

AND OTHER EMERGENCIES

Week 10: 4 – 10 March 2017
Data as reported by 17:00 10 March

1

New Event

29

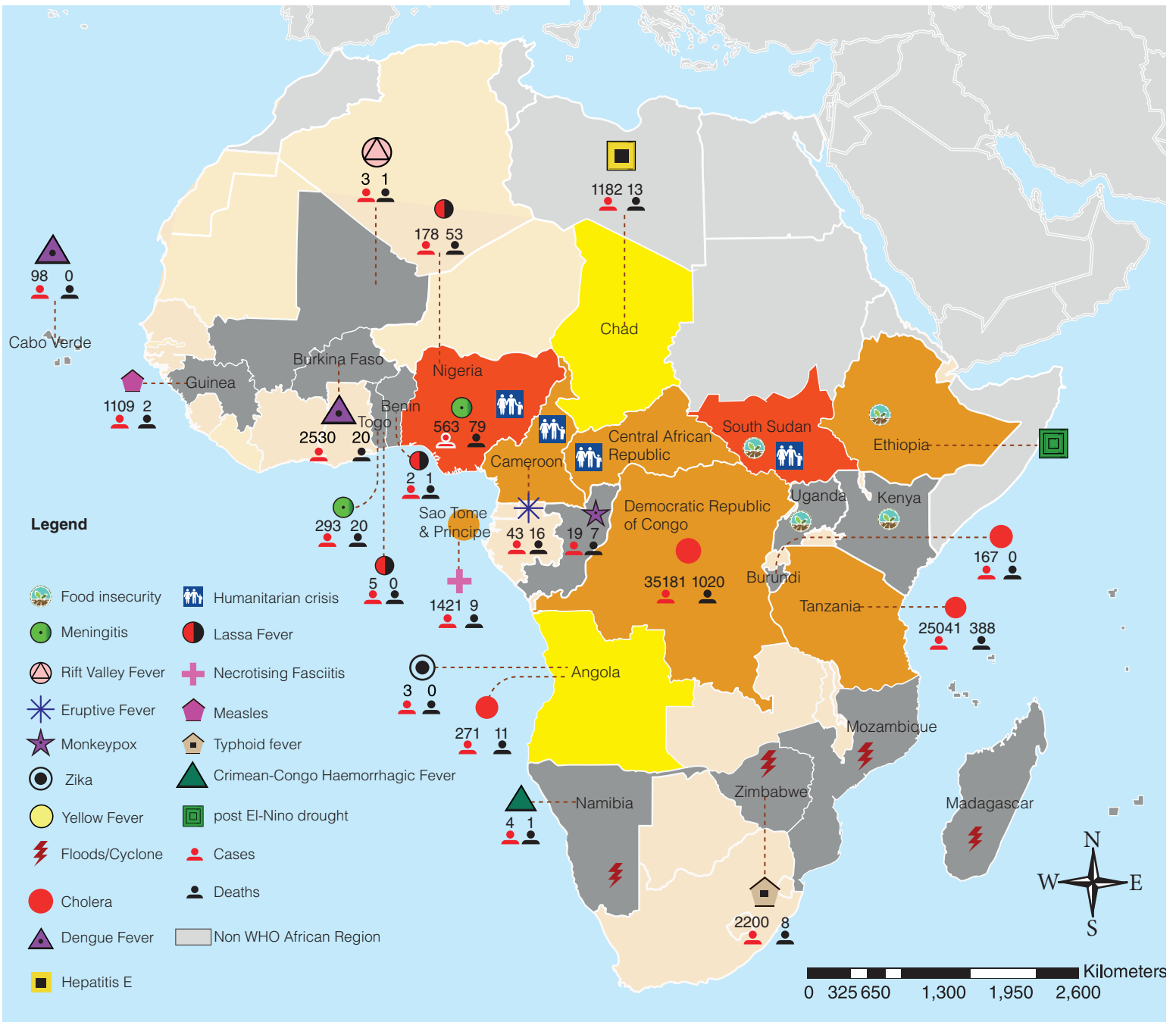
Ongoing events

21

Outbreaks

9

Humanitarian crises



2

6

2

20

Kilometers
0 325 650 1,300 1,950 2,600

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- This weekly update focuses on selected acute public health emergencies occurring in the WHO African region. WHO AFRO is currently monitoring 30 events, two at Grade 3, six at Grade 2, two at Grade 1 and twenty ungraded events.
- This week one new event is reported: a Cyclone in Madagascar
- The update also focuses on key ongoing events in the region, namely the two grade 3 humanitarian crises in Nigeria and South Sudan as well as outbreaks of Necrotising Cellulitis/Fasciitis in Sao Tome and Principe, Hepatitis E in Chad, Cholera in Democratic Republic of Congo, Monkeypox in Congo, Measles in Guinea and the pre-famine situation affecting a number of countries in the Horn of Africa.
- For each of these events, a brief description followed by the public health measures implemented and an interpretation of the situation is provided.
- A table is provided at the end of the report with information on all public health events currently being monitored.
- Major challenges to be addressed include:
 - Inadequate preparedness activities and IHR capacities leading to delayed response to some outbreaks and emergencies
 - The need for co-ordinated multi-partner and multi-sector responses to address all determinants.

