

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 14: 1 – 7 April 2017
Data as reported by 17:00 7 April 2017

1

New Event

38

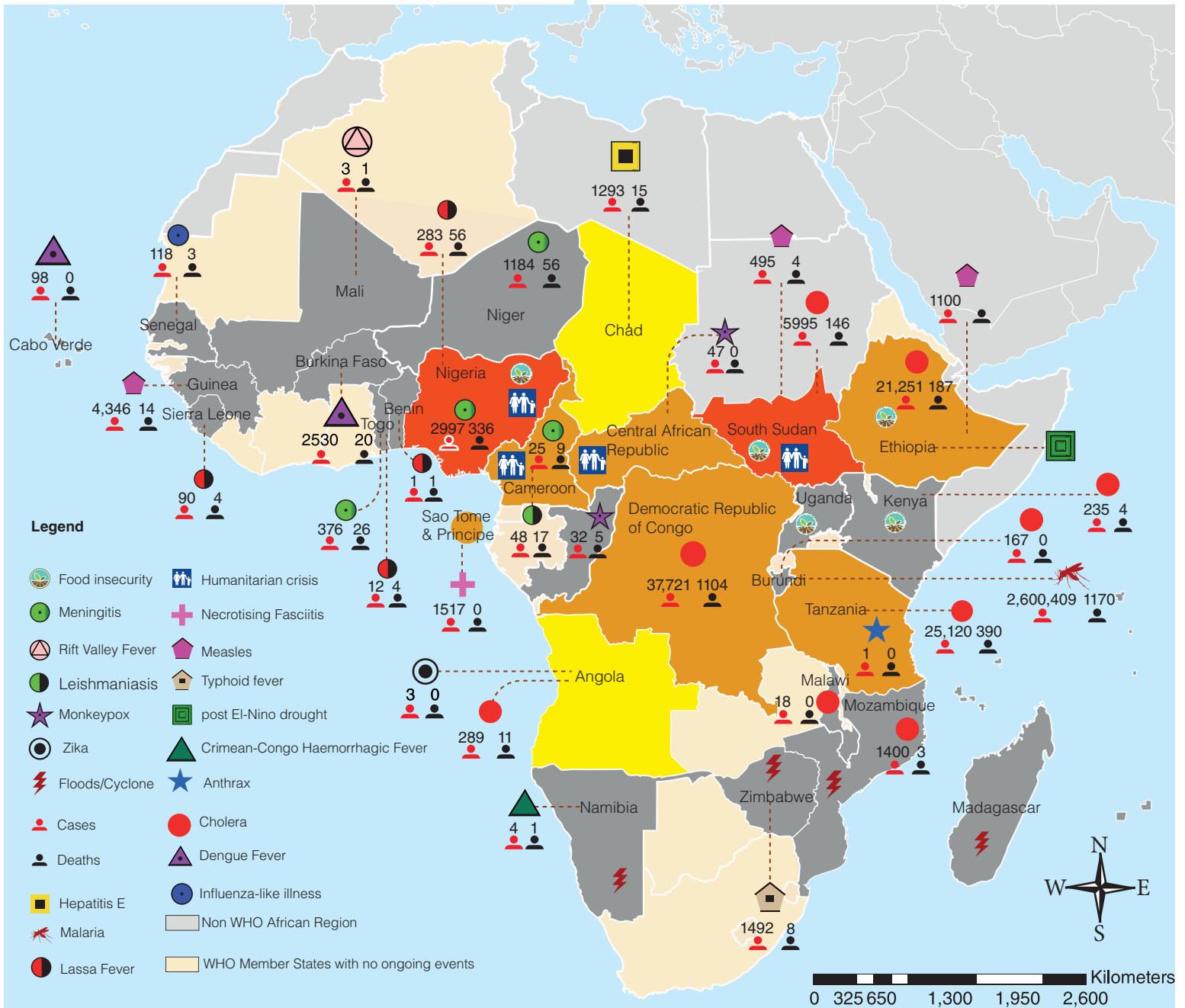
Ongoing events

31

Outbreaks

8

Humanitarian crises



2

Grade 3 events

6

Grade 2 events

2

Grade 1 events

29

Ungraded events

Overview

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- This weekly bulletin focuses on selected acute public health emergencies occurring in the WHO African region. WHO AFRO is currently monitoring 39 events: two Grade 3, six Grade 2, two Grade 1, and 29 ungraded events.
- This week, one new event has been reported: an outbreak of influenza-like illness in Senegal.
- The bulletin also focuses on key ongoing events in the region, including the two grade 3 humanitarian crises in Nigeria and South Sudan as well as outbreaks of acute watery diarrhea /cholera in Ethiopia, malaria in Burundi, and meningitis in Nigeria, Niger and Togo.
- 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 public health events currently being monitored in the region.
- Major challenges to be addressed include:
 - Reluctance of some countries to share data and information on outbreaks and other public health emergencies.
 - The security challenges that impede access to populations in need of humanitarian assistance and deter aid workers from providing life-saving interventions, especially targeting vulnerable and hard to reach populations.
 - Ongoing need for strong financial backing from donor partners to humanitarian actors, given the increasing complexity and scale of public health emergencies.

New event

Influenza-like illness

Senegal

118
Cases

3
Deaths

2.5%
CFR

Event description

On 28 March 2017, the Ministry of Health of Senegal notified WHO of an outbreak of influenza-like illness in Kédougou region in the South Eastern part of the country. The outbreak was detected on 22 March 2017 when a local school authority alerted the chief medical officer of Saraya district of clusters of influenza-like illness. During the same period, the local health facility reported 24 cases of influenza-like illness coming from the environs of the school. The acute respiratory infection, initially affecting mainly pupils under seven years, manifested with febrile respiratory features including cough, pain in the throat and sometimes dyspnea.

During the preliminary outbreak investigation, biological specimens comprising of 42 blood samples and five naso-pharyngeal swabs were obtained from the initial acute cases and shipped to Institut Pasteur, Dakar (IPD). The blood samples analyzed were negative for arboviruses while the five naso-pharyngeal swabs tested positive for pandemic influenza A (H1N1) by polymerase chain reaction (PCR) technique – thereby confirming the outbreak. Superimposed bacterial co-infection was also identified.

Between 20 March and 30 March 2017, a total of 118 cases of influenza-like illness including three deaths (case fatality rate of 2.5%) were reported from four villages (Sanéla, Manankoly, Nafadji, and Badioula) in Saraya district. These villages share borders with Mali and Guinea, whose population are served by Saraya health district, Kédougou region. About 65% of the recorded cases were children under seven years of age. No new cases have been reported since 30 March 2017.

