

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 25: 17 – 23 June 2017
Data as reported by 17:00 23 June 2017



1

New event

39

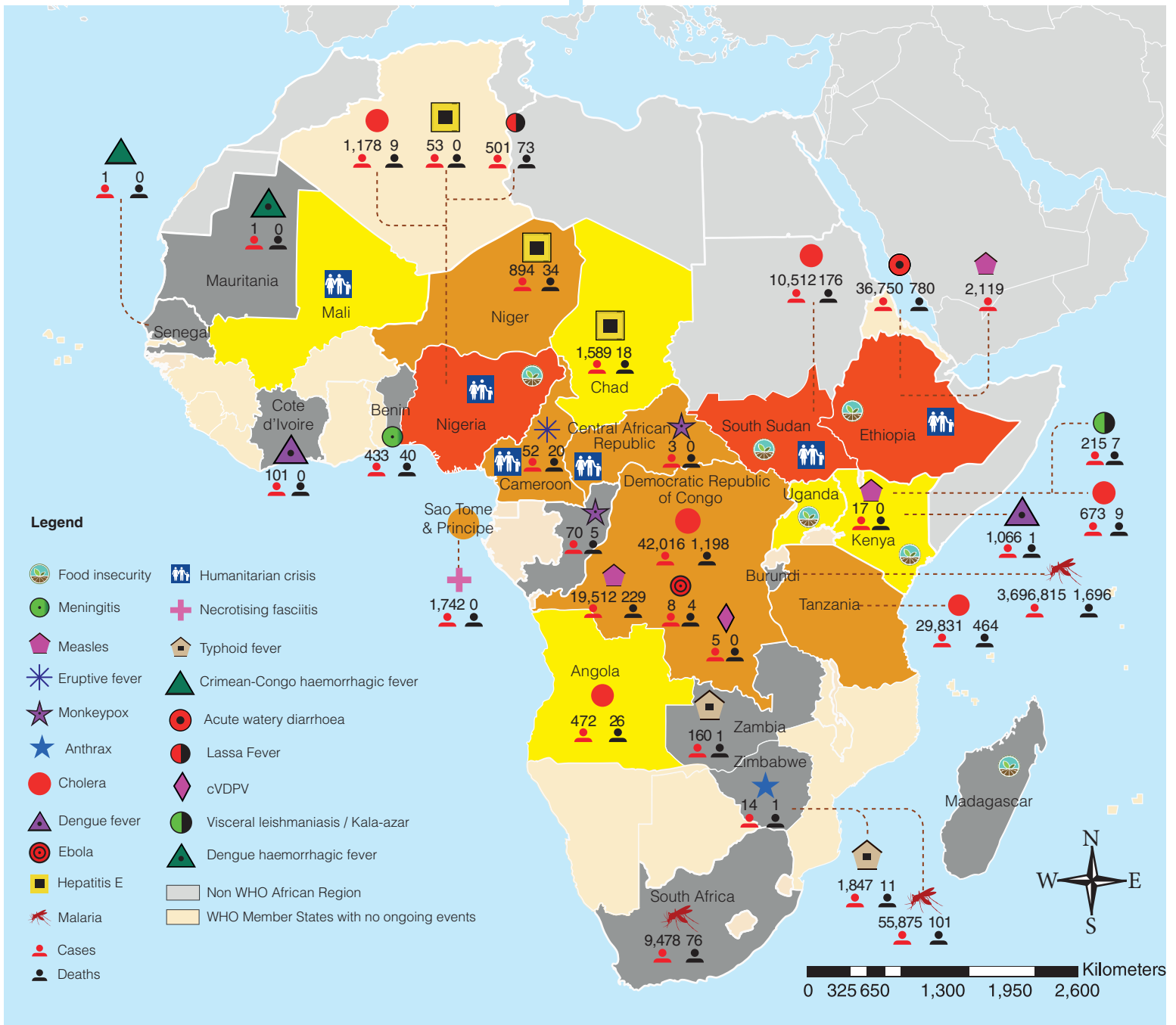
Ongoing events

30

Outbreaks

10

Humanitarian crises



3

Grade 3 events

7

Grade 2 events

5

Grade 1 events

25

Ungraded events

Overview

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- This weekly bulletin focuses on selected acute public health emergencies occurring in the WHO African region. WHO AFRO is currently monitoring 40 events: three Grade 3, seven Grade 2, five Grade 1, and twenty five ungraded events.
- This week's edition covers key ongoing events in the region, including the grade 3 humanitarian crises in South Sudan and Ethiopia, the grade 2 outbreak of Ebola virus disease in the Democratic Republic of Congo, and outbreaks of cholera and hepatitis E in Nigeria and Crimean-Congo haemorrhagic fever in Mauritania but detected in Senegal.
- 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 report with information on all public health events currently being monitored in the region.
- Major challenges to be addressed include:
 - Trans-boundary spread of communicable diseases, calling for accelerated efforts to strengthen cross-border surveillance and collaboration in the region.
 - The number of ongoing public health emergencies in the region has remained high with increasing complexity. The funding gaps are equally widening, impacting on the capacity of countries and partners to scale up response interventions.

The Nigeria Federal Ministry of Health has, on 23 June 2017, officially declared the end of the 2016/2017 meningitis outbreak in the country. This declaration comes four weeks after the number of new meningitis cases reported each week fell below the epidemic and alert thresholds in all Local Government Areas. Since onset of the outbreak on 18 December 2016, a total of 14,518 suspected / confirmed cases of meningitis were reported from 25 states, with 1,166 deaths, giving a case fatality rate of 8%.

The Nigeria Ministry of Health, working together with the Nigeria Centre for Disease Control (NCDC), the National Primary Healthcare Development Agency (NPHCDA), WHO and other partner organisations worked assiduously to control and reduce the impact of the outbreak on affected communities. The national outbreak response was coordinated within the framework of the National Emergency Operations Centre (EOC).

