

Overview

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- This weekly bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 42 events in the region. This week's edition covers key ongoing events, including the:
 - Undiagnosed paediatric eruptive fever in Cameroon
 - Dengue fever in Côte d'Ivoire
 - Hepatitis E in Niger
 - Humanitarian crisis in the Democratic Republic of the Congo
 - Humanitarian refugee crisis in Uganda
 - Humanitarian crisis in Madagascar
 - Humanitarian crisis/acute watery diarrhoea in Ethiopia
- For each of these events, a brief description followed by public health measures implemented and an interpretation of the situation is provided.
- A table is provided at the end of the bulletin with information on all new and ongoing public health events currently being monitored in the region, as well as events that have recently been closed.
- Major challenges include:
 - A serious but little-known humanitarian crisis in the Kasai Region of the Democratic Republic of the Congo, with devastating consequences. Humanitarian access is severely constrained, aggravating the dire humanitarian need.
 - The unprecedented influx of refugees in Uganda, especially from South Sudan, constraining the current response capacity.

Ongoing events

Undiagnosed paediatric eruptive fever

Cameroon

52
Cases

20
Deaths

38.5%
CFR

Event description

An insidious and atypical paediatric eruptive fever of an unknown etiology emerged in the northern regions of Cameroon on 16 February 2016. Retrospective investigation established that the initial cases developed the illness between November and December 2015. As of 21 July 2017, a total of 52 suspected cases, including 20 deaths (case fatality rate 38.5%) have been reported in eight health districts in the Far North Region, and one health district in the Northern Region.

The initial investigations conducted in early 2017 made a probable diagnosis of visceral and cutaneous leishmaniasis, on account of compatible results in seven cases analysed at the Centre Pasteur du Cameroun (CPC). However, inconsistencies in the clinical presentation and epidemiology of the disease prompted further testing at the Carlos III Health Institute, Madrid, which later ruled out leishmaniasis, histoplasmosis, aspergillosis, and other emerging and rare mycoses.

In view of the progression of the epidemic, the high fatality rate and the worsening health status of the reported cases (most of whom had returned to the community), the Cameroon Ministry of Public Health and WHO carried out an in-depth investigation from 10-21 July 2017. Active search using simplified community case definition identified 55 cases, of which four met the suspected case definition of persistent fever lasting more than 2 weeks, with associated skin lesions not attributed to other causes. Ten children were closely examined by the team of experts, and blood samples and biopsies were collected from nine children – results are pending. Of the children examined:

- Four were new suspected cases; of which, three had an illness suggestive of African Kaposi's sarcoma (with maculopapular rashes and lymphadenopathies). The case-patients were not responsive to antibiotic and systemic corticosteroid therapies; however, at least one case-patient was improving on antiprotozoal treatment.
- Three were previously diagnosed with leishmaniasis (at CPC) during the initial investigations; of which, two had since spontaneously healed without treatment, but were left with extensive scarring, and one possibly had lupus erythematosus or visceral leishmaniasis.
- Two children had cutaneous/subcutaneous nodules and papules without a history of persistent fever.
- One child did not have a rash and the illness was attributed to severe malnutrition.

Of the households surveyed in the affected communities, all shared their homes with livestock, 57% did not use long lasting insecticide treated nets (LLINs), and 86% used pesticides. Entomological investigations were not performed due to logistical challenges. Screening of 33 community members in Mokolo for leishmaniasis by rapid diagnostic test (RDT), found only evidence of past exposure in individuals aged 15-44 years (100% of 10 adults screened were RDT positive). Whereas there was limited evidence of past exposure in children aged less than 15 years (only one teenager was RDT positive out of 22 children screened).

Public health actions

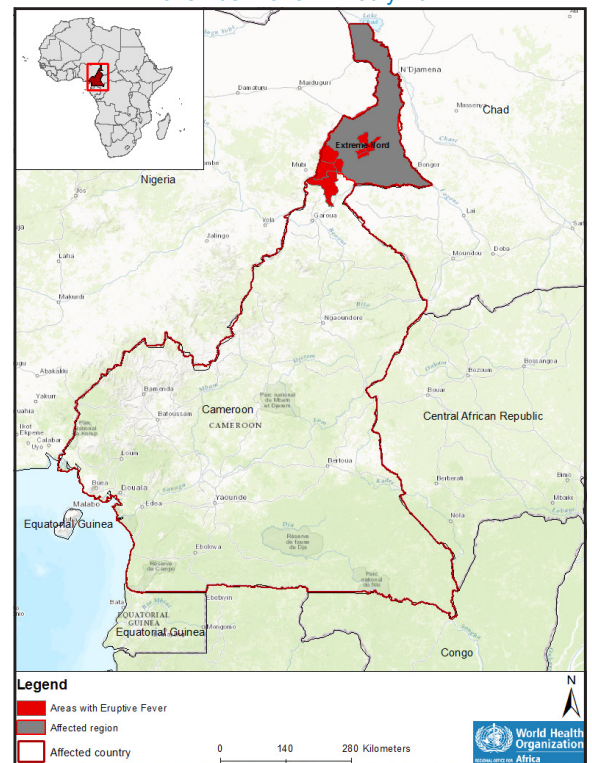
- WHO supported the Ministry of Public Health to deploy a team of experts made up of an epidemiologist, entomologist, clinician, and laboratory scientist to the affected region from 10-21 July 2017.
- Case monitoring and passive surveillance activities continue.
- Routine sampling and testing of cases by CDC-Atlanta is planned for newly presenting cases, and previous samples collected.
- WHO will support the country to develop case management and prevention strategies as soon as the diagnosis has been ascertained.

Situation interpretation

The identification of the cause of the insidious atypical paediatric eruptive fever in Cameroon continues to elude investigators. There is some evidence pointing to leishmaniasis but this has not been definitively confirmed as many cases (including some of those who died) do not fit the typical clinical presentation of leishmaniasis. The recent investigations suggested non-human immunodeficiency virus-related endemic African Kaposi's sarcoma as a possible diagnosis for some patients, but this too remains to be confirmed through histology, testing for human herpesvirus 8, and investigations of comorbidities. Further laboratory investigations of previously and newly collected blood samples and biopsies are eagerly awaited.

These investigations have faced several challenges, including difficulties in locating cases since many families are currently absent from home during the sowing season, limited public health staff for further follow up and investigation, and the absence of traps to conduct entomological investigations. The situation has also been worsened by the ongoing humanitarian crisis in the Far North Region of Cameroon, triggered by the influx of refugees and internally displaced persons due to insecurity in north-east Nigeria. The underlying high levels of food insecurity and malnutrition, combined with limited access to basic medical and social services, may be driving immunosuppression in the community, and in turn, contributing to this event.