Public health actions

- A multidisciplinary team from the Disease Prevention and Control unit of the Ministry of Health, Institut Pasteur, Dakar and WHO were deployed to Kédougou region on 29 March 2017 to conduct further investigation and support the response. A total of 44 suspected cases and 24 contacts were investigated, from which naso pharyngeal swab were collected; in addition to 35 oral swabs. The laboratory results are still pending.
- The Emergency Operation Centre (EOC) has been activated to coordinate response to the outbreak.
- WHO provided guidelines and tools for investigating and managing influenza outbreak.
- The Ministry of Health, the Syndromic Sentinel Surveillance Network (4S network) in Kédougou region and WHO have strengthened influenza surveillance activities at the sentinel sites and the community.
- Community sensitization in Kédougou region including the villages surrounding Saraya health district, Diakha Madina and Nafadji health facilities has been reinforced.

Situation interpretation

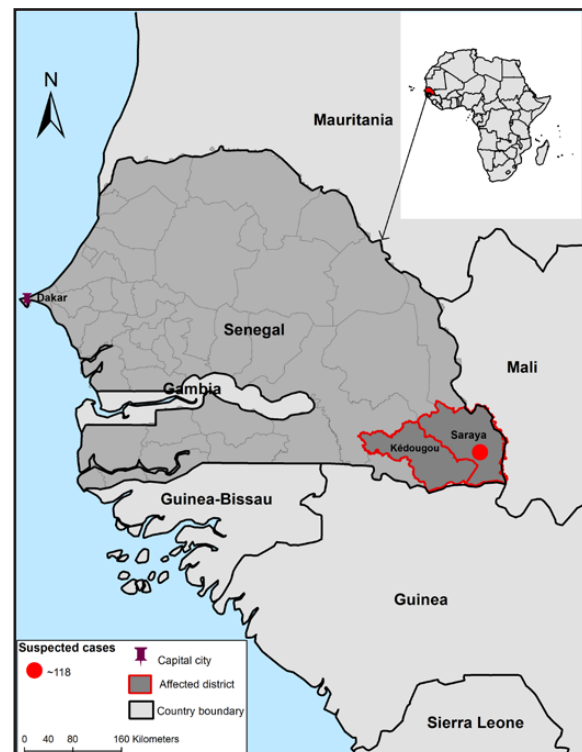
The influenza H1N1 virus that caused the 2009 pandemic is now a regular human influenza virus circulating seasonally worldwide. Senegal regularly experiences seasonal influenza outbreaks during rainy seasons, especially from July to October. The country has observed significant activity of pandemic influenza A (H1N1) virus subtype since 2010. Sixteen percent of 1,826 specimens analysed through the syndromic sentinel surveillance network in 2016 were positive for influenza. The predominant circulating virus subtype was influenza A, with 98% positivity rate. Out of these, 87% was influenza A (H3N2) subtype and 13% pandemic influenza A (H1N1) subtype. In January 2015, an unusual influenza activity was observed with predominance of influenza A (H1N1) subtype. The occurrence of the current influenza outbreak outside the usual season is therefore not uncommon.

The country has a good influenza preparedness system. The National Influenza Centre (P3 plus) biocontainment laboratory located in the Pasteur Institute of Dakar (IPD) has been part of the Global Influenza Surveillance Network (GISN) coordinated by WHO since 1996. The Senegalese syndromic sentinel surveillance network (4S network) for severe acute respiratory infection and influenza-like illness has representative coverage in the country including Kédougou region. Furthermore, the country is benefiting from the Pandemic Influenza Preparedness Framework (PIP) for determination of influenza burden of disease. The PIP Framework facilitates sharing of influenza viruses and access to vaccines and other benefits to improve global pandemic influenza preparedness and response.

These capabilities enhance the ability to detect unusual events in real-time, based on daily syndromic data. The good preparedness system led to early detection, notification and quick containment of this outbreak. There is need to remain vigilant and continue surveillance and laboratory activities for early detection of new influenza strains for rapid response and containment.

A burden of disease study carried out in Senegal (funded by the PIP project) showed that Influenza virus infection causes a substantial burden of outpatient visits, particularly among children under five of age. The current outbreak signifies the burden of influenza and affirms similar pattern as 40% of cases are children under five years of age. The study also highlighted the importance of vaccination in protecting populations at risk. There is a need for high level advocacy and communication to Member States to invest in protective measures including influenza vaccination, which is not systematically used or available because of limited financial supports.

Geographical distribution of Influenza-like illness cases in Senegal, 22 - 30 March 2017.



Ongoing events

Acute watery diarrhea/cholera

Ethiopia

21,251
Cases

187
Deaths

0.94%
CFR

Event description

Ethiopia continues to experience the outcome of the El Niño-caused drought and floods that subjected over 4.3 million people to require urgent humanitarian assistance. The emergency situation has been compounded by an outbreak of acute watery diarrhea/ cholera, primarily as a result of the prolonged water shortage and population displacements. The outbreak of acute watery diarrhea/cholera that begun in November 2015 in Oromia region was controlled but resurged in 2017. In week 13 (week ending 2 April), a total of 3,957 cases were reported from Oromia and Somali regions of the country. About 99% of these cases came from Somali region. As of 2 April 2017, a total of 21,251 cases and 187 deaths (case fatality rate of 0.94%) have been reported from six regions, namely Amhara, Afar, Oromia, SNNP, Somali and Tigray. Somali region remains the most affected, accounting for about 90% of the total caseload reported. Between 1 January and 2 April 2017, there has been a four-fold increase in the number of Woredas in the country that are actively reporting cases of AWD/cholera, compared to the same period in 2016.

