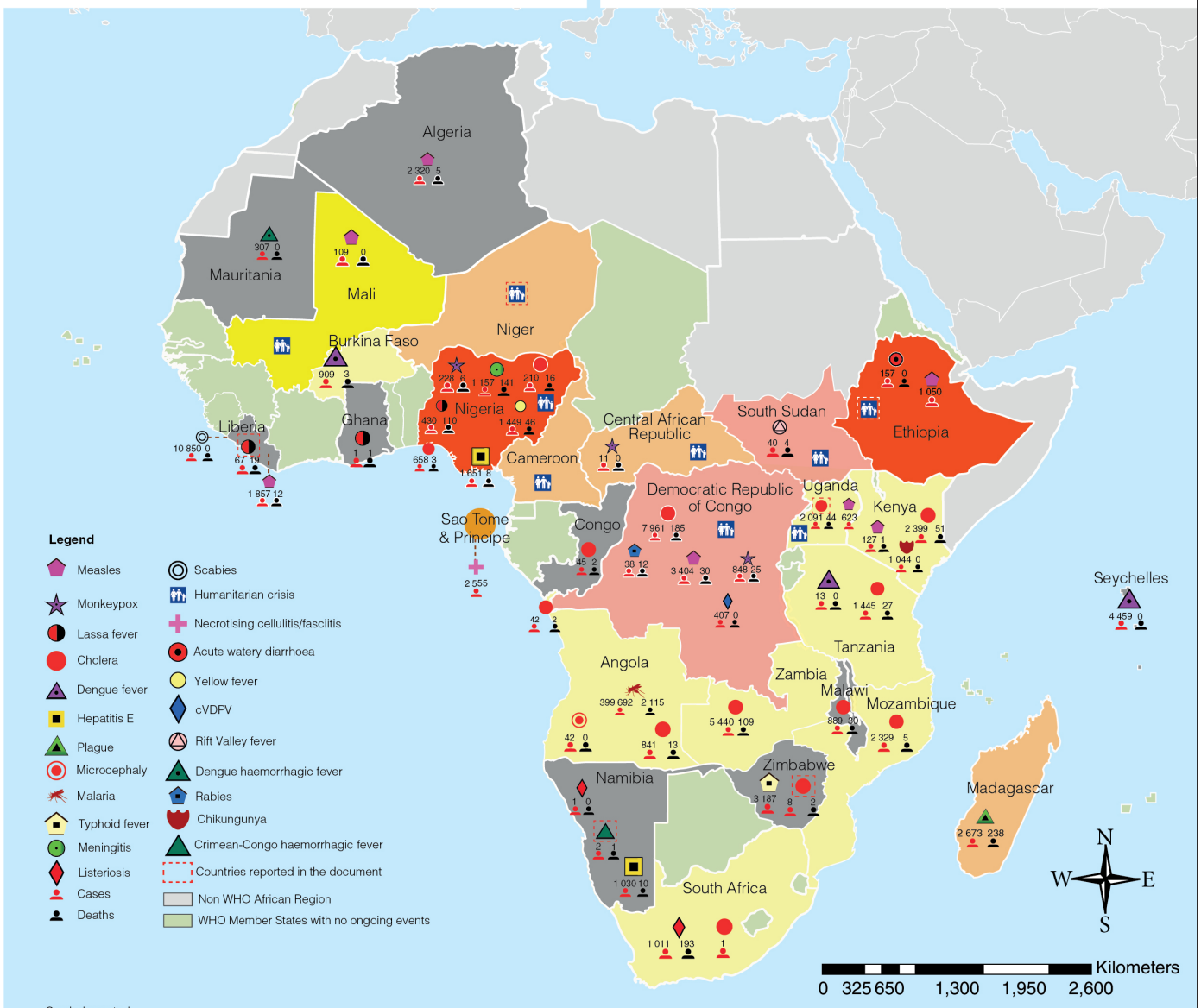
# WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 15: 07 - 13 April 2018
Data as reported by 17:00; 13 April 2018

World Health Organization
REGIONAL OFFICE FOR Africa
WHO Health Emergencies Programme

| 1 | 57 | 49 | 9 |
|---|---|---|---|
| New event | Ongoing events | Outbreaks | Humanitarian crises |




Graded events †

| 1 | 6 | 7 | 36 |
|---|---|---|---|
| Grade 3 event | Grade 2 events | Grade 1 events | Ungraded events |
| 4 | 1 | 1 | |
| Protracted 3 events | Protracted 2 event | Protracted 1 event | |

# Overview

## Contents



- This Weekly Bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 58 events in the region. This week's edition covers key ongoing events, including:

  - Cholera in Zimbabwe
  - Lassa fever in Liberia
  - Crimean-Congo haemorrhagic fever in Namibia
  - Cholera in Uganda
  - Humanitarian crisis in Niger
  - Humanitarian crisis in Ethiopia

- For each of these events, a brief description followed by public health measures implemented and an interpretation of the situation is provided.

- A table is given 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 issues and challenges include:**

  - Two haemorrhagic fever outbreaks are reported this week, both of which are persistent problems in their respective countries. This emphasises the importance of a One Health approach to surveillance and response in countries with endemic diseases with an animal host population or reservoir.

  - Cholera remains an ongoing issue in many countries in the region. This week we report on a newly declared cholera outbreak in Zimbabwe, who declared their most recent outbreak over only three weeks ago. We also report on an outbreak in Uganda where targeting WASH and risk communication activities appears to be effective. However the prevailing risk factors in both countries emphasise the need for a regional approach to this persistent disease.

# New event

**Cholera** | **Zimbabwe** | 8 **Cases** | 2 **Deaths** | 25% **CFR**

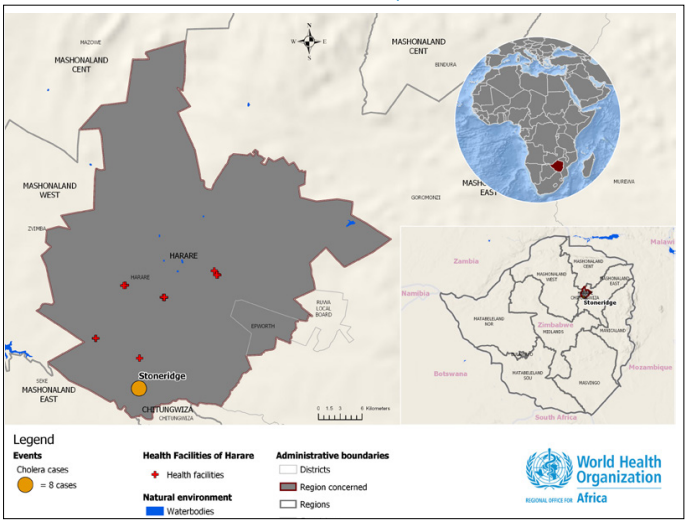
## EVENT DESCRIPTION

On 7 April 2018, the Ministry of Health formally notified WHO of a new cholera outbreak in Stoneridge, a peri-urban suburb 15 km south of Harare's city centre. The index case was a 24-year-old male whose symptoms of diarrhoea and vomiting began on 22 March 2018. He sought medical attention on 23 March 2018 and was admitted at Central Hospital until his death on 5 April 2018.

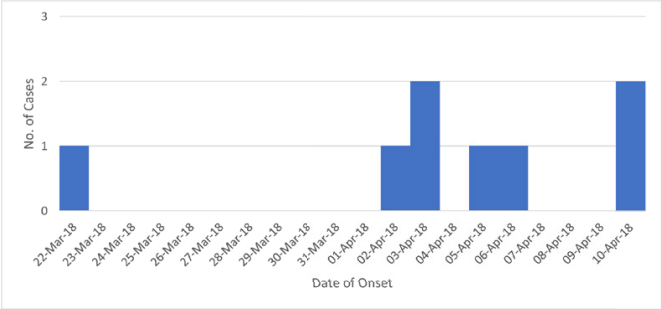
The index case's 46-year-old father and infant brother both suffered from diarrhoea and vomiting, and both their stool samples tested positive for *Vibrio cholerae* serotype Ogawa. The deceased's father had been visiting his son in hospital, taking care of him, and staying at his son's home prior to showing symptoms on 3 April 2018. He later died at his son's residence on 4 April 2018. The infant brother presented with vomiting and profuse diarrhoea on 4 April 2018 and has been admitted to hospital. As of 11 April 2018, there are eight cases (4 suspected, 3 confirmed, 1 probable), and two deaths (case fatality rate 25%). Seven cases originate from Stoneridge and one from Belvedere West.

