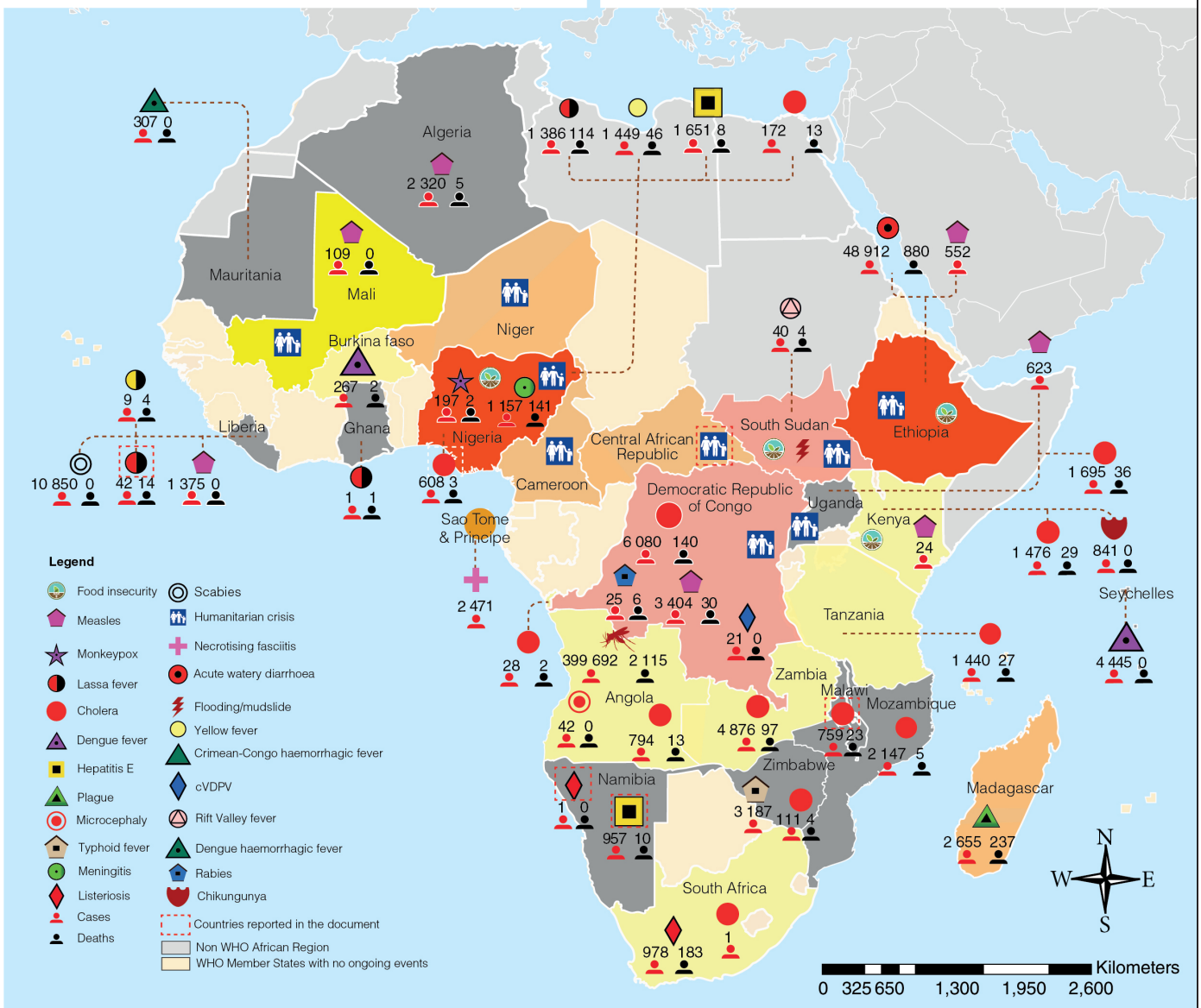
WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 11: 10 – 16 March 2018
Data as reported by 17:00; 16 March 2018

World Health Organization
REGIONAL OFFICE FOR Africa
WHO Health Emergencies Programme

2	48	41	9
New events	Ongoing events	Outbreaks	Humanitarian crises



2 Grade 3 events	5 Grade 2 events	8 Grade 1 events	31 Ungraded events
2 Protracted 3 events	1 Protracted 2 event	1 Protracted 1 event	

Overview

Contents

- This Weekly Bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 53 events in the region. This week's edition covers key new and ongoing events, including:

  - Listeriosis in Namibia
  - Cholera in north-east Nigeria
  - Cholera in Malawi
  - Hepatitis E in Namibia
  - Lassa fever in Liberia
  - 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 identification of the source of the listeriosis outbreak in South Africa and the confirmation of the disease in Namibia have caused various reactions in the region. While countries in the region should put in place adequate precautionary measures, these need to be done in line with provisions of the International Health Regulations (IHR 2005) and in keeping with the recommended public health measures.

  - The outbreak of cholera in Malawi continues. While the overall disease trend is declining, the case fatality rate remains high, with new deaths being registered. This outbreak needs to be contained and the fatalities prevented.

Extra-ordinary Strategic Meeting of Southern African Development Community Health Ministers on Listeriosis Preparedness and Response, Johannesburg, South Africa, 15 March 2018

BACKGROUND

On 15 March 2018, the Southern African Development Community (SADC) Health Ministers held an extra-ordinary strategic meeting on listeriosis preparedness and response in Johannesburg, South Africa. The meeting, convened by the current SADC Chair, South Africa, aimed to inform and share information about the ongoing listeriosis outbreak. The meeting followed the declaration of listeriosis outbreak by the South African Minister of Health in December 2017 and the recent announcement, in March 2018, of the source of the outbreak as polony and Viennas sausages from Enterprise, which is part of the Tiger Brand group. Products from this specific company were linked to patients, food sources and environmental samples, which all tested positive for *Listeria monocytogenes* and specifically ST6. Rainbow chicken limited also tested positive for *L. monocytogenes* but sequencing results are not available. Products from both companies were recalled. These products are also exported to other countries in the region.

PRESENTATION BY THE NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES, SOUTH AFRICA

The National Institute for Communicable Diseases (NICD), South Africa made a presentation on the background, epidemiology, clinical manifestations, and laboratory investigation of listeriosis in South Africa. The NICD offered to support the SADC countries with laboratory testing.

PRESENTATION BY WHO

The WHO presentation provided the global picture of listeriosis and emphasised the importance of judicious interpretation of the International Heath Regulations (IHR 2005) provisions related to trade and cross border movement of products. WHO reiterated the importance of sharing the different bacterial sequence types with other laboratories in the United States of America, Europe and Japan for further investigations.

KEY ISSUES DISCUSSED

- Most countries are not aware of listeriosis and in some cases, the health system report zero cases. This could be due to the fact that listeriosis is not a notifiable disease condition in many countries and thus the bacteria are not being tested for.
- Capacity building for healthcare workers in Member States was discussed since this disease is new for most of them. WHO is to develop guidelines and share with Member States.
- There is a need to communicate clinical guidelines to healthcare workers in the Member States.
- The issue of health education and risk communication was highlighted. WHO is to support Member States in health education and risk communication.
- Recall of products in Member States should be limited to the products from Enterprise and Rainbow chicken limited only; and should not involve other South African products. It is important to note that there is no ban on trade in the region, according to IHR 2005.
- The recall process should involve the products going back to the retailer and then back to the manufacturer for proper disposal. Disposal should be done correctly and be monitored independently.
- Sharing of the bacterial sequence types with other laboratories is necessary and the importance thereof, since every country would like to know the origins of the *L. monocytogenes* and from which product.
- There should be transparency in sharing of data and information among countries in the region.
- There is an opportunity to support countries with their food safety legislation, with regard to oversight of food processing plants and sharing of reports

DECISIONS TAKEN

The Ministers of Health deliberated on the implications of the recent outbreak of listeriosis in South Africa and the possible implications for the SADC region and made the following decisions:

- Called on SADC Member States to harmonize procedures for prevention, detection and response to listeriosis in the SADC Region.
- Encouraged cross-border collaboration among Member States sharing borders with respect to imports of processed foods; and partnerships to strengthen inter-ministerial actions to address listeriosis.
- Called on Member States to establish mechanisms for inter-sectoral and multisectoral coordination and effective communication to facilitate implementation of core public health capacities, all hazards risk assessment, including addressing risk management for listeriosis outbreak.
- Called on the SADC Secretariat to facilitate experience sharing and information exchange between Member States.
- Requested support of international and regional partners such as WHO to support capacity building for Member States.
- Called upon Member States to enhance compliance to food safety standards by the food industries as a critical measure to control listeriosis.
- Called upon Member States to enhance public health education on listeriosis.
- Strengthen enforcement of policies that are harmonised and aligned to the International Codex Alimentarius.

