World Health Organization

Key Messages regarding the IHR Temporary Recommendations to reduce the international spread of polio
February 2016

Purpose of this document

On 5 May 2014, the Director-General of the World Health Organization (WHO) declared the international spread of wild poliovirus (WPV) a Public Health Emergency of International Concern (PHEIC). The declaration followed advice given by an Emergency Committee under the International Health Regulations (IHR) and issued Temporary Recommendations to limit the international spread of wild poliovirus (WPV).

Since May 2014, the Emergency Committee has re-evaluated the evolving epidemiology every three months, and offered further strengthened recommendations and an ongoing assessment that the situation remained a PHEIC, most recently at its meeting in February 2016.

Key messages

In May 2014, recognizing the increasing risk international spread of wild poliovirus posed to the goal of a polio-free world (as more and more countries were becoming re-infected), WHO declared polio eradication to be a 'Public Health Emergency of International Concern', under the guidance of an Emergency Committee of the International Health Regulations (IHR). This declaration was further supported by evidence indicating that failure to eradicate polio could lead to global resurgence of the disease, resulting in 200,000 new cases every single year, within 10 years.

In November 2015, recognizing the progress achieved in bringing the world to the brink of eradicating wild polioviruses, and the growing importance of risks associated with cVDPVs, WHO – on ongoing advice of the IHR Emergency Committee - extended its PHEIC to countries also affected by cVDPVs.

The PHEIC means that countries affected by wild poliovirus or cVDPVs should: declare a national public health emergency, implement national emergency plans under the auspices of the head of state to ensure an all-of-government approach, and ensure the vaccination of international travellers.

Under the PHEIC, countries affected by wild or circulating vaccine-derived poliovirus transmission have taken extraordinary measures. Under the auspices of the respective heads of state, national polio emergencies were declared, eradication efforts intensified through an all-of-government approach, and systematic vaccination of international travellers implemented.

Wild poliovirus transmission has been curbed to its lowest levels in history. In 2015, fewer cases were reported from fewer areas of fewer countries than ever before. In September 2015, Nigeria – which was the global epicentre of polio transmission as recently as 2012 – was officially removed from the list of polio-endemic countries, not having reported a case since July 2014. Nowhere on the African continent has any wild polio case been reported in more

than 12 months. Only two countries remain endemic – Pakistan and Afghanistan. The world stands on the brink of an unprecedented public health success – the worldwide eradication of a human disease for only the second time in history (after smallpox in 1980).

In 2015, more countries were affected by cVDPV outbreaks (Ukraine, Guinea, Lao, Nigeria, Madagascar and Myanmar) than wild polioviruses (Pakistan and Afghanistan). The cVDPV outbreaks occurred infour WHO Regions.

The extension of the PHEIC is also particularly critical, in advance of the start of the phased withdrawal of OPVs, beginning with the switch from trivalent OPV to bivalent OPV in April 2016. The withdrawal of OPV is a critical part of the Polio Endgame Plan, to secure a lasting world free of all polioviruses (wild- or vaccine-derived).

At its meeting in February 2016, the Emergency committee noted that countries with embassies in Afghanistan and Pakistan,could facilitate implementation of Temporary Recommendations through adopting procedures that include proof of polio vaccination as part of visa application procedures from travellers departing Afghanistan and Pakistan. WHO and its partners will continue to support all Member States in their ongoing efforts to fully implement national emergency action plans and to implement the recommendations as outlined under the PHEIC.

We are closer to ending polio than ever before, with a record low 74 wild polio cases in two countries declared in 2015.

So long as wild and vaccine-derived polio exist anywhere, we must use all available tactics to safeguard progress, protect vulnerable children, and stay on track to eradicate the disease once and for all.

Q&As

Why has the WHO Director General (DG) made these recommendations for travellers?

- The Director-General of the World Health Organization (WHO) made the recommendations following her consideration of the advice and views of the International Health Regulations (IHR) Emergency Committee which was convened on 28-29 April 2014, and since then has re-evaluated the evolving epidemiology every 3 months.

