

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 32: 05 – 11 August 2017
Data as reported by 17:00; 11 August 2017



2

New events

42

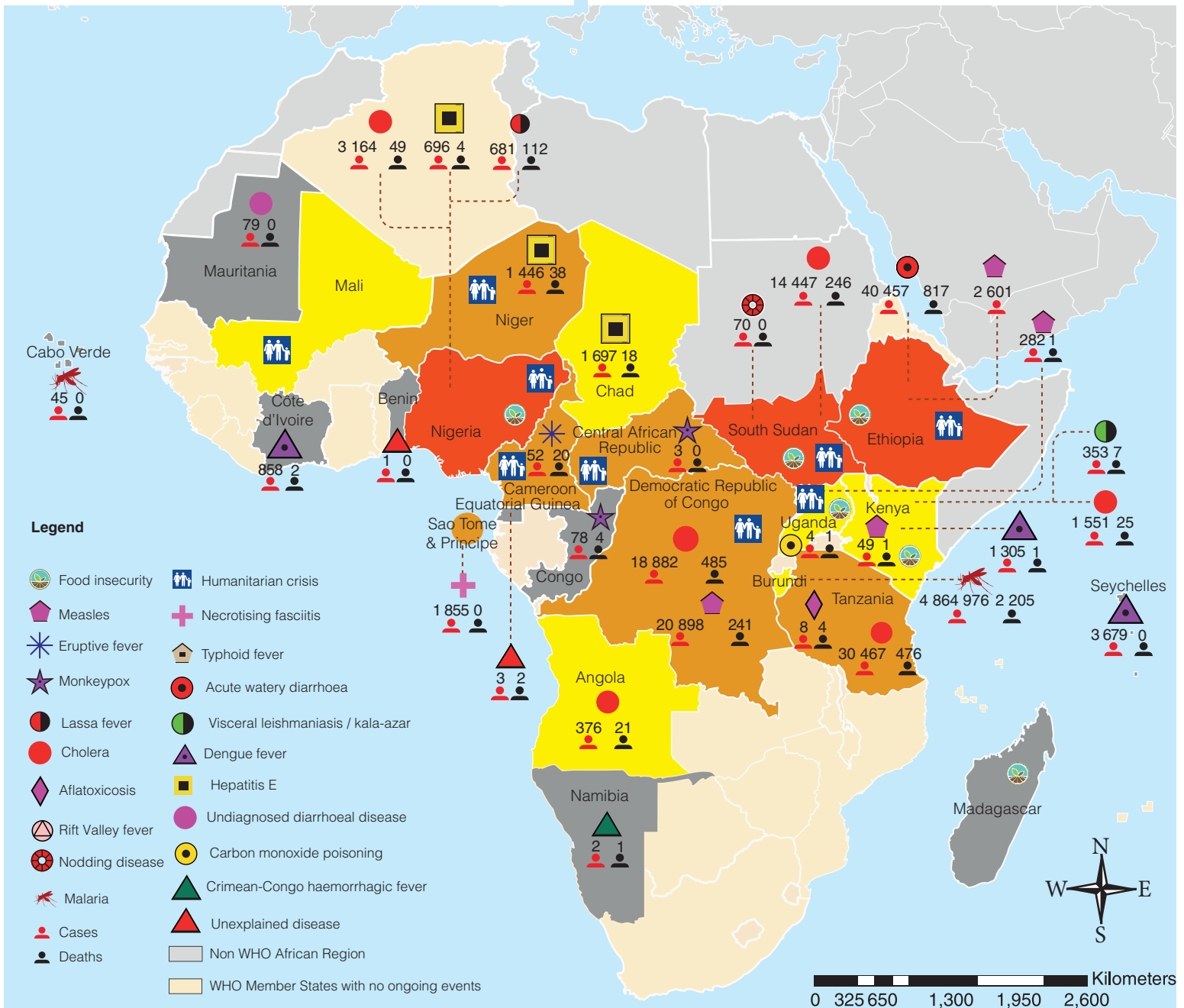
Ongoing events

32

Outbreaks

12

Humanitarian crises



1

Grade 3 event

2

Protracted 3 events

6

Grade 2 events

7

Grade 1 events

28

Ungraded events

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 44 events in the region. This week, two new events have been reported: Crimean-Congo haemorrhagic fever in Namibia and measles in Uganda. This week's edition also covers key ongoing events, including:

- Dengue fever in Seychelles
- Malaria in Burundi
- Cholera in the Democratic Republic of the Congo
- Cholera in the United Republic of Tanzania
- Hepatitis E in Chad
- Humanitarian crisis in Ethiopia
- Humanitarian crisis in South Sudan

➤ 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:

- The escalation of cholera outbreak in the Democratic Republic of the Congo, especially in the North-Kivu Province, is a major concern. The protracted cholera outbreak is taking place within the context of a severe humanitarian emergency, which needs to be addressed holistically.
- The outbreak of measles in the densely populated Kampala capital city, Uganda poses a serious public health threat to the vulnerable peri-urban population.

New events

Crimean-Congo haemorrhagic fever

Namibia

2
Cases

1
Deaths

50%
CFR

Event description

On 10 August 2017, the Namibia Ministry of Health notified WHO of a confirmed case of Crimean-Congo haemorrhagic fever (CCHF), following the death of a 64-year-old man in Windhoek Central Hospital. The case-patient was reportedly bitten by a tick on 29 July 2017 while disinfecting goats at his homestead in Ukwandongo Village, Okahao District, Omusati Region. He subsequently travelled to Windhoek on 1 August 2017 (in good health) to attend a social function. He became ill on 4 August 2017 (6 days after the tick bite) and presented to Khomasdal Medical Centre (the same day) with a headache, chills and body aches, nausea, vomiting, epistaxis, and fever. Blood samples were collected and malaria tests were negative. The patient was started on a course of antibiotics and discharged. However, after observing a low platelet count and raised transaminases, the attending clinician recalled the patient immediately, who was then admitted to the Roman Catholic Private Hospital in Windhoek. Showing no signs of improvement, the patient was transferred to Windhoek Central Hospital on 7 August 2017, where supportive care was continued. Suspecting CCHF, blood samples were collected on 8 August 2017 and sent to the National Institute for Communicable Disease (NICD) in South Africa. Laboratory result from NICD released on 10 August 2017 confirmed CCHF virus as the causative agent. The patient, however, died in the morning of 9 August 2017.

One additional suspected case was identified (further information on this case is not currently available). Thirty-one contacts, including family members (who were in close contact with the deceased) and healthcare workers in the three medical centres that attended to the case-patient have been listed and are being followed-up daily.

This is the third confirmed outbreak of CCHF in Namibia in 2017. The last two outbreaks occurred in Gobabis District, Omaheke Region in March 2017.

Public health actions

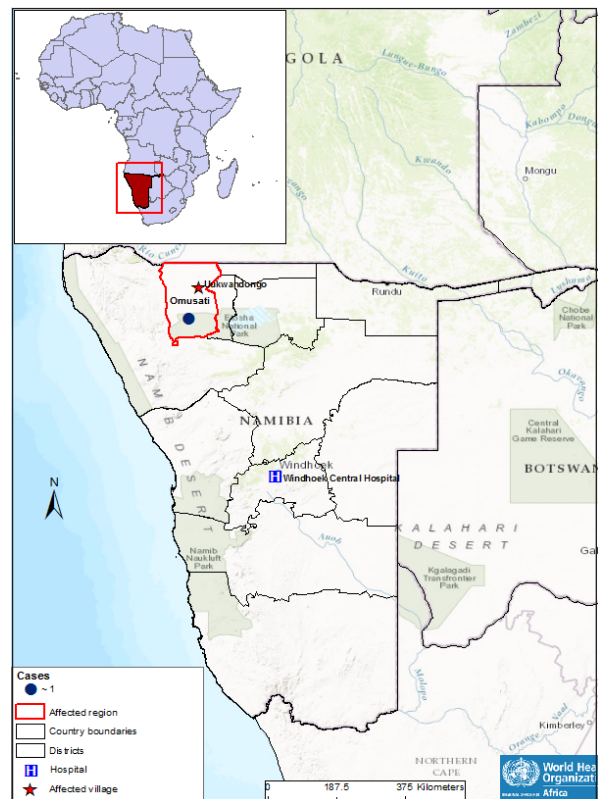
- Following the report of suspected CCHF, the Namibia Ministry of Health activated the multisectoral district and regional emergency response teams, covering key components such as contact tracing, communication, and case management and infection prevention and control (IPC). The regional authorities in Omusati and Khomas regions, stakeholders including veterinary services, WHO, City of Windhoek, and Infection Control Practitioners are part of the multisectoral response teams.
- Capacity for management of further cases has been enhanced, with adequate stocks of supplementary personal protective equipment (PPE) provided to the isolation facilities.
- Active surveillance activities including daily contact tracing were initiated, as well as health education for all contacts on signs and symptoms, the need for early reporting and prevention methods.
- Healthcare workers in the facilities that handled the case-patient were orientated on infection protection and control (IPC) techniques. Plans have been made for further IPC training of healthcare staff.
- Risk communication and social mobilisation activities are ongoing. The Ministry of Health issued a media release on 10 August 2017.
- The Ministry of Health, in collaboration with the veterinary services and the Namibia Field Epidemiology Laboratory Training Program (FELP), plans to carry out environmental investigations and to assess vector control activities in the affected district.

