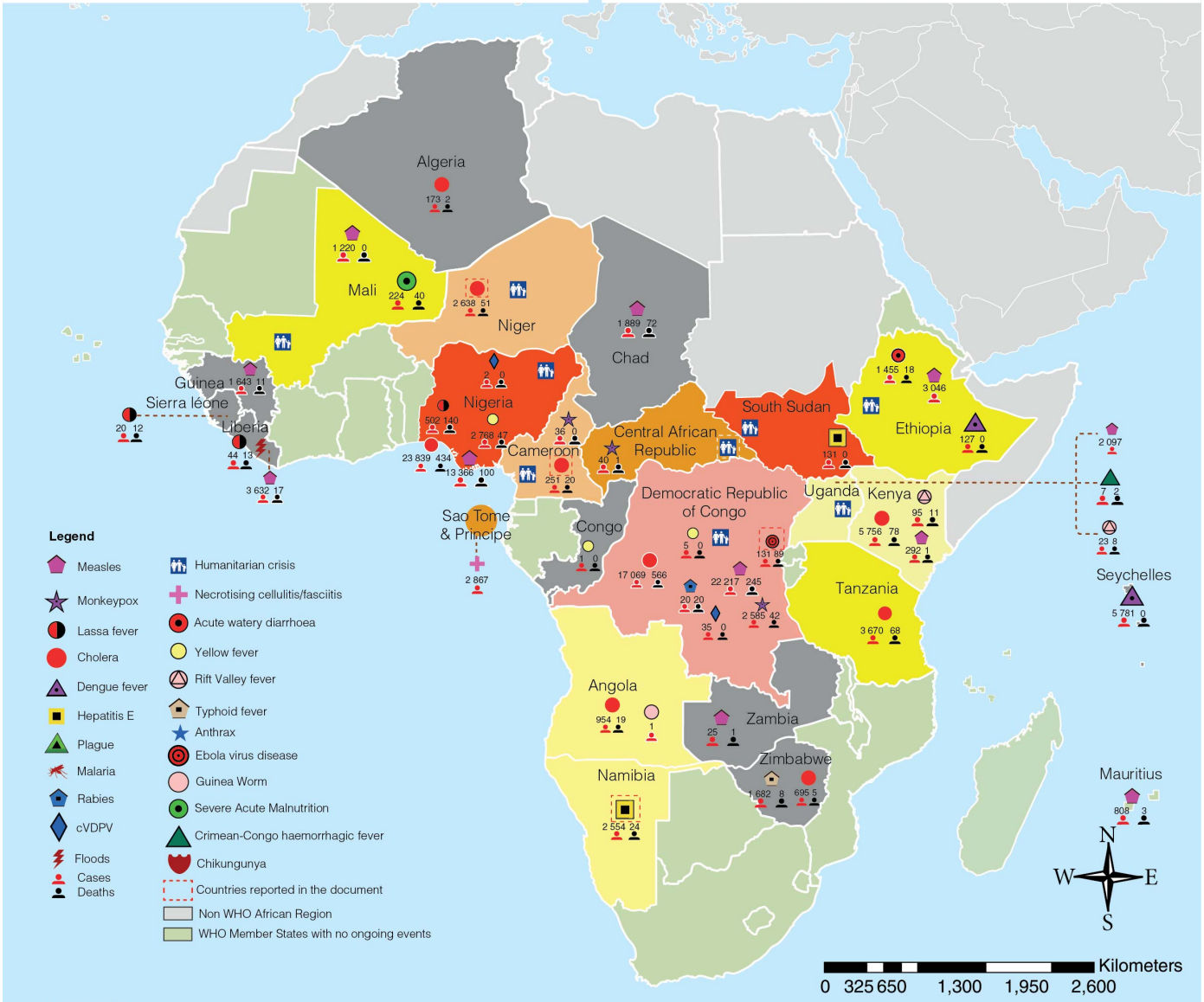
WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 36: 1 - 7 September 2018
Data as reported by 17:00; 7 September 2018

World Health Organization
REGIONAL OFFICE FOR Africa
WHO Health Emergencies Programme

1	54	44	11
New event	Ongoing events	Outbreaks	Humanitarian crises



Graded events †

2	4	7	33
Grade 3 events	Grade 2 events	Grade 1 events	Ungraded events
2	2	4	
Protracted 3 events	Protracted 2 events	Protracted 1 events	

Health Emergency Information and Risk Assessment

Overview

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- This Weekly Bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 55 events in the region. This week's edition covers key ongoing events, including:

  - Declaration of the end of the listeriosis outbreak in South Africa
  - Ebola virus disease in the Democratic Republic of the Congo
  - Cholera in Niger
  - Cholera in Cameroon
  - Hepatitis E in Namibia
  - Humanitarian crisis in Central African Republic.

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

- A table is provided at the end of the bulletin with information on all new and ongoing public health events currently being monitored in the region, as well as events that have recently been closed.

- **Major issues and challenges include:**

  - The Ebola virus disease (EVD) outbreak in the Democratic Republic of the Congo continues to evolve, with a good outlook overall. Two new health zones have reported one confirmed EVD case each. While these cases were detected quickly and response measures applied immediately, the event highlights the complexities around the response to the current outbreak. The presence of potential undocumented chains of transmission, reluctance by some communities to adopt Ebola prevention behaviours, delays by patients to seek care upon developing symptoms, inadequate infection prevention and control measures in healthcare facilities, and the potential of the virus to spread into insecure areas with limited access are some of the major issues of concern. These issues need to be addressed collectively by the national and local authorities, partners and the communities. Additionally, there is a need to continue sustained implementation of all components of the response, including preparedness in the non-affected provinces of the Democratic Republic of the Congo and its neighbouring countries.

  - The cholera outbreak in Niger is escalating, with several new cases and deaths occurring, and two additional districts being affected. The risk factors for propagation of the outbreak in the communities are prevalent, being compounded by the heavy rainfall and occasional floods. The current ongoing control interventions are not adequate to halt further transmission of infections. There is an urgent need to scale up implementation of all conventional cholera control measures, including deploying new tools such as oral cholera vaccine.

Declaration of the end of the outbreak

Listeriosis | **South Africa** | 1060 **Cases** | 216 **Deaths** | 20% **CFR**

On 3 September 2018, the Minister of Health of the Republic of South Africa officially declared the end of the listeriosis outbreak in the country. This declaration comes after the last laboratory confirmed listeriosis cases due to the outbreak strain were reported in the first week of June 2018 and, in the last two months, the incidence rate of laboratory confirmed listeriosis cases has dropped to pre-outbreak level.

The South African National Department of Health officially declared the listeriosis outbreak on 5 December 2017. On the 3 March 2018, the National Institute for Communicable Diseases (NICD) confirmed the source of the outbreak, caused by *Listeria monocytogenes* ST-6 strain, as ready-to-eat processed meat products owned by the Tiger Brands (the Enterprise Foods® Polokwane production facility). The bacterium was also identified at a RCL-owned facility (Rainbow Foods®). On 4 March 2018, a notice was issued to recall all ready-to-eat processed meat products produced at these facilities.

Between 1 January 2017 and 17 July 2018, a total of 1060 confirmed listeriosis cases, including 216 deaths (case fatality ratio 20.4%), were reported. All the nine provinces in South Africa were affected, with Gauteng Province reporting most (614, 58%) of the cases, followed by Western Cape (136, 13%) and KwaZulu-Natal (83, 8%). Neonates less than 28 days of age were the most affected group, accounting for 42% of all reported cases, followed by people aged 15-49 years at 32%. No other country in the sub region reported listeriosis cases linked to the South African outbreak.

The South African Department of Health, other national authorities, and partners implemented several measures to limit further spread of infections and associated mortality. The interventions undertaken included (but were not limited to): detailed epidemiologic, laboratory and environmental investigations, enhanced surveillance and care for patients, risk communication to vulnerable groups, immediate issuance of safety recall and compliance notices, measures related to exportation of the implicated products, and temporary closure of the implicated factory. Other interventions included legislative reforms regarding food safety, food safety regulations and standards around processed meat products, food monitoring and inspection of food processing, storage and transporting facilities.

WHO congratulates the Government of the Republic of South African, the Department of Health, government agencies, and health partners for the collective efforts and commitments to control this outbreak. WHO further commends the Department of Health and stakeholders for putting in place long-term measures to monitor, prevent and detect any potential future listeriosis outbreak. The other countries in the region are urged to draw lessons from this outbreak in order to improve their capacities for preparedness, prevention, early detection, and rapid control of any outbreak of food-borne diseases, and avoid related public health and economic consequences.

