

Health Information Update

Source: WHO, Event Information Site for IHR National Focal

Event Updates: **05 to 09 September 2018**

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2018-09-09	Republic of Korea (the)	Infectious	Coronavirus Infection	<p>On 8 September 2018, the National IHR Focal Point (NFP) of the Republic of Korea notified WHO of a laboratory-confirmed case of Middle East Respiratory Syndrome Coronavirus (MERS-CoV). The case is a 61 year old Korean male national who visited Kuwait on business from 16 August to 6 September. He returned to Korea via Dubai by EK860 (Kuwait to Dubai, 6-7 September) and EK322 (Dubai to Incheon, 7 September). On 28 August 2018, while in Kuwait, he developed diarrhea and visited a local hospital in Mangaf, Kuwait. Upon his return to Korea on 7 September 2018, he presented to a general hospital in Seoul with diarrhea and fever. A diagnosis of pneumonia was made, and due to his travel history, MERS was suspected. He was immediately transferred to the Seoul National University Hospital, where he was immediately placed in an isolation ward. A sputum sample was collected on 8 September 2018 and tested positive for MERS-CoV by RT-PCR on the same day at the laboratory of Seoul Provincial Institute of Public Health and Environment. Viral isolation is being performed. The case is currently in a stable condition.</p> <p>The Ministry of Health is closely monitoring 21 individuals who have had close contact with the patient, including his spouse, four flight attendants, eight passengers seated near the case (three rows ahead and behind the case), two airport employees, one taxi driver, one helper who moved the case's wheelchair to the taxi, and four health care workers. All identified contacts have been placed in quarantine at home and are currently asymptomatic. They will be monitored by local public health centers for 14 days after exposure. In addition, 415 individuals including the passengers on the same flight are under passive surveillance. Health authorities of the Republic of Korea are contacting the company of the index case to identify additional contacts in Kuwait. CCTV is also being used to identify possible contacts. The epidemiological investigation of the patient's exposures and travel history in Kuwait is ongoing.</p> <p>Infection with MERS-CoV can cause severe disease resulting in high mortality. Humans</p>	Public Health Risk (PHR)



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are infected with MERS-CoV from direct or indirect contact with dromedary camels. MERS-CoV has demonstrated the ability to transmit between humans, especially in health care settings without appropriate infection prevention and control measures. So far, the observed non-sustained human-to-human transmission has occurred mainly in healthcare settings.

The notification of a confirmed case in the Republic of Korea does not change the overall global risk assessment. WHO expects that additional cases of MERS-CoV infection will be reported from the Middle East and that sporadic cases will continue to be exported to other countries by individuals who have acquired the infection after exposure to infected dromedaries or dromedary products or human source (for example, in a health care setting). *To date, no cases have been associated with Hajj.* WHO continues to monitor the epidemiological situation and conducts the risk assessment based on the latest available information.

Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for acute respiratory infections and to carefully review any unusual patterns. Infection prevention and control measures are critical to prevent the possible spread of MERS-CoV between people in healthcare facilities. It is not always possible to identify patients with MERS-CoV infection early because, like other respiratory infections, the early symptoms of MERS are non-specific. Therefore, health-care workers should always apply standard precautions consistently with all patients, regardless of their diagnosis. Droplet precautions should be added to the standard precautions when providing care to patients with symptoms of acute respiratory infection; contact precautions and eye protection should be added when caring for probable or confirmed cases of MERS-CoV infection; airborne precautions should be applied when performing aerosol generating procedures. Community and household awareness of MERS and MERS prevention measures in the home may reduce household transmission and prevent community clusters. Until more is understood about MERS-CoV, people with diabetes, renal failure, chronic lung disease, and immunocompromised persons are considered to be at high risk of severe disease from MERS-CoV infection. Therefore, in addition to avoiding close contact with suspected or confirmed human cases of the disease, people with these conditions should avoid close contact with animals, particularly camels, when

