International Health Surveillance Division (IHS)

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Health Information Update

Source: WHO, Event Information Site for IHR National Focal
Event Updates: **15 to 17 December 2018**

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2018-12-17	**China**	**Zoonosis**	**Influenza due to identified avian or animal influenza virus A(H5N6)**	**On 21 November 2018, the National Health Commission of China notified WHO of one additional laboratory-confirmed case of human infection with avian influenza A(H5N6) virus in China. The case is a 10 year-old female from Jiangsu Province, China. She developed symptoms on 29 October 2018, and was hospitalized on 3 November 2018 with severe pneumonia. Antiviral treatment started on 6 November, then the patient died on 1 December 2018. The patient had no clear exposure to live poultry before the onset of illness. Contact tracing has been completed, and no additional cases were detected. Outbreak investigation did not reveal the source of infection, however two environmental specimens collected from patient's home and one from wholesale market nearby, were tested positive for avian influenza A/H5 subtype. To date and since 2014, 23 laboratory-confirmed cases and fifteen deaths of human infection with avian influenza A(H5N6) viruses have been reported to WHO through IHR notification, all from China. Previous human infection was reported in October 2018, from a resident of Guangxi Zhuang Autonomous Region, China, and also with no contact with poultry.** The Chinese Government has taken the following surveillance and control measures: 1. Close contact tracing; enhanced surveillance and disinfection of the residential place and environment in suspect exposure areas; investigate into live poultry sale activities in the area. 2. Conduct public risk communication and information sharing to guide the public and raise their awareness of self-protection. Although influenza A(H5N6) has caused severe infection in humans, until now human infections with the virus seem to be rare and no human-to-human transmission has been reported. The characterization of the virus through whole genome sequencing showed that the virus was unchanged. ***The risk of international disease spread is considered to be low at this point in time.*** WHO continues to assess the epidemiological situation and conduct further risk assessment based on the latest information.	**Public Health Risk (PHR)**
2018-12-17	**Saudi Arabia**	**Infectious**	**Coronavirus Infection**	**Between 31 October and 30 November 2018, the National IHR Focal Point of The Kingdom of Saudi Arabia reported eight (8) additional**	**Public Health Risk (PHR)**

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cases of MERS-CoV infection, including two deaths.

The details of the cases are reported below:

Case reported on 31 October

- ***A 53-year-old male non-national, worker and living in Riyadh city, Riyadh Region***. He developed fever, cough, and shortness of breath on 26 October and was admitted to hospital in Riyadh on 29 October, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 30 October tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 31 October. The patient had diabetes mellitus and acute renal failure as comorbid conditions. Investigation of history of exposure to any of the known risk factors in the 14 days prior to the onset of symptoms is ongoing. The patient who was in critical condition was admitted to the ICU and died on 1 November. Investigation of 3 household contacts was conducted and one case tested positive for MERS Co-V on 8 November.

Case reported on 07 November

- ***A 54-year-old male national, retired and living in Riyadh city, Riyadh Region.*** He developed fever, cough, and shortness of breath on 26 October and was admitted to hospital in Riyadh on 4 November, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 5 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 6 November. The patient has diabetes mellitus and hypertension as comorbid conditions. Investigation of history of exposure to any of the known risk factors in the 14 days prior to the onset of symptoms is ongoing. Currently, the patient is in stable condition in the ward. Investigation of 9 household contacts was conducted and no further cases were identified.

Case reported on 8 November

- ***A 53-year-old male non-national, driver and living in Riyadh city, Riyadh Region***. He developed fever on 6 November and was admitted to hospital in Riyadh on 7 November, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 7 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 8 November. The patient has no comorbid conditions. He is a household contact of the 53-year old male case reported to WHO on 31 October (see above). Investigation of history of exposure to any of the known risk factors in the 14

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				days prior to the onset of symptoms was completed. Currently, the patient is in stable condition in the ward. Investigation of 6 household contacts was conducted and no further cases were identified. - ***A 75-year-old male national, retired and living in Alasiah city, Quassim Region.*** He developed fever, cough, and shortness of breath on 2 November and was admitted to hospital in Riyadh on 6 November, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 6 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 7 November. The patient had diabetes mellitus and hypertension as comorbid conditions. Investigation of history of exposure to any of the known risk factors in the 14 days prior to the onset of symptoms is ongoing. The patient who was in critical condition was admitted to ICU and died on 15 November. Investigation of 9 household contacts was conducted and one case tested positive for MERS-CoV on 10 November. ***Case reported on 10 November*** - ***A 39-year-old male national, soldier living in Alasiah City, Quassim Region.*** He developed cough on 8 November and was admitted to hospital in Riyadh on 9 November, whereupon a chest X-ray the of pneumonia was confirmed. A nasopharyngeal swab collected on 9 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 10 November. The patient has no comorbid condition but is a heavy smoker. The patient is a household contact of the 75-year old male case reported to WHO on 8 November (see above). Currently, the patient is in stable condition in the ward. Investigation of 10 household contacts was conducted and no further cases were identified. ***Case reported on 13 November*** - ***A 67-year-old male national, retired living in Alasiah City, Quassim Region.*** He developed fever, cough and shortness of breath on 7 November and was admitted to hospital in Riyadh on 11 November, whereupon a chest X-ray the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 11 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at Riyadh regional laboratory on 12 November. The patient has diabetes mellitus as comorbid condition. Investigation of history of exposure to any of the known risk factors in the 14 days prior to the onset of symptoms is ongoing. Currently, the patient is in stable condition in the ward. Investigation of 18 household contacts was conducted and no	