It was reported that the index case patient had not travelled to areas affected by a previous outbreak of cholera, which was recently declared over on 23 March 2018.

Geographical distribution of cholera cases in Zimbabwe, 22 March 2018 – 11 April 2018




Number of cholera cases in Harare, Zimbabwe from 22 March - 11 April 2018




## PUBLIC HEALTH ACTIONS

- Harare City local authorities and the Ministry of Health and Child Care are responding to the outbreak with support from OXFAM, Médecins Sans Frontières (MSF) and other partners.
- Active surveillance is ongoing, including contact tracing of persons who attended the funerals of the two deceased.
- All suspected cases had samples taken for laboratory testing.
- Line lists of cases and deaths are being updated daily.
- Sensitization on early detection of cholera has been carried out in health facilities.
- Social mobilization is taking place and information, education and communication (IEC) material is being distributed, as well as door-to-door visits, education campaigns and road shows.
- Water, sanitation and hygiene (WASH) efforts are taking place and OXFAM is distributing Aquatab water purification tablets and non-food items (NFI) such as buckets with taps, and detergent in the community.
- A cholera treatment centre has been set up close to Stoneridge with the help of MSF.

## SITUATION INTERPRETATION

This is a newly reported outbreak of cholera, but Zimbabwe has had several cholera outbreaks in the recent past, with the last outbreak declared over on 23 March 2018 in the Chegutu municipality in Mashonland West province and Waterfalls area of Harare city. Stoneridge is one of many unplanned settlements near Harare with no piped water or sewerage reticulation system. Lack of safe water supply and infrastructure in the area could lead to further propagation of cases. Public health actions from local authorities and partners are underway to contain this outbreak, including case finding, implementation of WASH and social mobilization efforts. However, continued support from WHO and other national and international partners is needed to address the gaps surrounding shortage of equipment, laboratory supplies, medication, fuel, and staff required for the outbreak response. Neighbouring countries Malawi, Mozambique and Zambia are also experiencing cholera outbreaks, therefore significant efforts are required to bring cholera under control in the sub-region.

# Ongoing events

| Lassa fever | Liberia | 67 Cases | 19 Deaths | 28.3% CFR |
|---|---|---|---|---|

## EVENT DESCRIPTION

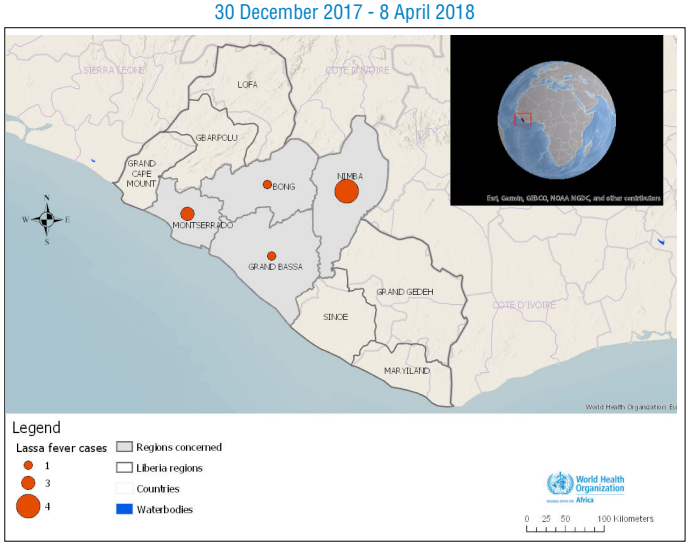
The Lassa fever outbreak is ongoing in Liberia with 25 new suspected cases, including five deaths reported since our last bulletin update *(Weekly Bulletin 11, 16 March 2018)*. Of these, two new confirmed cases were reported in week 12 and week 13 (week ending 1 April 2018).

The patient reported in week 12 was a 2-year-old female with symptom onset on 22 March 2018, who was admitted to hospital in the capital city, Monrovia on 29 March 2018 with symptoms of fever, malaise, vomiting, difficulty in breathing and later, convulsions. Clinical suspicion was Lassa fever infection and following collection of a blood sample on 29 March 2018 the patient tested positive for Lassa virus by RT-PCR at the National Reference Laboratory. The patient died on the day of admission and a safe burial was conducted.

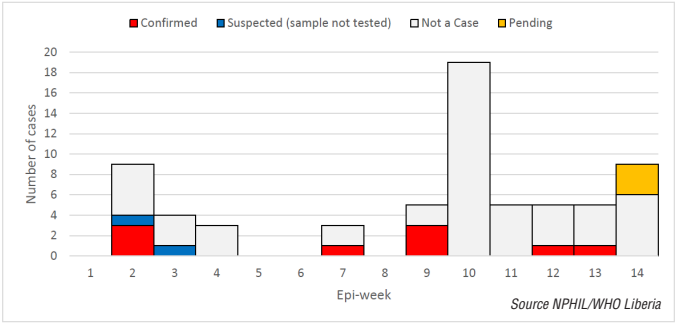
A retrospective investigation was conducted which established that the mother, a 33-year-old from Grand Bassa county died on 22 March 2018. She sought care at the district hospital on 18 March 2018 where the clinician suspected a viral haemorrhagic fever and isolated her. Following a negative test for Ebola virus on 20 March 2018, a positive RT-PCR result for Lassa virus was received on 30 March 2018. A total of 47 contacts from these two confirmed cases were identified, of which 60% are healthcare workers and are under follow up.

From January 2018 to date, a total of 67 suspected cases, including 19 deaths (case fatality rate 28.3%) have been reported from six counties. Of the total suspected cases, nine were confirmed positive by RT-PCR at the National Reference Laboratory. The confirmed cases originated from Nimba (4), Montserrado (3), Bong (1), and Grand Bassa (1). Eight of the nine confirmed cases died, a case fatality rate of 89%. The confirmed cases are predominately female (78%) and the age range among confirmed cases is 1 to 57 years old with a median age of 32 years.

Geographical distribution of Lassa fever cases in Liberia, 30 December 2017 - 8 April 2018




Epidemiological curve of Lassa fever cases in Liberia, 30 December 2017 - 8 April 2018




## PUBLIC HEALTH ACTIONS

- The county health team continues to coordinate the response to the outbreak, with technical support from the Ministry of Health, the National Public Health Institute of Liberia (NPHIL), WHO field offices, MSF, and OXFAM.
- Active surveillance and contact tracing are ongoing in the affected counties, who are sharing information to aid investigation and contact tracing
- The outbreak case definitions, along with patient screening tools which were adapted for previous outbreaks, remain in use.
- The National Public Health Reference Laboratory continues to provide laboratory diagnostic services and courier services have been strategically designated across the country to facilitate transport of specimens.
- An infectious disease isolation unit has been set up in Montserrado County to manage patients with Lassa fever.
- Lassa fever risk exposure assessment was conducted by a team of infection, prevention and control (IPC) specialists with respect to healthcare worker contacts in Montserrado and the MSF hospital has initiated chemoprophylaxis (oral ribavirin) for the high-risk contacts.
- Community engagement activities have begun in the affected communities with rapid response teams visiting the affected households and families, and providing information on the event.
- Antiviral medication (ribavirin) has been prepositioned at designated treatment sites to facilitate management of future cases.

