NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

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COMMUNICABLE DISEASES COMMUNIQUÉ

DECEMBER 2022, VOL. 21 (12)

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DECEMBER 2022, VOL. 21 (12)

EDITORIAL

Editor's Note – Dr Michelle Groome

As 2022 draws to a close, many can look forward to some much-needed rest over the festive season. It is a time to reflect on the past year and reset and refocus as we enter 2023. However, infectious agents do not take a break and increased travel over the holidays can lead to increased exposure and risk of contracting diseases both within South Africa and beyond our borders.

The number of measles cases in the South Africa is increasing and the outbreak is now affecting an increasing number of provinces. Please ensure that children's vaccinations are up to date to prevent measles and its complications, as well as other vaccine-preventable diseases.

The coastal areas of KwaZulu-Natal and Eastern Cape are a particularly high risk for rabies, although the disease may occur anywhere in South Africa. Avoid handling animals that you don't know and don't approach, touch or pick up stray dogs and cats. The higher temperatures and increased rainfall increase the risk of contracting malaria and individuals traveling to malaria-endemic areas should take adequate anti-malaria measures.

Since 2021, there has been an increase in cholera cases and their geographical distribution globally. In 2022, over 29 countries have reported cholera cases or outbreaks. There is an ongoing cholera outbreak in Malawi and the risk of importation into neighbouring countries remains high. Health care workers should be on alert and notify any cases of acute watery diarrhoea in patients with travel history to affected countries.

The Communiqué editorial team wishes you all a wonderful festive season.

CASE OF THE MONTH

Malaria caused by *Plasmodium ovale*

On 21 November 2022, NICD received a query regarding an adult male patient with an extensive travel history, who presented to a private hospital in KwaZulu-Natal Province with pyrexia of unknown origin. He was delirious on examination and spiked temperatures of up to 41ºC. His only other presenting complaints were a headache and a localised rash on the left side of his abdomen.

Upon further enquiry, it was noted that the patient had travelled to various African countries for work in the months prior to his admission, including Uganda, Zambia, Ivory Coast and Mali. He reported that he did not spend much time outside of his hotel room in the majority of the countries, aside from Mali where he visited a local mine. He recalled that whilst in Mali at the start of November, he started to feel ill with non-specific symptoms of fever and headaches. He reported that he had found two mosquito bites on his body, so presented to a local clinic where he was given antipyrexials and supportive treatment, but was not tested for malaria. The patient recovered within 48 hours and flew back to his home in South Africa on 11 November 2022.

The patient reported that he was completely well until 14 November 2022, when he developed a fever again. He presented to his local general practitioner (GP) in KwaZulu-Natal Province on 16 November 2022 and a malaria rapid diagnostic test (RDT) was performed and was negative. It is unclear whether or not any additional investigations were performed at this point, but the patient was sent home on antipyrexial treatment. His condition continued to deteriorate and he presented to casualty on 19 November 2022. In addition to delirium and intermittent temperature spikes, the admitting doctor also noted a non-itchy, non-blanching, erythematous, macular rash on the left side of the patient's abdomen. He was examined thoroughly for the presence of an eschar but none was found.

Before contacting NICD, the treating doctor had already performed a second malaria RDT which was negative, as well as a peripheral smear which was negative for malaria parasites and trypanosoma on thick and thin films. Ricketssial and arbovirus testing was also performed and the results were pending at the time of the consult. The blood culture that was taken on admission showed no growth after two days. The patient's COVID-19 PCR result was positive; however the marked thrombocytopenia was not in keeping with a typical COVID-19 infection. The blood results of note from 19 November 2022 to 20 November 2022, were a declining white cell count from 3.7 $x10^9$/L to 3.0 $x10^9$/L, a declining platelet count from 60 $x10^9$/L to 57 $x10^9$/L and declining haemoglobin level from 13.8 g/dL to 12.4 g/dL. His C-reactive protein increased from 44.6 mg/L to 53 mg/L and his procalcitonin was elevated at 1.42 ng/mL. His liver enzymes were also mildly deranged (GGT 77 IU/L, ALT 105 IU/L, AST 119 IU/L) and renal function was normal. The patient was initially treated with ceftriaxone, paracetamol and intravenous fluids.

After consultation with various specialists at NICD, samples were sent for malaria PCR, Crimean-Congo haemorrhagic fever and dengue fever testing. Doxycycline was also added to the treatment regimen to cover for tick-bite fever. On 23 November 2022, the malaria PCR came back positive for *Plasmodium ovale*. The patient was treated with artemether-lumefantrine (Coartem). He then received primaquine to eliminate the malaria relapse liver forms after his glucose-6-phosphate dehydrogenase (G-6-PD) level had been checked.

This case highlights the importance of having a high-index of suspicion for malaria in anyone who has travelled in Africa and presents with a persistent or recurrent fever, particularly if thrombocytopenia is present. Although the extensive travel history in this patient was of particular concern, malaria should be suspected even in those with no travel history who present with these symptoms, due to the possibility of odyssean malaria (https://www.nicd.ac.za/wp-content/uploads/2022/12/NICD_Communique-Monthly_Nov_20221114.pdf).

