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(IHS)

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## Health Information Update

Source: WHO, Event Information Site for IHR National Focal

Event Updates: 11 June 2018 to 20 June 2018

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2018-06-20	Venezuela (Bolivarian Republic of)	Infectious	Acute Flaccid Paralysis (AFP)	<p>On 7 June 2018, the WHO International Health Regulations (IHR) Regional Contact Point received an unofficial report of the detection of Sabin type 3 vaccine poliovirus in a sample of a Venezuelan patient with acute flaccid paralysis (AFP). The same day, a request for verification was sent to the Venezuela IHR National Focal Point (NFP). On 8 June, PAHO/WHO received updated information. The case is a 34-month-old male, unvaccinated, resident of an indigenous community in Delta Amacuro, Venezuela, with paralysis onset on 29 April 2018. The clinical-epidemiological investigation carried out indicated that the flaccid paralysis of a lower limb persisted as of 11 June. Other children from the same community were vaccinated in April with a bivalent oral polio vaccine, so the case may have acquired the attenuated virus from community contacts. The laboratory tests (genetic sequencing) recently performed at the regional reference laboratory confirmed the detection of Sabin type 3 poliovirus vaccine in the viral isolate obtained from this patient's sample collected on 30 April 2018. The results of the isolated poliovirus sequencing showed that the virus did not present genetic variation with respect to the prototype vaccine strain (Sabin type 3), thus ruling out a vaccine derived poliovirus (VDPV). The final classification of the case of AFP will be based on clinical and virological criteria; clinical evaluation expected 60 days after the onset of the paralysis (28 June) will include further assessment of possible causes of AFP and any residual neurological deficit.</p> <p>Preliminary results of the field investigation carried out in the community where the case occurred had identified an 8-year-old girl with a vaccine history of at least one dose of tOPV (trivalent oral polio vaccine), suspected as AFP. The clinical evaluation subsequently carried out by health professionals has ruled out that this is a case of AFP. No additional AFP cases have been identified to date through the active search for AFP cases carried out in the community. Every year, as part of the global polio eradication effort, more than 100,000 AFP cases are</p>	To be assigned

				<p>identified and investigated globally.</p> <p>Between 2011 and 2016, Venezuela’s national coverage polio vaccines (third dose of Polio vaccine) according to WHO UNICEF estimates (WUENIC)[1] has ranged from 73 to 87 in 2012 and 2015, respectively. The results of the isolated poliovirus sequencing showed that the virus did not present genetic variation with respect to the prototype vaccine strain (Sabin type 3), thus ruling out a vaccine derived poliovirus (VDPV). Nevertheless, the polio vaccination coverage under 95%, the high mobility of people and the health situation of this population, leave this community and other populations susceptible to the introduction of a new virus.</p> <p>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. <i>WHO’s International Travel and Health</i> (<a href="http://www.who.int/ith/en/">http://www.who.int/ith/en/</a>) 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.</p>	
2018-06-15	Saudi Arabia	Infectious	Coronavirus Infection	<p><b>Between 12 January and 31 May 2018, the National IHR Focal Point of The Kingdom of Saudi Arabia reported 75 laboratory confirmed cases of Middle East Respiratory Syndrome (MERS), including twenty-three (23) deaths.</b> Among these 75 cases, 21 cases were part of four distinct clusters (2 health care and 2 household clusters). The details of these clusters are described below:</p> <p><b>Cluster 1:</b> Between 2 and 4 February, a private hospital in Hafer Albatin Region reported a cluster of three (3) health care workers in addition to the suspected index case (four [4] cases in total).</p> <p><b>Cluster 2:</b> Between 25 February and 7 March, a hospital in Riyadh reported six (6) cases, including the suspected index. No health care workers were infected.</p> <p><b>Cluster 3:</b> Between 8 and 24 March, a household cluster of 3 cases (index case and 2 secondary cases) was reported in Jeddah. No health care workers were infected.</p> <p><b>Cluster 4:</b> Between 23 and 31 May, a household</p>	Public Health Risk

				<p>cluster was reported from Najran region with 8 cases including the suspected index case. This cluster is still under investigation at the time of writing. As of 31 May, no health care workers have been infected and the source of infection is believed to be camels at the initial patient's home.</p> <p>Infection with MERS-CoV can cause severe disease resulting in high mortality. Humans are infected with MERS-CoV from direct or indirect contact with dromedary camels. MERS-CoV has demonstrated the ability to transmit between humans. So far, the observed non-sustained human-to-human transmission has occurred mainly in health care settings.</p> <p>The notification of additional cases does not change the overall risk assessment. WHO expects that additional cases of MERS-CoV infection will be reported from the Middle East, and that cases will continue to be exported to other countries by individuals who might acquire the infection after exposure to animals or animal products (for example, following contact with camels) or human source (for example, in a health care setting). WHO continues to monitor the epidemiological situation and conducts 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 in health care facilities. <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> <p><b>As of 31 May, the total global number of laboratory-confirmed cases of MERS-CoV reported since 2012 is 2,220, including 1,844 cases that have been reported from the Kingdom of Saudi Arabia. Among these cases, 790 MERS-CoV associated deaths have occurred since September 2012.</b> The global number reflects the total number of laboratory-confirmed cases reported to WHO under IHR 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>	
2018-06-13	Nigeria	Infectious	Lassa Fever	<p><b>From 1 January 2018 to 10 June 2018, a total of 447 laboratory confirmed (437) and probable (10) cases have been reported with 119 deaths</b></p>	Public Health Risk

