

## **Statement of the Twenty-Fifth Polio IHR Emergency Committee**

The twenty-fifth meeting of the Emergency Committee under the International Health Regulations (2005) (IHR) on the international spread of poliovirus was convened and opened by the Director General on 23 June 2020 with committee members attending via teleconference, supported by the WHO Secretariat. Dr Tedros in his opening remarks said that while there has been amazing progress on wild poliovirus in Africa, there is still much more work to do to end transmission in Pakistan and Afghanistan. Similarly, the significantly greater than expected number of circulating vaccine derived polio virus type-2 (cVDPV2) outbreaks are another major challenge. The COVID-19 pandemic has had a significant impact on public health programs, including polio eradication. As a result, the risk of the international spread of polio is likely to have increased considerably. At the same time, the polio infrastructure that has been developed in Pakistan and Afghanistan has been used to assist with the tracking and tracing as part of the COVID-19 pandemic response.

He also remarked that the novel oral polio vaccine type-2, which will be made available under the Emergency Use Listing procedure (EUL), is expected to be an important new tool to stop the vicious cycle of using monovalent Sabin OPV2 to combat outbreaks, but in turn seeding new outbreaks of cVDPV2. Dr Tedros thanked the committee for their commitment and said he looked forward to receiving their advice.

The Emergency Committee reviewed the data on wild poliovirus (WPV1) and circulating vaccine derived polioviruses (cVDPV). The WHO Secretariat presented a report of progress for affected IHR States Parties subject to Temporary Recommendations. The following IHR States Parties provided an update at the teleconference on the current situation and the implementation of the WHO Temporary Recommendations since the Committee last met on 26 March 2020: Afghanistan, Burkina Faso, Mali and Pakistan. In order to ease the burden on affected State Parties in the exceptional situation following the determination of the COVID-19 outbreak as a Public Health Emergency of International Concern (PHEIC) on 30 January 2020, the following invited State Parties were asked to present their reports electronically only instead of attending via teleconference: Chad, Cote d'Ivoire, Ethiopia, Ghana, Malaysia, Niger, Nigeria, Philippines, Philippines, and Togo. All these States Parties have previously attended teleconferences of the committee to present their statements.

### **Wild poliovirus**

The global situation remains of great concern with the increased number of WPV1 cases that started in 2019 continuing in 2020. This year there have been 70 WPV1 cases as at 16 June 2020, compared to 57 for the same period in 2019, with no significant success yet in reversing this upward trend.

In Pakistan transmission continues to be widespread, as indicated by both acute flaccid paralysis (AFP) surveillance and environmental sampling. WPV1 transmission continues to be widespread, with southern Khyber Pakhtunkhwa becoming a new WPV1 reservoir, and some areas such as Karachi and the Quetta block having uninterrupted transmission. There has also been expansion of WPV1 to previously polio free areas in Sindh and Punjab.

In Afghanistan, the security situation remains very challenging. Inaccessibility and missed children particularly in the Southern Region have led to a large 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. The number of provinces reporting WPV1 has increased from three in 2019 to 11 in 2020. This would again increase the risk of international spread.

The Committee noted that based on results from sequencing of WPV1, there were recent instances of international spread of viruses from Pakistan to Afghanistan and from Afghanistan to Pakistan. The ongoing frequency of WPV1 international spread between the two countries and the increased vulnerability in other countries where routine immunization and polio prevention activities have both been adversely affected by the COVID-19 pandemic are two major factors that suggest the risk of international spread may be at the highest level since 2014. While border closures and lockdowns may mitigate the risk in the short term while in force, this would be outweighed in the longer term by falling population immunity through disruption of vaccination and the resumption of normal population movements.

The Committee noted that at its meeting 15 – 17 June, the African Regional Certification Commission had accepted the evidence presented by Nigeria that it was now free of WPV1 infection, and commended this achievement by the Government of Nigeria and its partners.