New events

Cyclone Enawo

Madagascar

Event description

On 7 March 2017 Cyclone Enawo hit north east Madagascar and moved to the south of the country. It has affected 21 health districts in the north, impacted a total of 4000 people including 6 deaths.

Public health response

- Prior to the event, WHO Madagascar supported the country to preposition emergency medical kits in the most at risk areas and secured funds for the quick purchase of drugs and other logistics.
- MoH requested technical and financial support from partners. Since the cyclone reached the country, WHO, as the lead of Health Cluster, is providing support to the MoH to (i) assess the health needs, (ii) coordinate the response interventions and (iii) make available drugs and other needed logistics for case management.
- WHO AFRO is shipping five kits inter-agency emergency health kits to support the response.
- A disaster evaluation missions, by plane, will take place from 10 to 11 March to fully assess the extent of the damage.

Situation interpretation

The country experienced a similar cyclone in 2007 with 100,000 people affected and 80 deaths as well as the loss of three health centres and severe damage to a further forty-eight. The consequences of this cyclone appear lower than expected, likely as a result of preparedness interventions implemented, especially the community engagement for the adherence of mitigation measures. Although it should be noted that the real magnitude will not be known until after the evaluation mission. In addition the disaster management plan is not finalized and required resources are not properly estimated. More details will be provided once available.

Event description

The measles outbreak in Guinea, which started in epi week 2 (week ending 15 January 2017) and declared by the Ministry of Health on 8 February 2017, is still going on. A total of 239 new cases were reported in the week ending 12 March 2017. As of 8 March 2017, a cumulative of 2,142 suspected and confirmed cases including six deaths [case fatality rate (CFR) of 0.28%] were reported from 37 districts. One hundred and sixty-eight (168) cases have been confirmed by the National Reference Laboratory in Conakry. The most affected age-group range from 9 months to 15 years.

Public health actions

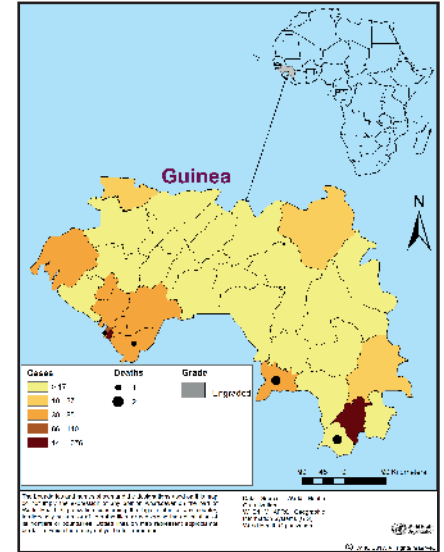
- WHO has deployed a team of experts to carry out detailed risk assessment and support the national response efforts. The team is working with the national authorities and partners to estimate the vaccine requirements, prepare request for vaccines, support micro-planning and implementation of reactive vaccination campaign.
- Outbreak coordination mechanisms have been established at the national level and in all the affected districts.
- Active surveillance including daily reporting and clinical management of case-patients are being strengthened.
- A comprehensive outbreak response plan and rapid risk analysis are being finalized.

Situation interpretation

According to WHO estimate, routine measles immunization coverage in Guinea ranged from 52 % to 62 % between 2011 and 2015. This low immunization coverage was exacerbated by the disruption of health care services delivery during the Ebola epidemic. Consequently, the number of unvaccinated susceptible children peaked up, resulting in the current measles outbreak. Provisional estimate shows that up to 3,631,335 children aged 6 months to 10 years should be targeted for measles vaccination. This requires a total of 4,284,976 doses of measles vaccines and the entire exercise has been estimated to cost USD 5,378,926. The major challenge at hand is to mobilize the required resources to conduct the reactive immunization campaign.

It is critical that the planned reactive measles vaccination campaign is conducted swiftly to contain and avert wider spread of the disease. Partners are urged to support preparation and micro-planning for the reactive campaign in the targeted districts in order to achieve high coverage. In the medium to long term, concrete strategy and plans should be developed to conduct catch-up immunization and strengthen routine immunization activities.

Geographical distribution of Measles cases reported in Guinea, 15 January - 12 March 2017.



Monkeypox

Congo

19
Cases

7
Deaths

36.8%
CFR

Event description

On 1 February 2017, the Congo Ministry of Health and Population (MOHP) notified WHO of an outbreak of monkeypox in Likouala province, located in the northern part of the country. The outbreak originated in Betou district on 16 January 2017 when the index case, a male hunter, developed illness. Subsequent cases emerged from three other districts between 27 January and 28 February 2017. As of 28 February 2017, a total of 19 cases including 7 deaths [case fatality rate (CFR) 36.8%] were reported from four (4) districts. Two (2) samples obtained from the suspected cases tested positive for monkeypox by PCR at the Institut National de Recherche Biomédicale (INRB), Kinshasa. Two additional samples are being analyzed.