New events

Listeriosis	Namibia	1 Case	0 Deaths	0% CFR

EVENT DESCRIPTION

On 13 March 2018, the Namibia Ministry of Health and Social Services reported a confirmed case of listeriosis in Tsumeb town in Oshikoto Region in the northern part of the country. The case, a 41-year-old man with a known chronic co-morbidity, was admitted to a private hospital in Windhoek on 5 March 2018. He had travelled from Tsumeb to Windhoek on 4 March 2018. On 12 March 2018, abdominal fluid bacterial culture isolated *Listeria monocytogenes*. The patient remains admitted in a stable clinical condition.

Preliminary investigations reportedly indicated that the patient consumed meat products (Viennas) purchased from a local butchery in Tsumeb two weeks prior to onset of illness. In-depth investigation, including food consumption history, is being undertaken. Food samples are also being collected for testing, as well as interviews with the business owner of the stores involved to trace the origin of the meat product.

PUBLIC HEALTH ACTIONS

- On 13 March 2018, the Minister of Health held a press conference to announce the event and disseminate public health preventive messages to the public.
- Active surveillance has been intensified, including active search for additional cases. Close contacts (wife and two children) who consumed the same food are being examined. Detailed investigation into the potential source of infection is being conducted.
- The Ministry of Health is working closely with relevant sectors, including the Ministries of Agriculture and Finance (customs and excise department), to respond to this event.
- Health education has been provided to the immediate family members and to the general public.

Geographical distribution of listeriosis cases in Namibia, 4 - 13 March 2018

SITUATION INTERPRETATION

The national authority in Namibia has reported a confirmed case of listeriosis in the country. Detailed investigations are ongoing to establish the source of this infection and any potential links between this case and the ongoing outbreak in South Africa. These investigations need to be methodical. It should be noted that the causative agent for listeriosis, *Listeria monocytogenes*, is widely distributed in nature (in soil, water, vegetation and faeces of some animals) and can easily contaminate foods. This fact does not negate the strong trade and travel links between countries in the region and South Africa.

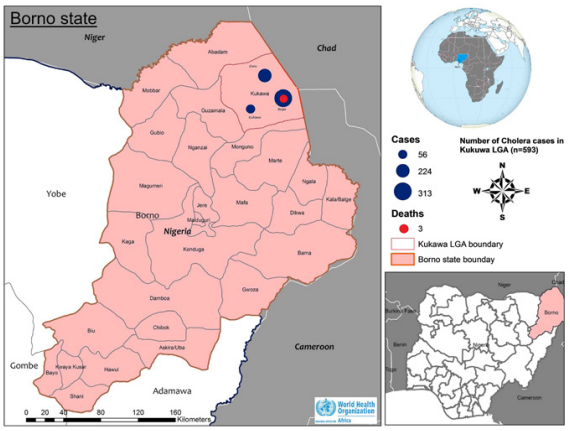
Countries in the region need to take adequate and judicious preventive measures, in line with provisions of the International Health Regulations (IHR 2005) and in keeping with recommended public health measures. In general, practising safe food handling and following the WHO Five Keys to Safer Food (Keep clean, Separate raw and cooked, Cook thoroughly, Keep food at safe temperatures, and Use safe water and raw materials) should be promoted widely. In particular, consumption of ready-to-eat meat products such as sausages, hams, patés and meat spreads; cold-smoked seafood (such as smoked salmon); and dairy products made of unpasteurized milk should be discouraged.

EVENT DESCRIPTION

On 8 March 2018, the Borno State Ministry of Health declared an outbreak of cholera in Kukawa Local Government Area (LGA). The initial cases of acute watery diarrhoea emerged on 13 February 2018 in Doro ward. Stool samples obtained from the initial cases were sent to the University of Maiduguri Teaching Hospital (UMTH) microbiology laboratory. Test results released on 13 February 2018 were positive for *Vibrio cholerae*. Since the beginning of the outbreak on 13 February 2018, a cumulative total of 608 suspected cholera cases and three deaths (case fatality rate 0.5%) has been reported, as of 16 March 2018. Three wards in Kukawa LGA have been affected, namely Doro (323 cases), Baga (229 cases and 3 deaths) and Kukawa (56 cases). Most of the cases in Doro ward came from Bunduram. Just under half (49%) of cases are in children under the age of 5 years and the male to female ratio is 1:1. Out of 77 samples tested using cholera rapid diagnostic tests, 69 (89%) were positive. Twenty-three (46%) out of 50 samples were culture positive.

The trend of cholera cases has been decreasing in the past one week, although a similar pattern was seen previously before the numbers spiked again. The highest number of cases per day, since the start of the outbreak, was reported on 23 February 2018, with 38 cases. On 16 March 2018, eight new cases were reported.

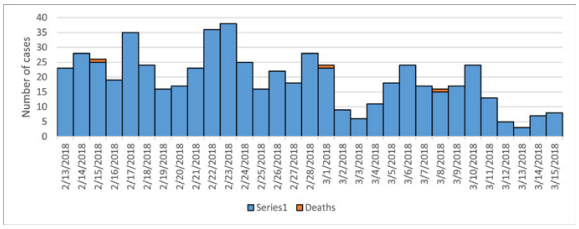
Geographical distribution of cholera cases in north-east Nigeria, 13 February – 14 March 2018



PUBLIC HEALTH ACTIONS

- On 11 March 2018, a Cholera Emergency Operations Centre (EOC) was activated in Maiduguri to coordinate response activities at state level, focusing on surveillance; case management; water, sanitation and hygiene (WASH); and risk communication. The committees meet on alternate days.
- At the LGA level, a daily multi-sectoral coordination meeting has been held since 22 February 2018 in Baga, chaired by the Primary Health Care (PHC) coordinator, and involving the State Ministry of Health, LGAs, ALIMA, Solidarités International, UNICEF and WHO.
- On 21 February 2018, the state rapid response team (RRT) was deployed to support the response activities in Kukawa LGA, after positive culture results were obtained. The team is made up of surveillance officers, WASH specialists and risk communication personnel.

Epidemic curve of cholera outbreak in Kukawa Local Government Area in Borno state, 13 February - 13 March 2018



- Surveillance has been intensified in all health facilities and communities in the LGA. WHO hard-to-reach teams were mobilized to support active surveillance, particularly community house-to-house search for cases, risk communication and distribution of oral rehydration salts.
- Two cholera treatment centres were established in Baga and Kukawa, along with two oral rehydration points in Bunduram and Doro. Health partners, ALIMA and MSF, are supporting case management.
- Implementation of WASH activities is ongoing, including water trucking, along with installation of communal storage and distribution facilities, water quality testing, construction of emergency latrines with installation of handwashing facilities, chlorination of existing wells, distribution of cholera kits, and spraying and disinfection.

SITUATION INTERPRETATION

The cholera outbreak in Kukawa, coming at the back of the just ended outbreak in the region, is so far localised. The response to the outbreak has been intense, beginning to show early results. The trend has been coming down considerably in the last week. However, gaps and challenges still remain. Laboratory testing has been specific for *Vibrio cholerae*, and, in view of the demographics of those affected (close to half of the cases are under 5 years), other potential causative organisms need to be investigated, particularly rotovirus. In addition, specimen transport and test media are in short supply.

