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衛生福利部 函

地址：11558台北市南港區忠孝東路六段488號
聯絡人：黃小姐
聯絡電話：23959825#4007
電子信箱：szuhsuan@cdc.gov.tw

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附件：附件1-世界衛生組織聲明、附件2-中文說明、附件3-英文說明(241740_11121004790-1.pdf、241740_11121004790-2.pdf、241740_11121004790-3.pdf)

裝

主旨：依據世界衛生組織最新會議聲明，更新來自小兒麻痺症高風險國家人民申請來臺簽證之疫苗接種紀錄規定，詳如說明段，請貴部轉知所屬領事事務局，請查照。

說明：

訂

一、依據本（111）年11月1日世界衛生組織（下稱WHO）第33次國際衛生條例緊急事件委員會會議對小兒麻痺病毒的聲明（Statement of the Thirty-third Polio IHR Emergency Committee，附件1）辦理。

線

二、隨COVID-19國際疫情趨緩，各國邊境逐步解封，跨境交流將愈趨頻繁；為保障國人健康，依據前揭聲明，建請貴部對來自小兒麻痺高風險國家阿富汗、馬拉威、莫三比克、巴基斯坦、馬達加斯加、剛果民主共和國及以色列等民眾申請來臺簽證時，無論其是否具有上述國家國籍，凡最近1年內曾在上述國家停留超過4週者，均應請其提供口服活性減毒（OPV）或不活化（IPV）之小兒麻痺疫苗接種證明文件（中英文說明詳如附件2、3）。

三、前述措施將維持至前揭各國同時符合WHO以下兩項標準：

(一)至少6個月內無新增感染個案；

(二)具文件證明該國於境內高風險區域實施有效的小兒麻

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痺病毒根除活動，如該國無相關證明文件，則必須符合以下評估標準（各流行國家之評估標準可能不同，需由WHO委員會進行評估報告）：

1、12個月內無新增感染個案，或12個月內急性無力肢體麻痺（AFP）發病個案均排除為小兒麻痺病毒感染。

2、12個月內環境或其他樣本均檢測為陰性。

正本：外交部

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電交 2022/11/22 16:39:51 文章

World Health Organization

Statement of the Thirty-third Polio IHR Emergency Committee

1 November 2022 | Statement | Reading time: 13 min (3433 words)

The thirty-third meeting of the Emergency Committee under the International Health Regulations (2005) (IHR) on the international spread of poliovirus was convened by the WHO Director-General on 12 October 2022 with committee members and advisers attending via video conference, supported by the WHO Secretariat. The Emergency Committee reviewed the data on wild poliovirus (WPV1) and circulating vaccine derived polioviruses (cVDPV) in the context of global eradication of WPV and cessation of outbreaks of cVDPV2 by end of 2023. Technical updates were received about the situation in the following countries and territories: Afghanistan, Algeria, Malawi, Mozambique, Pakistan, the United Kingdom of Great Britain and Northern Ireland, the United States of America and Yemen.

Wild poliovirus

The committee was concerned that since its last meeting in June 2022, Pakistan has reported twelve WPV1 cases all from southern Khyber Pakhtunkhwa (KP) province in Pakistan. Nine cases were from the district of North Waziristan, two from Lakki Marwat and one from South Waziristan bringing the total number of cases in 2022 in Pakistan to 20. Furthermore, there have been 31 additional positive environmental samples detected in districts in KP, Punjab, Sindh and Islamabad, bringing the total to 33 (65 isolates detected in 2021). However, no human polio case has been reported outside of southern KP. The committee noted that the key challenges which are driving transmission in southern KP include the complex security situation leading to inadequate campaign quality and missed children, community resistance (eg fake finger-marking without vaccination, refusals due to various reasons, vaccination boycotts), lack of female frontline workers, weak health infrastructure and service delivery, and sub-optimal routine immunization. Another challenge faced in the most recent campaign was the impact of widespread flooding.