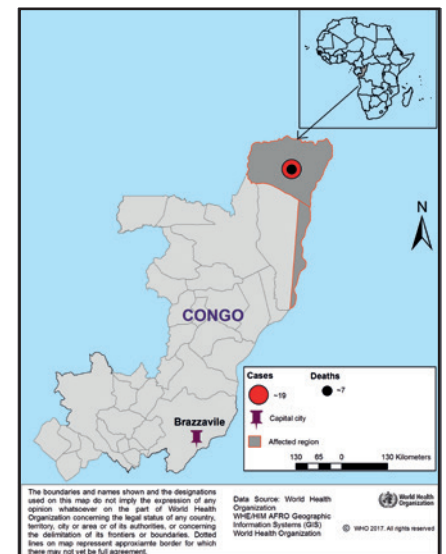
Public health actions

- A multi-sectoral epidemic management committee has been reactivated and an outbreak response plan is being developed.
- The national rapid response team comprising of MoHP, HCR and WHO was deployed to conduct outbreak investigation and risk assessment. The team also supported initial response measures such as strengthening local coordination mechanism, enhancing laboratory confirmation, and reinforcing social mobilization, infection prevention and control, and active surveillance including contact tracing and follow-up.
- WHO provided 200 sets of personal protective equipment (PPE) while HCR provided logistics for patients' isolation and clinical management.

Situation interpretation

Monkeypox is a zoonotic disease indigenous to Central Africa. In humans, the disease is similar to smallpox, though milder. The current monkey pox outbreak in Congo is occurring in areas/districts that experienced similar outbreaks in 2010. The high CFR of 36.8% (7/19) is a cause for serious concern for public health. Increased population movement and existence of refugees in the affected sub-region appears to be one of the predisposing factors for the spread of the outbreak. While the risk of a large and protracted outbreak is low, limited public health infrastructure, weak surveillance system coupled with shortage of financial resources remain potential challenges for effective containment of the outbreak. Immediate finalization of the response plan and mobilization

Geographical distribution of Monkeypox cases reported in the Republic of Congo, 01 February - 28 February 2017.



Event description

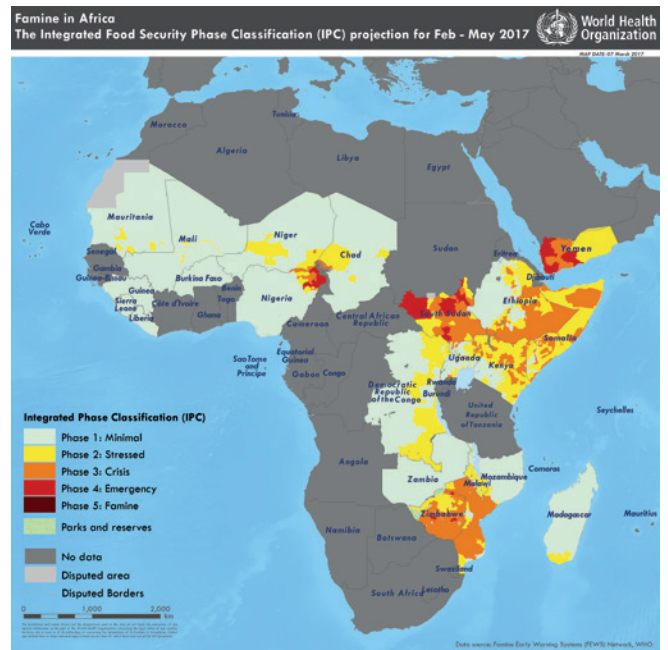
A deteriorating pre-famine humanitarian crisis is evolving in three countries in the Horn of Africa (Ethiopia, Kenya and Uganda); while the North Eastern part of Nigeria and South Sudan are already experiencing famine. It is estimated that close to 20 million people in the 5 countries in the African region [Ethiopia (5.6 million), Kenya (2 million), Nigeria (5.1 million), South Sudan (4.9 million), and Uganda (1.3 million)] are in need of relief food assistance. In addition, about 1 million children are suffering from severe acute malnutrition. The prolonged drought in these countries has predisposed the populations already facing severe food shortage to outbreaks of water-related diseases such cholera.

Public health actions

- A WHO multidisciplinary team is deployed to South Sudan to develop the health sector response. In addition, 1 subnational Health Cluster Coordinator has been deployed to the Regional Health Hub to support coordination of partners in the response.
- Urgent action should be taken to mobilize additional resource to fill the funding gap for the implementation of the 2017 action plan (USD 8.5m).
- There is need to strengthen nutrition surveillance to improve analysis and monitoring of the nutrition situation.

Situation interpretation

The adverse climatic conditions including prolonged droughts and El-Nino and the protracted conflict in South Sudan led to food insecurity, malnutrition, deteriorating water and sanitation situation, water-borne disease outbreaks, and loss of pasture and animal deaths. The food insecurity and famine situation is bound to worsen in the coming months given the fact that no meaningful cultivation has yet begun. Urgent multi-sectoral humanitarian assistance is needed at this time to avert deterioration of the pre-famine situation.