Geographical distribution of undiagnosed paediatric eruptive fever cases in Cameroon, November 2015 - 21 July 2017



Event description

The dengue fever outbreak in Côte d'Ivoire (mainly in Abidjan city) continues to evolve, with the trend generally increasing. Between 4 and 11 July 2017, 142 new suspected cases were reported, compared to 37 new cases reported from 27 June to 3 July 2017. As of 11 July 2017, a total of 623 suspected cases including two deaths (case fatality rate 0.3%) have been reported since the initial cases were detected on 22 April 2017. A total of 192 cases have been confirmed by polymerase chain reaction (PCR). Of these, 66% were dengue virus serotype 2 (DENV-2), 28.7% were DENV-3 and 5.2% were DENV-1. In addition, 90 samples were confirmed IgM positive by serology.

The majority of cases are being reported from Abidjan city. Cocody Bingerville, a health district in Abidjan, remains the epicentre of the outbreak, accounting for 78% of the total reported cases and 80% of the confirmed cases. About 55% of the affected people are aged 30 years and above, while 27% are between 15 and 29 years. Women are slightly more affected with 54% of the cases. The main predisposing factors for the outbreak are the ongoing rainy season, the high density of mosquito breeding sites, and insufficient community awareness on mosquito breeding and biting habits.

The suspected dengue fever outbreak in Abidjan was reported on 22 April 2017. The outbreak was later confirmed by the Institut Pasteur de Côte d'Ivoire (IPCI) on 28 April 2017 and the Ministry of Health (MoH) of Côte d'Ivoire notified WHO on 6 May 2017.

Public health actions

- The MoH through the Institut National d'Hygiène Publique (INHP) is coordinating the response to the outbreak.
- Vector control interventions are ongoing, including destruction of mosquito breeding sites (destroying, altering, removing, or recycling non-essential containers that provide larval habitats) and fumigation. To date, a total of 258 129 mosquito breeding sites have been destroyed/treated in 17 678 households visited.
- Active surveillance is being improved including dissemination of the case definition, active case finding, collection of samples for laboratory confirmation, and involvement of the private health sector. Private and public health sector personnel have been trained on disease surveillance and case management.
- Field investigation is being systematically performed and feedback on the findings is being provided.
- Community engagement is being strengthened through political, religious and community leaders' sensitization, as well as involvement of town mayors in disease prevention and control.

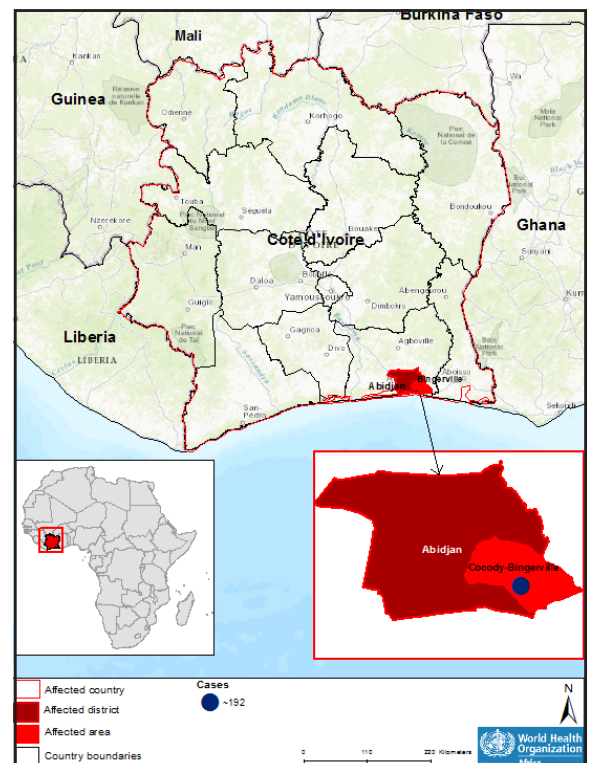
Situation interpretation

The current dengue fever outbreak in Côte d'Ivoire is taking place within the broader context of emergence of the disease in West Africa. The outbreak comes after recent outbreaks in Cape Verde and Burkina Faso, and ongoing suspected dengue fever outbreaks in Togo and Nigeria. Phylogenetic analysis of infected cases from Cote d'Ivoire showed homology with the strain responsible for the Burkina Faso outbreak. This is indicative of wider circulation of the virus in this part of Africa. The assessment performed at the beginning of the outbreak revealed high entomological indices. In addition, the current weather conditions and coastal location, including urban and semi-urban settings, denote the potential risk for dengue outbreak in Côte d'Ivoire.

The disease trend is increasing despite ongoing control measures. This is probably due to inadequate response efforts directed towards the control of the outbreak. Appropriate technical and financial support should be given to the country to avoid a large outbreak, as well as regional spread. This risk of regional spread is valid, as Abidjan is a business hub in West Africa, with high population movement both internally and with neighbouring countries.

The laboratory diagnostic capacity should be improved through provision of rapid diagnostic test kits at the health facility level, as well as reagents at the Institut Pasteur de Côte d'Ivoire. Based on the current trend of the disease in the WHO African region, all countries need to assess the risk of dengue fever outbreak and put in place adequate preparedness measures for timely detection and response.

Geographical distribution of dengue fever cases in Côte d'Ivoire, 22 April - 11 July 2017



Event description

The outbreak of hepatitis E in the Diffa Region of Niger continues to evolve. During week 29 (week ending 23 July 2017), 55 new suspected cases and no deaths were reported, compared to 74 new cases recorded in week 28 (week ending 16 July 2017). Between 2 January and 22 July 2017, a cumulative total of 1 446 suspected/confirmed cases including 38 deaths (case fatality rate 2.6%) have been reported. Adults between the ages of 20 and 34 years were the most affected and females accounted for 58% of the reported cases. Approximately 88% of the cases came from Diffa, N'Guigmi and Bosson health district in the Diffa Region.

Of the 1 446 suspect cases, 1 213 samples were collected and shipped to the Institut Pasteur Dakar (IPD) for analysis, representing 83.9% of the suspect cases. Of the 653 samples analysed between 11 April and 5 July 2017, 441 (67.5%) were positive for hepatitis E virus by PCR. Recent laboratory results from IPD released on 20 July 2017 confirmed hepatitis E in Zinder and Tahoua Regions for the first time.