The committee noted that although the ongoing WPV1 outbreak in Pakistan led to a risk of spillover into Afghanistan, there is no evidence of cross-border transmission to date in 2022. Two cases have been reported to date in 2022, one in Paktika province and a second in Kunar province in the East. The polio programme in Afghanistan has gained and sustained access across the country including nearly 3 million children previously inaccessible for almost four years. There remain approximately half a million missed children mostly in the southern region, due to the continued implementation of the mosque to mosque campaign modality. There are also clusters of refusals mainly in the South-East and East regions. Pockets of insecurity pose a threat to polio workers noting that eight vaccinators were killed on 24 February 2022 during a campaign.

The committee was very concerned about continued WPV1 transmission in the Tête province of northern Mozambique. Genetic sequencing confirms that all the viruses are related indicating the outbreak is due to international spread through a single importation event. While the quality of the rounds in the multi-country immunization response is improving, coverage has been insufficient to halt transmission. Furthermore, while synchronization of activities has been agreed upon by all countries involved in the response, it has yet to be implemented in practice. Zimbabwe has yet to conduct any immunization response although it shares a border with the outbreak zone in Tête. Surveillance activities have also been insufficiently coordinated across borders, with Mozambican citizens coming to Malawi for medical care for acute flaccid paralysis and being notified in Malawi rather than Mozambique. Surveillance in Mozambique relies on case finding during campaigns with a lack of active surveillance between campaigns. Other challenges include multiple emergencies, frontline worker fatigue and and high population movement within the subregion.

The committee noted with concern that several frontline health workers were killed in Afghanistan in February 2022, and commended the dedication of health care workers in all countries who are responding to these outbreaks.

Circulating vaccine derived poliovirus (cVDPV)

Northern Yemen, eastern Democratic Republic of Congo and northern Nigeria continue to account for more than 85% of the global cVDPV2 caseload. There have been four new countries reporting cVDPV2 - Algeria, Israel, the United Kingdom of Great Britain and Northern Ireland and the United States of America. The viruses detected in the latter three countries are genetically linked indicating long-distance international spread through air travel has occurred. In the USA, there has been a single cVDPV2 case whilst in Israel and the United Kingdom positive environmental isolates have been detected. The US case belongs to a community that has a low level of immunization coverage. Local transmission in these IPV only using countries represents a new risk and the committee noted that this phenomenon should remind all countries that until polio is eradicated, pockets of un- or under-immunized persons pose a risk of polio outbreaks, even in countries that have not reported indigenous transmission for a long time. The virus in Algeria is genetically linked to viruses circulating in Nigeria and is therefore an importation due to international spread. Furthermore, the detection of cVDPV2 in Benin, as has been seen in Ghana, Togo and Côte d'Ivoire appears to have resulted from reinfection caused by new international spread from Nigeria.

Three new countries have reported cVDPV1 - Democratic Republic of the Congo, Malawi and Mozambique.

The committee noted that much of the risk for cVDPV outbreaks can be linked to a combination of inaccessibility, insecurity, a high concentration of zero dose children and population displacement. These have been most clearly evidenced in northern Yemen, northern Nigeria, south central Somalia and eastern DRC. Despite the ongoing decline in the number of cases and lineages circulating, the recent episodes of international spread of cVDPV2 indicates the risk remains high.

The committee noted that the roll out of wider use of novel OPV2 continues under EUL. The committee also noted the delays to timely, quality outbreak response with countries delaying response with the immediately available vaccine until novel OPV2 vaccine became available. The committee noted the SAGE recommendation that timely outbreak response is of paramount importance and countries should use immediately available vaccines and avoid any delays that may occur while waiting for supply of novel OPV2 vaccine.

Conclusion

Although encouraged by the reported progress, 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 recognizes the concerns regarding the lengthy duration of the polio PHEIC and the importance of exploring alternative IHR measures in the future but concluded that there are still significant risks as exemplified by the importation and continued transmission of virus in Malawi and Mozambique. The Committee considered the following factors in reaching this conclusion:

Ongoing risk of WPV1 international spread:

Based on the following factors, the risk of international spread of WPV1 remains:

- the current outbreak of WPV1 in Pakistan where there have been 20 cases in 2022 with spread outside the source of the outbreak but within Pakistan
- high-risk mobile populations in Pakistan represent a specific risk of international spread to Afghanistan in particular
- the large pool of unvaccinated 'zero dose' children in southern Afghanistan constitutes a major risk of WPV1 re-introduction;
- the importation of WPV1 from Pakistan into Malawi and Mozambique, noting that the exact route the virus took remains unknown;
- sub-optimal immunization coverage achieved during recent campaigns in southeastern Africa, meaning ongoing transmission may be occurring;
- surveillance gaps means that such transmission may be missed;
- pockets of insecurity in the remaining endemic transmission zones.