Why were the Temporary Recommendations extended to countries affected by cVDPVs in November 2015?

- With strong progress towards the eradication of WPV in the end stages of the programme, more countries are affected by cVDPVs than by WPV outbreaks. In the Polio Endgame, the importance of cVDPVs is increasingly become evident.
- In 2015, cVDPVs occurredin fourWHO Regions, underlining significant gaps in population immunity at a critical point in the Polio Endgame. In the past at least five episodes of international spread of cVDPV have been recorded, all due to cVDPV type 2.
- The risk of cVDPVs on the polio endgame, the risk of international spread, the serious gaps in routine immunization coverage and the urgency of stopping type 2 cVDPVs in

advance of the withdrawal of the oral polio vaccine type 2 in April 2016 were evaluated by the committee in support of this decision.

- The long-term goal of eliminating the risk of cVDPVs will be achieved through the phased removal of OPVs, beginning with the switch from trivalent OPV to bivalent OPV in April 2016. However, in the interim, cVDPVs are also able to spread internationally, and must therefore be subject to the same control measures as WPVs.

Why is there an increased focus on cVDPVs this year?

- During 2015, the number of cases of cVDPVs has greatly reduced (31 in 2015 compared to 56 in 2014). Yet the fact that any cases continue to be found underlines the fact that populations continue to be under immunized, leading to the rare conditions through which VDPVs can emerge and start circulating.
- In 2015, with numbers of all types of poliovirus at a historic low, more countries have been affected by cVDPVs than by WPV outbreaks. Circulating VDPVs are taking greater precedence now because the number of WPV cases to date in is lower than it has ever been, shifting the focus onto cVDPVs. The definition of cVDPV cases has also been expanded this year to a more sensitive set of criteria. This may also lead to an increased focus on cVDPV cases.
- The goal of the Global Polio Eradication Initiative is to ensure that no child is ever again paralysed by any form of polio, whether caused by WPVs or cVDPVs. The same strategies are needed to stop any kind of outbreak, namely, maintaining strong disease surveillance and ensuring all children are vaccinated, particularly in hard-to-reach and underserved areas.

Should refugees in particular be immunized?

- Poliovirus can spread easily with any population movement. Poliovirus does not distinguish why a person or a population is travelling. It is simply very effective at spreading itself with population movements. That is why the recommendations are in place, to vaccinate travellers from polio-infected areas, to minimise the risk of further international spread of the virus.

Should adults be immunized, and why this particular schedule (iefour weeks to 12 months prior to travel)?

- Polio vaccination recommendations for travellers from polio-infected countries should apply to all residents and visitors, who spend more than four weeks in the country, of all ages. This is based on several lines of evidence that demonstrate older individuals play an important role in international spread of poliovirus, including observational and challenge studies and documented cases of adult travellers excreting wild poliovirus.
- Resident travellers from polio-infected countries should have received one documented additional dose of OPV or IPV a minimum of four weeks and a maximum of 12 months before each international travel. This is based on evidence from a number of studies demonstrating that immunologically-naive populations usually attain a maximum immune response within four weeks, and on studies demonstrating that intestinal immunity can wane within 12 months. (Travellers embarking on urgent travel that cannot be postponed should receive one dose of OPV or IPV before departure if they have not received a documented dose of polio vaccine within 12 months.)

What happens when a previously polio-free country is infected with wild poliovirus or a VDPVcirculates?

- Any polio-free State which becomes infected with wild poliovirus or where a VDPV circulates should immediately implement the relevant Temporary Recommendations for 'States infected with wild poliovirus or states infected with cVDPV but not currently exporting'.

For how long will these recommendations be in place?

- Temporary recommendations are valid for three months and may be extended or modified.Given the nature of poliovirus epidemiology, transmission and surveillance, the Director-General has requested the Emergency Committee reassess this situation in three months.

