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Health Information Update

Source: WHO, Event Information Site for IHR National Focal
Event Updates: **09 to 15 January 2019**

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2019-01-15	**Mozambique**	**Infectious**	**Poliomyelitis, acute paralytic, vaccine-associated**	**In Mozambique, two genetically-linked circulating vaccine-derived poliovirus type 2 (cVDPV2) isolates were detected. The first one, from an acute flaccid paralysis (AFP) case with onset of paralysis on 21 October 2018, in a six-year old girl with no history of vaccination, with genetic sequencing results indicating 10 nucleotide change from Sabin 2 and the second isolate from a community contact of the first case, in a one year and 3 months old, where a poliovirus type 2,(PV2) with 6 nucleotide change was isolated. Both cases are from Molumbo district, Zambézia province bordering Malawi.** In January 2017, a single VDPV2 virus had been isolated from a 5-year old boy with AFP, also from Zambézia province (Derre district). Outbreak response was conducted in the first half of 2017 with monovalent oral polio vaccine type 2 (mOPV2). WHO and its partners at the regional and country level are assisting the Ministry of Health and local public health authorities to conduct a thorough field investigation (clinical, epidemiological and immunological), assessing more clearly the extent and original source of circulation of this virus, and in planning and supporting implementation of an outbreak response as appropriate, in line with internationally-agreed outbreak response protocols. While national routine OPV3 immunization coverage in 2017 was high estimated at 80% and 60% IPV coverage, population immunity gaps remain at subnational levels, especially in Zambézia province (with 60% OPV3 coverage). WHO assessed the ***overall public health risk at the national level to be high due to decline in population immunity to type 2 poliovirus and the risk of international spread to be medium due to ongoing population movements.*** The detection of cVDPV2s underscores the importance of maintaining high routine OPV and IPV vaccination coverage everywhere to minimize the risk and	**Public Health Risk (PHR)**

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				consequences of any poliovirus circulation. These cVDPV2 outbreak and VDPV2 event also underscore the risk posed by any medium to low-level transmission of the virus. A robust outbreak response 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. 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 travelers 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 must continue as it 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 travelers.	
2019-01-12	**Argentina**	**Zoonosis**	**Hantavirus Pulmonary Syndrome**	**On 19 December 2018, the Argentina Ministry of Health and Social Development issued an epidemiological alert regarding an increase in HPS cases in Epuyén, Chubut Province. Between epidemiological week (EW) 44 of 2018 and EW 2 of 2019, there have been a total of 26 laboratory-confirmed cases of HPS in Epuyén, Chubut Province, including 9 deaths. Chubut Province is located in Patagonia in southern Argentina, and**	**Public Health Risk (PHR)**

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				Epuyén has a population of approximately 2,000 persons. The presumed index case had environmental exposure prior to symptom onset on 2 November. This case attended a party on 3 November 2018, and between 20-27 November 2018, 6 additional cases who attended the party had symptom onset. Between 7 December 2018 and 3 January 2019, an additional 17 cases had symptom onset, all of whom were epidemiologically-linked to previously confirmed cases. Potential human-to-human transmission is under investigation. One of the confirmed cases has been reported in a Chilean healthcare worker who resides in Palena Province, Los Lagos Region, Chile, and had symptom onset on 2 January 2019; this case had travel history to Epuyén for one day in mid-November, and later hosted and cared for a confirmed case from Epuyén while she was in her prodromal phase. Among 23 (out of 26) of the confirmed cases with available information, 52% are male, and the period of incubation ranged from 8 to 31 days. Approximately 50% of these confirmed cases had symptom onset within the past 3 weeks. Cases were confirmed by ELISA IgM *u* captura or by polymerase chain reaction (PCR). As of 9 January 2019, a total of 70 asymptomatic contacts have been identified and are being monitored for symptoms. In Argentina, four endemic regions have been identified: North (Salta, Jujuy), Centro (Buenos Aires, Santa Fe, and Entre Ríos), Northeast (Misiones) and Sur (Neuquén, Río Negro, and Chubut). Between 2013 and 2018, an average of 100 confirmed cases were registered annually, with the provinces of Buenos Aires, Salta, and Jujuy having the highest number. Between 2013 and 2018, 111 confirmed deaths from hantavirus were reported in Argentina, with a case-fatality rate of 18.6%, though this figure was close to 40% for some provinces in the southern region of the country. In Chile, the confirmed case in the Palena resident is the first confirmed case of hantavirus in Los Lagos Region in 2019. During 2018, there were 8 cases of hantavirus, including 2 deaths. HPS is a zoonotic, viral respiratory disease. The causative agent belongs to the genus Hantavirus, famil	

