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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: 27 September to 12 October 2018

Event Updated	Country	Hazard	Disease	Event Description	IHR Assessment
2018-10-12	Pakistan	Infectious	Typhoid Fever	<p>Between November and December 2016, the Aga Khan University in Karachi identified a trend of increasing antimicrobial resistance in patients presenting with typhoid fever from Hyderabad district of Sindh province. Cases initially were focused in the two tehsils, Qasimabad and Latifabad of Hyderabad district. Further localized surveillance by the Field Epidemiology and Laboratory Training Program (FELTP) in Sindh between November 2016 and May 2018 indicated increasing numbers of confirmed Ceftriaxone resistant typhoid cases, mostly from Hyderabad (71%), but also from Karachi (22%) the capital city of the province. Environmental surveys of water quality by the Municipal Corporation to more than half of the cases was found to be contaminated with E.coli. S.Typhi DNA was detected in 22% of water samples collected from community taps.</p> <p>The Regional Disease Surveillance and Response Unit (RDSRU) in Karachi developed and adopted standardized case definitions for surveillance of non-resistant typhoid fever, multi-drug resistant (MDR) typhoid fever and XDR typhoid fever. From 1 January 2018, surveillance data collection on MDR and XDR typhoid fever cases was initiated from eight hospitals, namely: Aga Khan University, Memon Medical Institute Hospital, Liaquat National Hospital, Civil Hospital Karachi, National Institute of Child Health, Dow University of Health Sciences, Jinnah Medical Postgraduate Center, and Taj Medical Complex Hamdard University Hospital. From 1 January 2017 to 30 September 2018, a total of 5056 cases of typhoid fever, of which 57% (2889) were defined as XDR typhoid fever were reported from Karachi. XDR cases were found in all age-groups, ranging from under 1 year to over 65 years with the most affected age group being 3-4 years with 20% (601) cases reported till date. Available data is mostly from laboratory confirmed XDR typhoid cases without information on history of antimicrobial usage, patients' characteristics such as main signs & symptoms, complications or treatment outcomes. There are scattered informal reports of XDR cases from other parts of Pakistan which need further verification. To date, six cases of travel associated infection with typhoid fever have been reported. In February 2018, a UK traveler reported as XDR typhoid fever case after returning from Pakistan, information on the travel destination is not available. Similarly, five cases in the US have also been reported with XDR typhoid fever after travel from Pakistan. The first case travelled to Karachi; the second case also had the history of travel to Karachi and as well as to Lahore and Islamabad, and the third case, pending confirmation, is a Pakistani resident (from Lahore) who travelled to the US where</p>	Public Health Risk (PHR)

