



**World Health  
Organization**

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## Speaker Key

GR	Gregory
BA	Dr Bruce Aylward
HR	Professor Helen Rees
CH	Chair
SB	Simeon Bennett – Bloomberg
AN	Anne [?] – BMJ
IS	Ishir [?] – [Name] Japanese Newspaper
JY	Jennifer Yang - The Toronto Star
MC	Maria Chang – Associated Press
TM	Tom Miles – Reuters
HE	Helen
HF	Imogen Faulks BBC
DE	Deborah
SB	Simeon Bennett
JB	Jason Beaubien

GR Good afternoon. This is the World Health Organisation from Geneva welcoming you to this virtual press conference on the outcomes of the IHR Emergency Committee on polio. In just two seconds I will hand over to Dr Bruce Aylward, the Assistant Director-General here at WHO responsible for polio among other areas and he will give some opening remarks after which we will open the floor to questions. Remember please, if you wish to ask a question, for those of you who are dialling in, dial zero one on your keypad. And for all of you there will be, shortly after the press conference is over, an audio transcript and then later in the day a written transcript on the WHO website which is WHO.int. So without further ado I will hand over to Dr Aylward. Thank you very much.

BA Thank you very much, Gregory. Good afternoon everybody and to those of you online I'm Bruce Aylward, the Assistant Director-General responsible for polio eradication and emergencies here at the World Health Organisation. With me on the line is Professor Helen Rees of the University of Witwatersrand in Johannesburg, South Africa. She was the chair of the Emergency Committee that we'll discuss today. And after I've spoken I'm going to ask her to make a couple of comments for you and then she will be available for some of the questions as well online from Johannesburg. And she apologises but she came down with a terrible flu over the weekend and was unable to get on the plane to be here with us personally. But we're going to try and make sure we can patch her in.

Now, the purpose of today's teleconference or rather press conference is to share with you the Director-General's decisions that she's made now on the advice of the Emergency Committee that was convened to look at the issue of the international spread of wild poliovirus. I'm going to walk you through some of the deliberations of the committee and its advice and then the Director-General's decisions regarding both whether this constitutes a public health emergency of international concern, and then if so, the temporary recommendations. I'll ask Helen to comment and then I'm happy to take some questions, Gregory, should we have time.

Okay, first to summarise the proceedings. The Emergency Committee for the international spread of wild poliovirus was convened by the Director-General under the International Health Regulations on Monday 28<sup>th</sup> April and on Tuesday 29<sup>th</sup> April 2014. They were convened by teleconference. There are 14 members of the committee and the names of those are available on the website which accompanies the statement which has just been posted and which I'm going to summarise for you now. The committee also drew on the expertise of three advisers whose names are also available to you.

There were ten countries that are currently infected by wild poliovirus. All of these affected parties participated in the information session of the meeting on the 28<sup>th</sup> April and those countries were Afghanistan, Cameroon, Equatorial Guinea, Ethiopia, Israel, Nigeria, Pakistan, Somalia and Syrian Arab Republic. Now these ten countries are countries that are considered to have active transmission of wild polio virus because the virus has been detected in the country or transmission of the virus within the previous six months.

Now, in terms of the meeting and its proceedings, it began with the WHO secretariat, myself, providing an update on the program, the global eradication initiative, to the committee with an assessment of recent progress in both stopping endemic polio viruses and imported polio viruses and also the status of international spread of wild virus in 2014. After that all of the affected countries, with the exception of Iraq that was unable to participate, presented on the recent developments in their countries and the actions they're taking to interrupt transmission.

So after reviewing this information the committee advised the Director-General that the international spread of polio to date in 2014 constitutes an extraordinary event and a public health risk to other states for which a coordinated international response is essential. The committee highlighted that this current situation in 2014 stands in stark contrast to the near cessation of international spread of wild poliovirus from January 2012 right through to the 2013 low transmission season for the disease. And just for those of you who aren't aware, the low transmission season for polio is about January to April of each year, after which we have the high season and usually a spike of cases as well as often, unfortunately, until recently at least, international spread of the disease.

The committee highlighted to the Director-General that if the situation as of today and April 2014 went unchecked, it could result in failure 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 the Public Health Emergency of International Concern, or PHEIC, had been met. And today on 5<sup>th</sup> May 2014 the Director-General has declared the international spread of wild poliovirus today in 2014 a public health emergency of international concern.

