檔　　號：
保存年限：

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

受文者：外交部

發文日期：中華民國112年5月22日
發文字號：衛授疾字第1122100159號
速別：最速件
密等及解密條件或保密期限：
附件：附件1-世界衛生組織最新聲明、附件2-中文說明、附件3-英文說明(366374_11221001590-1.pdf、366374_11221001590-2.pdf、366374_11221001590-3.pdf)

裝

主旨：依據世界衛生組織（下稱WHO）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。

訂

說明：

一、依據本（112）年5月12日WHO第35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-fifth Polio IHR Emergency Committee，附件1）辦理。

線

二、本部前以111年11月22日衛授疾字第1112100479號函及本年2月10日衛授疾字第1120000577號函，請貴部轉知所屬有關來自小兒麻痺症高風險國家人民申請簽證之配合事項諒達。

三、為防範境外移入小兒麻痺症，本部依據WHO最新聲明，更新小兒麻痺症高風險國家（共7國），除原有之阿富汗、馬拉威、莫三比克、巴基斯坦、馬達加斯加、剛果民主共和國等國外，新增剛果，並移除以色列。建請貴部對於來自上述國家的民眾申請來臺簽證時，凡最近1年內曾在該國停留超過4週（含）者（不分國籍別），均應請其提

112. 5. 22

領務局 總收發

1125115834
1120019533

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）。

正本：外交部
副本：

電交 2023/05/22 11:09:13 文章

Statement of the thirty-fifth Polio IHR Emergency Committee

12 May 2023 | Statement | Reading time: 12 min (3320 words)

The thirty-fifth 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 3 May 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, Benin, Burundi, the Central African Republic, Chad, the Democratic Republic of the Congo, Indonesia, Pakistan and Somalia.

Wild poliovirus

In Pakistan, the committee noted that since the last meeting, there has been one new case of WPV1 with onset 20 February 2023, in Khyber Pakhtunkhwa (KP) province, the first case since 15 September 2022. There have been three environmental surveillance positive samples in 2023, two in Punjab and one in KP, the most recent positive sample collected was 21 February 2023. Two of these three ES detections were linked to viruses circulating in Afghanistan.

In Afghanistan there have been no cases reported in 2023 with the last case occurring on 29 August 2022. However, there have been 18 positive environmental samples to date in 2023, all in the eastern region, three from Kunar and 15 from Nangarhar. Although the number of positive samples in Afghanistan was 18 in 2023 to date compared to 22 for the year 2022, this was in part due to more intensive surveillance in the country, with more sites being sampled and increased frequency of testing. This appears to signal considerable progress in the polio endgame and

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 the southern region. Afghanistan has increased the number of female front line workers to assist in accessing households. The next six months will be a critical opportunity to finally interrupt endemic WPV1 transmission.

There have been no new cases reported in the outbreak of WPV1 in southern Africa, with the most recent case having onset of paralysis on 10 August 2022 in Mozambique. There have been no new cases of WPV1 in Malawi, and it is now more than 16 months since the single case was detected in Malawi. However, the committee noted that GPEI outbreak response assessments which were conducted in October in Malawi and in November in Mozambique to review progress concluded that ongoing transmission could not be ruled out in either country, due to gaps in polio surveillance and suboptimal coverage in immunization campaigns. Based on Lot Quality Assurance Sampling, campaign quality was less than the target 90% in Malawi, Mozambique, Zambia and Zimbabwe in the recent round.

Globally there remain only three genetic clusters of WPV1, a major reduction in the genetic diversity of WPV1 which indicates that chains of transmission have been reduced to two in the remaining endemic countries Pakistan and Afghanistan, and one in Africa.

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 with spread of cVDPV2 to Burundi and Malawi. The committee noted that in the African Region, which now uses novel OPV2 exclusively, there have been two new cVDPV2 detected in DR Congo that have emerged from novel OPV2 use. However, novel OPV2 is retaining its enhanced genetic stability compared to Sabin OPV2, with most isolates analyzed through whole genome sequencing indicating no or minimal changes in genetic structure of novel OPV2. Only 2% of all isolates reported so far have shown evidence of losing key genetic modifications that reduce neurovirulence due to recombination and these have only been detected in Uganda, CAR, DRC and Burundi, versus the expected 75% for Sabin OPV2.

The committee was concerned that in Indonesia, there is evidence of missed transmission of cVDPV2 and that the occurrence of a case of cVDPV2 in Israel indicates ongoing transmission in the country. However, the committee noted that Indonesia had responded very quickly, and this was commendable.

The emergence and ongoing transmission of cVDPV1 in Madagascar, 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 factors are most evident in northern Yemen, northern Nigeria, south central Somalia and eastern DRC, but also in northern Mozambique.

The committee noted that the roll out of wider use of novel OPV2 continues under EUL, with over 600 million doses administered to date.

The committee noted that a few countries had outbreaks of more than one cVDPV indicating a significant immunity gap in their populations.

Conclusion

Although encouraged by the reported progress, the Committee unanimously agreed that the risk of international spread of poliovirus still 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:

<u>Ongoing risk of WPV1 international spread:</u>

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

- the ongoing transmission in eastern Afghanistan with cross border spread into Pakistan;
- the large pool of unvaccinated 'zero dose' children in southern Afghanistan constitutes an ongoing risk of WPV1 re-introduction into the southern region;
- 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 campaigns in southeastern Africa, in Malawi, Mozambique, Zambia and Zimbabwe, meaning there may be insufficient population immunity to halt transmission;
- although surveillance has improved, some gaps in the outbreak response zone means that such transmission may be missed;
- pockets of insecurity and inaccessibility in the remaining endemic transmission zones.

