Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Travel Medicine and Infectious Disease 18 (2017) 75–76

Contents lists available at ScienceDirect

Travel Medicine and Infectious Disease

journal homepage: www.elsevierhealth.com/journals/tmid

Zika in India and the need for transparent reporting

Dear Editor

We read with great interest a recent paper published in *Travel Medicine and Infectious Diseases* [1], indicating the challenges of co-circulation of arboviruses in South America and would like to highlight the situation with regard to Zika virus in India and the dangers of its under-reporting. On 15 May 2017, India reported its first three laboratory confirmed cases of Zika virus to World health Organization (WHO). However, these cases were confirmed during November 2016 to February 2017, but public outreach was circumvented to avoid panic among citizens [2]. Hiding of Zika cases by the Government of India has created consternation among international community. Under the International Health Regulations (IHR), a legal instrument binds on all WHO member states, governments are required to notify WHO of unusual health events within 24 hours [3]. Although WHO has declared Zika public health emergency to end in November 2016, the same month in which first case of Zika was identified in India, but we feel that Government of India should have informed national and global community to take precautionary measures. *Aedes aegypti*, a primary competent vector for Zika virus transmission is not only confined to India but also widely distributed in surrounding countries including Pakistan, China, Nepal, Bhutan and Bangladesh [4]. The Zika virus can establish itself in any tropical and temperate region with *Aedes* mosquitoes. We believe that keeping the Zika incidence under wraps could have transmitted disease to the adjacent countries by the cross-border movements. Such incidents of immediate Zika transmission from neighboring countries have previously been reported. On August 27, 2016, Singapore confirmed its first case of Zika and just after few days Malaysia reported Zika virus in a woman following her visit to Singapore [5]. Moreover, Singapore's swift response and transparency in reporting not only won the praise of WHO but also sparked warnings in neighboring countries.

By not disclosing the information in real time, India behaved as China did in the case of the severe acute respiratory syndrome (SARS) outbreak in 2003. China was widely criticized by the global community for trying to cover up the outbreak and the Chinese government was considered arguably partly responsible for SARS spreading to the other countries [6]. It is worth mentioning that none of the Zika-infected cases and their spouses or relatives had travelled to any country with Zika virus transmission which provides evidence of local circulation of virus and new cases may occur in the future [2]. Since the disclosure, India has been elevated in WHO's Zika virus classification from category 4 (area with established competent vector but no known documented past or current transmission) to category 2 (area either with evidence of virus circulation before 2015 or area with ongoing transmission that is no longer in the new or re-introduction phase, but where there is no evidence of interruption). It is pertinent to mention that most of the countries in category 4 are adjacent to India and there is high propensity of disease spillover to these regions due to the presence of multiple modes of Zika virus introduction and spread. Moreover, WHO's risk assessment suggested the significant fear of disease spread due to the wide geographical distribution of *Adese* mosquitos in various regions of the world [2]. Pakistan has history to follow disease outbreak in India due to similar climatic conditions and unchecked border crossings. Recently, Pakistan braved its first chikungunya outbreak soon after its outbreak in India [7]. We believe that collaborative efforts among countries on vector surveillance and control could go a long way. Moreover, in global public health scenario, India has the responsibility to keep the WHO and the global community informed, especially in the case of dreaded infectious diseases, for both global risk assessment and risk preparedness. Considering the potential risks of extraordinary clustering of microcephaly in newborns and Guillain-Barre syndrome in adults, we urge WHO to declare Zika a Public Health Emergency of International Concern (PHEIC).

Conflict of interest

None.

References

[1] Rodriguez-Morales AJ, Villamil-Gómez WE. Franco-Paredes C the arboviral burden of disease caused by co-circulation and co-infection of dengue, chikungunya and Zika in the Americas. Travel Med Infect Dis 2016 May-Jun;14(3):177–9. http://dx.doi.org/10.1016/j.tmaid.2016.05.004.

[2] Zika virus infection – India. World health organization (WHO) emergencies preparedness and response; disease outbreak news. May 26, 2017. http://www.who.int/ihr/publications/9789241596664/en/ (accessed: July 7, 2017).

[3] WHO. International health Regulations 2005. third ed. France: World Health Organization Press; 2016.

[4] Sahu PS, Sahu M, Ambu S. A review of concurrent infections of malaria and dengue in Asia. Asian Pac J Trop Biomed 2016;6(7):633–8.

[5] Press statement by ministary of health Malaysia. The 1st Zika virus case in Malaysia. Published: Sep 05, 2016. http://www.moh.gov.my/english.php/database_stores/store_view_page/22/448 (accessed: July 7, 2017).

[6] Zhao Jinqiu. The SARS epidemic under China's media policy. Media Asia 2016;30(4):191–6.

[7] Mallhi TH, Khan YH, Khan AH, Tanvir N, Qadir MI. First chikungunya outbreak in Pakistan: a trail of viral attacks. New Microbes New Infect 2017;19:13–4. http://dx.doi.org/10.1016/j.nmni.2017.05.008.

Tauqeer Hussain Mallhi*, Yusra Habib Khan
Discipline of Clinical Pharmacy, School of Pharmaceutical Sciences, Universiti Sains Malaysia, Penang 11800, Malaysia

Nida Tanveer
Punjab Medical College, Faisalabad, Pakistan

http://dx.doi.org/10.1016/j.tmaid.2017.07.005

Amer Hayat Khan
Discipline of Clinical Pharmacy, School of Pharmaceutical Sciences, Universiti Sains Malaysia, Penang 11800, Malaysia

Allah Bukhsh
Institute of Pharmaceutical Sciences, University of Veterinary & Animal Sciences, Lahore, Pakistan

* Corresponding author.
E-mail address: tauqeer.hussain.mallhi@hotmail.com (T.H. Mallhi).

5 July 2017
Available online 11 July 2017