Now, to put this in context, in 2013 about 60% of polio cases were the result of international spread of wild virus and there was also increasing evidence that adult travellers were contributing to the spread. During the low season in 2014, as I highlighted, there were ten countries that are considered to have active transmission of wild poliovirus and in contrast with previous years, there has already been a spread from three of these countries internationally. In Central Asia there's been spread from Pakistan into Afghanistan, in the Middle East from the Syrian Arab Republic into Iraq, and in Central Africa from Cameroon to Equatorial Guinea. It's for this reason that the committee believes and deems essential a coordinated international response to stop this international spread and prevent especially the

new spread with the onset of the high transmission season which will begin later this month from June 2014.

The committee also highlighted that the consequences of further international spread are particularly acute today given the large number of polio free but conflict torn and fragile states which have severely compromised routine immunisation services and are particularly at high risk of infection. It highlighted as well that these states will have extreme difficulty in mounting an effective response should they become re-infected.

Finally the committee made a number of recommendations to the Director-General but they first highlighted that the overriding priority to prevent international spread has got to be the interruption of wild virus transmission within the borders of the infected countries and highlighted the need for the full and immediate application in all geographic areas of the polio eradication strategies. The committee then provided advice to the Director-General for her consideration to reduce the international spread of wild poliovirus and this advice was based on a risk stratification of the ten states that currently have active transmission.

So on the basis of this advice, the Director-General is today, on 5<sup>th</sup> May 2014, issuing the following temporary recommendations under the International Health Regulations 2005: First, for countries that are currently exporting wild poliovirus, and this includes Pakistan, Cameroon and the Syrian Arab Republic, it's the assessment that these pose the greatest risk of further wild virus exportations in 2014 and there are five temporary recommendations issued by the Director-General for these countries. The first is that the head of state or at the level of head of state or government, the interruption of polio transmission should be officially declared a national public health emergency, if this has not already been done, to facilitate the mobilisation of all sectors to ensure the vaccination of all children, irrespective of where they live in the country.

The second recommendation issued by the Director-General is that these countries ensure that all residents and long term visitors to these countries receive a dose of the oral polio vaccine or the inactivated polio vaccine between four weeks and 12 months prior to international travel. The third recommendation is that these countries ensure those travellers undertaking urgent travel, that would be within less than four weeks, and have not received a dose of OPV or IPV, should receive a dose of the polio vaccine at least by the time of departure as this will still provide some benefit, particularly for frequent travellers. The fourth recommendation is that these countries should ensure that such travellers are provided with an international certificate of vaccination or prophylaxis in the form specified in the annex of the International Health Regulations. I think most of you are familiar with the yellow book for vaccination or a similar document to record the polio vaccination status and serve as proof of vaccination.

The final recommendation for states currently exporting wild poliovirus is that these measures should be sustained until specific criteria have been met which include that at least six months have passed without new exportations and there is full documentation and full application of the eradication strategies and activities in all infected and high risk areas. In the absence of such documentation it's recommended these measures remain in place for at least 12 months without new exportations. Once the state has met the criteria to be assessed as no longer exporting wild poliovirus, it would obviously be considered either as an infected state or as, if there's been sufficient time, it would be removed from that list as well.

Now, in terms of the second group of countries, and these are the states infected with wild poliovirus but not currently exporting, the Director General is issuing four temporary recommendations. These states include Afghanistan, Equatorial Guinea, Ethiopia, Iraq, Israel, Somalia and particularly Nigeria given the international spread from that country historically. These are judged as posing an ongoing though lower level of risk for new wild virus exportations in 2014. And the four recommendations are as follows: first that from the level of head of state of government they also declare, if not already done, that the interruption of wild poliovirus transmission is a national public health emergency and that they encourage, recommendation two, as a best practice that residents and long term visitors receive a dose of the polio vaccine four weeks to 12 months before travel and that for those undertaking urgent travel, they be encouraged to ensure a dose prior to departure.

Also, the third recommendation is that travellers who receive such vaccination have access to an appropriate document to record the vaccination status. The fourth recommendation for states which are not currently exporting but are infected is that they maintain these measures until two criteria have been met. The first of these is that at least six months have passed without the detection of wild poliovirus transmission in the country from any source, and secondly that there's documentation, a full application of the strategies in all infected and high risk areas. In the absence of such documentation it is the recommendation that these measures be maintained until at least 12 months have passed.