Kukawa LGA was not included in the oral cholera vaccination (OCV) campaigns that were carried out in high risk LGAs in 2017. The most affected communities are those hosting internally displaced persons (IDPs) with inadequate water, sanitation and hygiene provision (WASH). Implementation of WASH activities need to be further scaled up, since the current response has been mainly reactive, focusing on affected households and their surrounds. Open defecation is still widespread as latrines are in limited supply. Safe water supplies are also inadequate, although plans are being finalised to address this gap.

The high traffic between Baga town and Maiduguri due to the fish trade around the Lake Chad area provides for the potential for spread along this corridor. Local and international actors need to maintain a high level of alert for new cases.

Ongoing events

Cholera | **Malawi** | 759 **Cases** | 23 **Deaths** | 3.0% **CFR**

EVENT DESCRIPTION

The cholera outbreak in Malawi continues to evolve, with some reduction in trend observed in the last two weeks. In week 10 (week ending 11 March 2018), a total of 41 new cases and four deaths (case fatality rate 9.8%) were reported, compared to 76 cases and six deaths reported in week 9. The new cases reported during the reporting week originated from five districts, namely Lilongwe (17 cases and 4 deaths), Salima (12 cases), Karonga (8 cases), Dedza (3 cases), and Rumphi (1 case). Three of the deaths reported in week 10 occurred in the health facilities and one in the community.

Since the beginning of the outbreak on 24 November 2017, a total of 759 cases including 23 deaths (case fatality rate 3.0%) were reported, as of 14 March 2018. Thirteen out of 29 (45%) districts in the country have been affected, with five districts (Dedza, Karonga, Lilongwe, Rumphi, and Salima) reporting cases in the past two weeks. Karonga has been the most affected, with 46% (346) of the cases reported to date, followed by Lilongwe (31%, 239), the district that contains the capital city. Eight districts, namely Blantyre, Chikwawa, Dowa, Kasungu, Likoma, Mulanje, Nkhatabay, and Nsanje have not reported new cases in the least three weeks. Of 435 cases with known ages and gender, 70% (305) were aged 15 years and above and 51% (221) were females. A total of 84 stool samples have been collected and 78 (93%) tested positive for *Vibrio cholerae* O1 by culture.

PUBLIC HEALTH ACTIONS

- Coordination meetings between the health and water, sanitation, and hygiene (WASH) clusters take place every two weeks to review intervention activities and mobilize resources for planned interventions.
- The first round of an oral cholera vaccine campaign was conducted in Karonga district from 19 to 23 February 2018. Over 110 000 people received the vaccine, translating into an administrative coverage of 102%. The second round of the campaigns was conducted from 12-16 March 2018. The coverage data is being compiled.
- Active surveillance, including visits to the households and communities of the cases, is ongoing in the affected areas.

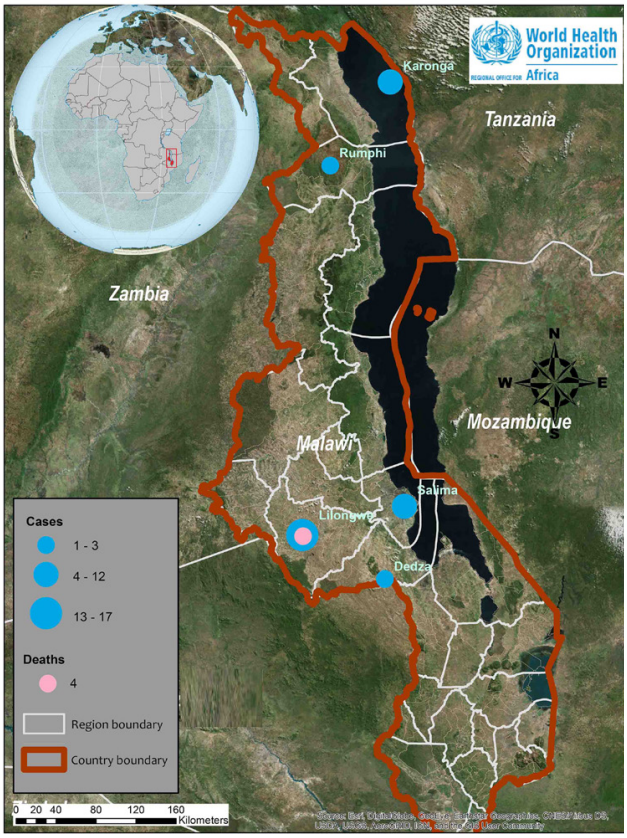
SITUATION INTERPRETATION

The continuous cholera outbreak in Lilongwe, Malawi remains a concern. While the overall disease trend has been declining, the rate has been sluggish. The outbreak has been ongoing for over 15 weeks. In addition, registering a total of ten deaths in the last two weeks (week 9 recorded 6 deaths and week 10 had 4 deaths) at this stage of the outbreak, particularly in the urban Lilongwe district, indicates deep-seated challenges that need to be addressed urgently.

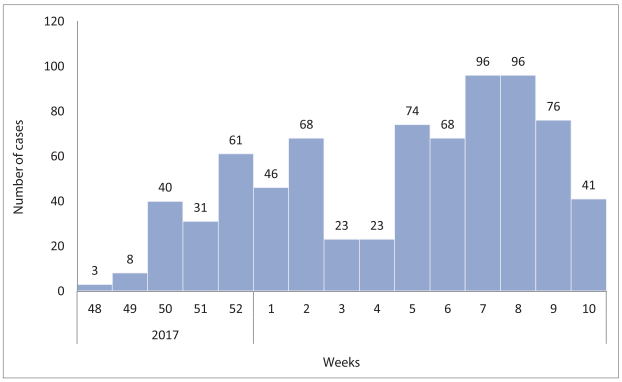
Reactive oral cholera vaccination campaigns (OCV) have been progressing well in parts of the country. Never-the-less, it is important to continue implementing the other conventional cholera control interventions, and not view the OCV campaigns as the principal response.

Investments from the national authorities and partners towards conventional health and WASH activities are critical. The major risk factors for propagation of the outbreak are still prevalent. For example, current figures indicate that sanitation coverage ranges between 40 and 60%, hand washing with soap is below 5%, and access to safe water is 74%. The situation is worse around the fishing communities on Lake Malawi and Lake Tanganyika where access to safe water and sanitation remain dismal.

Geographical distribution of cholera cases in Malawi, weeks 48, 2017 - 10, 2018



Weekly trend of cholera cases in Malawi, weeks 48, 2017 - 10, 2018



Hepatitis E | Namibia | 957 Cases | 10 Deaths | 1% CFR

EVENT DESCRIPTION

The outbreak of hepatitis E in Windhoek, Namibia continues, with a steady decline in trend. In the past four weeks (weeks ending 11 February to 11 March 2018), a total of 314 additional cases and seven deaths (case fatality rate 2.2%) have been reported. In week 10 (week ending 11 March 2018), 44 new cases were reported compared to 48 and 60 cases reported during weeks 9 and 8, respectively. As of 11 March 2018, eight patients were in admission, three of them in the postpartum period. The last confirmed case was admitted on 13 March 2018.

Since the beginning of the outbreak on 8 September 2017, a cumulative total of 957 cases and 10 deaths (case fatality rate 1%) have been reported, as of 11 March 2018. Six of the ten deaths occurred among pregnant mothers and the four men had co-morbidities. Seventy-three percent of the affected people are between 20 and 39 years and 13% are between 40 and 49 years. The majority, 57%, of cases are male. About 80% of the cases came from Havana (54%) and Goreangab (25%) informal settlements. Several other communities in the city have been affected, though reporting fewer numbers of cases. Additionally, 13 confirmed hepatitis E cases came from elsewhere in the country, namely Omusati (3), Otjozondjupa (3), Oshikoto (2), Oshana (2), Erongo (2), and Ohangwena (1). However, 11 out of the 13 cases were linked to and thus imported from Havana, Windhoek. The disease has been quickly contained in those regions.