Following this declaration, a few cases of listeriosis may occur since the disease has been endemic in the country. For the past five years, NICD has reported between 60-80 cases of listeriosis annually in the country. It remains a notifiable disease condition. People are encouraged to always embrace good food safety practices, including good hand hygiene practices, separation of raw and cooked food, thoroughly cooking food, proper storage of foods at safe temperatures and the use of safe water and raw materials

Ongoing events

Ebola virus disease | **Democratic Republic of the Congo** | 131 **Cases** | 89 **Deaths** | 68% **CFR**

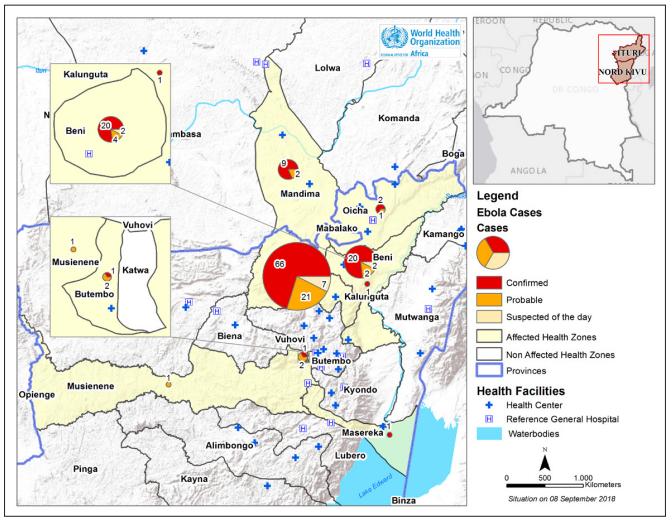
EVENT DESCRIPTION

The Ebola virus disease (EVD) outbreak in North Kivu and Ituri provinces, Democratic Republic of the Congo continues to evolve. Since our last situation report on 31 August 2018 *(Weekly Bulletin 35)*, 11 new confirmed EVD cases and 11 new deaths have been reported. By 6 September 2018, 14 other suspected cases were under investigation to confirm or exclude EVD.

As of 6 September 2018, a total of 131 confirmed and probable EVD cases, including 89 deaths (case fatality ratio 68%), have been reported. Of the 131 cases, 100 are confirmed and 31 are probable. Of the 89 deaths, 58 occurred in confirmed cases and 31 are probable. A total of 17 health workers have been affected, of which 16 are confirmed and one has died. Since the onset of the outbreak, 33 case-patients have recovered from the disease, and were discharged and re-integrated into their communities. Of the 113 confirmed and probable cases with known age and sex, females account for 55% (n=62), and the largest proportion (26%, n=29) of cases were aged 35-44 years.

Two new health zones in North Kivu Province, namely Kalunguta and Masereka, have reported one confirmed EVD case each. Five other health zones in North Kivu Province have been affected, namely: Mabalako (66 confirmed, 21 probable, 63 deaths), Béni (20 confirmed, 4 probable, 17 deaths), Butembo (1 confirmed, 2 probable, 3 deaths), Oicha (2 confirmed, 1 probable, 1 death), and Musienene (1 probable, 1 death). Mandima Health Zone in Ituri Province has reported nine confirmed and two probable cases, with three deaths.

Geographical distribution of confirmed, probable and suspected Ebola virus disease cases, Democratic Republic of the Congo, 8 September 2018



As of 7 September 2018, a total of 2426 contacts were under follow up, of which 2224 (97%) were seen on the reporting day. Over 2100 contacts have already completed 21 days of follow up.

Alerts have been reported and investigated in several provinces of the Democratic Republic of the Congo as well as its neighbouring countries, namely Burundi, Central African Republic, Rwanda, and Uganda, and to date, EVD has been ruled out in all these alerts.

PUBLIC HEALTH ACTIONS

- The Prime Minister and the Minister of Health of the Democratic Republic of the Congo visited various points of entry (PoEs) in Goma where health measures to screen travellers are being implemented.
- On 17 August 2018, the National Minister of Public Health visited patients admitted to treatment centres in Béni and Mangina, accompanied by a delegation from US Government agencies (CDC Atlanta, USAID, US Embassy in the Democratic Republic of the Congo).
- As of 3 September 2018, WHO has deployed a total of 193 experts in the various response pillars, of which 156 are based in Béni and Mangina.
- Systematic monitoring and rapid investigation of all alerts continues in all provinces of the Democratic Republic of the Congo, and in neighbouring countries.
- As of 2 September 2018, 37 points of entry in Democratic Republic of the Congo are functional for health screening. Since the beginning of the screening, over 2 million travellers have been screened, and 35 alerts have been reported, of which seven have been validated. Activities to strengthen PoE capacity in neighbouring countries as part of preparedness are on-going in collaboration with partners.
- As of 8 September 2018 a total of 7069 people have been vaccinated since the beginning of the vaccination exercise on 8 August 2018.

SITUATION INTERPRETATION

It is one month since the EVD outbreak in the Democratic Republic of the Congo was declared, and progress is continuously being made to contain the disease. The situation in Mangina, the initial epi-centre of the outbreak, has stabilized, and focus has now shifted to Butembo and the new health areas that have reported confirmed EVD cases. Currently, the major issues of concern include potential undocumented chains of transmission, reluctance by some communities to adopt Ebola prevention behaviours, spread of the disease through healthcare facilities with poor infection prevention and control measures, delays in patients reaching Ebola treatment centres once they develop symptoms, and the potential spread of the virus into insecure areas with limited access.

The national authorities, WHO and partners are working with communities to ensure that they understand and adopt Ebola prevention behaviours, including the need for safe and dignified burials. Healthcare workers have also been involved in improving infection prevention and control practices in health facilities. While all other components of the response, as well as preparedness and readiness in the non-affected provinces of the Democratic Republic of the Congo and in the neighbouring countries, are being undertaken.

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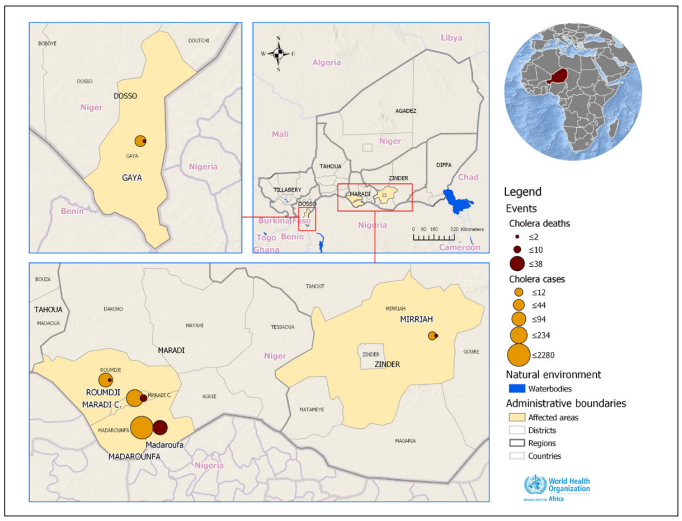
EVENT DESCRIPTION

The outbreak of cholera in Niger is rapidly increasing, with two new health districts affected during the reporting week. Since our last report on 31 August 2018 *(Weekly Bulletin 35)*, a total of 625 new suspected cholera cases and 14 deaths were reported from five health districts. From 3 September to 5 September 2018, 160 new suspected cholera cases and two deaths were reported. In week 35 (week ending 2 September 2018), a total of 379 suspected cholera cases and 11 deaths were reported. As of 5 September 2018, there were 97 patients on admission in the cholera treatment centres (CTCs) in Madarounfa (65), Gaya (13), Guidan Roumdji (11) and Maradi (8).

Since the beginning of the outbreak on 5 July 2018, a total of 2638 suspected cholera cases, including 51 deaths (case fatality ratio 1.9%), have been reported. The main age group affected is 15 years and above, accounting for 52% of the reported cases, while children under five years of age constitute 20% of the total caseload. Fifty-six percent of the reported cases are females.

Two new health districts, namely Damagaram Takaya (12 cases, 1 death) and Gaya (44 cases, 2 deaths), have been affected during the reporting week. Eighty-six percent (2280) and 75% (38) of the reported cases and deaths, respectively, came from Madarounfa District. Maradi District registered 234 cases and 10 deaths while Guidan Roumdji reported 94 cases with no deaths.

Geographical distribution of cholera cases and deaths in Niger, 5 July - 26 August 2018



Nineteen of 24 stool specimens collected and analysed at the Centre for Medical and Health Research were positive for *Vibrio cholerae* 01 Inaba by culture.

PUBLIC HEALTH ACTIONS

- The Epidemics Surveillance and Response Directorate of the Ministry of Health, in collaboration with the Regional Direction of Public Health in Maradi, are coordinating the response to the cholera outbreak, with technical support from WHO and partners. Direct implementation and supervision of the response activities are undertaken by the district health management teams. Weekly coordination meetings take place in Naimey, along with daily operational meetings in Maradi.
- Active surveillance has been strengthened in all health facilities, who are reporting on a daily basis and updating line lists of cases. There is continued supervision and capacity building of structures and staff for epidemiological surveillance and response monitoring.
- Case management free of costs is provided by three CTCs in Nyelwa, Dan Issa and Maradi, supported by Médecines sans Frontièrs (MSF).
- The WHO Country Office is providing technical support for coordinating the response at local and national level. WHO donated two interagency diarrhoeal disease kits and two interagency emergency health kits for the management of diarrhoeal diseases in the affected communities.
- Water, sanitation and hygiene (WASH) activities are ongoing. MSF has installed hand wash and disinfection facilities at the health centre level, while UNICEF supported chlorination of water at source and at household level.
- Sensitization of communities is being conducted through various channels of communication, including community radio and use of community relays and local leaders to disseminate cholera messages.

