

Statement of the Twenty-Second IHR Emergency Committee Regarding the International Spread of Poliovirus

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Statement

Geneva

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The twenty-second meeting of the Emergency Committee under the International Health Regulations (2005) (IHR) regarding the international spread of poliovirus was convened by the Director General on 16 September 2019 at WHO headquarters with members, advisers and invited Member States attending via teleconference, supported by the WHO secretariat.

The Emergency Committee reviewed the data on wild poliovirus (WPV1) and circulating vaccine derived polioviruses (cVDPV). The Secretariat presented a report of progress for affected IHR States Parties subject to Temporary Recommendations. The following IHR States Parties provided an update on the current situation and the implementation of the WHO Temporary Recommendations since the Committee last met on 14 May 2019: Afghanistan, Benin, Central African Republic (CAR), China, Democratic Republic of Congo (DR Congo), Ghana, Myanmar, Nigeria, Pakistan and Somalia.

Wild poliovirus

The Committee is gravely concerned by the significant further increase in WPV1 cases globally to 73 in 2019 year to date, compared to 15 for the same period in 2018, with most of the increase due to the ongoing outbreaks in Pakistan. In Pakistan transmission continues to be widespread, as indicated by both AFP (acute flaccid paralysis) surveillance and environmental sampling, although the Khyber Pakhtunkhwa province was of particular concern. The increasing refusal by individuals and communities to accept vaccination is a serious setback to eradication. The committee was very concerned about the current status of the management of the polio program in Pakistan, but understood that steps are being taken to get the program back on track.

Highlighting these concerns, the committee noted that based on sequencing of viruses, there were new and recent instances of international spread of viruses from Pakistan to Afghanistan, in addition to the earlier reported exportation of virus to Iran (but without further transmission. The resumption of WPV1 international spread between Pakistan

and Afghanistan suggests that rising transmission in Pakistan correlates with increasing risk of WPV1 exportation beyond the single epidemiological block formed by the two countries.

In Afghanistan, the deteriorating security situation has seriously hampered progress towards global polio eradication. Inaccessible and missed children particularly in the Southern Region mean there is a large and growing cohort of susceptible children in this part of Afghanistan. The risk of a major upsurge of cases is growing, with other parts of the country that have been free of WPV1 for some time now at risk of outbreaks. This would again increase the risk of international spread. Major efforts must be made to improve access if eradication efforts are going to progress.

The Committee noted the continued cooperation and coordination between Afghanistan and Pakistan, particularly in reaching high risk mobile populations that frequently cross the international border and welcomed the all-age vaccination now being taken at key border points between the two countries. The committee was concerned that after five years of vaccinating travellers as a means to limit the risk of international spread, there was some evidence of complacency about this aspect of the program, particularly at airports, and this must be addressed to prevent further international spread.

In Nigeria, there has been no WPV1 detected for three years, and it is possible that the African Region may be certified WPV free in early 2020. However, this will require careful assessment of the risk of missed transmission in inaccessible areas of Borno, and in other countries in the region where confidence in surveillance is lacking. The Committee commended the strong efforts to reach inaccessible and trapped children in Borno, Nigeria, even in the face of increased insecurity.

Vaccine derived poliovirus

The multiple cVDPV2 outbreaks on the continent of Africa are now at unprecedented levels and need to be treated by countries as a national public health emergency. The committee welcomed the decision by the Director-General to write to all infected countries to highlight the gravity of the situation of a cVDPV2 outbreak.

The multiple cVDPV2 outbreaks with international spread on the continent of Africa are very concerning especially given the widening mucosal immunity gap in young children. Outbreaks in Niger, Cameroon, Benin, Ghana and Ethiopia were seeded by exportation from Nigeria in west Africa and Somalia in the Horn of Africa. Furthermore, the global nature of the risk is highlighted by the appearance of cVDPV2 in China and the Philippines, with undetected transmission for about a year in China, and much longer in the Philippines. Use of mOPV2 is now clearly demonstrated as a source of cVDPV2 emergence in areas where the vaccine has been used. In addition, cVDPV2 has emerged in parts of countries distant from the mOPV2 implementation area and in neighbouring countries that have not used mOPV2, presumed to be due to the spread of Sabin-like viruses. To mitigate these risks, more attention will be needed to ensure sufficient

coverage in the target populations through good quality campaigns, rigorous management of unused mOPV2 vials, better education of health care workers and care-givers to avoid spreading Sabin2 viruses, and urgent steps to ensure early detection of virus. Countries particularly in sub-Saharan Africa must be on alert and prepared for importation of cVDPV2, review response arrangements, even in countries with good routine immunization and no history of mOPV2 use.