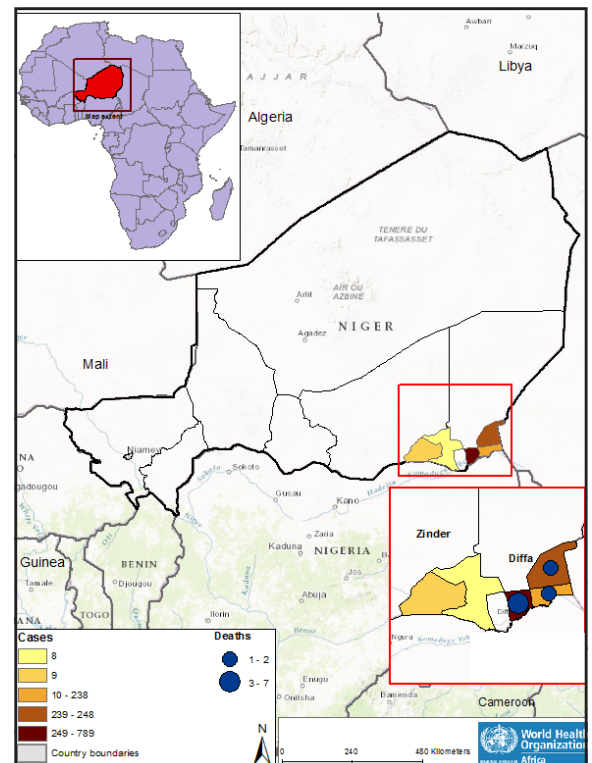
Public health actions

- The contingency plan was activated and weekly technical meetings are being held to coordinate outbreak response activities.
- Epidemiological surveillance is being strengthened in all the affected regions including active case search and mandatory reporting.
- The database is being managed, including line listing of suspected cases at the regional health directorates.
- Free medical treatment is being provided at all levels including referral of severe cases, mainly supported by WHO and Médecins Sans Frontiers.
- Authorities continue to collect and transport blood samples from suspected cases for analysis at the reference laboratory.
- Water, sanitation and hygiene (WASH) activities are ongoing in the affected regions (Diffa, Tahoua and Zinder), including trucking of drinking water, disinfection and chlorination at water points, distribution of chlorine tablets (Aquatab) to households, and installation of hand washing facilities at the health centres.
- Risk communication has been established with all administrative authorities and other public sector and religious leaders, engaging communities on correct personal and community hygiene practices, preventive measures and the need for early healthcare seeking, particularly among pregnant women.

Situation interpretation

The outbreak of hepatitis E in the Diffa Region of Niger continues to progress, with two other regions newly affected. The current response measures appear not to be halting further spread of the disease. The major drivers of the outbreak remain limited access to safe drinking water, inadequate sanitation, and poor personal and food safety practices – perpetuating the faecal-oral transmission cycle. Diffa Region, the epicentre of the outbreak, has vulnerable populations displaced by insecurity and conflict in the subregion. These communities face several challenges including food insecurity, limited access to essential healthcare services, access to clean water and proper sanitation. The onset of the rainy season, in the next few months, is likely to aggravate the outbreak situation. It is crucial for the Ministry of Health and international partners to scale up outbreak control interventions, especially provision of safe water and improved sanitation. There is also a need to improve epidemiological surveillance, including timeliness and completeness of reporting in the affected and non-affected regions.

Geographical distribution of hepatitis E cases in Niger, 2 January - 23 July 2017



Humanitarian crisis Democratic Republic of the Congo

Event description

A serious, but little-known, humanitarian crisis has been ongoing in the Democratic Republic of the Congo as a result of protracted civil and political unrest. The fighting and insecurity is mostly in the provinces of South- and North-Kivu, Ituri, Tanganyika, and Haut-Katanga. Since mid-August 2016, the security situation has significantly deteriorated in the Kasai Region. The insurgency has been characterized by armed confrontation, attacks on civil communities, extortion and looting of properties, arrest and unlawful detention of civilians, and gross human rights abuses. Over 600 cases of sexual-based violence have been reported since mid-August 2016. Overall, 7.3 million people are in need of humanitarian assistance, 5.9 million people are food insecure, 3.8 million people are internally displaced (1.4 million people in the Kasai Region alone), and there are 464 078 refugees. The major humanitarian needs include protection, food insecurity and access to basic social services such as healthcare, water, sanitation, shelter, and education. Humanitarian access is severely constrained, aggravating the dire humanitarian need.

Recent nutritional surveys revealed a nutritional crisis in several provinces, with global acute malnutrition (GAM) as high as 15% and severe acute malnutrition (SAM) at 4% (beyond the emergency thresholds) observed in certain areas. The situation is particularly bad in Dibaya and Kazumba territories (Kasai-Central), Kamonia (Kasai), Kabeya-Kamwanga and Miabi (Kasai Oriental), and Lusambo (Sankuru).

Over 170 health centres in Kasai and Kasai Central Provinces have been looted since the beginning of the insurgency in August 2016. As a result, more than 200 000 children do not have adequate access to healthcare in these two provinces. The water, sanitation and hygiene (WASH) situation along the Congo River, where most cholera cases have been reported, has remained dire. Thus, from 01 January to 30 June 2017, Upper Lomami reported 1 091 suspected cases of cholera including nine deaths. The situation is more than worrying in the health zones of Butumba, Kinkondja, Malemba and Mukanga. More than 200 cases of measles were reported towards the end of June 2017, leading to the declaration of an epidemic by the authorities.