SITUATION INTERPRETATION

The cholera outbreak in Niger is rapidly increasing, with large numbers of new cases and deaths occurring, and new districts being affected. The risk factors for further spread of the disease in the communities are huge. The latest WASH assessment carried out by UNICEF and WHO estimates that only 37% of the population in Maradi Region has access to basic sources of potable water, 75% of the population are said to practice open defaecation, with only 10% having access to basic sanitation. Currently, there is ongoing heavy rainfall, causing occasional floods in several places, likely to exacerbate the risk of contamination of water sources. The ongoing outbreak control measures on the ground have not been able to halt the propagation of the disease. All these factors are favourable for further escalation of the outbreak.

The national authorities and partners need to intensify and scale up implementation of conventional cholera control activities, along with ensuring the rapid initiation of a reactive cholera vaccination campaign.

Cholera | Cameroon | 251 Cases | 20 Deaths | 8% CFR

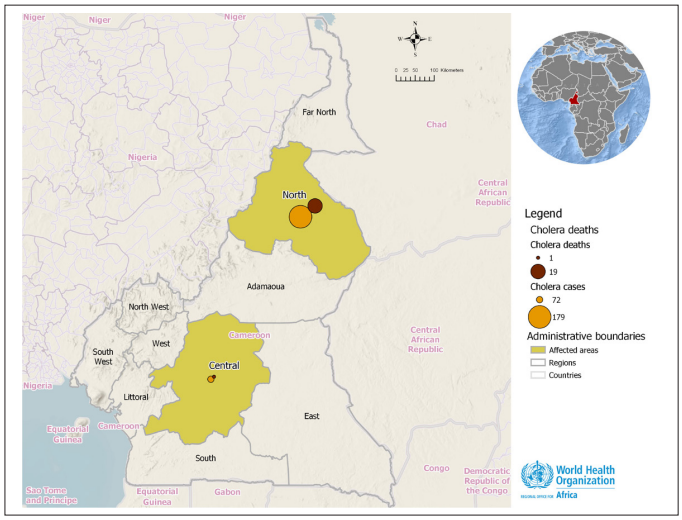
EVENT DESCRIPTION

The cholera outbreak in Cameroon continues insidiously, with active transmission ongoing, mainly in the North Region. Since our last report on 10 August 2018 *(Weekly Bulletin 32)*, an additional 90 suspected cholera cases and nine deaths have been reported. Between 31 August 2018 and 3 September 2018, 16 new suspected cholera cases and three new deaths were reported. No new cholera cases have been reported in the Central Region since 27 August 2018.

Since the beginning of the outbreak on 18 May 2018, a total of 251 suspected cholera cases, including 20 deaths (case fatality ratio 8%), have been reported as of 3 September 2018. Twenty-three out of 91 stools specimens collected and analysed at the Centre Pasteur du Cameroun in Garoua isolated *Vibrio cholerae* O1 Inaba by culture. The majority, 63%, of the cases are females and 57% of the reported cases are between 16 and 45 years old, while 8% are children five years and below.

The cholera outbreak has remained localized to the two regions initially affected, with North Region accounting for 71% (179 cases, 19 confirmed, 19 deaths) of reported cases. Central Region reported 72 suspected and four confirmed cases, with one death. Eight (53%) of the 15 health districts in North Region and three (10%) of the 30 health districts in the Central regions have reported cholera cases. The outbreak in the North Region started on 18 May 2018 in Guirviza health area, Mayo Oulo Health Zone (on the border with Nigeria), while the event in the Central Region started on 13 July 2018.

Geographical distribution of cholera cases and deaths in Cameroon, 18 May - 10 August 2018



PUBLIC HEALTH ACTIONS

- The Ministry of Health is coordinating the response to the cholera outbreak, with support from WHO, UNICEF, MSF, IMC and other partners. The multi-agency incident management system (IMS) has been established at both national and regional levels.
- WHO supported deployment of experts to the Northern Region, including an epidemiologist, one data manager and a communication expert. A second data manager was deployed in the Emergency Operations Centre in the Ministry of Health.
- Refresher training on case definition is being provided to health workers and community volunteers to enhance active surveillance in the affected districts.
- Cholera treatment units have been set-up, including one in the capital city of Yaoundé for management of cases. Local health facilities are also providing case management free of charge. WHO has provided four comprehensive care kits – three for the North Region and one each for Central and Littoral regions. Two kits have also been prepositioned in the regions of Adamaoua and the Far North.
- UNICEF completed training and deployment of 844 community health workers in the North Region to enhance social mobilization and community engagement activities. Communication and social mobilization activities are ongoing, with distribution of flyers, door-to-door outreach, mass meetings at social gatherings, as well as media awareness in national and local languages. Information dissemination is also being strengthened with production and dissemination of regular situation reports at the regional and national levels.
- Water, sanitation and hygiene activities are being scaled up, with the provision of sanitary equipment in affected communities as well as disinfection of toilets.

SITUATION INTERPRETATION

An insidious cholera outbreak has been ongoing in Cameroon since May 2018. Active transmission is now mainly limited to the North Region, where the case fatality ratio has remained high, and this is concerning. The high case fatality ratio of 8% is a manifestation of shortfalls in the response, which could be a result of inadequate case management, delay in seeking treatment due to factors such as limited access to healthcare facilities and insufficient risk communication. This high case fatality in particular, needs to be addressed, as well as the broader response to this insidious but persistent outbreak.

Hepatitis E | Namibia | 2554 Cases | 24 Deaths | 0.9% CFR

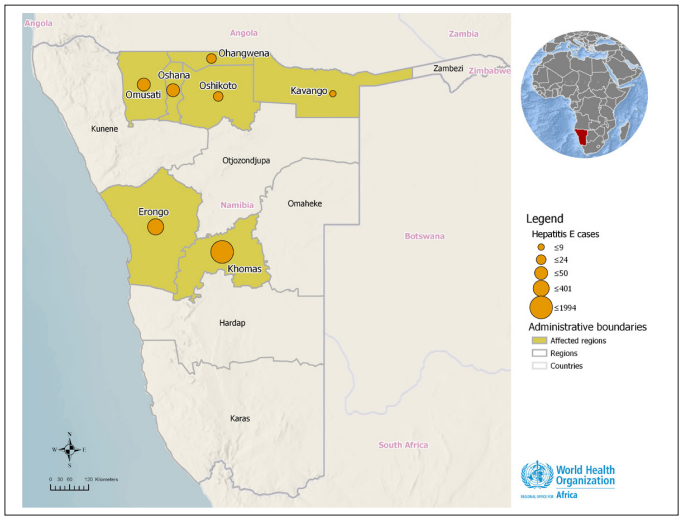
EVENT DESCRIPTION

The hepatitis E outbreak in Namibia has shown some improvement in the last two weeks. In week 34 (week ending 26 August 2018), 74 suspected hepatitis E cases were reported, compared to 77 cases in week 33. The outbreak attained the highest peak in week 31 when 150 suspected cases were recorded, with a number of smaller peaks in the past. Since our last report on 3 August 2018 *(Weekly Bulletin 31)*, a total of 119 suspected cases and four deaths have been reported.

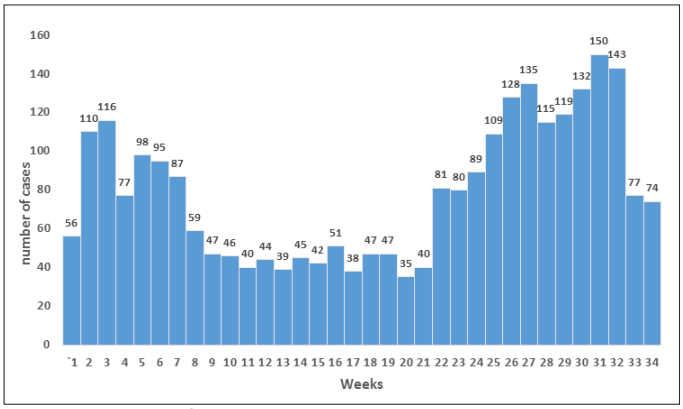
As of 26 August 2018, a total of 2554 suspected hepatitis E cases and 24 deaths (case fatality ratio 0.9%) have been reported, since the onset of the outbreak in September 2017. Of the 2554 cases, 395 have been laboratory confirmed by IgM ELISA. Of the 24 deaths, 11 (46%) occurred in women during pregnancy or post-delivery, while the remaining deaths have been associated with co-morbidities, including HIV/AIDS, hepatitis A and hepatitis B co-infection. Overall, 144 pregnant women have been affected. About 76% of the affected people are in the age-groups 20-39 years, with males constituting 59% of reported cases.