## SITUATION INTERPRETATION

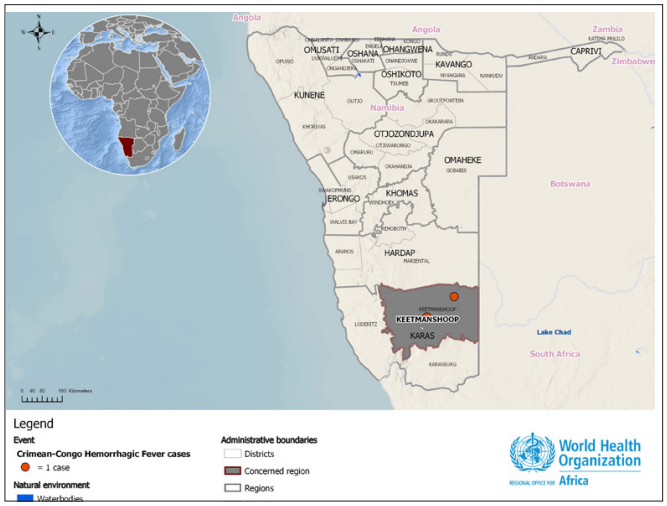
Lassa fever is endemic in certain parts of Liberia, with sporadic outbreaks during 2017, resulting in 30 confirmed cases reported from seven counties. This year shows a similar pattern, with nine confirmed cases to date from four counties. Although the Liberian government together with WHO and other health partners has built on lessons learned from response to previous outbreaks, more effort is needed to reinforce the response plan to prevent new cases and decrease the case fatality rate. As well as preventing human to human transmission through effective IPC practices, rat to human transmission needs to be minimized, requiring a One Health approach, which will entail effective social mobilization and community engagement strategies targeting vector control and environmental management especially in endemic areas. The fact that such a high proportion of contacts were healthcare workers emphasizes the need for continuing logistical and operational support to healthcare facilities to build effective isolation units, holding areas and clinical waste management disposal systems as well as ongoing training to reduce the risk of infection of healthcare workers.

## EVENT DESCRIPTION

A 36-year-old man from Keetmanshoop district began to experience symptoms of diarrhoea and vomiting on 22 March 2018, a day after assisting a neighbour with the slaughter of a tick-infested cow. On 26 March 2018, he attended the local clinic due to persistent nose bleeding and was referred to Keetmanshoop Hospital for epistaxis on the same day. He instead returned home, but following worsening symptoms returned to the hospital the following day. He was referred to Katutura Intermediate Hospital with thrombocytopenia, low platelet count, and severe epistaxis. His history suggested Crimean Congo haemorrhagic fever (CCHF) and a blood sample was collected and submitted to South Africa's National Institute for Communicable Diseases (NICD) where it is was later found to be positive for CCHF. In the meantime the patient had been transferred to the isolation unit at Windhoek Central Hospital, and died there on 3 April 2018. An outbreak was declared by the Ministry of Health the same day.

A second patient presented at Keetmanshoop Hospital on 3 April 2018 with a history of tick bites and symptoms of vomiting and fever, but had no epidemiological links with the previous case. A blood specimen was taken on 5 April 2018 and was submitted to NICD. The patient was isolated, and was in a stable condition as of 6 April 2018.

Geographical distribution of Crimean-Congo haemorrhagic fever cases in Namibia, March - April 2018




## PUBLIC HEALTH ACTIONS

- Technical Coordination Committee meetings were conducted between district and regional level coordination teams. Response pillar committees were identified including contact tracing, infection prevention, control and training, case management and surveillance, community sensitization and stakeholder engagement.
- Regular stakeholder meetings are being held in order to coordinate control efforts. These meetings were attended by Ministry of Agriculture, Ministry of Education and Culture, Ministry of Information, Communication, and Technology, Ministry of Gender Equality and Child Welfare, Namibian Police Force, Regional Council, members of the media, the Farmers Union, church leaders, and traditional leaders.
- Thirty-four exposed health personnel providing care to the patient are being monitored.
- Active contact tracing is being conducted by the contact tracing team in the affected communities and farming posts in Keetmanshoop.
- Two infection control trainings have been conducted for health personnel at district level.
- Safety measures have been taken to limit disease transmission such as disinfection and fumigation of exposed areas (ambulance, isolation room, operating room, etc.).
- Risk communication is being conducted in Damara Nama, Oshivambo and Afrikaans languages via community gatherings, radio spots, and leaflets educating the public about disease prevention.

## SITUATION INTERPRETATION

Namibia has detected sporadic cases of CCHF in the past year with at least three confirmed outbreaks occurring in 2017, showing that the disease is a persistent problem. The currently affected Kharas region last reported confirmed cases in 2014. The disease has a particularly high case fatality rate (10%-40%), but is however, not highly transmissible compared with other viral haemorrhagic diseases. Because human cases of CCHF are usually as a result of contact with ticks from infected livestock, a One Health approach is necessary, concentrating on vector control and avoiding tick bites, as well as the usual IPC measures. Risk communication in the community should be scaled-up throughout the country in order to minimize transmission.

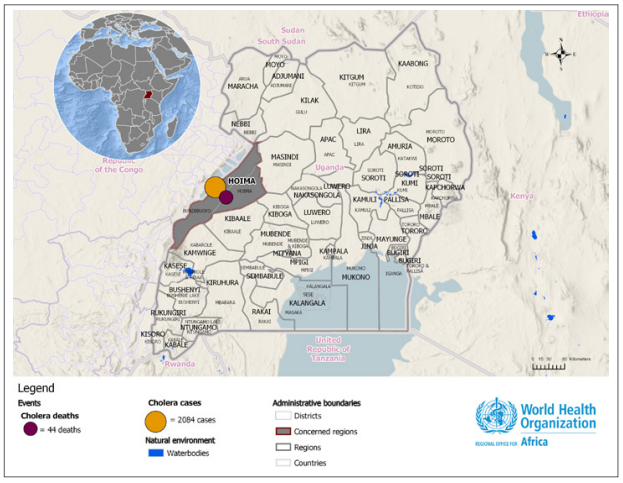
## EVENT DESCRIPTION

The outbreak of cholera in refugee settlements in Hoima District, Western Uganda, has been ongoing for 10 weeks. The outbreak was initially confirmed on 15 February 2018 in Kabwoya sub-county; however, a retrospective review of health records revealed that the first suspected case was identified on 11 February 2018. The Ugandan Ministry of Health officially declared the outbreak on 23 February 2018.

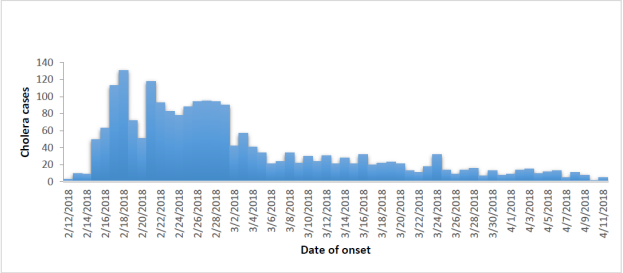
The case incidence continues on its downward trend. However, since our last report on 26 March 2018 (Weekly bulletin 12) an additional 265 cases with eight deaths have been reported and two additional sub-counties (Bugambe and Kahoora) affected. On 11 April 2018 five new suspected cases have been reported
Kyangwali and Kabwoya sub counties Buhuka (2 cases), Kasonga (2 cases) and Sebigoro (1 case).

Since the beginning of the outbreak, as of 9 April 2018, a cumulative total of 2 091 suspected cholera cases with 44 deaths (case fatality rate 2.1%) were reported across four sub-counties, namely Kyangwali, Kabwoya, Buseruka, Bugambe and Kahoora division. Most of the cases are newly arrived refugees from the province of Ituri in the Democratic Republic of the Congo. To date 24 out of 97 specimens tested positive for *Vibrio cholerae* by culture and 152 samples tested positive on cholera rapid diagnostic test.

Geographical distribution of cholera cases in Uganda, 11 February 2018 - 11 April 2018




Curve of Hoima District cholera outbreak distribution of case by date of onset 11 February - 11 April 2018




## PUBLIC HEALTH ACTIONS

- A district coordination meeting comprising of the District Health Management Team (DHMT), the Ministry of Health, UNHCR, and other partners was held on 12 April 2018. The meeting was co-chaired by the district and WHO.
- WHO continues to support surveillance and field investigation activities.
- With support from WHO, MSF is supporting case management in cholera treatment centres established in the refugee settlement.
- The DHMT, the Uganda Red Cross Society and Village Health Teams continue to support active case finding.
- UNICEF, UNHCR, and other partners are supporting water, sanitation and hygiene (WASH) activities including: enforcement of latrine construction, disinfection of households, distribution of Aquatabs to affected villages, installation of hand washing facilities and hygiene and sanitation sensitization at community level.
- UNICEF is sponsoring risk communication messages via radio talk shows and information, education and communication materials have been distributed within the affected communities.