The case also highlights the need to do malaria PCR testing in anyone with negative RDTs where malaria is suspected, as not all malaria RDTs test for the presence of non-falciparum malaria, and those that do are not as sensitive because the parasitaemia is generally low. The preferred treatment in non-falciparum infections is artemether-lumefantrine. For *P. vivax* and *P. ovale*, a follow-on treatment course of primaquine is essential to eradicate the residual hepatic phase to prevent relapse. Primaquine is contra-indicated in severe G-6-PD deficiency, pregnant women and infants under six months of age. For more information on malaria, please visit the malaria page on the NICD website.

(https://www.nicd.ac.za/diseases-a-z-index/malaria/)

Source: Division of Public Health Surveillance and Response Division, NICD-NHLS, kimantham@nicd.ac.za, lucilleb@nicd.ac.za, johnf@nicd.ac.za

ZOONOTIC AND VECTOR-BORNE DISEASES

Rabies

A case of human rabies was confirmed in Limpopo Province in December 2022. The case involved an 8-year-old boy from Mbokota Village, Makhado Municipality, Vhembe District. He was admitted to hospital with a fever, confusion, delirium, trouble breathing and hemiplegia. On examination, in addition to the above, the child had oral ulcers and thrush, a septic swelling of the lower lip, swelling around the eyes with associated discharge and discharge from his ears. Signs of mild cerebral oedema were noted. A reverse transcription-polymerase chain reaction (RT-PCR) detected rabies virus RNA in an ante-mortem saliva sample that was collected. The details of possible dog-bite exposure are still unknown.

As of 13 December 2022 a total of 13 laboratory confirmed human rabies cases were reported from South Africa. These cases were from the Eastern Cape (n=7), Limpopo (n=4, including the case reported here) and KwaZulu-Natal (n=2) provinces. A further six probable cases were identified (i.e. clinically and epidemiologically in keeping with the diagnosis of rabies, but without laboratory confirmation). These cases were reported from Eastern Cape Province (n=5) and KwaZulu-Natal Province (n=1) (Figure 1).

More information about rabies disease and prevention of rabies through rabies post-exposure prophylaxis can be found at www.nicd.ac.za.

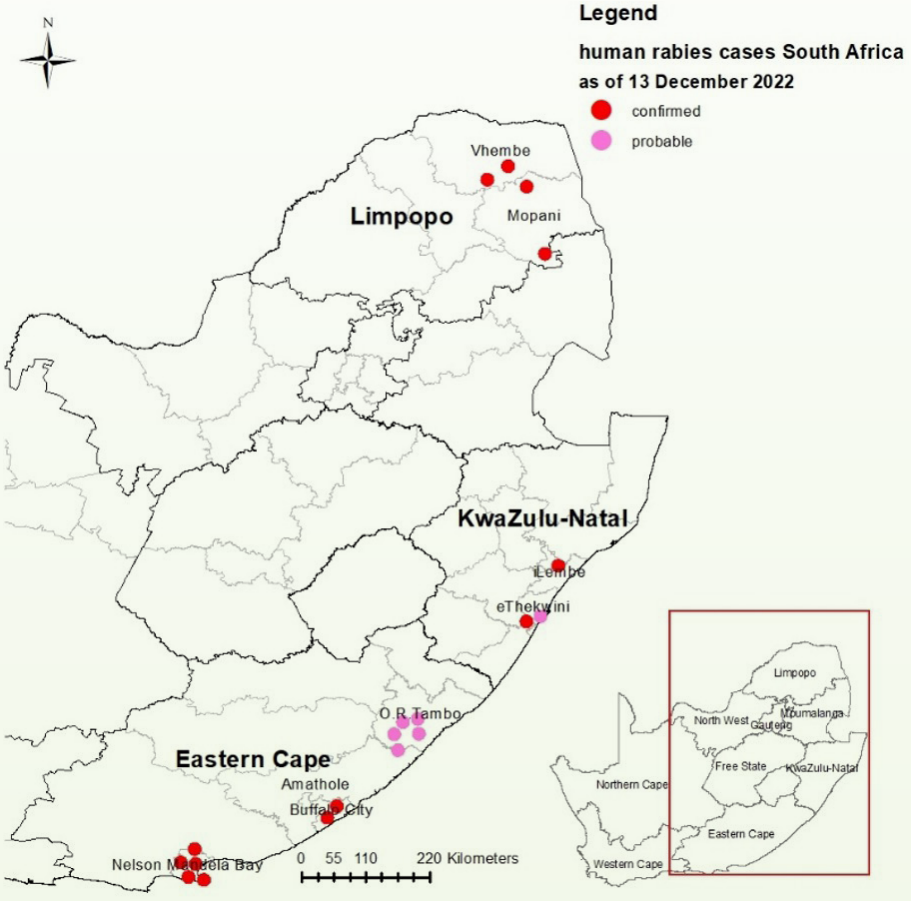

Figure 1. Distribution of laboratory-confirmed (n=13) and probable (n=6) human rabies cases in South Africa as of 13 December 2022 (Created from NHLS-NICD data).

