistan. This compares with 99 cases (25 from Afghanistan and 74 from Pakistan) and 773 positive environmental samples (124 from Afghanistan and 649 from Pakistan) in all of 2024.
3. Owing to the land border closure between Afghanistan and Pakistan, neither stool specimens from acute flaccid paralysis cases and contacts nor environmental samples have been able to be shipped to the Regional Reference Laboratory in Islamabad, Pakistan since 12 October 2025. As at end December 2025, more than 3000 stool specimens from approximately 1600 acute flaccid paralysis cases and contacts, and over 120 environmental samples from Afghanistan reportedly remain untested. WHO and the Global Polio Eradication Initiative (GPEI) are working closely with both country programmes to resume specimen shipment and expedite

¹ Eastern Afghanistan and adjoining Peshawar block of Pakistan; southern Afghanistan and adjoining Quetta block of Pakistan; eastern Democratic Republic of the Congo; north-western Nigeria; the Karachi and the southern Khyber Pakhtunkhwa blocks of Pakistan; the southern and central areas of Somalia; and northern Yemen.

testing of the pending samples. Once testing resumes, results from these pending specimens may lead to changes in the epidemiological picture and should therefore be interpreted accordingly.

4. Afghanistan and Pakistan continue intensive, largely synchronized supplementary immunization activity schedules. Afghanistan implemented two nationwide and five subnational vaccination rounds using the site-to-site strategy in 2025, with focused efforts to enhance operational and communication approaches to maximize coverage. Additionally, targeted fractional-dose inactivated polio vaccine campaigns were implemented in the high-risk areas of the east, south and south-east regions between August and September 2025. Pakistan has carried out five nationwide and one subnational vaccination round, reporting high coverage and lot quality assurance sampling pass rates at the national and provincial levels, supported by strong political leadership (including direct engagement of the Prime Minister and Federal Minister for Health). Nevertheless, campaign quality was reported uneven at the district and subdistrict levels owing to operational challenges and insecurity in parts of the Khyber Pakhtunkhwa and Balochistan provinces. Afghanistan and Pakistan polio eradication programmes continue to closely coordinate at the national and subnational levels, focusing on synchronized high-quality vaccination activities and vaccination at major border crossing points, as well as acute flaccid paralysis surveillance.

5. The GPEI conducted an independent programme audit in Karachi (Pakistan) during the last quarter of 2025. The audit concluded that the current systems and quality of available programme data in Karachi do not provide a sufficiently accurate picture of campaign quality to identify problems and guide the programme decisions and that more children are being missed than programme data indicate. The potential scale of missed children and overestimation of coverage is sufficient to explain the persistence of wild poliovirus type 1 (WPV1) transmission in the Karachi Bloc. The country programme is developing a workplan to implement the recommendations of the audit.

6. On 10 November 2025, the GPEI confirmed the detection of WPV1 in an environmental sample collected through routine surveillance in Hamburg, Germany, during the week of 6 October 2025. Genetic sequencing indicates that this WPV1 detection is linked to WPV1 previously identified in Kandahar, Afghanistan, in August 2025, suggesting a recent importation into Germany. No WPV1 detection has been reported in the subsequent environmental samples from the same locality and site. No cases of paralysis have been reported in Germany, and the virus has so far been detected only in wastewater. GPEI partners are collaborating with national and local health authorities, supported by the WHO Regional Office for Europe, to investigate the situation, assess risks and determine whether additional public health measures are required. This event underscores that until poliovirus is eradicated globally, all countries remain at risk of poliovirus importation. It highlights the critical importance of maintaining high vaccination coverage, strong disease surveillance and international cooperation to achieve and sustain a polio-free world.

7. There was no transmission of wild poliovirus type 1 in the WHO African Region in 2025. The outbreak that occurred in Malawi and Mozambique in 2022 was officially declared closed in May 2024 following an independent outbreak response assessment to review epidemiology and the quality of surveillance and immunization activities. The outbreak was linked to poliovirus circulating in Pakistan and triggered an emergency response across five countries of the African subregion. The last case was reported in August 2022.

