

# WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 15: 8 – 14 April 2017  
Data as reported by 17:00 14 April 2017

1

New Event

40

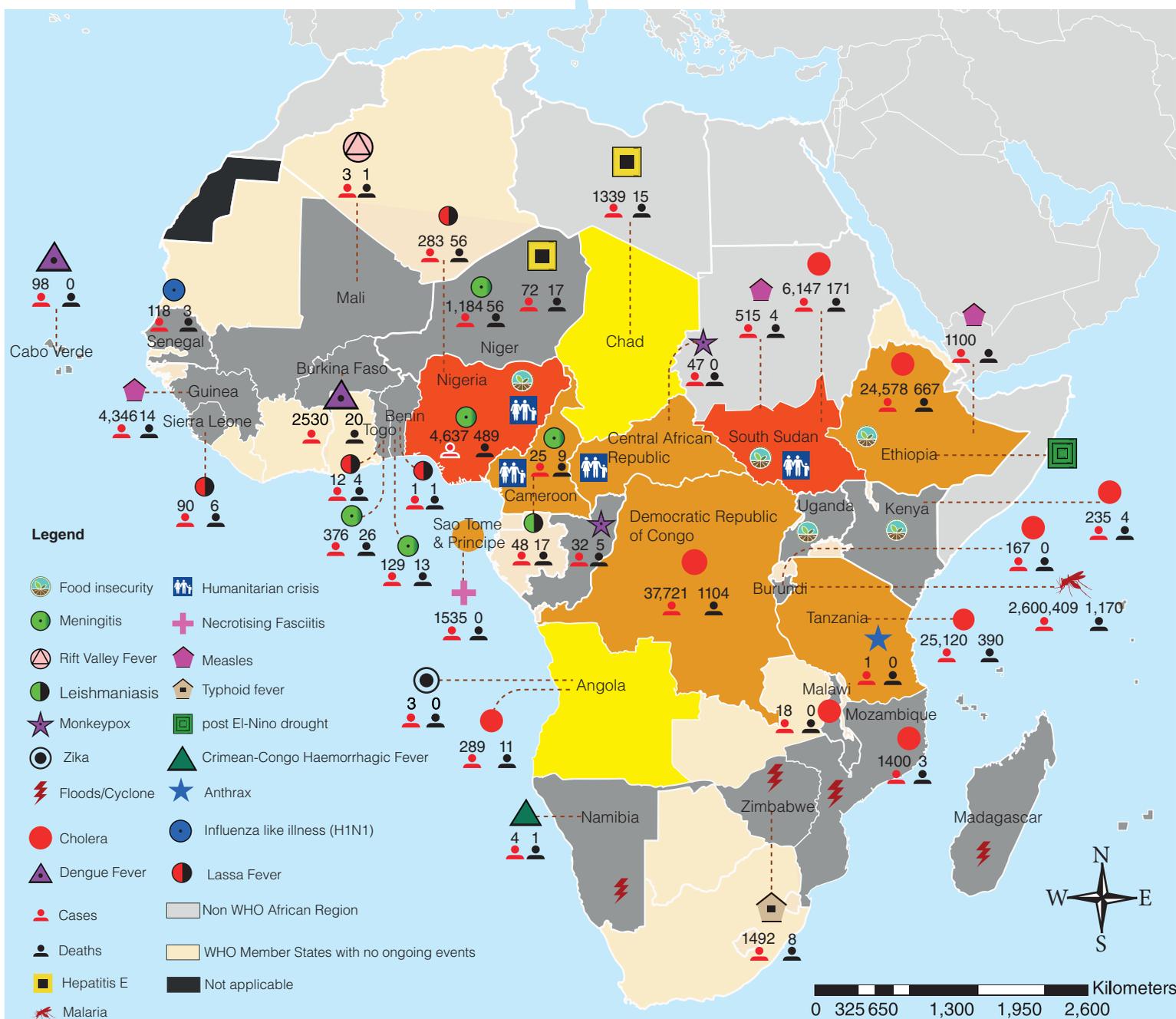
Ongoing events

33

Outbreaks

8

Humanitarian crises



2

Grade 3 events

6

Grade 2 events

2

Grade 1 events

31

Ungraded events

# Overview

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- This weekly bulletin focuses on selected public health emergencies occurring in the WHO African region. WHO AFRO is currently monitoring 41 events: two Grade 3, six Grade 2, two Grade 1, and 31 ungraded events.
- This week, one new event has been reported: an outbreak of hepatitis E in Niger.
- The bulletin also focuses on key ongoing events in the region, including the grade 3 humanitarian crisis in South Sudan as well as outbreaks of Lassa fever in 5 West African countries, measles in Guinea, acute watery diarrhoea/cholera in Ethiopia, and the food insecurity crisis in the Horn of Africa.
- For each of these events, a brief description followed by public health measures implemented and an interpretation of the situation is provided.
- A table is provided at the end of the bulletin with information on all public health events currently being monitored in the region.
- Major challenges to be addressed include:
  - Cross border spread of diseases and the need to build and maintain strong collaboration and corporation among State Parties, in line with provisions of the International Health Regulations (IHR 2005).
  - Deliberate investment in preparedness activities in order to strengthen disease surveillance for early detection, verification and response to public health events; and minimize their impacts.

# New event

Hepatitis E

Niger

72  
Cases

17  
Deaths

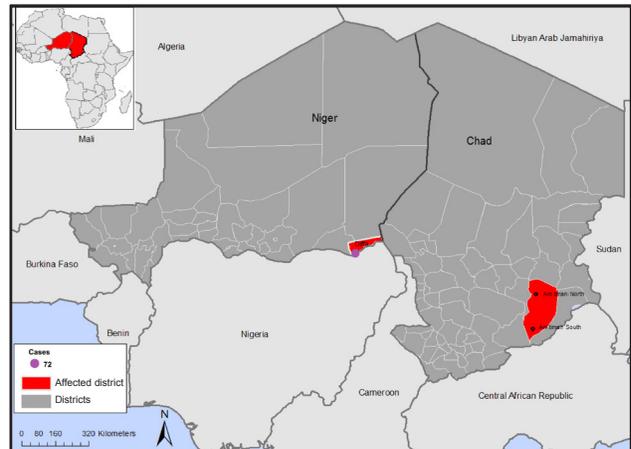
24%  
CFR

## Event description

The Niger Ministry of Health notified WHO on 12 April 2017 of an outbreak of hepatitis E in Diffa region located in the east of the country. The outbreak emerged on 09 January 2017 when clinicians at the Centre Mere-Enfant de Diffa started admitting pregnant women with acute jaundice syndrome. The initial case-patients presented with headaches, vomiting, fever, conjunctivitis, pelvic pain, and memory loss. The initial differential diagnosis was yellow fever, however, hepatitis E was later considered in light of the preponderance of pregnant mothers to the disease and the ongoing outbreak of hepatitis E in neighbouring Chad.