WHO congratulates and commends the Government of the Federal Republic of Nigeria, the Federal and State Ministries of Health, NCDC, government agencies and the health partners for the collective efforts to control this outbreak. WHO urges the government and all the stakeholders to draw lessons from this outbreak in order to improve preparedness, prevention, early detection, and rapid control of meningitis early detection and rapid control of meningitis in the next season.

New event

Hepatitis E

Nigeria

53 Cases | 0 Deaths | 0% CFR

Event description

On 18 June 2017, the Nigeria Federal Ministry of Health notified WHO of an outbreak of hepatitis E in the north-east Borno State. A cluster of 12 cases of acute jaundice syndrome was detected on 3 May 2017 in Damasak town in Mobbor Local Government Area (LGA), located at the border with the Republic of Niger where an outbreak of hepatitis E is ongoing. Four out of nine biological samples obtained from the initial cases tested positive for hepatitis E virus at a virology laboratory in Lagos, thus confirming the outbreak. In a related event, a total of 41 suspected cases of hepatitis E were reported from Ngala LGA, bordering Cameroon. As of 17 June 2017, a total of 53 suspected hepatitis E cases with no fatality have been reported from Damasak and Ngala LGAs. At least three pregnant women were among these cases. The ages of the affected persons ranged from 6 to 35 years. A total of 18 biological samples have been obtained from Damasak and Ngala and shipped to Lagos for further analysis. Detailed outbreak investigation and risk assessments are being conducted to establish the full extent of the hepatitis E outbreak.

The hepatitis E outbreak is occurring among displaced persons and returnees. Damasak, the third largest town in Borno state, was recaptured in July 2016 and the displaced populations started returning by January 2017. An estimated 90,000 returnees have currently resettled, with many staying in un-gazetted settlements, with limited access to social services.

Public health actions

- WHO and partners are providing technical, logistical and financial support to the state and federal authorities to respond to the hepatitis E outbreak, within the overall framework of humanitarian response.
- A joint investigation team from WHO, UNHCR, IOM, NRC and the Canadian Embassy was deployed in May 2017. The team interacted with health and community workers to establish active surveillance, including an active case search mechanism.
- Health workers are being sensitized and trained on disease surveillance, including application of case definitions.
- The Nigeria Red Cross is implementing water, sanitation and hygiene (WASH) interventions, including hygiene promotion, and establishing boreholes.
- Community volunteers and leaders have been engaged to conduct prevention and control activities at community level.
- Case management, mainly supportive care, is being provided at the local health facilities with the support of partners.
- Actions are ongoing to strengthen screening of returnees at the points of entry.

Situation interpretation

The current hepatitis E outbreak in the north-east Borno State of Nigeria is taking place within the context of the ongoing humanitarian crisis in the northern part of the country. The outbreak is occurring in the aftermath of increasing population movements within the Lake Chad basin, following the gradually improving security situation. The Diffa region in Niger and the Salamat region in Chad have ongoing outbreaks of hepatitis E. The increasing population movement within the region therefore set the stage for trans-boundary propagation of the disease. The areas located between north-east Nigeria, south of Chad and Niger, and the northern part of Cameroon have limited access to safe water and low latrine coverage with subsequent open defecation practices. These factors are the main drivers of the current hepatitis E outbreak in Nigeria and the region. The disease is known to spread fast in internally displaced persons (IDP) and refugee settings.

Given the current health system challenges, including the suboptimal surveillance performance and the limited access to the displaced and returning populations, the true extent of the outbreak could be underestimated. Therefore, the risk for subsequent propagation of the disease in Nigeria and in the neighbouring countries appears high. To that effect, there is an urgent need to develop a common subregional approach involving Nigeria, Niger, Chad, and Cameroon in response to this potentially serious outbreak of hepatitis E in the region.

Ongoing events

Ebola virus disease Democratic Republic of Congo

8
Cases

4
Deaths

50%
CFR

Event description

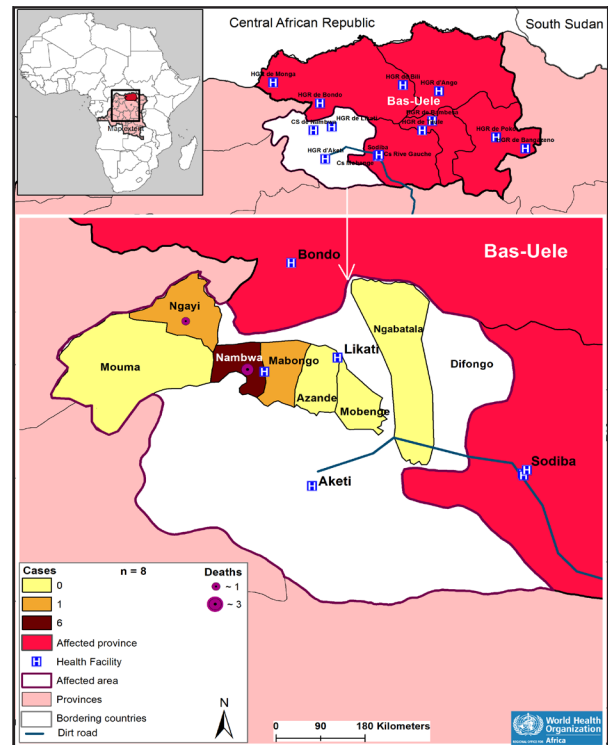
The Ebola virus disease (EVD) outbreak in Likati Health Zone, Bas Uele Province in the north-east of the Democratic Republic of Congo remains stable and under control. Since our last report on 16 June 2017, no new confirmed or probable cases have been reported. To date, a total of five confirmed and three probable cases have been reported. Between 19 June and 22 June 2017, 10 alerts have been investigated and all were discarded as they did not fit the case definition. Of the confirmed and probable cases, four survived and four died, resulting in a case fatality rate of 50%. The four survivors are being carefully followed up to avoid sexual transmission. The confirmed and probable cases were reported from Nambwa (four confirmed and two probable), Ngayi (one probable) and Mabongo (one confirmed).