### **Vaccine derived poliovirus (VDPV)**

The multiple circulating VDPV (cVDPV) outbreaks in four WHO regions (African, Eastern Mediterranean, South-east Asian and Western Pacific Regions) are very concerning, with one new country reporting an outbreak since the last meeting (Mali). Unlike historical experience, international spread of cVDPV2 has become quite common, with recent spread from Chad and CAR to Cameroon; Nigeria, Togo and Ghana to Cote d'Ivoire; Nigeria to Benin, Ghana to Burkina Faso, Nigeria to Mali, Togo to Niger, Ghana and Benin to Togo, Angola to DR Congo, and Pakistan to Afghanistan. In addition, a new local emergence attributable to mOPV2 use has recently occurred in Ethiopia.

In 2020, West Africa and Ethiopia are experiencing high levels of transmission of cVDPV2, and due to the pandemic, outbreak response has been significantly hampered, with many areas that have reported cases recently not having had an immunization response. The Committee repeated its strong support for the development and proposed Emergency Use Listing of the novel OPV2 vaccine which should become available mid-2020, and which it is hoped will result in no or very little seeding of further outbreaks.

### **Impact of COVID-19**

The Committee noted that in many polio infected countries, the COVID-19 pandemic has disrupted polio surveillance to a varying extent, sometimes significantly, resulting in an unusual degree of uncertainty regarding the current true polio epidemiology. All of the countries reported postponements of immunization responses to cases, further increasing risk. In addition, routine immunisation has also been adversely affected by the pandemic in many countries. There is evidence that in some polio infected countries, the pandemic may yet to have peaked. As international travel begins to return, there is unknown risk of exportation of polioviruses. There are many other challenges ahead, such as the effect of COVID-19 on community trust and support for immunization, the possibility of other epidemics such as measles, the risks to front-line workers and how these can be managed, and the risk of immunization activities being associated with COVID-19 outbreaks, either truly or spuriously.

On a positive note, the contribution of polio infrastructure, such as the National Emergency Operation Centre in Pakistan, to pandemic control efforts was significant. Going forward, the committee noted the opportunity to link polio eradication and pandemic response in positive ways.

## 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. However noting that many international borders are closed to prevent international spread of COVID-19, State Parties may not currently be able to enforce the Temporary Recommendations in all places. The Committee strongly urges countries subject to these recommendations to maintain a high state of readiness to implement them as soon as possible ensuring the continued safety of travelers as well as health professionals. The Committee recognizes the concerns regarding the lengthy duration of the polio PHEIC, but concludes that the current situation is extraordinary, with clear ongoing and increasing risk of international spread and ongoing need for coordinated international response. 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 ongoing WPV1 exportation from Pakistan to Afghanistan, and from Afghanistan to Pakistan;
  - ongoing rise in the number of WPV1 cases and positive environmental samples in both Pakistan and Afghanistan with formerly polio free areas within the countries reporting cases in 2020;
  - the quickly increasing cohort of inaccessible unvaccinated children in Afghanistan, with the risk of a major outbreak imminent if nothing is done to access them;
  - the urgent need to overhaul the leadership and strategy of the program in Pakistan, which although already commenced, is likely take some time to lead to more effective control of transmission and ultimately eradication;
  - increasing community and individual resistance to the polio program.
- Rising risk of cVDPV international spread: The clearly documented increased spread in recent months of cVDPV2 demonstrate the unusual nature of the current situation, as international spread of cVDPV in the past has been very infrequent. The number of new emergences of cVDPV2 in Africa raises further concern. The risk of new outbreaks in new countries is considered very high.
- COVID-19: This unprecedented pandemic is likely to continue to substantially negatively impact the polio eradication program and outbreak control efforts. The need to take extra precautions to prevent COVID-19 transmission will probably have an impact on vaccination coverage, and also hamper polio surveillance activities leading to increased risk of missed transmission.
- 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.
- Multiple outbreaks: The evolving and unusual epidemiology resulting in rapid emergence and evolution of cVDPV2 strains is extraordinary and not yet fully understood and represents an additional risk that is yet to be quantified.
- Weak routine immunization: Many countries have weak immunization systems that can be further impacted by various humanitarian emergencies including COVID19, 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.
- 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 and Myanmar, which all have sizable populations that have been unreached with polio vaccine

for prolonged periods.