Public health actions

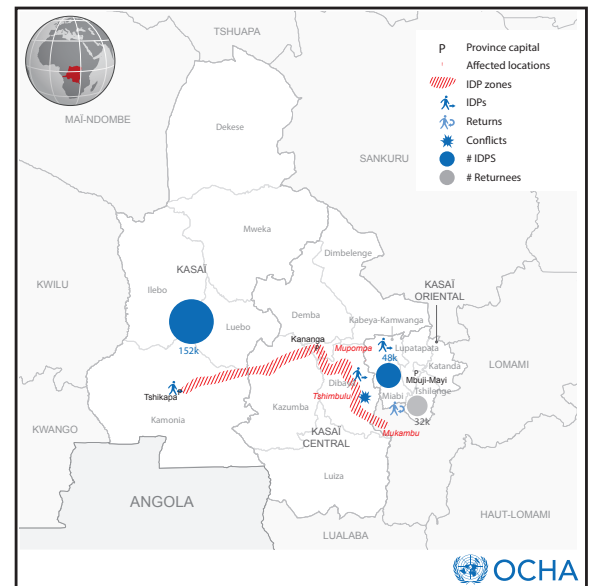
- Between 18 and 21 July 2017, the United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, Stephen O'Brien, visited the Democratic Republic of the Congo, including the conflict-affected Kasai Province, to conduct on-the-spot assessment and advocate for enhanced humanitarian assistance including funding.
- On 5 July 2017, the Nundu Health Zone authority launched a measles vaccination campaign for children aged 6 months to 14 years, during which 35 000 children were vaccinated. The authority needs additional resources to organize a vaccination campaign in the 18 remaining health areas.
- The International Rescue Committee (IRC) and AVSI launched a WASH project targeting four sites around Kalemie town. On 9 July 2017, more than 25 000 internally displaced persons (IDPs) received water, sanitation and hygiene assistance. The IDPs will have better access to water through pumping and conveying systems, the construction of latrines and showers, and the installation of hand washing points. They will also benefit from awareness-raising activities on hygiene and sanitation.

Situation interpretation

The Democratic Republic of the Congo has been experiencing a protracted complex emergency for more than 20 years. While the security situation has improved slightly since 2013, outbreaks of armed conflict and socio-political violence erupted in the Kasai region in August 2016, with devastating consequences. With the current spate of violence and insecurity, humanitarian access has been markedly restricted, in addition to the general problem of lack of infrastructure across the country. Current humanitarian interventions occur mainly in accessible areas. Health remains a major concern as a result of the prolonged and recurrent cholera and measles outbreaks. Provision of healthcare services has been disrupted, including routine immunization, disease surveillance, maternal and child health, trauma care, etc. Worrying levels of malnutrition have been reported in many provinces. At the same time, protection issues remain a major gap, given the high numbers of gross human right abuses, including sexual violence. Above all, there has been declining funding for humanitarian response. The 2017 humanitarian response plan of US\$ 812.5 million has received only 23% of this amount.

To avoid further deterioration of the humanitarian situation, the priority is to accelerate the implementation of life-saving interventions. The critical areas of intervention include nutrition, protection, health, food security, and WASH. There is also a need to strengthen the presence of partners on the ground to provide humanitarian aid. In order to foster a contextual and proportionate humanitarian response, it is important to strengthen synergies between humanitarian and development actors.

Population movement in Kasai region, February 2017



Event description

There has been an unprecedented surge in the number and the length of stay of refugees in Uganda. The country is currently hosting the highest numbers of refugees in Africa, and the third highest number globally. In 2016/2017, the country recorded the highest inflows ever, with the current average inflow rate standing at about 500-1 000 refugees per day. As of 1 July 2017, 1 309 698 refugees and asylum-seekers have been registered in Uganda. The refugee and asylum-seekers are largely from South Sudan, Somalia, Burundi, and the Democratic Republic of the Congo. Seventy-five percent of the refugees and asylum-seekers are from South Sudan. As of 01 July 2017, a total of 977 746 South Sudan refugees and asylum-seekers have been registered in Uganda. The country hosts 50% of all South Sudan refugees. Between 1 January and 23 July 2017, a total of 312 365 new refugees from South Sudan arrived in the country.

In Uganda, refugees and host communities live harmoniously. The refugees and asylum-seekers are in 28 settlements across 12 districts (including Kampala, the capital city). Women and children below 18 years represent 86% of the total refugee population, while children under 18 years make up 60% and the elderly 2%.

Public health actions

- WHO, in collaboration with the Ministry of Health, trained 2 376 village health teams (VHTs) from seven districts and provided them with the required tools for community-based disease surveillance.
- WHO provided five cholera kits (100 patients per kit) and 20 malaria modules, which are sufficient to treat 3 000 patients for 1 month.
- WHO also procured and donated assorted medicines worth US\$ 57 000 to supplement the refugee operations.
- Health staff at service delivery points have been trained on the implementation of infection prevention and control (IPC), which is intended to curtail transmission of infectious diseases to health workers and to prevent amplification of outbreak-prone diseases in the health facilities.
- WHO supported health facilities in the refugee settlements areas with 45 beds and 100 mattresses.
- Technical assistance was provided to the districts as they responded to shocks from the refugee emergency.

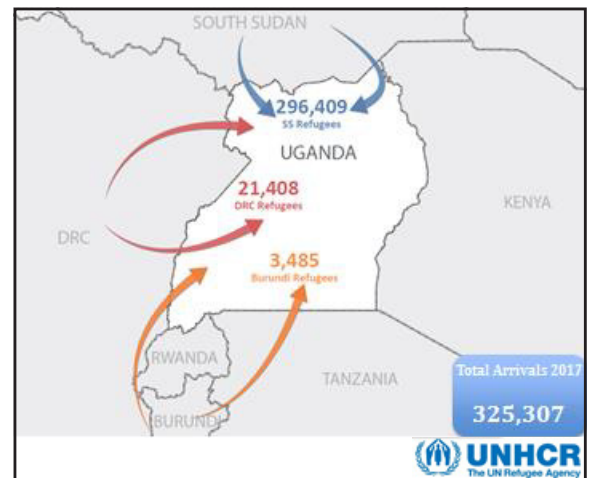
Situation interpretation

The current surge in the number and the protracted stay of refugees in Uganda is unprecedented. Uganda is currently home to over 1.3 million refugees, including 977 746 South Sudanese. The refugee policy in Uganda allows them to obtain a plot of land, start businesses and access healthcare and education alongside the host communities. However, these interactions provide the potential for transfer of any infectious diseases present among the refugees to or from the host communities, for which background immunity may not be present.

The current refugee situation is already imposing excessive pressure on the financial and operational capacities of the host communities, districts, government, and partners. The multi-partners' South Sudan refugee response plan, amounting to US\$ 673.19 million has a funding deficit of 83%. This means that the host government and the humanitarian partners are not able to provide the requisite assistance to the refugees and host communities. This, coupled with food shortages, drought and high unemployment is beginning to cause discontent among the indigenous populations.

A service availability and readiness assessment (SARA) needs to be conducted to facilitate comprehensive support to the district health systems. In addition, the health response should be broadened to include other critical areas like reproductive and child health, non-communicable diseases, and psychosocial support, among others. Mechanisms should be established to monitor host and refugee community health outcomes, as well as integration of refugee reporting to the national system.