## SITUATION INTERPRETATION

The cholera outbreak in Hoima district initially affected mainly refugees arriving from the Ituri province in the Democratic Republic of the Congo, where a large cholera epidemic is ongoing in the context of a prolonged humanitarian crisis. Due to the regular interaction between the refugees and the host community, the outbreak quickly spread from the refugee settlement to the surrounding host population. Although the incidence of the cholera outbreak is declining, following the implementation of targeted WASH activities together with risk communication actions, cases continue to be reported and new sub-counties have been affected. The persistence and spread of cholera cases is of concern and highlights the need to reinforce ongoing response interventions such as WASH, surveillance and risk communication, in order to prevent further transmission to districts bordering Lake Albert (Hoima, Kagadi, Ntoroko, Pakwach and Bulisa). The continuing influx of refugees from the Democratic Republic of the Congo indicates a need for urgent administration of the oral cholera vaccine in and around the affected areas in Uganda, as well as in the province of Ituri in neighbouring Democratic Republic of the Congo.

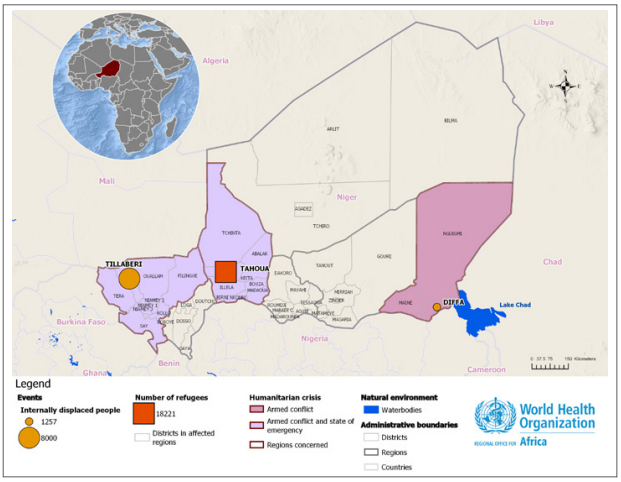
## EVENT DESCRIPTION

Niger continues to be negatively affected by a poor security situation which is causing serious population displacement and, together with natural disasters such as floods and drought, is impacting on the ability to respond to outbreaks of epidemic-prone diseases.

Armed conflicts continue in Diffa, Tillabéry and Tahoua, with a state of emergency in force in Tillabéry and Tahoua since March 2018. In Diffa, the security situation remains volatile. Since the start of 2018 there have been 48 targeted attacks by Boko Haram, resulting in kidnapping and abduction in Diffa, particularly near the Lake Chad Basin. A massive Chadian and Nigerian military presence in the area, has restricted humanitarian access to communities in the Lake Chad Basin because of impending military operations. Military operations are expected along the Komadougou River from April to June 2018. This has caused major displacement of people, reportedly about 1 257 individuals, particularly towards the islands in Lake Chad. This is of particular concern as these islands are likely to be the target of military action and access is strictly forbidden.

In Tillabéry, March 2018 was marked by the resurgence of threats by unidentified armed groups to the civilian population in localities bordering Mali. The past three months have seen strong militarization on the Mali and Burkina Faso borders. Between January and March 2018, an estimated 8 000 internally displaced people (IDPs) arrived in the commune of Inates, 6 685 of whom arrived in March 2018. There are nine integrated health centres and four health huts open, but overloaded by the number of people. Four health huts are closed as a result of the insecurity.

Location of internally displaced people, refugees, armed conflicts and declared States of Emergency in Niger, March 2018




In Tahoua Region, the departments of Tillia and Tassara are the most affected, mainly by the impact of insecurity in neighbouring Mali. As a result, the state of emergency was renewed in 2018 by the Government of Niger, including a curfew and closure of two food markets. The protection cluster reported 36 incidents between January and March 2018. As of February 2018, the refugee population in the area numbers 3 297 households (18 221 individuals). There is also refugee and returnee movement between Mali and Niger.

## PUBLIC HEALTH ACTIONS

- Civil-military coordination has been in place since January 2018, with security zones set up and patrols on the routes used by humanitarian actors, convoys and beneficiary populations in accordance with the Humanitarian Country Team operations. Secure zones are being set up in Tillabéry according to rules adopted after a meeting of the different military operators on 21 March 2018.
- In Diffa and Tillabéry, the humanitarian response continues in all sectors and the ban on mobile clinics along the Komadougou River and Lake Chad has been lifted.
- WHO deployed supplies to Diffa, Tillabéry and Tahoua in support of their regional health directorates and districts to ensure access to free care for vulnerable populations. The supplies were made up of three complete inter agency emergency health kits (IEHK 2015) which can treat 10 000 patients for 3 months for common diseases, three complete cholera kits including all necessary equipment for the initial response to a cholera outbreak including treatment for 300 patients, three each of A and B trauma kits, 16 emergency health kits (including anti-malaria medication for 10 000 people for 3 months), 20 complete kits for sample collection, and 48 triple packs for sample transportation.
- UNFPA provided reproductive health supplies and drugs.
- WHO continues support to the Ministry of Public Health, in collaboration with other humanitarian actors.

## SITUATION INTERPRETATION

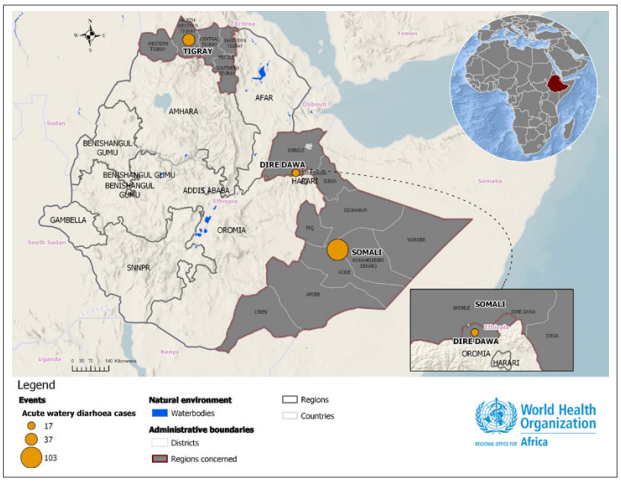
Continuing military action both in Niger and in neighbouring Mali drives the humanitarian crisis in the region, resulting in major population displacement and disruption of essential humanitarian services. As long as this continues, the humanitarian crisis will continue, requiring major political input from all parties to effect a cease fire. International humanitarian actors need to be able to access vulnerable populations and require the funding necessary to provide aid.

## EVENT DESCRIPTION

The El-Niño-induced drought continues to fuel the complex humanitarian crisis in Ethiopia, resulting in high levels of food insecurity and severe acute malnutrition (SAM). Somali region, in southern Ethiopia, is the most affected, with 1.7% of the population affected by SAM. The Southern Nations, Nationalities and People's Region (SNNPR) and southern Oromia regions are also affected. The drought has caused significant livestock losses, greatly reduced access to food and driven large-scale displacement, severe and prolonged water shortages and outbreaks of epidemic-prone diseases. In addition, the security situation remains tense along the Somali/Oromia borders, although there has been a slight improvement in Hudet, Moyale and Bale and Borena, allowing movement of supplies.

The displacement tracking matrix shows a 2.6% increase in the total number of internally displaced people (IDPs) across the country (1.74 million) including 1.2 million conflict-associated IDPs, a 12.7% increase, and a 67% decrease in those displaced for other reasons. Most IDPs are in Somali and Oromia regions and are accommodated in 916 sites. Of these IDPs 16%, mainly among host communities, have no access to essential primary healthcare services and another 30% have to travel more than 3 km to access healthcare. Only 37% of the conflict-associated IDPs have access to free medicines. Resettlement of 150 000 conflict-associated IDPs evicted from Somali Region to Oromia has started around 11 town administrations, with 23 000 resettled to date (week 14).

Geographical location of acute watery diarrhoea cases, Ethiopia, 30 December 2017 - 8 April 2018




A total of 479 SAM cases with associated medical complications were admitted to the 33 WHO prioritized stabilization centres (SCs) from week 1-14 2018. During week 14, 37 new cases were admitted to 29 of the 33 SCs. Fazan Zone has the highest numbers of new nutrition cases in the past two weeks.

The acute watery diarrhoea (AWD) outbreak continues, although there has been a decline in weekly cases recently, with a reduction to four cases in week 14, down from 13 cases in week 13. The cumulative number of cases from week 1 to week 14 2018 is 157 in Somali, Tigray regions and Dire Dawa City Administration, with no deaths. The expected week 11 peak, as has happened in the past two years, did not happen, likely due to heightened surveillance and maintenance of an efficient rapid response mechanism.

