World Health Organization
Regional Office for Africa

# Vaccine Preventable Diseases Bulletin

WHO/AFRO

January 2005 N° 053

## TFI 2004 - Proceedings, Recommendations and implications for 2005

The 12th meeting of the Task Force on Immunization (TFI) in Africa and the 11th meeting of the Africa Regional Inter-Agency Coordination Committee (ARICC) took place in Bamako, Mali, from 7th to 9th December 2004. Established by the Regional Director in 1991, the TFI is mandated to provide broad guidance to immunization programs in the African Region. On the other hand, the ARICC serves to bring together the major partners to harmonize approaches and to promote coherence as well as resource mobilization in support to immunization programs in the Region.
Officially opened by H.E. Ahmadou Toumani Toure - an ardent supporter of immunization and Polio eradication, who has chaired the Mali Inter-Agency Coordination Committee since its inception, the Bamako 2004 TFI took place in a context of:

• Accelerated implementation of Reaching Every District (RED) approach with 15 countries recording improvement in DPT3 coverage of 10 percentage points or more. Here, commendable progress was registered in Angola, DRC and Ethiopia.

• The observation of importations of Wild Polio Virus in 9 countries and re-establishment of indigenous virus transmission in 4 counties. In 2004, the AFR region had the unenviable record of contributing 80% of the global wild poliovirus.

• Resumption of OPV vaccination after a spate of OPV rejections in Northern Nigeria that had resulted in intense wild poliovirus transmission there.

• Two successful rounds of Polio supplemental immunization activities (SIAs) in 30 countries: the endemic, those that had experienced importations as well as those at high risk - reaching over 100 million children.

• Integrated OPV-Measles campaigns in Burkina Faso, Niger, Mali and Togo.

• Integration of insecticide treated nets (ITNs) distribution in Togo and Ghana - thus using the success of EPI in reaching the "traditionally un-reached" to address malaria one of the major causes of child mortality in the region.

• A release of the WHO progress estimates reporting a 50% reduction in measles mortality in the African region as compared to 1999.

• A new TFI membership having been appointed by the WHO/AFRO Regional Director.

In his feedback on the status of implementation of the Luanda 2003 TFI recommendations, Dr. Antoine Kaboré - the WHO/AFRO Director for the Prevention and Control of Communicable Diseases reported that out of the 16 recommendations; 9 had been fully achieved, 5 partially achieved, while 2 were not achieved.

Dr Francis Nkrumah - the long serving Chairman, who stood down after 11 years, congratulated the outgoing TFI members for their service, welcomed the in-coming members and passed the gavel to Prof. Peter Ndumbe as the new chair. The deliberations of the TFI themselves were conducted in a process that departed from tradition - with parallel working tracks intensively addressing the major themes of immunization. After 3 days of deliberations, and towards guiding the program over the next 12 months, TFI made the following recommendations:

**On Polio Eradication**

TFI endorses the proposed supplemental immunization activities schedule in Nigeria and the West and Central African blocs.

1.That WHO/AFRO supports the synchronization of SIAs within the region and between AFRO and EMRO regions.

2. The quality of SIAs be improved through:

- Systematic monitoring using standard indicators,
-Identifying and immunizing cross border populations e.g. migrants, nomads, refugees.

3. Countries, with partner support, improve operational collaboration between polio laboratories and national EPI programmes, and provide adequate resources to the polio laboratory network to sustain high-level performance.

4. TFI is concerned about the re-established poliovirus transmission in the Cote d'Ivoire, and recommends that WHO/AFRO urgently assesses and monitors the situation and takes appropriate action.

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**On Routine Immunization**

**On Reaching Every District (RED) Approach,**

5. That resources be mobilized through new and existing partnerships to support implementation of the RED strategy. This should include advocacy with governments for sustained district-level human and financial resources.

6. The RED approach be initiated in Central Africa, Nigeria and countries in conflict to improve routine vaccination coverage. This should include monthly reporting, feedback, and the development of reporting systems to collect and analyze data. Nigeria should report to 2005 TFI meeting on progress with this strategy, which uses the existing district/ward health systems.

7. All countries be provided with technical assistance to improve their use of data and monitoring of the basic RED indicators.