Situation interpretation

Recurrent focal CCHF outbreaks have been reported in Namibia in 1986 (3 cases), 1998 (1 case), 2001 (2 cases), 2002 (1 case) and 2010 (3 cases); scattered across five regions (Otjozondjupa, Khomas, Omaheke, Karas and Kavango). In early 2017, two cases (not epidemiologically linked) were confirmed in Omaheke Region. The recent case is the first confirmed exposure in Omusati Region. Outbreaks are typically related to the relative abundance of *Hyalomma* ticks, the reservoir and vector for the CCHF virus. Sporadic human infections may be expected in people with regular contact with livestock in endemic areas, but these are preventable through use of repellents, protective clothing and gloves to prevent tick bites, and avoiding contact with blood and body fluids of livestock.

If left untreated, CCHF is generally associated with a high fatality rate (10-40%), and there is a high propensity for onward person-to-person transmission through direct contact with infectious blood and body fluids. There is, therefore, a high risk of nosocomial infections, as well as secondary transmission when preparing bodies for burial. The early detection and declaration of this outbreak by the Namibia Ministry of Health, and the strong collaboration between the veterinary and public health services, illustrate one of the best practices of outbreak management and the One Health approach. Contact tracing and follow-up is being performed systematically, limiting the risk of a wider outbreak.

Geographical distribution of Crimean-Congo haemorrhagic fever cases in Namibia, 4 - 10 August 2017



Event description

On 8 August 2017, the Uganda Ministry of Health notified WHO of an outbreak of measles in the capital city, Kampala, and adjoining Wakiso District (which is part of the greater Kampala Metropolitan). The initial measles case was reportedly detected on the 24 April 2017 and the outbreak confirmed on 27 July 2017. As of 9 August 2017, a total 282 cases including one death (case fatality rate of 0.4%) have been reported from Kampala (216 cases and one death) and Wakiso (66 cases). All the five divisions of Kampala have been affected, namely Rubaga (66 cases), Central (58), Kawempe (50), Nakawa (27), and Makindye (21). Forty-seven percent (108/232) of the cases are in the age group 1-5 years, while 22% (52/232) are above 5 years old and 19% below 9 months. Forty percent (92/233) of the cases never had any measles vaccination while 39% had unknown vaccination status and only 3% were vaccinated previously.

Between 1 January and 9 August 2017, 59 samples have been collected, of which 33 tested positive for measles virus. The outbreak has been attributed to low routine immunization coverage due to shortage of vaccines at the health facility level.

Public health actions

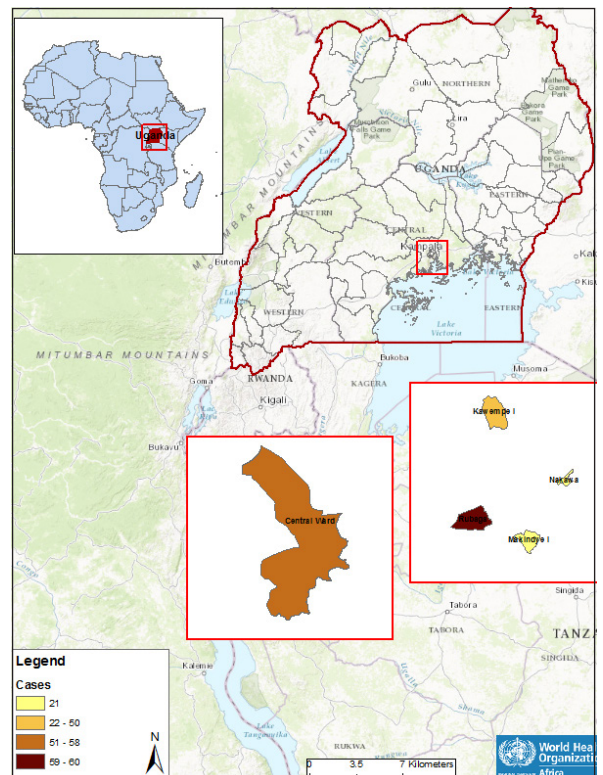
- On 8 August 2017, the Ministry of Health held a press conference to formally announce the measles outbreak and inform the public on measures being taken.
- The National Task Force has been reactivated to plan, implement and monitor response to the measles outbreak. The affected districts have also established coordination structures.
- Active surveillance has been strengthened, including active case search in the health facilities. Priorities have been given to health facilities with high patient loads and those in informal settlements.
- Health education sessions have started in all public health facilities, specialized children's clinics, clinics in slums/informal settlements, and established traditional and complementary medical providers.
- Preparation of district micro-plans to implement a reach every child (RED) campaign is being developed, with the support of partners (WHO and UNICEF).

Situation interpretation

Uganda is currently experiencing an outbreak of measles in the densely populated greater Kampala Metropolitan. The outbreak is being attributed to low immunization coverage, especially among large peri-urban populations. Preliminary analysis shows that only 3% of the reported cases had previous measles vaccination. Some of the factors responsible for the low immunization rates include inconsistent supplies of (measles) vaccines at operational levels, disruptions in community outreach services, and inadequate supportive supervision. The characteristics of the outbreak also point towards a weak surveillance system, probably leading to slow detection. Apart from the health system challenges, the current outbreak also illustrates the vulnerability of the populations living in peri-urban suburbs and slums, who have to fend for themselves in tough economic times, allowing many children to miss their vaccinations. The national authorities should maximize their efforts to achieve and sustain at least 95% coverage with two doses of measles-containing vaccine to control and prevent future outbreaks. Reactivation of immunization outreaches as well as strengthening static immunization is critical.

WHO and partners (UNICEF, AFENET, etc.) are working closely with the national authorities to plan and implement appropriate response measures, including enhancing surveillance and identifying and immunizing those at heightened risk of infection, as well as engaging communities to encourage vaccination for all those in need. Provision of more supplies of measles vaccine as well as involvement of private health providers in immunization activities is crucial.

Geographical distribution of measles cases in Uganda, 24 April - 9 August 2017



Ongoing events

Dengue fever

Seychelles

3 679
Cases

3
Deaths

0.08%
CFR

Event description

Seychelles has been experiencing an insidious dengue fever outbreak since December 2015. The current outbreak, which started in week 50 of 2015, increased exponentially from week 15 of 2016 and peaked in week 24 of 2016, during which 161 suspected cases were reported. This was followed by an extended period of low transmission until week 9 of 2017, when the incidence increased to attain a second smaller peak between weeks 20 and 23 of 2017. A switch to sentinel surveillance from week 23 of 2017 contributed to a decline in the absolute number of cases reported and samples submitted for testing. Nonetheless, similar declines have been observed in the proportion of cases testing positive in recent weeks, from about 55% in week 23 to about 20% in week 31, suggesting a true reduction in dengue virus activity.

From week 50 of 2015 to week 31 of 2017 (week ending 6 August 2017), cumulatively 3 679 suspected cases including three deaths (case fatality rate 0.08%) have been reported. Of these, 376 cases were admitted to hospital with moderate to severe illness. Overall, 60% of the cases were male, and people aged 15-29 years have been disproportionately affected. Indeed, 76% of cases were aged less than 40 years, possible due to protective effects of previous epidemics in 1978 when nearly 80% of the population was affected.

Out of 2 862 cases tested, 1 295 (45%) were laboratory confirmed, with dengue virus serotype 2 (DEN-2) predominating. Of 10 samples submitted to the National Institute for Communicable Disease in South Africa for phylogenetic analysis, all were DEN-2, and nine were closely aligned to a common clade circulating in India and Sri Lanka.