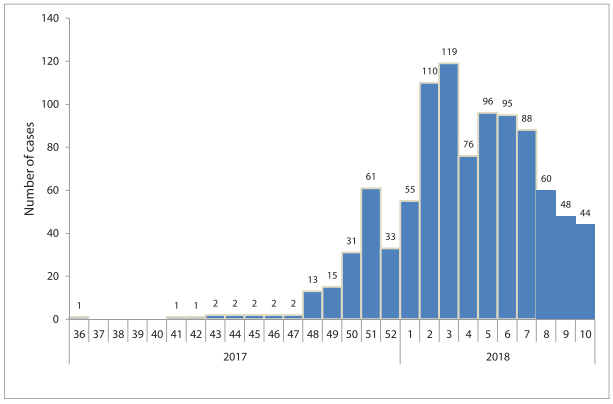
A total of 100 cases have been laboratory confirmed, 93 of them were immunoglobulin M (IgM) positive and seven IgG positive. The genotype of the virus has been identified as type 2 hepatitis E virus. Two cases have been classified as probable, 657 cases were epidemiologically linked and 198 cases remained suspected. The test results for 173 specimens are still pending.

PUBLIC HEALTH ACTIONS

- The National Health Emergency Management Committee continues to lead the response through the thematic working groups based on the response framework developed.
- The task force conducted a monitoring visit to the affected areas to take stock of the current field interventions, in addition to verification of some response activities.
- Enhanced surveillance continues, including active case search in Windhoek and other locations. The line lists of cases from five reporting health facilities are currently being validated to ensure appropriate data. An analytic study to define the key risk factors for propagation of the disease is being designed.
- A total of 13 water tanks have been erected in the most affected places in Windhoek and a water distribution network of 7 km has been completed. A total of 360 standpipes have been erected in the affected communities.
- The rehabilitation of vandalized and non-functional toilets continues and 350 toilets have been repaired.
- Approximately 746 m of sewer lines, including 17 manholes, were unblocked in Havana, and are being monitored regularly for recurring blockages.
- The Ministry of Information, Communication and Technology (MICT), have developed and translated television and radio jingles into various local languages. The messages will be aired by the Namibia Broadcasting Cooperation (NBC).

Geographical distribution of hepatitis E cases in Namibia, 11 February - 11 March 2018

Weekly trend of hepatitis E cases in Windhoek, Namibia, week 36, 2017 to week 10, 2018



SITUATION INTERPRETATION

The outbreak of hepatitis E in Windhoek, Namibia has been steadily declining following strong interventions by the national authorities and partners. Several medium- to long-term interventions have been implemented, especially in the WASH sector. Some of the key interventions include increasing the piped water distribution network in the city suburbs, dredging of river beds, and construction of public toilets. This type of response serves as a good example of where long-term, developmental interventions are implemented alongside short-term control measures.

Despite the gains so far, several challenges still exist, including the mushrooming illegal informal settlements. The latrine/toilet coverage remains low, with over 62% of people practising open defecation and about 12% still using contaminated water sources. To this end, there is a need to intensify outbreak control interventions, as well as more investment in medium to longer term development measures.

Lassa fever | Liberia

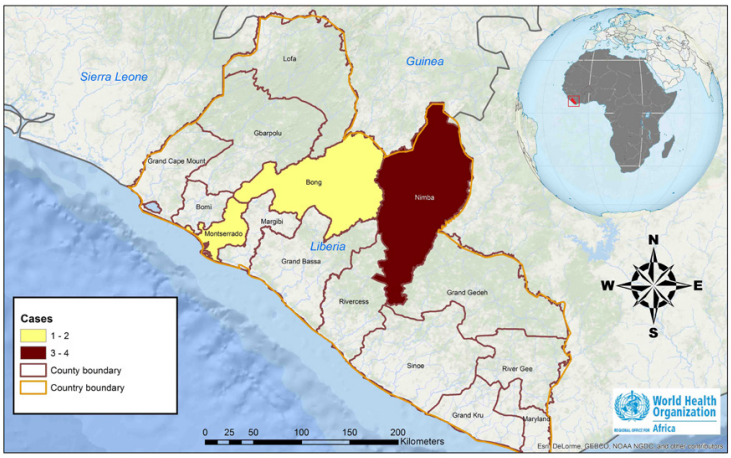
42 **Cases** | 14 **Deaths** | 33.3% **CFR**

EVENT DESCRIPTION

Liberia continues to experience sporadic cases of Lassa fever. In week 9 (week ending 4 March 2018), three confirmed cases and two deaths were reported from Montserrado (2 cases and 2 deaths) and Nimba (1) Counties. During week 10 (week ending 11 March 2018), 18 new suspected cases were reported from four counties; however, all of the cases tested negative for Lassa fever at the National Public Health Reference Laboratory (NPHRL) by real time polymerase chain reaction (RT-PCR). A total of 159 contacts of the last three confirmed cases are currently under follow-up in Montserrado (109), Nimba (21), and Margibi (29) Counties. Up to 102 contacts are healthcare workers.

Since the beginning of 2018, 42 suspected/confirmed cases, including 14 deaths (case fatality rate 33.3%), have been reported from five counties. Of the 42 cases, seven were confirmed at the NPHRL by RT-PCR. Six of the confirmed cases have died, resulting in a case fatality rate of 86% among the confirmed group. The confirmed cases were from Nimba (4), Montserrado (2) and Bong (1) counties. The majority (71%) of confirmed cases are females and the ages of the confirmed cases range from 1 to 57 years, with a median of 24 years. A total of 33 specimens tested negative.

Geographical distribution of Lassa fever cases in Liberia, 4 - 11 March 2018



PUBLIC HEALTH ACTIONS

- The county health teams are coordinating the response to the outbreak, with technical support from the Ministry of Health, the National Public Health Institute of Liberia (NPHIL), and WHO field offices.
- The national epidemic preparedness and response committee (NEPRC), with leadership from the NPHIL and participation of WHO, US CDC, and other partners, continue to provide technical, operational, and logistical support to the counties.
- A standardized Lassa fever case definition and a new screening tool have been adapted and disseminated to all health facilities in the country.
- Active surveillance, contact tracing, case management, infection prevention and control, and risk communication activities are ongoing.
- The NPHRL continues to provide laboratory diagnostic services and courier services have been strategically designated across the country to facilitate transport of specimens.
- An infectious disease isolation unit has been set up in Montserrado County to manage patients with Lassa fever.
- The Ministry of Health, NPHIL, and WHO supported training of 73 healthcare workers in Lassa fever case management, and infection prevention and control.
- Antiviral medication (Ribavirin) has been prepositioned at designated treatment sites to facilitate management of future cases.
- Rapid response teams have begun visiting affected communities to provide information about the outbreak and initiate community engagement activities. The scale up of a national social mobilization strategy is also planned.
- A new national Lassa fever preparedness and response plan is currently under review.

SITUATION INTERPRETATION

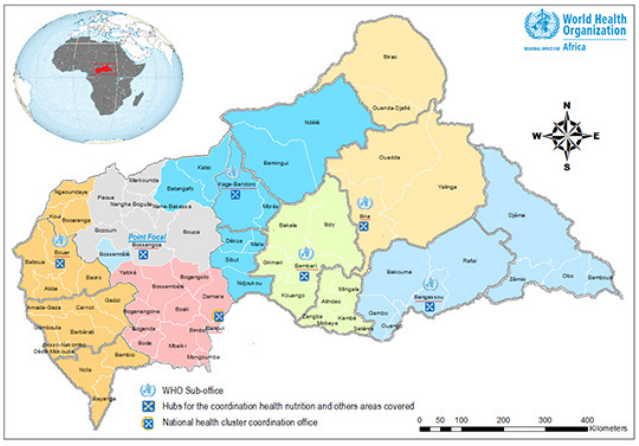
The Lassa fever outbreak in Liberia continues insidiously. A multidisciplinary outbreak response has been mounted; however, it has not been able to prevent further cases. Reduction of the risk of rodent-to-human transmission should be prioritized, which entails effective implementation of social mobilization and community engagement activities to promote vector control and environmental management. There is also a particular need for logistical and operational support and training to reduce the risk of infection of healthcare workers. Over 60% of the contacts currently being followed are healthcare workers. This is a clear indication of inadequate infection prevention and control practices. Implementation of these interventions needs to be intensified, especially in the counties known to be endemic for the disease.

