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Department of Health  
Bureau of Quarantine

International Health Surveillance Division

Quarantine Services and International Health Surveillance System (QSIHSS)

Health Information Update

Source: WHO, Event Information Site for IHR National Focal

Event Updates: 02 to 07 January 2019

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2019-01-07	Madagascar	Infectious	Measles	<p>From 4 October to 24 December 2018, 16 430 measles cases (362 laboratory confirmed and 16 068 epidemiologically linked) with 39 “facility-based” deaths (case fatality ratio: 0.2%) have been reported in 63 districts in 22 regions in Madagascar. The outbreak has spread to densely populated urban areas such as Toamasina, Mahajanga, Antsirabe, Toliara and the capital city Antananarivo. Most cases were reported from Analamanga (63%) and Boeny (19%) regions. The highest attack rates were observed in Antananarivo-Renivohitra district (626 per 100 000 inhabitants) and Ambato-Boina district (588 per 100 000 inhabitants) in Analamanga and Mahajanga regions respectively, with the national attack rate of 94 per 100 000 inhabitants. In the current epidemic, children aged 1 to 14 years account for 67% of the total number of cases. The age distribution in this group is as follows: under 5 years at 23%, 5-9 years at 23% and 10-14 years at 21%. Both sexes are equally affected with a male to female ratio of 1.05. The national immunization programme recommends routine measles immunization for children aged 9 months. According to WHO and UNICEF estimates, the measles immunization coverage in Madagascar was 58% in 2017. More than half of the cases (52%) reported during the current outbreak have not been vaccinated or have unknown immunization status. Madagascar has the highest proportion of malnutrition among children under five (47%) in the African region. Malnutrition increases children's vulnerability of serious complications and death from measles infection. The circulating genotype for the current measles outbreak in Madagascar is B3, usually found in Africa and Europe. No measles cases with travel history to Madagascar, however, have been reported in neighboring countries and initial investigations in Madagascar have not shown any link with cases from countries with measles outbreak in the Africa region or Europe. The measles outbreak has occurred concurrently with the resurgence of plague in the country, straining the public health response. The recent political election, with the risks of social tensions and conflict, has also reduced the response capacities to these public health events.</p> <p>The Ministry of Public Health of Madagascar is coordinating the response activities, with the support of WHO and other partners.</p>	Public Health Risk (PHR)



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				<p>Based on available information, <b>WHO estimates the overall risk for Madagascar from this measles outbreak to be very high.</b> Currently, several concomitant factors are likely to hinder or delay public health intervention and might jeopardize the response: post-election conflict situation, geographical isolation/remoteness of the cases, insecurity, hurricane period, multiple outbreaks. Targeted immunization campaigns and strengthening of routine immunization activities are paramount in the effective control of the outbreak. Administration of Vitamin A, specifically in a context of high rates of malnutrition, can reduce morbidity and mortality of measles infection. <b>The risk at regional level is low although the spread of measles to neighboring Indian Ocean islands and other African countries and Europe cannot be excluded.</b> Strengthening of surveillance in neighboring countries is recommended. <b>The overall global risk is considered to be low.</b></p> <p><u>Immunization is the only effective preventive measure against measles. Two doses of the measles containing vaccine (MCV) are recommended to ensure immunity.</u></p> <p><b>WHO does not recommend any restriction on travel and trade to Madagascar based on the information available on the current outbreak.</b></p>	
2019-01-03	France	Infectious	Dengue Fever	<p><b>On 26 December 2018, the National IHR Focal Point (NFP) for France notified the WHO Regional Office for Europe of an increase in cases of dengue infection in Guadeloupe, Martinique, and Saint Martin.</b></p> <p><i>Guadeloupe</i> Between epidemiological week (EW) 1 and EW 51 of 2018, <b>there have been a total of 513 suspected cases of dengue</b> and, during EW 46, EW 47, and EW 48, the cases were over the seasonal threshold. Of these, <b>14 cases of dengue were confirmed by the NS1 antigen test and/or RT-PCR.</b> The confirmed cases were reported by the communes: <b>Baie-Mahault (1), Goyave (3), Le Gosier (2), Les Abymes (3), Petit -Bourg (2), Pointe à Pitre (2), and Port-Louis (1).</b> Laboratory studies have identified DENV 1 as the dengue serotype currently circulating. Three outbreaks were identified in Convenance (<b>Baie-Mahault</b>), Caraque (<b>Les Abymes</b>), and Aiguille (<b>Goyave</b>).</p> <p><i>Saint Martin</i> Between EW 1 and EW 51 of 2018, <b>there have been a total of 104 suspected cases of dengue.</b> Of these, <b>9 cases of dengue were confirmed by NS1 antigen test and/or RT-PCR.</b> The confirmed cases were reported by the communes: <b>Friar's Bay (3), Concordia (5), and Marigot (1).</b> Laboratory studies have</p>	Public Health Risk (PHR)