Cases have been reported from all regions of the three main islands (Mahé, Praslin and La Digue), with the districts of Anse Royale (attack rate 67.3/1 000 population), English River (63.4) and Pointe Larue (62.9) on Mahé island being the worst affected overall. Within the past 3 weeks, most districts on the islands of Mahé and La Digue have reported new cases, with neighbouring Mont Fleuri and English River districts on the northeast coast of Mahé contributing the highest attack rates.

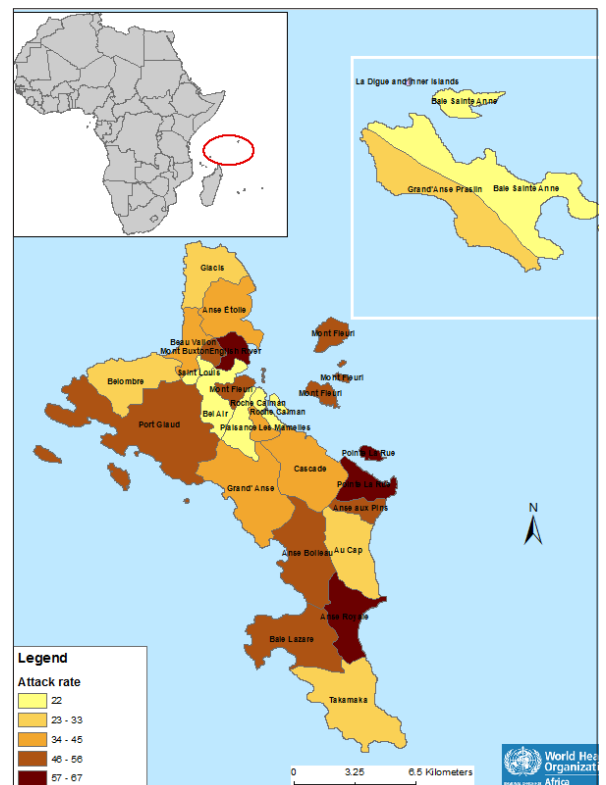
Public health actions

- A multisectoral approach is being undertaken in the response to the ongoing epidemic, coordinated by the Seychelles Ministry of Health. The Disease Surveillance and Response Unit continues to coordinate sentinel surveillance activities, which includes testing of all imported cases (to monitor if new strains are introduced), cases admitted to hospital, and cases presenting to one of six sentinel sites country-wide (to monitor the virus activity).
- Vector control activities (including outdoor fogging and environmental management) are ongoing. Fumigation of household premises is provided to individuals on request.
- Activities to sensitize political, religious and community leaders on prevention and control measures are ongoing.

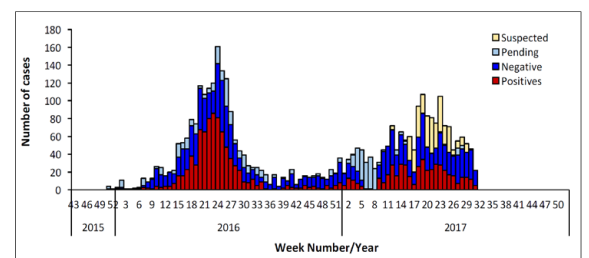
Situation interpretation

Seychelles has experienced several dengue fever outbreaks since the disease was first reported in 1976/1977. The current outbreak has been ongoing for nearly 2 years. While reduction in dengue virus activity has been observed in recent weeks, positive cases continue to be reported each week. The current period of unusually high rainfall and the coming rainy season (typically from November to January) raises concerns over increasing mosquito vector density and the potential for amplified transmission. Moreover, the introduction of new strains/genetic variants could lead to widespread severe disease. This, coupled with the challenges being encountered in responding to the current outbreak raises the risk profile of this event. There is therefore a need to reevaluate and improve preparedness and prevention activities, as well as ongoing control interventions, especially in the areas of vector control, social mobilization and case management, in order to control this protracted event.

Geographical distribution of dengue fever cases in Seychelles, December 2015 - 6 August 2017



Weekly trend of dengue fever cases in Seychelles, December 2015 - 6 August 2017



Event description

The outbreak of malaria in Burundi has shown marked improvement in the last weeks, though the overall situation remains serious. The incidence started declining after attaining the latest peak in week 26, during which 175 755 cases including 71 deaths were reported. In week 29 (week ending 23 July 2017), 131 566 clinical cases of malaria including 68 deaths (case fatality rate of 0.05%) were reported, compared to 152 137 cases with 68 deaths registered in week 28. These figures, however, are still much higher than last year, when 109 496 cases with 62 deaths were reported in week 28 of 2016.

Since the beginning of 2017, a total of 4 864 976 clinical cases of malaria including 2 205 deaths (case fatality rate 0.05%) have been registered across the country. While the entire country is reporting a high burden of malaria, the northern, central and eastern regions are most affected. Ten out of 18 provinces in the country are in epidemic phase, namely Karusi, Gitega, Muyinga, Kirundo, Kayanza, Ngozi, Bubanza, Cankuzo, Cibitoke and Ruyigi. The incidence of malaria in Burundi started increasing in 2014. However, the epidemic threshold was only reached in 2016. The outbreak was confirmed by a multidisciplinary investigation conducted in January 2017, which documented an increase in malaria incidence above the expected threshold. The Ministry of Health formally declared the outbreak on 13 March 2017.

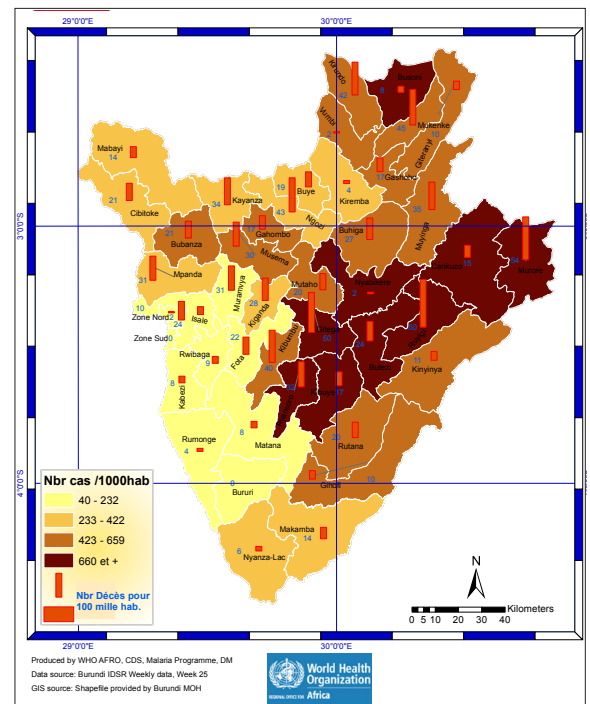
Public health actions

- The various thematic groups of the Malaria Task Force continue to monitor implementation of the response.
- WHO is strengthening its in-country capacity through deployment of additional experts (epidemiologist, entomologist, emergency coordinator, data manager, logistician, and operations manager), to support the response and strengthen coordination of partners in the health sector.
- Indoor residual spraying campaign has been ongoing in Cankuzo Province since 17 July 2017.
- Clinical case management has been strengthened through 122 mobile clinics operational in the six most affected provinces (Kirundo, Muyinga, Ngozi, Kayanza, Gitega, and Ruyigi) since 21 June 2017.
- A total of 126 health personnel have been deployed to 43 health districts to improve case management in healthcare facilities.
- Supervision of interventions by the central team was conducted in Muramvya and Ma-kamba Provinces.
- Supplies of anti-malarial medicines (1 264 800 artemisinin-based tablets and 27 300 vials of injectable Artesunate) and 275 350 rapid diagnostic tests (RDTs) were secured in July 2017. Distribution of the medicines and RDTs to health districts took place from 30 June to 17 July 2017. More than 100 000 doses of antimalarial medicines were distributed in July 2017 in eight of the 46 health districts.
- Preparations for universal distribution of long-lasting insecticidal nets (LLIN) are ongoing, with distribution of vouchers completed in 94% of the targeted population. The distribution is now scheduled for 14 August 2017.
- Pre-positioning of LLIN continues at pre-identified sites, attaining 80% as of 21 July 2017. Of the 18 provinces, seven have already received all LLINs (Bujumbura Mairie, Bujumbura, Kirundo, Karusi, Bubanza, Cankuzo, Muramvya), while four provinces (Muyinga, Ngozi, Bururi, Gitega) have major gaps.

