



International Health
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Department of Health
Bureau of Quarantine
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Health Information Update

Source: WHO, Event Information Site for IHR National Focal
Event Updates: 18 to 20 September 2018

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2018-09-20	Zimbabwe	Infectious	Cholera	<p>On 6 September 2018, a cholera outbreak was declared in Harare by the Ministry of Health and Child Care (MoHCC) of Zimbabwe and notified to WHO on the same day. Twenty-five patients were admitted to an Infectious Disease Hospital in Harare presenting with diarrhoea and vomiting on 5 September 2018. Most cases came from Glenview 8 and 3, and Budiro 1 and 2 suburbs. The alert case, a 25-year-old woman, presented in a collapsed state and died on the same day. A specimen collected from the woman tested positive for <i>Vibrio cholerae</i> O1 Ogawa. All patients had typical cholera symptoms including excessive vomiting and diarrhoea with rice water stools and dehydration. The Ministry of Health declared the outbreak based on the clinical presentation of 11 cases who tested positive for cholera using rapid diagnostic tests. On the same day, stool samples were taken for culture and sensitivity, and of the 39 samples taken, 17 were positive for <i>V. cholerae</i> O1 Ogawa. From the 1 to 9 September 2018, a rapid increase in daily cases was reported, peaking with >600 cases notified in one day. Since then, a slow decline in cases has been observed. As of 18 September 2018, 4607 cumulative cases including 76 confirmed cases and 38 deaths have been reported (case fatality ratio: 0.8%); of these, 4540 cases were reported from the densely populated capital Harare. The most affected suburbs in Harare are Glen View and Budiro. Cases epi-linked to the most affected localities in Harare have been reported recently across the country in Mashonaland Central province (Shamva District), Midlands province (Gokwe North), Manicaland province (Buhera District and Makoni District), Masvingo province and in Chitungwiza City.</p> <p>The Government has declared cholera as a disaster in Harare City on 14 September. Outbreak coordination committees at the national and district levels have been established. The WHO is supporting the Ministry of Health with the coordination and scaling up of the</p>	Public Health Risk (PHR)

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response, strengthening surveillance and mobilizing both national and international health experts to form a cholera surge team. WHO experts are providing technical support to laboratories on improving diagnostics and strengthening infection and prevention control in communities and health clinics. The Government is assessing the benefits of conducting an oral cholera vaccine (OCV) campaign and WHO has deployed an expert in OCV campaigns to Harare. Two cholera treatment centres were established by MSF in Glen View and at Beatrice Road Infectious Disease Hospital. A Cholera Treatment Unit at Budiriro was also established. WHO is providing cholera kits which contain oral rehydration solution, intravenous fluids and antibiotics for the treatment of cholera patients to Cholera Treatment Centers supported by partners. The recruitment of additional nurses to strengthen the response is ongoing. Risk communication activities in affected and at-risk districts are conducted by the government and health partners.

The outbreak started on 5 September and cases were increasing rapidly on a daily basis and affecting mainly Glenview and Budiriro suburbs of the West-South-Western district of Harare. The number of cases reported daily has however come down from a peak of >600 to between 200-300 daily cases. Cases epi-linked to this outbreak have been reported across the country from other provinces. Glenview, which is the epicentre of the outbreak, is an active informal trading area with mobile populations which come from across the city and the rest of the country for trade. Key risk factors for cholera in Zimbabwe are the deterioration of sanitary and health infrastructures and increasing rural-urban migration adding pressure on the water and sanitation infrastructure. In Harare, contaminated water from boreholes and wells are suspected to be the source of the outbreak. The water supply situation in Harare remains dire due to the high demand of water that is not being met by the city supply. The country's available response capacities are reduced as authorities are concurrently responding to a large typhoid outbreak which started in August 2018. The Zimbabwe government have declared cholera as a disaster in Harare City on 14 September 2018. **The overall risk is currently assessed as high at the national level, moderate at the regional and low at global levels.**