Hepatitis E

Chad

1182
Cases

13
Deaths

1.1%
CFR

Event description

WHO was notified of a Hepatitis E outbreak in Salamat region Chad in September 2016. As of 05 March 2017 there are 1182 suspected cases of acute jaundice syndrome (5 confirmed) and 13 deaths (CFR 1.1%) reported since week ending 3 September 2016. In week ending 5 March, 53 suspected cases and 0 death were reported. There has been a weekly decrease in the number of cases reported since week ending 19 February when 91 cases were reported.

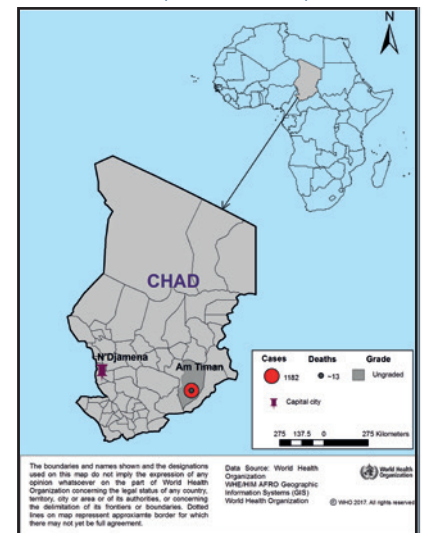
Public health actions

- The MOH is organising and coordinating the response with the support of WHO and other partners including UNICEF, MSF and local NGOs.
- A WHO emergency specialist and anthropologist departed for the affected area on 05 March in order to strengthen coordination and engage with communities on the benefits of chlorinated water which they are currently refusing to drink.
- WHO is scaling up deployment of experts to intensify the response efforts.

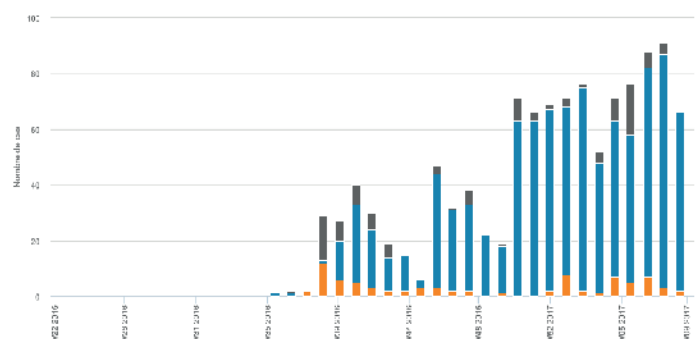
Situation interpretation

Low levels of sanitation, safe drinking water supplies, and poor community understanding of the risk factors for hepatitis E contribute to the persistence and spread of the epidemic. Surveillance and case management activities are well covered, compared to WASH (water, sanitation and hygiene) activities and outreach. Therefore a WASH expert and an expert in social mobilization, risk communication and community involvement are urgently needed in the country to assist in the control efforts. Monies from the Contingency Fund for Emergencies (CFE) (USD\$100,000) have been made available to the country, but additional local resources are needed to support the activities of teams involved in managing the epidemic. A concerted effort is required by all partners to mitigate the impact of this outbreak.

Geographical distribution of Hepatitis E cases reported in Chad, 2015 epi week 1 - 2017 epi week 8



Number of Hepatitis E cases reported in the Chad, 2015 epi week 1 - 2017 epi week 8



Event description

The Democratic Republic of Congo (DRC) has been experiencing recurrent cholera outbreaks since 2015. A pattern of cholera transmission has developed which demarcates the country into two groups of provinces. One group of provinces (A) has experienced episodic/ sporadic outbreaks, while outbreaks in the other (B) have been known, over the last couple of decades, to be protracted.

Group A consists of 12 provinces, namely Lualaba, Nord Oubangui, Sud Oubangui, Manhema, Tshopo, Bas-uele, Mongala, Equateur, Maindombe, Tshuapa and Kongo Central provinces, including the capital Kinshasa with an estimated population of 31.6 million inhabitants.

Group B is composed of the following 6 provinces: Haut-Katanga, Haut-Lomami, Ituri, Nord-Kivu, Sud-Kivu and Tanganyika provinces with an estimated total population of 36.3 million inhabitants.

Between the beginning of January and March 3, 2017 Cholera outbreaks have been reported in 15 out of 18 provinces. The total number of cases and deaths is 5829 and 203 (CFR 3.5%). Of the 15 provinces, 9 of these belong to Group A and have reported 2988 cases including 126 deaths (CFR 4.2%). These reporting Group A provinces are Manhema, Tshopo, Bas-uele, Mongala, Equateur, Maindombe, Tshuapa and Kongo Central and Kinshasa. All 6 group B provinces have reported cases totalling 2841 cases including 77 deaths (CFR 2.7%).

