Global Health Cast 33 April 11, 2023



Every Week

12.00 noon - CET

Dr. Melvin Sanicas

Prof. Dr. Joe Schmitt



What we talk about today

- COVID-19 update
- **SARS-CoV-2** Variants
- Most infectious diseases the WHO has identified to date
- Nipah Virus
- Pandemic potential of avian influenza (H5N1)
- Efficacy of bivalent RSVpreF vaccine to prevent RSV in infants



Figure 1. COVID-19 cases reported by WHO Region, and global deaths by 28-day intervals, as of 26 March 2023**





Figure 2. Percentage change in confirmed COVID-19 cases over the last 28 days relative to the previous 28 days, as of 26 March 2023**



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Weekly epidemiological update on COVID-19 - 30 March 2023 (who.int)

Figure 3. Percentage change in confirmed COVID-19 deaths over the last 28 days relative to the previous 28 days, as of 26 March 2023**





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Weekly epidemiological update on COVID-19 - 30 March 2023 (who.int)

Table 2. Weekly prevalence of SARS-CoV-2 VOIs and VUMs, week 6 to week 10 of 2023

Lineage	Countries	Sequences	2023-06	2023-07	2023-08	2023-09	2023-10
XBB.1.5*	90	115 426	35.63	39.27	42.97	46.99	45.06
BQ.1*	141	399 188	22.68	18.40	14.18	10.73	8.37
BA.2.75*	119	100 181	7.09	6.20	6.00	2.94	1.71
CH.1.1*	85	36 425	7.17	7.12	7.02	6.89	6.43
XBB*	119	73 147	6.15	7.40	9.63	12.88	19.73
XBF*	47	8063	1.40	1.29	1.25	1.19	1.40
Other ⁺	207	6 685 701	1.07	1.32	1.16	1.16	4.89
Unassigned	95	286 544	7.23	9.61	9.81	11.74	11.87

^{*}Denotes descendent lineages. The prevalence XBB.1.16* is included in XBB*. ⁺Others are other circulating lineages excluding the VOI, VUMs, BA.1*, BA.2*, BA.3*, BA.4*, BA.5*

Currently, WHO is closely tracking **one variant of interest (VOI)**, XBB.1.5, **and six variants under monitoring (VUMs)**. The VUMs are BQ.1, BA.2.75, CH.1.1, XBB, XBF and XBB.1.16; XBB.1.16 was added to this list on 22 March 2023. XBB.1.16 is a recombinant of BA.2.10.1 and BA.2.75 and has three additional mutations in the SARS-CoV-2 spike protein (E180V, F486P and K478R) compared to its parent lineage XBB.



9 of the most infectious diseases the WHO has identified to date:

- Nipah virus
- Crimean-Congo hemorrhagic fever
- Lassa fever
- Rift Valley fever
- Zika
- Ebola and Marburg
- Middle East respiratory syndrome (MERS)
- Severe acute respiratory syndrome (SARS)

Disease X (any unknown pathogen that could cause a future outbreak)



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Nipah Virus Transmission and Mortality





Impact of Nipah Virus

- Fatality rate among those infected ranges from 40% to 70%.
- 200 lives lost in Bangladesh in the last 20 years due to yearly outbreaks.
- Since the first reported case in 1999 in Malaysia, there have been 300 human cases and more than 100 deaths.
- Substantial economic impact as more than 1 million pigs were euthanized to contain the outbreak.
- Outbreaks have been recorded annually in some parts of Asia since then primarily in Bangladesh and India.



How to prevent Nipah Virus infection

Avoid consuming raw date palm sap or fruits contaminated or partly eaten by bats



Wash hands regularly with soap and clean water



With patients

Try to avoid coming into close contact with the patient

Cover nose and mouth when going near to the patient

Wash hands with soap and water after handling the patient



Healthcare workers need to follow strict infection control measures with suspected or confirmed cases

Nipah virus (who.int)



Next influenza pandemic:

H5N1?



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Does active bivalent preF-RSV RSV vaccination during pregnancy reduce the burden (RSV)– associated lower respiratory tract illness in infants?

METHODS

Double-blind- 1:1-randomized, 18 countries, pregnant women at 24 through 36 weeks' gestation

1 single intramuscular injection of 120 μ g of a bivalent (RSVpreF) vaccine or placebo.

Endpoints at days 90, 120, 150, 180 after birth

- medically attended severe RSV-associated LRTI (MA<u>S</u>-RSV)
- medically attended RSV-associated LRTI (MA-RSV)

RESULTS

3682 / 3676 pregnant women received vaccine / placebo; 3570 / 3558 infants were evaluated.

 MAS-RSV 90 days:
 6 vaccine group infants versus 33 infants placebo group:
 VE: 81.8%; 99.5% CI, 40.6 to 96.3);

 180 days:
 19 cases versus 62 cases:
 VE: 69.4%; 97.58% CI, 44.3 to 84.1).

 MA-RSV
 90 days:
 24 vaccine group infants versus 56 infants placebo group
 VE: 57.1%; 99.5% CI, 14.7 to 79.8); (n.s.)

Reported AE within 1 month after injection or within 1 month after birth were similar in the vaccine group (13.8% of women and 37.1% of infants) and the placebo group (13.1% and 34.5%, respectively).

CONCLUSIONS

RSVpreF during pregnancy was effective against medically attended severe RSV-associated LRTI in infants, no safety concerns were identified. (Funded by Pfizer; MATISSE ClinicalTrials.gov number, NCT04424316.)



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B Medically Attended RSV-Associated Lower Respiratory Tract Illness



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