Khomas region remains the most affected region, accounting for 78% (1994) of the reported cases, followed by Erongo 16% (401). In addition, five other regions, namely Omusati, Oshana, Oshikoto, Ohangwena, and Kavango, have active transmission, while sporadic cases occur in the remaining regions. Cases are coming mainly from informal settlements such as Havana and Goreangab in Windhoek, Democratic Resettlement Centre in Swakopmund and in similar settings in other regions.

Geographical distribution of cholera cases in Niger, week 1 – week 34, 2018



Weekly trend of hepatitis E cases in Namibia, week 1 – week 34, 2018



PUBLIC HEALTH ACTIONS

- The National Health Emergency Management committee, with support from WHO, continues to lead the response activities based on the national multisectoral preparedness and response plan. The response is structured under key thematic working groups (coordination, surveillance, infection prevention and control/case management, water sanitation and hygiene (WASH), and social mobilization). The other stakeholders involved in the response are the Municipality of Windhoek, the Ministry of Agriculture and Rural Water supply, WHO, UNICEF, UNFPA, Red Cross, and other partners. The thematic working groups in Windhoek-Khomas region have been replicated in Omusati and are being initiated in Erongo and Oshana regions.
- The Ministry of Health sent circular letters to all the regions to strengthen surveillance and enhance preparedness measures. The Ministry of Health has particularly intensified preparedness efforts in areas neighbouring the affected regions and the surveillance of epidemic-prone diseases has been enhanced.
- Health education materials and case management posters have been distributed to Khomas, Omusati and Erongo regions.
- Repair of water taps and sanitation facilities is ongoing in the affected communities.

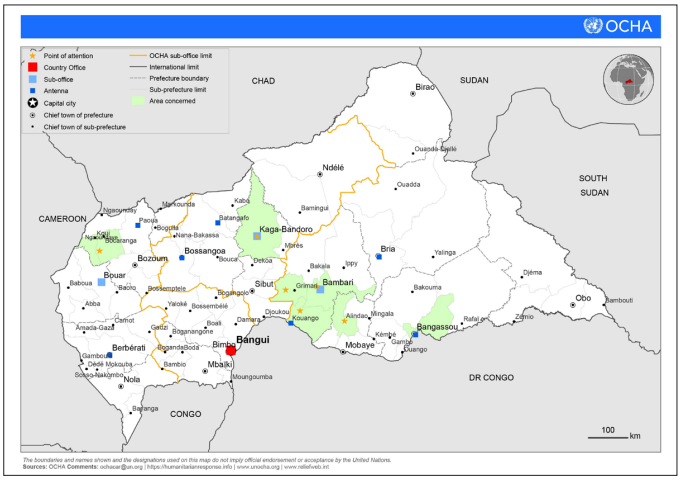
SITUATION INTERPRETATION

The outbreak of hepatitis E in Namibia has shown some improvement in the last two weeks. This relative reduction in trend needs to be monitored for sometime before making any conclusive deduction. There have been similar apparent declines in the past, only for the incidence to increase after some weeks. The difficulties in containing this outbreak have partly been attributed to insufficient control measures at community level, especially WASH, social mobilization activities, and sustained advocacy and risk communication to achieve the desired behavioural change. Other challenges include inadequate use of surveillance data as evidence to plan and implement effective control measures and vandalism and theft of repaired water taps and toilet facilities by community members in affected informal settlements.

The long incubation period of hepatitis E virus, ranging from two to 10 weeks, requires extended implementation of effective outbreak control measures to interrupt transmission of infections. As a result, response fatigue usually sets in, leaving the virus to flourish. There is a need to galvanize the required commitment and resources to bring this outbreak to a close.

EVENT DESCRIPTION

Humanitarian crisis in Central African Republic as of 6 August 2018



The humanitarian situation in Central African Republic continues to be of concern, with significant adverse consequences for the affected population. For the past two weeks (weeks 33 and 34), there has been increased tension and violence in many parts of the country. New hotspot areas are Batangato in the north-west and Zemio in the south-east of the country. Kaga Bandoro, the Bocaranga-Paoua axis and Alindao continue to be areas of concern, as reported in our last bulletin *(Weekly Bulletin 32)*. Around 6000 people arrived in the PK3 Bria Internally Displaced Persons (IDP) site following armed clashes on 25 August 2018, with deaths and injuries reported. In addition, since 10 August 2018, more than 2000 people who fled armed groups in villages on the Bria-Irabanda axis have returned to this IDP site, and 2500 new IDPs arrived at this site, following resumption of fighting on the Bria-Ippy and Bria-Irabanda routes since 31 August 2018. Heavy rains from 22-27 August 2018 caused flooding and collapse of houses, with at least 12 people injured in Kabo. The injured were admitted to Kabo Hospital under the care of Médicines sans Frontièrs (MSF).

There has also been limited humanitarian access for several weeks due to this deteriorating security situation, particularly in the east of the country where humanitarian actors have struggled to provide basic health services. In Grimari and Kouango, the water, sanitation and hygiene (WASH) and the nutritional situation have been progressively deteriorating since the departure of Action contre le Faim (ACF) and the Community Humanitarian Emergency Board (COHEB). In the sub-prefectures of Bocaranga, Koui and Ngaoundaye in the north-west, partners report significant health needs.

In June 2018, several warnings of excess deaths in children under five years from common diseases including acute diarrhoea and malaria were issued by humanitarian partners reporting in Mingala. This followed the closure of Mingala health centre after looting and destruction by armed groups, resulting in lack of medical supplies and personnel in the area. The area is particularly vulnerable to attack because of disputes over ownership of gold and diamond mines.

On 29 August 2018 a community relay team alerted authorities of two suspected viral haemorrhagic fever (VHF) cases in the village of Kitesa, Zemio region. Samples were taken on 30 August 2018 and sent to Institute Pasteur, Bangui, and a rapid response team was deployed to the area. These were found to be negative for the main causes of VHF (Ebola, Marburg fever, Lassa fever, Rift Valley fever, Crimean-Congo haemorrhagic fever, Dengue and Yellow fever).

Between weeks 23 and 32 of 2018, there were 59 cases of acute watery diarrhoea (AWD), including four deaths (case fatality ratio 6.7%) notified in the Mberewock Health Area, Ngaoundaye sub-prefecture. There was a peak in cases in week 29 (week ending 20 July 2018), with a declining trend thereafter, with no new cases reported by week 33 (week ending 17 August 2018), possibly as a result of WASH interventions by partners.

An alert was issued by the WHO sub-office in Kaga Bandoro after a significant increase in the number of confirmed malaria cases at the district hospital between weeks 32 and 35, with 279 cases and one death, rising to 1360 cases and two deaths in week 35 (week ending 31 August 2018). Most, more than 80%, of cases were in children under the age of five years. This increase coincides with the onset of the rainy season.

PUBLIC HEALTH ACTIONS

- WHO continues to coordinate and support health sector partners in the humanitarian response. During week 34 a total of three basic malarial kits, one additional malaria kit, one additional inter-agency health kit and two pneumo A kits were donated for the health response in Mbrès, coordinated by EDEN. A further five basic malaria kits were donated to MSF Spain for support in Batangafo.
- An emergency meeting of the health cluster and the National Malaria Control Programme was held on 4 September 2018 in response to the upsurge in Kaga Bandoro.
- Cooperazione Internazionale (COOPI), with the support of UNHCR, has distributed mosquito nets to new arrivals at the PK3 IDP site. The International Medical Corps and MSF France continue to provide care to IDPs in Bria.
- The Alliance for International Medical Action (ALIMA) deployed mobile clinics in villages in the Dékoa-Mala axis, as well as supporting the health centre and other health facilities in Mala, including multiple immunization sessions.
- WHO continues to support the Ministry of Health in the implementation of Ebola virus disease preparedness activities in the south east of the country, as well as the deployment of rapid response teams in areas reporting suspected VHF cases.
- WHO deployed an epidemiologist to investigate reports of an abnormally high number of deaths among children under the age of 10 years between May and June 2018.
- An inter-agency helicopter mission, with logistical support from MINUSCA, was held on 31 August 2018 in Nguendéré, which confirmed reports of excess child deaths from common causes after the destruction of health facilities.

SITUATION INTERPRETATION

The prolonged and complex security and humanitarian crisis in Central African Republic is impeding vulnerable and traumatized populations' access to basic health services and increasing the risk of epidemic-prone diseases. There are many challenges in this resource-constrained country, including availability of mosquito bed nets, poor supplies of medicines in health facilities, and weak emergency health systems. Central African Republic is at the peak of malaria transmission in the current rainy season, making the lack of humanitarian access caused by conflict particularly concerning, with negative effects on response capacity. National and international authorities need to act urgently to resolve security issues and return peace to the affected areas.