				<p><b>recorded among confirmed and probable cases (CFR 27%).</b> 1552 suspected cases were discarded as non-cases after negative results. A total of 21 states reported at least one or more laboratory-confirmed Lassa fever case, and 3 of the affected states have reported 81% of the confirmed cases: Edo (42%), Ondo (24%), and Ebonyi (15%). The other states affected are: Abia, Adamawa, Anambra, Bauchi, Benue, Delta, Ekiti, FCT, Gombe, Imo, Kaduna, Kogi, Lagos, Nasarawa, Osun, Plateau, Rivers, and Taraba. Thirty-eight healthcare workers have been affected in seven states– Ebonyi (16), Edo (13), Ondo (4), Kogi (2), Nasarawa (1), Taraba (1) and Abia (1) with nine deaths in Ebonyi (6), Kogi (1), Abia (1) and Ondo (1) (CFR: 21%) highlighting the urgent need to strengthen standard infection prevention and control practices in health care settings for routine management of patients, regardless of their presumed diagnosis. As of 10 June 2018, a total of 5508 contacts have been identified from 21 states. Of these 170 (3.1%) are currently being followed up. A total of 84 symptomatic contacts have been identified, of which 29 (35%) have tested positive from five states (Edo (13), Ondo (8), Ebonyi (3), Kogi (3), Bauchi (1) and Adamawa (1).</p> <p>Lassa fever is a viral haemorrhagic fever that is transmitted to humans via contact with food or household items contaminated with rodent urine or faeces. Person-to-person infections and laboratory transmission can also occur. The overall case fatality rate is 1%; it is 15% among patients hospitalized with severe illness. Early supportive care with rehydration and symptomatic treatment improves survival. The antiviral drug ribavirin seems to be an effective treatment for Lassa fever if given early on in the course of clinical illness. There is no evidence to support the role of ribavirin as a post-exposure prophylactic treatment for Lassa fever. Lassa fever is known to be endemic in Benin, Guinea, Ghana, Liberia, Mali, Sierra Leone and Nigeria, but probably exists in other West African countries as well.</p> <p>Although Nigeria is a Lassa fever endemic country and has developed the capacity for managing Lassa fever outbreaks, the current overall risk is considered moderate at the national level. While the country reported approximately 100 confirmed cases annually between 2014 and 2016, the current outbreak which began at the end 2017 recorded a total of 437 laboratory confirmed cases between 1 January and 10 June 2018. Regarding the</p>	
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2018-06-11	Kenya	Zoonosis	Rift Valley Fever	<p><b>On 8 June 2018 the Ministry of Health in Kenya confirmed an outbreak of Rift Valley fever (RVF).</b> On 2 June 2018 an 18 year old male patient was admitted in Wajir County in the North of Kenya with fever, body weakness, bleeding from the gums and mouth and reported having consumed meat from a sick animal. He was subsequently suspected of having RVF and died the same day. On 4 June two relatives of the index patient were admitted. Blood samples were taken and sent to the Kenya Medical Research Institute, one of which was confirmed positive for RVF on 06 June 2018. A further 7 suspected cases have been reported from whom samples have been taken for confirmatory testing. <b>In total, 10 cases have been reported five of whom have died (a case fatality rate of 50%).</b> Four counties, Kitui, Wajir, Kadjiado and Marsabit, have been reporting very high numbers of deaths and abortions among livestock including camels and goats. Additionally, it had been reported that local populations were consuming meat from dead and sick animals.</p> <p>Preparedness activities for Rift Valley fever have been ongoing since February 2018 in reaction to the heavy rains and flooding as well as the previous experience of RVF outbreaks. Activities included an alert to all County Directors in February 2018 and a general national alert in May 2018.</p> <p>Outbreaks of RVF are not uncommon in Kenya.</p>	To be assigned

				<p>The last documented outbreak was from November 2014 to January 2015 in the North East of Kenya and in 2006, a large outbreak killed more than 150 people. The case fatality rate (CFR) has varied widely in documented outbreaks but overall is less than 1%, in the current outbreak it is 50% however it should be noted investigations, including laboratory confirmation are ongoing and an increase in case count is likely. The prior experience of the country with RVF together with the preparedness activities undertaken over the preceding months is of benefit. However, of concern is the high number of reported deaths and abortions in livestock along with reports of communities eating meat from sick animals. The ending of Ramadan together with the high movement of cattle and people in this area increases the risk of further spread of the outbreak both within Kenya, and with neighbouring countries.</p> <p>Rift Valley fever (RVF) is a mosquito-borne viral zoonosis that primarily affects animals but also has the capacity to infect humans. The majority of human infections result from direct or indirect contact with the blood or organs of infected animals. Herders, farmers, slaughterhouse workers, and veterinarians have an increased risk of infection. Awareness of the risk factors of RVF infection and measures to prevent mosquito bites is the only way to reduce human infection and deaths.</p> <p><i>WHO advises against the application of any travel or trade restrictions on the Kenya based on the current information available on this event.</i></p>	
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\* 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.