Public health actions

WHO is proposing an in-depth review of the ongoing response and critical analysis of the outbreak data and information to serve as a basis to mobilize all sectors and partners to scale up funding and the response efforts. Amongst group B provinces where there has been consistent cholera transmission, instability due to internal hostilities continue to impede interventions. The vast geographical dispersion of the population in this group also poses a challenge, including island and wharf communities. As of the beginning of 2017, partners have contributed funding, human resources and technical assistance for the response, with WHO coordinating. The epidemic is now controlled in 3 group A provinces which have not reported cases as of week 8 (week ending 26 February): These provinces include Kinshasa, Kongo Central and Tshuapa.

Situation interpretation

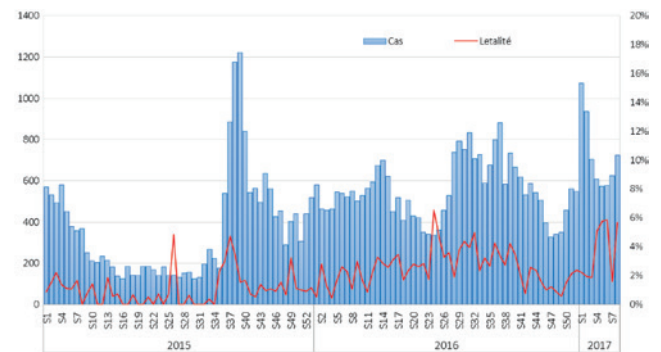
The pattern of cholera transmission in the two categories of provinces illustrates the need for targeted interventions and exploration of barriers, both environmental and behavioural. It is also necessary to ensure that group B provinces with protracted outbreaks do not become a constant source of infection to group A provinces. As such, DRC's plans for OCV implementation should be supported to ensure immunity protection, particularly for the Group A provinces. The population at risk in group A provinces 8 million and 6 million amongst group B provinces.

Amongst group B provinces, socio-political unrest needs to be addressed to allow interventions to proceed effectively. Without a peacebuilding, it is likely that we will continue to see protracted outbreaks of cholera and other diseases.

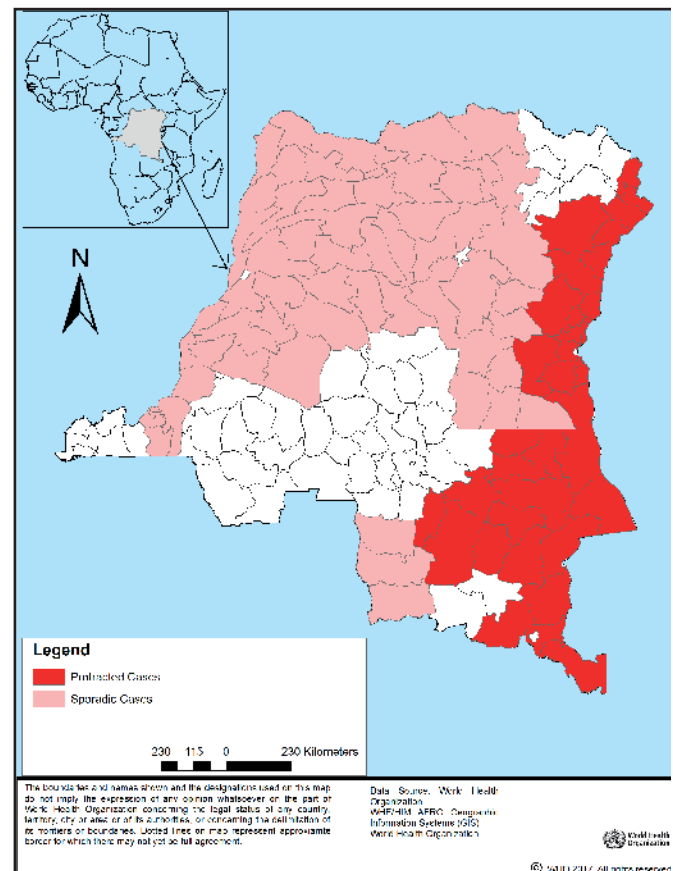
To engage the WASH sector, WHO assisted with the coordination of the development of the joint partner plan. The plan was established in conjunction with WASH partners: UNICEF, MSF, OXFAM GB and other International NGOs, like IMC, Solidarités International, ADRA and CARITAS Allemagne who have worked as part of the government's response plan to fight cholera. WHO also assisted in strengthening coordination of the response under the leadership of the Ministry of Health with regular meetings at national and provincial levels, organization of weekly teleconferences with affected provinces. These regular meetings include WASH partners. Where WHO identified gaps, measures were put in place to address them. These include:

- Procurement and distribution of 1000 carton of water purification tablets (containing 240 tablets each). These have been distributed in the provinces along the Congo River Mongala and Equateur (both group A) where there are fewer partners present.
- Temporary WASH experts sent to analyse and support the WASH response. Support of capacity building for health workers.
- Logistics support for case management through the construction of Maluku Cholera Treatment Centre and provision of logistics for chlorination and access to potable water.