Source: Centre for Emerging Zoonotic and Parasitic Diseases, NICD-NHLS; veerlem@nicd.ac.za

ZOONOTIC AND VECTOR-BORNE DISEASES

Current malaria situation in South Africa

Malaria is classified as a category one Notifiable Medical Condition (NMC), which requires immediate reporting via written or electronic notification within 24 hours of diagnosis. It is the responsibility of the healthcare practitioner who makes the diagnosis, following either a positive rapid diagnostic test (RDT) (bedside) test for malaria, and/or a positive test from a blood specimen submitted to a laboratory, to immediately notify the case.

Malaria cases are expected to increase, due to higher temperatures and increased rainfall in the malaria transmission areas. The National Department of Health (NDoH) has reported a total of 4 109 cases and 34 deaths for the period of January 2022 to October 2022. These figures are slightly lower than those for the same period in 2021 (4 300 cases and 49 deaths), but are likely to increase due to delayed data-capturing in the malaria information system.

Many more people will be exposed to malaria during the upcoming holiday season, due to the lifting of COVID-19-related travel restrictions and associated travel to higher transmission areas, both internally and outside the country, particularly in Mozambique (see malaria risk map). This is particularly concerning as Mozambique reported 9.4 million cases of malaria in the first nine months of the year, a 20% increase as compared to the same period in 2021.

In non-endemic areas, a large proportion of malaria cases are usually diagnosed in people with recent travel to or from malaria-endemic areas, known as imported malaria. In more rare instances, it is diagnosed in people with no notable travel history and is known as odyssean malaria. Odyssean malaria is caused by mosquitoes which have travelled and relocated to atypical areas via various transport mechanisms (sea, air, rail, road) and is generally a diagnosis by exclusion. From January 2022 to November 2022, there have been five cases of *P. falciparum* and two cases of *P. malariae* odyssean malaria reported in South Africa, with the majority of cases reported in Gauteng Province.

Individuals traveling to malaria-endemic areas are urged to take adequate anti-malaria measures. If visiting high risk areas, people should consider antimalarial prophylaxis – both doxycycline and atovaquone-proguanil are available without prescription from pharmacies. Travellers can also procure prophylactics from public sector travel clinics. All people in malaria risk areas should reduce contact with mosquitoes by limiting outdoor activity after dark, covering up bare skin (not forgetting feet and ankles), using mosquito repellents containing at least 10% DEET, ensuring mosquito screens on windows are closed, and using bed-nets, fans or air conditioning, if available. It is worth noting that malaria in South Africa is largely transmitted by outdoor biting mosquitoes, so limiting outdoor evening activities in endemic areas would be helpful. It is important to note that while these precautions will substantially reduce the chance of acquiring malaria, the risk is never completely removed.

All travellers returning from malaria-transmission areas, including very low-risk ones, should immediately report any flu-like illness (headache, fever, chills, fatigue, muscle, and joint pain) that occurs up to three weeks after potential exposure, to a healthcare professional. Children with malaria may present with non-specific symptoms (fever, loss of appetite, vomiting). Healthcare workers, particularly those in non-endemic areas, must remember to ask about travel to malaria-transmission areas in all patients who present with fever. All healthcare practitioners are advised to consider malaria as a differential diagnosis in any patients presenting with a progressive febrile condition (>38°C), even in the absence of travel history to a malaria-endemic region, especially if there is unexplained thrombocytopenia. It is also recommended that health promotion activities include creating awareness around malaria symptoms and the need to seek prompt medical assistance should these symptoms develop. There should be continued and strengthened surveillance of malaria in South Africa through the use of NMC and other relevant reporting mechanisms.

Malaria risk map, FAQs and further information on malaria prevention are available on the NICD website at www.nicd.ac.za.

Source: Centre for Emerging Zoonotic and Parasitic Diseases, NICD-NHLS; veerlem@nicd.ac.za , charlottes@nicd.ac.za, jaishreer@nicd.ac.za, shuneo@nicd.ac.za, johnf@nicd.ac.za.

ENTERIC DISEASES

Cholera – Alert for healthcare workers

The reported outbreak of cholera in Malawi is ongoing, with a total of 11 646 cumulative confirmed cases and 339 deaths reported between March 2022 and 6 December 2022. All 29 health districts in the country have been affected. Although cholera cases have not yet been reported in Mozambique, the risk of importation of cases from Malawi to neighbouring countries remains high. In addition, an increase in the number of diarrhoea cases has been reported in Bulawayo, Zimbabwe. Between May 2022 and November 2022, over 3 000 cases were reported, with the majority from three suburbs in Bulawayo, namely Luveve, Magwegwe and Mzilikazi.

Healthcare workers are advised to have a high index of suspicion for cholera in patients presenting with acute onset of watery diarrhoea, particularly if there is a history of travel to/from Malawi or neighbouring countries (including Zimbabwe and Mozambique), or if a household contact has recently travelled to these countries.