Public health actions

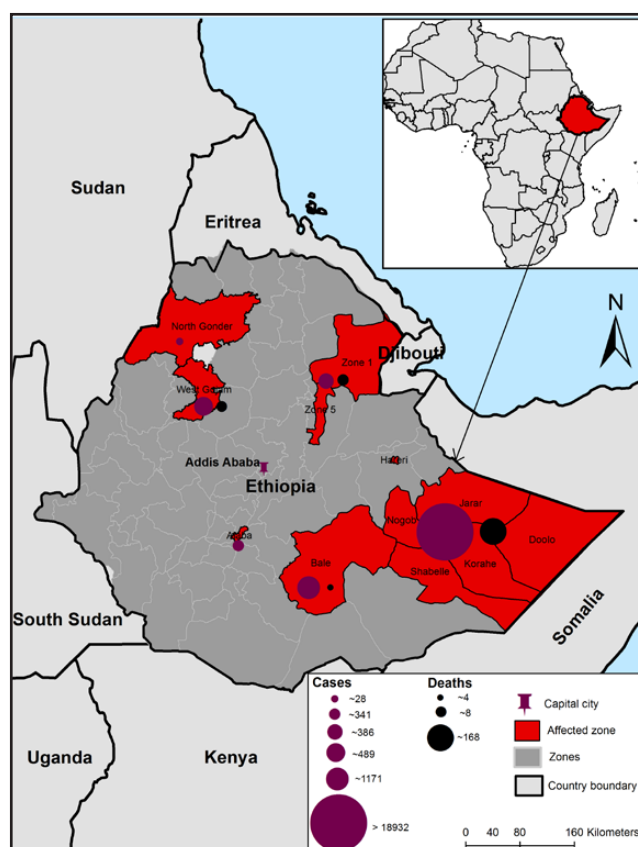
- WHO and the Global Outbreak Alert and Response Network (GOARN) partners deployed an emergency response team to Ethiopia to scale up response to the ongoing outbreak of AWD/cholera. The team is composed of an Incident Manager, Technical/Health Operations lead, Information Lead, and Health Cluster Lead.
- The WHO and GOARN emergency response team held consultative operational planning meetings with partners including MSF, IFRC, UNICEF, CDC, etc. This is aimed to systematically strengthen GOARN partners' involvement and support in the response to AWD/cholera outbreak at the field level.
- WHO Ethiopia and other partners are supporting the Command Post structure in Somali region to coordinate the response to the outbreak including monitoring and strengthening of adherence to infection prevention and control and case management practices, strengthening active surveillance, epidemiological analysis and laboratory support.
- Partners advocated to the government authorities to facilitate sharing of data for targeting control interventions.
- On the job training on infection prevention and control has been carried out at the treatment centres.
- Training and re-orientation of staff were conducted on surveillance and epidemiology of acute watery diarrhea/cholera.
- Technical support has been provided to increase the number of dedicated surveillance officers in Somali region.
- Water quality testing and monitoring was conducted in Korahe zone of Somali region.
- Partners were mobilized to scale up distribution of water treatment chemicals to the affected woredas in Somali region.
- WHO has approved USD 2.3 million from the Contingency Fund for Emergency on 06 April to scale up response to the crises in Ethiopia including the outbreak of acute watery diarrhea/cholera.

Situation interpretation

The outbreak of AWD/cholera in the Somali Region of Ethiopia has escalated in the past weeks. The major drivers responsible for the exacerbation of the outbreak include acute shortage of safe water as a result of the drought, high number of displaced population living in desperate situation with limited sanitation and inadequate hygiene and food safety practices.

WHO Ethiopia and other partners are working closely with the Federal Ministry of Health and the Regional Health Bureaus to respond to the ongoing public health emergencies, especially the current upsurge of AWD/cholera in the Somali region. The ongoing deployment of experts from WHO and the Global Outbreak Alert and Response Network (GOARN) partners aimed to scale up control interventions. The government of Ethiopia has been supportive of humanitarian actors' efforts to alleviate the suffering of the people following the adverse climatic condition and the subsequent AWD/cholera outbreak. The commitment of the GOARN partners and other humanitarian actors and the good gesture and resolve of the Ethiopian government to mitigate this crisis need strong financial backing from the Donor Partners. In 2016, the Health Sector mobilized only USD 32.5 million out of the required USD 60.3 million to support response activities in Ethiopia. With the expanding humanitarian needs, the revised funding requirement for 2017 is USD 42 million. Successful containment of the ongoing AWD/cholera outbreak will be directly dependent on the extent to which the earmarked funding is secured.

Geographical distribution of Acute watery diarrhea/cholera cases in Ethiopia, 1 January - 2 April 2017.

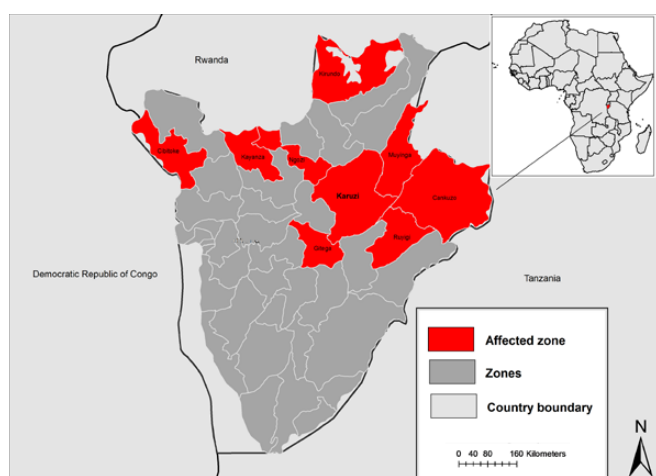


Event description

The malaria epidemic in Burundi, formally declared by Ministry of Health on 13 March 2017, is still continuing. During week 12 (week ending 26 March 2017), 162,458 new cases including 75 deaths were reported from across the country. During the reporting week, high incidences were observed in 9 provinces where the malaria trend surpassed the expected normal threshold for the season. The provinces include Gitega, Kirundo, Muyinga, Karusi, Kayanza, Ngozi, Ruyigi, Cankuzo, and Cibitoke. Between 01 January 2017 and 26 March 2017, a total of 2,600,409 clinical malaria cases and 1,170 deaths were reported in the country. In absolute terms, this reflects a 55% and 22% increase in caseload and fatality respectively, compared to the same period in 2016 when 1,804,258 cases and 841 deaths were registered.

The confirmation of the malaria outbreak in Burundi followed a multi-disciplinary investigation conducted in January 2017, which noted an increase in malaria cases from 4,716,152 in 2014 to 5,365,721 in 2015 and 8,144,484 in 2016, with 3807 deaths in 2016 alone. The overall incidence rate in 2016 was 51.9%.

Geographical distribution of Malaria cases in Burundi, 1 January -26 March 2017.



Public health actions

- The malaria control programme and WHO conducted a joint technical support field visits to 11 health districts to assess the local response capacity and implementation of strategies and interventions detailed in the response plan.
- The first batch of antimalarial medicines (artemisinin-based) has arrived in the country: 3,000 doses for children 2 to 11 months; 21,000 doses for children aged 1 to 5 years; 26,300 doses for children aged 6 to 13 years; 10,000 doses for 14 years and above. In addition, 6,605 rapid diagnostic tests donated by UNICEF and MSF have arrived.
- Indoor residual spraying was carried out in 12,744 households in Gashoho and Muyinga health districts from 18 - 31 March 2017, covering 69.3% of the planned 18,402 households. The activity is still going on.
- The Ministry of Health and health partners are supporting development of micro-plans at the health district level.
- Weekly coordination meetings of five sub-working groups (communication and resource mobilization, case management, prevention, monitoring and evaluation, and logistics) are on-going to monitor and implement the response plan.