Summary of major issues challenges, and proposed actions

Issues and challenges

- The Ebola virus disease (EVD) outbreak in the Democratic Republic of the Congo has entered its first month, and a lot of progress has been made. The situation in Mangina has greatly improved and attention is now focused on the areas that have active viral activity, especially Butembo – a trade hub of over 1 million people. Two new health zones have been affected during the reporting week, however, the cases were quickly detected and response measures applied immediately. The emergence of the recent new cases signifies the complexities around the response to the current outbreak, including the presence of potential undocumented chains of transmission, reluctance by some communities to adopt Ebola prevention behaviours, delays by patients to seek care upon developing symptoms, inadequate infection prevention and control measures in healthcare facilities, and the potential of the virus to spread into insecure areas with limited access. Addressing these issues require the collective involvement of all stakeholders, including the communities.
- The cholera outbreak in Niger has continued to deteriorate, with several new cases and deaths being reported, and two additional districts being affected. The risk factors for propagation of the outbreak in the communities are widespread, including limited access to safe potable water and basic sanitation and poor hygiene and food safety practices. These factors are being augmented by the ongoing heavy rainfall with occasional floods, leading to contamination of community water sources. The control interventions being undertaken are not adequate to interrupt further transmission of infections. The current situation calls for urgent attention to avoid further escalation of the situation.

Proposed actions

- The national authority and partners in the Democratic Republic of the Congo need to continue strengthening elements of response on the ground. Additionally, the neighbouring countries need to continue to enhance their readiness and preparedness capacity for rapid detection and response to any potential imported EVD cases.
- The national authorities and partners in Niger need to rapidly scale up implementation of cholera outbreak control interventions, including deploying new tools such as oral cholera vaccine. Adequate resources need to be mobilized and provided to the responders for effective implementation of these interventions.

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	6-Sep-18	6-Sep-18	8-Sep-18	695	46	5	0.7%	"On 6 September 2018, a cholera outbreak has been declared in Harare by the ministry of Health of Zimbabwe after confirmation of 11 cases for cholera on rapid diagnostic test kits and the clinical presentation. On the same day stool samples were taken for culture and sensitivity, and of the 39 samples taken, 17 were positive for *v. cholerae* Ogawa . By the 7 September 2018, a total of 58 suspected cholera patients were admitted at BRIDH. Five from Glenview 1, thirty five from Glenview 3, nine from Glenview 8, five from Budiriro, one from Mbare, one From Southdowns and one from Glenview 4. An estimated 695 cumulative suspected cases had been screened, 46 confirmed cases and 5 deaths as of 8 september 2018
Ongoing events										
Algeria	Cholera	Ungraded	25-Aug-18	7-Aug-18	30-Aug-18	173	74	2	1.2%	The outbreak was initially announced by the Ministry of Health of Algeria on 23 August 2018 following confirmation of 41 cases for *Vibrio cholerae* out of 88 suspected cases reported from four provinces (wilayas). By 30 August 2018, a total of 173 suspected cases with two deaths (CFR 1.2%) have been reported from six wilayas. Laboratory examinations conducted at Institute Pasteur of Algeria have confirmed 59 of the cases in five wilayas for *Vibrio cholerae* O1 ogawa as follow: Blida (39 cases with two deaths), Tipaza (15 cases), Alger (15 cases), Bouira (3 cases), and Medea (1 case) and Ain Defla (1 case).
Angola	Cholera	G1	2-Jan-18	21-Dec-17	29-Jul-18	954	12	19	2.0%	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). From 21 December 2017 to 18 May 2018, a total of 895 cases were reported from two districts in Uíge province. The neighbouring province of Luanda started reporting cases on 22 May 2018. From 22 May to 29 July 2018, 95 cases with seven deaths (CFR 7.4%) have been reported from fourteen districts in Luanda Province. Twelve cases have been confirmed for *Vibrio cholerae*. Fifty-seven percent of cases are males and 69% are aged five-year and above. The most affected district is Talatona having reported a total of 26 cases with five deaths (CFR 19%).