**On New Vaccine Introduction**

8. That WHO/AFRO and partners accelerate GAVI support for the introduction of Hepatitis B vaccine in at least 5 more eligible countries in 2005.

9. WHO/AFRO, governments and partners help countries to make informed decisions on vaccine introduction by

- working together to provide and disseminate existing data on disease burden from Haemophilus influenzae type b infection,
- providing support for generating additional local disease burden data as appropriate, and conducting systematic and comparable cost-effectiveness studies of Hib immunization in countries considering vaccine introduction.

**On Accelerated Disease Control**

10. That African governments, through their Ministries of Health, play a leadership role in accelerated disease control notably in the control of Measles and Yellow Fever and Maternal and Neonatal Tetanus elimination by:

- Increasing their financial contribution to programs.
- Ensuring improvements in program quality indicators.
- Ensuring that the cost of routine and SIAs is included in country budgets and financial sustainability plans.

11. WHO/AFRO documents countries' financial contribution, political advocacy commitment and programmatic planning for conducting disease control activities.

**On Yellow fever**

12. TFI accepts the Regional Strategic Plan for Yellow Fever control 2004 - 2008 and urges WHO/AFRO and all partners to proceed with its implementation.

**On Measles control**

TFI notes with satisfaction that the region - with particular support from the Measles Partnership has, as of end 2004 attained the goal of 50% measles mortality reduction as compared to 1999 estimates.

13. That WHO/AFRO prepares a new 5-year strategic plan aimed at consolidating the gains made to attain 95% reduction in measles mortality in the region and further to prepare for a regional goal for measles elimination 2010.

14. As a matter of priority, WHO/AFRO addresses the emerging programmatic issues from measles control strategies including:

- Comprehensive outbreak investigations,
- Evidence to determine age for vaccination and administration of a second dose during routine activities,
- Catch-up SIAs implementation strategy.

**On Rubella**

15. That WHO/AFRO reviews the evidence on rubella epidemiology in the region to determine what actions should be taken (e.g. providing guidance to countries when rubella outbreaks are detected, determining how to document the epidemiology of rubella and the burden of CRS in the Region). This should be done before discussing rubella immunization strategies.

**On Maternal and Neonatal Tetanus Elimination**

16. That WHO/AFRO and partners urgently mobilize adequate resources to address the persistent lack of funds for attaining the World Health Assembly goal of eliminating maternal and neonatal tetanus.

17. Supported by WHO/AFRO and partners, all countries conduct semi-annual review of district level data in 2005 to document progress so as to report on progress towards maternal and neonatal tetanus elimination to the World Health Assembly in 2006.

**On Immunization Systems Strengthening**

**On Improving national capacity to deliver EPI**

Given the need for countries to develop capacity strengthening plans based on detailed needs assessments, TFI recommends:

18. That WHO/AFRO develops a comprehensive training and capacity building plan for all aspects of immunization. This plan should be linked to an overall WHO/AFRO plan for human resource development and include a budget and indicators to monitor progress and measure impact.

19. Countries and partners increase efforts to deliver basic and in-service training based on current scientific knowledge and adapted to modern principles of adult learning. These efforts should use existing institutions and address important EPI concerns, such as implementation, logistics, supervision, programme and financial management.

20. Countries strengthen health systems by integrating training at the district level and by refreshing the skills of trainers and supervisors.

**On Immunization Safety**

21. That WHO conducts a thorough assessment of the prevailing situation with Vaccine Regulation in the Region and develop a capacity strengthening strategy, including the establishment of sub-regional networks, with a primary focus on:

- Licensing
- Surveillance of Adverse Events Following Immunization
- Authorization of clinical trials and evaluation of clinical data

22. WHO/AFRO organizes a review of the 1994 Yamoussoukro conference recommendations and assists governments to fully implement those not yet implemented.

**On Communication for immunization**

23. That WHO/AFRO, in collaboration with UNICEF and partners, analyze SIAs data relevant to monitoring and improving communication. These data should be reported to TFI.

24. Countries and partners ensure that micro-planning and funding for RED includes communication strategies within each of the 5 components.

25. Capacity building activities for EPI staff at all levels include communication skills development.

26. Countries and partners maintain polio and measles-funded communication experts through 2005 to support continuing disease control initiatives and communication for routine immunization at district and lower levels.