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				Bunyaviridae. The infection is acquired primarily through inhalation of aerosols or contact with infected rodent excreta, droppings, or saliva of infected rodents. Cases of human hantavirus infection usually occur in rural areas (forests, fields, farms, etc.) where sylvatic rodents hosting the virus might be found and where persons may be exposed to the virus. This disease is characterized by headache, dizziness, chills fever, myalgia, and gastrointestinal problems, such as nausea, vomiting, diarrhea, and abdominal pain, followed by sudden onset of respiratory distress and hypotension. Symptoms of HPS typically occur from 2 to 4 weeks after initial exposure to the virus. However, symptoms may appear as early as one week and as late as eight weeks following exposure. The case-fatality rate can reach 35-50%. In the Americas, HPS cases have been reported in several countries. Environmental and ecological factors affecting rodent populations can have a seasonal impact on disease trends. Since the reservoir for hantavirus is sylvatic rodents, mainly *Sigmodontinae* species, transmission can occur when people come in contact with the rodent habitat. Limited human-to-human transmission of HPS due to *Andes virus* in Argentina has been previously documented. There are no specific evidence-based procedures for HPS patient isolation. Standard precautions[1] should always be set in place, as well as rodent control measures. PAHO/WHO recommends that Member States continue efforts of detection, investigation, reporting, and case management for the prevention and control of infections caused by hantavirus. Particular vigilance should be carried out amongst travelers returning from the affected areas. Early identification and timely medical care improves clinical outcome. To raise the suspicion of impending HPS, clinicians must use a combination of the following three factors: epidemiological data for guidance of the possible exposure, manifestations of fever and myalgia, and thrombocytopenia. Care during the initial stages of the disease should include antipyretics and analgesics as needed. In some situations, patients should receive broad-spectrum antibiotics while confirming the	

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				etiologic agent. Effective clinical treatment depends largely on careful administration of intravenous solutions, hemodynamic monitoring and ventilation support. Given the rapid progression of HPS, clinical management should focus on the patient's hemodynamic monitoring, fluid management and ventilation support. Severe cases should be immediately transferred to intensive care units (ICU). Ribavirin, an antiviral agent, is not approved for either treatment or prophylaxis of hantavirus pulmonary syndrome infection. Health awareness campaigns must aim to increase detection and timely treatment of the illness and prevent its occurrence by reducing people's exposure. Preventive measures should cover occupational and eco-tourism related hazards. Most usual tourism activities pose little or no risk of exposure of travelers to rodents or their excreta. However, people who engage in outdoor activities such as camping or hiking, should take precautions to reduce possible exposure to potentially infectious materials. HPS surveillance should be part of a comprehensive national surveillance system and must include clinical, laboratory and environmental components. ***The implementation of integrated environmental management, with the goal of reducing rodent populations, is recommended.***	
2019-01-10	**Saudi Arabia**	**Infectious**	**Coronavirus Infection**	**During December 2018, the National IHR Focal Point of The Kingdom of Saudi Arabia reported total of (5) cases of MERS-CoV. Four cases were primary cases and 1 was a household contact. All cases but one were males and 3 cases had a history of contact with camels. Details of the cases are reported below:** **1. Case reported on 12 Dec** *A 45-year-old male national, soldier and living in Najran city, Najran Region. He developed fever, cough, and shortness of breath on 1 December and was admitted to hospital in Najran on 9 December, whereupon a chest X-ray confirmed the diagnosis of pneumonia. A nasopharyngeal swab was collected on 10 December and tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Jeddah regional laboratory on 11 December. He has diabetes mellitus and bronchial*	**Public Health Risk (PHR)**

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				asthma as comorbid conditions. Investigation of history of exposure to any of the known risk factors is ongoing. Currently, the patient is in stable condition in the ward. Investigation of 9 household contacts is ongoing. **2. Case reported on 13 Dec** *A 45-year-old male national, soldier and living in Sajer city, Riyadh Region. He developed fever, cough, and shortness of breath on 9 December and was admitted to the hospital on 11 December, whereupon a chest X-ray confirmed the diagnosis of pneumonia. A nasopharyngeal swab was collected on 11 December and tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 12 December. He has diabetes mellitus, hypertension, and bronchial asthma as comorbid conditions. He has a history of contact with camels and consumption of their raw milk in the 14 days prior to the onset of symptoms. Currently, the patient is in stable condition in the ward. Investigation of 11 household contacts is ongoing. Ministry of Agriculture has been informed and investigation of camels is ongoing.* **3.Case reported on 14 Dec** *A 53-year-old male national, retired and living in Riyadh city, Riyadh Region. He developed fever, cough, and shortness of breath on 8 December and was admitted to a hospital in Riyadh on 11 December, whereupon a chest X-ray confirmed the diagnosis of pneumonia. A nasopharyngeal swab was collected on 11 December and tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 12 December. He has diabetes mellitus, and chronic heart failure as comorbid conditions. He has a history of contact with camels and consumption of their raw milk in the 14 days prior to the onset of symptoms. Currently, the patient is in stable condition in the ward. Investigation of 10 household contacts is ongoing. Ministry of Agriculture has been informed and investigation of camels is ongoing.* **4. Case reported on 20 Dec** *A 47-year-old male national, solider and living in Alkharj city, Riyadh Region. He developed fever, cough, and shortness of breath on 15 December and was admitted to the*	