According to the Regional Director of Public Health in Diffa, 72 cases of acute jaundice syndrome including 17 deaths (case fatality rate of 23.6%) were reported by 10 April 2017. All 17 deaths occurred among pregnant mothers. Over 70% (52/72) of the case-patients and 100% of the deaths were reported from the Centre Mere-Enfant de Diffa while 20 case-patients and zero death came from Diffa district health care.

Geographical distribution of Hepatitis E cases in Niger, 9 January - 11 April 2017.



On 11 April 2017, the WHO Country Office in Niger relayed laboratory results from the Institut Pasteur Dakar (IPD). The results indicated that 14 samples obtained from the initial cases of acute jaundice syndrome in Diffa tested negative for yellow fever virus while 4 samples tested positive for hepatitis E virus. These results led to the formal declaration of hepatitis E outbreak by the Ministry of Health on 12 April 2017.

Detailed outbreak investigation and risk assessment are currently being conducted and the findings will be provided in the next bulletin.

## Public health actions

- The Ministry of Health convened an emergency meeting on 6 April 2017 to review and better understand the situation of the suspected outbreak. This was followed by another planning meeting held on 13 April 2017, after the release of the laboratory results.
- Preliminary outbreak investigation has been carried out in Diffa, during which the initial biological samples were obtained.
- MSF is supporting health care facilities in Diffa with medicines and other supplies to provide clinical care to the case-patients.
- A comprehensive response plan is being prepared and will be used to mobilize the resources required to mount effective outbreak control interventions.

## Situation interpretation

Hepatitis E is a liver disease caused by hepatitis E virus. The virus is shed in the stools of infected persons and enters the human body through the intestine. It is transmitted mainly through contaminated drinking water. The incubation period ranges from 2 to 10 weeks, with an average of 5 – 6 weeks. The disease is usually self-limiting and resolves within 2 – 6 weeks with most of the cases remaining ambulant. Occasionally a serious disease, known as fulminant hepatitis (acute liver failure) develops and a proportion of people with this condition can die. Fulminant hepatitis occurs more frequently in pregnancy, particularly in the second or third trimester, when the risk of acute liver failure, foetal loss and mortality is high. Case fatality rates as high as 20 – 25% have been reported among pregnant women in their third trimester. The disease is common in resource-limited countries with limited access to safe water, sanitation, hygiene, and health services. In these areas, the disease occurs both as outbreaks and as sporadic cases.

The Republic of Niger has confirmed an outbreak of hepatitis E, which is also the first outbreak of the disease in the country. All the fatal cases in this outbreak occurred among pregnant mothers. Most of the affected people are either refugees or internally displaced persons due to the Boko Haram conflict on the border with Chad and Nigeria. The affected populations therefore have limited access to safe water and inadequate sanitation, conditions favouring propagation of the disease.

Hepatitis E is a new disease in Niger and there is no diagnostic capacity in the country. There is an urgent need to mobilize adequate response capacity to this outbreak, addressing all the critical components including active surveillance, case management, public information, water and sanitation, and coordination. WHO is supporting the Ministry of Health to develop a comprehensive outbreak response plan. Partners are urged to participate in this planning exercise and in the subsequent implementation of control measures in the field.

# Ongoing events

## Lassa fever

## West Africa (Nigeria, Togo, Benin, Burkina Faso, and Sierra Leone)

### Event description

Five countries (Nigeria, Togo, Benin, Burkina Faso, and Sierra Leone) in West Africa are experiencing Lassa fever outbreaks. The current outbreak started on 16 December 2016 in Ogun State, Nigeria when the initial case, a healthcare worker, presented to a federal medical centre. This initial case followed the death of another hospital staff, whose cause of death was not well understood. The disease eventually increased in number and spread to 14 other states in Nigeria, and to three neighbouring countries of Benin, Togo and Burkina Faso.

In week 14 (week ending 09 April 2017), 1 new laboratory confirmed case was reported from Edo state while 9 new suspected cases were reported from Kano (5 cases) and Bauchi (4 cases) states of Nigeria. Laboratory results of the 9 suspected cases from Kano and Bauchi states are pending. As of 7 April 2017, a total of 430 suspected cases including 79 deaths (case fatality rate of 18.4 %) were reported from 15 states. Since our last report in week 12 (week ending 26 March 2017), the incidence caseload and fatality increased by 52% and 41% respectively. Active transmission is taking place in 13 states. A total of 148 cases have been classified as confirmed while 135 cases were probable. In Benin, the first case emerged on 06 February 2017 in Tchaourou health zone (close to the border with Nigeria) and subsequently confirmed on 17 February 2017. As of 11 March 2017, two confirmed cases including 2 deaths were reported in Benin. No new case has since emerged.

Two close contacts of the index case in Benin travelled to Togo. One of the contacts originated from Burkina Faso but resides in Nigeria. On 25 February 2017, the two contacts tested positive for Lassa fever and local community transmission was established in Togo. As of 2 April 2017, a total of 33 cases (25 suspected and 8 confirmed) including five deaths (case fatality rate of 15%) were reported from Oti and Kpendjal districts in Togo. Burkina Faso has not reported an indigenous case.

A separate outbreak of Lassa fever, with no links to the transmission chain in Nigeria, is going on in Kenema and Kailahun districts of Sierra Leone, where the disease is known to be endemic. The index case was reported on 28 December 2016 from Lower Bambara Chiefdom in Kenema district. Between 28 December 2016 and 11 April 2017, 100 suspected cases including 5 deaths (case fatality rate of 5%) have been reported. Of these, 8 samples tested positive for Lassa fever by Antigen Elisa test in Kenema Reference Laboratory.