Inflow of refugees in Uganda, July 2017



Event description

On 7 March 2017, the tropical cyclone Enawo, a category 4 cyclone on the Saffir-Simpson scale, hit the Sava region in Madagascar. This natural disaster triggered a humanitarian crisis in the region, with significant damage caused to homes, crops, schools, as well as water and sanitation infrastructure. Early assessments showed that the affected districts lost between 58-85% of their crops; more than 1 300 wells were flooded; and more than 250 water points (83 boreholes, 125 wells and 42 hand pumps) were damaged, resulting in 168 000 people without access to basic water, hygiene and sanitation resources.

Although the humanitarian situation has significantly improved due to comprehensive response activities, more than 73% of the population in the eight affected districts continue to use unprotected water points. A recent food security assessment showed that from June to September 2017, an estimated 409 000 people (25% of the affected area population) will be in need of humanitarian assistance. Surveys in the eight most affected districts found severe acute malnutrition (SAM) under the emergency threshold of 3%. Three districts were above the global acute nutrition (GAM) alert threshold of 10% and five districts were below the GAM alert threshold. In addition, preliminary results from the July 2017 Integrated Acute Malnutrition Phase Classification (IPC) exercise classified five districts as Phase 2 (Alert) and three districts as Phase 3 (Serious).

In the affected districts, the health of the population deteriorated after the disaster. From January to the end of May 2017, there were 9 323 cases of diarrhoea, 15 773 cases of acute respiratory infection (ARI) and 4 714 cases of malaria in children under 5 years, which were diagnosed and treated at the basic health centre (CSB) level in Androy and Anosy.

Geographical area affected by humanitarian crisis in Madagascar, March - July 2017



Public health actions

- Monthly inter-sectoral meetings are being conducted in Ambovombe.
- Among the most affected households, 41 875 people have benefitted from free disease case management since May 2017. Emergency medical kits were deployed in the targeted health facilities to support this initiative. With the support of WHO, 1 320 people living in remote villages benefitted from free healthcare through the regional mobile health team of Atsimo-Andrefana. UNICEF supported outreach activities using two to four mobile clinics per district to provide integrated health packages (diagnosis, curative services, immunization and antenatal care visit) for around 65 000 people in the most remote villages.
- Severely malnourished children have been treated at inpatient and outpatients facilities. UNICEF provided support to the Ministry of Health to deploy 13 mobile teams in the districts of Amboasary, Ambovombe, Ampanihy, Bekily, Beloha, Betioky and Tsihombe, to enhance access and coverage of the Community Management of Acute Malnutrition (CMAM) program. The World Food Programme provided supplementary feeding to around 20 000 beneficiaries for the prevention of moderate acute malnutrition where acute malnutrition rates are the highest.
- UNICEF rehabilitated 812 water points and supported the drilling of 122 boreholes and 11 mid-level water supply system to serve an estimated 248 370 people. In addition, UNICEF constructed rainwater collection systems in 25 health centres. UNICEF supported trucking of 4.3 million litres of water for 217 600 people, as well as water card vouchers (for 140 litres of water per week for 3 months) to 3 518 households (including 1 510 families with SAM, 464 new mothers and their newborns, and 1 617 pregnant women).

Situation interpretation

Madagascar is known to be one of the poorest countries in the world, with about 76% of the population living in poverty and unable to afford adequate nutrition or access to healthcare. The recent tropical cyclone escalated these nutrition and health problems. Infectious diseases such as malaria, diarrhoea and acute respiratory infections are the leading causes of death in children. Therefore, the disruption of basic healthcare services during this crisis, especially in remote rural areas, has the potential to increase the morbidity and mortality associated with these diseases, especially among children.

Responding to any type of crisis in Madagascar can be challenging because of poor roads and other infrastructure. However, with the multi-sectorial coordination of resources, food and safe water supply in the affected areas have significantly improved. The country received 65% of the US\$ 155 million required for the response; 771 000 people received food assistance; 27% of those in the most-affected districts received sustainable potable water; 38,000 cases of moderate acute malnutrition were treated in June 2017; and 230 356 children from 1 060 primary schools received daily hot meals in May 2017. Despite these improvements, continuous support to the region is needed to avoid further deterioration of the health and nutrition status of people in the affected districts.

Event description

The effects of the 2015/2016 El Niño-induced drought continue to be felt and are exacerbated further by poor spring rains in 2017. The effects include severe and prolonged water shortages, food insecurity resulting from crop losses and livestock deaths, population displacement and rising levels of severe acute malnutrition (SAM), along with outbreaks of epidemic-prone diseases. This has led to 7.8 million people receiving humanitarian assistance in the region in the first quarter of the year, which is expected to increase in the second half of the year. The influx of refugees from Somalia and South Sudan continues. Between 1 January and 15 July 2017, an average of 32 people per day arrived in southern Ethiopia, and the total number of Somali refugees in the country has reached 251 393 as of 15 July 2017. Of these, 88% are women and children. Refugees from South Sudan continue to arrive in western Ethiopia and the number of South Sudanese refugees has reached 379 376 as of 15 July 2017.

The outbreak of acute watery diarrhoea (AWD) continues to improve. In week 29 (week ending 23 July 2017), 190 new cases were reported in Amhara, Oromia and Somali Regions, compared with 331 cases in week 28.

There were 24 new cases of measles reported in week 29. To date, there have been 58 separate laboratory-confirmed measles outbreaks in the country. Oromia Region has 31% of reported cases, followed by Amhara (26%), Addis Ababa (20%) and SNNP (11%). Children under the age of 5 years make up 39% of the affected population, followed by 5-14 years at 37%.

Severe acute malnutrition (SAM) continues to affect the regions. Oromia is the most affected, with 1 496 new cases of SAM reported, 1 298 of which were managed at the outpatient therapeutic centres (OTPs) and 198 cases admitted to stabilization centres (SCs). Afar Region reported 300 SAM cases, 289 managed at OTPs and 11 cases admitted to SCs, while Amhara Region reported 360 cases of SAM, 341 of which were managed at OTPs and 19 admitted to SCs.