The mainstay of cholera treatment is fluid replacement. Mild-to-moderate cases may be treated with oral rehydration fluid. Severe cases require admission and intravenous administration of fluid. Antibiotic treatment is recommended for patients with moderate to severe dehydration, as it reduces disease severity and duration of illness, as well as the risk of further transmission.

The public are urged to drink water from safe water sources, ensure good hand hygiene before and after using the toilet, and before and after handling food.

Any patient presenting with acute watery diarrhoea with a history of recent travel to affected countries, or who has a household contact with recent travel to these countries, must immediately be notified as a suspected cholera case, even without laboratory confirmation.

When submitting stool specimens for microbiological testing, it is critical to request a culture for *Vibrio cholerae*, as many laboratories do not typically include this in routine testing.

Health professionals can contact the NICD 24-hour hotline on 0800 212 552 for queries or advice; please note that this service is only for health professionals.

For laboratory-related queries, please contact Mimmy Ngomane (mimmyn@nicd.ac.za; (011) 386 6235; 072 407 4667) or Juno Thomas (junot@nicd.ac.za; 073 170 8874).

Source: Centre for Enteric Diseases, NICD-NHLS, phutis@nicd.ac.za

RESPIRATORY DISEASES

Pertussis

For the year 2022, there has been an increase in pertussis cases detected in the pneumonia surveillance programme as compared to the first two years of the COVID-19 pandemic. From January 2022 to December 2022, 99 of 6 554 (1.5%) patients tested positive for pertussis. The increase in detection of pertussis cases started in July 2022, with 5.1% (5/99) of cases having tested positive in July, followed by 22.2% (22/99) in August, 27.3% (27/99) in September, 18.2% (18/99) in October, 24.2% (24/99) in November and 1.0% (1/99) in December (as of 8 December 2022) (Figure 2). The increase in laboratory-confirmed pertussis cases was predominantly detected from sentinel surveillance sites in Western Cape Province (81/99, 81.8%) (Figure 3). From 1 January 2022 to 8 December 2022, the pertussis detection rate was 3.6% (81/2 230) in Western Cape Province, 0.8% (8/968) in Mpumalanga Province, 0.4% (7/1 808) in Gauteng Province, 0.2% (1/589) in North West Province and 0.2% (2/959) in KwaZulu-Natal Province. Of all pertussis cases, 79.8% (79/99) were in children <5 years of age and of those, 68.3% (54/79) were children <3 months. Among the 96 pertussis-positive cases with data available on outcome, there were two mortalities reported, a child <3 months of age from Mpumalanga and a 49-year-old male from Gauteng.

In addition to the increase in pertussis cases identified at surveillance sites, there has been an increase in cases notified through the Notifiable Medical Conditions (NMC) surveillance system. From January 2022 to December 2022, 622 cases of pertussis were reported to the NMC, of which 583/622 (93,7%) have been reported since July 2022. More than half the cases (366/622, 58.8%) were reported from Western Cape Province. The majority of cases (369/622, 59.3%) were reported in children <5 years of age, of which 73.9% (273/369) were children aged <3 months. Among the 461 pertussis positive cases with data available on outcome, 6 mortalities were reported.

Pertussis, commonly known as 'whooping cough,' is a vaccine-preventable disease caused by *Bordetella pertussis* and is a Category 1 NMC. Clinicians are advised to be vigilant for cases, especially in very young children who may not present with typical symptoms (cough and whoop). Immunity following vaccination lasts for approximately five to six years. Episodic increases in pertussis cases occur in vaccinated populations every three to five years. Completion of childhood primary series (DTaP) and boosters is important for prevention. Clinicians are advised to be on the alert for cases, to conduct diagnostic testing where appropriate, to notify cases on the NMC app, prescribe post-exposure prophylaxis to close and high-risk contacts of suspected or confirmed cases, to vaccinate healthcare workers, and encourage pregnant woman to vaccinate where possible. Vaccination of healthcare workers against pertussis reduces transmission to vulnerable patients (e.g. neonates) and is recommended where resources are available. Maternal immunisation with acellular pertussis-containing vaccines (Tdap) is effective in preventing severe disease and mortality among young infants, before they receive their infant vaccines. NICD recommendations for pertussis diagnosis, management and public health response may be found on the NICD web page (http://www.nicd.ac.za/index.php/pertussis/). Notification forms can be accessed at http://www.nicd.ac.za/index.php/nmc/. An alert on increase in pertussis cases was posted on 13 Dec 2022 https: //www.nicd.ac.za/an-increase-in-pertussis-cases-13-dec-2022/.