EVENT DESCRIPTION

Serious violence continues in Central African Republic, particularly in the hot spots of Rafaï sub-prefecture, Markounda and Lower Kotto. Clashes between armed groups on 3 and 4 March 2018 caused internal displacement of around 6 000 people from the city of Rafaï, some of whom crossed into the Democratic Republic of the Congo. In Bangassou, armed groups looted the offices of the Catholic Organization for Relief and Development Aid (CORAID) and Médicines sans Frontièrs (MSF), resulting in temporary relocation of all humanitarian organization staff, including WHO, to Bangui. In Markounda, the entire population is either displaced to neighbouring sub-prefectures or into the surrounding countryside. More than 8 000 people have sheltered at the Catholic Church. On 5 March 2018, there were six fatalities during a UNICEF mission to evaluate school activities. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) reported tension in Lower Kotto, where 14 civilians were killed and six wounded in recurring clashes between armed groups. Of the wounded, five were transferred to Bangui. Several houses were also burned down. Humanitarian access in the area is threatened.

During week 9 (week ending 4 March 2018), three suspected cases of monkeypox were reported in Bria town in Haute-Kotto Prefecture. Samples obtained from the first two cases tested positive for monkeypox at the Institut Pasteur Bangui. Further investigations are ongoing.

WHO and Health cluster presence in Central African Republic as of February 2018



Bloody diarrhoea has been reported in the villages of Somboké and Ngoumourou in the Kaga Bandoro Health District. From weeks 1 to 9, a cumulative total of 118 cases of diarrhoea, with three deaths (case fatality rate 3%) have been reported from the area. Thirty-five stool samples sent to the Kaga District Hospital laboratory in Bandoro were positive for Entamoeba histolytica (10/35) and schistosomes (2/35). These samples will be sent to the Institute Pasteur Bangui to test for *Shigella*.

PUBLIC HEALTH ACTIONS

- A crisis committee has been revitalized in response to the monkeypox outbreak, being supported by WHO and partners. An isolation unit has been set up in Bria hospital, where the three patients are being treated, supported by the NGO IMC. The contacts of these cases are being monitored. Standard case definition for monkeypox has been disseminated to facilitate identification of cases and awareness about prevention is ongoing in the community and on the local community radio.
- The Ministry of Health is in the process of developing a monkeypox outbreak response plan, following the confirmation of the disease in Bria.
- Paoua health district authority has established a coordination structure, with support from WHO, UNICEF, MDA and the International Committee of the Red Cross (ICRC), aimed to improve provision of humanitarian services.
- The water, hygiene and sanitation (WASH) cluster, with support from UNICEF, has supplied 400 boxes of aqua tabs to households, restored and disinfected five water points in four villages, conducted door-to-door community awareness and in schools, and installed handwashing points in schools and health centres.
- WHO donated medical kits to health posts in Mbiti and Ngoumourou.
- WHO and UNICEF supported investigation of the reported bloody diarrhoea in the villages of Somboké and Ngoumourou. Health workers have been briefed on the management of diarrhoea and strengthening epidemiological surveillance. This response is being done in collaboration with the WASH cluster.

SITUATION INTERPRETATION

The continuing insecurity and the resulting displacement of people in Central African Republic remains a major concern in the region. The complete suspension of humanitarian activities in Bangassou is of particular concern and it is important for WHO to advocate that partners resume operations as soon as possible. Without humanitarian assistance, populations in need will become ever more vulnerable, which in itself will lead to greater tension. There is an urgent need for national and international intervention in the region to prevent further conflict and potential disease outbreaks.

Summary of major issues challenges, and proposed actions

Issues and Challenges

- The Namibian Ministry of Health reported the first confirmed case of listeriosis in the country. This event comes on the backdrop of the recent pronouncement by the South African national authorities pinpointing the source of the listeriosis outbreak in country. These events caused various reactions in the region.

  It should be stated that the South African Government and the national authorities have been very diligent and transparent in handling this outbreak, including taking appropriate public health and regulatory measures. It should also be noted that the causative agent for listeriosis, *Listeria monocytogenes*, is widely distributed in nature (in soil, water, vegetation and faeces of some animals) and can easily contaminate foods. Additionally, it is true that listeriosis was not a notifiable disease in many countries in the region. These facts do not negate the strong trade and travel links between countries in the region and South Africa. It only calls for due diligence in dealing with this situation.

- The outbreak of cholera in Malawi continues. While the overall disease trend is gradually declining, the case fatality rate remains high, with new deaths being registered. Ten new deaths were registered in the last two weeks in the urban Lilongwe district. This is indicative of deep-seated challenges that need to be addressed urgently.

Proposed actions

- The national authorities in Namibia need to conduct detailed and methodical investigations to establish the source of this infection and any potential links between this case and the ongoing outbreak in South Africa. The Member States in African Region need to put in place adequate precautionary measures; however, these should be done in line with provisions of the International Health Regulations (IHR 2005) and in keeping with the recommended public health measures. Emphasis should be put on promoting good manufacturing practices and safe food handling. In particular, consumption of ready-to-eat meat products such as sausages, hams, patés and meat spreads; cold-smoked seafood (such as smoked salmon); and dairy products made of unpasteurized milk should be discouraged.

- The national authorities and partners in Malawi need to increase investments towards conventional health and WASH interventions. There is a need to conduct an in-depth evaluation of the ongoing response. This should then inform development of high-impact, targeted interventions, addressing the deep-seated challenges.