The committee also highlighted and the Director-General reaffirmed and accepted that any polio free state which becomes infected with wild polio virus henceforth should immediately implement the advice for states infected with wild polio virus but not currently exporting. The Director-General has also decided, on the advice of the committee, that there should be international assessments of the outbreak response within one month of confirmation of the index case in any newly infected state to ensure that eradication activities and activities to interrupt transmission and the outbreak are fully on course. Now finally, the Director-General wanted to reaffirm that the World Health Organisation and its partners will of course support states in implementing these recommendations and the Director-General has requested a reassessment of the situation by the emergency committee in three months time.

So with that I have summarised the WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus. And prior to opening for questions and clarifications, I'd like to remind you that this has now been posted on our website, and Gregory is nodding, for those of you who can't see him in the room, to affirm that. The other thing I'd like to do is just open the floor for two or three minutes to our chair, if I might, Helen Rees, so that she could add comments as she deems appropriate.

GR Just one second before Dr Rees starts, to remind journalists that if they have a question to ask either of Dr Aylward or Dr Rees, to dial zero one on your keypad to get into the queue. Dr Rees, thank you.

HR Thank you very much and I apologise that I'm not in the room with Dr Aylward this morning. I think Dr Aylward has clearly outlined the deliberations and the recommendations from the Emergency Committee. I think just to stress a couple of things, firstly that the Emergency Committee as was outlined had 14 members, the members included three members from the three endemic countries, Afghanistan, Nigeria and Pakistan, and also had

significant membership from the regions that are most effected at the moment by on-going polio transmission. The committee spent fully the full time in very, very intense deliberations and subsequently afterwards in finalising those recommendations so it has really given extremely careful consideration, noting the seriousness that one considers any recommendation under the IHR.

I think particularly talking about the declaration, that this is a public health emergency of international concern, just to reiterate what Dr Aylward has already said is that the real concern that has arisen now that the committee applied their minds to was the issue of the low season transmission with exportation from three countries and that fundamentally if this is in the low season that this poses now a very real threat to the global eradication efforts.

I also want to stress that these are temporary recommendations and as has been said, the Director-General has identified that these will be reviewed as per the regulations in three months' time. I'll stop there and I'm sure there will be questions from colleagues and journalists, thank you.

GR Dr Rees thank you very much. Dr Aylward you have something to add, please go ahead.

BA Right, I did want to make one further comment because I have been asked frequently about the situation in 2014, beyond the international spread, and just so that you have full information, there's been 74 cases of polio due to wild poliovirus so far this year; 59 of those cases have been reported from Pakistan and within Pakistan, 46 of those 59 from the FATA (Federally Administered Tribal Areas) and 40 of those of those cases within Fata from just one agency. The other thing to highlight was that most recent cases have onset as recently as late April. By contrast no other country this year has reported more than four cases and the only country with four was Afghanistan.

And Cameroon and Syria have reported three cases and one case respectively and both of those countries, their last reported case so far was in January of this year. So just to put in context those countries which are exporting viruses, that question has come up a number of times.

GR Very good, thank you very much both Drs Aylward and Rees. So once again journalists who are online, please dial zero one if you wish to get into the queue. We will look first to questions from the room, if there are questions from the room. Simeon Bennett from Bloomberg please go ahead?

SB Thank you. Dr Aylward can you talk about how legally binding these recommendations are on the member states involved or whether these are recommendations that they can choose to adopt or not? Also can you talk about the extent to which, I guess why polio has resurged in the way it has and the part that conflicts in various countries have played in disrupting vaccination campaigns? And then finally what's the risk that polio could become endemic in some of these countries again, above and beyond the three countries where it remains endemic? Thanks.

BA I'm going to jump and take those questions so then for those of you who can't see me, I'm having a little trouble writing as I managed to have my shoulder reconstructed a week

ago, so I'm going to take some of these and I apologise if I should miss anyone's questions it's because I'm having trouble writing and nudge me again and we'll come right back to it.

First in terms of how legally binding the recommendations are. First to highlight that, these are in the context of the International Health Regulations and the International Health Regulations are of course binding on those states' parties who are party to the regulations. Within the context of those regulations, there are temporary recommendations. Now these recommendations are not legally binding in the strict sense of these countries but they do carry very, very... or sorry strict sense, but they do carry substantial weight because of course they are in the context of a legally binding international treaty, so I'd like to highlight that.

So then to take your question further, whether or not the countries could choose to not to implement those, I think there would be serious concern and potential consequences in the form of further deliberation about additional measures were that to be the case and certainly all countries with whom we've discussed so far, they're very, very keen to take all actions they can to reduce and eliminate spread. So I think there's a lot of goodwill to try and address this problem.