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				<p><b>identified DENV 1 as the dengue serotype currently circulating.</b></p> <p>Dengue epidemics in these territories usually occur after a shift in the predominant DENV serotype, when non-immune populations (e.g., tourists, people newly settled in the territories, or people not previously exposed to the circulating serotypes) are exposed to a new serotype through human movements inside territories or across neighbouring countries. Local transmission is through <i>Aedes</i> mosquito vectors present on the islands. In Guadeloupe, an epidemic of DENV 4 with DENV 2 co-circulation occurred in 2005. DENV 2 subsequently predominated from 2006–2007, and was replaced in 2008 by DENV 1 as the predominant strain with DENV 2 co-circulation and sporadic cases of DENV 3. DENV 1 was also predominant in 2010 with DENV 4 co-circulation. In Saint Martin, from 2002–2005, DENV 3 was the only serotype in circulation. In 2006, DENV 2 became predominant, with co-circulation of DENV 3 and DENV 4. From 2007 to 2008, DENV 1 was predominant (with co-circulation of DENV 2 during a 2008–2009 epidemic). In 2009, the predominant serotype reverted to DENV 2 (with co-circulation of DENV 4 during a 2008–2009 epidemic), and in 2010, the predominant strain was DENV 1 with co-circulation of DENV 2,4,5</p> <p>Health authorities in Guadeloupe and Saint Martin are implementing measures for the following: strengthening integrated vector control, enhanced surveillance of cases, updating clinical management guidelines, social mobilization, and emergency risk communications.</p> <p>Guadeloupe and Saint Martin have been reporting dengue cases throughout 2018; however, an increase was observed towards the end of the year exceeding the seasonal threshold in Guadeloupe during EW 46 to EW 48. The re-introduction of DENV 1 to the Caribbean islands may result in more severe secondary dengue virus infections and require comprehensive risk communications. <b><i>Due to the presence of the competent vector and, given that Guadeloupe is a popular tourist destination, the risk of spread to neighbouring islands and countries cannot be ruled out.</i></b></p> <p>On 21 November 2018, PAHO/WHO alerted Member States about an increase of dengue cases in countries and territories in the Americas and recommended coordinated actions both inside and outside of the health sector, including prioritizing activities to prevent transmission of dengue as well as deaths due to this disease. PAHO/WHO further recommends to follow the key recommendations regarding outbreak preparedness and response, case</p>
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				<p>management, laboratory, and integrated vector management as published in the 21 November 2018 PAHO/WHO Epidemiological Update on Dengue. There is no specific treatment for disease due to dengue; therefore, prevention is the most important step to reduce the risk of dengue infection. WHO recommends proper and timely case management of dengue cases. Surveillance should continue to be strengthened within all affected areas and at the national level. Key public health communication messages should continue to be provided to reduce the risk of transmission of dengue in the population. Additionally, integrated vector management (IVM) activities should be enhanced to remove potential breeding sites, reduce vector populations, and minimize individual exposures. This should include both larval and adult vector control strategies (i.e. environmental management and source reduction, and chemical control measures), as well as strategies to protect individuals and households. Where indoor biting occurs, household insecticide aerosol products, mosquito coils, or other insecticide vaporizers may also reduce biting activity. Household fixtures such as window and door screens and air conditioning can also reduce biting. Since <i>Aedes</i> mosquitoes (the primary vector for transmission) are day-biting mosquitoes, personal protective measures such as use of clothing that minimizes skin exposure during daylight hours is recommended. Repellents may be applied to exposed skin or to clothing. The use of repellents must be in strict accordance with label instructions. Insecticide-treated mosquito nets afford good protection for those who sleep during the day (e.g. infants, the bedridden, and night-shift workers) as well as during the night to prevent mosquito bites.</p> <p><b>WHO does not recommend any general travel or trade restrictions be applied based on the information available for this event.</b></p>	
2019-01-02	Nigeria	Infectious	Yellow Fever	<p>The current outbreak of yellow fever (YF) in Edo State in Nigeria is unusual in scale and severity, and the number of cases in time and place is very high in the context of the current national outbreak. The seasonal timing of the outbreak, in a period where many travellers enter the state from other states and countries for the Christmas holidays, adds to the risk for potential spread.</p> <p><b>On 22 November 2018, the WHO Country Office was informed of a cluster of suspected YF cases in Edo state. The cases presented with fever, yellowish discoloration of the eyes, dark or bloody urine, hiccups, altered consciousness, confusion and abdominal pain. As of 24 December 2018, a total of 139 suspected, presumptive positive, and confirmed cases,</b></p>	Public Health Risk (PHR)



