International Health Surveillance Division (IHS)

Ana Clarissa M. Tongcua, RN
*Surveillance Nurse*

Redentor L. Licuanan
*Statistician I*

Miriam Ysabelle K. Gaw, RN
*Nurse II, Surveillance Nurse*

Ferchito L. Avelino, MD
*Deputy Director and Officer in Charge – IHS Division*

FERDINAND S. SALCEDO, MD, MPH, CESO IV
*Bureau Director*

Contact Details

**Postal Address:** 25th and A.C. Delgado Streets, Port Area, Manila, Philippines (1018)
**Telefax:** +63 (02) 320-9105
**Email:** ihs@gmail.com
**Website:** quarantine.doh.gov.ph



# Health Information Update

Source: WHO, Event Information Site for IHR National Focal
Event Updates: **03 July 2018 to 02 July 2018**

| Event Updated | Country | Hazard | Disease | Event Description | IHR Assessment |
|---|---|---|---|---|---|
| 2018-07-03 | Democratic Republic of the Congo (the) | Infectious | Poliomyelitis, Acute Paralytic, Vaccine Associated | **In the Democratic Republic of the Congo, three different circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks have been detected in acute flaccid paralysis (AFP) cases. In February 2018, the government declared cVDPV2 to be a national public health emergency.**<br><br>The cVDPV2 strain initially detected and reported in June 2017 from Haut Lomami province had spread in late 2017 and early 2018 to Tanganyika and Haut Katanga provinces. The same virus was confirmed in Ituri province in June 2018, close to the border with Uganda, from an AFP case with onset of paralysis on 5 May 2018. Investigations remain ongoing, and WHO is elevating the risk of further national spread to 'very high' and the risk of international spread to 'high' due to the proximity of the recent case in Ituri to an international border. Maniema province is affected by a separate cVDPV2 outbreak, with two cases confirmed in 2017. The date of onset of paralysis of the most recent case was 18 April 2017. So far, no new cases have been detected in 2018, and there is no evidence that this virus has spread further geographically. The third and most recently detected outbreak of cVDPV2 was found in Mongala province and isolated from an AFP case in the Yamongili Health Zone. The onset date of paralysis was 26 April 2018. Circulation of the strain was confirmed when the same strain was isolated in stool specimens from two healthy community contacts.<br><br>Outbreak response is taking place, including use of monovalent OPV type 2 (mOPV2) in line with internationally-agreed upon outbreak response protocols. However, operational gaps in vaccination coverage continue to hamper implementation. High-risk populations remain under-immunised, and the response thus far has not prevented spread of the outbreak. The geographic extent of the outbreak response to all three strains is now being re-evaluated, given the confirmed spread of one of the strains to Ituri and confirmation of the new strain in Mongala. Surveillance and immunization activities are being | Public Health Risk |