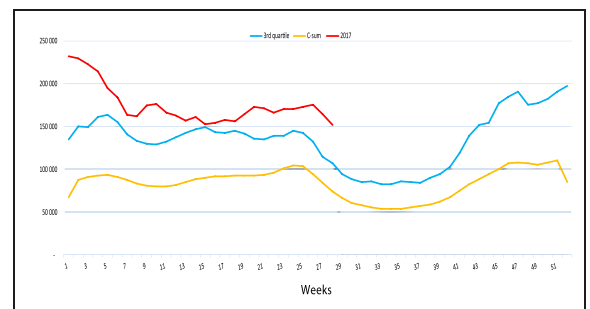
Situation interpretation

The outbreak of malaria in Burundi has started improving in the last 3 weeks, following enhanced efforts to strengthen the response operations. These improvements may be partly attributed to several key interventions, including stepping up supervision of response activities, conducting indoor residual spraying in hot-spot areas, securing supplies of anti-malarial medicines, and strengthening clinical management of cases. Despite this, the malaria outbreak remains serious and calls for further commitments from all stakeholders. The situation is even more worrying with the coming of the second rainy season, between October and December, when malaria transmission will intensify. In addition, several gaps still exist in the current response efforts, which need to be addressed diligently. Notably, there is a need to evaluate implementation of the current response to identify the bottlenecks and put in place remedial measures. As a matter of urgency, close supervision of response interventions require strengthening at all levels as well as improved coordination. The planned universal distribution of LLIN should be fast-tracked before the next high transmission season. Equally important is the urgent need to mobilize sufficient funds for the implementation of district micro-plans, including operation of mobile clinics. For this, the current funding gap of US\$ 9 million needs to be filled.

Geographical distribution of malaria cases in Burundi, 1 January - 30 July 2017



Weekly trend of malaria cases in Burundi, 1 January - 30 July 2017



Event description

The outbreak of cholera in the Democratic Republic of the Congo is escalating, with a dramatic increase in the number of new cases observed in the past 4 weeks. In week 30 (week ending 30 July 2017), 1 090 new suspected cholera cases including 11 deaths (case fatality rate 1.0%) were reported in the country, compared to 1 007 cases with 16 deaths (case fatality rate 1.6%) reported in week 29. This illustrates a rapid deterioration in the outbreak situation since week 25 (week ending 23 June 2017) when a total of 290 cases including three deaths were reported. Twelve (46%) out of the 26 provinces in the Democratic Republic of the Congo reported cases during the reporting week, with the most affected being North Kivu (700 cases, 2 deaths), accounting for 64% of the new cases. The other provinces with high transmission activity include South Kivu (108 cases), Haut-Lomami (101 cases, 1 death), Kongo-Central (59 cases), Tanganyika (49 cases, 1 death), Mai-Ndombe (20 cases, 1 death), and Kinshasa (15 cases, 2 deaths).

Since the beginning of 2017, 18 882 suspected/confirmed cholera cases including 485 deaths (case fatality rate 2.6%) have been reported, as of 4 August 2017. Since the beginning of the cholera outbreak in August 2015, a cumulative 48 234 cases including 1 302 deaths (case fatality rate 2.8%) have been registered in 20 out of the 26 provinces in the country. A total of 147 out of 517 health zones have been affected.

Public health actions

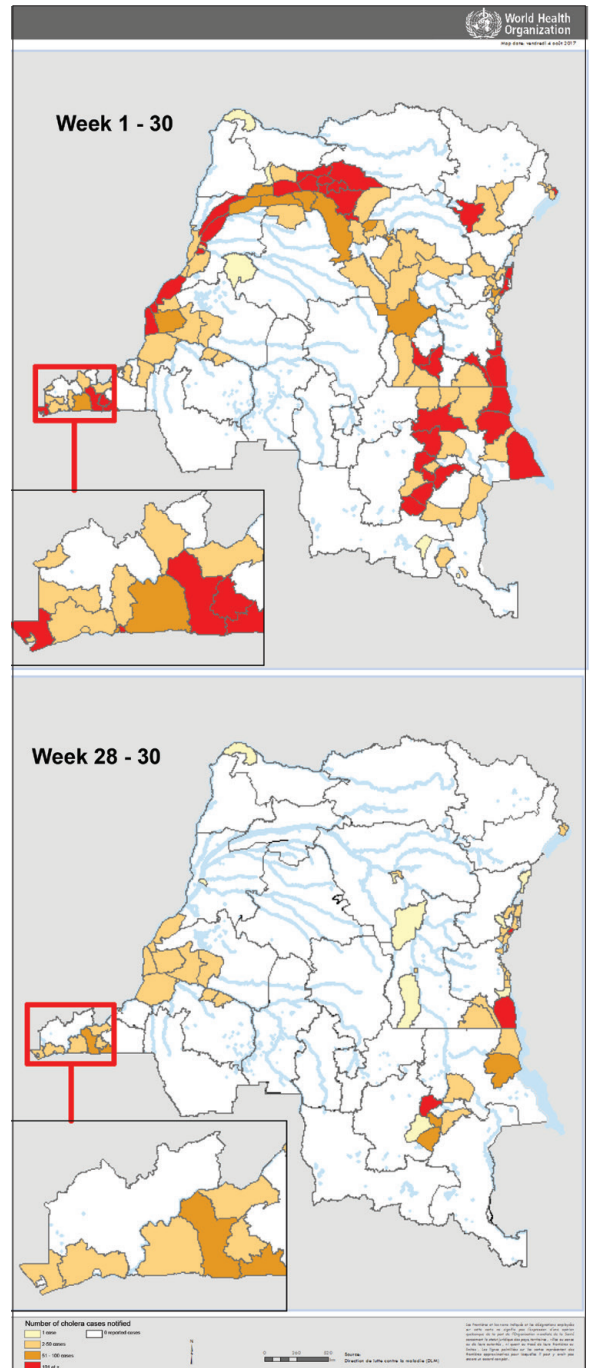
- WHO and partners continue to support the Ministry of Health to strengthen multisectoral coordination of the response interventions. Regular meetings of the cholera subcommittees are taking place at different levels.
- International non-governmental organizations including ALIMA, MSF and others continue to support provision of free treatment in affected provinces.
- The water, sanitation and hygiene (WASH) partners continue with chlorination at water points, installation of hand washing points, disinfection of water storage vessels, and activities to raise community awareness on safe water and hygiene practices.
- There is continuous dissemination of information, educational and communication materials, including regular articles in local newspapers and the WHO website, to maintain community awareness of the ongoing outbreak.

Situation interpretation

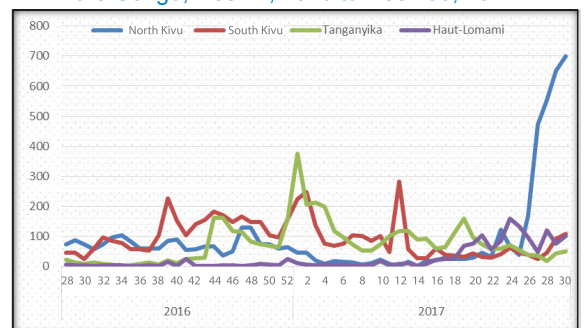
The outbreak of cholera in the Democratic Republic of the Congo is rapidly deteriorating despite the ongoing response efforts. This is an indication that the current interventions are not adequate to interrupt further transmission of infections and control the outbreak. It is important to note that the ongoing cholera outbreak is taking place within the context of a severe humanitarian emergency, which has not been adequately attended to. North Kivu Province, which is bearing the brunt of the current upsurge, is part of the conflict-affected areas, where there is an intense insurgency, ethnic clashes and social unrest, resulting in mass population displacements and humanitarian crisis. The response to the cholera outbreak therefore needs to be undertaken within a broader framework of the overall humanitarian context.

The outbreak of cholera in the Democratic Republic of the Congo calls for urgent attention from the global community. There is a need to re-strategize and invigorate the response efforts including involvement of more health partners to address current gaps.

Geographical distribution of cholera cases in Democratic Republic of the Congo, week 1 - 30, 2017



Weekly trend of cholera cases in North Kivu, South Kivu, Tanganyika, and Haut-Lomami, Democratic Republic of the Congo, week 2, 2016 to week 30, 2017



Event description

The United Republic of Tanzania is, once again, experiencing a flare-up of the cholera outbreak. During week 31 (week ending 6 August 2017), 198 new suspected cholera cases including four deaths (case fatality rate 2.0%) have been reported in Tanzania mainland, compared to 24 cases with zero deaths reported in week 30. The upsurge observed during the reporting week was a result of two new districts being affected, namely: Mbarali (195 cases and 4 deaths) and Mbeya (3 cases) in Mbeya Region. Five of the seven samples obtained from the new cases isolated *Vibrio cholerae* by culture at the Mbeya Regional Laboratory. The island of Zanzibar has reported zero cases and deaths in the past 26 days.