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Angola	Guinea worm disease	Ungraded	29-Jun-18	1-Apr-18	17-Aug-18	1	1	0	0.0%	Angola has reported for the first time a case of Guinea worm which was diagnosed in an eight-year-old girl from Cunene Province with onset of signs and symptoms in April 2018. The case was detected through a nationwide Guinea worm case search during the national immunization campaign against measles and rubella. The specimen was sent to the WHO Collaborating Center for Dracunculiasis Eradication at the United States Centres for Disease Control and Prevention, where a polymerase chain reaction (PCR) test confirmed the worm as *Dracunculus medinensis*.
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	27-Aug-18	-	-	-	-	The humanitarian situation in Cameroon remains precarious with several regions of the country affected. In the Far North, the situation is marked by attacks linked to Boko Haram thus generating an influx of refugees from Nigeria including mass displacement of the local population. In the north-west and south-western regions, the crisis is marked by fighting between separatist militia and government forces leading to displacement of about 160 000 people in these regions. The regions of the North, Adamawa and East are also affected by the huge influx of refugees from neighboring Central African Republic thus placing pressure on the limited resources available to the local population. The humanitarian needs include food, shelter, access to basic health services including water, sanitation and hygiene.
Cameroon	Cholera	G1	24-May-18	18-May-18	29-Aug-18	251	23	20	8%	Detailed update given above.
Cameroon	Monkeypox	Ungraded	16-May-18	30-Apr-18	13-Jun-18	36	1	0	0.0%	On 30 April 2018, two suspected cases of monkeypox were reported to the Directorate of Control of Epidemic and Pandemic Diseases (DLMEP) by the Njikwa Health District in the North-west Region of Cameroon. On 14 May 2018, one of the suspected cases tested positive for monkeypox virus by PCR. On 15 May 2018, the incident management system was set up at the National Emergency Operations Center. An investigative mission to the North-west and South-west from 1 - 8 June 2018, found 21 new suspected cases without active lesions. As of 13 June 2018, a total of 36 suspected cases have been reported from both North-west and South-west regions.
Central African Republic	Humanitarian crisis	Protracted 2	11-Dec-13	11-Dec-13	5-Sep-18	-	-	-	-	Detailed update given above.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Central African Republic	Monkey-pox	Ungraded	20-Mar-18	2-Mar-18	22-Aug-18	40	13	1	2.5%	The outbreak was officially declared on 17 March 2018 in the sub-province of Ippy, Bambari district. Since the beginning of the outbreak, three districts have been affected, namely Bambari, Bangassou and Mbaiki districts. Cumulatively, 40 cases of monkeypox with one death (case fatality ratio 2.5%) have been reported from 2 March to 22 August 2018 in the country, and 13 cases have been laboratory confirmed out of 23 samples tested. No new cases notified in the three districts after the end of the epidemic.
Chad	Measles	Ungraded	24-May-18	1-Jan-18	5-Aug-18	1 889	588	72	3.8%	Since week 18, there has been a dramatic increase in the number of measles cases reported. Ninety-eight cases with four deaths were reported in week 31 (week ending 5 August 2018), a reduction in the number of cases compared to the previous week when 162 cases with six deaths were reported. Two districts (Guereda and Massakory) entered the epidemic phase in week 31 bringing the total number of districts in the epidemic to eighteen. The number of cases reported since the peak in week 25 when 175 cases were reported has ranged from 98 to 162 with an average of 118 cases per week. As of week 31, there are 1 889 suspected cases with 72 deaths (CFR 3.8%). A total of 588 cases have been confirmed (IgM-positive -141, Epi-linked - 419, and clinically confirmed 28). Children aged 1 to 4 years are the most affected constituting 33% of cases reported. The high case fatality rate in this outbreak is of serious concern. The location of epidemic districts on the border with Libya, Sudan, Nigeria and the Central African Republic also has implication for the cross-border spread of the disease.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Congo (Republic of)	Yellow fever	Ungraded	10-Jul-18	9-Jul-18	29-Aug-18	1	1	0	0.0%	On 5 July 2018, a 20-year-old male from Bissongo market visited Bissongo health centre in Loandjili district, Pointe-Noire city, Congo, with fever for one day. On 9 July 2018, due to beginning of jaundice and persistent fever, he returned to the same health facility. The case did not have a history of Yellow fever (YF) vaccination and travelled to Ngoyo and Tchiamba Nzassi distrits, the latter one which is a rural district in Pointe-Noire located along the border with Angola during two weeks prior to symptoms onset. Following admittion with suspected YF as a differential diagnosis, a blood sample was collected on 10 July 2018 and sent to INRB in Kinshasa for testing. On 26 July 2018, the sample tested positive for YF by serology. On 30 July 2018, the lab sent a sample to IP Dakar for confirmation. On 21 August 2018, the sample tested positive by seroneutralization with high titres.
Democratic Republic of the Congo	Humanitarian crisis	G3	20-Dec-16	17-Apr-17	19-Aug-18	-	-	-	-	The humanitarian crisis in the country remains volatile. Inter-communal conflicts and violence perpetrated by militias including the kidnapping of humanitarian staff continue to contribute to mass population displacement and difficulty in access to humanitarian assistance in several localities in the east of the country.
Democratic Republic of the Congo	Cholera		16-Jan-15	1-Jan-18	19-Aug-18	17 069	0	566	3.3%	Six hundred ninety-eight cases with 35 deaths (CFR 5.0%) were reported in week 33 from 13 out of 26 provinces, an increase in cases compare to the previous week when 537 cases were reported. Five provinces (K. Oriental, South Kivu, Sankuru, Tanganyika and Kasai), reported 90.0% of the total cases in week 33. From week 1 to 33 of 2018, a total of 17 069 cases of cholera including 566 deaths (CFR 3.3 %) were reported. From week 1 of 2017, until week 22 of 2018, majority of cases were reported from endemic provinces; since week 23 of 2018 majority of the cases are reported from epidemic provinces. There has been an upward trend in the number of cases since week 24 of 2018, as it was the case in 2017.
Democratic Republic of the Congo	Ebola virus disease	G3	31-Jul-18	11-May-18	1-Sep-18	131	98	89	69%	Detailed update given above.
Democratic Republic of the Congo	Measles	Ungraded	10-Jan-17	1-Jan-18	30-Aug-18	22 217	505	245	1.1%	From 2018 week 1 to week 33 (ending 30 August 2018), 22 217 cases with 245 deaths (CFR 1.1%) have been reported. During week 33, a total of 1 045 new cases were reported with ten deaths (CFR 1.1%). Epidemic zones are mainly focused in the eastern part of the country.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Democratic Republic of Congo	Monkey-pox	Ungraded	n/a	1-Jan-18	30-Aug-18	2 585	-	42	1.6%	From week 1 to week 33, 2018, there have been 2 585 suspected cases of monkeypox including 42 deaths (CFR 1.6%). In week 33, a total of 103 suspected cases including one death have been reported. Suspected cases have been detected in 14 provinces. Sankuru Province has had an exceptionally high number of suspected cases this year.
Democratic Republic of the Congo	Polio-myelitis (cVD-PV2)	G2	15-Feb-18	n/a	31-Aug-18	35	35	0	0.0%	The latest case of cVDPV2 was reported from Yamaluka Health Zone, Mongala Province. As of 31 August 2018, a total of 35 cases with onset in 2017 (22 cases) and 2018 (13 cases) have been confirmed. Six provinces have been affected, namely Tanganyika (15 cases), Haut-Lomami (9 cases), Mongala (6 cases), Maniema (2 cases), Haut Katanga (2 cases), and Ituri (1 case). The outbreak has been ongoing since February 2017. A public health emergency was officially declared by the Ministry of Health on 13 February 2018 when samples from 21 cases of Acute flaccid paralysis were confirmed retrospectively for vaccine-derived poliovirus type 2.
Democratic Republic of Congo	Rabies	Ungraded	19-Feb-18	1-Jan-18	30-Aug-18	20	0	20	100.0%	This outbreak began towards the end of October 2017 in Kibua health district, North Kivu province. A total of 158 of dog bites have been reported from week 1 to week 33, 2018.
Democratic Republic of Congo	Yellow fever	Ungraded	16-Aug-18	1-Jul-18	17-Aug-18	5	4	0	0.0%	Samples from four out of five suspected cases have been confirmed for Yellow fever by Plaque Reduction Neutralization Test (PRNT) at Institute Pasteur Dakar (IPD). One of the cases is a 29-year-old male from Ango District in Bas Uele Province and the other is a 42-year-old male from Yalifafu district in Tshuapa Province. The other 2 cases are from Tshuapa and Lualaba Province. Vaccination status of the cases are unknown and detailed investigation is ongoing.
Ethiopia	Humanitarian crisis	G2	15-Nov-15	n/a	12-Aug-18	-	-	-	-	As of July 2018, an estimated 860 056 displaced people have been reported from Gedeo zone (SSNP region) with an additional 188,747 IDPs estimated to be spread across six woredas in West Guji zone (Oromia region). Peace negotiations are still on going and succeeded in some of the Woredas like Hambela Wamena where all IDPs returned to their original villages.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Ethiopia	Acute watery diarrhoea (AWD)	Protracted 1	15-Nov-15	1-Jan-18	12-Aug-18	1 455	-	18	1.2%	This has been an ongoing outbreak since the beginning of 2017. In most parts of the country, the situation has stabilized except for three region which continues to report cases. In weeks 31 and 32, a total of 251 AWD cases were reported from three regions, Afar (3) Dire Dawa (75), and Tigray (173). No new AWD cases have been reported from Somali region since week 25. From week 1 to 32 in 2018, a cumulative 1 455 AWD cases have been reported from Afar 1 004 (69%), Dire Dawa 92 (6%), Somali 116 (8%) and Tigray 243 (17%).
Ethiopia	Measles	Protracted 1	14-Jan-17	1-Jan-18	12-Aug-18	3 046	857	-	-	This has been an ongoing outbreak since the beginning of 2017. In 2018, a total of 3 046 suspected measles cases have been reported across the country including 102 new suspected cases reported in week 32. From the total suspected cases reported, 857 are confirmed cases (137 laboratory confirmed, 688 epi-linked and 52 clinically compatible). There are three new confirmed outbreaks have been reported from Tselemti woreda in Tigray region (10 cases), Dera woreda in Oromia region (4 cases), and Arthuma Fursi in Amhara region (32 cases). No new cases have been reported from the active woredas in Afar (Berhale woreda) and Gambella (Dimma woreda).