<u>Ongoing risk of cVDPV2 international spread:</u>

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

- the ongoing outbreaks of cVDPV1 and cVDPV2 in eastern Democratic Republic of the Congo which has caused international spread to neighbouring countries;

- the large outbreak of cVDPV1 particularly in DR Congo and the insufficient number and quality of bOPV immunization response campaigns to date;
- the long distance spread by air travel of cVDPV2 between Israel, the United Kingdom, the USA, and Canada;
- the ever-widening gap in global population intestinal mucosal immunity in young children in many countries since the withdrawal of OPV2 in 2016;
- insecurity and inaccessibility in those areas that are the primary sources of cVDPV 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 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 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 3 April 2023
Malawi	most recent detection 19 November 2021
Mozambique	most recent detection 10 August 2022
Pakistan	most recent detection 21 February 2023

cVDPV1

Madagascar	most recent detection 1 March 2023
Mozambique	most recent detection 27 February 2023
Malawi	most recent detection 1 December 2022
Democratic Republic of the Congo	most recent detection 6 March 2023
Congo	most recent detection 15 October 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 March 2023
2. Benin	most recent detection 23 February 2023
3. Botswana	most recent detection 17 January 2023
4. Burundi	most recent detection 7 March 2023
5. Cameroon	most recent detection 22 December 2022
6. Canada	most recent detection 8 Septembre 2022
7. Central African Republic	most recent detection 27 February 2023
8. Chad	most recent detection 13 February 2023
9. Côte d'Ivoire	most recent detection 22 March 2023
10. Democratic Republic of the Congo	most recent detection 5 March 2023
11. Djibouti	most recent detection 22 May 2022
12. Egypt	most recent detection 29 August 2022
13. Ghana	most recent detection 4 October 2022
14. Indonesia	most recent detection 23 February 2023/td>
15. Israel	most recent detection 13 February 2023
16. Malawi	most recent detection 2 February 2023/td>
17. Mali	most recent detection 26 October 2022
18. Mozambique	most recent detection 26 March 2022
19. Niger	most recent detection 12 January 2023
20. Nigeria	most recent detection 7 March 2023
21. Somalia	most recent detection 12 January 2023
22. Sudan	most recent detection 28 November 2022
23. Togo	most recent detection 30 September 2022
24. United Kingdom of Great Britain and Northern Ireland	most recent detection 8 November 2022
25. United States of America	most recent detection 22 September 2022
26. Yemen	most recent detection 14 December 2022
27. 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 cross-border 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 long-term 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 cross-border coordination to enhance surveillance for prompt detection of poliovirus, and vaccinate refugees, travelers and cross-border 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. Burkina Faso	most recent detection 28 December 2022
2. Eritrea	most recent detection 2 March 2022
3. Ethiopia	most recent detection 1 April 2022
4. Gambia	most recent detection 9 September 2021
5. Guinea	most recent detection 11 August 2021
6. Guinea-Bissau	most recent detection 26 July 2021
7. Liberia	most recent detection 28 May 2021

8. Mauritani	most recent detection 15 December 2021
9. Senegal	most recent detection 17 January 2022
10. Sierra Leone	most recent detection 1 June 2021
11. Tajikistan	most recent detection 25 July 2021
12. Uganda	most recent detection 2 November 2021
13. 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 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 the concerns regarding the lengthy duration of the polio PHEIC and the importance of exploring alternative measures, including instituting a polio IHR Review Committee that could make standing recommendations, and encourages further discussion regarding these alternatives. Nevertheless, the committee felt it was still too early to discontinue the PHEIC as it may send the wrong message at this critical juncture in polio eradication.

Noting the acute humanitarian crises still unfolding in Afghanistan, the committee 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, with female participation as front line health workers increasing from 10.7% in the October campaign to 12.5% in April.

The ongoing cVDPV2 outbreaks in Indonesia and Israel 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 and take steps to improve polio surveillance everywhere that such risks exist.

The Committee noted with concern the new conflict areas in Sudan that are disrupting health services and creating a new refugee crisis in neighboring countries. This situation must be closely monitored, as many of the neighboring countries already have cVDPV outbreaks resulting from low essential immunization coverage. More generally, noting the negative impact that the COVID-19 pandemic has had on essential immunization coverage in many of the polio affected countries, the committee stressed the importance of restoring essential immunization coverage. The committee recognized 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 is concerned by conflicts and insecurity in many of the infected countries as such circumstances allows the polioviruses to elude control in countries such as Yemen, Nigeria, Dr Congo, Mozambique and Sudan.

Overall, the committee once again noted that many of the members states affected by WPV1 or cVDPV outbreaks hove either low overall coverage or low subnational coverage.

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.

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 12 May 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 12 May 2023.

Subscribe to our newsletters →

針對來自阿富汗、馬拉威、莫三比克、巴基斯坦、馬達加斯加、剛果民主共和國及剛果的中華民國(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、剛果民主共和國及剛果的簽證申請者（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。

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

According to the recommendations of World Health Organization, all passports holders of Afghanistan, Malawi, Mozambique, Pakistan, Madagascar, DR Congo and Congo, and long-term residents who had stayed in these seven countries >4 weeks within the past year should submit vaccination records of Oral Polio Vaccine (OPV) or Inactive Polio Vaccine (IPV) within 12 months.