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附件：世界衛生組織第34次聲明(297512_11200005771-1.pdf)

主旨：有關貴部再次函詢本部依據世界衛生組織最新會議聲明，更新小兒麻痺高風險國家人民申請來臺簽證之疫苗接種紀錄案，復請查照。

說明：

一、復貴部本（112）年1月11日外授領二字第1115130323號函。

二、為防範自境外移入小兒麻痺症，本部自104年起即依世界衛生組織（WHO）西太平洋區署小兒麻痺症認證委員會建議，請貴部協助對來自小兒麻痺症高風險國家人民（不論國籍別）申請來臺簽證時，檢視其小兒麻痺疫苗接種證明文件。

三、本部前函係依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（Satement of the thirty-third Polio Emergency Committee），更新小兒麻痺症高風險國家名單，該聲明亦建議略以「高風險國家應確保所有自該國出境者（含：居民及在當地停留超過4週者），於出國前4週至12個月，接種1劑口服活性減毒（OPV）或不活化（IPV）小兒麻痺疫苗，並提供疫苗接種證明」。前述出境者係指當地居民及於當地停留超過4週者，非以該國

國籍者為限。

四、另查WHO於本年2月2日對於國際間小兒麻痺症傳播發布第34次緊急事件委員會會議最新聲明，該聲明指出小兒麻痺症國際傳播風險仍構成國際關注公共衛生緊急事件（Public Health Emergency of International Concern, PHEIC），評估各國國際傳播風險，仍將阿富汗、以色列等7國列為高風險國家（詳如附件），故為降低我國社區小兒麻痺疫情風險，仍建請貴部轉所屬駐外館處協助查核前述說明三出境者之相關疫苗接種文件，且由出境者自負責任及備妥相關疫苗接種證明文件。

五、另建請於辦理來臺簽證相關配合事項網站及受理申辦現場明顯處，加強宣導自高風險國家來臺人士應接種小兒麻痺疫苗，並備妥接種證明文件；至貴部建議請內政部移民署及交通部航港局針對免簽證、就業金卡或專案申請電子簽證之來臺旅客，查核其疫苗接種證明文件一事，本部將視境外移入疫情監測結果滾動調整。

正本：外交部

副本：

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World Health Organization

Statement of the thirty-fourth Polio IHR Emergency Committee

2 February 2023 | Statement | Reading time: 12 min (3350 words)

The thirty-fourth 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 25 January 2023 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 target of eradication of WPV and cessation of outbreaks of cVDPV2 by the end of 2023. Technical updates were received about the situation in the following countries: Afghanistan, Botswana, Canada, the Democratic Republic of the Congo, Indonesia, Madagascar, Nigeria, Pakistan, Sudan and Zambia.

Wild poliovirus

The committee noted that there has been no confirmed case of WPV1 in Pakistan since 15 September 2022 and Afghanistan since 29 August 2022 which signaled considerable progress in the polio endgame, although positive environmental samples were still being detected in 2023. Although the number of positive samples in Afghanistan was 22 in 2022 compared to only one in 2021, this was in part due to more intensive surveillance in the country, with more sites being sampled and increased frequency of testing. All positive samples were detected in the Eastern Region, principally in Nangarhar province. In Pakistan, all 20 cases occurred in the southern part of Khyber Pakhtunkhwa (KP) province. These findings demonstrate that transmission in the two endemic countries is now very low and restricted in geography. Although all areas of both countries are fully accessible during immunization rounds, there are areas of insecurity and vaccine refusals, with a high number of zero dose children in southern Afghanistan. The next six months will be a critical opportunity to finally interrupt endemic WPV1 transmission.

In the African region, there have been four cases of WPV1 in Mozambique with the most recent WPV1 case occurred in Tête province in Mozambique on 10 August 2022. No further cases have occurred in Malawi since the single index case with onset in November 2021. However, the committee noted that Outbreak Response Assessments carried out in October and November 2022 in these two countries concluded that due to gaps in immunization coverage during vaccination campaigns and gaps in surveillance missed transmission could not be ruled out.

Globally there remain only three genetic clusters of WPV1, a major reduction in the genetic diversity of WPV1, represented by one cluster in Pakistan, one in Afghanistan, and one in Africa.

The committee noted that there had been a recent containment breach at a vaccine manufacturer in the Netherlands, which resulted in WPV3 being detected in the environment, but with no evidence of transmission in the community.

Circulating vaccine derived poliovirus (cVDPV)

Despite the ongoing decline in the number of cVDPV2 cases and the number of lineages circulating, the risk of international spread of cVDPV2 remains high. Evidence of this includes the high transmission in DR Congo spreading to southern Africa (Zambia and Botswana), and spread from Chad to Sudan, and from Yemen to Djibouti and Somalia. However, the successful introduction of novel OPV2 and re-introduction of tOPV are expected to mitigate the risk of international spread of cVDPV2, particularly as supply issues are resolved. The recent agreement to vaccinate children in north Yemen is also a major step forward.

The long distance international spread of VDPV2 between Jerusalem, London, New York and Montreal has revealed a new risk phenomenon i.e. evolution of vaccine derived polioviruses in under-immunized pockets of populations who lack intestinal mucosal immunity in IPV-using countries. In Canada, it appears that importation without local transmission occurred in August 2022 and was detected in wastewater only, and subsequent testing has been negative.

The emergence of cVDPV2 in Indonesia is a concern, as the source of the virus is unknown. However, the committee noted that Indonesia had responded very quickly, and this was commendable.

The emergence and ongoing transmission of cVDPV1 in DR Congo and Mozambique is of concern in the context of the WPV1 outbreak in southern Africa, as it highlights gaps in population immunity to type 1 polioviruses including WPV1.

