GPEI Strategy for Control of cVDPV2 2020-2021

**Background**

Since 1988, the world has made incredible progress in the global effort to eradicate polio, with wild polio cases dropping by 99.9%. This progress is thanks to the large-scale administration of the oral polio vaccine (OPV) – an effective tool which has protected millions of children from paralysis.

In addition to protecting children from paralysis, OPV prevents person-to-person transmission of the virus and is vital to achieve eradication. However, in under-immunized communities, the live, weakened virus originally contained in OPV can circulate for an extended period and genetically revert into a form that causes paralysis. This is known as circulating vaccine-derived poliovirus (cVDPV). Once a cVDPV emerges, outbreak response is carried out per international guidelines in the same way as for wild poliovirus outbreaks: large-scale administration with OPV to rapidly boost population immunity. For cVDPV2 outbreaks, type 2 monovalent OPV is used to build immunity to the type 2 virus.

Following the certification of the eradication of wild poliovirus type 2 in 2015, countries around the world switched from the trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV)—which doesn’t carry the type 2 virus responsible for 90% of cVDPV outbreaks. In planning for the switch, the risk of further cVDPV2 cases was carefully considered and modelled. However, the number and scope of current outbreaks are greater than anticipated and cVDPV2 outbreaks have emerged as a major challenge in the final stage of eradication.

For more information on vaccine-derived polio, visit www.polioeradication.org

**Current Situation**

In 2020, almost four years after the global switch to bOPV, the world is facing increasing cVDPV2 outbreaks in parts of Africa, Southeast Asia, and the Middle East. In 2019, more than 260 cases of cVDPV2 were reported from 15 countries (data as of 22 January 2020).

These outbreaks are driven by several factors, including declining immunity levels to the type 2 virus among young children born after the switch, insufficient routine immunization coverage, regional migration patterns, and low-quality immunization campaigns. Additionally, the use of mOPV2 to stop cVDPV2 outbreaks has seeded new outbreaks in areas of low coverage within and on the borders of response zones.

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**Global cVDPV2 Cases, 2014-2019**

- **2014**
- **2015**
- **2016**
- **2017**
- **2018**
- **2019**

**Quick Facts on OPV SINCE 2010:**
- More than **20 billion** doses administered to more than one billion children
- **650,000** cases of paralysis averted every year
- **30,000** childhood deaths averted
A New Tool: The Potential of nOPV2

GPEI partners are actively engaged in the development of novel oral polio vaccine type 2 (nOPV2), a new tool that could prove critical to stopping cVDPV2 outbreaks and carries a lower risk of seeding new outbreaks. nOPV2 is a modification of the existing Sabin OPV type 2, specifically designed to improve the genetic stability of the vaccine. Studies to date suggest it would provide children with comparable protection as the current oral vaccine but with a much lower risk of mutating and causing paralysis.

Initial results from clinical trials of nOPV2 have been very encouraging. If given WHO EUL (see sidebar), nOPV2 could be available to address cVDPV2 outbreaks as early as mid-2020.

The GPEI is working with regional and country teams to prepare for possible use of nOPV2, providing technical and communications assistance as needed. The WHO Strategic Advisory Group of Experts on Immunization (SAGE) will also endorse a framework for prioritization to ensure the highest-risk areas that meet EUL criteria are the first to introduce the nOPV2 vaccine.