Background and Interpretation

The World Health Organization (WHO) originally issued a statement on 5 May 2014 declaring that the recent international spread of wild poliovirus was a Public Health Emergency of International Concern (PHEIC). Temporary Recommendations were issued for exporting and infected countries under the International Health Regulations (2005) (IHR). An earlier Briefing Note 2014/074, 3 October 2014 identified the recommendations for travellers from England, Wales and Northern Ireland to affected countries.

WHO has now reassessed their Temporary Recommendations [1] and this briefing note outlines the implication of this updated review.

Routine polio vaccine uptake in the UK is high and has been sustained at this high level for many years. The last indigenous case of wild poliovirus infection was in 1984 and the UK, along with the rest of the WHO European region, was declared polio-free in 2003. The risk of importation and local transmission of wild polio-virus from visitors from infected countries remains extremely low and has probably fallen in recent years.

However, there continue to be implications of the WHO recommendations for the UK, as the UK has significant numbers of travellers to and from the affected countries who are affected by these recommendations. The UK has a strong polio surveillance programme and it is important these enhanced surveillance activities continue.

The WHO Temporary Recommendations do not include entry screening of passengers from affected countries and PHE continues to not recommend the implementation of screening for vaccination or infection at point of entry in the UK for passengers from affected countries.

The approved recommendations for immunisation of travellers to affected countries from England are outlined in the Appendix. This is intended to be a specific communication that can be cascaded through SILS to primary care and other partners.

Implications for PHE Centre Screening and Immunisation Leads (SILs) and Health Protection Teams (HPTs)

There are a significant number of long-term visitors to exporting and infected countries (Pakistan, Cameroon, Afghanistan, Equatorial Guinea, Iraq, Israel, Somalia and Nigeria), in particular to Pakistan and Nigeria from the UK. PHE Centres may be asked for advice about travel to affected countries. As per normal arrangements, travel advice for professionals and the public should be obtained from the National Travel Health Network and Centre (NaTHNaC). NaTHNaC has recently updated its travel advice and country information pages in line with current recommendations [2].

PHE Centres should work with NHS and partners locally to ensure that all those at risk receive appropriate advice prior to long term (>4 weeks) travel to affected countries and ensure appropriate immunisation with polio vaccine as per guidance is undertaken. In particular, long term travellers who are contra-indicated OPV (because of immunosuppression, as a family contact or pregnancy) should receive inactivated polio-containing vaccine prior to departure. This activity should be supported by communication materials developed by PHE and NaTHNaC, which should be cascaded by PHE through SILS to primary care (see appendix).

PHE Centre HPTs should continue to be alert to the possibility of polio infection including both mild/non-paralytic febrile illness and meningeal, neurological or paralytic illness in recent arrivals from affected countries. Acute
poliomyelitis is a notifiable disease by law and all suspected cases should also be formally notified to the proper officer in the normal way. Further information and advice for health professionals [3] is available.

PHE Centre SILs should examine coverage of primary vaccinations at age 12 month and 5 years for areas with large populations with close links to affected countries. Areas with sizeable populations where primary vaccination uptake remains below 90% at the age of five years may need to consider supplementary vaccination activities. For populations where coverage exceeds 90% by age five years but may be lower in younger age groups, clinicians should be alerted to the need to use all opportunities, such as travel abroad, to ensure timely vaccination, and to improve coverage in these populations.

Implications for Local Authorities

This PHE briefing note is unlikely to have any direct impact on Local Authorities. Any enquiries should be directed to the local PHE Centre Health Protection team.

Recommendations to Public Health Laboratories

There is a need to raise awareness about testing for enteroviruses for all NHS microbiologists. As outlined in the polio surveillance SOP [4] CSF and faecal samples should continue to be tested locally and any enterovirus positive samples from a person with relevant symptoms sent to Colindale for typing. A request form for referral of samples to Colindale is available from the Virus Reference Department.