In terms of why the virus has resurged, recently... I'd first like to put the situation in context. Actually the eradication programme is in an extremely good position, aside from this spread in the low season and aside from the situation in Pakistan. If you look at the situation in the other endemic countries, first of all in Nigeria only two cases have been reported so far this year and this is following a steep decline in cases there last year and then again a real improvement in coverage in almost all areas of the country.

In Afghanistan, they've had four cases this year but all of those are related to spread from neighbouring Pakistan, or viruses that originated in neighbouring Pakistan and the endemic virus in Afghanistan we've had only one case in I believe it's nearly 18 months now, there was one late last November, so in both of those endemic countries, we're at a level of control that we've never seen prior in the programme.

The other thing I would highlight is that, for those of you who aren't polio experts, there were actually three types of polio when we set out to eradicate this disease nearly 25 years ago. We last saw the Type II wild poliovirus in 1999 but now it's been nearly two years since we have seen the Type III polio in Asia and over 18 months since we've seen it in Africa, so we're really tackling one remaining wild poliovirus, a major development in the last 24 months.

And then the last points, so I'm sorry to labour this point, but in those other countries, as I mentioned we've seen very, very few cases – one case in Iraq, it was in early February; one case in Syria, that was late January so far this year; Ecuador and Guinea, three cases; and Ethiopia only one case. So while the virus has resurged, I think it reminds us that until it's eradicated it is going to spread internationally and it's going to find and paralyse susceptible kids. The current conflict situations that we're dealing with globally further complicate obviously the implementation of the strategies but so far have not proven a barrier to the ability to interrupt it altogether.

There is always the risk that if the virus is reintroduced to a polio free area, it could become endemic again, indeed it could become endemic again in the entire world if we do not complete the eradication of this disease.

GR Thank you very much Dr Aylward, we'll move to a question online now from the BMJ, please, I believe your name is Anne – if you could state your name and ask your question?

AN It's Anne [name] from the BMJ. I just wondered what kind of support can people get [inaudible] Afghanistan [inaudible] proposals?

BA Okay, shall we take a couple of questions?

GR Just one at a time is okay.

BA Okay so in terms of the support they'll get, certainly from WHO and from our partner agencies, first there's going to be just the challenge of the documentation issues, so we'll make sure that the countries can access and have available the appropriate document to serve as proof as vaccination, per the IHR, that's relatively straight forward. The second thing that we will try and do is share best practice from other countries that have been vaccinating adult travellers for the Haj and for similar requirements sometimes, share best practices and build on those practices. The third thing we'll be doing is looking at what additional vaccine may be required and what measures are required to ensure countries have sufficient vaccine to implement this. I know that has been raised by some people as a potential barrier to implementation of this but I'll remind you we use billions of doses of vaccines in this programme and given the number of travellers, etc, from these countries this would be a very, very small fraction of that.

GR Thank you. We'll come to the room, please state your name and affiliation?

IS Ishir inaudible Japanese Newspaper. Just for the reference, how many cases during 2013 WHO detected the cases of polio, worldwide? And the second question is I was not sure what is the advice for the countries which are free right now of polio and what should they do – they should introduce some kind of travel restrictions or obligation for the vaccination? And thirdly, when was the last time that WHO declared public health emergency case and this is for which case?

BA Okay, the last one is the easiest one. The last time a public health emergency of international concern declared was during the pandemic a couple of years ago and that's been the only PHEIC declared to date.

In terms of the number of cases in 2014, I had to pull out my sheet here because we've been going back and forth to try and reconcile some data, whether it was 416 or 417 and the official number right now is 417 cases. I think for those of you who are aware of the programme, on our website [polioeradication.org](http://polioeradication.org) you can always find the figures, latest figures by country and usually for the last five years, they're updated weekly.

And then there was...

GR [Inaudible conversation].

BA Oh 2013 ... pardon me, if I said 2014 I meant 2013 total cases were 417. And then there was a question about the... oh for polio free countries, yes. At this time, the committee focussed on preventing the virus from leaving countries that were polio infected and it did not make specific recommendations to countries, polio free countries of arrival. As you know WHO provides guidance to all travellers whether to or from polio free countries and that guidance is available in our international travel and health document but the committee focussed very much on the responsibilities and obligations of countries that are infected to prevent the exportation. And part of the reason for doing this was to ensure there was minimal impact, certainly at this time, on any travel or trade between states.