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				WHO recommends proper and timely case management in Cholera Treatment Centres. Improving access to potable water and sanitation infrastructure, and improved hygiene and food safety practices in affected communities, are the most effective means of controlling cholera. Key public health communication messages should be provided. <i>WHO advises against any restriction to travel to and trade with the international community based on the information available on the current outbreak.</i>	
2018-09-20	Kenya	Zoonosis	Rift Valley Fever	<p>On 8 June 2018 the Ministry of Health in Kenya confirmed an outbreak of Rift Valley fever (RVF). 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. In total, 10 cases have been reported five of whom have died (a case fatality rate of 50%). 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. In addition, since the outbreak was confirmed, The Ministries of Health (MOH) and Ministry of Agriculture convened an emergency meeting together with the Ministry of Livestock (MOL) and key stakeholders on 08 June 2018. A joint MOH and MOL outbreak investigation has commenced. As part of previously commenced preparedness activities surveillance for RVF is being undertaken in communities,</p>	To be assigned

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				<p>health facilities and points of entry and treatment centres had been established in Wajir County. Active case search and community sensitization is being established in the affected areas. A ban on slaughter has been imposed in the affected areas has been imposed.</p> <p>Outbreaks of RVF are not uncommon in Kenya. 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 proceeding 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. Public health messages for risk reduction should focus on reducing the risk of animal-to-human transmission resulting from unsafe animal husbandry and slaughtering practices through hand hygiene and wearing gloves and other personal protective equipment when handling sick animals or their tissues or when slaughtering animals is recommended. Reducing the risk of animal-to-human transmission arising from the unsafe consumption of raw or unpasteurized milk or animal tissue. In endemic regions, all animal products should be thoroughly cooked before eating. Reducing the risk of mosquito bites through the implementation of</p>
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				<p>vector control activities (e.g. insecticide spraying and use of larvicide to reduce mosquito breeding sites), use of insecticide-impregnated mosquito nets and repellents, covering clothing. Restricting or banning the movement of livestock to reduce spread of the virus from infected to uninfected areas. Routine animal vaccination is recommended to prevent RVF outbreaks. Vaccination campaigns are not recommended during an outbreak as they may intensify transmission among the herd through needle propagation of the virus. Outbreaks of RVF in animals precede human cases, thus the establishment of an active animal health surveillance system is essential to providing early warning for veterinary and public health authorities.</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>	
2018-09-18	United Kingdom	Infectious	Monkeypox	<p>Two imported laboratory confirmed human monkeypox cases, with no apparent direct link to each other, have been reported in the United Kingdom on 7 and 11 September 2018, respectively. On 7 September 2018, Public Health England (PHE) confirmed the first case. The patient is a Nigerian naval officer who was attending a course at a naval base in Cornwall at the southwest of England. The individual reported a febrile illness before traveling to United Kingdom on 2 September 2018 on the flight BA082 from Abuja, Nigeria to Heathrow airport in London. He continued his journey by train to the military base in Cornwall the same day. The individual then sought medical advice for a rash that started in the groin on 3 September 2018 and continued to spread to the torso, face and hands on 4 September 2018. Prior to confirmation of MPXV infection, the patient received flucloxacillin ex juvantibus. Following an infectious disease specialist evaluation, the patient was isolated on 6 September 2018. Biological samples were sent to the Rare and Imported Pathogens Laboratory (RIPL), Public Health England in Porton Down for further testing. Monkeypox was confirmed on 7 September 2018. The patient was subsequently transferred to the high level isolation unit of Royal Free Hospital in London, where he remains in stable condition to date. According</p>	Public Health Risk