Public health actions

- There is resource mobilization at the highest level to fill the supply gap for treatment of SAM and moderate acute malnutrition (MAM). Somali Region and 21 priority one woredas in Oromia have been prioritized for SAM and MAM supplies until the end of 2017.
- Polio and measles immunization and nutritional screening are being conducted by partners at the Gambela and Benshangul Gumus border, targeting all children less than 14 years of age.
- Preparation for the phase II integrated measles campaign, to be implemented in the remaining seven zones, is ongoing. The campaign will run from 29 July to 4 August 2017.
- Currently WHO is working with the Federal Ministry of Health, the Regional Health Bureaus (RHBs) and partners to respond to the AWD outbreaks in Amahara, Oromia, Somali and Tigray Regions.
- WHO teams continue to provide orientation and support for infection prevention and control (IPC) during disinfection of closed AWD treatment facilities in Dollo and Jarar zones, and a team continues to provide on-the-job training in IPC at the treatment centres in the various regions. There is continued monitoring by the case management team to strengthen adherence to IPC and to provide oversight at the treatment centres.
- Water, sanitation and hygiene (WASH) and other environmental health activities are ongoing with procurement of water quality test kits and reagents for monitoring, distribution of water treatment chemicals, allocation of an additional 30 water trucks for Jijiga city, training of social mobilizers and orientation of biyole drivers, continued water trucking in the region to over 200 000 beneficiaries, and the implementation of a drought response plan that includes borehole drilling, water trucking, sanitation facilities, hygiene promotion and distribution of WASH non-food items.
- Funding of US\$ 3 million has been received from OCHA to support integrated surveillance/early warning and front-line response to start towards the end of August 2017, with a potential US\$ 1.6 million for AWD and other outbreaks supplies and treatment centres and an additional US\$ 3 million for Mobile Health and Nutrition Teams to be implemented by non-governmental organizations in Somali and Oromia regions.

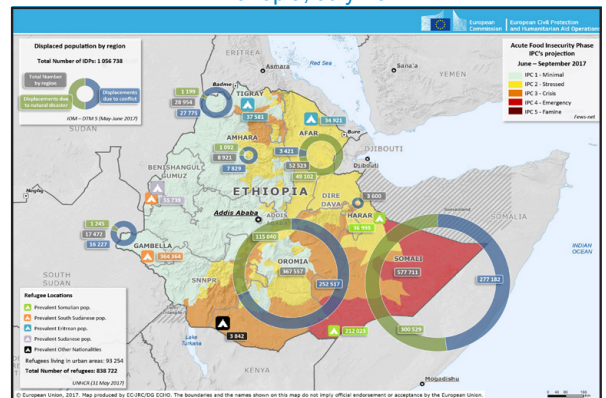
Situation interpretation

The overall humanitarian crisis in southeast Ethiopia remains serious and could deteriorate further with exacerbation of the situation in the neighbouring countries (Somalia and South Sudan), leading to increased population movements. The outbreak of AWD continues to improve, with reduced weekly incidence cases, attributed to the scaled up response and intervention by humanitarian partners and national authorities. However, the ongoing internal displacement of people and their livestock, as well as the influx of refugees from Somalia and South Sudan, could potentially exacerbate the outbreak.

The situation requires continued monitoring and implementation of control measures, with particular reference to WASH activities. Access to safe water continues to be a challenge, with over 1 million people still not reached; mainly in the Somali Region. Access is further challenged by the increasing number and wide geographic spread of internally displaced people. This is a particular problem with nomadic pastoralists who lack safe water and sanitation because of their mobility. Provision of water in the treatment centres as well as management of the combination of AWD and SAM, and other co-morbidities, have remained a challenge. Community-based surveillance of AWD needs to be strengthened, including information management. There is also inadequate laboratory capacity for testing and periodic surveillance of AWD and reporting of AWD deaths is problematic because a 'taboo' has arisen around these deaths.

Measles and SAM continue to affect these populations and WHO and all partners need to continue to work with the Federal Ministry of Health and the Regional Health Bureaus to ensure that the situation does not deteriorate.

Food insecurity, internally displaced persons and refugees in Ethiopia, July 2017



Summary of major challenges and proposed actions

Challenges

- A serious but little-known humanitarian crisis has been ongoing in the Kasai Region of the Democratic Republic of the Congo, with devastating consequences. The recent eruption of insecurity and violence has caused internal displacement of over 3.8 million people, including 1.4 million people in the Kasai Region alone. Humanitarian access is severely constrained, aggravating the dire humanitarian need. Health remains a major concern, including the prolonged and recurrent cholera and measles outbreaks. Protection issues are also serious, with over 600 cases of sexual-based violence reported.
- The influx of refugees in Uganda, especially from South Sudan, is unprecedented. Uganda is currently home to over 1.3 million refugees, including 977 746 South Sudanese. The current refugee situation is already constraining the financial and operational capacities of the host communities, districts, government, and partners. With a funding deficit of 83%, provision of the requisite assistance to the refugees and host communities remains a challenge.

Proposed actions

- To avoid further deterioration of the humanitarian situation, especially in the Kasai Region, the implementation of life-saving interventions need to be accelerated as a matter of priority. The critical areas of interventions include nutrition, protection, health, food security, and WASH. In parallel, the presence of humanitarian actors on the ground requires urgent boosting, as well as provision of funding for humanitarian operations.
- All stakeholders are urged to scale up provision of humanitarian assistance to the refugees in Uganda (and other parts of the region). In addition, the global communities are called upon to close the funding gaps for the multi-partners' refugee response plan.