The last confirmed case tested negative for Ebola virus for the second time on 21 May 2017. Accordingly, the countdown for the declaration of the end of the Ebola outbreak has started. If no new case is identified, the end of the outbreak will be declared on 2 July 2017.

Data modelling suggests that the risk of further cases is currently low, but not negligible, and decreases as each day passes without new confirmed/probable cases. As of the reporting date, 98% of simulated scenarios predict no further cases in the next 30 days.

The current EVD outbreak in the Democratic Republic of Congo was notified to WHO on 11 May 2017. The cluster of cases and deaths of previously unidentified illness had been reported since late April 2017. Likati Health Zone shares borders with two provinces in the Democratic Republic of Congo and with the Central African Republic. The affected area is remote and hard to reach, with limited communication and transport infrastructure.

Geographical distribution of Ebola virus disease cases in Democratic Republic of Congo, 22 April – 18 June 2017.



Public health actions

- Laboratory technicians from Likati, Nambwa, and Mabongo health areas have been trained on the use of Ebola rapid diagnostic test.
- The implementation of the free healthcare policy in Likati has increased service utilization by the population. Since 31 May 2017, 4,674 patients have had medical consultations in 10 health areas.
- Five nurses have been redeployed from Buta to Likati to strengthen implementation of the free healthcare policy.
- There is ongoing investigation to locate the hunter who is thought to have been a contact of the index case.
- National Red Cross volunteers conducted community dialogue with 607 people on hand washing and personal hygiene.
- Twenty community workers from Difongo and Kulu have been sensitized on Ebola prevention and control.
- Door-to-door sensitization is being conducted as well as evening screenings of health education videos.
- Dissemination of EVD messages is continuing using local radio stations. In addition, radio talk shows are being conducted by the local Ebola coordination committee, psychosocial and communication commissions.
- The post-outbreak psychosocial support plan is being finalized.
- Leaders of traditional healers' groups are being sensitized on infection preventive measures.
- Analysis of samples from ducks that had presented with haemorrhagic symptoms was negative for Ebola virus by PCR.

Situation interpretation

The EVD outbreak in Likati Health Zone, Bas Uele Province in the north-east of the Democratic Republic of Congo remains under control. However, the Ministry of Health with the support of WHO and partners continues to be vigilant, through enhancing surveillance, investigating alerts and testing suspected cases. These are critical functions that will contribute to the prevention of any EVD flare-ups.

As the Ministry of Health continues to reinforce these response pillars to detect cases, it will also be crucial to maintain dialogue with local communities as well as strengthen infection prevention and control (IPC) and WASH. A clear plan is also required to determine how these activities will be maintained after the declaration of the end of the outbreak.

The strengthening of the Likati health system is also critical. Large increases in healthcare facility utilization have already been observed and healthcare workers have been/are being trained. These are key aspects of sustainable service delivery. However, limited funding and infrastructure will need to be taken into consideration. Some hospitals are experiencing overflows of patients with ratios of one bed to four patients. In addition, regular supply of medicines and other commodities remains a challenge. WHO calls on partners to maintain technical and financial support to the Ministry of Health to ensure continued control of the outbreak and reinforcement of healthcare service delivery in Likati Health Zone and the entire country.

Event description

On 7 June 2017, the Nigeria Federal Ministry of Health notified WHO of an outbreak of cholera in Kwara State in the western part of the country. The initial cases of acute watery diarrhoea (AWD) started insidiously during the last week of April 2017. Seven stool samples obtained from the initial cases and analysed at the University of Ilorin Teaching Hospital (UIITH) laboratory isolated *Vibrio cholerae* O1 as the causative agent. The number of cases and deaths subsequently increased from the first week of May 2017. As of 14 June 2017, a total of 1,178 suspected cases and nine deaths (case fatality rate 0.8%) have been reported. Four local government areas have been affected, including Ilorin West (508 cases), Ilorin East (303 cases), Ilorin South (96 cases), and Moro (37 cases).

All age groups have been affected, although children below 5 years of age were the most affected group, accounting for 29% of the total caseload. The gender distribution of the affected people is proportionate, with 51% of the cases being male. Limited access to clean drinking water and poor hygiene and sanitation have been observed as the major predisposing factors for the propagation of the disease.

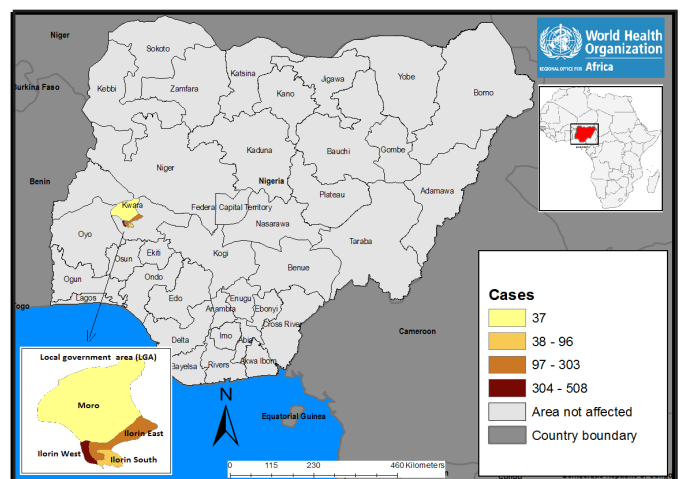
Public health actions

- The Kwara State Ministry of Health has established an emergency operations centre (EOC) to coordinate response to the outbreak, with support from Nigeria Centres for Disease Control (NCDC), Nigeria Field Epidemiology and Laboratory Training Programme (NFELTP), National Primary Health Care Development Agency (NPHCDA), the University of Ilorin Teaching Hospital (UIITH) and WHO.
- Active case search has been initiated in the affected communities, supervised by the disease surveillance and notification officers.
- Cholera rapid diagnostic tests (RDTs) are being distributed in selected facilities and healthcare staff trained in their use; aimed to improve laboratory investigations.
- On 15 June 2017, clinicians from the three worst affected LGAs were trained on cholera case management and IPC.
- Social mobilization activities are being carried out in the affected communities including dissemination of information 'jingles' using the local language, Yoruba. Preparation is being finalized to sensitize religious leaders in the affected state, to create awareness and prompt early presentation to healthcare facilities.
- Environmental assessment is being carried out in the affected communities; samples from two water points (a local community well and household drinking water) have been collected and are being analysed.