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				<p>to the Nigerian authorities, epidemiological investigation aboard the Nigerian ship where the first case was enrolled revealed exposure to symptomatic human cases while on board. The index case was another naval officer with onset of rash on 7 August 2018. In total, seven naval officers presented to the sick bay with symptoms of rash with date of onset between 8 August and 9 September 2018. Symptoms included 3-day fever, exanthema on the face, trunk and extremities, sore throat, malaise and photophobia. On 11 September 2018, PHE confirmed a second imported human case of monkeypox diagnosed in a resident of the United Kingdom. The case traveled to Nigeria on holiday before returning home to United Kingdom on 4 September 2018 on a plane via Paris (flights AF149 Lagos to Paris and AF1668 Paris to Manchester) while symptomatic. Connection between both flights was short (arrival at 6:20 am and departure at 08:00 am), hence exposure in the international zone of Charles de Gaulle airport is considered to be very low. Upon arrival, the second case first presented at Blackpool Victoria Hospital and was transferred to Royal Liverpool University Hospital for care, where monkeypox virus infection was confirmed. The preliminary information indicates that whilst in Nigeria the case consumed bush meat and came into contact with an individual with skin lesions similar to the patient's current lesions. The two reported cases had no known epidemiological link within the United Kingdom. Possible epidemiological links within Nigeria are currently being investigated.</p> <p>Authorities of the United Kingdom have contacted and informed contacts of the first case sitting within three rows (front and back) on the flight providing health advice. They are also monitoring healthcare workers not wearing appropriate personal protective equipment and community contacts who may have been exposed to the case. Contact tracing for the second case is continuing in the community, passengers and crew members of the flights from Paris to Manchester (French authorities are tracing contacts on the Lagos-Paris flight on 4 September 2018) and among healthcare workers. Authorities of the United Kingdom are in contact with the Ministry of Health Nigeria Centre for</p>
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				<p>Disease Control (NCDC). Authorities are also investigating the travel details of both cases while in Nigeria. Passive monitoring of contacts is mandated for 21 days after exposure to the case on the plane, while close contacts at the naval base are being actively monitored. PHE has released a press statement about this event on 8 September 2018 concerning the first case, followed by an update on the second case on 11 September 2018 at https://www.gov.uk/government/news/monkeypox-case-in-england, providing information about the cases, health advice and measures being taken to minimize the risk of any potential onward transmission. NCDC press statement has been released on 12 September at https://ncdc.gov.ng/news/152/re%3A-monkeypox-cases-in-the-united-kingdom. The United Kingdom authorities have decided to offer HCW on the HCID units pre-exposure prophylaxis with smallpox vaccine (Imvanex® – Bavarian Nordic). Close contacts are being offered post-exposure prophylaxis with the same vaccine. Vaccine has already been acquired by United Kingdom.</p> <p>Monkeypox is a sylvatic zoonosis with incidental human infections that occur sporadically in remote parts of Central and West Africa. It is caused by the monkeypox virus (MPXV) and belongs to the Orthopoxvirus family. Genomic sequencing showed two MPXV clades to exist (Congo Basin, and West African), consistent with observed differences in human pathogenicity and mortality in the two geographic areas. As opposed to the Western African clade, the MPXV Congo Basin clade can be transmitted by contact and droplet exposure via exhaled large droplets, and MPXV infection by this clade can be fatal in humans. The disease is self-limiting with symptoms usually resolving spontaneously within 14-21 days. There is currently no vaccine specifically for MPXV, however smallpox vaccine provides cross-protection. Increased susceptibility of humans to monkeypox is thought to be related to waning immunity linked to cessation of routine smallpox immunization. The animal reservoir remains unknown, although is likely to be rodents. Contact with live and dead animals through hunting and bush meat are presumed drivers of human infection. These are the first diagnosed human cases of monkeypox infection in the United Kingdom, reported in travelers</p>
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				<p>arriving from Nigeria, where a multistate monkeypox outbreak has officially been reported in September 2017. Authorities in the United Kingdom promptly initiated appropriate public health measures, including isolation of the primary case, contact tracing, surveillance and risk communication, therefore the risk of potential onward spread in the country is minimized. Residents and travelers to endemic countries should avoid contact with sick, dead or live animals that could harbor MPXV (rodents, marsupials, primates) and should refrain from eating or handling bush meat. The importance of hand hygiene using soap and water or alcohol-based sanitizer should be emphasized. Any illness during travel or upon return should be reported to a health professional, including information about all recent travel and immunization history. There is no specific treatment or vaccine for the MPXV infection. Timely contact tracing, surveillance measures and raising awareness of imported emerging diseases among health care providers are essential parts of preventing secondary cases and effective management of MPXV outbreaks. Health-care workers caring for patients with suspected or confirmed MPXV infection should implement standard, contact and droplet infection control precautions. Samples taken from people and animals with suspected monkeypox virus infection should be handled by trained staff working in suitably equipped laboratories.</p> <p><i>WHO does not recommend any restriction for travel to and trade with Nigeria or the United Kingdom of Great Britain and Northern Ireland based on available information at this point in time.</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.