

Situation Summary

From 2007 to 5 February 2016, Zika viral transmission has been documented in a total of 44 countries and territories. This includes 33 countries that reported transmission in between 2015 and 2016, 6 countries with indirect evidence of transmission, and 5 countries with a history of Zika transmission but no current reported transmission.

Brazilian national authorities estimate that between 497 593 and 1 482 701 cases of Zika virus infection have occurred since the outbreak began. After Brazil, Columbia has been the most-affected country so far, with 20 297 cases reported (up to 23 January 2016) since the country's first cases were detected in October 2015.

Autochthonous transmission has been reported from Barbados, Bolivia, Brazil, Colombia, Curaçao, Costa Rica, Dominican Republic, Ecuador, El Salvador, French Guiana, Guadeloupe, Guatemala, Guyana, Haiti, Honduras, Jamaica, Martinique, Mexico, Nicaragua, Panama, Paraguay, Puerto Rico, Saint Martin, Suriname, United States Virgin Islands, Venezuela (Bolivarian Republic of) all from AMOR and Cape Verde from AFRO. Fiji, Tonga, Samoa, Solomon Islands and Vanuatu reported from WPRO and Maldives from SEARO

While countries that have reported indication of viral circulation are Gabon from AFRO, Indonesia and Thailand from SEARO and Cambodia, Philippines and Malaysia from WPRO

Brazil has concluded the investigation into 1 113 of the 4 783 cases of reported cases of microcephaly: 709 cases were discarded, 17 cases had laboratory confirmation of Zika infection, and 387 cases had radiological findings compatible with a congenital infection. Of the 17 laboratory-confirmed cases, 2 were miscarriages and the remaining 15 cases were live births. Of the 76 reported deaths due to congenital malformations, Zika virus was identified in fetal tissue of 5 cases. Although the microcephaly cases in Brazil are spatio-temporally associated with the Zika outbreak, more robust investigations and research is needed to better understand this potential link.

In the context of Zika virus outbreak, Brazil, Colombia, El Salvador, Suriname, and Venezuela have reported an observed increase of Guillain-Barré syndrome (GBS), just as French Polynesia reported during the 2013 – 2014 outbreak.

No additional cases have been reported from SEARO after the three cases (one from Maldives and two from Thailand) reported to WHO in January 2016.

Regional Risk Assessment

1. There has been documented Zika virus in South and Southeast Asia since 1978. Additionally there have been documented cases among travelers returning from Indonesia, Maldives and Thailand, as well as several documented cases within Thailand, in the past few years.
2. The principal vector for Zika virus is the *Aedes* mosquito, which is the same vector that transmits dengue and chikungunya. These mosquitoes are present in all countries in the SEA region.
3. Most cases of Zika virus that have been described within the region have had fairly mild symptoms with a few having similar symptoms to dengue and chikungunya.
4. The present issues – microcephaly and Guillain-Barre syndrome – thus far have only been documented in Brazil and French Polynesia respectively.

A risk assessment tool is being drafted and will be shared as soon as developed.

Recommendations

Considering its expanded transmission in the Region of the Americas, and since the mosquito vector is present in most countries of our Region, WHO urges the Member States where the *Aedes* mosquito is circulating to continue their efforts to implement an effective public communications strategy aimed at reducing vector density

Surveillance

Zika fever surveillance should be set up based on the existing surveillance system for dengue and chikungunya, while taking the differences in clinical presentation into account. As appropriate for the epidemiological situation, surveillance should be focused to

- (i) determine if the Zika virus has been introduced to an area,
- (ii) monitor the spread of Zika virus fever once it is introduced, and
- (iii) monitor for neurological and autoimmune complications, as during some Zika virus and dengue outbreaks there have been reports of neurological and autoimmune complications. Member States are recommended, particularly in situations of possible ZIKV circulation, to establish or strengthen surveillance of neurological syndromes, of all age groups. This surveillance of neurological syndromes will contribute in establishing the possible relationship between neurological complications, Zika virus infection and previous infection with other agents.