The cVDPV1 outbreaks in Myanmar, PNG and Indonesia and cVDPV3 in Somalia highlight the gaps in population immunity due to pockets of persistently low routine immunization coverage in many parts of the world. However, these outbreaks seem to pose a lesser risk of international spread as bOPV vaccine is already available in these countries, is available for traveller vaccination, and global population immunity is far higher for type 1 and 3 than for type 2. It appears likely there has been missed transmission of cVDPV1 in Indonesia although there is no evidence so far that the virus has spread beyond Papua. Large inaccessible areas of Somalia are a significant constraint on achieving interruption of transmission, exacerbated by large nomadic population movements.

The committee noted that routine immunization was weak in all infected countries with consequent low coverage in many areas of these countries.

Inaccessibility is a major risk to interruption of transmission in Nigeria, Niger, Somalia and Afghanistan, and conflict in these countries and DR Congo makes control of these outbreaks even more challenging.

Conclusion

The Committee unanimously agreed that the risk of international spread of poliovirus remains a Public Health Emergency of International Concern (PHEIC) and recommended the extension of Temporary Recommendations for a further three months. The Committee considered the following factors in reaching this conclusion:

Rising risk of WPV1 international spread: The progress made in recent years appears to have reversed, with the committee's assessment that the risk of international spread is at the highest point since 2014 when the PHEIC was declared. This risk assessment is based on the following:

- the WPV1 exportation in 2019 from Pakistan to Iran and to Afghanistan;
- ongoing rise in the number of WPV1 cases and positive environmental samples in Pakistan, and to a lesser extent Afghanistan;
- the quickly increasing cohort of unvaccinated children in Afghanistan, with the risk of a major outbreak imminent if nothing is done to access these children;
- the urgent need to overhaul the program in Pakistan, which although already commencing, will take some time to lead to more effective control of transmission and ultimately eradication;
- increasing community and individual resistance to the polio program.

- Possible fatigue in implementing traveller immunization at airports increasing the risk of international spread beyond Pakistan and Afghanistan

Rising risk of cVDPV spread: The clearly documented spread of cVDPV2 from Nigeria to Niger, Cameroon, Benin, and Ghana, and from Somalia to Ethiopia demonstrate the unusual nature of the current situation, as international spread of cVDPV in the past has been very infrequent. The emergence of cVDPV2 in CAR and Angola, which had not used mOPV2, raises further concern. The risk of new outbreaks in new countries is considered extremely high, even probable. The outbreak of cVDPV1 in Myanmar on the border with Thailand in a population unreachable by the central government for immunization is an example of how border populations in countries affected by conflict can pose a special risk.

- Falling PV2 immunity: Global population mucosal immunity to type 2 polioviruses (PV2) continues to fall, as the cohort of children born after OPV2 withdrawal grows, exacerbated by poor coverage with IPV particularly in some of the cVDPV infected countries.
- Protracted outbreaks: The difficulty in rapidly controlling cVDPV outbreaks in Nigeria and DR Congo is another risk.
- Weak routine immunization: Many countries have weak immunization systems that can be further impacted by various humanitarian emergencies, and the number of countries in which immunization systems have been weakened or disrupted by conflict and complex emergencies poses a growing risk, leaving populations in these fragile states vulnerable to outbreaks of polio.
- Surveillance gaps: The appearance of highly diverged VDPVs in the Philippines, Somalia and Indonesia are examples of inadequate polio surveillance, heightening concerns that transmission could be missed in various countries. Furthermore, the missed transmission in China for a year illustrates that even countries with generally good surveillance can miss VDPV transmission.
- Lack of access: Inaccessibility continues to be a major risk, particularly in several countries currently infected with WPV or cVDPV, i.e. Afghanistan, Nigeria, Niger, Somalia, Myanmar and Indonesia, which all have sizable populations that have been unreached with polio vaccine for prolonged periods.
- Population movement: The risk is amplified by population movement, whether for family, social, economic or cultural reasons, or in the context of populations displaced by insecurity and returning refugees. There is a need for international coordination to address these risks. A regional approach and strong crossborder cooperation is required to respond to these risks, as much international spread of polio occurs over land borders.

Risk categories

The Committee provided the Director-General with the following advice aimed at reducing the risk of international spread of WPV1 and cVDPVs, based on the risk stratification as follows:

- States infected with WPV1, cVDPV1 or cVDPV3, with potential risk of international spread.
- States infected with cVDPV2, with potential risk of international spread.
- States no longer infected by WPV1 or cVDPV, but which remain vulnerable to re-infection by WPV or cVDPV.