Ethiopia	Dengue fever	Ungraded	18-Jun-18	19-Jan-18	29-Jul-18	127	52	-	-	An outbreak of Dengue fever which started on 8 June 2018 involving 52 cases in the flood-affected Gode Zone of Somali Region has been confirmed by laboratory testing. In week 30, two cases were reported from Liban Zone in Somali Region.
Guinea	Measles	Ungraded	9-May-18	1-Jan-18	12-Aug-18	1 643	418	11	0.7%	A measles outbreak was detected in epidemiological week 8, 2018. Cases has been reported in all parts of the country since the beginning of the year. The most affected zones include Kankan, Conakry and Faraneh. In week 32, 5 new suspected cases were reported and no samples sent to the laboratory. During the last 4 epidemiological weeks (week 29 to 30), 71 suspected cases were reported, 25 samples received at the laboratory, including 7 confirmed cases from 5 sub-prefectures. Since the beginning of the year, a total of 1 643 suspected cases were reported
Kenya	Cholera	G1	6-Mar-17	1-Jan-18	27-Aug-18	5 756	332	78	1.4%	The outbreak in Kenya is ongoing since December 2014. As of 27 August 2018, a total of 5 756 cases including 78 deaths have been reported since the 1 January 2018. Since week 23, the number of cases reported has decreased. During this outbreak 19 out of 47 counties in Kenya were affected. Currently, the outbreak is active in Garissa county with the last case reported on 19 August 2018.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Kenya	Measles	Ungraded	19-Feb-18	19-Feb-18	27-Aug-18	292	30	1	0.3%	Since June 2018 the second wave of measles outbreak was reported in three counties, Mandera, Garissa and Nairobi. Mandera County has reported a total of 130 cases including 8 confirmed cases from Mandera West sub county, Takaba Sub-county Hospital and Mandera North Sub county. Garissa County reported a total of 13 cases and 3 confirmed cases from Garissa sub-county. Nairobi county has reported 4 confirmed cases from Kamukunji sub county and a total of 4 confirmed cases have been reported from Kitui East sub county, Kitui County. Initially, cases were reported from Wajir (39 cases and 7 confirmed) and Mandera County (102 cases with 4 confirmed cases and one death). The date of onset of the index case in Wajir County was on 15 December 2017 from Kajaja village.
Kenya	Rift Valley fever (RVF)	G1	6-Jun-18	11-May-18	13-Aug-18	95	21	11	11.6%	Following the initial confirmation of RVF by PCR on 7 June 2018, a total of 95 cases including 11 deaths (CFR 11%) have been reported from three counties in Kenya. Twenty-one samples submitted to the KEMRI tested positive by PCR for RVF. Wajir has reported 82 cases with six deaths, Marsabit reported 11 cases with three deaths and Siaya country reported 1 case with one death. The Eldas sub-county in Wajir has reported the highest number of cases (79) since the 11 May 2018. The last case was reported on 20 July 2018.
Liberia	Floods	Ungraded	14-Jul-18	14-Jul-18	27-Aug-18	-	-	-	-	Liberia is experiencing very heavy rainfall that has resulted in flooding in eight districts across five counties (Margibi, Montserrado, Grand Bassa, Sinoe, and Bomi) affecting about 54 687 people (57% women and 22% children) with one death in a 4-year-old child). The flood which started on 11 July 2018, has led to destruction of infrastructures and the water supply system forcing the people to look for alternative and unsafe water sources, thus increasing the risk for waterborne diseases. The affected people received humanitarian aid of food and nonfood items as well as treated for various illnesses by mobile medical teams.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Liberia	Lassa fever	Ungraded	14-Nov-17	1-Jan-18	12-Aug-18	44	20	13	29.5%	Two deaths due to suspected Lassa fever were reported during week 32 (week ending 12 August 2018). From 1 January to 12 August 2018, 155 suspected cases with 37 deaths have been reported. Samples from twenty cases were confirmed by PCR at the National Reference Laboratory while 111 tested negative (not a case). Thirteen deaths (CFR 65%) have been reported among confirmed cases. Females constitute 60% (12/20) of confirmed cases. The age range among confirmed cases is 1 to 65 years old with a median age of 32 years. Cumulatively, 44 confirmed and suspected cases (negative cases removed) have been reported with 13 deaths.
Liberia	Measles	Ungraded	24-Sep-17	1-Jan-18	19-Aug-18	3 632	3 372	17	0.5%	There has been a gradual decline in the number of suspected cases since the peak in week 14 when approximately 230 suspected cases were reported. A total of 541 suspected cases of measles with one death were reported from 15 counties in Liberia since week 20 to week 33 (week ending 19 August 2018). O the total suspected cases, 62% were reported from Grand Kru (136), Maryland (79), River Gee (62), and Montserrado (57) Counties. From week 1 to week 33 of 2018, 3 632 suspected cases have been reported including 17 deaths (CFR:0.4%). Cases are epidemiologically classified as follows: 242 (6.6%) laboratory confirmed, 858 (23.7%) epi-linked, 2 635 (62.9%) clinically compatible, and 254 (7%) discarded.
Mali	Humanitarian crisis	Protracted 1	n/a	n/a	20-Jul-18	-	-	-	-	The complex humanitarian crisis exacerbated by the political-security crisis and intercommunity conflicts continue in Mali. More than four million people (nearly a quarter of the population) are affected by the humanitarian crisis, including 61 404 who are internally displaced and nearly 140 000 who are refugees in neighbouring countries such as Niger, Mauritania and Burkina Faso (data from CMP report, 7 June 2018). The health system is still weak, while the health need is increasing. The departure of health system personnel and incidents targeting health infrastructure, personnel and health equipment are worsening the existing health system. There are 1.7 million people in need of health assistance in the face of inadequate numbers of health care workers (3.1 per 10 000 people, compared to the WHO recommended 17 per 10 000). The security incidents are increasing in Mopti and Meneka.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Mali	Severe acute malnutrition	Ungraded	1-Aug-18	15-Mar-18	5-Aug-18	224	0	40	17.9%	Three villages in the commune of Mondoro, Douentza district, Mopti Region, Central Mali are experiencing an epidemic of malnutrition following the inter-communal conflict that prevails in the locality. From mid-March to 5 August 2018, a total of 224 cases including 40 deaths (CFR 17.9%) have been reported from three villages (Douna, Niagassadiou and Tiguila) in the commune of Mondoro, Douentza district, Central Mali. This disease is manifested by the following signs: oedema of the lower limbs, myalgia, functional impotence, dyspnoea sometimes followed by death. A dozen samples from patients analyzed at INRSP in Bamako showed iron deficiency anaemia.
Mali	Measles	Ungraded	20-Feb-18	1-Jan-18	26-Aug-18	1 220	312	0	0.0%	From Week 1 to Week 34 of 2018, a total of 1 220 suspected cases with zero deaths have been reported. The cumulative blood samples from 914 suspected cases have been tested of which 312 were confirmed (IgM-positive) at the National Reference Laboratory (INRSP). Over 66% of confirmed cases are below 5 years old. The affected health districts are Maciana, Bougouni, Kati, Koutiala, Kokolani, Kolondieba, Ouélessebougou, Sikasso, Douentza, Macina,Tombouctou, Dioila, Taoudenit and Kalabancoro. Reactive vaccination campaigns, enhancement of surveillance, and community sensitization activities are ongoing in the affected health districts.
Mauritius	Measles	Ungraded	23-May-18	19-Mar-18	26-Aug-18	808	808	3	0.4%	As of 26 August 2018, 808 confirmed cases of measles have been reported including three deaths (CFR 0.4%). All cases have been confirmed by the virology laboratory of Candos (IgM antibodies). The onset of symptoms of the first cases was in week 12. The incidence is highest in the age groups 0 - 4 and 25 - 39 years of age. The three deaths were in women between the ages of 28 and 31 years. The most affected districts are Point Louis, Black river and Pamplemousses. A single genotype of measles virus, D8, was detected in 13 samples. The source of infection of measles is most likely an imported case.
Namibia	Hepatitis E	G1	18-Dec-17	8-Sep-17	29-Jul-18	2 554	395	24	0.9%	Detailed update given above.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Niger	Human-itarian crisis	G2	1-Feb-15	1-Feb-15	2-Aug-18	-	-	-	-	The security situation in Niger's Diffa Region remains precarious. According to USAID's Lake Chad Basin complex emergency report dated 2 August 2018, Boko Haram-related insecurity continues to restrict food access and livelihood activities for displaced populations in Diffa Region, Southeast Niger. Limited access to pasture is also undermining livestock activities in Diffa's pastoral zones, reducing herders' purchasing power. According to the report, crisis levels of acute food insecurity may persist in parts of Diffa through January 2019, although food security in many areas could improve to Stressed levels beginning in October. UNHCR's June 2018 report indicated around 104 288 internally displaced people in the Diffa Region. From January–June, relief actors admitted nearly 7 000 children ages five years and younger experiencing severe acute malnutrition for treatment in Diffa, including nearly 650 patients with medical complications, according to the UN Children's Fund (UNICEF).
Niger	Cholera	G1	13-Jul-18	13-Jul-18	28-Aug-18	2 638	19	51	1.9%	Detailed update given above.
Nigeria	Human-itarian crisis	Protracted 3	10-Oct-16	n/a	5-May-18	-	-	-	-	The security situation in north-east Nigeria remains volatile, with frequent incidents, often suicide attacks using person-borne improvised explosive devices (PBIED) and indiscriminate armed attacks on civilian and other targets. On 1 May 2018, an attack in Mubi town in Adamawa State resulted in 27 deaths and more than 50 injuries, while 13 people were killed in Zamfara State on 3 May 2018. In a related incident that took place on 5 May 2018, at least 45 people from Gwaska village in Kaduna State (outside north-east Nigeria) died in fighting between bandits and armed militia. Internal displacement continues across north-east Nigeria, especially in Borno, Adamawa and Yobe states, partly fuelled by deteriorating living conditions and the ongoing conflict. The number of internally displaced persons (IDPs) across the six states (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe) in northeast Nigeria increased to over 1.88 million in April 2018, from 1.78 in February 2018. In addition, there are over 1.4 million returnees in the area. The communal conflicts between herders and farmers, which has been taking place since January 2018 outside north-east Nigeria, also displaced approximately 130 000 people in Benue, Nasarawa, Kaduna, and Taraba States.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Nigeria	Cholera	G1	7-Jun-17	1-Jan-18	26-Aug-18	23 839	45	434	1.8%	In week 34 (week ending 26 August 2018), a total of 228 suspected cases including 9 deaths (CFR: 3.9%) were reported from three states: Zamfara (105 cases with 5 deaths), Kano (96 cases with four deaths), and Katsina (27 cases). As of 26 August 2018, a total of 23 893 suspected cases including 434 deaths (CFR 1.8%) have been reported from 18 States since the beginning of 2018. There is an overall increasing trend in the nub-mer of cases reported with Zamfara and Kano States contributing to the increasing trend. No new cases were reported in the last three weeks from Adamawa, Anambra, Ebonyi, Niger, Plateau, Nasarawa, Gombe, Kogi, and Jigawa States. There is an almost equal proportion of males and females affected.