- Population movement: While border closures may have mitigated the short term risk, conversely the risk once borders begin to be re-opened is likely to be higher.

### **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 State, Nigeria)

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 May 2020)

Pakistan (most recent detection 8 June 2020)

##### **cVDPV1**

Malaysia (most recent detection 12 February 2020)

Myanmar (most recent detection 9 August 2019)

Philippines (most recent detection 28 November 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 as long as the response is required.
- Ensure that all residents and long-term 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 cross-border 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 cross-border populations. Improved coordination of cross-border 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 or demonstrated risk of international spread**

Afghanistan	(most recent detection 15 May 2020)
Angola	(most recent detection 9 February 2020)
Benin	(most recent detection 16 January 2020)
Burkina Faso	(most recent detection 30 March 2020)
Cameroon	(most recent detection 5 May 2020)
CAR	(most recent detection 5 February 2020)
Chad	(most recent detection 9 May 2020)
China	(most recent detection 18 August 2019)
Cote d'Ivoire	(most recent detection 9 May 2020)
DR Congo	(most recent detection 8 February 2020)
Ethiopia	(most recent detection 16 March 2020)
Ghana	(most recent detection 11 March 2020)
Malaysia	(most recent detection 22 January 2020)
Mali	(most recent detection 6 February 2020)
Niger	(most recent detection 15 March 2020)
Nigeria	(most recent detection 1 January 2020)
Pakistan	(most recent detection 2 May 2020)
Philippines	(most recent detection 16 January 2020)
Somalia	(most recent detection 8 May 2020)
Togo	(most recent detection 3 May 2020)
Zambia	(most recent detection 25 November 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 long-term visitors to receive a dose of IPV 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 cross-border coordination to enhance surveillance for prompt detection of poliovirus, and vaccinate refugees, travelers and cross-border 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**

- none

**cVDPV**

- Mozambique cVDPV2 (most recent detection 17 December 2018)
- PNG cVDPV1 (most recent detection 6 November 2018)
- Indonesia cVDPV1 (most recent detection 13 February 2019)

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 cross-border 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.

## Additional considerations

Impact of COVID-19 on the polio program:

- The committee urges all countries, but particularly those at high risk of polio, to maintain a high level of polio surveillance throughout the ongoing pandemic, noting that the postponement of polio immunization campaigns whether preventive or in response to outbreaks may lead to an increase in polio transmission including international spread. There may be opportunities to strengthen polio and COVID-19 surveillance synergistically.
- Secondly, outbreak affected countries should resume immunization response campaigns as soon as feasibly possible. The planning and implementation of the response should employ a flexible approach whereby some activities are put on hold as the transmission of COVID-19 intensifies and then resumed as the COVID-19 transmission reverses back from community transmission to the interruption of COVID-19 transmission. Critically, campaigns should be planned and implemented in such a way that they protect front line polio workers and also the communities they serve so that COVID-19 transmission is not increased. This includes ensuring teams have access to appropriate personal protective equipment, teams are selected so that high risk workers are not put on the front-line, and that the risks related to the pandemic are factored into the selection and planning of areas targeted by polio campaigns.
- Given the risk of international spread, countries need to ensure that they are ready to use appropriate polio vaccines, as recommended by the Strategic Advisory Group of Experts on Immunization, in response to new outbreaks.
- The committee urged countries to maximize the use of polio assets to synergistically address the COVID19 pandemic, noting that polio affected countries may be vulnerable to poorer outcomes in the pandemic due to health care system fragility and poorer health status of the population generally.
- Lastly the pandemic should serve as a reminder to high risk countries with poor immunization coverage that infectious disease outbreaks can lead to social and economic disruption as well as straining the health care system, and countries can increase their population resilience and recovery through prioritising robust immunization programmes. This is relevant not only to polio, but to all other vaccine preventable diseases particularly measles. In particular, countries whether eligible for Gavi support or not should plan to implement a second dose of IPV now being introduced to protect children from paralytic polio.

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 3 July 2020 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 3 July 2020.