Criteria to assess States as no longer infected by WPV1 or cVDPV:

- Poliovirus Case: 12 months after the onset date of the most recent case PLUS one month to account for case detection, investigation, laboratory testing and reporting period OR when all reported AFP cases with onset within 12 months of last case have been tested for polio and excluded for WPV1 or cVDPV, and environmental or other samples collected within 12 months of the last case have also tested negative, whichever is the longer.
- Environmental or other isolation of WPV1 or cVDPV (no poliovirus case): 12 months after collection of the most recent positive environmental or other sample (such as from a healthy child) PLUS one month to account for the laboratory testing and reporting period
- These criteria may be varied for the endemic countries, where more rigorous assessment is needed in reference to surveillance gaps (e.g. Borno)

Once a country meets these criteria as no longer infected, the country will be considered vulnerable for a further 12 months. After this period, the country will no longer be subject to Temporary Recommendations, unless the Committee has concerns based on the final report.

TEMPORARY RECOMMENDATIONS

States infected with WPV1, cVDPV1 or cVDPV3 with potential risk of international spread

WPV1

- Afghanistan (most recent detection 27 August 2019)
- Pakistan (most recent detection 26 August 2019)
- Nigeria (most recent detection 27 Sept 2016)

cVDPV1

- Papua New Guinea (most recent detection 7 November 2018)
- Indonesia (most recent detection 13 February 2019)
- Myanmar (most recent detection 23 July 2019)

cVDPV3

Somalia (most recent detection 7 Sept 2018)

These countries should:

- Officially declare, if not already done, at the level of head of state or government, that the interruption of poliovirus transmission is a national public health emergency and implement all required measures to support polio eradication; where such declaration has already been made, this emergency status should be maintained as long as the response is required.
- Ensure that all residents and longterm visitors (i.e. > four weeks) of all ages, receive a dose of bivalent oral poliovirus vaccine (bOPV) or inactivated poliovirus vaccine (IPV) between four weeks and 12 months prior to international travel.
- Ensure that those undertaking urgent travel (i.e. within four weeks), who have not received a dose of bOPV or IPV in the previous four weeks to 12 months, receive a dose of polio vaccine at least by the time of departure as this will still provide benefit, particularly for frequent travellers.
- Ensure that such travellers are provided with an International Certificate of Vaccination or Prophylaxis in the form specified in Annex 6 of the IHR to record their polio vaccination and serve as proof of vaccination.
- Restrict at the point of departure the international travel of any resident lacking documentation of appropriate polio vaccination. These recommendations apply to international travellers from all points of departure, irrespective of the means of conveyance (e.g. road, air, sea).
- Further intensify crossborder efforts by significantly improving coordination at the national, regional and local levels to substantially increase vaccination coverage of travellers crossing the border and of high risk crossborder populations. Improved coordination of crossborder efforts should include closer supervision and monitoring of the quality of vaccination at border transit points, as well as tracking of the proportion of travellers that are identified as unvaccinated after they have crossed the border.
- Further intensify efforts to increase routine immunization coverage, including sharing coverage data, as high routine immunization coverage is an essential element of the polio eradication strategy, particularly as the world moves closer to eradication.
- Maintain these measures until the following criteria have been met: (i) at least six months have passed without new infections and (ii) there is documentation of full application of high quality eradication activities in all infected and high risk areas; in the absence of such documentation these measures should be maintained until the state meets the above assessment criteria for being no longer infected.
- Provide to the Director-General a regular report on the implementation of the Temporary Recommendations on international travel.

States infected with cVDPV2s, with potential or demonstrated risk of international spread

- Angola (most recent detection 14 August 2019)
- Benin (most recent detection 30 June 2019)
- Cameroon (most recent detection 20 April 2019)
- CAR (most recent detection 21 August 2019)
- China (most recent detection 25 April 2019)
- DR Congo (most recent detection 26 July 2019)
- Ethiopia (most recent detection 22 July 2019)
- Ghana (most recent detection 23 July 2019)
- Mozambique (most recent detection 17 December 2018)
- Niger (most recent detection 3 April 2019)
- Nigeria (most recent detection 8 August 2019)
- Philippines (most recent detection 22 August 2019)
- Somalia (most recent detection 8 May 2019)

These countries should:

