



Statement of the Seventeenth IHR Emergency Committee Regarding the International Spread of Poliovirus

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The seventeenth 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 30 April 2018 at WHO headquarters with members, advisers and invited member states attending via teleconference.

The Emergency Committee reviewed the data on wild poliovirus (WPV1) and circulating vaccine derived polioviruses (cVDPVs). 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 7 February 2018: Afghanistan, Democratic Republic of Congo (DR Congo), Pakistan, Kenya, Somalia and Syrian Arab Republic.

Wild polio

Overall the Committee was encouraged by continued progress in WPV1 eradication, with the number of cases globally remaining low in 2018. In addition, there has now been no international spread of WPV1 since October 2017.

The Committee commended the continued high level commitment seen in both Afghanistan and Pakistan, and the high degree of cooperation and coordination, particularly targeting the high risk mobile populations that frequently cross the international border. The joint planning to cease transmission in the two recognized zones of transmission (the northern corridor which extends from Nangarhar to Islamabad and Rawalpindi, and the southern corridor from Kandahar to Quetta Block) is a key to success in achieving WPV eradication in Pakistan and Afghanistan, the region, and globally.

The Committee commended the achievements in Pakistan that have resulted in a sustained reduction in the number of cases, with only one case so far in 2018, and a fall in the proportion of environmental samples that have tested positive for WPV1. No orphan virus (viruses that are not closely related to any other virus based on genetic analysis) has been detected so far in 2018, giving some confidence

that surveillance is working well. Notable achievements include better quality supplementary immunization activities (SIA) and improved communication to reduce missed children. However, environmental surveillance continues to detect WPV1 transmission in many high risk areas of the country such as Karachi, Peshawar and the Quetta Block. The robust response to environmental detections of WPV was welcomed.

The Committee was concerned by the stagnation in progress in Afghanistan and the ongoing risks to eradication posed by the number of inaccessible and missed children, particularly in the southern and eastern regions, resulting in fourteen cases in 2017, and already seven cases in 2018. The continued inaccessibility in Kandahar, Paktika, and parts of Nangarhar and Kunar, and issues with vaccine acceptance in some high risk areas particularly in Kandahar, the Bermel district of Paktika, and Kunar are the biggest challenges. Of greatest concern are the children chronically unreached by the polio program, these numbering around 13,000 children in Shahwalikot and 40,000 children living in areas controlled by militant anti- government elements in the eastern region.

The Committee commended the innovations that continue to be made in Nigeria to reach children in Borno, where the number of inaccessible children has fallen from 160,000 in late 2017 to around 104,000 currently. While certain cross border activities are being undertaken, such as international synchronization of vaccination campaigns, these efforts appeared to be insufficient to ensure that any poliovirus still circulating undetected is not exported to neighboring Lake Chad basin countries. The Committee also noted that routine immunization coverage is low, particularly in high risk areas of northern Nigeria. The country however has declared routine immunization a national public health emergency and is actively planning for Gavi transition with strengthening of its routine immunization program in mind. Although it is over 19 months since the last detection of WPV1 in Nigeria, the outbreak response assessment by global polio experts concluded ongoing undetected transmission could not be ruled out.

There is ongoing concern about the districts of the neighboring countries of the Lake Chad basin region that have been affected by the Boko Haram insurgency, with the consequent lack of services and presence of IDPs and refugees. The risk of international spread from Nigeria to the Lake Chad basin countries or further afield in sub-Saharan Africa remains substantial. The Committee was encouraged that the Lake Chad basin countries, Cameroon, Chad, the Central African Republic (CAR), Niger and Nigeria continued to be committed to sub-regional coordination of immunization and surveillance activities. However, there are widespread persistent gaps in population immunity across these countries, and the ongoing population movement in the sub-region and insecurity are major challenges. The committee urged that work to characterize and vaccinate transient and permanent populations on the Lake Chad islands continue urgently.

Vaccine derived poliovirus

The committee noted that in DR Congo, the vaccine-derived polio outbreak has now been declared a public health emergency, with resources being made available for an emergency operation centre, appointment of a national outbreak coordinator, and other resources. However, there has been further transmission into new areas not covered by previous mOPV2 campaigns, with the report of a case in Haut Katanga province, and another eight cases reported in previously affected provinces. Further

rounds with mOPV2 are being planned. Risks are compounded by poor surveillance in many areas, and widespread gaps in population immunity. It was noted that upcoming elections with the possibility of civil unrest posed an additional risk to the ability of the country to halt the outbreak. The movement of refugees and IDPs increases the risk of further spread, and the IPV shortage in neighboring countries is another risk, with the under 2 age group vulnerable to type 2 infection. In DR Congo, insecurity and geographical remoteness of the affected area pose significant challenges to controlling the outbreak.