Measles cases continue to be reported from five regions: Addis Ababa, Amhara, Oromia, SNNPR and Somali. The total number of confirmed cases in week 14 was 399, mainly from Somali Region (Dollo Zone).

## PUBLIC HEALTH ACTIONS

- The Ethiopia Humanitarian Fund (EHF) called for proposals for the first allocation of funds in 2018. The main focus is on nutrition interventions, with the health sector receiving a lower allocation.
- WHO is providing technical and operational support to the Somali Regional Health Bureau (RHB), with WHO zonal surveillance officers conducting 142 alert investigation missions to date this year for measles, AWD, pertussis, Dengue fever, rubella and acute flaccid paralysis, along with immediate responses and sample collection.
- WHO recruited a water, sanitation and hygiene (WASH) specialist for the Somali Region to strengthen proactive WASH responses and offer guidance to the RHB and other response actors in the region, along with administrative staff to support the Somali Regional sub-office. Other RHBs in the rest of the regions have similar support.
- WHO zonal technical officers in the Somali Region/Shebele Zone most affected by AWD conducted community awareness, active case finding and supervision of case management in health centres in Gode, Elalale, Kelafo, Mustahil, Garbo and Horahsgash, as well as three field visits to Dolo Aldo to support responses to Dengue fever and measles outbreaks (training hospital staff, providing rapid diagnostic tests and surveillance forms).
- Supplies for the treatment of 3 300 severe dehydration cases and 4 000 moderate dehydration case were distributed by WHO to Oromia, Addis Ababa, Afar, SNNPR, Amhara, Tigray, Dire Dawe, Harrer, Beneshangul Gomuz and Ganbella.
- Nutrition response activities included training in management of SAM with associated medical complications, capacity building through training of trainers on management of SAM, and supporting supervision and training of eight woredas in Sitti Zone from February 2018 to the end of March 2018.

## SITUATION INTERPRETATION

The continuation of the El-Niño-induced drought in the region is a major concern, as the proximal driver of this protracted humanitarian crisis. There are challenges around poor adaptation of administrative procedures to respond to emergency events, and underfunding for WHO actions, related to overall underfunding of the humanitarian health sector generally. The health sector is competing with the nutrition sector for funds, with 7.3 million people in need of food distribution and treatment of acute malnutrition. In addition, there are challenges around recruiting and maintaining staff for essential positions. International donors need to upscale funding urgently to allow full responses to this crisis, which is threatening to deteriorate further in 2018.

# Summary of major issues challenges, and proposed actions

## Issues and challenges

- Haemorrhagic fevers are among the leading causes of morbidity and mortality in the region. This week sees reports of outbreaks of two diseases that are persistent problems in their respective countries, CCHF in Namibia and Lassa fever in Liberia. For both of these diseases the reservoir population is in animals, ticks for the former and rats for the latter, emphasising the importance of a One Health approach when responding to these outbreaks.
- Cholera remains an ongoing issue in many countries in the region. This week we report on a newly declared cholera outbreak in Zimbabwe, who declared their most recent outbreak over only three weeks ago. Although effective surveillance enabled early detection of this outbreak the same prevailing risk factors likely caused the outbreak, namely poor water and sanitation conditions.

## Proposed actions

- WHO should continue to assist countries in bringing together all necessary actors during a response to an outbreak. For those involving animal host or reservoir populations such as Lassa fever and CCHF it is essential that Ministries of Agriculture and Environment are lead contributors to response actions and supported appropriately by agencies and partners specialized in these areas. Actions should include enhanced surveillance of the diseases of human interest in the animal population, detailed case investigation by joint human and animal public health teams and targeted risk communication activities. Without the effective engagement of the One Health community, outbreaks will continue to occur on a regular basis.
- Without long term investment by national authorities with the support of international donors, cholera will remain a persistent and deadly disease in the region. Investment into access to safe drinking water, effective water and sanitation infrastructure and education on hygiene and behavioural practices are all needed to reduce the morbidity and mortality from cholera, which continues to have a significant socio-economic impact in the region. This hampers the ability to achieve the sustainable development goals by 2030.