- Officially declare, if not already done, at the level of head of state or government, that the interruption of poliovirus transmission is a national public health emergency and implement all required measures to support polio eradication; where such declaration has already been made, this emergency status should be maintained.
- Noting the existence of a separate mechanism for responding to type 2 poliovirus infections, consider requesting vaccines from the global mOPV2 stockpile based on the recommendations of the Advisory Group on mOPV2.
- Encourage residents and longterm visitors to receive a dose of IPV (if available in country) four weeks to 12 months prior to international travel; those undertaking urgent travel (i.e. within four weeks) should be encouraged to receive a dose at least by the time of departure.
- Ensure that travellers who receive such vaccination have access to an appropriate document to record their polio vaccination status.
- Intensify regional cooperation and crossborder coordination to enhance surveillance for prompt detection of poliovirus, and vaccinate refugees, travellers and crossborder populations, according to the advice of the Advisory Group.
- Further intensify efforts to increase routine immunization coverage, including sharing coverage data, as high routine immunization coverage is an essential element of the polio eradication strategy, particularly as the world moves closer to eradication.
- Maintain these measures until the following criteria have been met: (i) at least six months have passed without the detection of circulation of VDPV2 in the country from any source, and (ii) there is documentation of full application of high quality eradication activities in all infected and high risk areas; in the absence of such documentation these measures should be maintained until the state meets the criteria of a 'state no longer infected'.
- At the end of 12 months without evidence of transmission, provide a report to the Director-General on measures taken to implement the Temporary Recommendations.

States no longer infected by WPV1 or cVDPV, but which remain vulnerable to re-infection by WPV or cVDPV

WPV1

Chad (last case 14 Jun 2012)

cVDPV

- Syria (last case 21 Sept 2017)
- Kenya (last env positive specimen 21 March 2018)

These countries should:

- Urgently strengthen routine immunization to boost population immunity.
- Enhance surveillance quality, including considering introducing supplementary methods such as environmental surveillance, to reduce the risk of undetected WPV1 and cVDPV transmission, particularly among high risk mobile and vulnerable populations.
- Intensify efforts to ensure vaccination of mobile and crossborder populations, Internally Displaced Persons, refugees and other vulnerable groups.
- Enhance regional cooperation and cross border coordination to ensure prompt detection of WPV1 and cVDPV, and vaccination of high risk population groups.
- Maintain these measures with documentation of full application of high quality surveillance and vaccination activities.
- At the end of 12 months* without evidence of reintroduction of WPV1 or new emergence and circulation of cVDPV, provide a report to the Director-General on measures taken to implement the Temporary Recommendations.

*For the Lake Chad countries, this will be linked to when Nigeria is considered no longer infected by WPV1 or cVDPV2.

Additional considerations

The committee urged all countries, particularly those in Africa, be on high alert for the possibility of cVDPV2 importation and respond to such importations as a national public health emergency. This means countries should ensure polio surveillance can rapidly detect cVDPV2, and plans are in place to respond rapidly with well planned and executed mOPV2 campaigns, and with strict procedures to ensure unused vials are returned and managed so that inappropriate or accidental use is avoided. Campaign communications need to address issues around avoiding spreading excreted Sabin-like viruses through good hygiene. Noting that most cVDPV2 outbreaks have been assessed as grade 2 according to the WHO Health Emergency Program framework, in some circumstances it may be more appropriate to make it grade 3. The committee noted the recommendations of the SAGE Polio Working Group and reinforced their recommendations that new capacity to ensure mOPV2 supply is of critical importance, and endorsed that Emergency Use Listing be considered to accelerate the availability of novel OPV2 that is in development. The committee urged the GPEI and donor partners

to ensure that funding of outbreak response was sufficient and mechanisms to relay funds to infected districts should be urgently implemented reflecting the urgency of the response.

The committee noted that as the risk of international spread of WPV1 was the highest since 2014, the risk of exportation events from Pakistan and Afghanistan through air travel was also greater than in recent years and urged both countries to ensure adequate funding and monitoring of airport and travel vaccination was in place. While travel vaccination may not be a major priority in terms of impact on the control of WPV1 in the two countries, it represents a critical control point in preventing international spread.

Based on the current situation regarding WPV1 and cVDPV, and the reports provided by affected countries, the Director-General accepted the Committee's assessment and on 25 September 2019 determined that the situation relating to poliovirus continues to constitute a PHEIC, with respect to WPV1 and cVDPV. The Director-General endorsed the Committee's recommendations for countries meeting the definition for 'States infected with WPV1, cVDPV1 or cVDPV3 with potential risk for international spread', 'States infected with cVDPV2 with potential risk for international spread' and for 'States no longer infected by WPV1 or cVDPV, but which remain vulnerable to re-infection by WPV or cVDPV' and extended the Temporary Recommendations under the IHR to reduce the risk of the international spread of poliovirus, effective 25 September 2019.

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