All events currently being monitored by WHO AFRO

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Newly reported events								
Malaria	Cabo Verde	Ungraded	26-Jul-17	52	0	0.0%	During July 2017 (weeks 26-29), a sudden and unseasonal increase in malaria cases was observed in the capital city, Praia. Thus far during July, 47 cases have been reported, against an average of 1 case per month recorded for the same period in the past 5 years. The area typically observed seasonal malaria during October-December. About half the cases observed are adult males aged 20 years and older.	26-Jul-17
Ongoing events								
Cholera	Angola	G1	04-Jan-17	455	24	5.3%	Since early December 2016, cases have been detected in Cabinda (225), Soyo (225) and Luanda (5).	28-Jun-17
Malaria	Burundi	G1	01-Jan-17	4 376 804*	1 996*	0.05%	*Counts include cases notified during 2017 YTD only. Weekly case counts are exceeding 2016 rates and on the rise. During week 25, 173 355 cases, including 102 deaths were reported (22% above same period last year).	30-Jun-17
Cholera	Burundi	Ungraded	15-Jul-17	6(5)	0	2.1%	A small cluster of six cholera cases in and around Bujumbura, was investigated. The National Institute of Public Health isolated Vibrio cholerae O1 serotype Ogawa in 5/6 stool samples collected from the cases on 13 and 14 July 2017. Three of the confirmed cases were from Gatumba (Isare Health District) and two came from Gahehe (Bujumbura North Zone District), while the suspected case came from Ngagara/Chanic.	15-Jul-17
Humanitarian crisis	Cameroon	G2 extension	-	-	-	-	-	29-Jun-17
Eruptive fever	Cameroon	Ungraded	16-Feb-17	52	20	38.5%	Detailed update given above.	21-Jul-17
Humanitarian crisis	Central African Republic	Downgraded to G2	-	-	-	-	-	17-Jul-17
Monkeypox	Central African Republic	Ungraded	14-Apr-17	3 (2)	0	0.0%	During week 24 (week ending 18 June 2017), one new case was confirmed by the Institut Pasteur Bangui in a camp in Toma, Lobaye Prefecture. Further investigations supported by the Ministry of Health and WHO revealed 24 of 26 (92.3%) of close contacts had antibodies (IgG) against monkeypox, and 4 against cowpox. This suggests a high level of circulation of the virus in the region, and may explain the low number of cases recorded during these outbreaks. Including this latest case, just 2 confirmed cases and 1 suspected case have been reported since the event was first notified to WHO on 14 April 2017.	13-Jul-17
Hepatitis E	Chad	G1	01-Sep-16	1 658 (98)	18	1.1%	The outbreak of hepatitis E in the Salamat region of Chad remains serious, with a high risk of escalation. During week 28 (week ending 16 July 2017), 14 suspected cases and zero deaths were reported. Of the 18 deaths reported, five (28%) were pregnant women.	16-Jul-17
Monkeypox	Congo (Republic of)	Ungraded	01-Feb-17	78 (7)	4	5.1%	Since 27 Jan 2017, suspected cases of monkeypox have been reported in the department of Likouala and the department of Cuvette (unconfirmed). Suspected cases have been reported from Bétou, Enyelle, Dongou, Impfondo and Owando districts.	14-May-17
Dengue	Cote d'Ivoire	Ungraded	06-May-17	623 (282)	2	0.3%	Detailed update given above.	11-Jul-17
Humanitarian crisis	Democratic Republic of the Congo	Ungraded	August 2016	-	-	-	Detailed update given above.	21-Jul-17
Cholera	Democratic Republic of the Congo	G2	02-Jan-15	44,415	1,244	2.8%	-	02-Jul-17
Measles	Democratic Republic of the Congo	Ungraded	10-Jan-17	20 898 (312)	241	1.2%	The incidence of new cases has declined since the current outbreak peaked in early 2017.	11-Jun-17
Humanitarian crisis/AWD	Ethiopia	Upgraded to G3	15-Nov-15	39 344*	801*	2.0%	This complex emergency includes outbreaks of AWD and measles (reported separately below). *Counts reported are AWD cases and deaths for 2017 YTD only. Continued drop in the number of new cases reported. A detailed update on the protracted event will be provided every second week.	23-Jul-17
Measles	Ethiopia	Ungraded	14-Jan-17	2 426* (1 008*)	-	-	*Count include cases notified during 2017 YTD only. Detailed update given above.	16-Jul-17
Floods	Guinea	Ungraded	15-Jul-17	-	-	-	During the night of 3-4 July 2017, heavy rain caused the overflow of the waters of the river Tile, and flooding in 14 of 22 neighbourhoods in N'zérékoré, Guinea. Nine neighbourhoods have suffered material and human damages. An estimated 545 households and 3 274 people have been affected, including 1 038 men, 1 089 women and 1 147 children. Among displaced persons, 13 were wounded, 2 had diarrhoea, 13 were febrile, and one person with a medical history of tuberculosis died. In 240 households surveyed, 131 collapsed, 56 were fissured and are at risk of collapse, and 12 were dilapidated. A poultry farm was destroyed and 26 water points were damaged.	27-Jul-17
Drought/food insecurity	Kenya	G1	-	-	-	-	SMART surveys highlighted the rates of Global Acute Malnutrition rates increased across the country. An estimated 7.8 million population are in IPC3-5 during May/June 2017.	27-Jul-17
Cholera	Kenya	G1	10-Oct-16	1 474 (430)*	18*	1.2%	*Counts reported are for 2017 YTD only. Six counties have active cholera outbreak: Garissa (528 cases), Nairobi (578 cases), Kajiado (9 cases), Nakuru (20 cases), Kisumu (25 cases) and Homabay (16 cases). The outbreaks have been reportedly controlled in 9 other counties. 158 new cases were reported in the week ending 25 July 2017	25-Jul-17
Measles	Kenya	Ungraded	12-Mar-17	49 (12)	1	2.0%	The outbreak has been reported in Dagahaley, Dadaab and IFO refugee camps in Garissa County since 21 March 2017, and from communities in Mandera County since 8 June 2017. No new cases have been identified in Garissa since the last case was reported on 4 June 2017, where the outbreak remains controlled. The last probable case in Mandera County was reported on 5 July 2017.	25-Jul-17