# All events currently being monitored by WHO AFRO

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| **New events** | | | | | | | | | | |
| Zimbabwe | Cholera | Ungraded | 7-Apr-18 | 5-Apr-18 | 11-Apr-18 | 8 | 3 | 2 | 25.0% | Detailed update given above. |
| **Ongoing events** | | | | | | | | | | |
| Algeria | Measles | Ungraded | 13-Mar-18 | 25-Jan-18 | 11-Mar-18 | 2 320 | - | 5 | 0.2% | A total of 2 320 cases including 5 deaths have been reported from 13 wilayas: El Oued, Ouargla, Illizi, Tamanrasset, Biskra, Tebessa, Relizane, Tiaret, Constantine,Tissemsilt, Medea, Alger, and El-Bayadh. |
| Angola | Cholera | G1 | 2-Jan-18 | 21-Dec-17 | 1-Apr-18 | 841 | 5 | 13 | 1.5% | On 21 December 2018, two suspected cholera cases were reported from Uíge district, Uíge province. Both of these cases had a history of travel to Kimpangu (DRC). Cases are being reported from two districts of Uíge province (Uíge the seat of the provinces and the rural district of Son-go). By week 14, Uíge cholera outbreak involved two districts (Uige the seat of the provinces and the rural district of Songo), there was an increase to 22 cases of cholera between the EW 12 and EW 13, with zero deaths. |
| Angola (Cabinda province) | Cholera | Ungraded | 8-Mar-18 | 18-Feb-18 | 25-Mar-18 | 42 | - | 2 | 4.8% | This outbreak began during week 7 of 2018. During week 12, Cabinda reported 7 cases and 0 deaths. The cases are restricted to five neighborhoods in poor suburban areas. |
| Angola | Malaria | Ungraded | 20-Nov-17 | 1-Jan-17 | 30-Sep-17 | 399 692 | - | 2 115 | 0.5% | The outbreak has been ongoing since the beginning of 2017. In the province of Benguela, a total of 244 381 malaria cases were reported from January to September 2017 as compared to 311 661 reported in all of 2016. In the province of Huambo, 155 311 malaria cases were reported from January to September 2017, as compared to 82 138 cases during the same period in 2016. Epidemiological investigations are ongoing in these two contiguous provinces. |
| Angola | Microcephaly - suspected Zika virus disease | Ungraded | 10-Oct-17 | End September | 29-Nov-17 | 42 | - | - | - | A cluster of microcephaly cases was detected in Luanda in late September 2017 and reported on 10 October 2017 by the provincial surveillance system. Of the 42 cases, three were stillbirths and 39 were live births. Suspected cases have been reported from Luanda province (39), Zaire province (1), Moxico province (1), and Benguela province (1). |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Burkina Faso | Dengue | G1 | 4-Oct-17 | 31-Dec-17 | 25-Mar-18 | 909 | - | 3 | 0.3% | From week 1 to week 52 of 2017, 15 096 cases and 30 deaths were reported. The trend in the number of cases has decreased since week 44 of 2017. From week 1 to week 12 of 2018, a total of 909 suspected cases and 3 deaths were reported in the country. In the central region, 19 suspected cases (of which 9 are probable) and 0 deaths are reported. Dengue virus serotypes 1, 2, and 3 are circulating. |
| Cameroon | Humanitarian crisis | G2 | 31-Dec-13 | 27-Jun-17 | 3-Nov-17 | - | - | - | - | At the beginning of November 2017, the general security situation in the Far North Region worsened. Terrorist attacks and suicide bombings have continued and are causing displacement. Almost 10% of the population of Cameroon, particularly in the Far North, North, Adamaoua, and East Regions, is in need of humanitarian assistance as a result of the insecurity. To date, more than 58 838 refugees from Nigeria are present in Minawao Camp, and more than 21 000 other refugees have been identified outside of the camp. In addition, approximately 238 000 internally displaced people (IDPs) have been registered. |
| Central African Republic | Humanitarian crisis | G2 | 11-Dec-13 | 11-Dec-13 | 11-Apr-18 | - | - | - | - | The security situation remains tense and precarious in many places across the country. The joint operation by the Internal Security Forces (ISF) of the Central African Armed Forces (FACA) supported by MINUSCA against a self-defense group is causing several deaths and injuries in the Muslim neighborhood of PK5. Further clashes between armed groups and MINUSCA forces in Tagbara village (70 km north of Bambari on the Ippy axis) resulted in several deaths including women and children and internally displaced persons. Public health actions to control the monkey pox epidemic in the Ippy sub-prefecture are ongoing. Currently, 2.5 million people are in need of humanitarian aid including 1.1 million people targeted for the health cluster partners. There are around 688 700 IDPs across the country, of which 70% are living with host families. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Central African Republic | Monkeypox | Ungraded | 20-Mar-18 | 2-Mar-18 | 4-Apr-18 | 11 | 6 | 0 | 0.0% | The outbreak was officially declared on 17 March 2018 in the sub province of Ippy. In this reporting period, 2 new suspected cases have been reported from Bangassou. As of 11 April 2018 eleven cases including six confirmed cases have been reported from Bambari district (9) and Bangassou (2). |
| Congo (Republic of) | Acute watery diarrhoea (AWD) | Ungraded | 21-Mar-18 | n/a | 10-Apr-18 | 45 | 3 | 2 | 4.4% | As of 10 April 2018, 45 suspected cases of cholera including 2 deaths were reported in the departments of Plateaux (33 suspected) and Likouala (12 suspected) near the Congo River. The 3 confirmed cases were tested by RDT and/or culture. |
| Democratic Republic of the Congo | Humanitarian crisis | Protracted 3 | 20-Dec-16 | 17-Apr-17 | 1-Apr-18 | - | - | - | - | The humanitarian and security situation remains very fragile in several provinces of the country, particularly in Ituri, North Kivu, South Kivu. A precarious calm is observed in the Kasaï region, thus favouring the return of the displaced. Displacement from these provinces continues and new IDPs are lacking basic services. |
| Democratic Republic of the Congo | Cholera | G3 | 16-Jan-15 | 1-Jan-18 | 24-Mar-18 | 7 961 | 0 | 185 | 2.3% | This is part of an ongoing outbreak. From week 1 to 12 of 2018, a total of 7 961 cases including 185 deaths (CFR: 2.3%) were reported from DRC. In week 12, there were 497 new cases with 10 deaths reported. Nationwide, a total of 60 492 cases including 1 288 deaths (CFR; 2.1%) have been reported since January 2017. |
| Democratic Republic of the Congo | Measles | Ungraded | 10-Jan-17 | 1-Jan-18 | 4-Mar-18 | 3 404 | - | 30 | 0.9% | This outbreak is ongoing since the beginning of 2017. As of week 8 in 2018, a total of 48 326 cases including 563 deaths (CFR 1.2%) have been reported since the start of the outbreak. In 2018 only, 3 404 cases including 30 deaths (0.9%), were reported. |
| Democratic Republic of the Congo | Poliomyelitis (cVDPV2) | Ungraded | 15-Feb-18 | n/a | 30-Mar-18 | 407 | 22 | 0 | 0.0% | On 13 February 2018, the Ministry of Health declared a public health emergency regarding 21 cases of vaccine-derived polio virus type 2. Three provinces have been affected, namely Haut-Lomami (8 cases), Maniema (2 cases) and Tanganyika (11 cases). The outbreak has been ongoing since February 2017. |
| Democratic Republic of Congo | Rabies | Ungraded | 19-Feb-18 | 1-Jan-18 | 1-Apr-18 | 38 | 0 | 12 | 31.6% | This outbreak began towards the end of October 2017 in Kibua health district, North Kivu province. During Week 12 of 2018, seven new cases and two deaths were reported. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Democratic Republic of Congo | Monkeypox | Ungraded | n/a | 1-Jan-18 | 1-Apr-18 | 848 | 34 | 25 | 2.9% | From weeks 1-12 of 2018 there have been 848 suspected cases of monkeypox including 25 deaths. Of the suspected cases, 34 have been confirmed samples. Suspected cases have been detected in 14 provinces. Sankuru Province has had an exceptionally high number of suspected cases this year (106 cases) compared to the same time period last year (44 cases). |
| Ethiopia | Humanitarian crisis | Protracted 3 (combined) | 15-Nov-15 | n/a | 8-Apr-18 | - | - | - | - | Detailed update given above. |
| Ethiopia | Acute watery diarrhoea (AWD) | | 15-Nov-15 | 1-Jan-18 | 8-Apr-18 | 157 | - | 0 | 0.0% | This is an ongoing outbreak since the beginning of 2017. In 2018 only, from 1 January 2018 to 10 April 2018, a total of 157 cases have been reported from three regions, Somali, Tigray and Dire Dawa regions with no death reported. In week 14, 4 cases were reported in a reduction from 13 new cases in week 13. Between January and December 2017, a cumulative total of 48 814 cases and 880 deaths (CFR 1.8%) have been reported from 9 regions. |
| Ethiopia | Measles | | 14-Jan-17 | 1-Jan-18 | 8-Apr-18 | 1 050 | 399 | - | - | This is an ongoing outbreak since the beginning of 2017. Between January and December 2017, a cumulative total of 4 011 suspected measles cases have been reported across the country. In 2018 only, a total of 1 050 suspected cases including 399 confirmed cases, have been reported from 5 regions (Addis Ababa, Amhara, Oromia, SNNPR, and Somali). |