**On Integration**

27. That Ministries of Health expand national level ICC beyond immunization and toward integrated child survival activities.

28. A working group be established to discuss policy and programmatic issues which will build consensus on key interventions related to integration (insecticide treated bed nets, anti-helminthics, EPI, surveillance, breastfeeding etc).

29. WHO/AFRO develop a strategic framework on integration, taking into account experiences with strengthening district health systems in 8 countries under review.

**On the Response to the Global Immunization Vision and Strategy (GIVS)**

30. That WHO/AFRO incorporates TFI comments and its own assessment before drafting a final response the GIVS document. Member states and partners are encouraged to send their comments directly to WHO-HQ by 31 January 2005.

A subcommittee of 3 TFI members drafts a response to the GIVS document to be shared with all TFI Members by 15 January 2005. The final document should be forwarded to WHO/AFRO by 31st January, 2005.

**Implications of the TFI recommendations for programming in the AFRO-IVD Area of Work**

While continuing with all those elements of the programme that worked well, the synthesis from the above is that the programmatic emphasis for 2005 should be on improving population immunity and to consolidate the gains in the various disease control initiatives (e.g. Polio eradication, Measles control). This should be achieved in the context of promoting increasing country ownership and sustainability of the national immunization programmes

**The 11th Annual Meeting of the Africa Regional Inter-Agency Coordinating Committee (ARICC)**

The 11th Annual Meeting of the Africa Regional Inter-Agency Coordinating Committee (ARICC), made up of major immunization partners, met on the 9th December, 2004 to review the financial status of WHO and UNICEF and evaluate the Plan of Action for 2005. Dr. Deo Nshimirimana, Regional Adviser Vaccine Preventable Diseases (WHO/AFRO) presented the review of the ARICC Recommendations made the previous two years, and of the 16 recommendations eight were achieved, five were partially achieved or in progress and three were not achieved. The financial report for 2004 from WHO and GAVI was presented, followed by an overview of the preliminary financial report from UNICEF. Dr. Nshimirimana presented the WHO/AFRO Plan of Action for 2005 for the committee to discuss.

The following is a summary of the discussion by the participants:

- All partners were recognized for their contribution and hard work towards polio eradication.
- Budget templates should be standardized and show links to strategic plans
- Reporting formats should be standardized to show total expenditures by all partners in relation to budget line including gaps in funding. This information should go to donors so that decision-making concerning funding can be directed towards those gaps. In addition, bilateral contributions should be captured in reporting templates.
- Participants would like to be informed of increased workload as it relates to increased activities and funding to ensure that the critical activities are being completed in a timely fashion.
- Advocacy and fund raising profile should be increased for routine immunization throughout the region.

# Measles case-based Surveillance Feedback Table, January 2005

In January 2005, a total of 223 suspected cases were reported in the Region and 94% of these have been investigated with blood specimen. Lab results are available for 81% of the tested cases and only 4 cases have become positive for measles IgM testing. Reports have not been received from the central block and from Namibia, South Africa, Swaziland and Zambia.