Situation interpretation

The malaria outbreak situation in Burundi remains severe with 9 provinces in epidemic phase having high incidence rates. The response to the outbreak has not yet gained the required momentum to transition to emergency mode. The resources and other inputs are not sufficient to provide comprehensive coverage to all the affected provinces. Meanwhile, effective strategies for control of malaria outbreak are not being fully implemented, namely, presumptive treatment in severely affected areas and expansion of mobile services to under-served populations. In addition, the national treatment protocol is not being adhered to, especially the use of second-line treatment (Quinine and clindamycin), resulting in expiry of clindamycin and subsequent stock-outs throughout the country.

There is an urgent need to continue mobilizing resources from the government and partners for the implementation of effective interventions spelled out in the response plan. There is also a need to accelerate the deployment of additional field staff to support case management in districts in the most affected provinces.

While donor partners who made commitments are beginning to fulfil them, the remaining gaps are still huge. Availability of multiple partners in Burundi including government agencies (Ministry of Health, the Ministry of Environment, Ministry of Agriculture, Ministry of Interior affairs) and all technical and financial partners (UNICEF, USAID, GFATM, World Bank, WVI, etc) offers an opportunity to garner support for the control of the malaria outbreak. WHO will continue to coordinate technical assistance to support the country to implement effective evidence-based and coordinated response based on the national response plan. The support from partners is needed at all levels to rapidly contain this outbreak.

Event description

The trend of the meningitis outbreak in the Plateau region of Togo, notified to WHO on 3 February 2017, has significantly reduced in the past weeks. This reduction can partly be attributed to the reactive mass vaccination campaign carried out from 1 to 5 March 2017. During week 13 (week ending 2 April 2017), no new case of meningitis was reported in the whole country; compared to two new cases reported from Akebou district during week 12 (week ending 26 March 2017). While all districts in the country have come out of meningitis epidemic phase, Tone and Kpendjal districts remain in alert phase.

As of 26 March 2017, a total of 376 cases with 26 deaths (case fatality rate of 6.9%) have been reported since onset of the outbreak in January 2017. The predominant pathogen identified in Akebou district was *Neisseria meningitidis* W135, accounting for 64% of the positive PCR test results from the "Institut National d'Hygiène" Laboratory of Lomé.

Public health actions

- The Ministry of Health, with support from WHO and other partners, submitted new vaccines request to the International Coordinating Group (ICG) for a reactive mass vaccination campaign in Tone district targeting 108,014 people aged two to 29 years. The request was approved by ICG and vaccines are expected in the country in the coming days.
- Survey conducted to validate the administrative coverage for the reactive mass vaccination campaign in Akebou district revealed that 99.9 % of the targeted people were vaccinated.
- Partners including UNICEF, UNDP, UNFPA, Togo Plan, Togo Red Cross, WHO, etc. are providing technical support to the Ministry of Health in implementing response measures in Tone and Kpendjal districts. The interventions cover the areas of case management, surveillance, communication, coordination, and supervision.

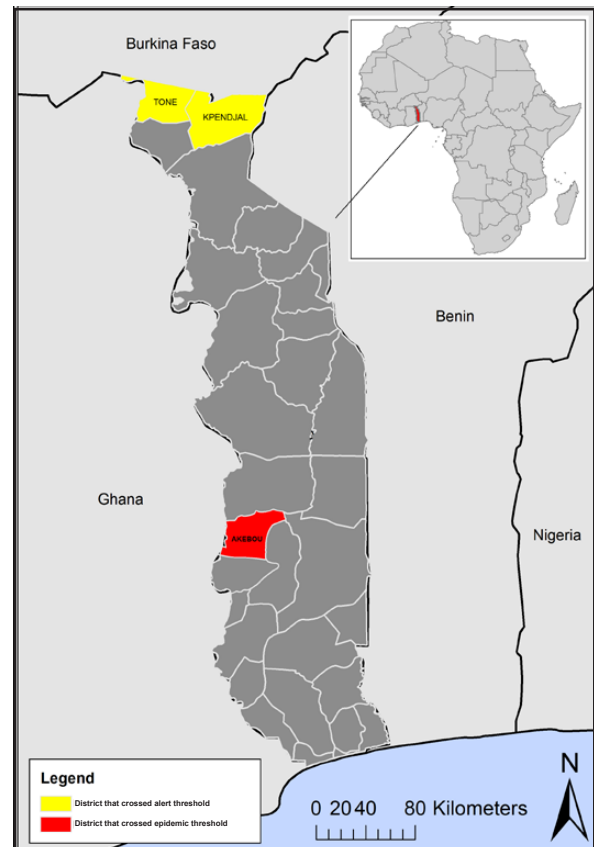
Situation interpretation

The Togo Ministry of Health and its health partners have demonstrated the importance preparedness, early detection and prompt response to public health events. The quick control of the outbreak in Akebou is mainly due to readiness of the health system following the large outbreak in 2016. The high quality of the vaccination campaign, as well as effective coordination of the response, led to the prevention of further spread of the disease. The ICG support including timely approval of vaccines for Tone district (in alert phase) will probably break further disease transmission. The situation in Kpendjal district, where the alert threshold was crossed in week 13 (week ending 2 April 2017), should be closely monitored and adequate measures timely implemented.

The challenge of sample transportation is being addressed through financial support from WHO. This should improve timely laboratory confirmation, pathogen identification as well as early detection of outbreak. Following the current trend of the outbreak, the risk of further spread remains low at the national, regional and global levels.

The persistent constraint encountered during the fight against meningitis epidemic in the Plateau region is lack of laboratory capacity for culture and/or molecular testing. There are only three laboratories in the country with these capabilities, which include Dapaon (regional hospital center laboratory), Kara University hospital center laboratory and the "Institut National d'Hygiène" Laboratory of Lomé in Lomé. In the meantime, strengthening sample transportation from district level to these laboratories will be crucial.

Geographical distribution of Meningitis cases in Togo, 1 January - 2 April 2017.