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				hospital on 18 December, whereupon a chest X-ray confirmed the diagnosis of pneumonia. A nasopharyngeal swab was collected on 19 December and tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 20 December. He has diabetes mellitus as comorbid conditions. He has a history of contact with camels and consumption of their raw milk in the 14 days prior to the onset of symptoms. Currently, the patient is in stable at home isolation. Investigation of 13 household contacts is ongoing. Ministry of Agriculture has been informed and investigation of camels is ongoing. **5. Case reported on 26 Dec** *A 80-year-old female national, housewife and living in Sajer city, Riyadh Region. She developed fever, cough, and shortness of breath on 23 December and was admitted to the hospital on 25 December, whereupon a chest X-ray confirmed the diagnosis of pneumonia. A nasopharyngeal swab was collected on 25 December and tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 26 December. She has diabetes mellitus and hypertension as comorbid condition. He is a household contact of case reported 13 December. Currently, the patient is in stable condition in the ward. Investigation of 10 household contacts is ongoing.* 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. 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 dromedary camels, animal products (for example, consumption of camel's raw milk), or humans (for example, in a health care setting). WHO continues to monitor the	

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				epidemiological situation and conducts risk assessment based on the latest available information. ***Since 2012 until 31 December 2018, the total number of laboratory-confirmed MERS-CoV cases reported globally to WHO is 2,279, with 806 associated deaths***. 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. ***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.***	
2019-01-09	**Japan**	**Infectious**	**Rubella (German Measles)**	**On 21 December 2018, the Japanese Ministry of Health, Labour and Welfare (MHLW) notified WHO of an increase of rubella cases in Japan. In 2018, the number of reported cases increased from the week starting 24 June 2018 onwards. Between 1 January and 9 December, 2,586 cases have been reported. Most cases (81%) were adult males. Only 19cases (1%) were imported from other countries. Of 397 cases tested for virus genotype, 369 cases (93%) were infected with 1E genotype strain of rubella virus. In recent weeks, the number of reported cases has gradually decreased from a peak of 216 cases per week at the end of October 2018 to 121 cases per week at the beginning of December 2018.** Japan experienced a nationwide rubella epidemic from 2012 to 2013, with more than 16,000 cases and 45 congenital rubella syndrome (CRS) cases reported during this period. The 2B genotype strain was the virus primarily responsible for that epidemic. Routine vaccination for rubella was first introduced in 1977 for women and then expanded to men in 1995. Therefore, the prevalence of antibodies among men born between 1962 and 1979 is lower than other age groups. A sero-epidemiological analysis in 2012 indicated that an accumulation of susceptible individuals among adult males aged 30 to 49 years was likely driving the 2012/2013 epidemic. After that epidemic, the number of reported cases decreased until 2017: the annual number of reported cases were 319 in 2014; 163 in 2015; 126 in 2016; and 93 in 2017. Both clinical	**Public Health Risk (PHR)**

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				diagnosed and laboratory confirmed rubella cases became a notifiable disease in 2008. Since January 2018, laboratory confirmation for all clinical rubella cases and prompt contact tracing have been enhanced. The following actions were implemented by MHLW and local governments: ▪ Conducted epidemiological investigations including contact tracing. Strengthened risk communication for healthcare professionals and the public. Encouraged appropriate implementation of rubella routine immunization and facilitating adult catch-up rubella vaccination campaigns at workplaces. ▪ Issued recommendation on rubella antibody testing for pregnant women, women planning pregnancy and persons living with pregnant women; this testing is provided with financial assistance from MHLW and local governments. MHLW and local governments recommend vaccination for women planning pregnancy and persons living with pregnant women who have insufficient immunity against rubella. ▪ Increased supply of the vaccine for medical institutions in epidemic areas with large rubella case numbers reported (i.e., Tokyo Metropolis and Chiba, Kanagawa, Saitama, Aichi, Osaka and Fukuoka Prefectures.). ▪ Additionally, MHLW and local governments are planning to introduce free antibody tests for men aged between 39 and 56 and require those without sufficient immunity to be vaccinated to strengthen herd immunity. The targeted age group was not vaccinated for rubella under the previous national immunization program. MHLW aims to increase antibody prevalence from 80% to 85% through targeted vaccination among this age group by the Tokyo 2020 Olympics in July and will continue efforts to obtain a prevalence greater than 90% in this age group by March 2021. WHO recommends that all countries that have not yet introduced rubella-containing vaccine (RCV), should consider doing so using existing, well-established measles immunization programmes. SAGE recommends the acceleration of the incorporation of	

				rubella vaccination into routine immunization programmes to ensure that additional gains in controlling rubella can be made. WHO recommends targeted vaccination campaigns for population groups with low rubella immunization coverage (such as adult males in the current outbreak in Japan), as a supplementary measure to prevent further rubella spread and lower the risk of devastating CRS cases. These persons should receive at least 1 dose of RCV or have an antibody test demonstrating adequate rubella immunity. WHO recommends that all countries create demand for immunization among both children and adults by strengthening public awareness of CRS, and of the importance of achieving high population immunity broadly across all age and gender groups to help prevent this devastating condition. ***WHO does not recommend any restriction on travel and trade to Japan based on the information available on the current outbreak.***	

*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.

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