| Ghana | Lassa fever | Ungraded | 1-Mar-18 | 27-Feb-18 | 2-Mar-18 | 1 | 1 | 1 | 100.0% | On 1 March 2018, WHO was notified of a confirmed case of Lassa fever. The index case was a 26 year-old male who presented at a public hospital in Accra on 23 February 2018, with symptoms of general weakness, severe headache, joint pains, and vomiting of blood. On 23 February 2018, a blood sample was sent to the lab for confirmation and tested positive by PCR on 26 February 2018. He died on 28 February 2018. All contacts have been listed and they are currently monitored. |
| Kenya | Chikungunya | Ungraded | mid-December 2017 | mid-December 2017 | 8-Apr-18 | 1 044 | 36 | 0 | 0.0% | As of 8 April 2018, a total of 917 cases including 32 confirmed, were reported from Mombasa county and 127 cases including 4 confirmed cases have been reported from Lamu county. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Kenya | Cholera | G1 | 6-Mar-17 | 1-Jan-18 | 8-Apr-18 | 2 399 | 108 | 51 | 2.1% | The outbreak in Kenya is ongoing since 2017. Between 1 January 2017 and 07 December 2017, a cumulative total of 4 079 cases were reported from 21 counties (data until 31 December 2017 not available). In 2018, a total of 2 399 cases have been reported since the first of January. Currently, the outbreak is active in 7 counties: Garissa, Turkana, West Pokot, Trans Nzoia, and Tana River, Nakuru, and Nairobi counties. The outbreak has been controlled in 7 counties; Mombasa, Kirinyaga, Siaya, Tharaka Nithi, Meru, Basia, and Muranga. |
| Kenya | Measles | Ungraded | 19-Feb-18 | 19-Feb-18 | 8-Apr-18 | 127 | 11 | 1 | 0.8% | The outbreak is located in two counties, namely Wajir and Mandera Counties. As of 8 April 2018, Wajir County has reported 39 cases with 7 confirmed cases, Mandera has reported 88 cases with 4 confirmed cases and one death. |
| Liberia | Measles | Ungraded | 24-Sep-17 | 1-Jan-18 | 25-Mar-18 | 1 857 | 180 | 12 | 0.6% | From week 1 to week 48 of 2017, 1 607 cases were reported from 15 counties, including 225 laboratory confirmed, 336 clinically compatible and 199 epi-linked. From week 1 to week 12 of 2018, 1 857 cases have been reported including 12 deaths. Cases are epidemiologically classified as follows: 180 laboratory confirmed, 916 epi-linked, 338 clinically compatible, 154 discarded, and 269 pending. |
| Liberia | Lassa fever | Ungraded | 14-Nov-17 | 1-Jan-18 | 8-Apr-18 | 67 | 9 | 19 | 28.4% | Detailed update given above. |
| Liberia | Scabies | Ungraded | 11-Jan-18 | 11-Dec-17 | 18-Jan-18 | 10 850 | 17 | 0 | 0.0% | A total of 10 850 cases have been reported from five counties: Montserrado (9 647), Grand Bassa (687), Rivercess (315), Margibi (185), and Bong (16). All 17 confirmed cases have been reported from Montserrado county. |
| Madagascar | Plague | G2 | 13-Sep-17 | 13-Sep-17 | 1-Apr-18 | 2 673 | 557 | 238 | 8.9% | From 1 August 2017 to 10 April 2018, a total of 2 673 cases of plague were notified, including 557 confirmed, 829 probable and 1 287 suspected cases. Out of them 2 032 cases were of pulmonary, 436 were of bubonic, 1 was of septicaemic form and 204 cases unspecified. |
| Malawi | Cholera | Ungraded | 28-Nov-17 | 20-Nov-17 | 8-Apr-18 | 889 | 195 | 30 | 3.4% | The number of cholera cases reported in week 14 (2-8 April 2018) is lower than the previous week's cases. There were 15 cases and 3 deaths during week 14, verses 30 cases and 1 death during week 13. All new cases and deaths were reported from Lilongwe district. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Mali | Humanitarian crisis | Protracted 1 | n/a | n/a | 19-Nov-17 | - | - | - | - | The security situation remains volatile in the north and centre of the country. At the last update, incidents of violence had been perpetrated against civilians, humanitarian workers, and political-administrative authorities. |
| Mali | Measles | Ungraded | 20-Feb-18 | 1-Jan-18 | 11-Feb-18 | 109 | 49 | 0 | 0.0% | A total of five health districts have reached the epidemic threshold (Ansongo, Bandiagara, Douentza, Kadiolo, and Yanfolila). Forty-nine samples were confirmed positive by serology (IgM) at the national reference laboratory INRSP. |
| Mauritania | Dengue haemorrhagic fever | Ungraded | 30-Nov-17 | 6-Dec-17 | 22-Feb-18 | 307 | 165 | - | - | In November 2017, the MoH notified 3 cases of dengue fever including one hemorragic case (Dengue virus type 2) with a history of Dengue virus type 1 infection in 2016. As of 10 February 2018, the national reference laboratory confirmed the diagnosis of 165 out of 307 RDT positive samples. Dengue type 1 and type 2 are circulating in the country with a higher proportion of subtype 2 (104/165). |
| Mozambique | Cholera | G1 | 27-Oct-17 | 12-Aug-17 | 8-Apr-18 | 2 329 | - | 5 | 0.2% | The cholera outbreak is ongoing. From mid-August 2017 through 8 April 2018, cases have been reported from two provinces; Nampula (1 646 cases and 2 deaths) and Cabo Delgado (683 cases and 3 deaths) provinces. This outbreak started in mid-August 2017 in Memba district, Nampula Province and Cabo Delgado Province started reporting cases from week 1 of 2018. No cases have been reported from Erati and Nacrpoua districts since the beginning of the year. |
| Namibia | Crimean-Congo haemorrhagic fever | Ungraded | 29-Mar-18 | 29-Mar-18 | 6-Apr-18 | 2 | 1 | 1 | 50.0% | Detailed update given above. |
| Namibia | Hepatitis E | Ungraded | 18-Dec-17 | 8-Sep-17 | 25-Mar-18 | 1 030 | 112 | 10 | 1.0% | This is an ongoing outbreak since 2017. The majority of cases have been reported from informal settlements in the capital district Windhoek. The most affected settlement is Havana, accounting for about 573 (56%) of the total cases, followed by Goreagab settlements with 256 (25%) cases. The most affected age group is between 20 and 39 years old representing 75% of total cases. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Namibia | Listeriosis | Ungraded | 13-Mar-18 | 12-Mar-18 | 13-Mar-18 | 1 | 1 | 0 | 0.0% | On 13 March 2018, WHO was notified of a confirmed case of listeria in Windhoek. The index case; a 41 years-old male, with chronic hepatitis B; developed liver cirrhosis and was admitted to the hospital on 5 March 2018. Bacterial Culture was done in which *Listeria monocytogenes* was isolated. The patient has no travel history outside Namibia. Investigations are ongoing to establish if there are any links between this case and the outbreak in South Africa. |
| Niger | Humanitarian crisis | G2 | 1-Feb-15 | 1-Feb-15 | 11-Apr-18 | - | - | - | - | Detailed update given above. |
| Nigeria | Humanitarian crisis | Protracted 3 (combined) | 10-Oct-16 | n/a | 31-Jan-18 | - | - | - | - | Conflict and insecurity in the north east of Nigeria remain a concern and resulted in a large scale of displacement. Most affected areas recently are along the axis from Monguno to Maiduguri, namely in Gasarwa, Gajiram, Gajigana, Tungushe, and Tungushe Ngor towns. Initial estimates for the number of IDPs in recent months is between 20 000 and 36 000; many are in dire need of humanitarian services. |
| Nigeria | Cholera (nation wide) | Ungraded | 7-Jun-17 | 1-Jan-18 | 3-Mar-18 | 210 | 2 | 16 | 7.6% | There is an ongoing outbreak since the beginning of 2017. Between 1 January and 31 December 2017, a cumulative total of 4 221 suspected cholera cases and 107 deaths (CFR 2.5%), including 60 laboratory-confirmed were reported from 87 LGAs in 20 states. Between weeks 1 and 9 of 2018, 210 suspected cases including two laboratory-confirmed case and 16 deaths (CFR 7.6%), have been reported from 28 LGAs in 9 states. Most recently, cases have also been reported from Yobe and Bauchi states. During 27 February 2018 to 31 March 2018, Bauchi State reported 673 cases including 11 deaths (CFR 1.6%). During 28 March to 10 April, Yobe State reported 278 cases including 15 deaths (CFR 5.4%). |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Nigeria | Lassa fever | G2 | 24-Mar-15 | 1-Jan-18 | 8-Apr-18 | 430 | 408 | 110 | 25.6% | From 1 January to 8 April 2018, a total of 1 781 suspected cases and 146 deaths have been reported from 20 states. Nine states are not in the active phase of the outbreak, while the following 11 states are in the active phase: Abia, Bauchi, Ebonyi, Edo, Gombe, Kogi, Ondo, Osun, Plateau, Taraba, and the Federal Capital Territory (FCT). Of the suspected cases, 408 have been confirmed, 9 are probabale, 1 351 are negative (not a case), and 13 are pending results. Twenty-seven healthcare workers have been affected in 7 states: Abia (1), Ebonyi (16), Edo (3), Benue (1), Kogi (2), Nasarawa (1), and Ondo (3). A total of 1022 cases including 127 deaths were reported from week 49 of 2016 to week 51 of 2017. |
| Nigeria | Hepatitis E | Ungraded | 18-Jun-17 | 1-May-17 | 31-Dec-17 | 1 651 | 182 | 8 | 0.6% | The number of cases has been decreasing since week 51 of 2017. Forty-three new cases were reported in Kala/Balge LGA in week 52 (ending 31 December 2017). |
| Nigeria | Yellow fever | Ungraded | 14-Sep-17 | 7-Sep-17 | 11-Mar-18 | 1 449 | 96 | 46 | 3.2% | A total of 1 449 cases have been reported from 30 states: Abia, Borno, Kogi, Kwara, Kebbi, Plateau, Zamfara, Enugu, Oyo, Anambra, Edo, Lagos, Kano, Nasarawa, Katsina, Niger, Bayelsa, Rivers, Cross Rivers, Kaduna, Sokoto, Jigawa Imo, Delta State, Akwa Ibom, Ebonyi, Ekiti, FCT Abuja, Ogun, Ondo and Osun State). Ninety-six cases from seven states (Kwara, Kogi, Kano, Zamfara, Kebbi, Nasarawa, and Niger) have been laboratory-confirmed at IP Dakar. |