The cumulative number of cholera cases reported in Tanzania mainland from 15 August 2015 to 6 August 2017 is now 25 778, including 407 deaths, case fatality rate 1.6%. From 21 March to 6 August 2017, Zanzibar has reported a total of 359 suspected/confirmed cholera cases with four deaths (case fatality rate 1.1%). Since the start of the outbreak in August 2015, the cumulative number of cases and deaths from Zanzibar is 4 689 including 72 deaths (case fatality rate 1.5%).

Public health actions

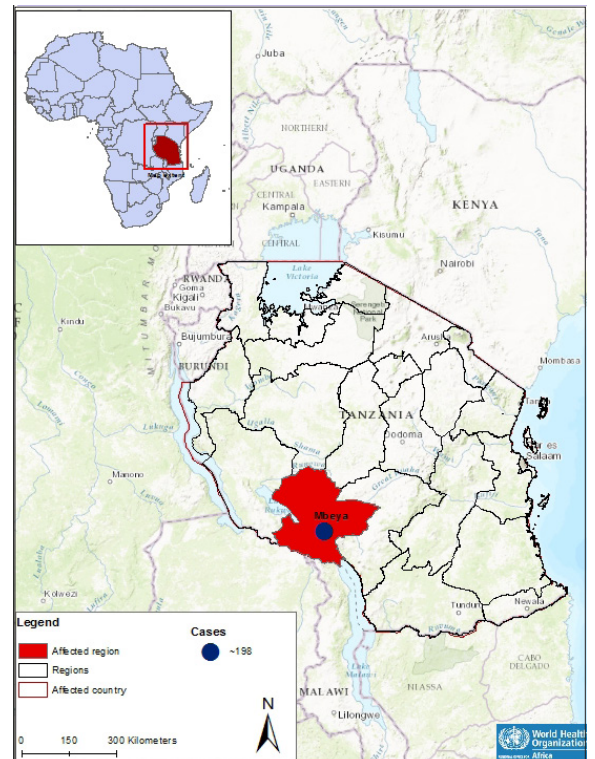
- The Ministry of Health (MOH), with support of WHO and other partners, continues to guide and monitor implementation of cholera control activities through the National Task Force meetings and field visits in affected areas.
- There is continued identification of sources of infection, intensified community engagement and leadership at MOH level to prevent transmission. A Rapid Response Team has been deployed in Mbeya Region since 6 August 2017.
- Regions are being followed up to ensure prompt reporting of all suspected cholera cases, as well as laboratory confirmation of suspected cases.
- There is continued advocacy for household water treatment, as well as bulk water chlorination in Dar es Salaam, along with community mobilization to promote safe water utilization, and improve sanitation and hygiene practices. Distribution of water guard, oral rehydration solution and chlorine tablets (Aqua tabs) continues in hotspot regions, along with distribution of medical supplies.
- There are sustained health promotion activities in communities through the media, community gatherings, and madrassas.
- There are efforts to reinforce public health regulations on hygiene and food safety practices
- Community sensitization and awareness is ongoing through local radio, national television and social media.

Situation interpretation

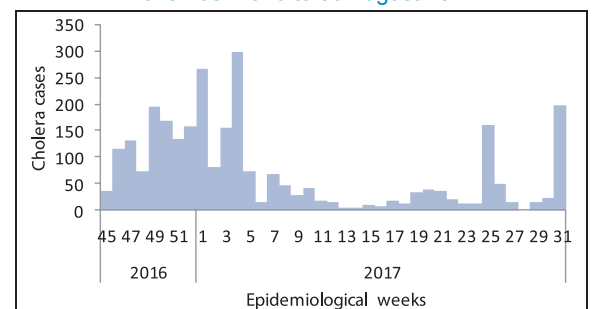
The current upsurge of cholera cases in Tanzania mainland was partly a result of a backlog of cases caused by non-reporting in Mbarali District, highlighting the importance of prompt reporting, to allow correct interpretation of weekly statistics and ensure that the appropriate response measures are in place. The outbreak in Mbarali District has been attributed to water scarcity and resulting use of contaminated water sources.

However, the spike in new cases in Tanzania mainland also highlights the importance of improved water, sanitation and hygiene (WASH) interventions at community, ward and district levels. It also emphasizes the importance of ongoing advocacy for a multisectoral approach and community engagement, and the need for efforts to address social determinants of health.

Geographical distribution of cholera cases in Tanzania, week 31, 2017



Weekly cholera trend for Tanzania mainland, November 2016 to 06 August 2017



Event description

The hepatitis E outbreak in the Salamat Region of Chad remains precarious even though a slight decrease has been observed in the previous weeks. Since our last report in week 29, 39 new cases have been reported, with no deaths or hospitalizations. These cases were reported from Amtiman North (8 cases), Amtiman South (3 cases), Amsiné (5 cases) and Aboudeia (10 cases). As of 6 August 2017, 1 697 suspected/confirmed cases including 77 hospitalizations and 18 deaths (case fatality rate of 1.1%) have been reported since the beginning of the outbreak in August 2016. Pregnant women have been disproportionately affected, with 64 reported cases, 20 hospitalizations and five deaths (case fatality rate among pregnant women, 7.81%).

This outbreak of hepatitis E was detected on 1 August 2016 and confirmed in January 2017. The Ministry of Health officially declared the outbreak on 14 February 2017.

Public health actions

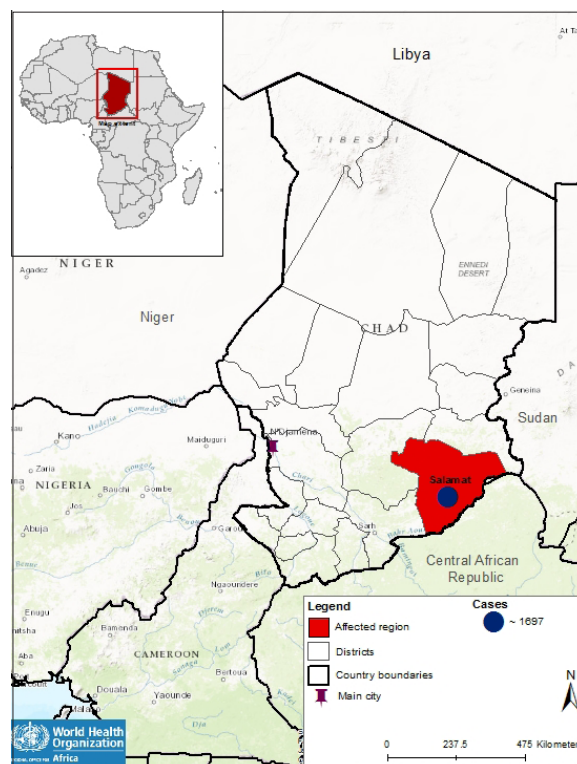
- The Ministry of Health, in collaboration with WHO and other partners, continue to coordinate, investigate and respond to the outbreak. Weekly technical coordination meetings are held with officials from the Ministry of Health, district health authorities, and partners.
- Chlorination activities were re-started on 3 August 2017 by the Health Delegation in collaboration with UNICEF. A total of 154 chlorinating agents and 18 hygiene promoters have been recruited.
- The water, sanitation and hygiene (WASH) coordination team distributed 1 594 078 liters of water to families most in need in week 31.
- Case management is ongoing in the local health facilities with the support of MSF.
- Community sensitization and risk communication activities continue to be strengthened in the affected areas through general community information sessions.

Situation interpretation

The hepatitis E outbreak in the Salamat region remains a concern, even though there has been a slight decline in the number of new cases. The perpetual lack of water, sanitation and hygiene (WASH) actors on the ground and the poor living conditions in the affected areas are some of the key factors that may contribute to the escalation of the situation. The response efforts have further been affected by the end of WHO financial assistance to the Aboudeia Health District to fund 85 Red Cross volunteers for active case detection and chlorination. This comes as a consequence of underfunding.

It is now crucial for the response team to take advantage of the current subdued transmission activity to intensify WASH activities in the affected region and conduct large-scale social mobilization activities to cover all the communities. Nevertheless, these can only be undertaken with improved funding and involvement of more actors.