| Country | Population under case-based surveillance (millions) | Total reported measles cases (summary or case-based) | Blood specimens collected | | | Lab results available | | Lab results | | No. cases confirmed by epidemiological linkage | Total confirmed cases (lab+epi linkage) | Measles Deaths (deaths among measles cases confirmed by lab and epidemiologic link) | % districts with at least 1 case with blood specimen/ year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | n | n | % (target: >=80%) | Annualized rate per 100,000 pop (target: >1/100,000) | n | % (target: >=80%) | no. IgM positive | % IgM positive (target: <10%) | n | n | | (target: >=80%) |
| Burundi | 6,7 | 5 | 5 | 100% | 0,9 | 5 | 100% | 0 | 0% | 0 | 0 | 0 | 6% |
| Eritrea | 2,9 | 2 | 2 | 100% | 0,8 | 2 | 100% | 0 | 0% | 0 | 0 | 0 | 33% |
| Ethiopia | 67,9 | 55 | 45 | 82% | 0,8 | 44 | 98% | 0 | 0% | 0 | 0 | 0 | 30% |
| Kenya | 32,7 | 16 | 15 | 94% | 0,6 | 11 | 73% | 0 | 0% | 0 | 0 | 0 | 18% |
| Rwanda | 8,1 | 2 | 2 | 100% | 0,3 | 2 | 100% | 0 | 0% | 0 | 0 | 0 | 5% |
| Tanzania | 34,6 | 15 | 14 | 93% | 0,5 | 14 | 100% | 0 | 0% | 0 | 0 | 0 | 7% |
| Uganda | 25,6 | 45 | 45 | 100% | 2,1 | 45 | 100% | 0 | 0% | 0 | 0 | 0 | 36% |
| **Eastern block** | **178,5** | **140** | **128** | 91% | 0,9 | **123** | 96% | **0** | 0% | **0** | **0** | **0** | 18% |
| Cameroon | 14,3 | - | - | - | - | - | - | - | - | - | - | - | - |
| D. R.Congo | 27,6 | - | - | - | - | - | - | - | - | - | - | - | - |
| **Central Block** | **41,9** | **0** | **0** | N/A | 0,0 | **0** | N/A | **0** | N/A | **0** | **0** | **0** | 0% |
| Benin | 7,2 | 3 | 3 | 100% | 0,5 | 3 | 100% | 3 | 100% | 0 | 3 | 0 | 11% |
| Burkina Faso | 13,2 | 2 | 2 | 100% | 0,2 | 2 | 100% | 1 | 50% | 0 | 1 | 0 | 2% |
| Gambia | 1,7 | 4 | 4 | 100% | 2,8 | 4 | 100% | 0 | 0% | 0 | 0 | 0 | 67% |
| Ghana | 20,7 | 24 | 24 | 100% | 1,4 | 24 | 100% | 0 | 0% | 0 | 0 | 0 | 17% |
| Guinea | 8,9 | - | - | - | - | - | - | - | - | - | - | - | - |
| Mali | 11,4 | - | - | - | - | - | - | - | - | - | - | - | - |
| Senegal | 10,4 | 3 | 3 | 100% | 0,3 | 2 | 67% | 0 | 0% | 0 | 0 | 0 | 6% |
| Togo | 5,1 | 2 | 2 | 100% | 0,5 | 0 | 0% | - | - | 0 | 0 | 0 | 7% |
| **Western block** | **78,6** | **38** | **38** | 100% | 0,6 | **35** | 92% | **4** | 11% | **0** | **4** | **0** | 9% |
| Angola | 17,2 | 5 | 3 | 60% | 0,2 | 0 | 0% | - | - | 0 | 0 | 0 | 2% |
| Botswana | 1,6 | - | - | - | - | - | - | - | - | - | - | - | - |
| Lesotho | 2,1 | 12 | 12 | 100% | 6,9 | 12 | 100% | 0 | 0% | 0 | 0 | 0 | 35% |
| Malawi | 10,4 | 15 | 15 | 100% | 1,7 | 0 | 0% | - | - | 0 | 0 | 0 | 8% |
| Namibia | 1,8 | - | - | - | - | - | - | - | - | - | - | - | - |
| South Africa | 43,4 | - | - | - | - | - | - | - | - | - | - | - | - |
| Swaziland | 1,0 | - | - | - | - | - | - | - | - | - | - | - | - |
| Zambia | 9,8 | - | - | - | - | - | - | - | - | - | - | - | - |
| Zimbabwe | 11,3 | 13 | 13 | 100% | 1,4 | 0 | 0% | - | - | 0 | 0 | 0 | 14% |
| **Southern block** | **98,6** | **45** | **43** | 96% | 0,5 | **12** | 28% | **0** | 0% | **0** | **0** | **0** | 4% |
| **Regional total** | **397,6** | **223** | **209** | 94% | 0,6 | **170** | 81% | **4** | 2% | **0** | **4** | **0** | 8% |

Indicator not met

Indicator met

# AFP Surveillance Performance Indicators

**(Data submitted from countries as of 31 December 2004, update 21 Feb. 05)**

Among the 43 countries that submitted AFP databases for December, certification standard performance targets for non-polio AFP rate and stool adequacy rate were attained in 91% (39/43) and 86% (37/43) respectively. Wild poliovirus cases were confirmed in 11 countries namely Nigeria, Niger, Côte d'Ivoire, Bénin, Mali, Guinea, Burkina-Faso, Cameroon, CAR, Chad, and Botswana. 84% of confirmed cases were from Nigeria. WPV information from Regional Polio lab network as of 31 December 2004: Wild poliovirus cases with onset from January were 785 for Nigeria, 25 for Niger, 5 for Burkina Faso 6 for Benin, 19 for CAR, 19 for Chad, 17 Cote dIvoire, 18 for Mali, 5 for Guinea, 13 for Cameroon and 1 for Botswana.