All events currently being monitored by WHO AFRO

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Con-firmed cases	Deaths	CFR	Comments
New events										
Namibia	Listeriosis	Ungraded	13-Mar-18	12-Mar-18	13-Mar-18	1	1	0	0.0%	Detailed update given above.
Nigeria (Borno State)	Cholera	Ungraded	n/a	13-Feb-18	16-Mar-18	608	23	3	0.5%	Detailed update given above.
Ongoing events										
Algeria	Measles	Ungraded	13-Mar-18	25-Jan-18	11-Mar-18	2 320	-	5	0.2%	A total of 2 320 cases including 5 deaths have been reported from 13 wilayas: El Oued, Ouargla, Illizi, Tamanrasset, Biskra, Tebessa, Relizane, Tiaret, Constantine, Tissemsilt, Medea, Alger, and El-Bayadh.
Angola	Cholera	G1	2-Jan-18	21-Dec-17	11-Mar-18	794	5	13	1.6%	On 21 December 2018, two suspected cholera cases were reported from Uige district, Uige province. Both of these cases had a history of travel to Kimpangu (DRC). The number of weekly cases had a decreasing trend from week 2 to week 8, with an increase in cases in week 10, with 40 cases.
Angola (Cabinda province)	Cholera	Ungraded	8-Mar-18	18-Feb-18	11-Mar-18	28	-	2	7.1%	A suspected case in Cabinda province was reported on 18 February 2018, which tested positive by a Rapid Diagnostic Test (RDT). Between 5 and 11 February 2018, 12 cases and one death (8.3%), were reported from the province.
Angola	Malaria	Ungraded	20-Nov-17	1-Jan-17	30-Sep-17	399 692	-	2 115	0.5%	The outbreak has been ongoing since the beginning of 2017. In the province of Benguela, a total of 244 381 malaria cases were reported from January to September 2017 as compared to 311 661 reported in all of 2016. In the province of Huambo, 155 311 malaria cases were reported from January to September 2017, as compared to 82 138 cases during the same period in 2016. Epidemiological investigations are ongoing in these two contiguous provinces.
Angola	Micro-cephaly - suspected Zika virus disease	Ungraded	10-Oct-17	End Sep-tember	29-Nov-17	42	-	-	-	A cluster of microcephaly cases was detected in Luanda in late September 2017 and reported on 10 October 2017 by the provincial surveillance system. Of the 42 cases, three were stillbirths and 39 were live births. Suspected cases have been reported from Luanda province (39), Zaire province (1), Moxico province (1), and Benguela province (1).
Burkina Faso	Dengue fever	G1	4-Oct-17	31-Dec-17	13-Jan-18	267	-	2	0.7%	From week 1 to week 52 of 2017, 15 096 cases and 30 deaths were reported. The trend in the number of cases has been decreasing since week 44 of 2017. The majority (79%) of cases reported in weeks 1 and 2 of 2018 have been reported in the central region, notably in Ouagadougou (the capital). Dengue virus serotypes 1, 2, and 3 are circulating.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	3-Nov-17	-	-	-	-	At the beginning of November, the general security situation in the Far North Region worsened. Terrorist attacks and suicide bombings are continuing and causing displacement. Almost 10% of the population of Cameroon, particularly in the Far North, North, Adamaoua, and East Regions, is in need of humanitarian assistance as a result of the insecurity. To date, more than 58 838 refugees from Nigeria are present in Minawao Camp, and more than 21 000 other refugees have been identified out of the camp. In addition, approximately 238 000 Internally Displaced People have been registered.
Central African Republic	Humanitarian crisis	G2	11-Dec-13	11-Dec-13	28-Feb-18	-	-	-	-	Detailed update given above.
Democratic Republic of the Congo	Humanitarian crisis	G3	20-Dec-16	17-Apr-17	11-Mar-18	-	-	-	-	The humanitarian and security situation remains very fragile in several provinces of the country, particularly in Ituri, North Kivu, South Kivu, Maniema, and Haut-Katanga. Displacement from these provinces continues and new IDPs are lacking basic services.
Democratic Republic of the Congo	Cholera		16-Jan-15	1-Jan-18	4-Mar-18	6 080	0	140	2.3%	This is part of an ongoing outbreak. From week 1 to 8 of 2018, a total of 6 080 cases including 140 deaths (CFR: 2.3%) were reported from DRC. In week 8, 571 new cases with 22 deaths have been reported, including 37 cases from Kinshasa. Fifty-four percent of the cases reported in week 8 from endemic areas (North Kivu, South Kivu, Tanganyika). Nationwide, a total of 60 492 cases including 1 288 deaths (CFR; 2.1%) have been reported since January 2017.
Democratic Republic of the Congo	Measles		10-Jan-17	1-Jan-18	4-Mar-18	3 404	-	30	0.9%	This outbreak is ongoing since the beginning of 2017. As of week 8 in 2018, a total of 48 326 cases including 563 deaths (CFR 1.2%) have been reported since the start of the outbreak. In 2018 only, 3 404 cases including 30 deaths (0.9%), were reported.
Democratic Republic of the Congo	Poliomyelitis (cVDPV2)	Ungraded	15-Feb-18	n/a	16-Feb-18	21	21	0	0.0%	On 13 February 2018, the Ministry of Health declared a public health emergency regarding 21 cases of vaccine-derived polio virus type 2. Three provinces have been affected, namely Haut-Lomami (8 cases), Maniema (2 cases) and Tanganyika (11 cases). The outbreak has been ongoing since February 2017 and the date of onset of paralysis in the last case was 3 December 2017.
Democratic Republic of Congo	Rabies	Ungraded	19-Feb-18	1-Jan-18	10-Feb-18	25	0	6	24.0%	This outbreak began toward the end of October 2017 in Kibua health district, North Kivu province. During Week 6 of 2018, three cases were reported.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Con-firmed cases	Deaths	CFR	Comments
Ethiopia	Humanitar-ian crisis	Protract-ed 3	15-Nov-15	n/a	28-Jan-18	-	-	-	-	The complex humanitarian crisis in Ethiopia continues into 2018. As of 28 January 2018, there were about 6.3 million people in need of health assistance, over 1.7 million people internally displaced, and over 900 000 refu-gees. Currently, Oromia region has 669 107 internally displaced people (IDPs) settled in various temporary sites and living with host communities in six zones over 43 woredas (districts).
Ethiopia	Acute watery diarrhoea (AWD)		15-Nov-15	1-Jan-17	21-Feb-18	48 912	-	880	1.8%	This outbreak has been ongoing since the beginning of 2017. Between January and December 2017, a cumulative total of 48 814 cases and 880 deaths (CFR 1.8%), have been reported from 9 regions. In 2018 only, a total of 98 cases have been reported from two regions, Somali and Dire Dawa regions.
Ethiopia	Measles		14-Jan-17	1-Jan-18	18-Feb-18	552	13	-	-	This is an ongoing outbreak since the begin-ning of 2017. Between January and December 2017, a cumulative total of 4 011 suspected measles cases have been reported across the country. In 2018 only, a total of 552 suspected cases including 191 confirmed cases, have been reported across the country. Most of the cases in 2018 have been reported from Somali region (28%), followed by Oromia (22%), SNNP (21%), and Addis Ababa (18%). Most affected groups are children under five years of age (32%) and children between 5 and 14 years old (43%).
Ghana	Lassa fever	Ungraded	1-Mar-18	27-Feb-18	2-Mar-18	1	1	1	100.0%	On 1 March 2018, WHO was notified of a confirmed case of Lassa fever. The index case was a 26 year-old, male who presented at a public hospital in Accra on 23 February 2018 with symptoms of general weakness, severe headache, joint pains, and vomiting of blood. On 23 February 2018, a blood sample was sent to the lab for confirmation; tested PCR positive on 26 February 2018. He died on 28 February 2018. All contacts have been listed and they are currently monitored.
Kenya	Chikun-gunya	Ungraded	mid-De-cember 2017	mid-De-cember 2017	26-Feb-18	841	36	0	0.0%	As of 26 February 2018, a total of 782 cases including 32 confirmed cases, were reported from Mombasa county and 59 cases including 4 confirmed cases have been reported from Lamu county.
Kenya	Cholera	G1	6-Mar-17	1-Jan-18	26-Feb-18	1 476	34	29	2.0%	The outbreak in Kenya is ongoing since 2017. Between 1 January 2017 and 07 December 2017, a cumulative total of 4 079 cases with have been reported from 21 Counties (data until 31 December 2017 not available). In 2018, a total of 1 476 cases have been reported as since the first of January. Currently, the outbreak is active in 6 counties: Garissa, Siaya, Tharaka Nithi, Meru, Tana River, and Turkana counties. The outbreak was recently controlled in Mombasa, Kirinyaga, and Siaya.
Kenya	Measles	Ungraded	19-Feb-18	19-Feb-18	26-Feb-18	24	6	0	0.0%	The outbreak is located in Wajir County. Date of onset of the index case was on 15 Decem-ber 2017. As of 26 February, the outbreak has spread to four villages in Wajir East. Most of the affected persons had unknown vaccina-tion status (79%). The affected sub-county was not part of the response campaign conducted in 2017.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Liberia	Meningococcal disease	Ungraded	19-Jan-18	23-Dec-17	29-Jan-18	9	2	4	44.4%	A cluster of undiagnosed illness and deaths were reported from Lofa county, northeastern Liberia. Samples taken from two suspected cases were positive for *Neisseria meningitidis* serogroup W. All seven samples collected as of 29 January were negative for Ebola and Lassa fever viruses by PCR, negative for yellow fever by serology (IgM), and negative for typhoid by WDAL. Additional testing is ongoing.
Liberia	Measles	Ungraded	24-Sep-17	1-Jan-18	3-Dec-17	1 375	69	-	-	From week 1 to week 48 of 2017, 1 607 cases were reported from 15 counties, including 225 laboratory confirmed, 336 clinically compatible and 199 epi-linked. From week 1 to week 8 of 2018, 1 375 cases have been reported.
Liberia	Lassa fever	Ungraded	14-Nov-17	1-Jan-18	12-Mar-18	42	7	14	33.3%	Detailed update given above.
Liberia	Scabies	Ungraded	11-Jan-18	11-Dec-17	18-Jan-18	10 850	17	0	0.0%	A total of 10 850 cases have been reported from five counties: Montserrado (9 647), Grand Bassa (687), Rivercess (315), Margibi (185), and Bong (16). All 17 confirmed cases have been reported from Montserrado county.
Madagascar	Plague	G2	13-Sep-17	13-Sep-17	22-Feb-18	2 655	552	237	8.9%	Cases include pneumonic (2 025, 76%), bubonic (424, 16%), septicaemic (1) and unspecified (205, 8%) forms of disease. Of the 2 025 clinical cases of pneumonic plague, 401 (20%) have been confirmed, 639 (32%) are probable and 985 (49%) remain suspected. The trend in the number of cases has been decreasing since 10 October 2017.
Malawi	Cholera	Ungraded	28-Nov-17	20-Nov-17	14-Mar-18	759	84	23	3.0%	Detailed update given above.
Mali	Humanitarian crisis	Protracted 1	n/a	n/a	19-Nov-17	-	-	-	-	The security situation remains volatile in the north and centre of the country. At the last update, incidents of violence had been perpetrated against civilians, humanitarian workers, and political-administrative authorities.
Mali	Measles	Ungraded	20-Feb-18	1-Jan-18	11-Feb-18	109	49	0	0.0%	A total of five health districts have reached the epidemic threshold (Ansongo, Bandiagara, Douentza, Kadiolo, and Yanfolila). Forty-nine samples were confirmed positive by serology (IgM) at the national reference laboratory INRSP.
Mauritania	Dengue haemorrhagic fever	Ungraded	30-Nov-17	6-Dec-17	22-Feb-18	307	165	-	-	In November 2017, the MoH notified 3 cases of dengue fever including one haemorrhagic case (Dengue virus type 2) with a history of Dengue virus type 1 infection in 2016. As of 10 February, the national reference laboratory confirmed the diagnosis of 165 out of 307 RDT positive samples. Dengue type 1 and type 2 are circulating in the country with a higher proportion of subtype 2 (104/165).
Mozambique	Cholera	G1	27-Oct-17	12-Aug-17	15-Mar-18	2 147	-	5	0.2%	The cholera outbreak is ongoing. Cases have been reported from two provinces; Nampula (1 635 cases and one death) and Cabo Delgado (512 cases and 4 deaths) provinces. This outbreak started in mid-August 2017 from Memba district, Nampula Province and Cabo Delgado Province started reporting cases from week 1 of 2018. No cases have been reported from Erati and Nacrpoua districts since the first week of January.
Namibia	Hepatitis E	Ungraded	18-Dec-17	8-Sep-17	11-Mar-18	957	100	10	1.0%	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	Humanitarian crisis	G2	1-Feb-15	1-Feb-15	16-Feb-18	-	-	-	-	The humanitarian situation in Niger remains complex. The state of emergency has been effective in Tillabéry and Tahoua Regions since 3 March 2017. Security incidents continue to be reported in the south-east and north-west part of the country. This has disrupted humanitarian access in several localities in the region, leading to the suspension of relief activities, including mobile clinics.
Nigeria	Humanitarian crisis	Protracted 3	10-Oct-16	n/a	31-Jan-18	-	-	-	-	Conflict and insecurity in the north east of Nigeria remain a concern and resulted in a large scale of displacement. Most affected areas recently are along the axis from Monguno to Maiduguri, namely in Gasarwa, Gajiram, Gajigana, Tungushe, and Tungushe Ngor towns. Initial estimates for the number of IDPs in recent months is between 20 000 and 36 000; many are in dire need of humanitarian services.
Nigeria	Cholera (nation wide)	Ungraded	7-Jun-17	1-Jan-18	4-Feb-18	172	1	13	7.6%	The is an ongoing outbreak since the beginning of 2017. Between 1 January and 31 December 2017, a cumulative total of 4 221 suspected cholera cases and 107 deaths (CFR 2.53%), including 60 laboratory-confirmed were reported from 87 LGAs in 20 States. Between weeks 1 and 5 of 2018, 172 suspected cases including one laboratory-confirmed case and 13 deaths (CFR 7.56%), have been reported from 23 LGAs in 7 States.
Nigeria	Lassa fever	G2	24-Mar-15	1-Jan-18	11-Mar-18	1 386	365	114	8.2%	A total of 1 386 suspected cases and 114 deaths have been reported from 19 active states: Anambra, Bauchi, Benue, Delta, Ebonyi, Edo, Ekiti, Gombe, Imo, Kaduna, Kogi, Lagos, Nasarawa, Ondo, Osun, Plateau, Rivers, Taraba, and the Federal Capital Territory (FCT). Sixteen healthcare workers have been affected in six states: Ebonyi (9), Edo (3), Benue (1), Kogi (1), Nasarawa (1), and Ondo (1). A total of 1022 cases including 127 deaths were reported from week 49 of 2016 to week 51 of 2017.
Nigeria	Hepatitis E	Ungraded	18-Jun-17	1-May-17	31-Dec-17	1 651	182	8	0.6%	The number of cases has been decreasing since week 51. Forty-three new cases were reported in Kala/Balge LGA in week 52 (ending 31 December 2017).
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	7-Mar-18	1 449	96	46	3.2%	A total of 1 449 cases have been reported from 30 states: Abia, Borno, Kogi, Kwara, Kebbi, Plateau, Zamfara, Enugu, Oyo, Anambra, Edo, Lagos, Kano, Nasarawa, Katsina, Niger, Bayelsa, Rivers, Cross Rivers, Kaduna, Sokoto, Jigawa Imo, Delta State, Akwa Ibom, Ebonyi, Ekiti, FCT Abuja, Ogun, Ondo and Osun State). Ninety-six cases from seven states (Kwara, Kogi, Kano, Zamfara, Kebbi, Nasarawa, and Niger) have been laboratory-confirmed at IP Dakar.
Nigeria	Monkeypox	Ungraded	26-Sep-17	24-Sep-17	22-Dec-17	197	68	2	1.0%	Suspected cases are geographically spread across 22 states and the Federal Capital Territory (FCT). Sixty-eight laboratory-confirmed cases have been reported from 14 states/territories (Akwa Ibom, Abia, Bayelsa, Benue, Cross River, Delta, Edo, Ekiti, Enugu, Lagos, Imo, Nasarawa, Rivers, and FCT).