Number of Cholera cases reported in the Democratic Republic of Congo, 2015 epi week 1 - 2017 epi week 8



Geographical distribution of protracted and sporadic Cholera outbreaks by district reported in the Democratic Republic of Congo, 2015 epi week 1 - 2017 epi week 8



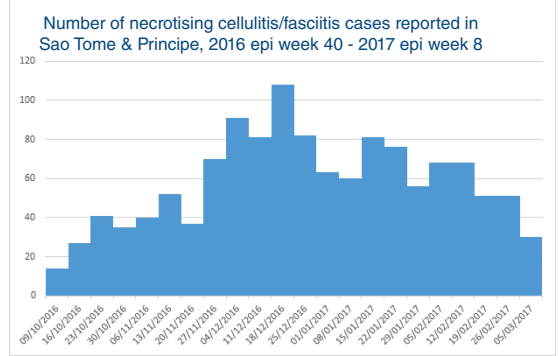
The necrotizing cellulitis/fasciitis disease outbreak in Sao Tome and Principe was reported to WHO on 24 January 2017 with cases reported since September 2016. As of 5 March 2017, a total of 1,421 cases with 9 deaths from associated pathologies have been reported with all seven districts having reported cases. The overall attack rate (AR) is 7.0/1000 inhabitants in a population of 193,711, variations are seen by district. The most affected being Caue (south) with an AR of 19.4/1000, Lembá 12.5/1000 and Lobata (north) with 7.9. The least affected health district is the island of Príncipe with an AR of 1.7/1000 inhabitants. Males appear to be more affected than females (57%:43%). 30 cases were reported in week ending 5 March, a 40% decline compared to the previous two weeks.

Public health actions

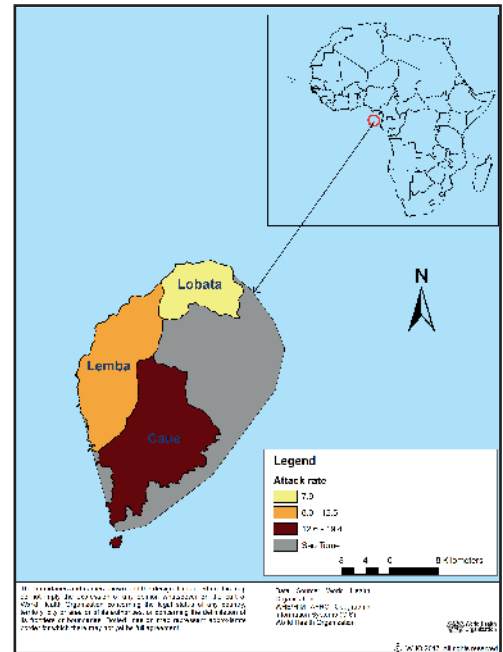
- WHO continues to scale up the response to this outbreak to support MOH by deploying additional technical expertise, initiating a co-ordination mechanism and determining the causative organism.
- Five experts covering epidemiology, laboratory and microbiology identified by GOARN are being deployed to support the WHO Country office this week, in addition to the personnel who arrived last week.
- A support team (Finance, Admin and HR) will be deployed this weekend from the WHO Inter Country Support Team West
- Two WHO epidemiologists are currently in country undertaking further investigations. The case definition has been defined and agreed by the MoH. Active case search for those in the early stage of infection is being carried out. A case control study is being implemented to identify the risk factors for the disease.
- The dermatologist and infectious disease specialist examined patients at different stages of the disease and determined that patients present with various and different types of skin ulcerations and frequently indicated the use of anti-inflammatories due to the pain.
- A UK lab team is being deployed this week to support the identification of the causal agent.

Situation interpretation

The scale up of the response to this outbreak is essential. There are a number of urgent needs that need to be addressed in order to control the outbreak, particularly the verification of the causative organism and mode of transmission which will guide measures to be implemented. Early identification of cases is being prioritised in order to minimise recovery time, as well as the health benefits this will also assist in minimising the socio-economic to the individual, their families and the country.



Geographical distribution of Necrotising Cellulitis/fasciitis cases reported in Sao Tome & Principe, 2016 epi week 40 - 2017 epi week 8



Humanitarian crisis

South Sudan

Event description

The protracted humanitarian crisis continues with severe food shortages and insecurity. According to recent Integrated food security phase classification (IPC) update, a population of 4.9 million are in need of food and nutrition assistance. This number is expected to rise to 5.5 million by July 2017. In former Unity State the nutrition status is classified as very critical (Global Acute Malnutrition (GAM)>30% and Severe Acute Malnutrition (SAM) about 10%) with Leer, Mayendit and Koch as the most affected counties. Volatility of the security situation continues to impede delivery of health services and emergency responses. As a result, there have been correlated protracted measles and cholera outbreaks.

The weekly number of Cholera cases continues on a downtrend from a peak in mid-2016. Cumulatively, 5574 cases including 137 deaths (CFR 2.46%) have been reported, and there is an increase of 15 cases compared to 75 in week 9, 2017. The new cases are distributed between Yirol East (13) and Malakal Town (2 cases).