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Visceral leishmaniasis / kala-azar	Kenya	Ungraded	05-May-17	353 (212)	7	2.0%	Two counties, Marsabit (n=234) and Wajir (n=119) have been affected by outbreaks since early 2017. Outbreaks remain active in both areas, with the last cases reported on 16 July and 17 June 2017 within the two counties, respectively.	25-Jul-17
Dengue	Kenya	Ungraded	09-May-17	1 305 (706)	1	0.1%	The outbreak has been reported in Mombasa County (n=1 223) and Wajir County (n=82). The last cases reported on 7 July and 20 June 2017 within the two counties, respectively.	25-Jul-17
Food insecurity	Madagascar	Ungraded	23-Feb-17	-	-	-	Detailed update given above.	15-Jul-17
Humanitarian crisis	Mali	G1	-	-	-	-	-	-
Rift Valley fever	Mali	Ungraded	07-Jul-17	1 (1)	-	-	Single confirmed case (IgM positive by ELISA, PCR negative) in a 10-year-old child, son of a farmer from Oulésébougou, illness onset 4 June 2017, results reported 6 July 2017. A Rapid Response Team deployed on 8 July; results pending for 19 blood samples collected from febrile community and family members, and more than 108 blood samples from animals. No further cases reported to date.	17-Jul-17
Hepatitis E	Niger	Ungraded	06-Apr-17	1 446 (441)	38	2.6%	Detailed update given above.	23-Jul-17
Humanitarian crisis	Niger	G2 extension	Beginning 2015	-	-	-	-	-
Humanitarian crisis	Nigeria	Protracted 3	-	-	-	-	A detailed update on this protracted event will be provided every second week. See also below an update on ongoing outbreaks.	27-Jul-17
Lassa fever	Nigeria	Ungraded	01-Dec-16	549 (196)	109	19.9%	Since the onset of this current outbreak in December 2016, 17 out of 36 states in Nigeria have reported at least one confirmed case. Five states have reported confirmed Lassa fever cases in the last 21 days: Anambra, Rivers, Ondo, Edo and Plateau. The CFR in confirmed and probable case groups collectively stands at 36.7%.	07-Jul-17
Cholera	Nigeria	Ungraded	07-Jun-17	1 803* (18)*	32*	1.8%	*Case counts refer to the ongoing outbreak affecting 5 LGAs in the Kwara State (1 620 cases, 22 deaths), and a newly detected outbreak in 3 LGAs in Zamfara State (183 cases, 10 deaths). In addition to these, this past week outbreaks have also been detected in 3 LGAs in Lagos. WHO is collating further information on these new events.	27-Jul-17
Hepatitis E	Nigeria	Ungraded	18-Jun-17	426 (42)	4	0.9%	The outbreak in Borno State is worsening, with the number of cases doubling in the past weeks. Seven LGAs have so far been affected: Ngala (355 cases), Damasak (43), Monguno (23), Askira (1), Uba Bayo (1), Chibok (1), and Gubio (1). 43 infected pregnant women including four deaths (case fatality rate 9.3%) have been reported in Ngala.	15-Jul-17
Necrotising cellulitis/fasciitis	Sao Tome & Principe	G2	10-Jan-17	1,819	0	0.0%	There has been a steady decline in the disease trend since the beginning of 2017; however, this trend has stagnated in recent weeks, with on average 21 cases (range 8-34 cases) being reported each week for the past 21 weeks. The most affected districts are Caue-South, Lembá and Lobata-North.	27-Jul-17
Dengue	Seychelles	Ungraded	20-Jul-17	3 551 (1 263)	-	-	Ongoing dengue epidemic since end of 2015 to date. For the past two weeks (10 July-16 July 2017), 106 suspected cases were reported. Generally there has been a downward trend in the number of suspected cases since week 24.	20-Jul-17
Humanitarian crisis	South Sudan	G3 extension	-	-	-	-	A detailed update on this protracted event will be provided every second week. See also below an update on the ongoing cholera outbreak.	26-Jul-17
Cholera	South Sudan	Ungraded	20-Feb-17	18 029 (1 912)*	327*	1.8%	*Counts reported in total suspected cholera cases reported on IDRS during 2017 YTD only. Cases continue to decline this past week.	23-Jul-17
Nodding disease	South Sudan	Ungraded	30-Jun-17	70	-	-	Unconfirmed media reports of over 70 cases of nodding disease in among children in Maridi, Jubek, Amadi and Gbude state since mid-2016. WCO staff are so far unable to confirm the event due to an upsurge insecurity in the country and affected provinces. More details will be provided when available.	23-Jul-17
Cholera	Tanzania	G2	15-Aug-15	30,245	475	1.6%	Since the outbreak started in August 2015: 25 556 cases including 403 deaths on the Tanzania mainland, and 4 689 including 72 deaths from Zanzibar. During week 29 ending 23 July, 14 new cases were reported on the mainland only.	26-Jul-17
Aflatoxicosis	Tanzania	Ungraded	28-Jun-17	8	4	50.0%	Between 15 June and 13 July 2017, two unrelated clusters of suspected acute aflatoxicosis, affecting two families in separate towns in Kiteto District, Manyara Region in the northern part of Tanzania. Details of these clusters were reported in the week 29 bulletin.	26-Jul-17
Dengue	Togo	Ungraded	18-Jun-17	12 (3)	0	0.0%	Two events investigated by MOH. (1) From Awossinou-Gbogbo Polyclinic: 9 suspected cases since January 2017, of which: 3 cases were confirmed (IgM positive), 2 cases were probable (RDT positive) and 4 cases were negative/excluded. No deaths were recorded. Cases come from several districts of the Gulf prefecture: Sagbado, Tokoin hospital, Agoe Atchanvé, Sogbossito, Agoenyivé, with no cluster of cases. (2) From British School of Lome: 3 suspected cases, of which 1 RDT positive in school children, 2 children from same family, no other cases identified in the school.	06-Jul-17
Drought/food insecurity	Uganda	G1	-	-	-	-	-	24-Jul-17
Humanitarian crisis - refugee	Uganda	Ungraded	-	-	-	-	Detailed update given above.	24-Jul-17

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Typhoid fever	Zambia	Ungraded	22-Apr-17	162	1	0.6%	A suspected outbreak was declared in Mpika District, Muchinga province on 4 May 2017. Since then, 162 suspected cases were reported, the last detected on 17 July 2017. Non-typhoidal Salmonella was isolated from 2 cases. There was insufficient information to conclude typhoid was the cause; however, symptoms were attributed to consumption of contaminated water.	18-Jul-17
Recently closed events								
Malaria	Zimbabwe	Ungraded	07-Mar-17	55,875	101	18.1%	Case counts are up to 1 March 2017. Manicaland (n=31 111, 55%), Mashonaland East (n=8,822, 15.6%), Masvingo (n=8 062) and Mashonaland Central (n=5 739, 10.1%) account for the vast majority of these cases. Detailed further information about this event has not been forthcoming; however, widespread outbreaks were noted between the typical transmission season (November-May). While most outbreaks have been controlled through interventions and the onset of winter, some areas may still be experiencing localised outbreaks. The event may be reopened pending new reports from the MoHCC of transmission exceeding the epidemic threshold.	21-Jul-17
Circulating vaccine-derived polio virus (cVDPV)	Democratic Republic of the Congo	Ungraded	02-Jun-17	5(5)	0	0.0%	This includes 3 separate events: 2 unrelated clusters of cVDPV2 (2 cases each) and a single case of cVFPV1. No new cases have been reported since the original cluster. In response to the epidemic, the Ministry of Health with support of WHO has implemented two mass immunisation campaigns with bivalent oral polio vaccine.	27-Jul-17
Crimean-Congo haemorrhagic fever (CCHF)	Senegal	Ungraded	19-Jul-17	1 (1)	0	0.0%	A single confirmed case in a young shepherd in Fatick District, Kamsaté, Senegal within onset of illness on 29 June 2017. See the week 29 bulletin for a detailed report of the case. Follow-up completed for 21 contacts of the case; none have shown any sign of illness.	27-Jul-17

Data are taken from the most recently available situation reports sent to WHO AFRO. Numbers are subject to change as the situations are dynamic.



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