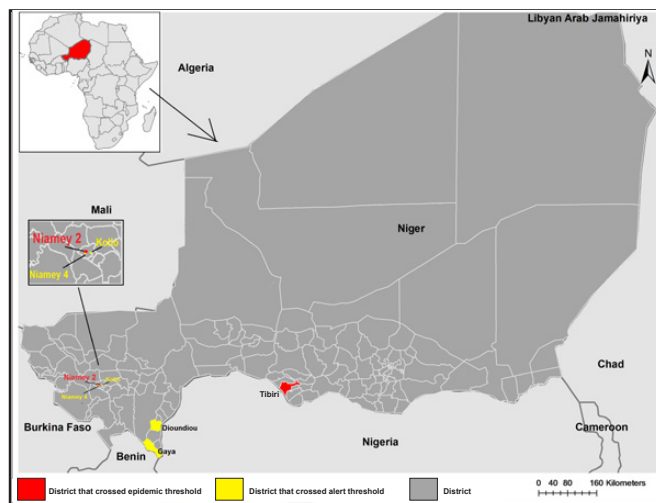


Event description

The Republic of Niger has been reporting sporadic cases of meningitis since the beginning of the year 2017. In week 7 (week ending 19 February 2017), Niamey 4 district crossed the meningitis alert threshold. The number of districts in alert phase subsequently increased to four in week 8 (week ending 26 February 2017) and later to seven in week 11 (week ending 19 March 2017). During week 12 (week ending 26 March 2017), Niamey 2 district surpassed the epidemic threshold, with the attack rate of 23.8 case per 100,000 inhabitants. In week 13 (week ending 2 April 2017), two districts (Niamey 2 in Niamey region and Tibiri in Dosso region) are in epidemic phase while four districts (Gaya, Dioundou, Kollo and Niamey 4) are in alert phase. As of 2 April 2017, a cumulative of 1,184 suspected cases including 56 deaths (case fatality rate of 4.7%) have been reported nationwide.

The meningitis outbreak has been confirmed at the Centre de Recherche Médicale et Sanitaire (CERMES) laboratory in Niamey. Of the 865 cerebrospinal fluid samples collected, 398 tested positive for meningitis pathogens by PCR. The main serotype isolated was *Neisseria meningitidis* C, accounting for 68 % of positive samples. The other pathogens were *Streptococcus pneumoniae* (17 %), *Neisseria meningitidis* X (9 %) and *Haemophilus influenzae* (4%).

Geographical distribution of Meningitis cases in Niger, 1 January - 2 April 2017.



Public health actions

- The Minister of Health made the official declaration of the outbreak and activated the national task force.
- Ceftriaxone and other logistics have been supplied to health facilities to ensure free treatment for meningitis patients.
- Active surveillance has been strengthened including data analysis to facilitate early detection of outbreaks based on thresholds.
- Laboratory diagnostic capacity is being strengthened through provision of diagnostic tests for confirmation and serotyping.
- Application for 303,316 doses of bivalent meningitis AC vaccines for reactive vaccination campaigns in epidemic areas is being prepared for submission to the International Coordinating Group.
- The affected districts are being supported to develop micro-plans for reactive vaccination campaign.
- Community engagement and mobilization has been reinforced to promote early health care seeking and uptake of the coming immunization exercise.

Situation interpretation

The Republic of Niger is one of the countries in the meningitis belt where recurrence of meningitis outbreaks is common. In 2015, the country experienced a large-scale meningitis outbreak due to *Neisseria meningitidis* C, which is emerging following mass vaccination campaign with meningitis A vaccines in the country. The management of the 2015 outbreak was affected by shortage of vaccines at the international level, causing insufficient immunization of the affected communities. The population is therefore still susceptible to new serotypes of pathogens, explaining the current outbreak. Based on lessons learnt in 2015, adequate and sufficient vaccines should promptly be made available for timely reactive vaccination campaign in order to prevent geographical spread of the outbreak. In addition, a deeper understanding needs to be sought why meningitis outbreaks in Niger usually begin from Niamey 2 district.

This outbreak has the potential to spread nationally and to neighbouring countries. The populations susceptible to *Neisseria meningitidis* C and other new serotypes is high in Niger and the neighbouring countries. It will be important to come up with initiative to conduct large scale vaccination against *Neisseria meningitidis* C and other new serotypes.

The main challenges being faced during response to this outbreak include the urgent need for vaccines and operational funds to conduct reactive vaccination campaigns in the epidemic areas; as well as the need for rapid diagnostic test (pastorex) for laboratory confirmation.

Event description

Nigeria started reporting sporadic cases of meningitis in Zamfara state during week 50 of 2016 (week ending 18 December 2016). The disease trend steadily increased reaching epidemic proportion. The Federal Ministry of Health notified WHO of the outbreak on 22 February 2017. The disease eventually spread to four other states, namely Katsina, Kebbi, Niger, and Sokoto. Seventeen local government areas (LGAs) have surpassed the epidemic threshold while eight other LGAs are in alert phase. This picture shows expansion of the outbreak since its onset in Zamfara State. The total population at risk is estimated to be 1,144,960 people. Zamfara, Katsina and Sokoto states are the most affected, accounting for about 93% of the total cases reported.

As of 3 April 2017, a total of 2,997 cases and 338 deaths (case fatality rate of 11.2%) have been reported nationwide. A total of 146 cases have been laboratory confirmed by Pastorex and culture at the national reference laboratory. *Neisseria meningitidis C* was the predominant serotype isolated, constituting 83 % of the confirmed cases. The most affected age group is 5 to 14 years of age.

Public health actions

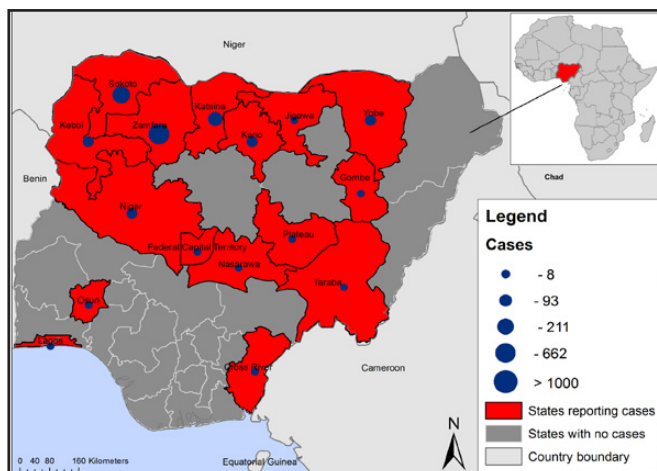
- The Ministry of Health activated the Emergency Operation Centre and appointed an incident manager.
- The first batch of 500,000 doses of bivalent meningitis AC vaccines has been granted by the International Coordinating Group (ICG) for reactive vaccination in Zamfara States. Supplementary request for vaccines targeting the remaining states are being finalized.
- The reactive vaccination campaign in Zamfara State targeting 351,171 people aged from 1 to 29 years is scheduled for 5 – 9 April 2017.
- A team from the Nigeria Centres for Disease Control have been deployed to Sokoto to support responses interventions.
- WHO deployed four international experts to Nigeria to provide high level technical support for the outbreak management and laboratory confirmation.
- Risk assessment is being carried out continuously in the five most affected States, namely Zamfara, Katsina, Kebbi, Niger and Sokoto.