Ongoing risk of cVDPV2 international spread:

Based on the following factors, the risk of international spread of cVDPV2 appears to remain high:

- the explosive outbreak of cVDPV2 in northern Yemen and ongoing high transmission in eastern Democratic Republic of the Congo and northern Nigeria, which have caused international spread to neighbouring countries;
- ongoing cross border spread including into newly infected countries such as Algeria, and re-infection of Benin;
- the long distance spread by air travel of cVDPV2 between Israel, the United Kingdom and the USA;
- the ever-widening gap in population intestinal mucosal immunity in young children since the withdrawal of OPV2 in 2016 and consequently high concentration of zero dose children in certain areas, especially the four areas mentioned above (second dot point)
- insecurity in those areas that are the source of polio transmission.

Other factors include

- Weak routine immunization: Many countries have weak immunization systems that can be further impacted by humanitarian emergencies including conflict and protracted complex emergencies poses a growing risk, leaving populations in these fragile states vulnerable to polio outbreaks.
- Lack of access: Inaccessibility continues to be a major risk, particularly in northern Yemen which have sizable populations that have been unreached with polio vaccine for extended periods of more than a year.

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:

1. States infected with WPV1, cVDPV1 or cVDPV3.
2. States infected with cVDPV2, with or without evidence of local transmission:
3. 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.

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 29 August 2022
Malawi	most recent detection 19 November 2021
Mozambique	most recent detection 10 August 2022
Pakistan	most recent detection 15 September 2022

cVDPV1

Madagascar	most recent detection 9 May 2022
Mozambique	most recent detection 5 August 2022
Malawi	most recent detection 15 August 2022
DR Congo	most recent detection 16 August 2022

cVDPV3

Israel	most recent detection 24 March 2022

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 longterm visitors (> 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 (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 (road, air and / or 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 cVDPV2, with or without evidence of local transmission:

1. Algeria	most recent detection 21 August 2022
2. Benin	most recent detection 17 August 2022
3. Burkina Faso	most recent detection 28 December 2021
4. Cameroon	most recent detection 29 October 2021
5. Central African Republic	most recent detection 12 August 2022
6. Chad	most recent detection 22 June 2022
7. Côte d'Ivoire	most recent detection 18 July 2022
8. Democratic Republic of the Congo	most recent detection 20 August 2022
9. Djibouti	most recent detection 22 May 2022
10. Egypt	most recent detection 29 August 2022
11. Eritrea	most recent detection 2 March 2022
12. Ethiopia	most recent detection 16 September 2021
13. Gambia	most recent detection 9 September 2021
14. Ghana	most recent detection 6 September 2022
15. Israel	most recent detection 16 June 2022
16. Mauritania	most recent detection 15 December 2021
17. Mozambique	most recent detection 26 March 2022
18. Niger	most recent detection 13 August 2022
19. Nigeria	most recent detection 13 August 2022
20. Senegal	most recent detection 18 November 2021
21. Somalia	most recent detection 21 July 2022
22. Togo	most recent detection 22 March 2022
23. Uganda	most recent detection 2 November 2021
24. Ukraine	most recent detection 24 December 2021
25. United Kingdom of Great Britain and Northern Ireland	most recent detection 31 May 2022
26. United States of America	most recent detection 20 June 2022

27. Yemen	most recent detection 16 August 2022

States that have had an importation of cVDPV2 but without evidence of local transmission should:

Officially declare, if not already done, at the level of head of state or government, that the prevention or interruption of poliovirus transmission is a national public health emergency

- **Undertake urgent and intensive investigations to determine if there has been local transmission of the imported cVDPV2**
- **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.**
- **Further intensify efforts to increase IPV immunization coverage, including sharing coverage data.**
- **Intensify national and international surveillance regional cooperation and crossborder coordination to enhance surveillance for prompt detection of poliovirus.**