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				<p>he was diagnosed and treated. There is no detailed information on the two new recent cases. All these cases have been successfully treated.</p> <p><i>The risk of XDR Salmonella Typhi at national level is considered high</i> due to insufficient water, sanitation and hygiene (WASH) measures, poor vaccination coverage, and lack of surveillance for typhoid fever and antimicrobial resistance (AMR). S. Typhi confirmatory testing and antimicrobial resistance testing is only conducted by major labs and tertiary care hospitals. These challenges coupled with the empirical antimicrobial treatment hinder the ability to ascertain the distribution and spread as well as containment of XDR S. Typhi. Outbreaks of MDR typhoid and sporadic cases of infection with ceftriaxone resistant S. Typhi have been reported in several countries. However, this is the first time a large scale outbreak caused by XDR S. Typhi has been observed in Pakistan. <i>The risk at Regional level is considered moderate</i> due to the existence of similar environment and approaches to treatment of typhoid fever and wide spread overuse of antimicrobials which is compounded by considerable levels of migration within the region. . It may be noted that there are reports of sporadic cases of XDR typhoid caused by haplotype H58 S. Typhi globally with localized outbreaks especially in South and South East Asia and parts of Africa. <i>Globally the risk is considered low</i> due to availability of antimicrobials and rational prescribing practices including applying antimicrobial sensitivity susceptibility testing in Pakistan in order to de-escalate antimicrobial therapy. However, S. Typhi has a global distribution, and as such, the potential for travelers to spread this resistant clone cannot be ignored. The high level of resistance in the H58 clonal strain identified to be circulating in parts of Pakistan increases the potential risk at all three levels.</p> <p><u>WHO recommends typhoid vaccination in response to confirmed outbreaks of typhoid fever, and recommends vaccination should be considered for travelers to typhoid-endemic areas. Further, where the TCV is licensed, WHO recommends TCV (among the available typhoid vaccines) as the preferred vaccine in view of its improved immunological properties. Typhoid vaccination should be implemented in the context of other efforts to control the disease.</u> Also, seeing how quickly S. Typhi can acquire new resistance mechanisms, WHO recommends strengthening surveillance of Antimicrobial resistance (AMR) to monitor known resistance, detect new and emerging resistance, control its spread and share the surveillance data locally and internationally in a timely manner. WHO recently published surveillance standards for "Typhoid and other invasive salmonellosis".[1] Currently, azithromycin could be recommended as the only remaining reliable and affordable first-line oral therapeutic option to manage patients with XDR typhoid in low resource settings. There are also intravenous antimicrobials that require hospital settings but they could hardly be considered for empiric</p>
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				<p>treatment due to potentially serious side effects. There is a need to ensure that patients suggestive of typhoid fever are tested microbiologically to detect S. Typhi (define antimicrobial susceptibility) wherever possible to inform patient management and contribute to the surveillance efforts, and that the confirmation testing is performed when an XDR phenotype is detected. Verification and advanced testing (including molecular methods) of S. Typhi strains with unusual resistance should be performed by designated expert laboratories that provide confirmatory testing, where such capacity exists within countries. In countries where no laboratory capacity currently exists, regional collaboration may be an option whereby a neighboring country's reference laboratory or a WHO Collaborating Centre can fulfil this role.</p> <p>To make a sustained difference in the continuing problem of antimicrobial resistance, the Government of Pakistan, provincial governments in collaboration with WHO and other partners has been leading initiatives that address antimicrobial resistance, which also focuses on XDR/MDR Gram-negative bacteria as well.</p>	
2018-10-08	Sudan (The)	Infectious	Chikungunya a Virus Disease	<p>On 31 May 2018, the State Ministry of Health of the Red Sea State in Sudan reported four suspected cases of chikungunya fever from Swakin locality, in Red Sea State. Among the signs and symptoms were sudden onset of fever, headache, joint pain and swelling, muscle pain and/or inability to walk. The first suspected case of chikungunya in the neighboring Kassala State was reported on 8 August 2018, in a male travelling from the Red Sea State. Since, cases have been reported in three localities of the State (Kassala, West Kassala and Rural Kassala). On 10 August, among 24 collected blood samples, 22 samples tested positive for chikungunya by PCR and ELISA at the National Public Health Laboratory (NPHL) in Khartoum. On 9 September, an additional 100 samples were collected and pooled in batches of ten: 50% of pools tested positive for mixed chikungunya and dengue viruses, and all pools were positive for chikungunya virus. From 31 May through 02 October 2018, seven States (Kassala, Red Sea, Al Gadaref, River Nile, Northern State, South Darfur, Khartoum) have been affected with a total of 13,978 cases of chikungunya, 95% of which from Kassala State. No hospital admission or death have been officially reported. Approximately 7% of the reported cases were children < 5 years of age and 60% were females.</p> <p><i>The overall risk of chikungunya at the national level is very high</i> because of the presence of Aedes aegypti in most parts of the country, availability of breeding sites in houses and uncoordinated community involvement in vector control aggravated by the ongoing rainy season which favours the proliferation of the vector and spread of the outbreak to other States in the country. Also, in the absence of a</p>	Public Health Risk

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				<p>good surveillance system to clearly define the dynamics of the outbreak, it is a big challenge to identify the public health actions to control the outbreak. The lack of financial and technical resources to respond to needs, if not addressed immediately and properly, may lead to further escalation of the number of cases and eventually overwhelm the already over-stretched capacities of the country. The risk at Regional level is considered moderate. WHO Regional Office is already mobilizing its resources to support the ongoing outbreak and is prepared to support other neighbouring countries if the outbreak spreads outside Sudan. Overall risk at Global level is low.</p> <p>Prevention and control of chikungunya rely heavily on reducing the number of natural and artificial water-filled container habitats that support breeding of the mosquitoes. This requires mobilization of affected communities. During outbreaks, insecticides may be sprayed to kill flying mosquitoes, applied to surfaces in and around containers where the mosquitoes land, and used to treat water in containers to kill the immature larvae. For protection during outbreaks of chikungunya, clothing which minimizes skin exposure to the day-biting vectors is advised. Repellents can be applied to exposed skin or to clothing in strict accordance with product label instructions. For those who sleep during the daytime, insecticide-treated mosquito nets afford good protection. Basic precautions should be taken by people travelling to risk areas and these include use of repellents, wearing long sleeves and pants and ensuring rooms are fitted with screens to prevent mosquitoes from entering.</p>	
2018-10-04	China	Zoonosis	<p>Influenza due to Avian or animal influenza virus (A/H5N6)</p>	<p>On 30 September 2018, the Health Planning 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 22 year-old male from Guangdong Province, China. He developed symptoms on 25 September 2018, and was admitted to hospital the next day with severe pneumonia. At time of reporting, the case patient was in critical condition. The patient had contact with live poultry before the onset of illness, including slaughtering and eating the poultry. Contact tracing is ongoing. To date, a total of 21 laboratory-confirmed cases and fourteen deaths of human infection with avian influenza A(H5N6) viruses have been reported to WHO through IHR notification since 2014, all from China. Previous human infection was reported in August 2018, from a resident of Guangxi Zhuang Autonomous Region.</p> <p>Although influenza A(H5N6) has caused severe infection in humans, until now human infections with the virus seem to be rare and no ongoing human-to-human transmission has been reported. However, the characterization of this virus is ongoing and its implication to the evolution and potential emergence of a pandemic strain is unknown. The risk of</p>	Public Health Risk