Public health actions

- Three rapid response teams (RRT) have been deployed by the Ministry of Health with support from WHO to support the cholera response in Bor, Mingkaman and Yirol East.
- An emergency oral cholera vaccination (OCV) campaign, led by MSF, has been approved for Malakal Town with a target population of 16,500.
- 475,020 doses of OCV were approved by the International Coordinating Group for OCV to be used in two-dose campaigns in Bentiu PoC, Mingkaman IDP settlement and Bor PoC.
- Preliminary data show at least 30,772 people aged more than 1 year were vaccinated with OCV by MedAir in Leer Town, Thonyor, and Padeah, Leer county during the WFP Food count registration from 24-26 February 2017
- A stakeholder meeting to develop a plan on rational use of OCV alongside other tools like WASH and social mobilization was conducted in Juba from 8-9 March, 2017.

Situation interpretation

While cholera cases are still being reported, the number of cases reported weekly continues to decrease, highlighting the success of response measures implemented. However, risk factors that could continue to drive transmission are still present and need to be addressed. These include use of untreated water from the River Nile, household drinking and tank water. This has been difficult to address due to the worsening economic situation and influxes of internally displaced persons in affected areas. The substantial increase in the cost of safe water from water trucks has become a prohibitive factor that has forced household to use unsafe water sources. There is need to secure unsafe water sources to interrupt transmission along with continued efforts ensuring the population has access to safe water.

The humanitarian crisis in north-east Nigeria has evolved over the years leading to widespread displacement and devastation and a desperate shortage of essential health care. As of 3 March almost 6 million people are in need with 1.9 million internally displaced persons (IDPs). Out of these, Borno county alone has 1.5 million IDPs and the numbers in camps are increasing. The ongoing conflict has had a serious impact on the availability of appropriate health care. Malaria, Acute Respiratory Infection, Acute Watery Diarrhoea, and Severe Acute Malnutrition cause the highest morbidity burden, while Maternal and Neonatal deaths and malnutrition account for the highest mortality. The area is also experiencing a number of outbreaks including meningitis and Lassa fever. On 01 March 2017, Borno State confirmed an outbreak of Lassa fever in Zabarmari, Jere LGA, it's first in almost five decades.

Public health actions

- The health sector partners under the leadership of the World Health Organization, ratified it's 2017 humanitarian response strategy at a workshop held in Maiduguri on 28 February 2017.
- A visit by the UN Security Council to the crisis affected Lake Chad Region was concluded on 06 March 2017 in Nigeria after previously being in Cameroon, Chad and Niger. The Council emphasized that "barely enough is being done" to aid the crisis in the Lake Chad Basin.
- The Independent Oversight and Advisory Committee field visit was concluded on 06 March 2017 and a final report is pending
- A draft cholera preparedness plan has been developed with the MOH and other partners.
- WHO has taken a number of actions in support of the government's efforts to contain the Lassa fever outbreak. This includes rapid training on clinical case management, contact tracing, mobilizing a network of healthcare workers at the hospital, building public awareness, supplying personal protective equipment, decontamination supplies, infrared thermometers as well as medical and laboratory supplies. Clinical monitoring of the identified 59 contacts in Borno State is also on-going.
- In the last Early Warning, Alert and Response System (EWARS) report received a total of 98 out of 160 reporting sites (including 26 IDP camps) in 13 LGAs submitted their weekly reports. Completeness of reporting was 61% and timeliness was 64% (target 80% respectively). Nineteen indicator-based alerts were received and 68% was verified.
- The WHO AFRO incident management system is transitioning to emergency coordination and recovery with adjusted terms of reference and budgeted work plan.

Situation interpretation

The security situation continues to have a severe impact on the health care system. There are some difficulties in recruiting and retaining experienced staff for the response. There is need to increase overall support to the health sector and WHO, including reinforcing the human resources in Abuja and field locations.

There remains limited funding available for the immediate health sector humanitarian response and the longer term early recovery as the health aspects of the crisis are still not gaining the required attention. WHO has only 19% of funding available for the appeal, and the health sector has only 3% of the funding it requires. Current declarations and trends regarding the risk of famine in some countries of sub Saharan Africa (including parts of Nigeria) present an opportunity to more clearly highlight the situation to a wider audience. A medium to long term health sector strategy and operational document needs to be finalised with a view to mobilising increased resources from donors.

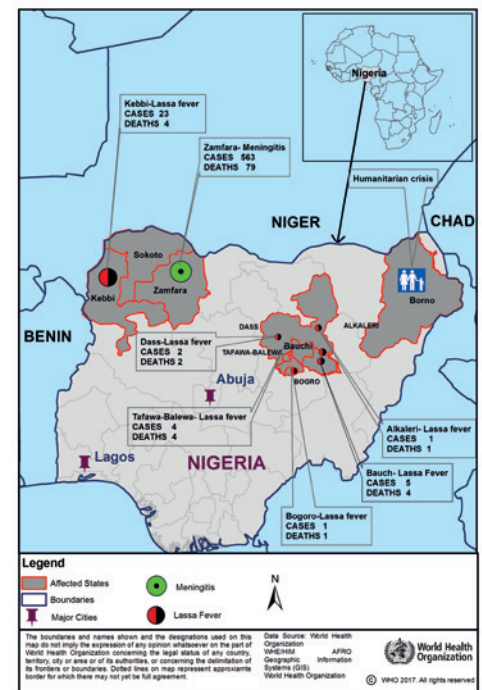
Summary of major challenges and proposed actions