States with local transmission of cVDPV2, with risk of international spread should in addition to the above measures:

- **Encourage residents and longterm visitors to receive a dose of IPV four weeks to 12 months prior to international travel.**
- **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.**

For both sub-categories:

- **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

1. China	most recent detection 25 January 2021
2. Congo	most recent detection 1 June 2021
3. Guinea	most recent detection 11 August 2021
4. Guinea-Bissau	most recent detection 26 July 2021
5. Iran (Islamic Republic of)	most recent detection 20 February 2021
6. Liberia	most recent detection 28 May 2021
7. Kenya	most recent detection 13 January 2021
8. Mali	most recent detection 23 December 2020
9. Sierra Leone	most recent detection 1 June 2021
10. Sudan	most recent detection 18 December 2020
11. South Sudan	most recent detection 18 April 2021
12. Tajikistan	most recent detection 13 August 2021

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

The Committee recognizes that border vaccination may not be feasible at very porous borders in Africa but was concerned by the lack of synchronization and cross border coordination in response to the WPV1 importation in southeast Africa. Outbreak response assessments are being carried out currently and urged the countries most directly involved in the response – Malawi and Mozambique - to facilitate these assessments. The committee also noted with concern that most AFP cases were being detected during campaigns and more systematic surveillance efforts are required including training of clinicians to identify and respond to AFP cases.

Noting the acute humanitarian crisis still unfolding in Afghanistan, the committee urged that polio campaigns be integrated with other public health measures wherever possible including malnutrition screening, vitamin A administration and measles vaccination. The committee also strongly encouraged

house to house campaigns be implemented wherever feasible as these campaigns enhance identification and coverage of zero dose and under-immunized children.

In Pakistan, the opportunity to interrupt polio transmission in the coming low season noting that the reported cases are geographically limited to south KP with positive environment isolates detected elsewhere in KP, Punjab and Sindh. The committee urged Pakistan to grasp the upcoming opportunity.

The committee noted the situation in northern Yemen with concern where it is estimated several million children have still not been accessed for immunization. The committee strongly encouraged more urgent dialogue with all relevant stakeholders to enable children to be vaccinated and protected.

The cVDPV2 outbreaks in Jerusalem, London and New York highlight the importance of sensitive polio surveillance, including environmental surveillance, in all areas where there are high risk sub-populations and the committee urges all countries to take heed of the lesson learnt through this event and take steps to improve polio surveillance everywhere that such risks exist.

The committee noted the ongoing work around the duration of the polio PHEIC, and possible amendments to the IHR, and suggested that the committee be kept informed of developments.

Based on the current situation regarding WPV1 and cVDPVs, and the reports provided by affected countries, the Director-General accepted the Committee's assessment and on 21 October 2022 determined that the poliovirus situation 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 21 October 2022.

針對來自阿富汗、馬拉威、莫三比克、巴基斯坦、馬達加斯加、剛果民主共和國及以色列的中華民國(臺灣)簽證申請者之說明

根據世界衛生組織的建議，所有來自小兒麻痺症高風險國家阿富汗、馬拉威、莫三比克、巴基斯坦、馬達加斯加、剛果民主共和國及以色列的簽證申請者（曾於過去一年內停留該國超過四週），不論是否具有上述國家國籍，均應請其提供過去一年內接種口服活性減毒小兒麻痺病毒疫苗（OPV）或不活化小兒麻痺病毒疫苗（IPV）之證明。接種證明需記錄於由醫院或醫療人員開立之國際預防接種證明書（黃皮書）中。

Note for the ROC (Taiwan) Visa Applicants from Afghanistan, Malawi, Mozambique, Pakistan, Madagascar, DR Congo and Israel

According to the recommendations of World Health Organization, all passports holders of Afghanistan, Malawi, Mozambique, Pakistan, Madagascar, DR Congo and Israel, and long-term residents who had stayed in these four countries >4 weeks within the past year should ~~must~~ submit vaccination records of Oral Polio Vaccine (OPV) or Inactive Polio Vaccine (IPV) within 12 months. Applicants must provide a Yellow Book (International Certificate of Vaccination or Prophylaxis) issued by a hospital or medical/healthcare provider as proof of vaccination.