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				further cases were identified. **Case reported on 18 November** - ***A 52-year-old male national, retired and living in Riyadh city, Riyadh Region.*** He developed fever, fatigue, cough, and shortness of breath on 7 November and was admitted to hospital in Riyadh on 16 November, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 17 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 18 November. The patient has diabetes mellitus and hypertension as comorbid conditions. Investigation of history of exposure to any of the known risk factors in the 14 days prior to the onset of symptoms is ongoing. Currently, the patient is in critical condition admitted to ICU on mechanical ventilation. Investigation of 8 household contacts was conducted and no further cases were identified. **Case reported on 21 November** - ***A 29-year-old female national, housewife and living in Riyadh city, Riyadh Region***. She developed fever, cough, and shortness of breath on 12 November and was admitted to hospital in Riyadh on 19 November, whereupon a chest X-ray, the diagnosis of pneumonia was confirmed. A nasopharyngeal swab collected on 20 November tested positive for MERS-CoV by PCR (UpE and Orf1a genes) at the Riyadh regional laboratory on 21 November. The patient is pregnant and has no comorbid condition. Investigation of history of exposure to any of the known risk factors in the 14 days prior to the onset of symptoms is ongoing. Currently, the patient is in stable condition in the ward. Investigation of 7 household contacts was conducted and no further cases were identified. 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 epidemiological situation and conducts risk assessment based on the latest available information. **Since 2012 until 30 November 2018, the total number of laboratory-confirmed MERS-CoV cases reported globally to WHO is 2,274, 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. 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. It is not always possible to identify patients with MERS-CoV early because like other respiratory infections, the early symptoms of MERS-CoV are non-specific. Therefore, healthcare 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. MERS-CoV appears to cause more severe disease in people with diabetes, renal failure, chronic lung disease, and immunocompromised persons. Therefore, these people should avoid close contact with animals, particularly camels, when 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. ***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.***	
2018-12-15	**Democratic Republic of the Congo (DRC)**	**Infectious**	**Poliomyelitis, acute paralytic, vaccine-associated**	**In the Democratic Republic of the Congo (DRC), two genetically-linked circulating vaccine-derived poliovirus type 2 (cVDPV2) isolates were detected, from an acute flaccid paralysis (AFP) case (with onset of paralysis on 7 October 2018, in a 29-month old child), and a contact of a second AFP case (the case is an 11-year old child), from Haut-Katanga province (Mufunga-Sampwe district). The isolated viruses are a new emergence and**	**Public Health Risk (PHR)**

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				unrelated to previously-detected cVDPV2s affecting the country. This is the fourth distinct outbreak of cVDPV2 detected in the country since June 2017. In total, 42 cVDPV2 cases have now been confirmed since detection of the first outbreak in June 2017, including 20 cases in 2018. WHO and partners are responding to these outbreaks, including through the use of monovalent oral polio vaccine type 2 (mOPV2) in line with internationally-agreed upon outbreak response protocols. However, operational gaps in the response continue to hamper the full implementation of these protocols, as high-risk populations remain under-immunized, and the response thus far has not controlled the outbreak nor prevented its spread. The emergence of the fourth outbreak of cVDPV2 is possibly linked to inability to implement good quality outbreak response with mOPV2. The geographic extent of the outbreak response to all four strains is now being re-evaluated, given geographic spread of some of these strains and emergence of the new strain. Surveillance and immunization activities continue to be strengthened in the country and in neighboring countries. *In February 2018, the government declared cVDPV2 to be a national public health emergency.* Provincial governors on 26 July 2018 convened an urgent meeting and signed the 'Kinshasa Declaration for Polio Eradication'. The high-level meeting was convened by HE the Minister of Health, as well as the WHO Director-General and the Regional Director for Africa. Provincial governors committed to providing the necessary oversight, accountability and resources needed to urgently improve the quality of the outbreak response being implemented across the country. It is now critical that the remaining operational gaps in outbreak response are urgently filled, with the appropriate oversight and engagement. The polio outbreak response is being conducted simultaneously to an ongoing Ebola outbreak affecting North Kivu province, in the east of the country (close to provinces affected by cVDPV2). As in the past, the polio teams are coordinating closely with the broader humanitarian emergency network, to ensure both outbreaks are addressed in a coordinated manner (as was the case during the 2018 Ebola outbreak in Equateur province, which was successfully stopped). ***WHO assesses the overall public health risk associated with these four outbreaks at the national level to be very high and the risk of international spread to be high due to the emergence of a fourth outbreak and geographic spread of other outbreaks, including close to international borders.*** This risk is magnified by known population movements between the affected areas of	

				Democratic Republic of the Congo, Uganda, Central African Republic, Zambia and South Sudan. ***In July 2018, considering the epidemiology of the reported polio cases, genetic analyses of the isolated polioviruses, risk of further in-country transmission and international spread as well as the country capacity to respond, the outbreak has been graded as Grade 2 public health emergency based on the WHO Emergency Response Framework.*** The detection of cVDPV2s underscores the importance of maintaining high routine vaccination coverage everywhere to minimize the risk and consequences of any poliovirus circulation. These events also underscore the risk posed by any 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. ***WHO does not recommend any restrictions on travel and/or trade to the Democratic Republic of the Congo based on the information available for the current cVDPV2 outbreaks.***	

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