

Risk Assessment:

Although recent IM data were not available, past assessment indicated weak immunization performance; 0-dose NPAFP data are intermediate. Because no WPV has been isolated for more than 12 months and surveillance performance is strong, Sudan may have interrupted WPV transmission. A field surveillance assessment would verify the quality of surveillance. Nonetheless, with weak immunization performance, strong assessed surveillance performance, and >12 months without WPV cases, South Sudan is considered to have a moderate, decreasing risk of failure to detect and interrupt WPV transmission by the end of 2010. Upcoming elections are a concern and contingency plans are needed to sustain program achievements.

South Sudan has shown substantial progress and currently has a moderate, decreasing risk of failure to detect and interrupt WPV transmission by the end of 2010. No further detection of WPV since June 2009 with improved surveillance indicators is highly encouraging. Upcoming elections are a concern; contingency plans are needed to ensure continued progress.

Endemic Countries

Endemic countries	WPV History		Current Quarter Risk Assessment			Prior Quarter
	Date of last WPV	Weeks since last WPV (as of 1 Oct.)	Immunization performance (strong, intermediate, weak)	Surveillance performance (strong, intermediate, weak)	Overall risk of failure to detect and interrupt WPV transmission (risk / trend)	Overall risk of failure to detect and interrupt WPV transmission (risk / trend)
1 Afghanistan *	4-Sep-10	4	Weak	Intermediate	High: stable	High: stable
2 India	16-Sep-10	2	Strong	Strong	Moderate: decreasing **	Moderate: decreasing **
3 Nigeria *	27-Sep-10	1	Weak	Intermediate	High: decreasing	High: decreasing
4 Pakistan*	29-Sep-10	< 1	Weak	Intermediate	High: increasing	High: increasing

* Country reported at least 1 case with an October onset as of 2 November 2010

** There is evidence of WPV circulation in three or more states within the last 6 months (refer to methods section).

AFGHANISTAN

Epidemiologic Situation:

Eighteen WPV cases (10 WPV1 and 8 WPV3) were confirmed through 30 September 2010, compared with 24 (15 WPV1 and 9 WPV3) during the same time period in 2009. The number of districts affected by WPV have remained largely unchanged in 2010 (13) compared with 2009 (12). Three cVDPV2 cases were identified in Afghanistan during 2009–2010.

Immunization Performance:

The MPI target is <10% missed children during at least 4 SIAs in each of the 13 conflict-affected districts with persistent transmission in the Southern Region. Available IM data using the house-to-house method for 2010 SIAs in the 13 high-risk districts indicate that this target has rarely been met in 2010 SIAs. Outside the house monitoring in July available for three districts indicate much higher proportion missed children compared with the house-to-house monitoring. IM data are adjusted for areas targeted but not accessed during SIAs.

The reported immunization status of NPAFP children indicates high coverage nationally (1% 0-dose children) and sub-nationally (all provinces having <10% 0-dose children). The overall proportion of children 6–35 months of age with 4+ doses of OPV (94%) is consistent with the Pol3 estimate (83%). However, these data mask substantial differences in high-risk districts of the south region. Because of MPI SIA monitoring data, immunization performance is weak.

Surveillance Performance:

The MPI target for all endemic, re-established transmission, and “importation belt” countries is NPAFP rate >2 in all sub-national levels (GPEI#2). Overall AFP surveillance performance indicators generally meet targets nationally and sub-nationally, despite access problems in the conflict-affected districts. Adequate specimen collection from children with AFP is <80% in one province. Surveillance performance is strong by these indicators and generally supported by genomic sequence analysis. Recently, however, virologic analysis indicates a distant genetic linkage, indicating missed chains of transmission and intermediate surveillance performance in the Kandahar area.

Risk Assessment:

The number of WPV cases is essentially unchanged from the same time period in 2009. Afghanistan has a high, stable risk of failure to detect and interrupt WPV transmission by the end of 2011 because both WPV1 and WPV3 continue to circulate in insecure districts in the Southern Region. Additionally, three cVDPV2 cases have been identified during 2009–2010 suggesting poor routine immunization and a need to balance mOPV/bivalent OPV (bOPV) use in SIAs with at least two tOPV SIAs per year.

Afghanistan has a high, stable risk of failure to detect and interrupt WPV transmission by the end of 2011 because of ongoing problems in accessing children in insecure southern areas.

INDIAEpidemiologic Situation:

During January–September 2010, 39 WPV cases (16 WPV1, 23 WPV3) were confirmed, compared with 504 (64 WPV1, 439 WPV3, 1 mixed WPV1/WPV3) during the same time period in 2009. The number of districts affected also decreased in 2010 compared with 2009: 7 vs. 28 districts for WPV1 (including one WPV1/WPV3), and 12 vs. 40 districts for WPV3.

The latest identified WPV1 in Uttar Pradesh was in November 2009. The WPV1 outbreak in Tajikistan (imported in late 2009 or early 2010) was related to WPV1 last isolated in 2009 in western Uttar Pradesh. Three WPV1 cases were confirmed in Bihar in 2010, the latest with onset 1 September. All of these cases in Bihar were from one block of Champaran East district which borders Nepal’s Rautahat district where WPV1 circulation was observed earlier in 2010. WPV1 virus related to Bihar 2009 strains were isolated from AFP