Challenges

- The importance of preparedness interventions to mitigate consequences of outbreaks or emergencies is highlighted in effective preparation to the Cyclone in Madagascar which lowered the potential impact. However the opposite is seen in other situations such as the large measles outbreak in Guinea where the low vaccination coverage has led to a large wide ranging measles outbreak.
- Limited public health infrastructure, weak surveillance system coupled with shortage of financial resources remain potential challenges for effective containment of the outbreaks in many African countries as seen in the monkeypox outbreak in Republic of Congo.
- The concerted and coordinated multi-partner response is highlighted in nearly all outbreaks and emergencies, particularly to avert the pre-famine situation in many countries in the Horn of Africa.
- The recurrence of cholera outbreaks in DRC highlights the need for an in-depth analysis to identify the pattern of transmission, areas that are making progress and the impact of targeted interventions including the use of OCV.

Proposed actions

- WHO Regional Office and Country Offices should continue to support member states to conduct preparedness activities and ensure appropriate response plans are available. Both of which would enable swifter responses and therefore minimise morbidity and mortality, and other impacts of health emergencies.
- There remains a continued need to advocate for co-ordinated multi-partner responses to all outbreaks and humanitarian emergencies.



All events currently being monitored by WHO AFRO

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Updates
OUTBREAKS							
Cholera	DRC	2	1 Jan 2015	35,181	1020	2.9	Detailed update above
Cholera	Tanzania	2	04 April 2015	25,041	388	1.5	40% decrease in cases compared to week 8
Necrotising cellulitis/fasciitis	Sao Tome & Principe	2	10 Jan 2017	1421	9	0.6	Detailed update above
Hepatitis E	Chad	1	1 Sept 2016	1182 (5)	13	1.1	Detailed update given above
Cholera	Angola	1	4 Jan 2017	271	11	4.1	AFRO & HQ risk assessment to review grading and implement Oral Cholera Vaccine (OCV) package
Cholera	Burundi	-	28 July 2016	167 (5)	0	0	No reported cases since 30 January 2017, outbreak appears to be under control, heightened surveillance needs to be maintained.
Dengue fever	Burkina Faso	-	29 Oct 2016	2530	20	0.8	No update received
Typhoid fever	Zimbabwe	-	21 Nov 2016	2200 (88)	8	0.4	Cases continue to decrease, 69.4% of cases in Harare. Need to review and update guidelines for the management of typhoid
Lassa fever	Nigeria	-	18 Dec 2016	178 (73)	53 (37)	29.8 (50.7)	Outbreak in 13 states, 7 new suspected cases reported in epi week
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.
Zika virus	Angola	-	6 Jan 2017	3	0	0	No new cases reported
Rift Valley fever	Mali	-	01 Feb 2017	3 (3)	1		No further cases have been reported in epi week 9 samples awaiting laboratory confirmation at IPD
Monkeypox	Congo	-	01 Feb 2017	19	7	36.8	Detailed updated given above
Meningitis	Togo	-	03 Feb 2017	293 (28)	20	6.8	The vaccination campaign completed on 5 February with 100% coverage
Monkeypox	CAR	-	09 Feb 2017	5	0	0	No new cases this week
Measles	Guinea	-	15 Feb 2017	2142	6	0.3	Detailed update given above
Eruptive fever	Cameroon	-	20 Feb 2017	43	16	37.2	Investigations continue into the aetiology of the event
Meningitis	Nigeria	-	20 Feb 2017	563 (38)	79	14	13 LGAs affected in Zamfara state
Lassa fever	Benin	-	21 Feb 2017	2 (1)	1		Detailed update given above
Crimean-Congo Haemorrhagic Fever	Namibia	-	23 Feb 2017	4 (2)	1	25	Additional positive case notified this week with no known epi link to index case. Investigations ongoing
Lassa fever	Togo	-	24 Feb 2017	5 (2)	0		Detailed update given above

EMERGENCIES						
Humanitarian crisis	South Sudan	3				Detailed update given above, famine declared in parts of the country on 20 Feb
Humanitarian crisis	Nigeria	3				Detailed update given above
post El-Nino drought	Ethiopia	2				Continuing responses to measles, meningitis, acute watery diarrhoea and severe acute malnutrition as well as food insecurity as a result of drought emergency
Humanitarian crisis	Cameroon	2				
Humanitarian crisis	Central African Republic	2				
Cyclone	Mozambique	-	16 Feb 2017			No major public health needs have been reported following the cyclone. The WCO and AFRO continue to monitor the situation
Famine/pre-famine (Food insecurity)	South Sudan, Kenya, Uganda, Ethiopia, North East Nigeria	-	February 2017			Detailed update given above
Floods	Zimbabwe	-	02 Mar 2017			No public health needs are reported this week.
Cyclone	Madagascar	-	07 Mar 2017			Detailed update given above

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

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