### Public health actions

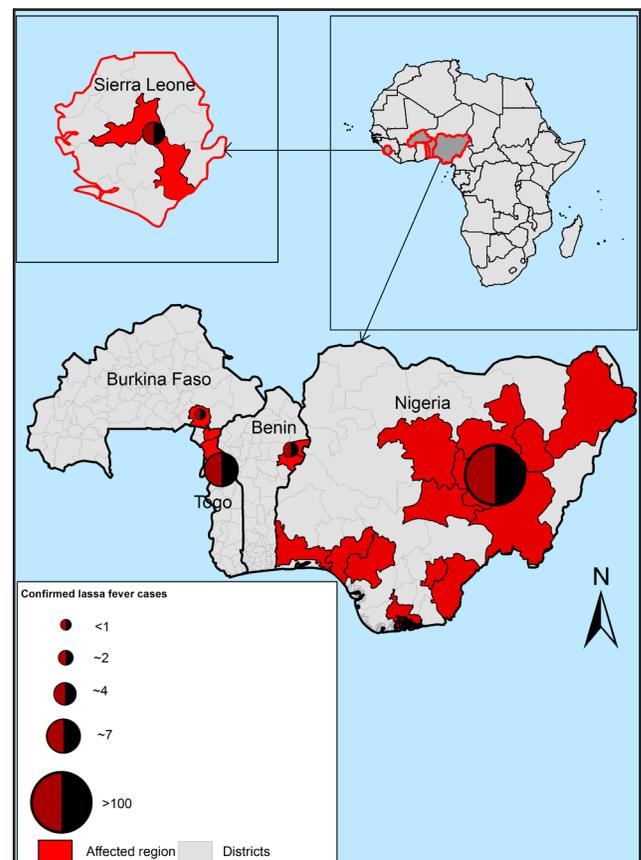
- The national task forces and/or the emergency operation centres have been activated in all the affected countries to coordinate the response to the outbreaks.
- Contact identification and follow-up were/are being conducted: 99 contacts are under follow up in Nigeria; 90 contacts completed followed-up in Benin, 135 in Burkina Faso and 144 in Togo.
- Engagement and empowerment of community leaders and their subjects was carried out in Togo to promote prevention and control measures at household and community levels.
- WHO and partners are providing technical and financial support towards response to the outbreaks. Safe burials were performed in all the affected countries.
- Risk assessments were performed in all the affected countries. Cross-border collaboration including information exchange mechanism was established among Benin, Togo, Burkina Faso, and Nigeria. Regular joint teleconferences coordinated by WHO AFRO were held to provide guidance on the management of the outbreaks.

### Situation interpretation

Lassa fever is endemic in West Africa where recurrent outbreaks have occurred, commonly in Nigeria and in the Mano River countries including Liberia and Sierra Leone. The frequency and magnitude of Lassa fever outbreaks in Nigeria and neighbouring countries since 2016 is a concern. Nigeria experienced a large scale Lassa fever outbreak in 2016, during which 273 suspected cases including 149 deaths (case fatality rate of 55 %) were reported from 23 states. Benin and Togo experienced Lassa fever outbreaks in 2016 as well. As it happened in 2016, Nigeria seems to be the source of the current outbreaks in the neighbouring Benin and Togo. There is intense population movement between Nigeria and these countries.

The current outbreaks highlight the need to strengthen preparedness and readiness for Lassa fever prevention and control in all West African countries. It is critical to strengthen cross-border collaboration among the West African countries and to develop a road map for prevention and control of future outbreaks including mitigating the high fatality being observed. The collaboration between WHO and WAHO should be used to provide high level support to the West African countries to this end.

Geographical distribution of Lassa fever cases in West Africa, 1 January - 2 April 2017.



### Event description

The outbreak of hepatitis E in the Salamat region of Chad remains precarious, with high potential to escalate. During week 14 (week ending 9 April 2017), 25 cases of acute jaundice syndrome and zero death were reported from Amtiman North [10 cases], Amtiman South [8 cases] and Aboudeïa [7 cases]. Meanwhile in week 13 (week ending 2 April 2017), 41 cases and zero death were registered. Close to 50% (20/41) of the cases reported in week 13 originated from Aboudeïa, which notified cases of acute jaundice syndrome for the first time.

As of 9 April 2017, 1,339 cases of acute jaundice syndrome including 15 deaths (case fatality rate of 1.1%) were reported since onset of the outbreak in August 2016. Of the 15 reported deaths, 4 occurred among pregnant women. Overall, 99 cases of acute jaundice syndrome tested positive for hepatitis E virus: 66 in a laboratory in Amsterdam affiliated to MSF and 33 cases from the Institut Pasteur in Yaoundé. The outbreak is still localized to Amtiman and Aboudeïa districts.

### Public health actions

- A high level mission comprising of senior officials from the Ministry of Health and the WHO Representative visited the affected areas from 15 – 17 March 2017 to assess the situation on the ground. The field mission was followed by a stakeholder's meeting convened by the Prime Minister, who urged partners to support government's efforts to contain the outbreak. He underlined provision of safe water to the population in Am Timan and Aboudeïa as a priority.
- Weekly technical coordination meetings are being conducted involving officials from the central Ministry of Health, district health authorities, partners (MSF, Chad Red Cross, Am Timam City Council, UNICEF, WHO, etc.).
- Red Cross volunteers, under the supervision of WHO, the Red Cross Health Delegates and the Health District of Aboudeïa, are conducting active search in the communities of Am Timam and Aboudeïa.
- Water treatment using chlorine tablets is ongoing. About 1.4 million litres of water have been treated.
- A total of 150 volunteers have been trained on personal and environmental hygiene practices. The volunteers are providing health education and sensitization to the communities.
- MSF supported the local authority to establish 15 hygiene committees comprising of 10 persons. The committees are conducting hygiene promotion in the communities.
- WHO is strengthening its response capacity on the ground through deploying one water, sanitation and hygiene (WASH) expert and one communication/ social mobilization specialist. The experts will support the local epidemiologist already stationed in Am Timan.
- WHO approved additional US \$ 100,000 from the Contingency Funds for Emergencies to support response operations in the affected communities.

### Situation interpretation

The outbreak of hepatitis E in the Salamat region of Chad continues to evolve, with one new district being affected. The potential of the outbreak to escalate is high given the prevailing predisposing factors. Only 25% of the 63,000 people in Am Timan, the epicenter of the outbreak, have access to clean and safe water. Meanwhile, about 30% of the 13,000 people in Aboudeïa have access to safe water. The local community continues to fetch and drink water from rain pools (ponds), sharing with animals and birds. The affected communities also have poor sanitation, commonly practicing free range open defecation. With these factors, in addition to the onset of rainy season expected soon, the risk of further spread of hepatitis E, as well as of cholera, remains very high.