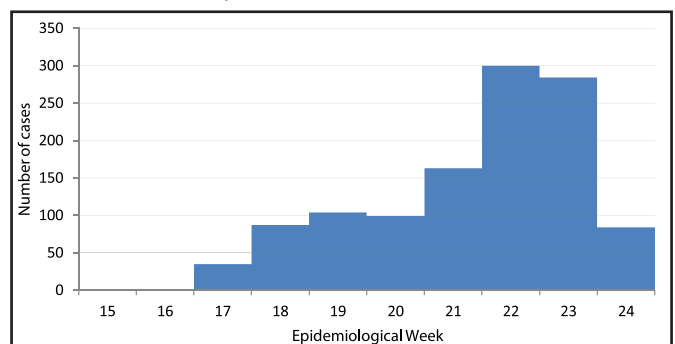
Situation interpretation

Nigeria is experiencing a new and rapidly evolving cholera outbreak in Kwara State. While Nigeria has ample capacity to respond to cholera outbreaks, this outbreak comes at a time when the country is already constrained by the ongoing humanitarian emergency and multiple diseases outbreaks. Many staff and resources are already committed in the response to this humanitarian situation. The state and federal Ministries of Health, with support from partners, are working to scale-up response efforts, including establishing active surveillance systems. However, these efforts are being challenged by limited human, logistic and financial resources. These factors, in addition to the ongoing humanitarian crisis in Nigeria, could result in worsening of the cholera outbreak in the country. The necessary resources need to be mobilized urgently, including funding to scale up response operations. In addition, the need to establish appropriate cholera treatment centres is overriding. Meanwhile, the neighbouring states and countries should embark on implementing preventive activities, including heightened surveillance.

Geographical distribution of cholera cases in Nigeria, April 2016 - 14 June 2017.



Weekly trend of cholera cases in Kwara State, Nigeria, April 2017 - 14 June 2017

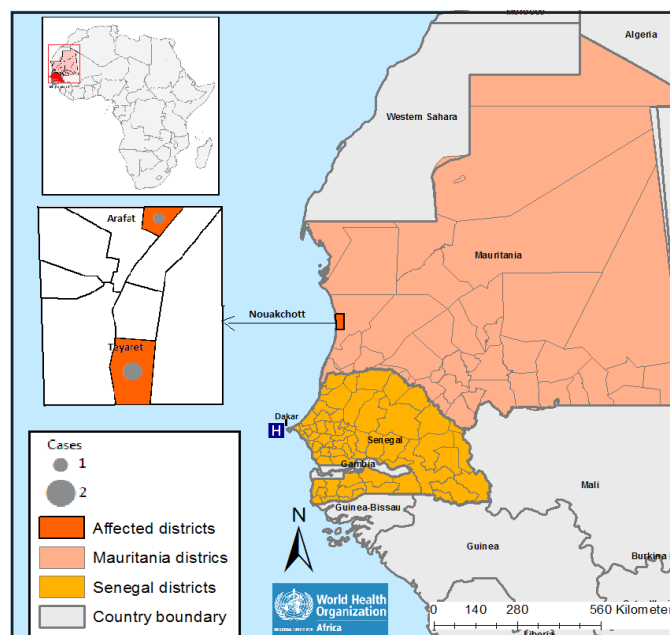


Event description

On 6 June 2017, the Senegalese Ministry of Health and Social Welfare notified WHO of one new confirmed case of Crimean-Congo haemorrhagic fever (CCHF) detected from a patient who came from Nouakchott in Mauritania. This event is unrelated and not linked to the two CCHF cases previously reported from the same city (weekly bulletin 19). The most recent case-patient is a 39 year-old female residing in Tayaret, Nouakchott. Her illness began on 27 May 2017 with fever, epigastric pain, rectal bleeding and lower back pain. She was initially admitted for 4 days in a military hospital in Nouakchott where presumptive treatment for malaria was provided, and she was discharged. Her clinical condition, however, persisted and she consulted a private clinic in Nejah, where blood tests revealed severe thrombocytopenia and anaemia requiring a transfusion. Due to limited blood transfusion services, the case-patient was transferred to Hospital Center De Fann (HCDF) in Dakar, Senegal on 3 June 2017. The case-patient travelled in a private vehicle accompanied by two family members and a driver. On arrival, the case-patient presented with haemorrhagic features including gingivorrhagia, petechial purpura and ecchymotic purpura and bleeding from injection sites and was promptly isolated. The diagnosis of CCHF was confirmed by the Institut Pasteur of Dakar by serology and PCR on serial specimens collected on 3 and 5 June 2017.

The confirmation of CCHF triggered an immediate public health investigation and actions in both Senegal and Mauritania. A total of 15 contacts were identified, including five healthcare staff of the clinics and hospitals in Mauritania and 10 other close contacts. There has been no evidence of further transmission to date. Investigations into potential sources of infection revealed that the family frequented a local livestock market to purchase meat and slaughter animals.