| Nigeria | Monkeypox | Ungraded | 26-Sep-17 | 24-Sep-17 | 25-Feb-18 | 228 | 89 | 6 | 2.6% | Suspected cases are geographically spread across 24 states and the Federal Capital Territory (FCT). Eighty-nine laboratory-confirmed cases have been reported from 15 states/territories (Akwa Ibom, Abia, Bayelsa, Benue, Cross River, Delta, Edo, Ekiti, Enugu, Lagos, Imo, Nasarawa, Rivers, and FCT). |
| Nigeria | Meningitis | Ungraded | 26-Dec-17 | 1-Sep-18 | 6-Mar-18 | 1 157 | 128 | 141 | 12.2% | Cases have been reported from 15 states: Zamfara (539), Katsina (245), Sokoto (129), Jigawa (51), Yobe (50), Niger (39), Cross River (25), Kebbi (25), Bauchi (20), Kano (21), Gombe (3), Plateau (4), Borno (3), Adamawa (2) and Kaduna (1). As of 6 March 2018, 128 (37.9%) of 337 samples tested were positive for bacterial meningitis, including 78 (60.9%) positive for *Neisseria meningitidis* serogroup C (NmC). |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Nigeria (Borno State) | Cholera | Ungraded | n/a | 13-Feb-18 | 10-Apr-18 | 658 | 23 | 3 | 0.5% | A total of 658 cases have been reported from Borno State including 3 deaths. Of the 84 samples tested using rapid diagnostic tests (RDTs), 72 (85.7%) were positive, while 23 of 55 (42%) samples were culture positive. |
| São Tomé and Principé | Necrotising cellulitis/ fasciitis | Protracted 2 | 10-Jan-17 | 25-Sep-16 | 08-April-2018 | 2 555 | 0 | 0 | 0.0% | From week 40 in 2016 to week 13 in 2018, a total of 2 555 cases have been notified. In week 13, 16 cases were notified, which shows a half decrease compared to week12. The attack rate of necrotising cellulitis in Sao Tome and Príncipe is 12.9 cases per 1 000 inhabitants. The most affected district are Caue (attack rate: 19.8 cases per 1 000 inhabitants ) and Cantagalo (8.8 cases per 1 000 inhabitants). |
| Seychelles | Dengue fever | Ungraded | 20-Jul-17 | 18-Dec-15 | 19-Feb-18 | 4 459 | 1 429 | - | - | A total of 4 459 cases have been reported from all regions of the three main islands (Mahé, Praslin, and La Digue). The trend in the number of cases has been decreasing since week 23. |
| South Africa | Listeriosis | G2 | 6-Dec-17 | 4-Dec-17 | 9-Apr-18 | 1 011 | 1 011 | 193 | 19.1% | This outbreak is ongoing since the beginning of 2017. To date, 748 (73.9%) cases were reported in 2017 and 263 (26.0%) cases in 2018. Around 80% of cases are reported from three provinces; Gauteng (59%, 592/1 011), Western Cape (12%, 125/1 011) and KwaZulu-Natal (7%, 72/1 011). Following the source identification ; the national authorities with support from WHO and other partners ; have taken measures to limit further infections and associated mortality including but not limited to the issuance of safety recall notices, compliance notices, measures related to exportation of implicated products, and risk communication with vulnerable groups. Since the recall of implicated food products (on 4 March 2018), a total of 43 laboratory-confirmed cases have been reported. |
| South Africa | Cholera | Ungraded | 26-Feb-18 | 6-Mar-18 | 10-Mar-18 | 1 | 1 | 0 | 0.0% | The index case is a 37 year-old female from the border district of Umkhanyakude, in KwaZulu-Natal province. She presented at the clinic on 7 February 2018 with severe abdominal pains, diarrhoea, vomiting, and severe dehydration. *Vibrio cholerae* 01 Ogawa was confirmed by the National Institute of Communicable Diseases (NICD), Centre for Enteric Diseases on 15 February 2018. The patient had no travel history. No other cases were reported. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| South Sudan | Humanitarian crisis | Protracted 3 | 15-Aug-16 | n/a | 8-Apr-18 | - | - | - | - | Following the conflict in December 2013, about 4 million people have fled their homes, 1.9 million people are internally displaced, 2.1 million are refugees, and 7 million people are in need of humanitarian assistance. The country is currently facing a severe economic crisis and high inflation making health emergency operations expensive and hence difficult for delivering humanitarian assistance. As of 8 April 2018, the security situation remains volatile with reported incidents of cattle raiding and revenge killings between communities in various locations hampering humanitarian service delivery. |
| South Sudan | Rift Valley fever (RVF) | Ungraded | 28-Dec-17 | 7-Dec-17 | 9-Mar-18 | 40 | 6 | 4 | 10.0% | As of 9 March 2018, 40 suspected cases of Rift Valley fever have been reported from Yirol East (37) and Yirol West (3) counties of the Eastern Lakes State, including six confirmed cases (one IgG and IgM positive and five IgG only positive), three cases who died and were classified as probable cases with epidemiological links to the three confirmed cases, 19 were classified as non-cases following negative laboratory results for RVF (PCR and serology), and samples from 12 suspected cases are pending complete laboratory testing. A total of four cases have died, including the three initial cases and one suspect case who tested positive for malaria (case fatality rate: 10.0%). |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| Tanzania | Cholera | G1 | 20-Aug-15 | 1-Jan-18 | 25-Mar-18 | 1 445 | - | 27 | 1.9% | This is part of an ongoing outbreak. The trend of reported cholera cases shows an increase to five cases and zero deaths in week 12 from zero cases and deaths in week 11, 2018. From week 1 to 12 of 2018, a total of 1 445 cases with 27 deaths (CFR: 1.9%) were reported from Tanzania Mainland, no case was reported from Zanzibar. The last case reported from Zanzibar was on 11 July 2017. Since the start of the outbreak on 15 August 2015, Tanzania mainland reported 30 051 cases including 493 deaths (CFR 1.6%) and Zanzibar reported 4 688 cases including 72 deaths (CFR 1.5%). In total, 34 739 cases including 565 deaths (CFR 1.6%) were reported for the United Republic of Tanzania. |
| Tanzania | Dengue fever | Ungraded | 19-Mar-18 | n/a | 21-Mar-18 | 13 | 11 | - | - | An outbreak of Dengue fever is ongoing in Dar es Salaam. Further information will be provided when it becomes available. |
| Uganda | Humanitarian crisis - refugee | Ungraded | 20-Jul-17 | n/a | 2-Mar-18 | - | - | - | - | The influx of refugees to Uganda has continued as the security situation in the neighbouring countries remains fragile. Approximately 75% of the refugees are from South Sudan and 17% are from DRC. An increased trend of refugees coming from DRC was observed recently. Landing sites in Hoima district, particularly Sebarogo have been temporarily overcrowded. The number of new arrivals per day peaked at 3 875 people in mid-February 2018. |
| Uganda | Cholera | G1 | 15-Feb-18 | 12-Feb-18 | 11-Apr-18 | 2 091 | 24 | 44 | 2.1% | Detailed update given above. |
| Uganda | Measles | Ungraded | 8-Aug-17 | 24-Apr-17 | 3-Oct-17 | 623 | 34 | - | - | The outbreak is occurring in two urban districts: Kampala (310 cases) and Wakiso (313 cases). |
| Zambia | Cholera | G1 | 4-Oct-17 | 4-Oct-17 | 4-Apr-18 | 5 440 | 565 | 109 | 2.0% | As of 4 April 2018, 4 998 cases and 93 deaths have been reported in Lusaka district. From other districts outside Lusaksa, 442 cases and 16 deaths have been reported. Since the begining of the outbreak, Zambia has reported a cumulative total of 5 440 cases including 109 deaths. |
| Zimbabwe | Typhoid fever | Ungraded | - | 1-Oct-17 | 24-Feb-18 | 3 187 | 191 | 0 | 0.0% | Since the beginning of the outbreak in October 2017, a total of 3 187 cases including 191 confirmed cases have been reported. In 2018 alone, 1 094 cases were reported mainly from Mbare (438 cases) and Kuwadzana (205 cases). The outbreak has spread from its epicentre in Matapi to other areas such as Mbare and Nenyere. |

| Country | Event | Grade† | WHO notified | Start of reporting period | End of reporting period | Total cases | Confirmed cases | Deaths | CFR | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| **Recently closed events** | | | | | | | | | | |
| Liberia | Meningococcal disease | Ungraded | 19-Jan-18 | 23-Dec-17 | 29-Jan-18 | 9 | 2 | 4 | 44.4% | A cluster of undiagnosed illness and deaths were reported from Lofa county, northeastern Liberia. Samples taken from two suspected cases were positive for *Neisseria meningitidis* serogroup W. All seven samples collected as of 29 January were negative for Ebola and Lassa fever viruses by PCR, negative for yellow fever by serology (IgM), and negative for typhoid by WDAL. Additional testing is ongoing. |

†Grading is an internal WHO process, based on the Emergency Response Framework. For further information, please see the Emergency Response Framework: http://www.who.int/hac/about/erf/en/.
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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**Data sources**
Data and information 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.

Health Emergency Information and Risk Assessment

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