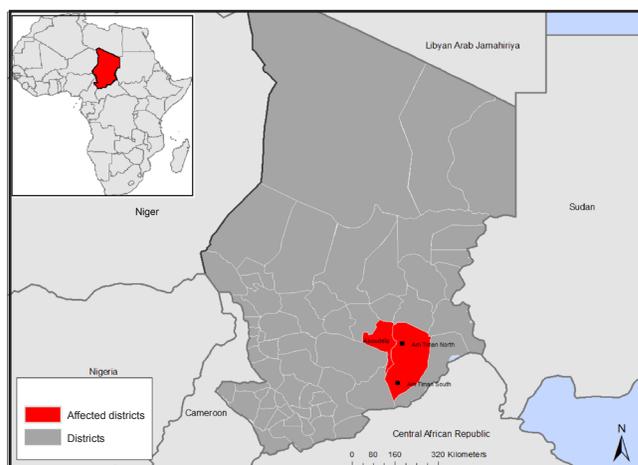
The subtle nature of propagation of hepatitis E and its long incubation periods usually creates a false impression that the outbreak is not serious. Past outbreaks of hepatitis E in other parts of Africa have been protracted, insidious as it were, causing high morbidity and claiming more lives. The preponderance of the disease to pregnant mothers amplifies its impact as more mothers and their babies die.

The response to this outbreak is not yet comprehensive and intensive enough to curtail further transmission. The response suffered further setback by the withdrawal of MSF from the field and subsequent handing over of their activities to the Ministry of Health. While UNICEF and other partners have committed to scale up their response operations for WASH component, this is coming later in April and May 2017. The current sub-optimal response provides the perfect opportunity for the disease to spread further. Effective response to this outbreak requires scaling up WASH interventions.

There is an urgent need to deploy experienced response teams including a senior epidemiologist to coordinate the teams in the field. There is also need to strengthen surveillance activities in other adjoining districts to ensure that cases are detected early and responded to promptly and effectively.

WHO will continue to mobilize partners to support the Government in its efforts to control the outbreak, with emphasis on provision of clean water to the affected populations in Amtiman and Aboudeïa. WHO will also continue to advocate to the national authorities to improve sanitation services and safe water supply in the affected areas.

Geographical distribution of Hepatitis E cases in Chad, August 2016 - 9 April 2017.



### Event description

The measles outbreak situation in Guinea has greatly improved as reactive mass vaccination campaigns take effect. The weekly incidence of cases reduced by 68% in the last three weeks, from a peak of 746 cases reported in week 11 (week ending 19 March 2017) to 242 cases registered in week 14 (week ending 14 April 2017). Between 01 January and 9 April 2017, a cumulative of 4,893 suspected cases including 17 deaths (case fatality rate of 0.4%) were reported. Of these cases, 3,906 were either laboratory confirmed at the Guinea National Laboratory for Haemorrhagic Fever or had established epidemiological links to confirmed cases. Twenty two health districts attained the epidemic threshold of three confirmed measles cases in a health district in a week. Twelve case-patients were hospitalized in health facilities by 9 April 2017.

The measles outbreak in Guinea, reported to have started in 2016, was formally notified and declared by the National Agency for Health Security on 8 February 2017. Extensive immunization campaigns are being undertaken, targeting 1,040,081 children aged 6 months to 10 years. The vaccination campaign in N'zerekore health district ended on 19 March 2017 and the disease trend is waning down.

In neighbouring Liberia, routine surveillance data indicates an increase in the number of suspected measles cases. In week 14 (week ending 9 April 2017), 62 suspected cases of measles were reported compared to 35 suspected cases in the same week of 2016. Measles outbreak has been confirmed in Foya health district, which borders Gueckedou - one of the districts in Guinea with active measles outbreak. It is unclear whether the outbreak in Foya is linked to the one in Guinea. Nonetheless, the potential for cross border spread of the disease is high given the proximity and movement of people in the sub-region. An investigation team comprising of local health authorities and WHO is currently investigating the situation in Liberia. Meanwhile, surveillance has been intensified along the Liberia-Guinea border.

### Public health actions

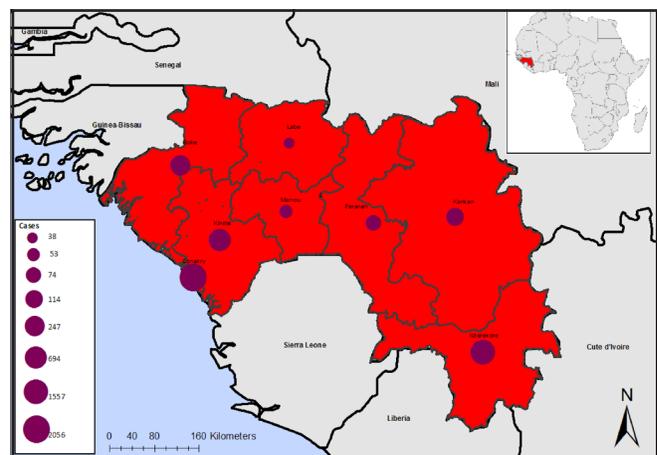
- The National Agency for Health Security and the National Immunization Programme, with support from Partners, are coordinating the response to the measles outbreak through weekly strategic meetings.
- Daily coordination meetings are being held at the national and regional levels to follow up on planned activities, analyse the outbreak situation, and identify challenges and proposed solutions.
- Mass measles vaccination campaign in 5 health districts of Conakry is ongoing while mass vaccination in 21 other health districts is planned for 26 April 2017.
- MSF funded operational costs for vaccination exercises in 5 health districts of Conakry while WHO and other partners supported supervision and monitoring of the activities.
- UNICEF supported dissemination of preventive messages in local languages through 10 local radio stations.
- WHO supported deployment of 76 national consultants to 38 health districts to support response to the outbreak.
- The Guinea National Laboratory for Haemorrhagic Fever continues to provide diagnostic services for measles and rubella.