Communications activity

Together with NaTHNaC, national PHE communications at Colindale have developed messages to the media and the public with regards to the international situation and to confirm the updated guidance with regards to vaccination of long term visitors to infected countries. PHE Centres that consider any supplementary vaccination activities should liaise with their regional/Centre communications team for advice on media/stakeholder activity to support this. Contact: infections-pressoffice@phe.gov.uk

References/Sources of information

Appendix: Approved Communication for Dissemination by SILS to Primary Care

Polio – Public Health Emergency of International Concern - Public Health England and National Travel Health Network and Centre
updated recommendations for healthcare professionals advising travellers to affected countries
9 April 2015

Public Health England (PHE) and the National Travel Health Network and Centre (NaTHNaC) have updated their advice for travellers from England, Wales and Northern Ireland for countries according to the following risk categories:

1. states currently exporting wild polio virus
2. states infected with wild polio virus but not currently exporting
3. states no longer infected by wild poliovirus, but which remain vulnerable to international spread

The recommendations have considered the recent World Health Organization (WHO) temporary recommendations under International Health Regulations (2005) to reduce the international spread of wild polio virus (first issued 5 May 2014) and WHO guidance for the implementation of the Temporary Recommendations.

All travellers:

- should practise strict food, water and personal hygiene precautions. Polio is transmitted by the faecal-oral route (through close personal contact with an infected individual)
- should have completed a primary vaccination course according to the UK schedule (previous poliomyelitis does not confer immunity against another episode of poliomyelitis)
- who have not completed a primary course of polio vaccine or have not had a polio vaccine booster in the last 10 years should receive a polio vaccine before travel

1. Category 1: Travellers to countries currently exporting wild poliovirus: Equatorial Guinea (until 4 April when it will move to risk category 2) and Pakistan:

- Travellers to settings with extremely poor hygiene (e.g. refugee camps), or likely to be in close proximity with cases (e.g. healthcare workers), and/or visiting for 6 months or more, are advised to have a booster dose of polio-containing vaccine if they had not received vaccination in the past 12 months*.
- Travellers who intend to visit these countries for four weeks or more should be aware that proof of vaccination, given four weeks to 12 months before departure from the country, an International Certificate of Vaccination or Prophylaxis (ICVP), may be required on exit. Failure to produce this
documentation may result in vaccination at the point of departure most likely with oral polio vaccine.

- **Immunosuppressed and their household contacts or pregnant individuals (in whom OPV is contraindicated)** who plan to travel to these countries for one month or more are advised to receive inactivated polio vaccine (IPV) within 1 year before planned departure from these countries and to ensure this is recorded on an ICVP.
- Further information relating to the advice and ICVP issues is available on the NaTHNaC website.

2. **Category 2: Travellers to countries infected with wild polio virus but not currently exporting: Afghanistan, Cameroon, Iraq (until 19 May when it will move to risk category 3), Israel (until 28 April when it will move to risk category 3), Nigeria and Somalia:**

- Travellers to settings with extremely poor hygiene (e.g. refugee camps), or likely to be in close proximity with cases (e.g. healthcare workers), and/or visiting for six months or more, are advised to have a booster dose of polio-containing vaccine if they had not received vaccination in the past 12 months*.
- Travellers are encouraged to carry documentary evidence of their polio vaccination status (an International Certificate of Vaccination or Prophylaxis is NOT required by these countries).
- Further information relating to this advice is available on the NaTHNaC website.

3. **Category 3: Travellers to countries no longer infected by wild poliovirus, but which remain vulnerable to international spread: Ethiopia, Syrian Arab Republic.** [Should there be no further detection of wild poliovirus in Israel by 8 April and in Iraq by 19 May, these countries will also meet the criteria for this risk category.]

These travellers should follow the usual advice for [all travellers].

*Although previous complete vaccination will give good personal protection against polio, there is evidence that immunity in the gut wanes over time following vaccination. This means the virus can be carried and excreted, thus posing a risk to public health, but little risk to the vaccine protected individual. An additional dose of polio vaccine will boost gut immunity and reduce the risk of international spread of the virus.*