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Con-firmed cases	Deaths	CFR	Comments
Nigeria	Meningitis	Ungraded	26-Dec-17	1-Sep-18	6-Mar-18	1 157	128	141	12.2%	Cases have been reported from 15 states: Zamfara (539), Katsina (245), Sokoto (129), Jigawa (51), Yobe (50), Niger (39), Cross River (25), Kebbi (25), Bauchi (20), Kano (21), Gombe (3), Plateau (4), Borno (3), Adamawa (2) and Kaduna (1). As of 6 March 2018, 128 (37.9%) of 337 samples tested were positive for bacterial meningitis, including 78 (60.9%) positive for *Neisseria meningitides* serogroup C (NmC).
São Tomé and Principé	Necrotising cellulitis/ fasciitis	Protract-ed 2	10-Jan-17	25-Sep-16	17-Feb-18	2 471	0	0	0.0%	From week 40 in 2016 to week 7 in 2018, a total of 2444 cases has been notified. In week 7, 16 cases were notified from five districts. The case rate of necrotising cellulitis in Sao Tome and Príncipe is 12.4 cases per 1000 inhabitants.
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	21-Jan-18	4 445	1 429	-	-	A total of 4 445 cases have been reported from all regions of the three main islands (Mahé, Praslin, and La Digue). The trend in the number of cases has been decreasing since week 23.
South Africa	Listeriosis	G1	6-Dec-17	4-Dec-17	14-Mar-18	978	978	183	18.7%	This outbreak is ongoing since the beginning of 2017. A total of 748 laboratory-confirmed listeriosis cases were reported in 2017, and 230 cases in 2018. Around 80% of cases are reported from three provinces; Gauteng, Western Cape, and KwaZulu-Natal provinc-es. Following the source identification; the national authorities with support from WHO and other partners, have taken measures to limit further infections and associated mor-tality including but not limited to the issuance of safety recall notices, compliance notices, and measures related to exportation of impli-cated products, and risk communication with vulnerable groups.
South Africa	Cholera	Ungraded	26-Feb-18	6-Mar-18	10-Mar-18	1	1	0	0.0%	The index case is a 37 years-old female from the border district of Umkhanyakude, in KwaZulu-Natal province. She presented at the clinic on 7 February 2018 with severe abdominal pains, diarrhoea, vomiting, and se-vere dehydration. *Vibrio Cholerare* 01 Ogawa was confirmed by the National Institute of Communicable Diseases (NICD), Centre for Enteric Diseases on 15 February 2018. The patient had no travel history. No other cases were reported.
South Sudan	Humanitar-ian crisis	G3	15-Aug-16	n/a	11-Mar-18	-	-	-	-	The security situation across the country re-mains unpredictable with reports tribal clash-es and cattle raiding in various locations. This limited the access to the affected communities as well as delivering humanitarian assistance.
South Sudan	Rift Valley fever (RVF)	Ungraded	28-Dec-17	7-Dec-17	9-Mar-18	40	6	4	10.0%	As of 9 March 2018, 40 suspected cases of Rift Valley fever have been reported from Yirol East (37) and Yirol West (3) counties of the Eastern Lakes State, including six confirmed human cases (one IgG and IgM positive and five IgG only positive), three cases who died and were classified as probable cases with epidemiological links to the three confirmed cases, 19 were classified as non-cases follow-ing negative laboratory results for RVF (PCR and serology), and samples from 12 suspected cases are pending complete laboratory testing. A total of four cases have died, including the three initial cases and one suspect case who tested positive for malaria (case fatality rate: 10.0%).