### Situation interpretation

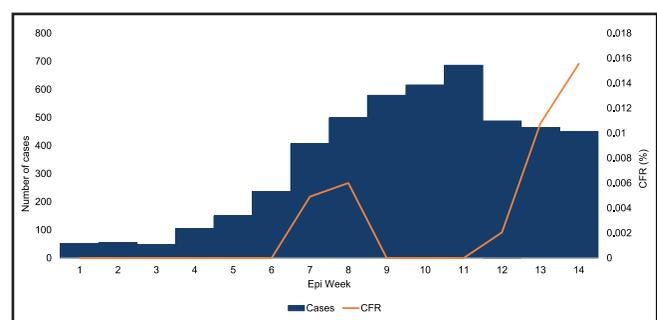
The measles outbreak in Guinea has shown remarkable reduction in incidence cases being reported. The improved coverage of mass vaccination has started to yield positive results. Twenty two health districts are currently in epidemic phase. This requires concerted efforts to quickly immunize the vulnerable children to protect them and avert further propagation of the current outbreak. The Measles and Rubella Initiative (MRI) approved funding for 18 health districts while other partners are providing additional vaccine and financial supports to the Ministry of Health. The Ministry of Health and Partners are currently working to identify the existing gaps in terms of funds, vaccines and logistic requirements.

After controlling this outbreak, attention needs to be focused on strengthening routine immunization in the whole country. The 2014-2015 Ebola epidemic globally disrupted provision of health care services including routine immunization. As part of the post-Ebola recovery, particular attention should be paid to restore basic infrastructures and systems for routine immunization to avoid recurrence of similar outbreaks of vaccine-preventable diseases.

Geographical distribution of measles cases in Guinea, 1 January - 9 April 2017.



Weekly trend for measles cases in Guinea, 1 January - 9 April 2017.

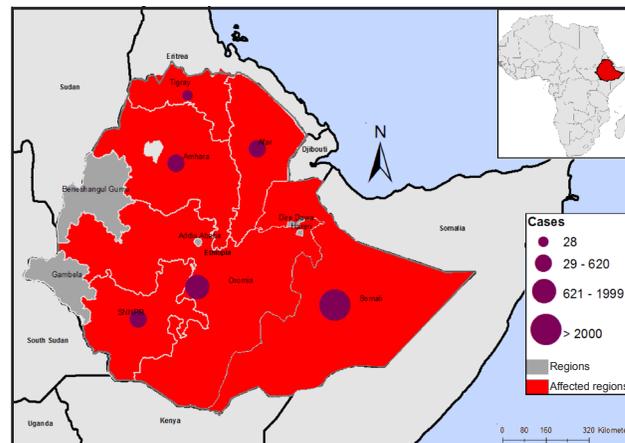


### Event description

The Somali region of Ethiopia continues to experience a huge outbreak of acute watery diarrhoea/cholera since the beginning of the year. In week 14 (week ending 09 April 2017), a total of 4,200 new cases of acute watery diarrhoea/cholera were reported from Afar, Amhara, Oromia and Somali regions in the country. In the past three weeks, the epidemic trend has plateaued, with 4,104 cases reported in week 13 (week ending 2 April 2017) and 4,358 cases in week 12 (week ending 26 March 2017). This trend is being closely monitored.

Since the beginning of 2017, a total of 24,578 cases including 667 deaths (case fatality rate of 2.7%) were reported from six regions: Amhara, Afar, Oromia, SNNP, Somali and Tigray. Eighty-nine percent of these cases and 96% of the deaths occurred in Somali region. In 2017, the outbreak rapidly spread from 13 to 43 Woredas (districts) in 8 out of the 11 zones of the region. The reported attack rates and case fatality rates are unusually high, with 21 Woredas presenting cumulative attack rates above 1% and 15 Woredas presenting case fatality rates above 2% (emergency threshold is 1%). The underlying risk exposure factors in this outbreak include the acute water shortages, population movements, and rising malnutrition; all linked to the effects of the El Nino-induced drought.

Geographical distribution of Acute watery diarrhoea/cholera cases in Ethiopia, 1 January - 9 April 2017.



### Public health actions

- WHO has deployed additional international technical experts to reinforce its response surge capacity in Ethiopia.
- The WHO Representative, the Humanitarian Coordinator and Heads of other UN Agencies visited the Somali region to assess the situation on the ground and identify priority areas for actions.
- WHO Regional Director visited Ethiopia this week to meet with national authorities and partners in order to scale up the response.
- An updated acute watery diarrhoea/cholera operational plan for Somali region for the next 30 to 60 days has been finalized and shared with key donors and humanitarian partners in Ethiopia.
- A Command Control Centre has been established at the Regional Health Bureau equipped with Wi-Fi internet connection to facilitate communication.
- Continued advocacy with government authorities for full access to data for effective priority setting and targeting interventions is being conducted.
- 105 treatment centres have been set up, reclassified and priority packages of interventions for each category defined.
- 30 additional dedicated surveillance officers have been recruited and deployed in Somali region to enhance technical support and improve active surveillance.
- 1000 rapid diagnostic test kits and treatment kits were donated to the government for delivery to Somali region. This will fast track diagnosis at the point of care and improve patients care.

### Situation interpretation

The Somali region of Ethiopia is facing a severe and large scale outbreak of acute watery diarrhoea/cholera. The outbreak still has high potential to expand in the weeks ahead in light of the existing aggravating factors and worsening humanitarian crisis. The outbreak also has high potential for spread to other regions in the country and beyond. Strong multi-sectoral interventions need to be rapidly and effectively implemented to avert further deterioration of the situation and loss of more lives. The WHO Country Office and the surge teams are actively mobilizing humanitarian actors to scale up the response to this outbreak, in addition to the overall humanitarian response.

### Event description

The overall security situation in many parts of South Sudan is getting worse day by day. Currently, there are reports of intensified fighting in the vicinity of Wau, which is also the main transport corridor to the northern parts of the country. About 16 people reportedly lost their lives and many others were injured.

About 42% (4.9 million people) of South Sudan population is estimated to be severely food insecure. Two counties, Leer and Mayendit with about 100,000 people were already in famine while Koch and Panyijiar were on the brink of famine by February 2017. This situation highlights the need to urgently provide therapeutic feeding, identify and treat co-morbidities in malnourished children to avert catastrophic mortality rates.

In week 14 (week ending 9 April 2017), completeness of weekly reporting was 59% for routine surveillance sites and 81% for the internally displaced persons (IDPs) sites. Malaria accounted for 28% and 10% of all consultations in the routine surveillance and IDP sites respectively. Malaria transmission is currently low and within the expected levels countrywide.

Cholera transmission has continued through the dry season, being associated with overuse and contamination of the scarce remaining water sources. During week 14, cholera outbreak was confirmed in Ayod county in Fangak state. This raises the number of affected counties to 14 in 9 states. As of 9 April 2017, a total of 6,147 cholera cases including 171 deaths [65 in the facilities and 106 in the community] (case fatality rate of 2.75%) were reported.