GR Thank you. Just to specify what Dr Aylward already mentioned, the first and only PHEIC before today, public health emergency of international concern, was declared on 25th April 2009, at the beginning of the H1N1 [?] pandemic.

The next question comes from online that will be Jennifer Yang from the Toronto Star?

JY Hi there. Thanks very much Dr Aylward for taking our questions, I just wanted to confirm you mentioned Israel as one of the ten countries where polio remains active, could you just clarify what's happening in Israel?

BA Okay. As some of you may be aware, wild poliovirus was detected in Israel, it's a virus of Pakistani origin, and it's part of the virus group that's circulating widely in the Middle East in 2013. This virus was found in Israel in May of last year, when they looked retrospectively they believe it had been in the country as early as February, first circulating mainly in the south of the country and then found in sewage samples collected quite widely. In Israel they never had any cases, they only found the virus in the sewage which means of course they had a highly vaccinated population so no-one was getting paralysed but the virus was still able to circulate and this is because they used mainly an inactivated polio virus vaccine, what's called IPV, that doesn't provide immunity in the guts or the intestines and for that reason the virus could still circulate without causing paralysis.

Now since that time, Israel conducted one nationwide campaign with the oral vaccine to boost immunity in the guts and then it conducted a second campaign mainly in the south where most of the transmission had been. And then from this January, it began introducing the oral vaccine as a booster dose in its routine programme. Since then they've almost... I say almost... they've found very, very little virus in the sewage and only in one site now in the southern part of the country and I think the last positive sample they detected was probably in April.

GR Thank you.

JY [Inaudible] come from human cases in Israel?

UM There've been no cases, no confirmed cases in the country, but the prolonged detection of the virus in the sewage, combined with the genetic sequencing of those viruses, confirms that it was circulating in the country. I think, again, for those journalists not familiar with polio, it is a virus that paralyses between one and 200, and maybe one in a thousand of the people that actually get infected, but again, if they're protected with the inactivated polio vaccine or the SALT vaccine, they will not get paralysed themselves, but they can still get

infected and pass the virus on. And we believe that's what was happening in Israel, until they reintroduced booster doses of the oral vaccine. It's sort of a unique circumstance, we think, where this virus was able to circulate.

CH Thank you. The next question also comes from online. Maria Chang of Associated Press. Please go ahead.

MC Hi, thanks for taking my question. I have a couple of things I wanted to ask about. First of all, are there any specific measures to curb the violence that we've seen against the health workers in Pakistan? Is there any ramped up vaccination campaigns planned that are different from before? And, secondly, I wanted to ask if there's any thought to reconsidering the 2018 eradication deadline, and, Bruce, if you have any thoughts on what the prospects are that you'll meet the 2014 deadline of interrupting transmission. Thanks.

BA Thanks, Maria. First, there's been tremendous work, actually, in Pakistan this year to try and curb and eliminate the violence in terms of the attacks on health workers. What happened was, in the province of KP or Khyber Pakhtunkhwa where most of those attacks were occurring, and particularly in Peshawar, the capital, the government launched what it calls its Peshawar Plan, and this was a unique approach, where they cordoned off huge areas at a time. They banned the riding of motorcycles during the period of the campaigns and put in place a whole new security approach. With that, they linked a lot of additional interventions, health interventions, and they conducted 12 campaigns over, I believe, it was about a three and a half to four month period, this spring. They had not one single attack or incident in the whole Peshawar area during that period. And, following a visit of the Director General, Doctor Chan, with our Regional Director, Dr Alwan, to meet with the Prime Minister and the President about one month ago, there was a discussion to expand that to districts immediately surrounding Peshawar, which has been done. And again, with no security incidents. So although some incidents have occurred, they have not been in those areas and the government feels strongly that it is finding a strategic approach to properly protect and expand the services being delivered.

In terms of the 2018 deadline, I think, from the date I presented earlier, clearly, the world has the opportunity to stop transmission of this disease by that time and certify that achievement. In terms of the 2014 working target, to try and stop the transmission, again, from the data presented, clearly, Pakistan is the only country that would currently be considered as off track in terms of its ability to meet that deadline. That is primarily, of course, because vaccination has yet to be restarted in some corners of that country.

CH Thank you. Next question from Tom Miles from Reuters.