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Con-firmed cases	Deaths	CFR	Comments
Tanzania	Cholera	G1	20-Aug-15	1-Jan-18	11-Mar-18	1 440	-	27	1.9%	This is part of an ongoing outbreak. From week 1 to 10 of 2018, a total of 1 440 cases with 27 deaths (CFR: 1.9%) were reported from Tanzania Mainland, no case was reported from Zanzibar. The last case reported from Zanzibar was on 11 July 2017. The trend of reported cholera cases from Tanzania Mainland this week significantly decreased to 18 cases and no deaths compared to 116 cases and no deaths in week 9. In week 10 cases have been reported from two regions: Dodoma (12 cases) and Ruvuma (6 cases). Since the start of the outbreak on 15 August 2015, Tanzania mainland reported 30 046 cases including 493 deaths (CFR 1.6%) and Zanzibar reported 4 688 cases including 72 deaths (CFR 1.5%). In total, 34 734 cases including 565 deaths (CFR 1.6%) were reported for the United Republic of Tanzania.
Uganda	Humani-tarian crisis - refugee	Ungraded	20-Jul-17	n/a	2-Mar-18	-	-	-	-	The influx of refugees to Uganda has contin-ued as the security situation in the neighbour-ing countries remains fragile. Approximately 75% of the refugees are from South Sudan and 17% are from DRC. An increased trend of refugees coming from DRC was observed recently. Landing sites in Hoima district, particularly Sebarogo have been temporarily overcrowded. The number of new arrivals per day peaked at 3 875 people in mid-February 2018.
Uganda	Cholera	G1	15-Feb-18	12-Feb-18	15-Mar-18	1 695	18	36	2.1%	The outbreak of cholera in Hoima District continues to evolve. Three sub-counties in the district have been affected; Kabwoya, Buse-ruka, and Kyangwali. Since the beginning of March, there are on average; 25 new cases reported daily. Most of the new cases are from new arrives refugees from DRC.
Uganda	Measles	Ungraded	8-Aug-17	24-Apr-17	3-Oct-17	623	34	-	-	The outbreak is occurring in two urban districts: Kampala (310 cases) and Wakiso (313 cases).
Zambia	Cholera	G1	4-Oct-17	4-Oct-17	15-Mar-18	4 876	67	97	2.0%	On 15 March 2018, 40 new cases and no deaths were reported in Lusaka district. From other districts outside Lusaksa three new cases were reported, namely Kafue (2 cases) and Shibuyunji (1 case). Since the start of the outbreak, Lusaka district reported a total of 4 483 cases with 83 deaths; the cumulative number of cases from other districts is 393 with 14 deaths.
Zimbabwe	Cholera	Ungraded	22-Jan-18	8-Jan-18	13-Mar-18	111	13	4	3.6%	A cholera outbreak was declared in Chegutu Municipality in Mashonaland West Province in the first week of March 2018, following zero reported cases since the last case on 10 February 2018. On 8 of March 2018, a 12-year-old female from the capital Harare; was tested positive for cholera. Following the investigation; 21 asymptomatic individuals had rectal swabs taken for culture, and of these, 3 were positive for cholera making the total of confirmed cases to 4 cases. Between 8 January and 13 March 2018, a total of 111 cases and four deaths (CFR 3.6%°) were re-ported. Thirteen cases have been confirmed.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Con-firmed cases	Deaths	CFR	Comments
Zimbabwe	Typhoid fever	Ungraded	-	1-Oct-17	24-Feb-18	3 187	191	0	0.0%	Since the beginning of the outbreak in October 2017; a total of 3 187 cases including 191 confirmed cases have been reported. In 2018 alone, 1 094 cases were reported mainly from Mbare (438 cases) and Kuwadzana (205 cases). The outbreak has spread from its epi-centre in Matapi to other areas such as Mbare and Nenyere.
Recently closed events										
Benin	Lassa fever	Ungraded	13-Jan-18	8-Jan-18	5-Mar-18	24	5	9	37.5%	Twenty-four cases (5 confirmed, 3 probable and 16 suspected) including 9 deaths were reported from five departments: Atacora (9), Bourgou (8), Collines (4), Alibori (2), and Couffo (1). Three confirmed cases had a history of travel to Nigeria.
Uganda	Rift Valley fever (RVF)	Ungraded	22-Nov-17	14-Nov-17	12-Mar-18	9	6	5	55.6%	No new cases have been confirmed since 29 January 2018. The last confirmed case died on the same date. On 12 March 2018; 42 have passed since the death of the last confirmed case.
Uganda	Crime-an-Congo haemor-rhagic Fever (CCHF)	Ungraded	27-Dec-17	23-Dec-17	11-Mar-18	2	2	0	0.0%	No new cases have been confirmed since 6 January 2018. The last confirmed case was discharged on 28 January. On 11 March 2018, 42 days have passed since the discharge of the last case.

†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.

Correspondence on this publication may be directed to:
Dr Benido Impouma
Programme Area Manager, Health Information & Risk Assessment
WHO Health Emergencies Programme
WHO Regional Office for Africa
P O Box. 06 Cité du Djoué, Brazzaville, Congo
Email: afrooutbreak@who.int

Contributors
P. Mhata (Namibia)
O. Ogundiran (north-east Nigeria)
K. Msyamboza (Malawi)
G. Williams (Liberia)
C. Itama (Central African Republic)

Graphic design
Mr. A. Moussongo

Editorial Team
Dr. B. Impouma
Dr. C. Okot
Dr. E. Hamblion
Dr. B. Farham
Dr. V. Sodjinou
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Dr. I. Soce-Fall, *Regional Emergency Director*
Dr. B. Impouma
Dr. Z. Yoti
Dr. Y. Ali Ahmed
Dr. M. Yao
Dr. M. Djingarey

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

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