Situation interpretation

Nigeria is one of the countries in the meningitis belt where the risk of meningitis outbreak is high and recurrent. The country experienced meningitis outbreak in 2015 in the same areas currently affected and implemented control measures including reactive vaccination campaign. The 2015 outbreak (as well as the current ones) was mainly caused by *Neisseria meningitidis C*. Since implementation of the large-scale mass immunization campaign with meningitis A vaccine in the African region, the subsequent outbreaks reported are mainly caused by new serotypes including *Neisseria meningitidis* sero-groups C and W135. This tendency has also been reported in other countries including Togo (in 2016 and 2017) and Niger (in 2015 and 2017). While the large-scale intervention highlighted the efficacy of mass immunization campaign in the prevention and control of meningitis outbreak, it also brought to the fore a phenomenon of emergence of new pathogens. The recurrence of meningitis outbreak in Nigeria is probably due to the low immunity of the population against the emerging serotypes. The most affected age group (5 to 14 years old) has not experienced infections due to these new serotypes in the last decades. This makes this age group susceptible to the meningitis serotypes C and W135.

The current outbreak has the potential to spread to the neighboring countries. Three of the five affected states (Zamfara, Sokoto and Katsina) share borders with Niger, where meningitis outbreak has been confirmed in Niamey 2 district this reporting week. Although no epidemiological link has so far been established between the outbreaks in the two countries, the risk of spread from Nigeria to Niger and other countries is high given the level of population movement between these countries. WHO anticipated this risk four weeks ago during the regular joint teleconferences with Nigeria, Togo, Benin, Burkina Faso, Niger and Ghana; and urged these countries to heighten preparedness and readiness. Solutions are also being sought to address the gaps in laboratory diagnostic capacity. The in-country mission from WHO Headquarters and the Regional Office will assess the laboratory capacity and identify urgent actions to be implemented.

Geographical distribution of Meningitis cases in Nigeria, 1 January - 3 April 2017.



NB: In the absence of raw data on local government areas (LGA), it was not possible to show the LGA that crossed epidemic threshold.

Event description

The humanitarian crisis in South Sudan remains dire with famine, food insecurity and outbreaks of cholera and measles on-going. The security situation is volatile. On 1 April 2017, unknown armed groups attacked Massna area (7 kilometres from Wau town), killing three people and injuring others. This incident, coming in the aftermath of the attack on aids workers, is just one mention out of the many security instances that impede access to displaced populations.

During week 12 (week ending 26 March 2017), completeness of routine weekly surveillance reporting was 49% compared to 70% for the early warning alert and disease network (EWARN) at the internally displaced persons sites. Malaria remains the leading cause of morbidity across the country, accounting for 27% and 13% of all consultations in the routine surveillance and EWARN sites respectively. Cholera transmission remains active in Duk, Ayod and Fangak counties in Jonglei states, among other areas. During week 14 (week ending 7 April 2017), 24 new cases and zero death were reported; compared to 82 cases reported in week 13 (week ending 2 April 2017). These areas with the most active transmission are largely swampy, limiting access to health partners. As of 1 April 2017, a total of 5,955 cases with 146 deaths (case fatality rate of 2.5%) were reported from 14 counties in 9 states.

In week 12 (week ending 26 March 2017), 20 suspected cases of measles were reported from Yambio and Gogrial West. From 01 January to 26 March 2017, a cumulative of 495 suspected measles cases including 4 deaths (case fatality rate of 0.8%) have been reported from 17 counties in the country. Most of the cases originated from Wau, Gogrial East and Gogrial West counties.

Public health actions

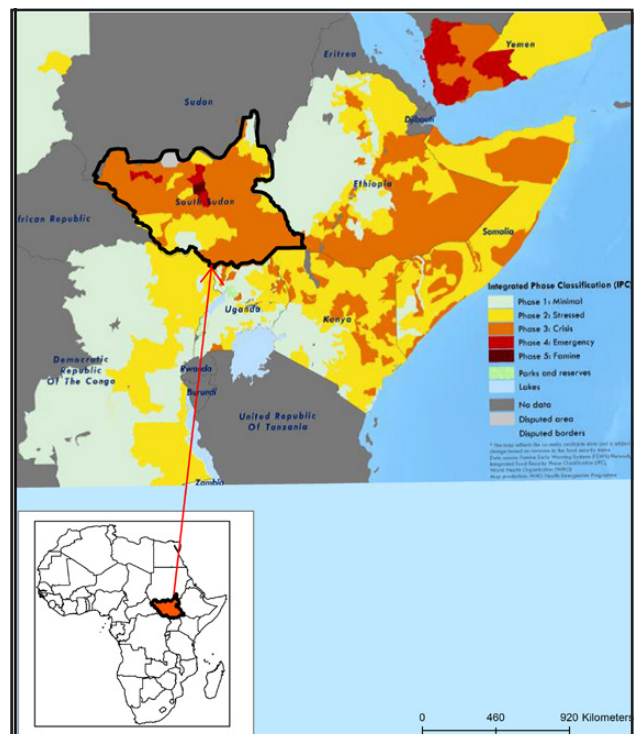
- Humanitarian partners continue to provide assistance to the famine affected counties of Unity state.
- As part of continued efforts to control the ongoing cholera outbreak, an oral cholera vaccine campaign was conducted in Malakal town during the reporting week, reaching 10,000 persons.
- During the reporting week, WHO donated diarrhoea disease kits to Fangak and Ayod counties. In addition, WHO facilitated deployment of 12 health care workers to support case management in Minkaman and Duk counties.
- WHO donated 10 basic and 5 supplementary antimalarial kits and other essential medicines to Save the Children Fund for response in Mayendit county.
- WHO delivered assorted lifesaving medicines and medical supplies to Ezo county to alleviate the alarming humanitarian needs in Yamngri payam.

Situation interpretation

The continuing outbreak of cholera in South Sudan, largely in remote hard to reach areas, remains a big concern. The situation is being exacerbated by highly mobile pastoralists who aggregate in cattle camps, with poor sanitation and limited access to safe water. To that effect, the Ministry of Health has requested WHO to facilitate provision of medicines and essential supplies to these remote areas. WHO in collaboration with other health partners have resorted to chartering flights to deliver lifesaving medicines and other medical supplies to these remote places. This life saving intervention will ostensibly demand additional financial and material resources from WHO.

The suspension of the 10,000 dollars annual fees for aids workers previously imposed by the government of South Sudan will greatly facilitate deployment of more aid workers by humanitarian partners. This will go a long way in backstopping the gaps in provision of humanitarian assistance, notwithstanding the prevailing security situation.