| Country | estimates population (million) | All AFP Cases | Reported AFP cases - class 6 | Annualized Non-polio AFP rate | AFP cases with 2 stools within 14d (0-14d) | % | Confirmed Total | wild | Compatible (virologic Class system | Classification System V=Virologic C=Clinical | AFP rate | Percent Districts with timeliness of routine reporting |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cen.Afr. Rep. | 3,5 | 120 | 120 | **4,5** | 90 | 75% | 30 | 30 | 6 | V | 6,0 | |
| Eq. Guinea | 0,5 | 6 | 6 | **3,0** | 6 | 100% | | | | V | 3,0 | |
| Cameroon | 16,7 | 219 | 219 | **2,5** | 169 | 77% | 13 | 13 | 1 | V | 2,7 | |
| Chad | 8 | 124 | 124 | **2,2** | 91 | 73% | 23 | 23 | 14 | V | 2,7 | |
| Congo | 2,8 | 35 | 35 | **1,8** | 32 | 91% | | | 1 | V | 1,8 | |
| Gabon | 1,2 | 7 | 7 | **1,0** | 7 | 100% | | | 0 | V | 1,0 | |
| S.T. & Princ | 0,1 | 0 | 0 | **0,0** | 0 | | | | 0 | | 0,0 | |
| **Central Block** | **32,8** | **511** | **511** | **2,5** | **395** | **77%** | **66** | **66** | **22** | | 2,9 | |
| Benin | 6,4 | 107 | 107 | **3,3** | 96 | 90% | 6 | 6 | 1 | V | 3,5 | 100% |
| Senegal | 9,5 | 146 | 146 | **3,2** | 130 | 89% | | | 0 | V | 3,2 | 63% |
| Niger | 10,4 | 180 | 180 | **2,7** | 152 | 84% | 25 | 25 | 8 | V | 3,2 | 47% |
| Guinea | 7,2 | 102 | 102 | **2,6** | 88 | 86% | 5 | 5 | 0 | V | 2,8 | 64% |
| Burkina Faso | 11,9 | 155 | 155 | **2,5** | 127 | 82% | 9 | 9 | 6 | V | 2,6 | 85% |
| Guinea-Bissau | 1,2 | 13 | 13 | **2,2** | 11 | 85% | | | 0 | V | 2,2 | 23% |
| Mali | 10 | 123 | 123 | **2,0** | 102 | 83% | 18 | 18 | 0 | V | 2,3 | 32% |
| Gambia | 1,3 | 12 | 12 | **2,0** | 12 | 100% | | | 0 | V | 2,0 | 98% |
| Cote d'Ivoire | 16 | 161 | 161 | **1,9** | 141 | 88% | 17 | 17 | 1 | V | 2,1 | 53% |
| Ghana | 19,5 | 158 | 158 | **1,8** | 129 | 82% | | | 10 | V | 1,8 | 86% |
| Togo | 5 | 64 | 64 | **2,6** | 63 | 98% | | | 0 | V | 2,6 | 63% |
| Sierra Leone | 4,8 | 33 | 33 | **1,5** | 29 | 88% | | | 0 | V | 1,5 | 62% |
| Cape Verde | 0,4 | 3 | 3 | **1,5** | 2 | 67% | | | 0 | V | 1,5 | 65% |
| Mauritania | 2,7 | 17 | 17 | **1,3** | 16 | 94% | | | 0 | V | 1,3 | 23% |
| Liberia | 4,3 | 15 | 15 | **0,7** | 13 | 87% | | | 0 | V | 0,7 | 41% |
| Algeria | 28,9 | 80 | 80 | **0,8** | 53 | 66% | | | 0 | | 0,8 | |
| **Western block** | **139,5** | **1369** | **1369** | **2,0** | **1164** | **85%** | **80** | **80** | **26** | | 2,1 | **65%** |
| Nigeria | 109,3 | 4813 | 4813 | **8,2** | 4362 | 91% | 789 | 789 | 58 | V | 9,8 | |
| DR.Congo | 52 | 773 | 773 | **3,1** | 725 | 94% | | | 11 | V | 3,1 | |
| Angola | 12,9 | 121 | 121 | **2,0** | 106 | 88% | | | 2 | V | 2,0 | 27% |