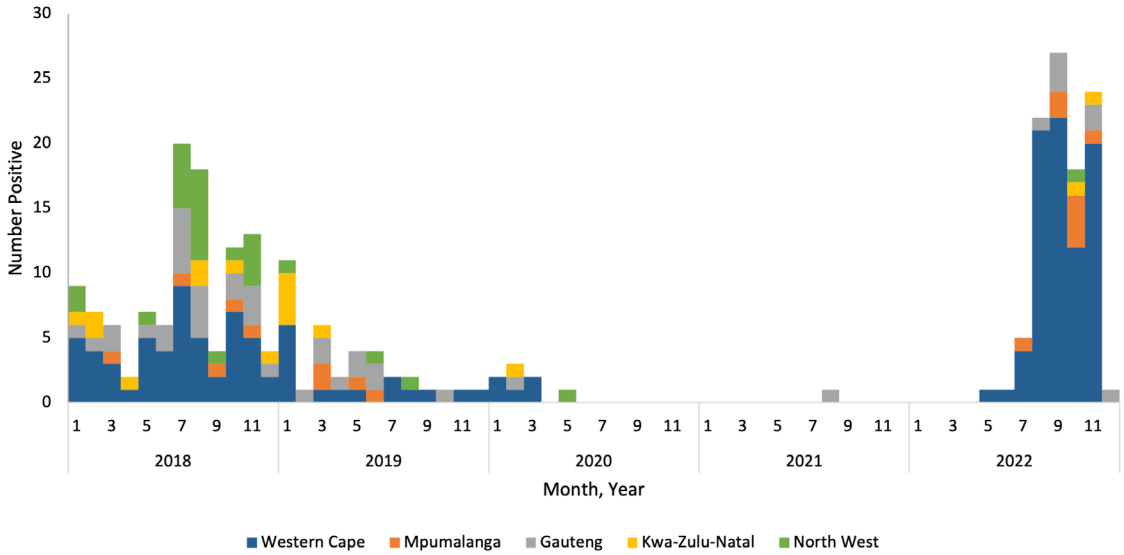

Figure 2. Number of laboratory-confirmed pertussis cases from pneumonia surveillance programme by year, month and province, South Africa 2018-2022

RESPIRATORY DISEASES

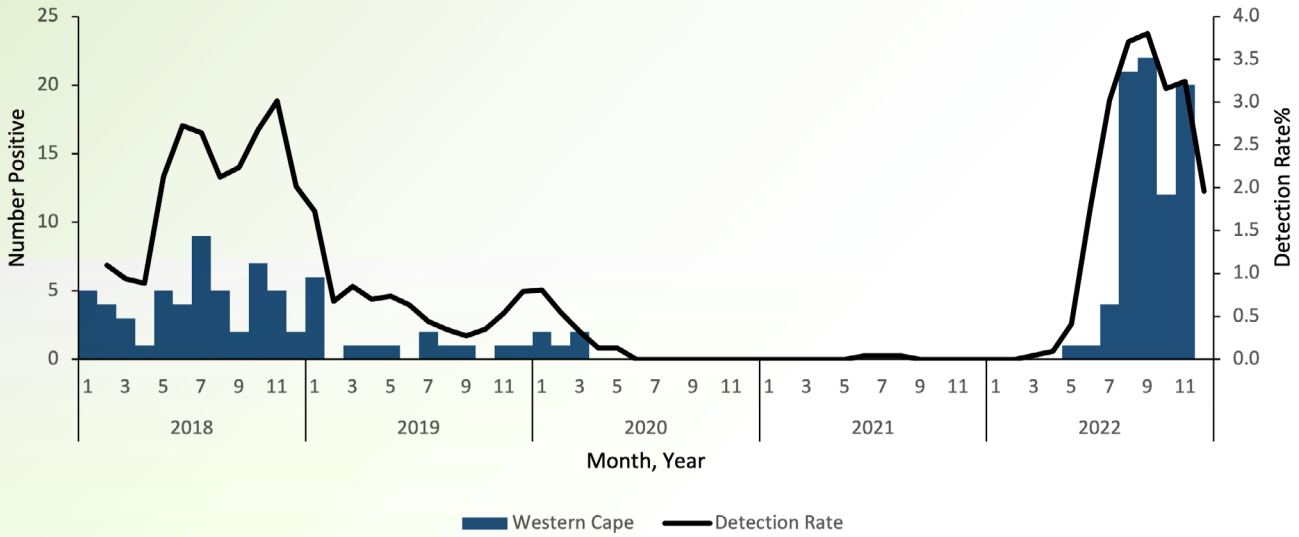

Figure 3. Number of laboratory-confirmed pertussis cases from pneumonia surveillance programme and 3-weeks rolling average detection rate by year, month in Western Cape, South Africa 2018-2022 *Increased detection rate in December, may be due to low numbers of samples tested compared to previous months.

Source: Centre for Respiratory Diseases and Meningitis, NICD-NHLS; namhlab@nicd.ac.za

VACCINES AND IMMUNOLOGY

South African measles outbreak 2022

Between 11 October 2022 and 12 December 2022, a cumulative total of 169 laboratory-confirmed measles cases have been reported across four provinces in South Africa, namely North West, Mpumalanga, Limpopo, and Gauteng. From epidemiological week 40 to week 49, laboratory-confirmed measles cases have increased in Limpopo Province and Mpumalanga Province, to 98 and 50 cases, respectively (Figure 4). A measles outbreak was declared in the Ngaka Molema District in North West Province on 2 December 2022, and in Ekurhuleni District in Gauteng Province on 6 December 2022. A total of 13 laboratory-confirmed measles cases have been reported by North West Province, whilst 8 have been reported by Gauteng Province. Of the cumulative total, 44% of cases were amongst children 5-to-9 years of age, and 28% were in children 1-to-4 years of age.