Geographical distribution of Crimean-Congo haemorrhagic fever (CCHF) cases in Senegal, 27 May - 23 June 2017.



Public health actions

- The Senegalese Ministry of Health and Social Welfare activated the Health Emergency Operations Centre to coordinate the response. With support from the Pasteur Institute of Dakar and WHO, an investigative mission was carried out to collect further information about the case and assess the risk.
- Health workers in the hospital in Dakar have been oriented on IPC practices, including the use of personal protective equipment.
- In Mauritania, a One Health approach rapid response plan has been drafted and is being implemented. Joint animal and human health investigations are being conducted in the two large livestock markets and slaughter houses in Nouakchott, and areas at risk of virus circulation are being mapped.
- A ministerial note was drawn up to strengthen surveillance, particularly for officials and practitioners in the border regions with Mauritania.
- Preparations are going on for activities planned to improve local awareness and case management capacity, including training of healthcare staff, redistribution of standard operating procedures, provision of ELISA tests to the national laboratory, and reinforcing standard IPC procedures.

Situation interpretation

The Senegalese national authorities have reported another imported case of CCHF. This recent case is unrelated to the two previously reported from Nouakchott as they reside over 20 kilometres apart with no apparent epidemiological links between the two events. The occurrence of three cases within a short time period may be an indication of a much bigger burden of CCHF in Mauritania. In 2003, the country experienced a large outbreak of CCHF in Nouakchott, with a total of 119 suspected cases (24 confirmed) and 29 deaths. Most of the cases were attributed to direct contact with infected livestock.

In response to the current CCHF events, the Ministries of Health and Livestock in Mauritania launched a joint investigation and risk assessment to fully understand the extent of disease. The findings from this assessment are being eagerly awaited. Nevertheless, effective prevention and control measures in the local community, done under the One Health approach, should be implemented. These recent events also highlight the critical need for healthcare practitioners to maintain a high index of suspicion for CCHF and other viral haemorrhagic fevers, and prompt rapid isolation, laboratory investigations and treatment. Efforts should be directed towards enhancing local capacity to detect, investigate, confirm, and manage cases. CCHF is a zoonotic disease transmitted to humans by tick-bites or through contact with viraemic animal tissues during and immediately post-slaughter. As infection in domestic livestock is usually not apparent, it can be challenging to control the disease outside of well a managed livestock population. Prevention, therefore, focuses on raising awareness of measures to reduce exposure among people with frequent contact with animals, as well as practicing standard infection control precautions to prevent nosocomial transmission. Close collaboration between animal and human health sector in the context of One Health needs to be strengthened in Mauritania.

Event description

The drought-induced humanitarian crisis and the accompanying infectious diseases outbreaks especially in the south-eastern parts of Ethiopia are still continuing. Currently, the outbreak of acute watery diarrhoea (AWD) is active in Amhara, Oromia and Somali Regions. There was a decrease in the number of AWD cases reported in week 24 (week ending 18 June 2017): a total of 661 cases were reported from the three regions compared to 1,080 cases reported in week 23 (week ending 11 June 2017). Since the beginning of 2017, a total of 37,459 cases including 784 deaths (case fatality rate 2.1%) have been reported from six regions of Somali, Oromia, Amhara, Afar, SNNP and Tigray. Eighty-nine percent of the reported cases and 96% of the deaths were reported in Somali Region alone.

The measles outbreak is still persisting. During week 24, a total of 37 new suspected measles cases were reported in the country. Since the beginning of 2017, a total of 2,119 suspected measles cases were reported from across the country. This includes 979 confirmed cases (434 laboratory-confirmed, 490 epidemiologically-linked and 55 clinically compatible cases). Of the reported cases, 18.5% had not received any measles vaccination and 44.1% had an unknown status. Oromia is still the most affected region, with 32% of reported cases, followed by Amhara (28%), Addis Ababa (17%) and SNNPR (11%).

During the same week, a total of 1,564 new severe acute malnutrition (SAM) cases were reported in Oromia region. Of these, 1,350 were managed at the outpatient therapeutic programmes (OTPs) and 214 admitted in the stabilization centres (SCs). Since the beginning of 2017, a cumulative of 31,874 SAM cases were reported in the region, including 28,445 cases managed at the OTPs and 3,429 cases admitted in the SCs in the region.

Public health actions

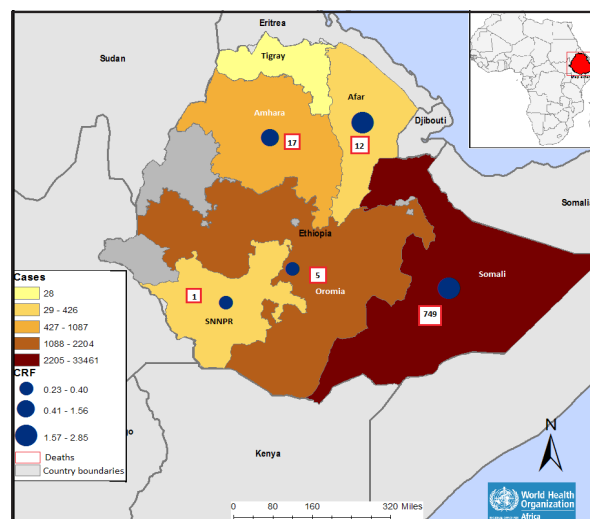
- The Federal Ministry of Health (FMoH) and the Regional Health Bureaus (RHBs), continue to respond to the AWD outbreak in Amhara, Oromia and Somali Regions, with the support from WHO and partners.
- WHO Ethiopia Country Office is revising its strategy of intervention to a more regionally driven and owned approach, aimed to operationalize the Public Health Emergency Management (PHEM) in the country.
- Additional surge personnel have been deployed to Amhara, Somali and Oromia region to boost response activities.
- A meeting of cluster heads was convened by the humanitarian advisor in the office of the president of the Somali region.
- On-the-job training on infection prevention and control (IPC) are being carried out at cholera treatment centres. Meanwhile, case management teams continue to monitor and strengthen adherence to IPC and other case management protocols.
- Active surveillance is being reinforced in Amhara, Oromia and Somali regions and active case search continues in communities in these regions.
- WASH activities are ongoing in collaboration with the RHB and other partners in AWD-affected woredas in Somali region.