In countries **without** autochthonous transmission of Zika virus infection, they are recommended to:

- Strengthen event-based surveillance to detect the first cases. Health authorities must be on alert for the emergence of clusters of rash febrile syndrome of unknown etiology (in which dengue, chikungunya, measles, rubella, and parvovirus B19 have been ruled out), and test for Zika virus infection

In countries **with** autochthonous transmission of Zika virus infection, they are recommended to:

- Monitor the trend and geographical spread of the virus to detect the introduction into new areas;
- Monitor potential neurological and autoimmune complications, as well as the impact on public health;
- Identify risk factors associated with Zika virus infection, and when the capacity exists,
- Identify circulating Zika virus lineages.

These efforts will be the basis for developing and maintaining effective control measures. Once the introduction of the virus is documented, ongoing surveillance should be maintained in order to monitor epidemiological and entomological changes that may affect the transmission of Zika virus. Any changes detected by the surveillance system should be promptly communicated to the national authorities in order to ensure timely decisions for actions as warranted.

Please see below is a provisional case definition for Zika virus infection. ***HQ is convening a meeting to finalize and harmonize the definition***

- **Suspected case:** Patient with rash or elevated body temperature ($> 37.2^{\circ}\text{C}$) with one or more of the following symptoms (not explained by other medical conditions):
 - Arthralgia or myalgia
 - Non-purulent conjunctivitis or conjunctival hyperemia
 - Headache or malaise
- **Confirmed case:** A suspected case with laboratory positive result for the specific detection of Zika virus

Preparedness

Information of lab detection and procedures which will be share with you in due time

Response

International reporting

Given the recent introduction of Zika virus in the Americas and to contribute to integrated arbovirus surveillance, national public health authorities are encouraged to inform WHO through the established International Health Regulations (IHR) channels, any laboratory-confirmed cases of Zika virus infection that are registered in the countries of the Region.

Case management

There is no specific antiviral treatment for Zika virus. Symptomatic treatment after excluding more severe conditions such as malaria, dengue, and bacterial infection is recommended.

It is important to differentiate Zika virus infection from dengue due to severe clinical outcomes in some dengue cases. In addition, cases of co-infection, Zika and dengue, could occur. Compared with dengue, Zika virus infection has a mild to moderate clinical picture, the onset of fever is more acute and shorter in duration, and no shock or severe bleeding has been observed.

Because Zika virus outbreaks could cause additional burdens on all levels of the health care system, it is necessary to develop and implement protocols and well established plans for the patient screening and treatment.

Treatment

- There is no vaccine or specific treatment for Zika virus infection. Therefore, treatment is geared toward relieving symptoms.
- Treatment is symptomatic and supportive, including rest and the use of acetaminophen or paracetamol to relieve fever. The use of antihistamines to control pruritus usually associated with the maculo-papular rash could be recommended.
- Using aspirin is not advised due to the risk of bleeding and developing Reye's syndrome in children younger than 12 years of age. The use of other nonsteroidal anti-inflammatory drugs is not advised either, since the cause of the clinical symptoms could be dengue or chikungunya, pathologies in which the use of Non-steroidal Anti-inflammatory Drugs (NSAIDs) is contraindicated.
- Patients should be advised to drink plenty of fluids to replenish fluid lost from sweating, vomiting and other insensible losses.

Patient isolation

To prevent infection of other persons, a Zika virus-infected patient should avoid being bitten by *Aedes* mosquitoes during the first week of illness (viremic phase). The patient is recommended to stay under a bed net (treated or without insecticide), or stay in a place with intact window/door screens. In addition, physicians or health care workers who attend to Zika virus-infected patients should protect against mosquito bites by using insect repellent and wearing long sleeves and pants.

Prevention and control measures

Prevention and control measures directed at the reduction of vector density are fundamental and can prevent transmission if effective.

The Integrated Management Strategy for the Prevention and Control of Dengue (IMS –Dengue) provides the basis for preparedness for Zika virus. In the current situation, the intensification of comprehensive prevention and control of IMS-dengue is recommended. These recommendations include:

- Intersectoral participation and collaboration at all levels of government and health, education, environment, social development and tourism sectors.
- Participation of non-governmental organizations (NGOs) and private organizations; Maintain risk communication and mobilization for the whole community.

Mosquito control is the only measure that can interrupt the transmission of vector borne viruses such as dengue, chikungunya, and Zika.

information of Integrated Vector Management which will be shared with you in due time.

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