TM Thanks, Gregory. Hi, Dr Aylward . A couple of questions. If I understand this right, basically, everybody who lives in Pakistan and these other two countries in the states currently exporting the virus, they're going to need a certificate to leave the country. So I wonder when that's going to be put in place, how soon will travellers from Pakistan and the others need to show one of these when they leave? In the case of Pakistan, I'm unclear as to where they're exporting it to, apart from Afghanistan, and I wonder if this is not a sledgehammer to crack a nut by demanding a certificate from everybody if the greatest risk is

to Afghanistan, where the border is, obviously, notoriously porous. In Syria, I wonder how realistic this is and whether the government reassurance is what matters, given that there's a refugee population that may not be taking orders from the government. So if you could clarify any of that, and I think you mentioned you've already been in touch with some of these countries. What reassurance have they given you and one other thing I wanted to ask is, is this the strongest measure you could take, or did you consider any other stronger measure? Thanks very much.

BA Tom, I think I have all your questions. If I miss one, please come right back. Then, Helen, if you don't mind, at the end of my comment I'm going to go to you because the question is did we consider stronger measures. In fact, it was the Committee, of course, that advised us, so you might advise on what additionally the Committee may have considered. Tom, if I remember your first question, it was about Pakistan specifically and the risk posed, and whether this might be a sledgehammer for a nut. If we look at the countries currently infected around the world, that is reporting virus from the last six months, the Pakistan virus has been reported from Israel, from Iraq, from Syria, and it was also found at one point in the sewage in the West Bank in Gaza. And as recently as December this year, that virus was also found in greater Cairo sewage. It was virus from Pakistan which also caused the outbreak in China two years ago as well. So, in fact, the majority of these re-infected areas, the virus circulating actually traced back to Pakistan within the last 12 to 18 months. In terms of implementation of these recommendations, in Syria, yes, I believe very much it's possible. In terms of government controlled areas, relatively straightforward is a big word to use in the current context there, but indeed these can be implemented if not four to 12 weeks prior to travel, because a lot of travel there right now, as everyone knows, is quite unpredictable and on very short notice, certainly at point of departure.

Now, in terms of refugee populations moving especially across borders not controlled by the government, or in other areas with IDPs, there is a great deal of support being provided by a combination of NGOs, UN agencies, in the case of the UNHCR, of course. And we have standard practice already with them, since the outbreak, in the Horn of Africa, last year, to ensure appropriate implementation of vaccination strategies there. So, in fact, certainly official refugee populations are some of the easiest to deal with. The other thing that we're doing, Tom, in those countries, is doing synchronised polio campaigns to ensure, for those refugees that are missed, they get a dose during those synchronised campaigns across those multiple countries.

Now, in terms of the countries themselves, you asked do they provide reassurance and I said, yes, indeed they did. A number of the countries, Tom, have already experienced implementing vaccination requirements for the Hajj for polio in particular, and even for all residents. So they're already thinking in that context as to how to expand that to ensure vaccination at point of departure. In terms of stronger measures, perhaps I can turn to Helen. But, indeed, there are a number of additional measures that could be considered going forward, should these ones not prove sufficient to stop international spread. Helen, perhaps you want to speak about that?

HE Yes, thank you. When these emergency committees meet, first of all, they are deliberately external experts to WHO, so there's an independent view that is given as advice to the Director-General. We were asked to particularly look at the current situation and say, first of all, as you've said, is this a public health emergency of international concern? And,

secondly, what are the measures? The measures, clearly, have to be appropriate for the situation that you identify. We identified, as the critical situation at the moment, the fact that three countries were exporting wild polio virus during the low season, and that this was the major issue that we had to focus upon. We also recognise that, in terms of international health regulations, you are really required to look at what can be introduced that will have the necessary public health impact but has the least possible impact on travel and on trade. So there are, obviously, other things that you can do, and we could have done more things, we could have looked at the other countries. You can see, we've divided them into different categories. But we felt, at this present point of time, the first recommendation we should do was on the three countries that were exporting, because these, indeed, provide the greatest risk to global transmission. The other criteria for a PHEIC is to say is there a great risk? What is the risk? And is there a significant risk to international transmission of an infectious disease? And, in this case, indeed, there was. And the second criteria is, does international coordination responding to that risk, will that assist? And we felt that international coordination would also assist. We had seen that a couple of countries were now introducing their own criteria around travel, and we felt that, globally, it was going to be much more useful for the global effort, to have a single integrated approach.

Now, however, it's stressed that these are called temporary recommendations. We will look at how things have been implemented, what the impact is after three months, and then the Director General has indicated that she will ask the Emergency Committee to review. Should we see things change, we can then alter those recommendations in the context of the international health regulation. Over.