Situation interpretation

The humanitarian crisis in the south-eastern part of Ethiopia remains serious. The latest risk assessment shows that the main underlying factors identified during the previous risk assessment are still present. These include population displacement, food insecurity, lack of sanitation, rising levels of malnutrition, and prolonged water shortage. However, during week 24, some decrease was observed in the number of AWD cases from Amhara, Oromia and Somali regions.

WHO and partners continue to reinforce the ongoing implementation of the AWD response in Amhara, SNNP and Somali within the framework of the six pillars.

Geographical distribution of humanitarian crisis/
acute watery diarrhoea cases in Ethiopia,
as of 18 June 2017.



Event description

The security situation in South Sudan continues to deteriorate during the month of June 2017, hampering humanitarian response efforts. Recent incidents include attacks on humanitarian vehicles in Lainya County, grounding of a United Nations humanitarian flight in Boma State, fighting in Manyo and Panyikang counties, and an attack on travellers along the Juba-Nimule highway. By the end of May 2017, over 1.8 million internally displaced persons (IDPs) and an additional 1.75 million refugees in neighbouring countries have been registered.

The latest Integrated Food Security Phase Classification (IPC) analysis released on 21 June 2017 showed that the situation remains critical across the country, with some 6 million people (50% of the population) facing severe food insecurity. This is the greatest number of people ever to experience severe food insecurity (IPC 3, 4 and 5) in the country. On a positive note, the report indicated that famine has eased in South Sudan following a significant scale-up in the humanitarian response. Famine is no longer occurring in Leer and Mayendit counties, and further deterioration was prevented in Koch and Panyijiar counties as a result of immediate and sustained multi-sector humanitarian assistance delivered since March 2017. Nonetheless, the report warned that 1.7 million people are facing a food security 'Humanitarian Emergency' (IPC4) and approximately 45,000 people will likely face 'Humanitarian Catastrophe' (IPC5) in June-July 2017.

In week 23 (week ending 11 June 2017), completeness of the routine surveillance reporting was 71% while completeness of the early warning alert response system (EWARS) reporting from the IDP sites was 89%. During the reporting week, a total of 506 new cholera cases including 17 deaths (case fatality rate 3.6%) were reported. The numbers of new cases have started to decline in sites where oral cholera vaccines were deployed, with the exception of Aburoc IDP settlement. Since the onset of the outbreak in June 2016, 10,832 suspected cases of cholera including 176 deaths (case fatality rate 1.6%) have been reported. Cholera has been confirmed in 23 counties across South Sudan, with active transmission ongoing in nine areas.

Public health actions

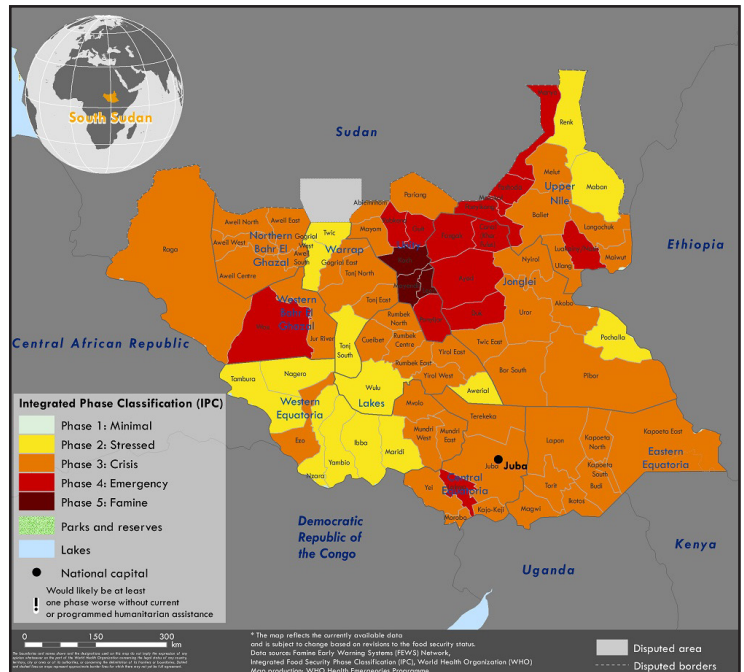
- A joint need assessment was conducted in 18 settlements in Mangalla and Gemeiza where an estimated 20,000 displaced persons have recently settled. The immediate humanitarian needs identified were food, health and non-food items.
- WHO convened a health cluster coordination meeting, bringing together all health actors to deliberate on the best ways to support provision of health services.
- WHO Wau Hub provided malaria modules, basic units, emergency kits (type A and B), gloves and anaesthetic kits for distribution to Raja County and Wau Teaching Hospital following reports of severe shortages of drugs and supplies.
- The logistics cluster coordinated a convoy of humanitarian supplies including food and non-food items from Juba on 15 June 2017. This convoy had been returned three times at the checkpoint in the last 3 months.
- Cholera case management kits have been deployed to health partners to support the response in Ayod, Tonj East, Kapoeta South, Kapoeta North and Kapoeta East. Cholera vaccines have been deployed in Leer, Bor PoC, Malakal Town, Bentiu PoC, Mingkaman IDP settlement and Aburoc IDPs.
- WHO supported training of 54 health workers sessions (at the Juba Teaching Hospital) on cholera case management and infection prevention and control. Another 15 health workers were trained on water quality surveillance.