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including 26 deaths (CFR 19%), have been reported across 15 of 18 LGAs in Edo state. Blood specimens were obtained from 115 cases and sent for laboratory diagnosis; 42 (30%) samples were presumptive in-country based on IgM serology and sent to the regional reference laboratory, Institut Pasteur de Dakar (IPD), for confirmation. So far, of the initial 42 samples sent to IPD, 32 (76%) were confirmed by RT-PCR. Differential diagnosis was performed for Dengue, West Nile, Zika, Chikungunya, Rift valley fever, Crimean Congo haemorrhagic fever at IPD and was negative for all samples. 66 (48%) of the suspected cases and 19 (45%) of 42 presumptive positive cases were reported from one LGA (Uhunmwonde). Uhunmwonde is a rural LGA with farming communities and frequent population movements and is located in close proximity to Benin City. Males represent the majority of cases (102 of 139, 73%), and the most affected age group is 10-19 years with 42 cases (30%), followed by age 20-29 age group with 35 cases (25%). Initially, the affected LGAs were rural but since week 48, suspected cases have been reported from 3 urban LGAs. There has also been a report of 2 presumptive positive and one confirmed case in Oredo LGA, which includes the densely populated state capital Benin City. A cluster of 3 cases has been reported in a neighbouring state (Delta) with a travel history to a farming community in Edo state where other suspected cases have been reported. Of the 3 cases, 2 presented with severe symptoms including jaundice and have since died. The third case had mild symptoms. A sample collected from one of the cases tested presumptive positive and has been sent to IPD for confirmation.

Population immunity in Edo state is low, estimated at less than 50% (based on routine immunisation administrative data) in 2018, and the state just concluded a 6 – day Yellow Fever Reactive Vaccination Campaign implementation in 13 LGAs to boost population immunity. Entomological studies have revealed elevated indices of competent vectors, including *Aedes aegypti*, the mosquito species responsible for rapid amplification of arboviral disease in urban environments. Land-use practices, namely cultivation close to dwellings, may further exacerbate the spread of yellow fever disease in this setting. Since September 2017, when the Nigeria Centre for Disease Control (NCDC) informed WHO of a confirmed case of YF in Kwara State, Nigeria has been responding to successive YF outbreaks. The country officially notified WHO (via the International Health Regulations, 2005) on 15 September 2017. Since then and as of 16 December 2018, 217 specimens/ cases tested IgM positive in-country. Eighty-two cases



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(including 13 deaths) were confirmed by IPD; these cases were reported from 27 LGAs in 14 States and have resulted in response campaigns in selected LGAs in six States.