Classification of food insecurity in South Sudan, as of 29 March 2017



Event description

The prolonged conflict in north-east Nigeria has created a deepening humanitarian crisis, with 1.8 million internally displaced persons and 6.9 million people in need of urgent humanitarian health assistance across Borno, Adamawa and Yobe states. According to 'Cadre Harmonise', a partnership of humanitarian actors, the population facing food insecurity in the region is projected to rise to 5.2 million between June and August while more than 50,000 people are expected to experience famine-like conditions. Borno state will be the worst affected, with 43,066 persons expected to be in Phase 5 food insecurity, followed by Adamawa with 3,690 persons and Yobe states with 3,295 persons.

During week 12 of 2017 (week ending 26 March 2017), 91 out of 149 reporting sites (including 20 internally displaced persons' camps) in 13 local government areas (LGAs) submitted their weekly reports. This reflects a completeness of reporting rate of 58%, as opposed to the minimum target of 80%. Although the surveillance system is sub optimal, there have been improvements compared to the past weeks. Out of the 21 alerts received, 86% were verified.

Public health actions

- Between 25 and 19 March 2017, 1.9 million children under five years of age were vaccinated against wild poliovirus. This activity was carried out by 14,000 volunteers.
- WHO signed a Memorandum of Understanding with UNDP to rehabilitate and revitalize targeted health facilities in Borno state using European Union funds. UNDP will be responsible for the infrastructure work while WHO will provide equipment and supplies, carry out capacity building and training, and provide incentives to the staff working in these facilities.
- In the past one month, the WHO-supported hard to reach teams screened 8,590 children aged 6 to 59 months for malnutrition using the mid upper arm circumference (MUAC) method. The children identified with acute malnutrition were referred to the nearest facility for therapeutic treatment. In addition, WHO donated essential medicines to treat other medical complications in patients with severe acute malnutrition.
- The health sector is working on a co-leadership arrangement aimed to promote partners' operational presence and ability to deliver health services at the state and LGA levels.
- The Ministry of Health, with support from WHO, is strengthening surveillance in Dikwa local government area following the continuous influx of internally displaced persons, totalling to 150,000 people.

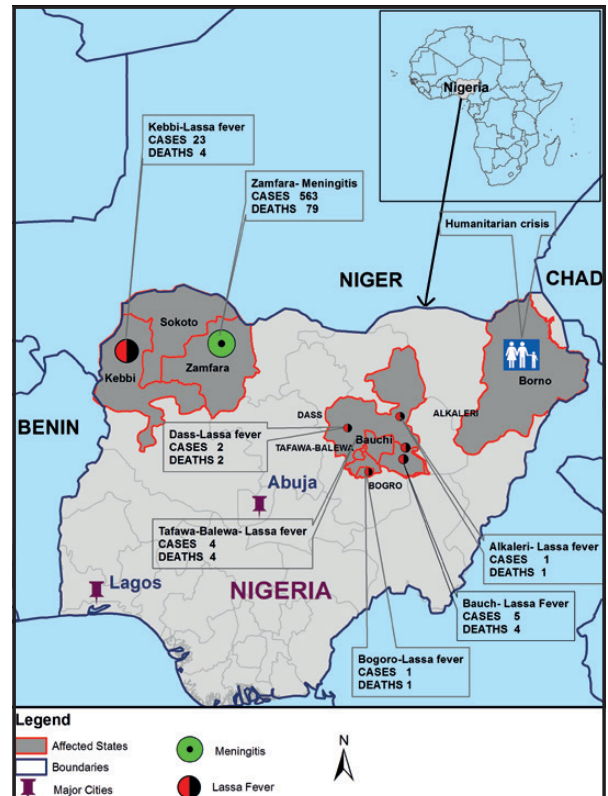
Situation interpretation

The security situation in north east Nigeria is still unstable. Accessibility continues to constitute the major issue in the provision of humanitarian assistance. Despite security challenges, health partners have started reconstructing and revitalising health facilities, as one of the priorities indicated in the early recovery and livelihood sector strategy.

Over the past week, there has been consistent population influx to Dikwa from the surrounding areas of Bama and Ngala. In addition, there has been increased influx of refugees from Niger to the same place. This inflow of unprotected population poses the risk of measles outbreak and further propagation of meningitis. Surveillance and case management need to be strengthened in these internally displaced persons' sites.

Scaling up response towards malnutrition and improving access to food for the poorest and vulnerable people, especially in remote hard to reach areas, should be the priority for humanitarian actors in the coming months.

Geographical distribution of events in Nigeria, as of 5 March 2017



Summary of major challenges and proposed actions

Challenges

- Reluctance by some countries to share data and information on outbreaks and other public health emergencies: proper management and protection of people at risk of public health emergencies depends on transparency and willingness to share data and information on the epidemics and other emergencies. There is a growing concern and pattern, in selected countries, of not sharing critical data and information on acute public health events that are currently occurring. This pattern does not help WHO and partners in assessing the magnitude of the situation and taking appropriate remedial measures.
- The security challenges limiting access to vulnerable and hard to reach populations: outbreaks of many communicable diseases are occurring within complex emergency settings, for instance, the outbreaks of cholera in South Sudan, Ethiopia and the Democratic Republic of Congo, where insecurity prevails. Inadvertently, access to affected population with effective outbreak containment measures are curtailed.
- The continuous need for strong financial backing from donor partners: there are a number of events reported on this week where successful containment will be dependent on financial backing from donor partners, these include the AWD/cholera outbreak in Ethiopia, the malaria outbreak in Burundi, and the meningitis outbreak in Niger and Nigeria.

Proposed actions

- WHO Country Offices should continue to dialogue with the national authorities on the importance and need to share data and information in a timely manner, in accordance with provisions of the International Health Regulations. Quality data is essential to support evidence-based decisions and the resulting response actions including resource mobilization.
- WHO should continue to advocate to the governments and partners for the need to mobilize resources to ensure implementation of effective interventions to the ongoing public health emergencies.