In week 13 (week ending 2 April 2017), 20 suspected measles cases were reported from 6 counties. Since the beginning of 2017, a total of 515 suspect measles cases including 4 deaths (case fatality rate of 0.78%) have been reported from 17 counties. Measles outbreaks have been confirmed in five counties, namely Wau, Aweil South, Gogrial West, Gogrial East, and Juba. At least 46 measles IgM positive and 36 rubella IgM cases have been confirmed. Most counties have not attained the non-measles febrile/rash illness rate of at least 1/100,000. This highlights the need to enhance measles case-based investigation and sample collection. The follow-up measles campaign is scheduled for 4 - 15 May 2017.

During week 14, one suspected Guinea worm case was reported from Bentiu. More than 3,000 alerts have been investigated in 2017 and 3 samples have been collected, two of which tested negative while the third is still pending. In 2016, 6 Guinea worm cases were confirmed compared to 4 in 2015. The Ministry of Health through the South Sudan Guinea Worm Eradication Program (SSGWEP) continues to offer cash reward of 5,000 South Sudanese pounds for reporting a case of Guinea worm.

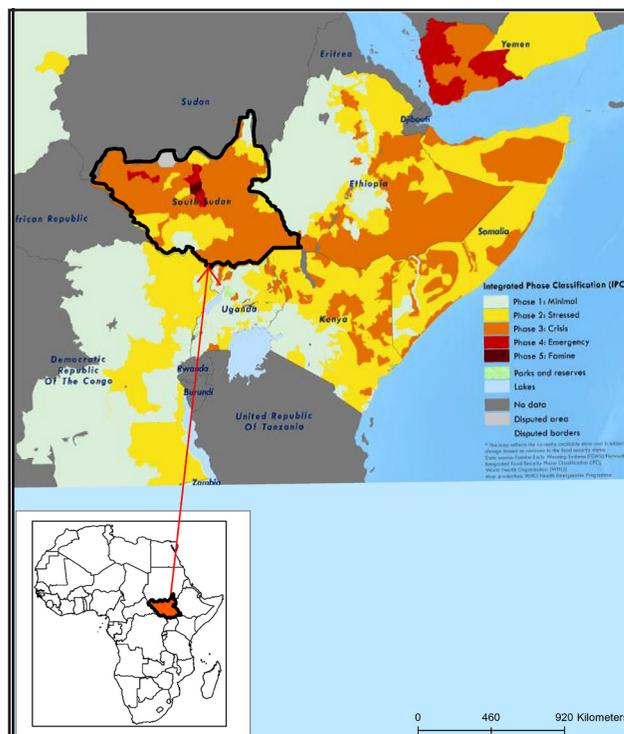
### Public health actions

- The Global Emergency Coordinators together with Heads of UN Agencies including the WHO Representative flew to Mayendit as part of famine assessment mission. Mayendit is among the counties where famine have been declared. WHO have field presence (1 field supervisor and 5 field assistants) and have supported health partners on the ground with Interagency Emergency Health kits.
- WCO has submitted CERF proposal for 1 million US dollars to fill critical gaps and health needs in the famine affected counties of Mayendit, Leer, Koch and Panyijiar.
- In response to increased violence around Wau, WHO supplied 30 cartons of trauma, surgical and anaesthetic kits to Wau teaching hospital.
- In Ayod county, rapid response teams have been trained and deployed with two diarrhoea disease kits to support cholera control activities in the affected cattle camps.
- A total of 43,197 individuals aged 1 year and above received oral cholera vaccines in Leer, Malakal Town, and Bor Protection of Civilians Camp in 2017.
- WHO supported deployment of 8 health workers to Mingkaman IDPs settlement in Aerial county where the outbreak of cholera is still on-going. WHO also dispatched 2 diarrhoea disease kits (DDKs) and 5 antimalarial modules to Mingkaman.
- Another team of 8 health workers have been deployed to augment the response in Duk county where a cholera outbreak has been reported in cattle camps.

### Situation interpretation

South Sudan is currently experiencing a complex humanitarian crisis due to the protracted armed conflict coupled with looting and destruction of vital infrastructure including health facilities and other social amenities. As a result, population displacement continues to expand and increasing vulnerability of the population to disease outbreaks and food insecurity. Despite the increasing vulnerabilities and public health needs, access remains constrained. Timely delivery of lifesaving interventions is being curtailed and this is a major concern for humanitarian actors. There is continuous engagement of the authorities for negotiated access to deliver humanitarian services to populations in need. A WHO strategy to access remote hard-to-reach populations has been developed and implementation is already underway to prevent excess morbidity and mortality in famine affected areas.

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



### Event description

The humanitarian impacts of the El Nino-induced drought in the Horn of Africa remain serious. According to the Famine Early Warning Systems Network (FEWSNET), the first rainy season (usually from March to May) has delayed in several parts of the region by 20-30 days. These areas were already significantly affected by the below-average rains in 2016. The delayed rainy season has aggravated the dire humanitarian needs, which are bound to persist until the next major rainy season of 2018. As of March, a total of 11 million people were facing crisis or emergency food insecurity levels. The majority of Somalia, south eastern Ethiopia, and north eastern Kenya are expected to be in Crisis Integrated Food Security Phase Classification (IPC) 3 between February and September 2017, with some areas of Somalia in Emergency (IPC Phase 4).

The drought-induced displacement is rising exponentially in addition to the populations fleeing conflicts, mainly in Somalia and South Sudan. South Sudan conflict is one of the key contributors of internal displacements and regional refugees, with reported 3.5 million fleeing for safety, out of which 1.6 million are refugees. Food insecure Ethiopia (345,687), Kenya (95,106) and Uganda (779,622) are hosting most of the influx. The recent months have been particularly noticeable with 0.5 million fleeing the country since July 2016.

The drought situation is being compounded by outbreaks of communicable diseases. As of 7 April 2017, a total of 43,215 cases of acute watery diarrhoea/cholera outbreaks in Somalia, Ethiopia and Kenya were reported to WHO. These numbers are set to rise with the onset of the rainy season. There are also increasing suspected measles cases reported, with close to 4,000 cases mostly in Somalia.