Geographical distribution of hepatitis E cases in Chad, 1 August 2016 - 30 July 2017



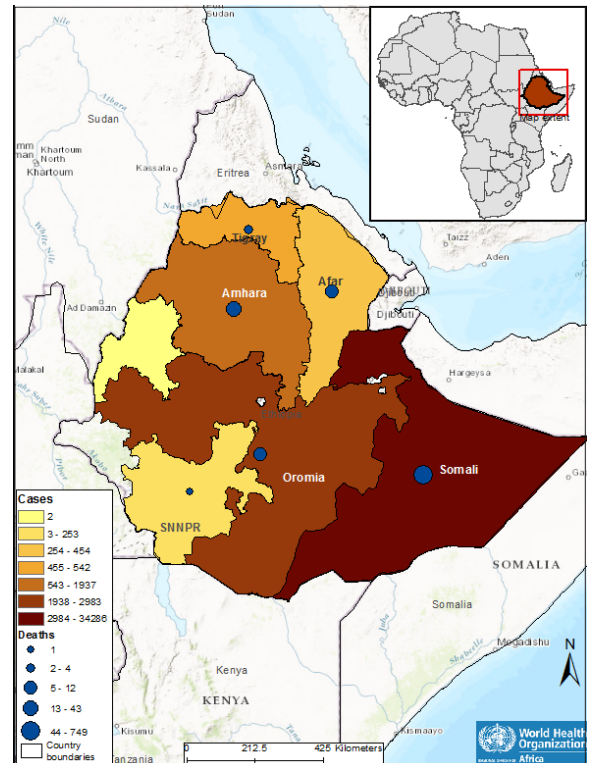
Event description

The humanitarian crisis in Ethiopia remains serious. There has been a slight increase in the incidence of acute watery diarrhoea (AWD) in Ethiopia, with new geographical areas being affected. In week 31 (week ending 6 August 2017), a total of 491 cases were reported from five regions: Amhara (194 cases, 40%), Tigray (182 cases, 37%), Somali (50 cases, 10%), Oromia (49, 10%), and Afar (16 cases, 3%). This increase comes after the AWD incidence went to a low of 296 cases in week 27. Between 1 January and 6 August 2017, 40 457 cases including 817 deaths (case fatality rate 2.0%) have been reported from seven regions of Ethiopia (Somali, Oromia, Amhara, Afar, SNNP, Tigray, Beneshangul Gumuz). Of these, 85% (34 286/40 457) of the cases and 91.7% (749/817) of the deaths were reported in Somali Region alone.

The outbreak of measles is still ongoing. During week 31 (week ending 6 August 2017), 137 new suspected measles cases were reported (although the majority were historical cases from previous weeks). Between 1 January and 6 August 2017, a total of 2 601 suspected measles cases were reported from across the country. During this period, 58 laboratory-confirmed measles outbreaks have been reported. Of the reported cases, 17.2% had zero previous doses of measles vaccine, and 43.8% had an unknown immunization status. Oromia Region remains the most affected region with 31% of the reported cases, followed by Amhara (26%), Addis Ababa (20%), and SNNPR (11%). The age distribution shows that children under 5 years of age were the most affected, at 39% of the affected population, while children 5-14 years represented 37% of those affected.

Oromia Region continues to report a high burden of malnutrition. During week 31, a total of 1 623 new severe acute malnutrition (SAM) cases were reported in the Region. Out of these reported cases, 1 428 were managed at the outpatient therapeutic programme (OTPs) and 195 cases were admitted to the stabilization centres (SCs) in the affected zones in the region. Between 1 January and 6 August 2017, a total of 41 879 SAM cases were reported in Oromia Region. These include 37 170 cases managed at OTPs and 4 709 cases admitted to SCs.

Geographical distribution of cholera cases in Ethiopia, 1 January - 6 August 2017



Public health actions

- The case management team continues to monitor and strengthen the adherence to infection, prevention and control (IPC) measures and other case management protocols in the affected regions.
- WHO teams provided orientation and supervision for IPC during disinfection of closed AWD treatment facilities in Dollo and Jarar zones; the process is on-going.
- The second phase of the integrated measles campaign in Somali Region has been concluded. The campaign covered the seven zones not covered during the initial campaign. Reports are expected soon.
- Active surveillance has been reinforced in Amhara, Beneshangul Gumuz, Oromia, SNNP and Somali regions.
- Water, sanitation and hygiene (WASH) partners continue to support distribution of water treatment chemicals to AWD-affected woredas in Somali Oromia and Amhara regions, in collaboration with the RHB and other partners.
- The WASH partners supported direct implementation of hygiene promotion activities during the Kulubi religious festivals through provision of hand washing soaps, adequate waste collection and disposal, construction of latrines and provision of PPEs.
- WHO and partners supported development of a preparedness plan for future religious events in Oromia Regions in conjunction with the RHB and other partners.
- Social mobilization activities continue, including engagement of religious and community leaders, teachers and other leading figures in risk communication and health promotion. A mobilization team launched an awareness creation campaign.

Situation interpretation

The humanitarian crisis in Ethiopia remains serious, with AWD, measles and malnutrition being the major public health problems. The spread of AWD to new geographical areas raises concerns over possible resurgence of the outbreak. The current upsurge in AWD cases in Amhara and Tigray may partly be attributed to various religious gatherings, where contaminated holy water sites, contaminated rivers, and poor hygiene and sanitation practices were identified as risk factors. Access to safe water continues to be a challenge, with over 1 million people still not reached. Access is further challenged by the increasing number and wide geographic spread of internally displaced persons and refugees.

While efforts are being stepped up to address malnutrition, concrete interventions at field level are still inadequate. As a result, the number of new SAM cases continues to rise weekly, especially in Oromia Region.

A recent reassessment of this event (based on the revised WHO Emergency Response Framework) has maintained a very high level of risk at country and regional levels, given the resurgence of AWD aggravated by ongoing drought, rising rates of malnutrition, and continued internal displacement of people and their livestock, and high rates of population movement across borders. The overall risk at global level is considered moderate due to the risk of further spread to additional areas especially the Arabian Peninsula. Yemen is currently in the midst of a huge outbreak of cholera. These factors have all contributed to a decision to transition the complex humanitarian crises to a protracted 3 emergency. This new grade indicates the level of operational response to be sustained by WHO over a prolonged period.

Event description

The security situation in South Sudan has resulted in mass displacement of people, food insecurity and weakening of health systems, with concomitant effects on the spread of communicable diseases such as the current cholera outbreak, which started in mid-2016. Fighting between government and opposition forces continues, as does cattle raiding, the latter particularly in Equatoria Region. An inter-cluster assessment (led by the Protection Cluster) conducted in Kolmarek, Jonglei State on 21 July 2017 established that 6 000 individuals were affected by violence associated with a cattle raid, of whom 3 387 were reported to be in need of assistance.

Fighting among internally displaced persons (IDPs) in Bentiu Protection of Civilians (POC) area in Unity State, resulted in up to 1 000 IDPs moving to Leer for safety. Continuing rumours of an attack on Bentiu, with unconfirmed reports of a possible build-up of opposition forces, have forced a review of contingency and relocation plans for the Bentiu POC site by humanitarian actors. Humanitarian access is constrained and as a result, the numbers and the needs of IDPs in several areas affected by fighting have not been assessed and in some regions, aid workers have been relocated and UN and NGO agencies have evacuated staff.

Food insecurity continues to be a major concern, with 1.7 million people at elevated risk of famine. Leer, Mayendit and Koch in Unity State, and Ayod in Jonglei are most affected. The situation is exacerbated by incidents of looting. For example, an incident took place on 19 July 2017 in Tonj East, involving a World Food Program (WFP) warehouse containing 245 metric tons of food items. Malnutrition remains a major public health emergency in parts of South Sudan and 10 out of 12 surveys conducted from March to May 2017 showed global acute malnutrition (GAM) above the emergency threshold of 15%.

There is active cholera transmission in Kapoeta and Tonj East counties. In week 31 (week ending 6 August 2017), 102 new cholera cases and one death (case fatality rate 1.0%) were reported. The cumulative total number of cholera cases since the start of the current outbreak on 18 June 2016 is 19 742 cases and 355 deaths (case fatality rate 1.8%). Since the start of 2017, 14 549 cases, including 247 deaths (case fatality rate 1.7%), have been reported

Public health actions

- Oral cholera vaccination is planned by WHO and partners in Kapoeta and Tonj East counties, where 500 000 doses have been deployed.
- Food distribution and measles and polio vaccination and vitamin A supplementation targeting 48 000 IDPs is ongoing in Yei, Central Equatoria, and an IRNA has been done in Lainya and Wonduruba, Central Equatoria and an inter-cluster response is ongoing, including distribution of food.
- In Upper Nile, the inter-cluster working group (ICWG) has planned assessments for Pigi and Gerachol, Balliet and the Melut POC is expected to finally close, with relocation of residents by the end of August 2017.
- In Lakes region, the WFP is to prioritize Annual, Abang and Aluakluak where there are unverified reports of hunger-related deaths.
- WHO and other partners are planning to conduct an assessment in the area of Yambio County, Western Equatoria, where there are reports of 4 000 IDPs following attacks by opposition forces and an interagency team is currently in Mvolo to conduct rapid assessment of reported severe food insecurity and hunger-related deaths among 28 827 IDPs, displaced by cattle raids.