The response to the outbreak is being coordinated through a multi-agency, multi-partner Incident Management System (IMS). A national Emergency Operations Centre (EOC) has been activated to monitor the outbreak at the Nigeria Centre for Disease Control (NCDC). Rapid Response Teams continue to support Edo state in ongoing outbreak investigation and response. YF surveillance has been intensified and active case finding is ongoing in affected LGAs and neighbouring States. Supervisory visits to the yellow fever laboratory network are ongoing to strengthen laboratory capacity. WHO CO and state office have been actively monitoring and responding to the yellow fever outbreak since the start of the outbreak. Starting from 15 December, YF experts from WHO (AFRO and HQ) were deployed to support local authorities in investigating this event, assess the risk of further amplification, and assist in conducting reactive vaccination campaigns, among other activities. Entomological surveys were conducted in Kwara, Zamfara, Kebbi, Kano, Katsina, Ekiti, Rivers, Anambra, and Benue States by entomologists from the National Arbovirus Research Institute (NARI). A vector control strategy, tailored to the local context, is being developed with of WHO regional and global vector control experts. Routine yellow fever vaccination was introduced to Nigeria’s Expanded Programme on Immunization (EPI) in 2004, but the overall population immunity in areas affected by the current outbreak remains below herd immunity thresholds. National preventive and reactive mass vaccination campaigns have been conducted in the country since 2017 (~33 million doses). A proposal has been submitted to Gavi to vaccinate twelve states over the next three years (~23 million doses). In addition, the country has initiated a large scale reactive yellow fever vaccination campaign in Edo State as of 18 December. The International Coordination Group (ICG) on Vaccine Provision, funded by Gavi, approved release of 3.1 million doses of Yellow fever vaccines to replenish in-country stocks of vaccine that have been mobilised to facilitate a timely response before the Christmas holidays.

Yellow fever is an acute viral haemorrhagic disease transmitted by infected mosquitoes and has the potential to spread rapidly and cause serious public health impact. There is no specific treatment, although the disease is preventable using a single dose of yellow fever vaccine, which provides immunity for life. Supportive care to treat dehydration,



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respiratory failure and fever and antibiotic treatment for associated bacterial infections is recommended.

The yellow fever (YF) outbreak has been active in Nigeria since September 2017. Cases are reported from 36 states and the Federal Capital Territory. The recent confirmation by the regional reference laboratory of the YF outbreak in Edo State, with the probable epicentre in Uhunmwonde LGA, represents an unprecedented outbreak in Nigeria. ***Given the rapid evolution of the situation in Edo state, the national risk is assessed as high*** due to: the high CFR (19%) in Edo state; the potential for ongoing local transmission and amplification due to low vaccination coverage; presence of competent vectors including *Aedes sp.*; the proximity of a case to Benin City (major urban centre and capital of Edo state); and the potential spread to new LGAs. There is currently a ***moderate risk at regional level due to the possible movement of the individuals of affected states to adjacent areas and neighbouring countries and particularly if there is arrival of unvaccinated visitors over the festive end of year season. The current overall risk is low at the global level.*** Nigeria is facing several concurrent public health emergencies, including cholera, circulating Vaccine Derived Polio Virus, monkey pox, measles, and Lassa fever outbreaks in other states, and a humanitarian crisis in the northeast of the country.

Nigeria is a high priority country for the Eliminate Yellow Fever Epidemic (EYE) strategy. Phased preventive yellow fever vaccination campaigns are planned to cover the entire country by 2024. Vaccination is the primary intervention 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. WHO recommends vaccination against yellow fever for all international travellers more than 9 months of age going to Nigeria, as there is evidence of persistent or periodic yellow fever virus transmission. Nigeria 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 vaccines recommended by WHO are safe, highly effective and provide life-long protection against infection. 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 with a WHO approved vaccine. A booster dose of approved yellow fever vaccine cannot be required of international travellers as a condition of



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				<p>entry. WHO encourages its member states to take all actions necessary to keep travellers well informed of risks and preventive measures including vaccination. Travellers should also be made aware of yellow fever symptoms and signs and instructed to seek rapid medical advice when presenting signs. Viraemic returning travellers may pose a risk for the establishment of local cycles of yellow fever transmission in areas where the competent vector is present.</p> <p><b>WHO does not recommend any restrictions on travel or trade to Nigeria on the basis of the information available on this outbreak.</b></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.