Are there any recommendations for polio-free states?

- No, there are no Temporary Recommendations for polio-free states.

Should polio-free states screen travellers from polio-affected countries for proof of vaccination?

- No. The current Temporary Recommendations do not recommend that polio-free countries screen arriving passengers for their polio vaccination status.However, some individual polio-free countries will require proof of such vaccination for a visa or for entry. It is important to ensure travellers know the requirements of the country to which they are travelling.

Does WHO recommend that travellers from a state exporting polio who may not have been vaccinated, or lack proof of vaccination as provided in these temporary recommendations, NOT be allowed to travel?

- States exporting polio should ensure that all international travellers are vaccinated and provided a certificate of vaccination before departure. If necessary (e.g. urgent travel), vaccination can be given at the time of departure to minimize any impact on travel, while still providing some benefit to the individual and community.

What kind of authority do these temporary recommendations have?

- IHR Temporary Recommendations are an agreed procedure of the IHR, which is an internationally binding agreementby all the WHO Member States, to ensure coordinated international response to a public health emergency of international concern. AllMember States expect that polio-infected and exporting Stateswill fully implement them.Internationally coordinated actions under the IHR also reduce the likelihood of individual countries putting in place restrictions on travel and trade that are not warranted.

Dothese Temporary Recommendations need to be endorsed by the World Health Assembly?

- No, the World Health Assembly adopted the IHR in 2005, and these came into force in 2007.The WHO Director General sought the advice of the Emergency Committee, convened under the IHR.

Which countries are most at risk of polio re-infection or re-emergence?

- As long as polio circulates anywhere in the world, all countries are at risk.
- However, at particular risk are those areas with close geographic, cultural, socioeconomic and/or other ties with polio-infected countries, and those with evidence of historical

spread of poliovirus due to population movements (e.g. West Africa, Central Africa, the Horn of Africa, the Middle East).

- Furthermore, there are some particularly vulnerable countries, with deficits in vaccination coverage (e.g. countries in conflict or affected by complex emergencies, such as Central African Republic, and/or countries with significant gaps in their national vaccination programme).

How effective is polio vaccination and how effective is vaccination of travellers in limiting international spread?

- Polio vaccination of travellers reduces the risk of international spread by boosting intestinal mucosal immunity and reducing the risk of transient carriage of the poliovirus by travellers.
- Polio vaccines are among the most effective vaccines and their widespread use has led to a reduction of 99.9% in polio incidence worldwide since 1988. The disease is on the brink of eradication due to effective vaccination.
- The following measures can helpto minimise the risk and consequences of a country becoming re-infected with poliovirus:
    - maintaining high levels of population immunity;
    - maintaining very sensitive disease surveillance and rapid outbreak response capacity; and,
    - fully implementing relevant polio vaccination recommendations for travellers as outlined in WHO's International Travel and Health. (Note: since the implementation of vaccination requirements for Hajj pilgrims, there has been no evidence of spread of polio to or from Saudi Arabia).

How far can polio really spread?

- Polio usually spreads locally and across porous borders (eg West Africa).
- There is also significant historical evidence of long-distancespread via international air travel or other means (e.g. during the past 10 years there has been spread from Pakistan to the Middle East and Australia, from India to Angola, from Nigeria to Somalia, from Chad to Switzerland, from India to Tajikistan and further to Russia).
- These Temporary Recommendations, if fully implemented, will reduce the risk of international spread of polio. However, only complete eradication of polio will eliminate that risk. The best things countries can do to minimise the risk and consequences of international spread of polio are:
    - stop transmission of poliovirus (in both endemic and re-infected countries);
    - maintain high levels of population immunity;
    - maintain very sensitive disease surveillance and response capacity; and,
    - fully implement relevant polio vaccination recommendations for travellers as outlined in WHO's International Travel and Health.

Will these recommendations affect the movement of goods and international trade?

- No. The current epidemiological situation does not warrant any restrictions on international trade.