8. As at 31 December 2025, a total of 202 circulating vaccine-derived poliovirus (cVDPV) cases had been reported for the year 2025, of which 192 were cVDPV type 2, three cVDPV type 1 and seven were cVDPV type 3. Moreover, 229 positive environmental samples (all cVDPV type 2) were also reported in 2025. This compares with 463 cVDPV cases (448 type 2; 11 type 1; four type 3) and 296 positive environmental samples reported in all of 2024. The outbreak of cVDPV type 2 in the Democratic Republic of the Congo is declining, with ongoing intensive vaccination response. The Lake Chad basin, especially northern Nigeria, and Yemen, Ethiopia, Somalia and Sudan in the Horn of Africa, are the key drivers of transmission. New outbreaks of cVDPV type 2 and cVDPV type 1 have been reported in Namibia and Lao People's Democratic Republic, respectively. The cVDPV type 2 outbreak in Indonesia, detected in 2024, was declared closed in October 2025 following an assessment by independent experts. It is important to note that Indonesia faces continued risk from Papua New Guinea's cVDPV type 2 outbreak (resulting from importation of virus previously circulating in Indonesia) and inadequate immunization coverage in key Indonesian provinces that could lead to cVDPV outbreaks. In 2025, four countries in the WHO European Region reported cVDPV type 2 detection through wastewater surveillance, including Germany, Israel, Poland and the United Kingdom of Great Britain and Northern Ireland. The United Kingdom reported two cVDPV type 2 detections with the most recent in September; Germany, 17 detections with the most recent in October; Israel, two detections with the most recent in February; and Poland, one detection with the most recent in January 2025. All the cVDPV type 2 detections but one in Israel are genetically linked to the emergence group NIE-ZAS-1, originating in Nigeria. One of the two detections in Israel was linked to the emergence of SUD-RED-1, originating from Sudan. No human cases were reported from any of the European Region countries. All the countries in the WHO European Region with cVDPV detection are continuing to strengthen surveillance and address any subnational population immunity gaps to prevent community transmission. The cVDPV detection in the European Region reinforces the risk of global cVDPV type 2 spread due to the ongoing population movement. Three countries, Cameroon, Chad and Guinea, reported cVDPV type 3 outbreaks in 2025. Cameroon and Chad were affected by cocirculation of cVDPV types 2 and 3 during the year. Notably, the same cVDPV type 3 emergence caused the outbreaks in both countries, indicating cross-border transmission, with one cVDPV type 3 case reported in Cameroon (with paralysis onset in May 2025) and five cVDPV type 3 cases reported in Chad (with paralysis onset in June, July and October 2025). Three cVDPV type 1 cases were reported in 2025, one each from Algeria, the Democratic Republic of the Congo and Lao People's Democratic Republic. Moreover, cVDPV type 1 outbreaks were reported in Djibouti and Israel, based on environmental surveillance detections, with the latest detections in May and July 2025, respectively.

9. A total of 37 circulating cVDPV type 2 emergence groups were detected in 2025, compared with 30 in 2024, 27 in 2023, 22 in 2022, 29 in 2021, 36 in 2020 and 44 in 2019. Of these, two were newly detected in 2025 and are derived from the novel oral polio vaccine type 2. Since its introduction in 2021, about 2 billion doses of the novel oral polio vaccine type 2 have been administered and a total of 43 circulating vaccine-derived poliovirus type 2 emergences have been associated with it. The novel oral polio vaccine type 2 continues to demonstrate significantly greater genetic stability and a substantially lower risk of reversion to neurovirulence compared with Sabin type 2 oral poliovirus vaccine. Much of the risk of vaccine-derived poliovirus emergences is attributed to a combination of inaccessibility, insecurity, high concentration of zero-dose and undervaccinated children, and population displacement. These factors continue to be most evident in the eastern Democratic Republic of the Congo, Ethiopia, northern Nigeria, the southern and central areas of Somalia and northern Yemen. The current resource-constrained environment further challenges the full and effective implementation of critical eradication activities.

10. In view of funding constraints, the GPEI Strategy Committee, under the auspices of the Polio Oversight Board, has approved a GPEI Action Plan for 2026. The plan aims to implement programme strategies and operational approaches in a resource-efficient manner by identifying efficiencies and addressing redundancies, while ensuring continued progress towards achieving the goals of the Polio Eradication Initiative. Progress towards implementation of the plan will be closely monitored by the GPEI Strategy Committee on a quarterly basis, with interim adjustments made as required.

11. Global efforts to eradicate poliovirus continue and the international spread of poliovirus remains a public health emergency of international concern, as per the recommendation of the Emergency Committee under the International Health Regulations (2005) on the international spread of poliovirus. The Director-General, on the advice of the Emergency Committee, has issued temporary recommendations addressed to countries infected with poliovirus or those that remain vulnerable to reinfection.²

12. The forty-third meeting of the Emergency Committee under the International Health Regulations (IHR) (2005) on the international spread of poliovirus, held on 1 October 2025, was the first emergency committee held after the entry into force of the 2024 amendments to the International Health Regulations (2005) on 19 September 2025 for 182 of 196 States Parties. Key relevant amendments to the International Health Regulations (2005) include broader poliovirus notification requirements and the introduction of the determination of pandemic emergency, a higher-level global public health alert with respect to a public health emergency of international concern. The Director-General accepted the Emergency Committee's recommendation, after a thorough review of the epidemiological and programmatic situation, that the poliovirus situation continues to constitute a public health emergency of international concern with respect to WPV1 and cVDPV, but the poliovirus situation does not constitute a pandemic emergency. The Director-General made the same determination following the forty-fourth meeting of the Emergency Committee held on 1 March 2026.

Action by the Standing Committee

13. The Standing Committee is invited to note the report. In its discussions, it is further invited to provide comments and guidance in respect of the questions set out below.

- Given the current resource constraints, what effective approaches could be adopted to ensure continued support for polio eradication?
- What additional steps should be taken to sustain political will in support of polio eradication, including the mobilization of domestic resources by Member States?

² See [statement of the forty-third meeting of the Emergency Committee under the International Health Regulations \(2005\) \(IHR\)](#) on the international spread of poliovirus (accessed 30 January 2026).