Nigeria	Lassa fever	Ungraded	24-Mar-15	1-Jan-18	26-Aug-18	502	492	140	27.9%	The outbreak is continuing with less than ten cases reported each week. In week 34 (week ending 26 August 2018), three new confirmed cases with two deaths were reported. From 1 January to 26 August 2018, a total of 2 434 suspected cases have been reported from 22 states. Of the suspected cases, 492 were confirmed, 10 are probable, 1 931 negative (not a case). Thirty-nine healthcare workers have been affected since the onset of the outbreak in seven states with ten deaths. Seventeen states have exited the active phase of the outbreak while five Edo, Ondo, Ebonyi, Bauchi and Gombe states still remain active.
Nigeria	Measles	Ungraded	25-Sep-17	1-Jan-18	19-Aug-18	13 366	901	100	0.7%	In week 33 (week ending 19 August 2018), 159 suspected cases of measles were reported from 28 States. Since the beginning of the year, a total of 13 366 suspected measles cases with 901 laboratory confirmed cases and 100 deaths (CFR 0.75%) were reported from 36 States compared with 16 833 suspected cases with 108 laboratory confirmed and 101 deaths (CFR, 0.60 %) from 37 States during the same period in 2017.
Nigeria	Polio-myelitis (cVD-PV2)	Ungraded	1-Jun-18	1-Jan-18	8-Aug-18	2	2	0	0.0%	Circulating vaccine-derived polio virus type 2 (cVDPV2) was confirmed in a stool sample from a case of acute flaccid paralysis (AFP) with symptom onset on 16 June 2018 in Yobe State. This is the second AFP case since the beginning of 2018 with a confirmed cVDPV2. The first was an AFP case in Kaugama district, Jigawa state, with onset on 15 April 2018.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	19-Aug-18	2 768	47	47	1.7%	From the onset of this outbreak on 12 September 2017, a total of 2 768 suspected yellow fever cases including 47 deaths have been reported as at week 33 (week ending on 19 August 2018), from 504 LGAs in all Nigerian states. No new in-country presumptive positive case in the reporting week and the last case confirmed by IP Dakar was on 6 June 2018 from River State. A total of 47 out of 126 presumptive positive samples were laboratory confirmed at IP Dakar.
São Tomé and Principé	Necrotising cellulitis/ fasciitis	Protracted 2	10-Jan-17	25-Sep-16	26-Aug-18	2 883	0	0	0.0%	From week 40 in 2016 to week 33 in 2018, a total of 2 867 cases have been notified. In week 34 (week ending 26 August 2018), 16 cases were notified. It should be noted that 55% of the cases notified during the last 3 weeks come from the district of Me-zochi. The case-fatality rate of cellulitis in São Tomé and Príncipe is 14.6 cases per 1000 inhabitants.
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	26-Aug-18	5 781	1 430	-	-	As of week 34, a total of 5 781 suspected cases have been reported from two of the three main islands, Mahé and Praslin. A decreasing trend has been observed in the last two weeks. During week 34, a total of Twenty-Seven (27) suspected cases were reported; Twenty-Two (22) samples were tested of which Twenty (20) were negative, One (1) confirmed positive, One (1) probable, One (1) suspected cases not tested and four (4) pending testing. Currently in circulation, there are three serotypes DENV1, DENV2 and DENV3. From One Hundred and Eighty-Seven (187) serotyping done; Forty-Eight (48) were serotype as DENV1, Eighty-Three (83) as DENV2 and Fifty-Six (56) as DENV3.
Sierra Leone	Lassa fever	Ungraded	8-Jun-18	1-Jan-18	1-Jul-18	20	20	12	60.0%	A total of 20 confirmed Lassa fever cases with 12 deaths have been reported since the beginning of the year, amounting to a case fatality rate (CFR) of 60 %. The cases have been reported from two districts, Bo (two cases with two deaths) and Kenema (18 cases with 10 deaths). The last confirmed case was reported during week 23 from Kenema district involving a 32 year old female who died while in admission at Kenema Government Hospital.
South Sudan	Humanitarian crisis	Protracted 3	15-Aug-16	n/a	26-Aug-18	-	-	-	-	The humanitarian situation in South Sudan has remained volatile and unpredictable since the beginning of the crisis four years ago. Inter-communal violence continues in spite of peace efforts and humanitarian workers are often targeted by militia factions. The humanitarian situation is characterized by mass displacement of the population, economic crisis with hyperinflation, food insecurity, and frequent disease outbreaks.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
South Sudan	Hepatitis E	Ungraded	-	3-Jan-18	26-Aug-18	131	16	-	-	No new case of hepatitis E was reported in week 34. As of 24 August 2018, 131 suspect cases have been reported in 2018. Of the total suspect cases, 16 cases have been confirmed by PCR (15 in Bentiu PoC and 1 in Old Fangak). No new cases identified after active follow up in Fangak. Only 5 HEV cases have been admitted. At least 45% of the cases are 1-9 years of age; and 66% being male. Among the females, most cases have been reported in those aged 15-44 years (who are at risk of adverse outcomes if infected in the 3rd trimester of pregnancy).
Tanzania	Cholera	Protracted 1	20-Aug-15	1-Jan-18	2-Sep-18	3 670	50	68	1.9%	During week 35, 54 new cases with no deaths were reported from Ngorongoro DC in Arusha Region. As of week 35, a total of 3 670 cases with 68 deaths (CFR: 1.9%) were reported from Tanzania Mainland since the beginning of 2018. No case was reported from Zanzibar (the last case was reported on 11 July 2017). Cholera cases in 2018 increased and nearly doubled during the period of January – August 2018 (3 670 cases), when compared to the same period in 2017 (2 308 cases).
Uganda	Humanitarian crisis - refugee	Ungraded	20-Jul-17	n/a	21-Jun-18	-	-	-	-	Uganda continued to receive new refugees precipitated by increased tensions mainly in the neighboring DRC and South Sudan. Despite resp onding to one of the largest refugee emergencies in Africa, humanitarian funding has remained low especially to the health sector. Current refugee caseload stands at almost 1.5 million refugees and asylum seekers from South Sudan, DRC, Burundi, Somalia and others countries. Daily arrival stands at approximately 250 – 500 per day. A total of 376 081 refugees and asylum seekers were received in 2017.
Uganda	Crimean-Congo haemorrhagic fever (CCHF)	Ungraded	24-May-18	-	17-Jul-18	7	3	2	28.6%	On 23 May 2018, a 35-year-old male suspected of having a viral haemorrhagic fever died at a hospital in Mubende. Test result released on 24 May 2018, confirmed the case as positive for Crimean-Congo haemorrhagic fever (CCHF) by PCR at Uganda Virus Reasearch Institute. As of 18 June 2018, there were a total of five cases (one confirmed and four suspected) and two deaths (CFR 40%). Three of the suspected cases were identified from the same household as the confirmed case in Nkooko sub-county. Samples taken from the suspected cases were negative for CCHF. As of 17 July 2018, two new CCHF cases were confirmed from Mbarara RRH. The cases are a couple from Nakivale Refugee settlement from Isingiro district. Contact tracing is ongoing in the district and 42 out of 57 contacts were under follow up on day of report.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Uganda	Measles	Ungraded	8-Aug-17	1-Jan-17	24-Jul-18	2 097	568	-	-	As of 24 July 2018, a total of 2 097 cases have been reported of which 568 cases have been confirmed either by epidemiological link or laboratory since the beginning of the year. One hundred ninety-nine (199) cases were laboratory confirmed by IgM. Fourty-two districts in the country have confirmed a measles outbreak. Kampala and Wakiso were the index districts to report an outbreak, these are both metropolitan and business districts. The number of reported suspected and confirmed cases has decreased gradually since May 2018.
Uganda	Rift Valley fever (RVF)	Ungraded	29-Jun-18	20-Jun-18	14-Aug-18	23	19	8	34.8%	One new case from Kiruhura district has been confirmed for Rift Valley fever by PCR at Uganda Virus Research Institute on 14 August 2018. From 18 June to 14 August 2018, a total of 23 suspected cases with eight deaths (CFR 34.8%) have been reported from 11 districts in Western Uganda. Nineteen(19) cases have been confirmed by PCR at the Uganda Virus Research Institute (UVRI). The most affected district is Insingiro having reported 11 cases with two deaths (CFR 18.2%). Ninety-six percent (96%) of cases reported are males, the majority of whom are herdsman and butcher.
Zambia	Measles	Ungraded	2-Aug-18	6-Jul-18	28-Aug-18	25	6	1	4.0%	On 1 August 2018, an outbreak of measles was reported in the Paul Mambilima catchment area of Mansa District in Luapula Province, Zambia. The affected community lies astride the international border with the Democratic Republic of the Congo. The first case has been traced to a one-year-old child who died in Lukanga Village in the Paul Mambilima catchment area after presenting with fever, conjunctivitis, and rash. As of 28 August 2018, a total of 25 cases with one death (CFR 4%) have been reported. The last case was reported on 17 August 2018. Age of cases range from four months to 42 years. Six out of eight samples collected have tested IgM-positive.
Zimbabwe	Typhoid	Ungraded	7-Aug-18	6-Jul-18	28-Aug-18	1 682	9	8	0.5%	On 7 August 2018, WHO was notified by the Ministry of Health and Child Care of Zimbabwe of a suspected outbreak of Typhoid fever in Gweru City, Midland Province of Zimbabwe. A total of 1 682 cases with eight deaths (CFR 0.5%) have been reported as of 28 August 2018. Nine cases have been confirmed. There is a decline in the daily number of cases reported since the peak on 8 August 2018 when 186 cases were reported.
Recently closed events										
South Africa	Listeriosis	Ungraded	6-Dec-17	1-Jan-17	26-Jul-18	1 060	1 060	216	20.4%	Detailed update given above.

†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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