Situation interpretation

The intense conflict in South Sudan since mid-2016 has been the driving force of human suffering, including the ongoing food insecurity, inaccessibility to social services and various outbreaks of communicable diseases. The recently released IPC report highlights the staggering number of people (6 million) facing severe food insecurity during June and July. Without intensified humanitarian interventions, this situation will worsen, given the limited cultivation occurring in the conflict-affected areas. Outbreaks of cholera may also escalate following the onset of the rainy season.

WHO and other partners continue to provide humanitarian assistance to the populations in need. Under the South Sudan Humanitarian Response Plan (HRP), WHO requires a total of US\$ 12.3 million for 2017, of which 21% has been received. WHO requires an additional US\$ 8 million to effectively respond to the health needs, bringing the total funding requirement for the next 9 months to US\$ 20.8 million, with a 90% funding gap. The overall health clusters' humanitarian funding requirement stands at US\$ 123 million, currently only 10.9% has been funded.

Food insecurity crisis in South Sudan
The Integrated Food Security Phase Classification (IPC)
projection for Feb - May 2017



Summary of major challenges and proposed actions

Challenges

- The trans-boundary spread of communicable diseases has been highlighted this week by the repeated detections of CCHF in Mauritanian nationals seeking healthcare in Senegal, and the propagation of hepatitis E in the Lake Chad Basin. While considerable progress has been made to strengthen measures at the international airports, cross-border surveillance has remained weak at the ground crossing points, where most transmissions occur.
- The number of ongoing public health emergencies in the region has remained high, with increasing complexity. At the same time, the funding gaps to provide effective response interventions by the countries and partners to these emergencies are continuously widening, impacting on the scale and quality of the response. The humanitarian response in South Sudan is a case in point, but this applies to many other emergencies in the region.

Proposed actions

- Member States are called upon to step up efforts to strengthen cross-border surveillance and collaboration at subregional level. The actions need to be taken at the operational and local levels where actual community interactions take place. This should include use of innovative interventions at the community level.
- WHO will continue to conduct high level advocacy to the donor community, humanitarian agencies and the governments to provide the required funding and other resources to ensure implementation of effective interventions to the ongoing public health emergencies in the region.

All events currently being monitored by WHO AFRO

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Newly reported events								
Hepatitis E	Nigeria	Ungraded	18-Jun-17	53 (4)	-	-	Detailed update given above	17-Jun-17
Ongoing events								
Humanitarian crisis	Nigeria	Protracted 3	-	-	-	-	A detailed update on this protracted emergency will be provided every second week to coincide with bi-weekly situation updates from the country.	13-Jun-17
Humanitarian crisis	South Sudan	G3 extension	-	-	-	-	Detailed update given above	21-Jun-17
Humanitarian crisis/AWD	Ethiopia	Upgraded to G3	15-Nov-15	37,459	784	2.1%	This complex emergency includes outbreaks of AWD and measles, detailed update given above. Counts listed here include the cumulative total AWD cases and deaths reported during 2017 only.	18-Jun-17
Humanitarian crisis	Cameroon	G2 extension	-	-	-	-	-	-
Humanitarian crisis	Central African Republic	Downgraded to G2	-	-	-	-	-	-
Humanitarian crisis	Niger	G2 extension	Beginning 2015	-	-	-	-	-
Cholera	Democratic Republic of Congo	G2	02-Jan-15	42,016 (253)	1,198	2.9%	551 new cases and 6 new deaths were reported in epi week 20. Free access to medical treatment continues to be provided by the Ministry of Health with the support of partners.	04-Jun-17
Cholera	Tanzania	G2	04-Apr-15	29,831	464	1.6%	Following moderate declines in cases in the Dar es Salaam region on the mainland, the current focus of the outbreak is in fewer districts on Unguja Island in the Zanzibar archipelago.	11-Jun-17
Necrotising cellulitis/ fasciitis	Sao Tome & Principe	G2	10-Jan-17	1,742	-	-	Following initial declines in case incidence from the peak of the outbreak during December 2016, and a period of 12 weeks with on average 24 cases per week, case numbers appear to have dropped again with about 10 cases per week reported in the last 2 weeks.	14-Jun-17
Ebola Virus Disease	Democratic Republic of Congo	G2	08-Mar-17	8 (5)	4	50.0%	Detailed update given above	19-Jun-17
Drought/ food insecurity	Kenya	G1	-	-	-	-	-	-
Drought/ food insecurity	Uganda	G1	-	-	-	-	-	-
Humanitarian crisis	Mali	G1	-	-	-	-	-	-
Hepatitis E	Chad	G1	01-Sep-16	1,589 (98)	18	1.1%	During week 24, 29 new suspected cases were reported in Salamat Region (against 43 cases last week) and 8 new cases in Amtinma North region (against 27 cases last week. Confirmation of a suspected case from Lake is pending.	20-Jun-17
Cholera	Angola	G1	04-Jan-17	472	26	5.5%	Since the onset of the outbreak on 13 December 2016, case incidence has declined in Soyo (Zaire), but the outbreak continues in Cabinda.	11-Jun-17
Malaria	Burundi	Ungraded	01-Jan-17	3,696,815	1,696	0.05%	An upward trend has been recorded during the last 5 weeks. The Ministry of Health has developed an accelerated response plan. UNICEF has donated 4,194,500 doses of antimalarial medication. The overall humanitarian situation remains of concern with close to 150,000 IDPs (37,000 returnees) and over 61,427 refugees.	29-May-17
Cholera	Kenya	Ungraded	10-Oct-16	673 (114)	9	1.3%	10 counties have reported cholera in 2017: Vihiga, Kericho, Mombasa, Kiambu, Tana River, Garissa, Nairobi, Murang'a, Turkana and Nakuru. Garissa, Nairobi, Murang'a, Turkana and Nakuru have all reported cases in the last week, while the outbreak appears to have been controlled in other areas.	19-Jun-17
Typhoid fever	Zimbabwe	Ungraded	21-Nov-16	1,847 (121)	11	0.6%	Cases were predominately reported from the city of Harare. The outbreak peaked during the early months of 2017. The incidence of new cases has remained low throughout May and June 2017.	08-Jun-17
Lassa fever	Nigeria	Ungraded	01-Dec-16	501 (175)	73	14.6%	Case counts include 175 confirmed and 14 probable cases. Incidence of new cases has continued to decline since the outbreak peaked in week 9 of 2017. With the recent addition of Anambra, 9 states are currently reporting active outbreaks.	09-Jun-17
Measles	Ethiopia	Ungraded	14-Jan-17	2,119 (976)	-	-	Detailed update given above	18-Jun-17
Cholera	South Sudan	Ungraded	20-Feb-17	10,832	176	1.6%	Detailed update given above	21-Jun-17
Measles	Democratic Republic of Congo	Ungraded	10-Jan-17	19,512 (305)	229	1.2%	The incidence of new cases has declined since the current outbreak peaked in early 2017.	23-May-17
Monkeypox	Congo (Republic of)	Ungraded	01-Feb-17	70 (7)	5	7.1%	Reported from four different districts in Likouala Department and one district in Cuvette department.	23-Apr-17
Eruptive fever	Cameroon	Ungraded	16-Feb-17	52 (7)	20	38.5%	The event was reclassified as eruptive fever following negative results for leishmaniasis.	23-May-17
Food insecurity	Madagascar	Ungraded	23-Feb-17	-	-	-	Insufficient food security persists according to the SMART nutritional study.	31-May-17
Malaria	Zimbabwe	Ungraded	07-Mar-17	55,875	101	18.1%	Manicaland (n=31,111, 55%), Mashonaland East (n=8,822, 15.6%), Masvingo (n=8,062) and Mashonaland Central (n=5,739, 10.1%) provinces account for the vast majority of cases.	01-Mar-17
Measles	Kenya	Ungraded	12-Mar-17	17 (9)	0	0.0%	The outbreak has been reported in Dagahaley, Dadaab and IFO refugee camps in Garissa County. Date of onset of index case was 21 March 2017. The last reported confirmed and probable cases experienced illness onset on 26 May and 4 June 2017, respectively. No new cases were reported in the last week.	19-Jun-17
Hepatitis E	Niger	Ungraded	06-Apr-17	894 (167)	34	3.8%	The outbreak is currently confined to the Diffa Region, south-eastern Niger. Of 307 samples tested to date, hepatitis E virus was detected in 167 (54%) by PCR	19-Jun-17
Monkeypox	Central African Republic	Ungraded	14-Apr-17	3 (1)	0	0.0%	The last case detected was reported in Week 20.	01-Jun-17
Anthrax	Zimbabwe	Ungraded	15-Apr-17	14	1	7.1%	Anthrax was isolated from hippo carcass, which community members had consumed.	25-Apr-17