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 evident in northern Yemen, northern Nigeria, south central Somalia and eastern DRC.

The committee was concerned to hear from several countries that climate related disasters, including both flooding and drought, were causing greater vulnerability to several disease outbreaks, including polio. Ongoing conflict in several polio-affected countries also continued to pose significant challenges to the polio programme. National elections in several affected countries have the potential to cause further disruption. Declining immunization coverage in several countries that previously maintained high coverage was disappointing, and highlights the importance of maintaining and strengthening essential immunization.

The committee noted that the rollout of wider use of novel OPV2 continues under EUL, with 560 million doses administered to date. The committee also noted there have been delays in outbreak response because countries postponed responses until novel OPV2 vaccine became available rather than using the immediately available vaccine (mOPV2 or tOPV) 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 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 recent 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 an ongoing 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 mean 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 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 Botswana, Canada, Sudan and Zambia
- the long distance spread by air travel of cVDPV2 between Israel, the United Kingdom and the USA, and the recent importation without apparent further spread to Canada;
- the ever-widening gap in population intestinal mucosal immunity in young children since the withdrawal of OPV2 in 2016;
- insecurity in those areas that are the source of polio transmission.

Other factors include

- Weak routine immunization: Many countries have weak immunization systems that were further impacted by the COVID-19 pandemic. These services can be further affected by humanitarian emergencies, including conflict and protracted complex emergencies, which poses a continued risk, leaving populations in these fragile areas vulnerable to polio outbreaks.
- Lack of access: Inaccessibility continues to be a risk, particularly in northern Yemen and south central Somalia, which have sizable populations that have not been reached 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 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 1 January 2023
Malawi	most recent detection 19 November 2021
Mozambique	most recent detection 10 August 2022
Pakistan	most recent detection 2 January 2023

cVDPV1

Madagascar	most recent detection 26 October 2022
Mozambique	most recent detection 20 November 2022
Malawi	most recent detection 1 December 2022
Democratic Republic of the Congo	most recent detection 29 October 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 12 December 2022
2. Benin	most recent detection 11 October 2022
3. Botswana	most recent detection 13 December 2022
4. Burkina Faso	most recent detection 28 December 2021
5. Cameroon	most recent detection 30 October 2022
6. Canada	most recent detection 30 August 2022
7. Central African Republic	most recent detection 23 November 2022
8. Chad	most recent detection 2 November 2022
9. Côte d'Ivoire	most recent detection 18 July 2022
10. Democratic Republic of the Congo	most recent detection 15 November 2022
11. Djibouti	most recent detection 22 May 2022
12. Egypt	most recent detection 29 August 2022
13. Eritrea	most recent detection 2 March 2022
14. Ethiopia	most recent detection 1 April 2022
15. Ghana	most recent detection 4 October 2022
16. Indonesia	most recent detection 9 October 2022
17. Israel	most recent detection 16 June 2022
18. Mozambique	most recent detection 26 March 2022
19. Niger	most recent detection 13 August 2022

20. Nigeria	most recent detection 11 November 2022
21. Senegal	most recent detection 17 January 2022
22. Somalia	most recent detection 31 August 2022
23. Sudan	most recent detection 6 December 2022
24. Togo	most recent detection 30 September 2022
25. Ukraine	most recent detection 24 December 2021
26. United Kingdom of Great Britain and Northern Ireland	most recent detection 31 May 2022
27. United States of America	most recent detection 22 September 2022
28. Yemen	most recent detection 24 October 2022
29. Zambia	most recent detection 6 December 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 novel OPV2 stockpile.**
- **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.**

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. Republic of Congo	most recent detection 1 June 2021
2. Gambia	most recent detection 9 September 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. Mauritani	most recent detection 15 December 2021
8. Sierra Leone	most recent detection 1 June 2021
9. South Sudan	most recent detection 8 April 2021
10. Tajikistan	most recent detection 13 August 2021
11. Uganda	most recent detection 2 November 2021
12. Ukraine	most recent detection 24 December 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 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.**

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. The committee also noted with concern that most AFP cases in Mozambique had been detected during campaigns and more systematic

surveillance efforts are required including training of clinicians to identify and respond to AFP cases. The committee commended Indonesia and Sudan for their active cooperation with neighbouring countries.

Noting the acute humanitarian crises still unfolding in Afghanistan and other countries, the committee urged that polio campaigns be integrated with other public health measures wherever appropriate including interventions such as other routine vaccines, medicines (diarrhea, pneumonia, malaria etc), nutrition services (micronutrient sachet, Vit A supplementation, deworming), and reproductive health services (contraception, antenatal care and iron folate distribution). 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. The committee noted and strongly supported the ongoing use of female vaccinators, enhancing access to households.

The cVDPV2 outbreaks in Jerusalem, London and New York highlight the importance of sensitive polio surveillance, including environmental surveillance, in 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 that a few countries had outbreaks of more than one cVDPV, indicating once again a significant immunity gap in populations.

The Committee urged the polio program to continue to address delays in specimens being transported for testing for polioviruses, leading to problems with the reverse cold chain, as several countries mentioned this as an issue for polio outbreak control.

The Committee requested the secretariat to provide information on any facility breach in poliovirus containment including reports on root cause analysis, and preventive and corrective actions taken or planned for the incident to enable the development of any recommendations that may be needed.

The Committee recognizes the concerns regarding the lengthy duration of the polio PHEIC and the importance of exploring alternative measures, including the convening of an IHR Review Committee for polio that could advise the Director-General on possible IHR standing recommendations, and encourages further discussion regarding these alternatives.

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 1 February 2023 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 1 February 2023.