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				<p><i>international disease spread is considered to be low at this point in time.</i> WHO continues to assess the epidemiological situation and conduct further risk assessment based on the latest information.</p>	
2018-10-02	Nigeria	Undetermined	Monkeypox	<p>On 26 September 2017, WHO was alerted to a suspected outbreak of monkeypox in Yenagoa Local Government Area (LGA), Bayelsa state. The index cluster was reported in a family. All of whom developed similar symptoms of fever and generalized skin rash over a period of 4 weeks. Epidemiological investigation into the cluster show that all infected cases had a contact with monkey about a month prior to onset. From the onset of the outbreak in September 2017, a total of 269 suspected cases across 26 States and 115 confirmed cases across 17 States had been reported by September 15, 2018. Seven deaths, four of which were in patients with a preexisting immuno-compromised condition. Two health care workers were among the confirmed cases, with the most affected age group being 21-40 years and 79% of confirmed cases being males. In 2018, a total of 76 cases has been reported, 37 are confirmed, one probable and two deaths. These cases were reported in 15 States (Rivers, Akwa-Ibom, Bayelsa, Cross River, Delta, Edo, Enugu, Imo, Lagos, Nasarawa, Oyo, Abia, Anambra, Plateau and the Federal Capital Territory).</p> <p>Genetic sequencing suggests multiple introduction of the monkeypox virus into the population with evidence of human to human transmission. The isolates are closely related to the West African, Nigerian1971 strain. Other West and Central African countries reporting sporadic confirmed monkeypox cases since 2016, are Central African Republic, Cameroon, Democratic Republic of the Congo, Liberia, Nigeria, Republic of the Congo, and Sierra Leone.</p> <p>The Federal Ministry of Health through the Nigeria Centre for Disease Control (NCDC) in collaboration with the State's Ministry of Health and WHO are investigating suspected cases and monitoring contacts. Enhanced surveillance ongoing in all States especially in most affected states. National Interim Monkeypox guideline review was held on 20-21 September, in Abuja while Regional Monkeypox training is scheduled to commence in October 2018. Animal surveillance will commence in October, 2018 in collaboration with the US- CDC. This will commence with a training in a wild life sanctuary and subsequently in some affected states.</p> <p>Monkeypox is a sylvatic zoonosis with incidental human infections that occur sporadically in the rain forests of Central and West Africa. It is caused by the monkeypox virus (MPXV) and belongs to the <i>Orthopoxvirus</i> family, the same group of viruses as smallpox. Two distinct MPXV clades exist Congo Basin and West African consistent with observed differences in human pathogenicity and mortality in the two geographic</p>	Public Health Risk

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				<p>areas. The animal reservoir remains unknown, however, evidence suggests that native African rodents may be potential sources. Contact with live and dead animals through hunting and bush meat are presumed drivers of human infection. The disease is self-limiting with symptoms usually resolving spontaneously within 14-21 days. Severe cases occur more commonly among children and are related to the extent of virus exposure, patient health status and severity of complications. The case fatality has varied widely between epidemics but has been between 1% and 10% in documented events. There is no specific treatment or vaccine for the MPXV infection.</p> <p>Residents and travelers to endemic areas/ 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. 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. 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. WHO does not recommend any restriction for travel to and trade with Nigeria based on available information at this point in time.</p>	
2018-09-27	Saudi Arabia	Infectious	Coronavirus -us Infection	<p>Between 1 June and 16 September 2018, the National IHR Focal Point of The Kingdom of Saudi Arabia reported thirty two (32) additional cases of Middle East Respiratory Syndrome (MERS), including ten (10) deaths.</p> <p>Among these 32 cases, 12 cases were part of 5 distinct clusters (1 healthcare and 4 household clusters). The details of these clusters are described below:</p> <p>Cluster 1: Between 1 June and 8 June, four (4) additional cases in a previously reported household cluster were reported in Najran (http://apps.who.int/ihreventinformation/event/2012-e000288). The initial case reported in this cluster was reported on 30 May (52 year old male living in Najran City). One of the secondary cases was a health care worker.</p> <p>Cluster 2: Between 9 July and 14 July, a household cluster of two (2) cases was reported from Afif city, Riyadh region. No health care workers were infected.</p> <p>Cluster 3: Between 3 and 4 September, a renal hemodialysis centre in Buraidah City, Al-Quassim Region reported a</p>	Public Health Risk

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				<p>cluster of two (2) patients. No other hemodialysis patients or health care workers were infected.</p> <p>Cluster 4: Between 1 and 16 September, a household cluster of two (2) cases, including the suspected index case with reported dromedary exposure was reported from Buraidah City, Al-Quassim Region. No healthcare workers were infected.</p> <p>Cluster 5: Between 10 and 16 September, a household cluster of two (2) cases, including the suspected index case with reported dromedary exposure was reported from Riyadh City, Riyadh Region. No healthcare workers were infected.</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. 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. 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. <i>Since 2012 until 16 September, the total number of laboratory-confirmed MERS cases reported globally, to WHO are 2,254 and 800 associated deaths.</i></p> <p>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, health-care 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</p>
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				<p>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.</p> <p><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>
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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.