### Public health actions

- The WHO emergency support team based in Nairobi continued to engage partners including UNICEF, IOM, OCHA, and UNAIDS, UNFPA, WFP, UNHCR, OCHA, UNDP, MSF, etc.
- A comprehensive sub-regional response plan is being developed under the leadership and coordination of WHO with active participation of all partners.
- Health information management group has been formed under the leadership and coordination of WHO.
- Health coordination group for East and Horn of Africa has been established and the terms of reference are being drafted.
- Risk analysis is ongoing, with integration of data from the health, food and nutrition, and WASH sector as well as population movement in affected areas.

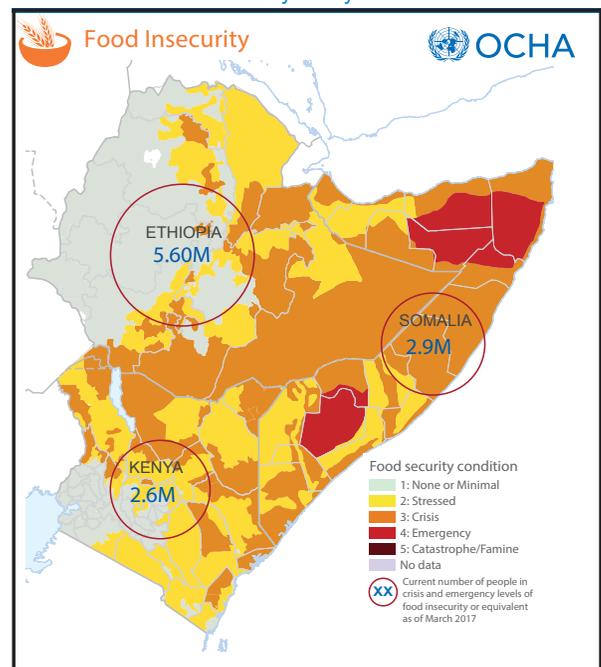
### Situation interpretation

The governments in the Horn of Africa countries and the health partners have prioritized control of acute watery diarrhoea/cholera and measles, improved access to food and safe water, and nutritional treatment for malnourished children. Despite the ongoing interventions, WHO remains concerned that life-saving health interventions are not scaling up as quickly as needed. Some of the factors include limitations in some countries to share data and information on outbreaks and other public health emergencies, lack of strong financial backing from donor partners and security challenges that impede access to vulnerable populations in hard-to-reach locations.

The total humanitarian requirements for the drought response in Somalia, Ethiopia, and Kenya stands at US\$1.94 billion. Donors are encouraged to fulfil their pledges and commitments and fast-track disbursement of funds to partners for field operations.

Violence and insecurity continue to hinder humanitarian space, especially in the rural areas. This highly insecure environment, coupled with donor aid restrictions, is severely compromising humanitarian actors' capacity to respond. In addition, administrative hurdles imposed by the national authorities at different levels remain a major concern. These bureaucracies significantly constraint the ability of humanitarian actors to scale up the regional drought response.

Classification of food insecurity in the Horn of Africa, February - May 2017



# Summary of major challenges and proposed actions

## Challenges

- The international trans-boundary transmission of diseases is again a key theme in the events reported this week. The potential cross border spread of hepatitis E in Chad and Niger, Lassa fever in Nigeria, Togo and Benin, and measles in Guinea and Liberia are some of the examples. Strengthening cross-border collaboration and corporation is key for international health security. Closer working relationships between Ministries of Health of neighbouring countries need to be strengthened and maintained. There is a need to establish formal agreements for sharing of communications and data in order to enhance cross border response to outbreaks.
- The importance of preparedness activities to strengthen surveillance and outbreak response are highlighted in many events this week. From the need to strengthen routine immunization to prevent future outbreaks, for example in the measles outbreak in Guinea, to improving early detection of events, through regular refresher training on priority epidemic prone diseases, to preventing high case fatality rates, as seen in Lassa fever in Nigeria. The delays in detection, confirmation and notification of outbreaks need to be addressed and improved.

## Proposed actions

- WHO should continue to promote stronger cross border collaboration and corporation as part of IHR (2005) requirements to strengthen international health security. Formal communications and data sharing agreements between Ministries of Health should be established, disease surveillance and outbreak situation reports shared and regular meetings held to increase collaboration.
- Preparedness activities across the spectrum of disease surveillance and response should be prioritized. Countries should undertake regular evaluation to ascertain weaknesses in preparedness and response systems and take appropriate remedial interventions.