The committee noted that in Syria, there has been no new case for more than six months, giving hope that transmission may have stopped. However, while AFP surveillance indicators are good, and environmental surveillance is now in operation, low level transmission cannot yet be ruled out.

The new outbreak of cVDPV2 with international spread affecting Somalia and Kenya is a major concern, together with the recent detection of cVDPV3 by environmental sampling in Mogadishu. While the robust response to date was commendable, the lack of clarity about where the virus emerged and circulated for a prolonged period prior to detection means that it remains unsure whether the population currently being targeted is sufficient. The persistently inaccessible districts in the South and Central zones of Somalia makes an effective response extremely difficult, with more than 300,000 children aged under 5 years believed to be living in these districts. Nomadic and refugee movement make other areas in the sub-region (e.g. Somali region of Ethiopia, north east Kenya, and Yemen) potentially at risk of international spread.

The new outbreak of cVDPV2 recently detected in Jigawa, Nigeria, again underlines the vulnerability of northern Nigeria to poliovirus transmission.

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:

- Although the risk of international spread of WPV may be diminishing as transmission falls, the impact of any delay in eradicating WPV caused by international spread, should it occur now, would be even more grave in terms of delaying certification and the need to maintain human and financial resources for a longer period to achieve eradication. The risk of global complacency developing increases as the numbers of WPV cases remains low and eradication becomes a tangible reality, and removing the PHEIC now could contribute to greater complacency, particularly at an inopportune time given the upcoming Hajj with its heightened population movement.
- Many countries remain vulnerable to WPV importation, as evidenced by gaps in population immunity in several key high risk areas, and also the current number of cVDPV outbreaks, both type 2 and 3, which only emerge and circulate due to lack of polio population immunity.
- Inaccessibility to vaccination programs remains another major risk, particularly in several countries currently infected with WPV or cVDPV, i.e. Afghanistan, Nigeria and Somalia, which all have sizable populations that have been unreached with polio vaccine for prolonged periods.

- 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, particularly between Afghanistan and Pakistan, Nigeria and its Lake Chad neighbors, and countries in and bordering the Horn of Africa and DR Congo.
- The inaccessible population in Borno state in Nigeria remains substantial despite the commendable efforts to reach all settlements. These populations have not received polio vaccine since WPV1 was detected in 2016, so ongoing transmission in these unreached pockets cannot be ruled out. The risk of transmission in the Lake Chad sub-region appears considerable, with significant gaps in population immunity in these vulnerable countries, compounded by international population movement.
- The new international outbreak of cVDPV2 affecting Somalia and Kenya, with a highly diverged cVDPV2 that appears to have circulated undetected for up to four years highlights that there are still high-risk populations in South and Central zones of Somalia where population immunity and surveillance are compromised by inaccessibility.
- The ongoing spread of cVDPV2 in DR Congo demonstrates significant gaps in population immunity at a critical time in the polio endgame; the lack of IPV vaccination in several countries neighboring DR Congo heightens the risk of international spread, as population immunity is rapidly waning.
- The increasing number of countries in which immunization systems have been weakened or disrupted by conflict and complex emergencies poses another risk. Populations in these fragile states are vulnerable to outbreaks of polio. Outbreaks in fragile states are exceedingly difficult to control and threaten the completion of global polio eradication during its end stage.
- 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 (eg 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
- Pakistan
- Nigeria

cVDPV3

- Somalia

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.
- 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 travelers.
- Ensure that such travelers 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 travelers 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 travelers 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 travelers 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 risk of international spread

- DR Congo
- Kenya
- Nigeria
- Syrian Arab Republic
- Somalia

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 travelers 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, travelers 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

- Cameroon(last case 9 Jul 2014)
- Central African Republic(last case 8 Dec 2011)
- Chad (last case 14 Jun 2012)
- Niger(last case 15 Nov 2012)

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 noted that in all the infected and vulnerable countries, routine immunization was generally quite poor, if not nationally, then in sub-national pockets. The Committee also noted that surveillance in these areas may also be sub-optimal, particularly where access is compromised by

conflict. The Committee strongly encourages all these countries to make further efforts to improve routine immunization and strengthen surveillance in such areas, and requested international partners to support these countries in rapidly improving routine immunization coverage to underpin eradication.

The Committee also urged that Nigeria and the Lake Chad countries increase cross border efforts and joint planning and response. Intensified effort is needed to identify and reach vulnerable populations in the sub-region, particularly in the Lake Chad islands. Nigeria should ensure continuing political commitment and take measures to counter fatigue in the fight against polio. Similarly, the DR Congo government needs to pay more attention to prevention of international spread of cVDPV2 from DR Congo, noting that neighboring countries are affected by the global shortage of IPV.

Based on the current situation regarding WPV1 and cVDPV, and the reports provided by Afghanistan, DR Congo, Kenya, Pakistan, and Somalia, the Director-General accepted the Committee's assessment and on 7 May 2018 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 7 May 2018.

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