BA Thanks. If I might just add, Tom, I realise I missed part of your question, and that was about when the travellers would need to have this in place. Now, obviously, this would want to be done as rapidly as possible, and it's effective, as of today, the recommendation of the Director General. But it will be a decision of the countries themselves as to how they want to handle their departing travellers and how quickly they will be able to ensure documentation, etc, is appropriate. But that may take a few days to get the policy sorted out in the country and then a couple of weeks to get the logistics of the appropriate documentation, etc, in place. But there is the expectation that this will be extremely fast. Now, the reason for that, Tom, goes back to the fact that we are entering the high season for polio. This is not something you can take a week or two weeks to make a decision whether or not you're going to do it or how. Those have to be made very, very quickly, and implemented very, very quickly, and it is, as Helen stressed, in the interests of these countries, to get this in place extremely quickly, because the risk of exportation will go up with the high season, which is starting, really, as we speak. So a huge incentive, one hopes, for the countries, to do this very, very quickly.

Tom, you did ask also about additional measures, and some of the things discussed were whether or not there should be full vaccination in addition to the additional dose, and have that documented. Should more countries be subject to the similar recommendations? Should there be recommendations to countries of arrival on how they handle? Should there also be recommendations around travel itself? So there are a huge number of additional measures that could be put in place, should this fail to stop transmission. But those will be the decision of the emergency committee. And, as Helen mentioned, the Director General stressed that she will call the committee back even sooner than three months, should there be a problem with implementation or should there be evidence of continued international spread.

CH Thank you and now over to Imogen Foulkes [?] BBC.

IF Is it your expectation that in countries concerned, if somebody is wishing to travel and cannot prevent this certification of vaccination, that they will be prevented from travelling?

BA I think, as Helen said, our intent and the intent of the entire IHR is to minimise any restrictions on travel and trade and certainly at this point we would hope that countries would ensure that people are to travel, but this decision will remain with the countries receiving travellers, and they may differentiate, depending on the risks that they perceive from those countries.

IF Just to follow up, if you've made these recommendations, presumably you will be hoping that people without the certificate of vaccination do not travel.

BA We'll be hoping that they get vaccinated at the point of departure if they have to.

CH Thank you very much. We're coming to the end of the press conference and we'll take the last question and maybe one or two more. One more question from Deborah McKenzie, please.

DM Thanks. I want to know if there's any way of doing some sort of quality control to see whether people have actually just vaccinated their certificates or there might be some random sampling to see if people have actually sera converted to a recent vaccination, who have a certificate, just to see how effective it is? And does having declared a site actually give governments more of a stronger position to actually go into areas with some sort of force to back them up, if necessary, if they need to access people in areas that are subject to conflict?

BA Okay, thanks Deborah. First, in terms of quality control, we will be relying on surveillance, basically, to tell us whether or not this is working. If we were to look at zero conversion rates of travellers and things like that, we could still actually see spread and still see transient carriage, so the ultimate assessment of this will be whether or not exportations stop and, again, I think, as most of you are aware we can within days now genetically sequence a virus and know where it arose from, what its origin was and how recently it left there, so we actually have quite a good mechanism for knowing whether or not these measures will be working and there's not an intent right now to chase zero conversion or other things like that. We would be looking at whether or not transmission or exportations stop and if they don't stop then calling back the committee to get further advice on additional measures. In terms of the intent and whether or not this might result in the use of force to access some areas and I think you mentioned, Deborah, conflict-affected areas, I think the real goal here or the real need, rather – this is not the goal of these measures – the real need is to ensure in areas where children are not being vaccinated that there is a negotiated access to these children under whatever terms necessary to ensure their vaccination. Certainly, the World Health Organization would not be promoting the use of force. That would run counter to anything we would be promoting. Sorry, Deborah, did I get your questions?

DE Fine. I didn't want to suggest that the WHO was suggesting the use of force just that whether it might give governments kind of more of a feeling of legitimacy if they really felt they needed to get more access to an area and perhaps put more money and manpower into it.

BA Right. I think we're looking at more money, more manpower, more negotiation under the terms that are acceptable to the local populations, parents there that want to make sure their kids don't get paralysed and, again, I think our experience in 25 years of eradication and negotiating access is that this is possible without the use... certainly, without the use of force usually.

GR Thank you. Back to Simeon Bennett in the room. Thank you, please.