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Typhoid fever	Zambia	Ungraded	22-Apr-17	160 (12)	1	0.6%	The outbreak is currently confirmed to Mpika District, Muchinga province.	04-Jun-17
Malaria	South Africa	Ungraded	03-Apr-17	9,478 (4,484)	76	0.8%	Figures shown are for 2016/17 season from September to May. There has been a high number of cases in Limpopo Province during the recent season compared to previous years.	06-Jun-17
Visceral leishmaniasis / Kala-azar	Kenya	Ungraded	05-May-17	215 (149)	7	3.3%	Two counties, Marsabit (n=105 cases) and Wajir (n=110) have been affected by outbreaks since early 2017. These outbreaks appear to be ongoing, with 28 and 3 new cases detected within the last week from the two counties, respectively.	19-Jun-17
Dengue fever	Cote d'Ivoire	Ungraded	06-May-17	101 (33)	0	0.0%	A confirmed case of dengue fever was reported by Institute Pasteur Dakar on 28 April 2017. Between 27 and 24 May 2017, there have been 18 new cases reported.	29-May-17
Dengue fever	Kenya	Ungraded	09-May-17	1,066 (613)	1	0.1%	Outbreak has been reported in Mombasa (n=991, of which 568 are confirmed) and Wajir (n=75, of which 45 are confirmed) counties. Following a peak during May 2017, the frequency on new cases continues to decline in the both counties.	19-Jun-17
Circulating vaccine-derived polio virus (cVDPV)	Democratic Republic of Congo	Ungraded	02-Jun-17	5(5)	0	0.0%	This includes 3 separate events: 2 unrelated clusters of cVDPV2 (2 cases each) and a single case of cVDPV1. No new cases have been reported since the original cluster	31-May-17
Crimean-Congo haemorrhagic fever (CCHF)	Senegal, ex-Mauritania	Ungraded	06-Jun-17	1 (1)	0	0.0%	Case is an adult from Nouakchott, Mauritania, transferred by the family to Senegal for treatment. This is the third confirmed case from Mauritania in a period of less than 2 months, with no apparent links between this case and the initial two. Local investigations are ongoing.	08-Jun-17
Dengue haemorrhagic fever	Mauritania	Ungraded	07-Jun-17	1 (1)	0	0.0%	Single confirmed in a traveller from Angola presented with symptoms of haemorrhaging to healthcare on 31 May 2017. The case later tested positive for dengue virus infection.	07-Jun-17
Cholera	Nigeria	Ungraded	07-Jun-17	1,178 (7)	9	0.8%	Detailed updated given above	14-Jul-17
Recently closed events								
Cyclone	Madagascar	Ungraded	07-Mar-17	-	-	-	850,000 people affected. There is medication available for mobile clinics, however some districts have run out of antimalarial drugs.	31-May-17

Data is taken from the most recently available situation reports sent to WHO AFRO. Numbers are subject to change as the situations are dynamic.



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