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				<p>visiting farms, markets, or barn areas where the virus is known to be potentially circulating. General hygiene measures, such as regular hand washing before and after touching animals and avoiding contact with sick animals, should be adhered to. Food hygiene practices should be observed. People should avoid drinking raw camel milk or camel urine, or eating meat that has not been properly cooked.</p> <p><u>As of August 2018, the total global number of laboratory-confirmed cases of MERS-CoV reported since 2012 is 2249, including 798 MERS-CoV associated deaths.</u> The global number reflects the total number of laboratory-confirmed cases and deaths reported to WHO under IHR (2005) to date. The total number of deaths includes the deaths that WHO is aware of to date through follow-up with affected member states.</p> <p><i>WHO does not advise special screening at points of entry with regard to this event nor does it currently recommend the application of any travel or trade restrictions.</i></p>	
2018-09-05	Congo (the)	Zoonosis	Yellow Fever	<p>On 5 July 2018, a 20-year-old male living in the neighbourhood of the Bissongo market visited Bissongo health centre in Loandjili district, one of the health districts of Pointe-Noire city, Congo (the), with fever for one day. On 9 July 2018, due to beginning of jaundice and persistent fever, he returned to the same health facility. The case did not have a history of yellow fever vaccination or haemorrhagic symptoms. There was a history of travel to Ngoyo and Tchiamba Nzassi districts, the latter one which is a rural district in Pointe-Noire located along the border with Angola, during two weeks prior to symptoms onset. He was admitted to the health facility and received anti-malarial and antibiotic treatments. As yellow fever was also suspected as a differential diagnosis, a blood sample was collected on 10 July 2018 and sent to Institut National de Recherche Biomedicale (INRB) in Kinshasa for testing. On 26 July 2018, the sample tested positive for yellow fever by serology. On 30 July 2018, INRB of Kinshasa sent a sample to Institut Pasteur de Dakar for confirmation. On 21 August 2018, the sample tested positive by seroneutralization with a high titre. Following the confirmation of the YF case, an investigation was done in the affected department. A retrospective active search in the registers from 16 (out of 34) health centres in Pointe Noire found 70 additional suspect cases meeting the clinical case definition for YF who had presented for care year to date (56 of which were already recorded in the national surveillance system). Two of the suspected cases</p>	Public Health Risk (PHR)

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reported staying in Angola. Of these, 43 samples were collected and sent to INRB and results were negative. Entomological surveys have revealed high densities of mosquito vectors responsible for urban yellow fever (*Aedes aegypti*), signalling the potential for human to human transmission and rapid amplification. Larval sites have been found around the homes of suspected and probable cases and this situation could worsen with the arrival of the rainy season.

The national committee for outbreak management has been activated following the declaration by the Ministry of Health and Population (MoHP) of a yellow fever outbreak in Pointe Noire on 22 August 2018. WHO was notified on 23 August 2018 in line with the IHR regulations (2005). WHO is supporting the country in the preparation of an emergency response plan and an ICG request for reactive mass vaccination campaign targeting the Pointe Noire department (which has a population of approximately 1 million people). WHO is also supporting resource mobilization as the country is not eligible for Gavi support. WHO will support the MoHP in implementing targeted vector control activities for adult mosquitoes and larvae in areas where the confirmed case lives and works (100-200m perimeter). By providing technical support for effective management of the outbreak, the Organization is also strengthening the surveillance at the points of entry, case management, public awareness, and recommending the use of mosquito nets during the day time.

The overall risk at national level is high due to the confirmation of a yellow fever case in a densely populated urban city of Pointe Noire (1 158 331 inhabitants) with suboptimal immunisation coverage in the affected community and potential risk of spread within Congo, especially Brazzaville. Entomological surveys in the affected area revealed high densities of *Aedes aegypti*, responsible for the urban form disease, signalling the potential for rapid amplification. The approaching rainy season may potentially increase this risk. Thus, the risk of an urban epidemic needs to be controlled urgently, though there is not yet indication of active urban transmission on the data available. ***The risk at the regional level is considered moderate due to the lack of available information to describe the scope and the dynamic of the outbreak and because of the cross border movements, particularly between Cabinda (Angola) and Gabon where a possible spill over cannot be ruled out.*** Pointe-Noire is a port city and oil industry hub with an international airport and intense population movement with links to other large cities. Angola and the

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* A p u b l i c h e a l t h r i s k i s s o m e t h i n g t h a t i					<p>Democratic Republic of the Congo have recently conducted mass preventive and reactive vaccination campaigns respectively, though population immunity levels in DRC are overall low in the areas not targeted by the 2016 reactive campaigns, including the areas neighbouring Pointe Noire. No YF cases possibly related to Pointe Noire have been reported outside the country at this stage. The risk at the global level is currently considered low. Both risks need to be closely monitored and be reassessed regularly.</p> <p>Vaccination is the primary mean for prevention and control of yellow fever. In urban centres, targeted vector control measures are also helpful to interrupt transmission. WHO and partners will continue to support local authorities to implement these interventions to control the current outbreak. <i>WHO recommends vaccination against yellow fever for all international travellers 9 months of age going to the Congo, as there is evidence of persistent or periodic yellow fever virus transmission. Congo (the) also requires a yellow fever vaccination certificate for travellers over 1 year of age arriving from countries with risk of yellow fever transmission. Yellow fever vaccination is safe, highly effective and provides life-long protection.</i> In accordance with the IHR (2005), Third edition, the validity of the international certificate of vaccination against yellow fever extends to the life of the person vaccinated. A booster dose of yellow fever vaccine cannot be required of international travellers as a condition of entry.</p> <p>WHO does not recommend any restrictions on travel and trade to the Congo on the basis of the information available on this outbreak.</p>	
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s (or is likely to be) hazardous to human **health** or could contribute to a disease or an infectious condition in humans.