SB Just two final questions. First of all, can you confirm whether in fact in Pakistan there are already vaccination booths at airports? Is that something that's already happening and is it happening elsewhere, as well? And then, secondly, given what you said about Israel and the detection of the virus in sewage samples of there that being related to the use of the inactivated polio vaccine; given that same vaccine is used in Western Europe and the US and other developed countries, is there a case to be made for reintroduction of oral polio vaccine in those countries to ensure not only that disease is prevented but that transmission of virus is prevented as well? Thank you.

BA Thanks Simeon. In terms of what's happening currently in Pakistan, the government did report at the executive board of the World Health Assembly when it met in January that it was establishing booths at some points of departure. I understand that that has not been extensively implemented but there is a renewed effort to do that. Similar measures have been reported in other places. Now, that said, you asked specifically about airports but you remember that most international spread is actually across land borders although the majority of cases last year were due to distant spread because of explosive outbreaks there were more events happening directly across borders and as a result Pakistan has established vaccination booths right across its border with Afghanistan, across its border with China, the border with India and also with Iran. So, it has historically been vaccinating at those focusing mainly on young children and now we anticipate it will look at the vaccination of older travellers as well.

In terms of Israel, that's an excellent question and for those of you who didn't hear the question was given what we saw there with an IPV-using country and the circulation of virus despite very high coverage, does this have implications for Western Europe and elsewhere? We don't believe so. Now, the reason for that is we think the combination of climatic circumstances, demographics, etc, in Israel are relatively unique and, in fact, just before this outbreak was found we'd actually done mathematical modelling of this with a group from Imperial College that showed that this could happen exceptionally and then we did find it, which is kind of reassuring. Although, I think it would not deem necessary the re-introduction of oral vaccines in other IPV-using areas, but it would certainly send a very loud, you know, reaffirmation and the need to really maintain vigilance for the virus.

Many countries of Western Europe, elsewhere, already sample their sewage for viruses, etc, to continue to looking, to know what is happening but also to make sure that they have an emergency preparedness plan in place which allows them to access whatever vaccines they might need to stop the virus if, indeed, it is re-introduced. So, I think that's more the takeaway from most countries that would be using IPV at this time and, certainly, the bigger implications are what happens after global eradication because we do need to stop, eventually, the oral polio vaccines because extremely rarely, of course, they can cause vaccine-associated polios; very, very rarely but when there's no polio in the world that's a risk

we don't want to take. So, at that time, we will be relying on IPV in most areas to maintain immunity and, again, I think, we'll have to make sure, at least in the initial post OPV period we have really great surveillance and we can come back with a stockpile of oral vaccines. So, right now, we've contracted 1.1 billion doses of oral polio vaccine for a stockpile for that period. So, it's helped reaffirm that that was a good investment.

GR Okay. I believe we still have a couple of questions online and then we'll close, if that's okay. NPR, National Public Radio, if you could give your name please.

JB Yes, this is Jason Beaubien with National Public Radio in the US. I have just a question in terms of specifically when people are leaving the country, this would be OPV not IPV that people are being vaccinated with, is that correct?

BA I must say I'm impressed with the questions, 25 years of polio eradication and I think the journalists working with us know this programme as well as we do. Jason, historically we've said ideally OPV would be used to boost travellers. Now, we did a study last year with the government of India in one of the last areas to eradicate polio and what we found was that if people had already received a lot of doses of oral vaccine or of they lived in an area where they would have been exposed to the wild virus, so their gut, so to speak, has already seen the virus, if we gave them a dose of IPV that would really boost their mucosal immunity as well and this is one of the key shifts in our recommendations to travellers that was just published in International Travel and Health, that as a result of that, we've tried to make our recommendations even more workable – these are our recommendations to travellers – to say that a dose of either OPV or IPV could be given prior to travel and, indeed, the Emergency Committee concurred that in the context of what we're seeing right now that that is appropriate. So, that's a bit of a shift but an important one, Jason, as that makes it easier for some countries to implement the policy as well. Is that clear?

JB So, it could be either one; that's the recommendation?

BA That's correct.

GR Thank you very much. If that's Anne from BMJ.

AN That's fine.

GR All right. Then I guess we're finished. Thank you very much to all for those who have attended both in person and online today. Just a couple of reminders before we go that there will be an audio file up in a few minutes on the WHO website, [www.who.int](http://www.who.int). Later today, probably early evening, there will be also the written transcript up on the website and the full statement on the outcomes of the IHR Committee is already up on the website in the WHO Media Centre under statements. Thank you very much. Goodbye.