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 |
|-----------------------------------|--|-------|-----------------------------|--------------------------------------|---------------|---------------------|--|---------------------|
| OUTBREAK | | | | | | | | |
| Cholera | DRC | 2 | 1 Jan 2015 | 37,721 | 1104 | 2.9 | 2017 continues to see an increase of cases than during the same time period in 2016 with the provinces of Tanganyika, South Kivu, Maniema, Ecuador, Mongala, Bas-Uélé, Tshopo and Maniema most affected. | 31/03/2017 |
| Cholera | Tanzania | 2 | 04 April 2015 | 25,120 | 390 | 1.6 | Only 3 cases reported in epi week 13. Surveillance team encouraging regions and districts to test suspected cases | 03/04/2017 |
| Necrotising cellulitis/ fasciitis | Sao Tome & Principe | 2 | 10 Jan 2017 | 1517 | 0 | 0 | The outbreak has still not been officially declared by the MOH and the number of experts in the field is relatively low, preventing the implementation of certain strategies. | 05/04/2017 |
| Hepatitis E | Chad | 1 | 1 Sept 2016 | 1293 (5) | 15 | 1.2 | 25 cases reported in epi week 12 | 26/03/2017 |
| Cholera | Angola | 1 | 4 Jan 2017 | 289 | 11 | 3.8 | AFRO & HQ risk assessment to review grading and implement Oral Cholera Vaccine (OCV) package | 26/02/2017 |
| Cholera | Kenya | | 10 Oct 2016 | 235 (36) | 4 | 1.7 | 8 new cases reported during week 11 (week ending 16 March 2017). | 16/03/2017 |
| Dengue fever | Burkina Faso | - | 29 Oct 2016 | 2530 | 20 | 0.8 | Two epidemiologists conducting retrospective hospital-based record review Reagents required for the diagnosis of dengue and arbovirus and training of lab technicians. | 23/03/2017 |
| Dengue fever | Burkina Faso | - | 29 Oct 2016 | 2530 | 20 | 0.8 | Two epidemiologists conducting retrospective hospital-based record review Reagents required for the diagnosis of dengue and arbovirus and training of lab technicians. | 23/03/2017 |
| Typhoid fever | Zimbabwe | - | 21 Nov 2016 | 1492 (75) | 8 | 0.4 | No update available | 20/03/2017 |
| Lassa fever | Nigeria | - | Dec 2016 | 283 (99) | 56 | 19.8 | Outbreak in 13 states | 17/03/2017 |
| Dengue fever | Cabo Verde | - | 4 Jan 2017 | 98 (19) | 0 | 0 | Investigations by the deployed entomologist and virologist from IPD determined the recent circulation of the virus and the presence of <i>Aedes aegypti</i> as the vector. | 09/03/2017 |
| Monkeypox | Congo | - | 1 Feb 2017 | 32 (4) | 5 | 15.6 | Surveillance in affected areas is weak. Training for health-care workers undertaken, however involvement of communities in reporting cases is needed. | |
| Meningitis | Togo | - | 03 Feb 2017 | 376 (28) | 26 | 6.9 | No update given | |
| Monkeypox | Central African Republic | - | 09 Feb 2017 | 47 | 0 | 0 | Cases in Pygmies communities in the municipalities of Moboma, Balé-Koko and Nola located in large forest areas. Epidemiological survey conducted to characterise outbreak | 04/04/2017 |
| Measles | Guinea | - | 08 Feb 2017 | 4346 (3486) | 14 | 0.03 | 75 cases reported in the last week. Vaccination campaign scheduled for 7-15 April | 03/04/2017 |
| Cholera | Mozambique | - | 16 Feb 2017 | 1400 | 3 | 0.2 | No update received | 13/03/2017 |
| Meningitis | Niger | - | 19 Feb 2017 | 1184 | 56 | 4.7 | Detailed update above | |
| Meningitis | Nigeria | - | 20 Feb 2017 | 2997 | 336 | 11.2 | Five states are currently affected, most common serotype NeisseriaMeningitidis serotypeC in 83% of samples tested | 03/04/2017 |
| Leishmaniasis | Cameroon | - | 20 Feb 2017 | 48 | 17 | 35.4 | No update received | 24/03/2017 |
| Lassa fever | Benin | - | 21 Feb 2017 | 1 (1) | 1 | 100 | No new cases reported | 20/03/2017 |
| Crimean-Congo Haemorrhagic Fever | Namibia | | 23 Feb 2017 | 4 (2) | 1 | 25 (50) | No new cases reported | 28/03/2017 |
| Lassa fever | Togo | - | 24 Feb 2017 | 12 (7) | 4 | 57 | No update available | 19/03/2017 |
| Meningitis | Cameroon | | 9 Mar 2017 | 25 | 9 | 36 | No new cases this week | 26/03/2017 |
| Lassa fever | Sierra Leone | - | | 90 (7) | 6 | 6.7 (86) | Late referral of cases from communities to health facilities resulting in high case fatality rate. Community sensitization ongoing. Health workers were sensitized on observing infection prevention and control while managing cases. | 05/04/2017 |
| Anthrax | Tanzania | - | 11 Mar 2017 | 1 | 0 | - | Investigation undertaken by district team. Laboratory confirmation awaited. 36 contacts developed symptoms | |
| Malaria | Burundi | - | 13 Mar 2017 | 2,600,409 | 1170 | 0.04 | Detailed update given above | 05/03/2017 |
| Cholera | Malawi | - | 15 Mar 2017 | 18 | 0 | 0 | 1 case reported in the last week, CTC set up to manage cases. | 19/03/2017 |
| Measles | South Sudan | - | Beginning 2017 | 495 | 4 | 0.84 | The follow-up measles campaign is scheduled for 17th to 28th April 2017 | 26/03/2017 |
| AWD/Cholera | Ethiopia | - | Beginning 2017 | 21,251 | 187 | 0.94 | Reported in 6 regions; Amhara, Afar, Oromia, SNNP, Somali and Tigray with 90% in Somali region. 3957 cases reported in week 13. | 02/04/2017 |
| Measles | Ethiopia | - | Beginning 2017 | 1100 (496) | | | Measles campaign targeting around 22.5 million children been conducted from February to current | 02/04/2017 |
| Influenza like illness (H1N1) | Senegal | | 28 Mar 2017 | 118 | 3 | 2.5 | Detailed update given above | |
| EMERGENCIES | | | | | | | | |
| Humanitarian crisis | South Sudan | 3 | | | | | Detailed update given above | 26/03/2017 |
| Humanitarian crisis | Nigeria | 3 | | | | | Detailed update given above | 17/03/2017 |
| Post El-Nino drought | Ethiopia | 2 | | | | | Detailed update given above | 02/04/2017 |
| Humanitarian crisis | Cameroon | 2 | | | | | No update available | |
| Humanitarian crisis | Central African Republic | 2 | | | | | No update available | |
| Food insecurity | South Sudan, Kenya, Uganda, Ethiopia, NE Nigeria | - | 23 Feb 2017 | | | | OCHA and IGAD estimate up to 22.9 million people are food insecure in the Horn of Africa. | |
| Floods | Zimbabwe | - | 02 Mar 2017 | | | | The Government of Zimbabwe has declared the flooding situation affecting 36 districts in the country a national disaster, and has appealed for international assistance. They estimate 251 people killed and 128 others injured by various impacts of the floods. An estimated 100,000 people lack access to safe drinking water | |
| Cyclone | Madagascar | - | 07 Mar 2017 | | | | No update available | |

Data sources

Data is provided by Member States through WHO Country Offices via regular situation reports, teleconferences and email exchanges. Situations are evolving and dynamic therefore numbers stated are subject to change.

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