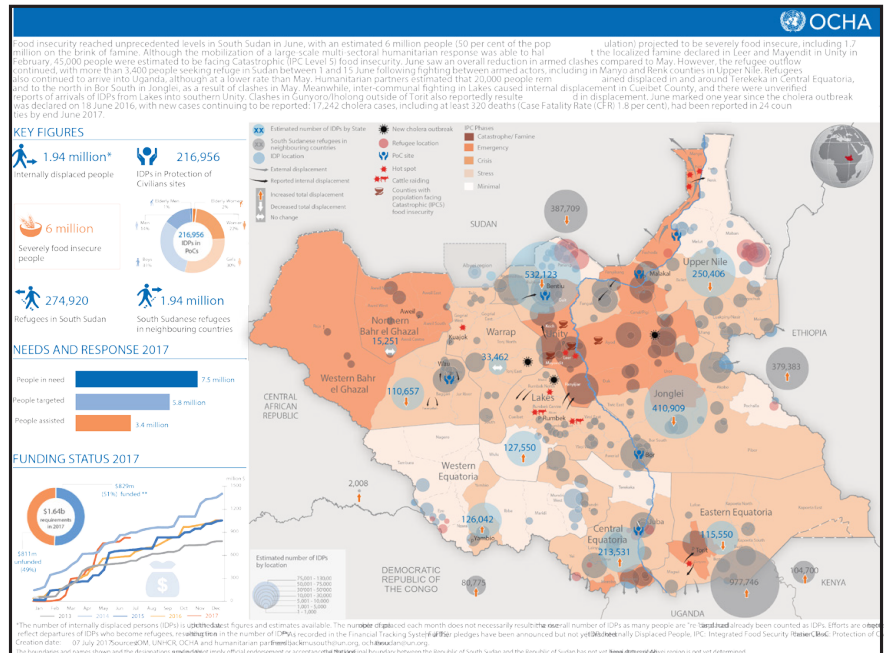
Situation interpretation

There is no indication that the security situation in South Sudan will improve in the foreseeable future. The severe food insecurity is likely to be prolonged, affected particularly by continuing displacement of people from Equatoria Region, and hyperinflation affecting the urban poor, whose purchasing power has been massively reduced.

Although the mass administration of cholera vaccine in affected areas is expected to reduce the incidence of the disease and break the chain of transmission, continuing underfunding of the water, sanitation and hygiene (WASH) pipeline may adversely affect this. A combined multi-pillar approach is critical to effectively control this outbreak, of which cholera vaccination is only one component. As the rainy season sets in, the incidence of malaria is also expected to rise, leading to high rates of morbidity and mortality.

Other core areas that are underfunded are reproductive health and general public health, and donors are urged to ensure that timely funding is available by the third quarter to ensure that critical interventions continue.

Humanitarian snapshot in South Sudan, June 2017



Summary of major challenges and proposed actions

Challenges

- The outbreak of cholera in the Democratic Republic of the Congo is rapidly escalating despite ongoing control measures. This outbreak is taking place within the context of a severe humanitarian emergency, which needs to be attended to more comprehensively. The response to this cholera outbreak, therefore, needs to be undertaken within the broader framework of the overall humanitarian context.
- Uganda is currently experiencing an outbreak of measles in the densely populated greater Kampala Metropolitan area. The current outbreak is being attributed to low immunization coverage, as a result of many health systems issues as well as socio-economic dynamics. This urban outbreak could have serious public health consequences, especially to the vulnerable peri-urban population, if not addressed rapidly.

Proposed actions

- The outbreak of cholera in the Democratic Republic of the Congo calls for urgent attention from the global community. There is a need to re-strategize and invigorate the response efforts including involvement of more health partners to address current humanitarian challenges
- WHO and partners (UNICEF, AFENET, etc.) to support the national authorities to plan and implement appropriate response measures, including identifying and immunizing the growing number of unvaccinated children. Provision of more supplies of measles vaccine as well as involvement of private health providers in immunization activities is crucial.

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								
Unexplained disease (Lassa fever suspected)	Benin (ex Nigeria)	Ungraded	03/08/2017	1	0	0.0%	On July 29, 2017, a patient with Lassa fever-like illness (fever, intense cough, maculopapular rash, <i>haematemesis</i> , <i>melena</i> , conjunctival injection, anorexia, muscle pain, dysphagia and cutaneous hyperaesthesia) was isolated and treated in a private clinic in Gohomey, Benin. The patient (originally from Benin) resides in Abeokuta in Ogun State, Nigeria, which is currently reporting a Lassa fever outbreak. A sample collected and tested at the Cotonou P3 laboratory was negative for Lassa fever. The patient was discharged when the symptoms improved.	05-Aug-17
Unexplained disease (carbon monoxide poisoning suspected)	Uganda	Ungraded	07/08/2017	4	1	25.0%	On 7 August, media reported the death of a 20-year-old pregnant woman who died of unknown cause. Viral haemorrhagic fever was suspected based on the symptoms of the woman, including bleeding from the ears, nose and mouth. Three of her housemates were admitted with symptoms ranging from confusion, limb pain/weakness and respiratory distress. Samples of the 4 cases contacts tested negative for by PCR at Uganda Virus Research Institute (UVRI) for Ebola, Marburg, CCHF, RVF and Sosuga (novel paramyxovirus) viruses. Post mortem reports high levels of carboxyhaemoglobin, suggesting carbon monoxide poisoning may be the cause of this event.	11-Aug-17
Measles	Uganda	Ungraded	08/08/2017	282	1	0.4%	Detailed update given above.	10-Aug-17
CCHF	Namibia	Ungraded	09/08/2017	2 (1)	1	50.0%	Detailed update given above.	10-Aug-17
Unexplained disease (VHF/varicella suspected)	Equatorial Guinea	Ungraded	09/08/2017	3	2	66.7%	WHO was informed of 3 cases including 2 deaths classified as suspected viral haemorrhagic fever in the Bata city hospital. Cases included: (i) a 42 years old male, onset 21 July with fever, skin rash (papulovesicles similar to chickenpox), bilateral pneumonia, haemoptysis and died 26 July; (ii) his 1 year-old daughter with skin rash seeking healthcare on 4 August, treated as outpatient; and (iii) a 27 years-old male hospitalized on 2 August with skin rash and bilateral pneumonia and died on 6 August. Blood samples are being analysed at the CIRMF WHO Collaborating Centre in Gabon. Samples from cases (ii) and (iii) have tested negative for Ebola. Testing for other pathogens is ongoing. Varicella is one of the possible underlying causes discussed.	10-Aug-17
Ongoing events								
Cholera	Angola	G1	04/01/2017	376*	21*	5.6%	*Counts reported are for 2017 YTD only. Since early December 2016, cases have been detected in Cabinda (225), Soyo (225) and Luanda (5).	28-Jun-17
Malaria	Burundi	G1	01/01/2017	4 864 976*	2 205*	0.05%	*Counts include cases for 2017 YTD only. Detailed update given above.	23-Jul-17
Malaria	Cabo Verde	Ungraded	26/07/2017	45	0	0.0%	An outbreak of indigenous malaria was reported in the capital city of Praia, Santiago Island, peaking in week 29. 53% of cases were adult males aged 20 years and older.	30-Jul-17
Humanitarian crisis	Cameroon	G2 extension	-	-	-	-	-	23-Jul-17
Eruptive fever	Cameroon	Ungraded	16/02/2017	52	20	38.5%	An outbreak of atypical paediatric eruptive fever of an unknown etiology emerged in the northern regions of Cameroon during November-December 2015. Investigations to date are yet to identify a definitive cause; however, evidence is pointing to leishmaniasis in some cases and endemic African Kaposi's sarcoma in others. A detailed update was provided in the week 30 bulletin.	21-Jul-17
Humanitarian crisis	Central African Republic	Downgraded to G2	-	-	-	-	-	17-Jul-17
Monkeypox	Central African Republic	Ungraded	14/04/2017	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	01/09/2016	1 697 (98)	18	1.1%	Detailed update given above.	06-Aug-17
Monkeypox	Congo (Republic of)	Ungraded	01/02/2017	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	06/05/2017	858 (375)	2	0.2%	From 19 to 25 July, 122 new suspected cases were reported, 120 of them in Abidjan. Three subtypes of dengue virus have been isolated: DENV-2 (174 cases), DENV-3 (76 cases) and DENV-1 (13 cases). In addition, 112 samples were confirmed IgM positive by serology. Of 77 yellow fever virus cross reactions, further testing confirmed dengue virus on 31 samples tested to date.	25-Jul-17
Humanitarian crisis	Democratic Republic of the Congo	Ungraded	August 2016	-	-	-	The fighting and insecurity continue to cause a humanitarian crisis with severe public health impact, mostly in the provinces of South- and North-Kivu, Ituri, Tanganyika, and Haut-Katanga. And since mid-August 2016, the security situation has significantly deteriorated in the Kasai Region. A detailed update was provided in the week 30 bulletin.	21-Jul-17
Cholera	Democratic Republic of the Congo	G2	02/01/2015	18 882*	485*	2.6%	*Counts reported are for 2017 YTD only. Detailed update given above.	04-Aug-17