The number of measles cases in the South Africa is increasing. It is imperative to know the signs and symptoms. Measles patients present with fever, rash, and one or more of the following symptoms: cough, red eyes, and runny nose. Complications of measles include pneumonia, diarrhoea, dehydration, encephalitis, blindness, and death. Measles complications are more severe in malnourished children and young infants under 2 years of age. Persons of any age who are not vaccinated can become infected with the measles virus. Clinicians and caregivers should have a high index of suspicion for measles in anyone presenting with the aforementioned signs and symptoms. Road-to-health booklets should be checked to ensure measles vaccinations are up-to-date. Measles vaccines are given routinely at 6 and 12 months of age in public healthcare facilities and are also available in combination with rubella antigens in the private sector. It is never too late to vaccinate against measles.

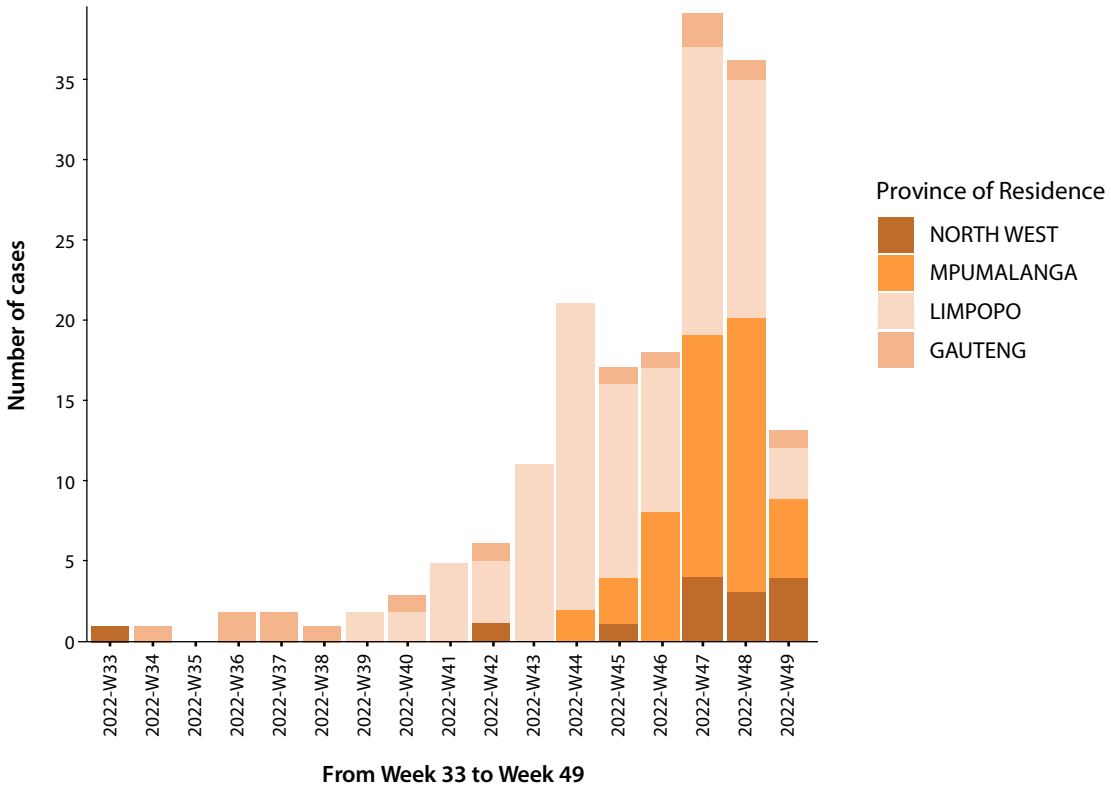

Figure 4. The epidemiological curve showing the number of measles cases in South Africa from week 33 to week 49 (14 August to 7 December), 2022 by province (*Only includes provinces that have declared an outbreak)

Source: Centre for Vaccines and Immunology, NICD-NHLS, chenoas@nicd.ac.za

TUBERCULOSIS

Tuberculosis investigation at Sarepta High School – Western Cape Province

Tuberculosis (TB) is a public health problem in South Africa. TB diagnosis in congregate settings, such as schools, warrants rigorous and timeous further investigation, as it tends to raise parental anxiety and public/media attention.[1] On 18 August 2022, the Centre for TB (CTB) at NICD was alerted (through the NHLS Greenpoint laboratory) to TB active case-finding activities at a school in Cape Town. This was prompted following confirmation of two cases of multidrug-resistant-TB (MDR-TB) in sisters with a known DR-TB contact in August 2022, as well as an earlier case of fluoroquinolone-resistant-TB in a security guard in March 2022.