| Ethiopia | 67,3 | 507 | 507 | **1,6** | 428 | 84% | | | 6 | V | 1,6 | 82% |
| **Spec.Situa.block** | **241,5** | **6214** | **6214** | **4,9** | **5621** | **90%** | **789** | **789** | **77** | | 5,6 | |
| Botswana | 1,6 | 35 | 35 | **4,9** | 32 | 91% | 1 | 1 | 0 | V | 5,0 | |
| Namibia | 1,8 | 21 | 21 | **2,6** | 18 | 86% | | | 0 | V | 2,6 | 73% |
| Zambia | 11,3 | 140 | 140 | **2,5** | 128 | 91% | | | 0 | V | 2,5 | 98% |
| Swaziland | 1 | 12 | 12 | **2,4** | 11 | 92% | | | 0 | V | 2,4 | 100% |
| Zimbabwe | 11,3 | 118 | 118 | **1,8** | 90 | 76% | | | 0 | V | 1,8 | |
| Madagascar | 14,9 | 102 | 102 | **1,5** | 83 | 81% | | | 0 | V | 1,5 | |
| Malawi | 10,9 | 79 | 79 | **1,5** | 69 | 87% | | | 0 | V | 1,5 | 60% |
| Mozambique | 18,1 | 105 | 104 | **1,4** | 91 | 88% | | | 0 | V | 1,4 | 44% |
| South Africa | 43,4 | 194 | 193 | **1,3** | 172 | 89% | | | 1 | V | 1,3 | |
| Lesotho | 2,1 | 10 | 10 | **0,9** | 10 | 100% | | | 0 | V | 0,9 | 47% |
| **Southern block** | **116,4** | **816** | **814** | **1,6** | **704** | **86%** | **1** | **1** | **1** | | 1,6 | |
| Eritrea | 2,7 | 35 | 35 | **3,2** | 28 | 80% | | | 1 | V | 3,2 | 100% |
| Uganda | 22,2 | 204 | 204 | **2,0** | 186 | 91% | | | 0 | V | 2,0 | 84% |
| Kenya | 29,5 | 247 | 244 | **1,6** | 220 | 90% | | | 0 | V | 1,6 | 94% |
| Rwanda | 8,1 | 63 | 63 | **1,6** | 59 | 94% | | | 1 | V | 1,6 | 100% |
| Tanzania | 34,5 | 158 | 158 | **1,0** | 149 | 94% | | | 4 | V | 1,0 | 10% |
| Burundi | 6,7 | 36 | 36 | **1,2** | 32 | 89% | | | 0 | V | 1,2 | 100% |
| **Eastern block** | **103,7** | **743** | **740** | **1,5** | **674** | **91%** | **0** | **0** | **6** | | 1,5 | 66% |
| **Regional total** | **633,9** | **9653** | **9648** | **3,0** | **8558** | **89%** | **936** | **936** | **132** | | 3,3 | |

*red background indicates countries with wild poliovirus

* Green indicates countries with certification-level surveillance

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Comoros | 0,7 | | 0 | **0,0** | 0 | | 0 | 0 |
| Mauritius | 1,1 | | 0 | **0,0** | 0 | | 0 | 0 |
| Seychelles | 0,1 | | 0 | **0,0** | 0 | | 0 | 0 |

[1] Annualized non-Polio AFP rate for 100,000 under 15 year olds: this is a measure of the sensitivity of AFP surveillance (target for certification is > 1.0 per 100,000 under 15 year olds)

[2]Adequate stools refer to 2 stool specimens collected within 14 days of onset of paralysis, 24-48 hours. This indicator measures the timeliness of investigation of AFP cases. This influences the chances of isolating of wild poliovirus if this is the cause of the AFP.

[3] Wild virus refers to laboratory confirmed wild polioviruses.