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Global Polio Eradication Initiative
Implementing the Polio Eradication and Endgame Strategic Plan 2013–2018

This document is presented to the Regional Committee for Europe to update Member States on progress in polio eradication, including the implementation of temporary recommendations under the *International Health Regulations (2005)* to prevent international spread of poliovirus, preparations for the introduction of inactivated polio vaccine into routine schedules globally, and the development of a framework to guide polio "legacy" planning.

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Progress in polio eradication

1. In 2013, the World Health Assembly endorsed a comprehensive Polio Eradication and Endgame Strategic Plan 2013–2018 (the Plan) to guide an intensified global effort to complete the eradication of all poliovirus and certify the remaining WHO regions polio-free by the end of 2018. Strong international support for the Plan was reflected in the immediate pledging of US$ 4.5 billion against the US$ 5.5 billion budget. By early 2014, important progress had been achieved against all four of the objectives set out in the Plan.

2. The three endemic countries – Afghanistan, Nigeria and Pakistan – have restricted the virus to fewer regions than ever before and in 2013, for the first time in the history of the Global Polio Eradication Initiative (GPEI), all cases caused by a wild virus were due to a single serotype, type 1. However, the fragility of this progress was underlined when polio re-emerged in five previously polio-free countries in 2013. Outbreaks in central Africa, the Horn of Africa and the Middle East reinforced the urgency of ending transmission in any infected area.

3. By the end of 2013, cases were declining in Afghanistan (14 cases versus 37 in 2012) and Nigeria (53 cases versus 122 in 2012) due to intensified efforts. Similarly, in the Horn of Africa and the Middle East cases were either no longer being detected (Kenya, Somalia) or had declined substantially (Ethiopia, Syrian Arab Republic) as the result of intensive outbreak response activities. However, cases continued to increase in Pakistan (93 in 2013 versus 58 in 2012) and a new outbreak occurred in Cameroon, due to a virus last seen in Chad in 2011; surveillance and genetic sequencing data suggest the virus had entered Cameroon at least one year previously, but had not been detected due to gaps in surveillance.

International spread of wild poliovirus

4. Since April 2013 there has been a striking increase in international spread of poliovirus. This has occurred despite the continuing decline in endemic virus in Afghanistan and Nigeria (with no documented international spread from either country since April 2013).

5. On 5 May 2014, on the advice of an Emergency Committee under the *International Health Regulations (2005)*, the Director-General of the World Health Organization declared the international spread of wild poliovirus to be a "public health emergency of international concern" (PHEIC) and issued temporary recommendations for "states currently exporting wild poliovirus" and "states infected with wild poliovirus but not currently exporting". At the time of the PHEIC declaration, three countries met the criteria for "states currently exporting wild poliovirus": Cameroon, Pakistan, and the Syrian Arab Republic; seven countries met the criteria for "states infected with wild poliovirus but not currently exporting": Afghanistan, Equatorial Guinea, Ethiopia, Iraq, Israel, Nigeria and Somalia.

6. Since 5 May 2014, there have been further polio cases in Pakistan (104 in 2014 to 5 July) and cases and viruses of Pakistan origin have been detected in Afghanistan. The Syrian Arab Republic has neither reported polio cases nor exported poliovirus into other countries since the declaration. Cameroon reported two further cases in July 2014. On 18 June 2014, Brazil reported that wild poliovirus of Equatorial Guinea origin had been detected in a single sewage sample that was collected in the state of Sao Paolo in March 2014. No polio cases or further positive samples have been detected in Brazil since. WHO immediately informed Equatorial Guinea that under the *International Health Regulations (2005)* it was now considered an "exporting country" and should implement the vaccination requirements for "states currently exporting wild poliovirus".

7. At its second meeting on 31 July 2014, the Committee advised that the international spread of polio in 2014 continues to constitute an extraordinary event and a public health risk to other states for which a coordinated international response continues to be essential. The international spread of poliovirus in 2014 continues to threaten the ongoing effort to eradicate globally one of the world's most serious vaccine preventable diseases. It was the unanimous view of the Committee that the conditions for a PHEIC continue to be met.

8. The Committee noted that the application of the temporary recommendations by affected States Parties remains incomplete. Additional efforts are required to declare and/or operationalize national emergency procedures, to improve vaccination coverage of international travellers and to ensure eradication strategies are fully implemented to international standards in all infected and high risk areas.

9. The Committee reiterated that the overriding priority for all polio-infected States must be to interrupt wild poliovirus transmission within their borders as rapidly as possible through high quality application in all geographic areas of the polio eradication strategies.

10. Based on this advice and the reports made by affected States Parties, the Director-General accepted the Committee's assessment and declared that the international spread of wild poliovirus in 2014 continued to constitute a PHEIC.

Oral polio vaccine withdrawal and inactivated polio vaccine introduction

11. The major objectives of the Plan include the withdrawal of oral polio vaccine (OPV) in a phased manner, starting with type 2-containing OPV. In this context the Plan calls on all countries which currently use only OPV to introduce at least one dose of inactivated polio vaccine (IPV) into their routine immunization schedules by the end of 2015. Introduction of IPV will reduce the risks associated with type 2 OPV removal, facilitate outbreak control and interruption of polio transmission and hasten eradication.

12. With the support of the GAVI Alliance, regional leadership, and high-level advocacy, strong progress has been made by countries in the planning of IPV introduction within the Endgame timelines. As of end July 2014, 72 countries are already using IPV, 49 countries have made a formal commitment to introduce IPV and an additional 35 had declared their intent to introduce IPV in their routine immunization programme by the end of 2015. These countries account for approximately 96% of the global birth cohort.

13. Remaining risks to further progress with IPV introduction include: (i) the need for all OPV-only using countries to license IPV in time to enable use in the routine immunization programme; (ii) ensuring that very large countries (China and India) meet their stated objectives; and (iii) securing the needed financial resources for countries which do not receive support from the GAVI Alliance before the end of 2015.

14. Provided all prerequisites are met[1] and the absence of all persistent circulating vaccine derived type 2 polioviruses has been demonstrated for a period of at least six months, the

[1] (i) Introduction of at least one dose of inactivated poliovirus vaccine; (ii) access to a bivalent oral polio vaccine that is licensed for routine immunization; (iii) implementation of surveillance and response protocols for type 2 poliovirus (including constitution of a stockpile of monovalent oral polio vaccine type 2);(iv) completion of phase 1 poliovirus containment activities, with appropriate handling of residual type 2 materials; (v) verification of global eradication of wild poliovirus type 2.

withdrawal of type 2 OPV will happen in a synchronized manner across all OPV using countries through a global switch from trivalent OPV to bivalent OPV (bOPV). Discussions on the timing and decision-making process for announcing the switch will be tabled at the next meeting of the Executive Board.

15. Following the switch, all OPV-using countries (144) must be able to use bOPV in their routine programme. However, currently WHO prequalified bOPV is licensed only for use in campaigns. Since a formal licensing process could not be undertaken by all manufacturers in all countries in time for the switch, a global approach is being explored, based on the WHO prequalification process, through which OPV-using countries would grant acceptance of bOPV vaccine for use in their routine programme, whilst in parallel, undertaking the more lengthy registration process.

Polio legacy planning

16. Legacy planning aims to ensure a polio-free world in the long term. It also will ensure that the knowledge, capacities, processes and assets created by the GPEI continue to benefit other health priorities beyond certification of polio eradication and eventual programme closure. Activities are under way to better understand processes for transitioning GPEI assets to other health priorities and to develop a global framework for legacy planning.

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