A response was already in progress by the district DR-TB coordinator, and samples had already been collected. Due to consumable constraints at Greenpoint laboratory, CTB offered to process the samples. A total of 178 samples were received between 22 August 2022 and 25 August 2022, 57% of cases were female and the median age of cases was 17 years (IQR: 16 to 18). Two samples were *Mycobacterium tuberculosis* (MTB) positive, and both were susceptible to Rifampicin, resulting in a positivity rate of 1.1%. The two patients were an 18-year-old male and a 17-year-old female. Given the difference in the TB susceptibility profiles, there appears to be no epidemiological link between the index case and the two new cases.

There is currently no national guideline on TB outbreak investigation in our endemic environment. Therefore, approaches are ad-hoc and tailored to respective scenarios. Engagement with the National TB Control Programme is ongoing to develop this guideline.

1. Tuberculosis outbreaks in schools: experiences from the Western Pacific Region. Manila, Philippines. World Health Organization Regional Office for the Western Pacific; 2020. License: CC BY-NC-SA 3.0 IGO.

Source: Centre for Tuberculosis, NICD-NHLS, shaheedvo@nicd.ac.za

Mycobacterium tuberculosis

BEYOND OUR BORDERS

The 'Beyond our Borders' column focuses on selected and current regional and international diseases that may affect South Africans travelling outside the country.

Ebola – Uganda

On 20 September 2022, an outbreak of Sudan ebolavirus (SUDV) was declared in Uganda. As of 15 December 2022, 142 confirmed cases, 55 deaths (CFR = 39%) and 87 recoveries have been reported. In addition, 22 probable cases, which could not be confirmed by laboratory testing, have been recorded. Nine districts have been affected, with confirmed cases in the following: Mubende, Kassanda, Kyegegwa, Bunyangabu, Kagadi, Wakiso, Masaka, Jinja and Kampala, the country's capital. Six contacts are actively being followed-up in Kassanda District, and the follow-up rate in the past 24 hours was 100%. Cumulatively, 19 healthcare workers have been infected and 7 have died in the current SUDV outbreak. Since 30 November 2022, no new cases have been confirmed.

Multiple outbreak control interventions are being employed, with a focus on Mubende District and the surrounding districts. This includes daily coordination meetings and ongoing surveillance, laboratory testing and contact tracing. Infection prevention control, risk communication and community engagement as well as social mobilisation, are being practised throughout all nine districts and remain of utmost importance.

WHO has not recommended any limitations on travel. The global risk is considered low. The risk of importation to South Africa is considered low, however, steps are being taken to prepare for the possibility of imported cases.

Source: https://www.afro.who.int/countries/uganda/publication/ebola-virus-disease-uganda-sitrep-75

Mpox

According to WHO and as of 19 December 2022, the multi-country mpox outbreak has resulted in 82 033 laboratory confirmed cases, 1 534 probable cases and 66 deaths in 110 countries worldwide and is still considered a public health emergency of international concern (PHEIC). The name change from monkeypox to mpox was announced on 28 November 2022. The name change was implemented following consultation between WHO, global experts and extensive public engagement, in order to diminish the stigma associated with the original naming of the disease and virus.

Overall, the global risk assessment remains moderate, while the Region of the Americas is the only WHO Region to still have a high-risk status. Of the cases notified in the past four weeks, 90.5% were from this Region. Seven countries reported an increase in the number of weekly cases, with the highest being Panama. The number of laboratory confirmed mpox cases in South Africa remains unchanged, at a total of five cases to date. Sixty-eight other countries have also reported no new cases in the past 21 days. Globally, the 10 most affected countries which make up 85.7% of the cases reported, are the United States of America, Brazil, Spain, France, Colombia, the United Kingdom, Germany, Peru, Mexico, and Canada.

Overall epidemiological findings from the multi-country outbreak are as follows:

- Men make up 96.6% of all mpox cases reported, with a median age of 34 years.
- Males between the ages of 18 to 44 years make up 79.8% of all cases reported.
- Amongst cases where sexual orientation was reported, 85.3% have identified as being men who have sex with men (MSM) and 73.1% of all cases have been transmitted through sexual contact.
- At least 51.5% of all reported cases with a known HIV-status are HIV-positive.
- The most commonly reported symptoms have been any rash (mainly systemic and genital), followed by a fever, at 82.1% and 56.2% respectively.

WHO advises that all cases be monitored closely and that case-finding, laboratory investigation, contact-tracing and clinical management still be performed with care. Practising infection prevention and control and risk communication and community engagement remain of utmost importance in reducing the transmission of disease amongst our communities.

Source: https://worldhealthorg.shinyapps.io/mpx_global/

BEYOND OUR BORDERS

Polio

As of 6 December 2022, there have been 30 confirmed cases of wild poliovirus type 1 (WPV1) globally in the past 12 months, with the majority occurring in endemic countries (Pakistan n=20; Afghanistan n=2), as well as 8 cases in Mozambique. There have also been 539 cases of circulating vaccine-derived poliovirus (cVDPV) globally for the same period, with the majority being VDPV type 2 (n=457), mainly in the Democratic Republic of the Congo (n=191) and Yemen (n=158).