| | | | | | |
|---|---|---|---|---|---|
| | | | | strengthened in neighbouring countries.<br><br>WHO is elevating the risk of further national spread to 'very high', and the risk of international spread to 'high'. This risk is magnified by known population movements between the affected area of DR Congo and Uganda, Central African Republic and South Sudan, and the upcoming rainy season (which is associated with increased intensity of virus transmission).The detection of cVDPV2s underscores the importance of maintaining high routine vaccination coverage everywhere, to minimize the risk and consequences of any poliovirus circulation. These events also underscore the risk posed by any low-level transmission of the virus. A robust outbreak response as initiated is needed to rapidly stop circulation and ensure sufficient vaccination coverage in the affected areas to prevent similar outbreaks in the future. WHO will continue to evaluate the epidemiological situation and outbreak response measures being implemented.<br><br>It is important that all countries, in particular those with frequent travel and contacts with polio-affected countries and areas, strengthen surveillance for AFP cases in order to rapidly detect any new virus importation and to facilitate a rapid response. Countries, territories and areas should also maintain uniformly high routine immunization coverage at the district level to minimize the consequences of any new virus introduction. ***WHO's International Travel and Health recommends that all travellers to polio-affected areas be fully vaccinated against polio. Residents (and visitors for more than four weeks) from infected areas should receive an additional dose of OPV or inactivated polio vaccine (IPV) within four weeks to 12 months of travel***. As per the advice of the Emergency Committee convened under the International Health Regulations (2005), efforts to limit the international spread of poliovirus remains a Public Health Emergency of International Concern (PHEIC). Countries affected by poliovirus transmission are subject to Temporary Recommendations. To comply with the Temporary Recommendations issued under the PHEIC, any country infected by poliovirus should declare the outbreak as a national public health emergency and consider vaccination of all | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | international travellers. | |
| 2018-07-02 | Colombia | Infectious | Poliomyelitis, Acute Paralytic, Vaccine Associated | **In March 2018, the Colombia Ministry of Health and Social Protection reported a case of acute flaccid paralysis (AFP) to the Pan American Health Organization / World Health Organization (PAHO/WHO) through the PAHO/WHO Integrated Surveillance Information System (ISIS) for vaccine-preventable diseases.** The case is an 11-month-old female from the municipality of Tuluá-Valle del Cauca, Colombia, with the following vaccination schedule: 1st dose (IPV) 9 June 2017, 2nd dose (bOPV) 14 August 2017, and 3rd dose (bOPV) 13 October 2017. Notably, she had a history of recurrent suppurative otitis, allergic colitis since two months of age, recurrent urinary tract infection, recurrent pyoderma, and gastritis. The onset of AFP was 1 March 2018. The diagnosis was: AFP, primary immunodeficiency with predominantly humoral involvement, and urinary tract infection. Serial samples of stool were taken and sent to the Colombia National Institute of Public Health, national reference laboratory, which reported the detection of poliovirus 1 vaccine type or Sabin Like (SL)1. Subsequent sequencing analysis, conducted at the global reference laboratory for polio, confirmed that the virus reverted to a vaccine-derived poliovirus (VDPV). Since the case has a primary immunodeficiency, it has been characterized as immunodeficiency-related vaccine derived poliovirus (iVDPV). No additional cases of AFP have been identified through active institutional and community search.<br><br>Prolonged replication of VDPVs has been observed in a small number of people with rare immune deficiency disorders. Because they are not able to mount an immune response, these people are not able to clear the intestinal vaccine virus infection, which is usually cleared within six to eight weeks. They therefore excrete iVDPVs for prolonged periods. The occurrence of iVDPVs is a very rare event. Only 65 cases have been documented worldwide between 1961 and 2012. Of these, most stopped excretion within six months or died. Three people excreted the virus for more than 5 years. Between 2011 and 2016, Colombia's national polio vaccination coverage (third dose of Polio vaccine) has ranged from 85% to 91% in 2011 and 2016, respectively, according to WHO UNICEF | None/ Not Applicable |

| | | | | | |
|---|---|---|---|---|---|
| | | | | estimates (WUENIC)[1]. PAHO/WHO will continue to evaluate the epidemiological situation and support the strengthening of epidemiological surveillance and vaccination activities in Colombia.<br><br>WHO reiterates to all Member States the importance of reaching and maintaining polio vaccination coverage of more than 95% in each district or municipality, maintaining high quality of AFP epidemiological surveillance, and updating the national poliovirus outbreak response plans in order to rapidly detect any new virus importation and to facilitate a rapid response. **The WHO International Travel and Health guide (http://www.who.int/ith/en/) recommends that all travelers to polio-affected areas be fully vaccinated against polio. Residents (and visitors for more than 4 weeks) from affected areas should receive an additional dose of OPV or inactivated polio vaccine (IPV) within 4 weeks to 12 months before travel.** | |

* A **public health risk** is something that is (or is likely to be) hazardous to human **health** or could contribute to a disease or an infectious condition in humans.