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Measles	Democratic Republic of the Congo	Ungraded	10/01/2017	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	Ethiopia	Regraded Protracted 3	15/11/2015	-	-	-	This complex emergency includes outbreaks of AWD and measles (reported separately below). A detailed update on the protracted event will be provided every second week.	23-Jul-17
Acute watery diarrhoea (AWD)	Ethiopia	Ungraded	15/11/2015	40 457*	817	2.0%	*Counts reported are for 2017 YTD. Of 491 new cases reported in week 31. The recent resurgence is predominantly occurring in the northwest regions of Amhara (194 cases) and Tigray (182 cases) this past week.	06-Aug-17
Measles	Ethiopia	Ungraded	14/01/2017	2 601*	-	-	*Counts reported are for 2017 YTD. There have been 58 separate laboratory-confirmed measles outbreaks in the country. 137 new cases were reported in week 31.	31-Jul-17
Drought/food insecurity	Kenya	G1	-	-	-	-	This event forms part of a larger food insecurity crisis in the Horn of Africa. SMART surveys highlighted that the rates of Global Acute Malnutrition increased across the country. An estimated 7.8 million population are in IPC3-5 during May/June 2017.	27-Jul-17
Cholera	Kenya	G1	10/10/2016	1 551 (457)*	25*	1.6%	*Counts reported are for 2017 YTD only. During week 30 (week ending 30 July 2017), 108 new suspected cases were reported from eight counties, of which 76% were from Nairobi (59 cases) and Kisumu (23 cases) counties. Detailed national updates are not available this week due to the current elections; however, an update from the outbreak in Nairobi as of 6 July reported 16 new cases in the past week, totally 921 cases to date.	31-Jul-17
Measles	Kenya	Ungraded	12/03/2017	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 since 4 July and 5 July in the two counties, respectively.	31-Jul-17
Visceral leishmaniasis / kala-azar	Kenya	Ungraded	05/05/2017	353 (212)	7	2.0%	Marsabit (n=279) and Wajir (n=119) counties have been affected by outbreaks since early 2017. Outbreaks remain active in both areas. 23 new cases were reported from Marsabit county in the last week. The last cases reported from Wajir County occurred 17 June 2017.	31-Jul-17
Dengue	Kenya	Ungraded	09/05/2017	1 305 (706)	1	0.1%	The outbreak has been reported in Mombasa County (n=1 223) and Wajir County (n=82). There were no new cases this week. The last cases reported on 7 July and 20 June 2017 within the two counties, respectively.	31-Jul-17
Food insecurity	Madagascar	Ungraded	23/02/2017	-	-	-	Food insecurity continues in the south parts of the island. 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. A detailed update was provided in the week 30 bulletin.	15-Jul-17
Undiagnosed diarrhoeal disease	Mauritania	Ungraded	27/07/2017	79	0	0.0%	On 16 July 2017, the Ministry of Health were informed of an outbreak of diarrhoeal disease at Cheikh Zayed Hospital, Wilaya, Nouakchott, which at the time included 40 cases of non-febrile, non-riziform, watery diarrhoea without blood/mucus from 7 separate locations. 10 stool samples collected were negative for bacteria (apart of one positive Escherichia coli, not typed). In a second cluster altered on 25 July 2017 from Centre Hospitalier Mère-Enfant, 39 children presented with similar symptoms over a period of 25 days, of whom 17 were hospitalised for 2-3 weeks. Investigations are ongoing but a viral cause is suspected.	03-Aug-17
Humanitarian crisis	Mali	G1	-	-	-	-	Limited information is available on this event. At the last update (3 May), the security situation remained unstable, and incidents of violence and inter-ethnic conflicts were increasingly spreading.	03-May-17
Hepatitis E	Niger	Ungraded	06/04/2017	1 446 (441)	38	2.6%	During week 29, 55 new suspected cases and no deaths were reported, compared to 74 new cases recorded in week 28. Overall, approximately 88% of the cases came from Diffa, N'Guigni and Bosson health district in the Diffa Region.	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.	31-Jul-17
Lassa fever	Nigeria	Ungraded	01/12/2016	681 (212)	112	16.4%	Active transmission is currently being reported in five states (Bauchi, Edo, Ogun, Ondo, and Plateau). In week 30 (week ending 30 July 2017), 13 new (of which 8 were confirmed)suspected cases were reported from four states, namely: Plateau (5), Ondo (5) Bauchi (2), and Ogun (1).	28-Jul-17
Cholera	Nigeria	Ungraded	07/06/2017	3 164* (26)*	49*	1.5%	*Counts reported are for 2017 YTD only. Detailed update given above.	27-Jul-17
Hepatitis E	Nigeria	Ungraded	18/06/2017	696 (42)	4	0.6%	The outbreak is concentrated in Borno State, with incidence steadily declining after peaking in week 26. During week 30, 7 new suspected cases were reported, all from Ngala LGA.	31-Jul-17
Necrotising cellulitis/fasciitis	Sao Tome & Principe	G2	10/01/2017	1 855	0	0.0%	The epidemic curve has plateaued. Between 8-32 new cases have been reported each week for the past 23 weeks.	10-Aug-17
Dengue	Seychelles	Ungraded	20/07/2017	3 679 (1 295)	-	-	Detailed update given above.	06-Aug-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.	06-Aug-17
Cholera	South Sudan	Ungraded	20/02/2017	14 447*	246*	1.7%	*Counts reported 2017 YTD only. Cases continue to decline this past week.	06-Aug-17
Nodding disease	South Sudan	Ungraded	30/06/2017	70	-	-	Unconfirmed media reports of over 70 cases of nodding disease among children in Maridi, Jubeck, Amadi and Gbude state since mid-2016. WCO staff are so far unable to confirm the event due to an upsurge in insecurity in the country and affected provinces. More details will be provided when available.	23-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
Cholera	Tanzania	G2	15/08/2015	30 467	476	1.6%	Detailed update given above.	06-Aug-17
Aflatoxicosis	Tanzania	Ungraded	28/06/2017	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 Kiteo District, Manyara Region in the northern part of Tanzania. No further cases have been reported to date. 30 blood samples collected during community investigations have been submitted for aflatoxin testing, and 28 blood samples for pesticide poisoning; results pending.	06-Aug-17
Drought/food insecurity	Uganda	G1	-	-	-	-	This event forms part of a larger food insecurity crisis in the Horn of Africa. The northern and eastern regions are predominantly affected.	24-Jul-17
Humanitarian crisis - refugee	Uganda	Ungraded	-	-	-	-	As of 1 July 2017, 1 309 698 refugees and asylum-seekers have been registered in Uganda, largely from South Sudan, Somalia, Burundi, and the Democratic Republic of the Congo. A detailed update on this humanitarian crisis was provided in the week 30 bulletin.	24-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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Correspondence on this publication may be directed to:

Dr Benido Impouma

Programme Area Manager, Health Information & Risk Assessment

WHO Health Emergencies Programme

WHO Regional Office for Africa

P O Box. 06 Cité du Djoué, Brazzaville, Congo

Tel: +4724139773

Email: impoumab@who.int

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Please contact (afrooutbreak@who.int) for any clarifications.

Contributors

Dr. L. Kakonku (Benin)
Dr. M. Muita (Tanzania)
Dr. A. Diazo (Chad)
Dr. M. Livinus (Ethiopia)
Dr. G. Guracha (South Sudan)

Graphic design

Mr. A. Moussongo

Data sources

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Editorial Team

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Dr. C. Okot
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