The 33rd meeting of the Emergency Committee under the International Health Regulations (IHR) (2005) on the international spread of poliovirus which was convened by the WHO Director-General on 12 October 2022, unanimously agreed that the risk of international spread of poliovirus remains a Public Health Emergency of International Concern (PHEIC) for a further three months. The committee considered the following factors in reaching this conclusion: the ongoing risk of WPV1 and cVDPV2 international spread, and other factors including weak routine immunization and lack of access to immunization.

Some of the proposed recommendations are for countries with local transmission to intensify and strengthen routine immunization to boost population immunity, and to encourage international travellers and long term visitors to endemic countries to receive a dose of polio vaccine prior to international travel.

Sources: http://polioeradication.org/wp-content/uploads/2022/12/weekly-polio-analyses-WPV-20221206.pdf
http://polioeradication.org/wp-content/uploads/2022/12/weekly-polio-analyses-cVDPV-20221206.pdf
https://www.who.int/news/item/01-11-2022-statement-of-the-thirty-third-polio-ihr-emergency-committee

WHO AFRO UPDATE

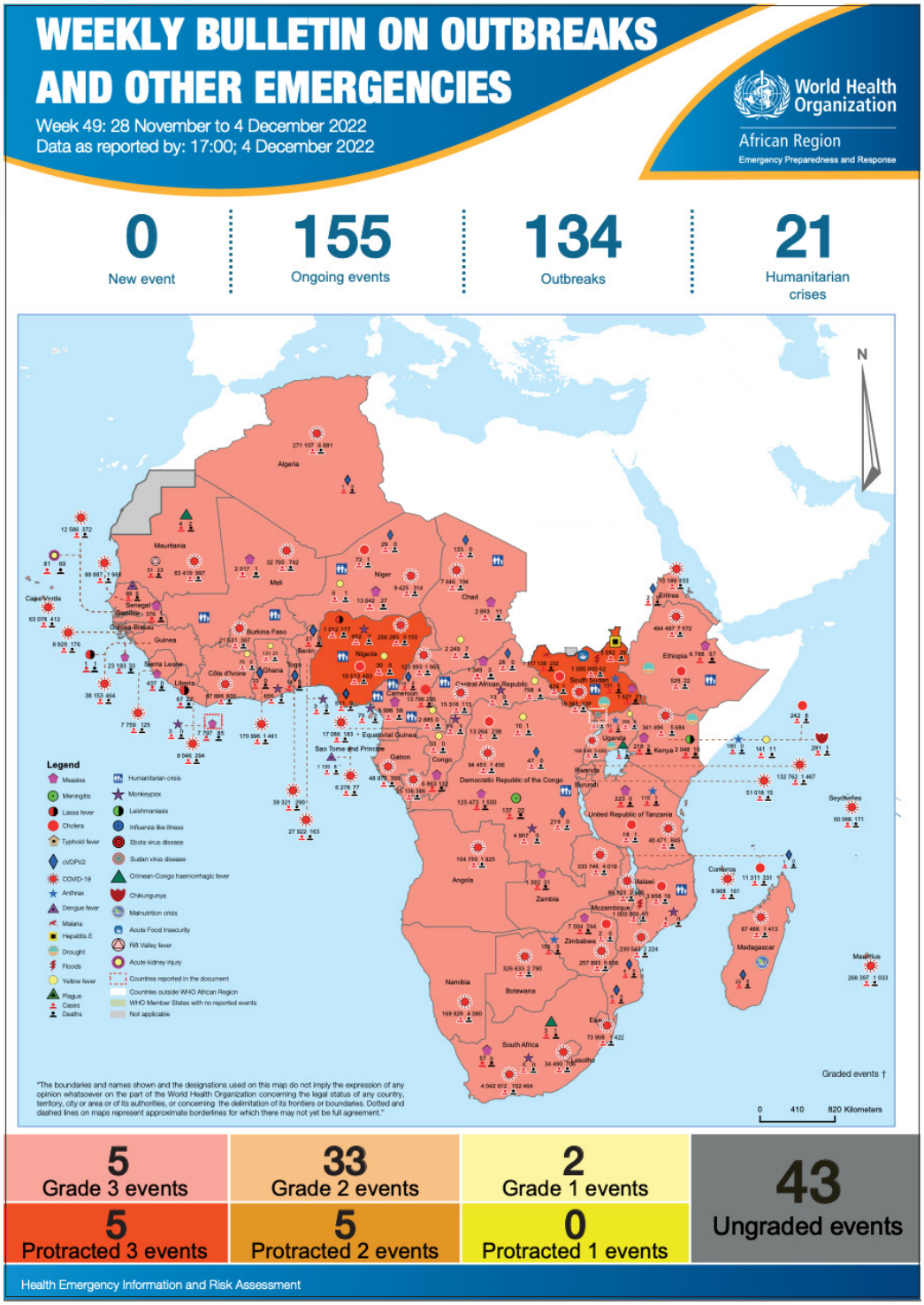

Figure 5. The Weekly WHO Outbreak and Emergencies Bulletin focuses on selected public health emergencies occurring in the WHO African Region. The African Region WHO Health Emergencies Programme is currently monitoring 155 events. For more information, see link below: https://www.afro.who.int/health-topics/disease-outbreaks/outbreaks-and-other-emergencies-updates