# All events currently being monitored by WHO AFRO

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
<b>OUTBREAK</b>								
Cholera	DRC	2	1 Jan 2015	37,721	1104	2.9	2017 continues to see an increase of cases than during the same time period in 2016 with the provinces of Tanganyika, South Kivu, Maniema, Ecuador, Mongala, Bas-Uélé, Tshopo and Maniema most affected.	31/03/2017
Cholera	Tanzania	2	04 April 2015	25,120	390	1.6	Only 3 cases reported in epi week 13. Surveillance team encouraging regions and districts to test suspected cases	03/04/2017
Necrotising cellulitis/ fasciitis	Sao Tome & Principe	2	10 Jan 2017	1,535	0	0	17 new cases reported in week 14. The outbreak has still not been officially declared by the MOH and the number of experts in the field is relatively low, preventing the implementation of certain strategies.	05/04/2017
Hepatitis E	Chad	1	1 Sept 2016	1,339 (98)	15	1.2	25 new suspected cases including 2 positive for Hepatitis E by RT reported in epi week 14.	26/03/2017
Cholera	Angola	1	4 Jan 2017	289	11	3.8	AFRO & HQ risk assessment to review grading and implement Oral Cholera Vaccine (OCV) package	26/02/2017
Hepatitis E	Niger	-		72	17	24	Patients (mainly refugees) in Diffa presenting with conjunctival jaundice were confirmed Hepatitis E positive. Diffa borders with Tchad where there is an ongoing Hepatitis E outbreak. This constitutes the first recorded Hepatitis E outbreak in the country.	16/03/2017
Cholera	Kenya	-	10 Oct 2016	235 (36)	4	1.7	8 new cases reported during week 11 (week ending 16 March 2017).	16/03/2017
Dengue fever	Burkina Faso	-	29 Oct 2016	2,530	20	0.8	Two epidemiologists conducting retrospective hospital-based record review Reagents required for the diagnosis of dengue and arbovirus and training of lab technicians.	23/03/2017
Typhoid fever	Zimbabwe	-	21 Nov 2016	1,492 (75)	8	0.4	Floods due Cyclone Dineo are compromising water quality, hygiene practices and are likely to exacerbate the typhoid outbreak. 1,934 suspected typhoid cases, 59 confirmed and 5 deaths have been reported since January 2017	20/03/2017
Lassa fever	Nigeria	-	Dec 2016	283 (99)	56	19.8	Outbreak in 13 states	7/4/2017
Dengue fever	Cabo Verde	-	4 Jan 2017	98 (19)	0	0	Investigations by the deployed entomologist and virologist from IPD determined the recent circulation of the virus and the presence of <i>Aedes aegypti</i> as the vector.	09/03/2017
Monkeypox	Congo	-	1 Feb 2017	32 (4)	5	15.6	Surveillance in affected areas is weak. Training for health-care workers undertaken, however involvement of communities in reporting cases is needed.	
Meningitis	Togo	-	03 Feb 2017	376 (28)	26	6.9	The trend the outbreak has continued on a downtrend likely due to reactive mass vaccination campaign conducted from 1 to 5 March 2017. Affected districts include Akebou, Tone and Kpendjal.	19/03/2017
Meningitis	Benin	-		129 (13)	13	10	11 new suspected cases between 13/03/2017 – 19/03/2017 from Malanville commune. A total of 40 specimens have been tested between 13 March and 12 April. 12 are positive for <i>Neisseria meningitidis</i> C and 1 for <i>Streptococcus pneumoniae</i> .	14/04/2017
Monkeypox	Central African Republic	-	09 Feb 2017	47	0	0	Cases in Pygmy communities in the municipalities of Moboma, Balé-Koko and Nola located in large forest areas. Epidemiological survey conducted to characterise outbreak	04/04/2017
Measles	Guinea	-	08 Feb 2017	4,346 (3,486)	14	0.03	75 cases reported in the last week. Vaccination campaign scheduled for 7-15 April	03/04/2017
Cholera	Mozambique	-	16 Feb 2017	1400	3	0.2	A cross-border teleconference was held between Zimbabwe, Mozambique, Malawi WHO country offices on 31 March, to strengthen the response coordination between the 3 countries.	13/03/2017
Meningitis	Niger	-	19 Feb 2017	1184	56	4.7	Detailed update above	
Meningitis	Nigeria	-	20 Feb 2017	4,637	489	11	Five states are currently affected, most common serotype <i>Neisseria Meningitidis</i> serotype C in 83% of samples tested. Targeted reactive vaccination campaigns to be launched in Zamfara, Sokoto and Katsina states between 5-10 April 2017.	10/04/2017
Leishmaniasis	Cameroon	-	20 Feb 2017	48	17	35.4	On 7 April 2017, Cameroon sent an official requested for the technical and financial support of WHO and CDC.	24/03/2017
Lassa fever	Benin	-	21 Feb 2017	1 (1)	1	100	No new cases reported	20/03/2017
Crimean-Congo Haemorrhagic Fever	Namibia		23 Feb 2017	4 (2)	1	25 (50)	No new cases reported	28/03/2017
Lassa fever	Togo	-	24 Feb 2017	12 (7)	4	57	Detailed update given above	19/03/2017
Meningitis	Cameroon		9 Mar 2017	25	9	36	No new cases this week	26/03/2017
Lassa fever	Sierra Leone	-		90 (7)	6	6.7 (86)	Late referral of cases from communities to health facilities resulting in high case fatality rate. Community sensitization ongoing. Health workers were sensitized on observing infection prevention and control while managing cases.	10/04/2017
Anthrax	Tanzania	-	11 Mar 2017	1	0	-	Investigation undertaken by district team. Laboratory confirmation awaited. 36 contacts developed symptoms	-
Malaria	Burundi	-	13 Mar 2017	2,600,409	1,170	0.04	Detailed update given above	05/03/2017
Cholera	Malawi	-	15 Mar 2017	18	0	0	1 case reported in the last week, CTC set up to manage cases.	19/03/2017
Cholera	South Sudan	-	Beginning 2017	6,147	187	0.94	Reported in 6 regions; Amhara, Afar, Oromia, SNNP, Somali and Tigray with 90% in Somali region. 3957 cases reported in week 13.	02/04/2017
Measles	South Sudan	-	Beginning 2017	515	4	0.78	Overall downtrend continues. 20 new suspected cases reported from Wau, Yambio, Tonj North, Jur River, Nzara and Gogrial West. Laboratory results include 46 measles IgM and 36 rubella IgM confirmations. A measles vaccination campaign is scheduled for 17 – 28 April 2017.	2/04/2017
AWD/Cholera	Ethiopia	-	Beginning 2017	24,578	667	2.7	Reported in 6 regions; Amhara, Afar, Oromia, SNNP, Somali and Tigray with 90% in Somali region. 4200 cases reported in week 14 (3–9 April).	09/04/2017

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Measles	Ethiopia	-	Beginning 2017	1,100 (496)			Measles campaign targeting around 22.5 million children been conducted from February to current	02/04/2017
Influenza like illness (H1N1)	Senegal		28 Mar 2017	118	3	2.5	1 new case reported as of 4 April 2017. 23 out of 29 specimens have tested positive for H1N1 with Streptococcus pneumoniae, Haemophilus influenzae B, Moraxella catarrhalis co-infections.	4/04/2017
<b>EMERGENCIES</b>								
Humanitarian crisis	South Sudan	3					Detailed update given above	26/03/2017
Humanitarian crisis	Nigeria	3					Detailed update given above	17/03/2017
Post El-Nino drought	Ethiopia	2					Detailed update given above	02/04/2017
Humanitarian crisis	Cameroon	2						
Humanitarian crisis	Central African Republic	2						
Food insecurity	South Sudan, Kenya, Uganda, Ethiopia, NE Nigeria	-	23 Feb 2017				OCHA and IGAD estimate up to 22.9 million people are food insecure in the Horn of Africa.	
Floods	Zimbabwe	-	02 Mar 2017				The Government of Zimbabwe has declared the flooding situation affecting 36 districts in the country a national disaster, and has appealed for international assistance. They estimate 251 people killed and 128 others injured by various impacts of the floods. An estimated 100,000 people lack access to safe drinking water	
Cyclone	Madagascar	-	07 Mar 2017				There is persistence of floods with landslides in the district of Maroantsetra; 433,985 people affected; 943 Internally displaced; 89 people killed and 253 people wounded.	11/04/2017



#### **Data sources**

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

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