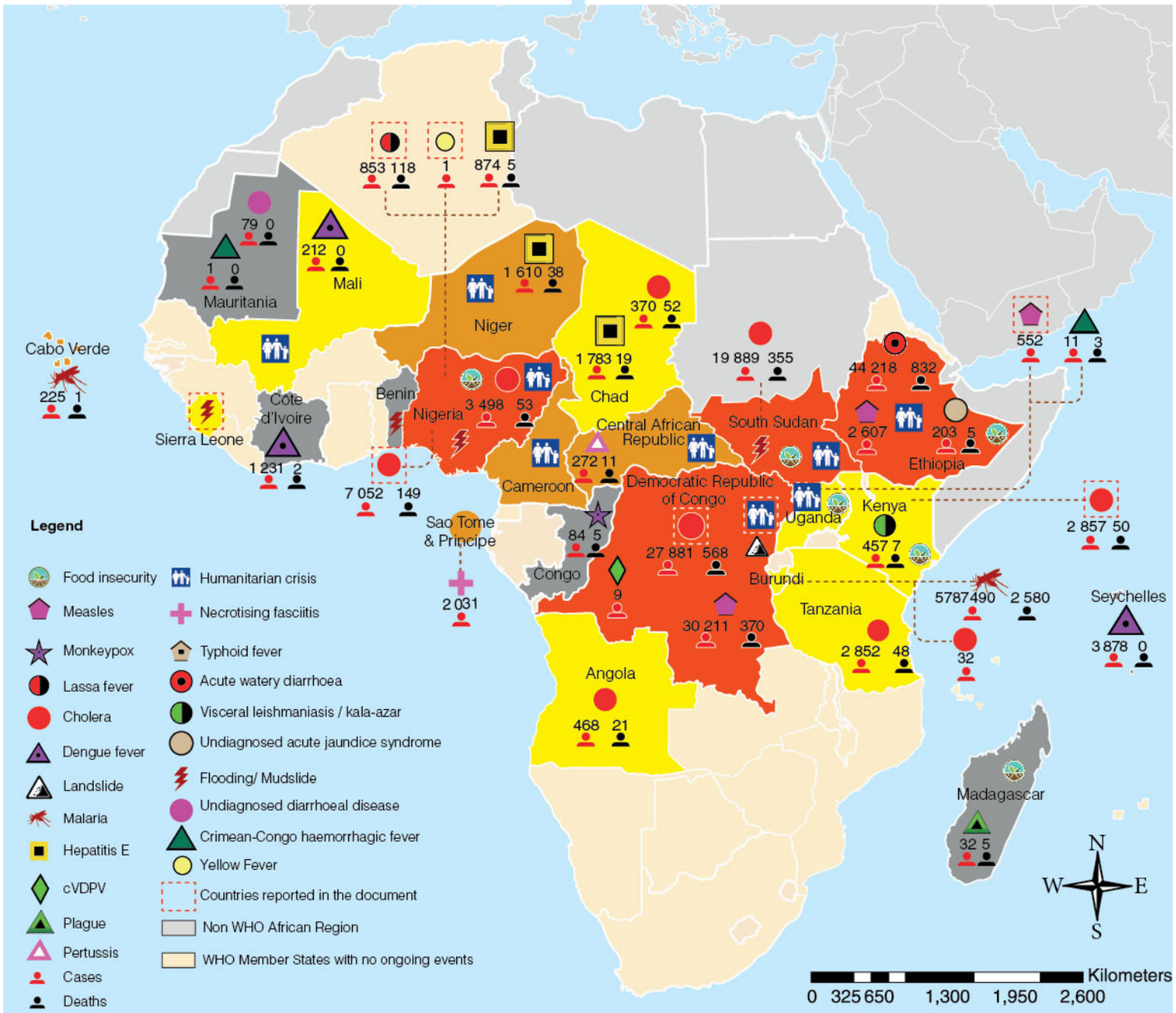
WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 38: 16 - 22 September 2017
Data as reported by 17:00; 22 September 2017

World Health Organization
REGIONAL OFFICE FOR Africa
WHO Health Emergencies Programme

1	45	30	16
New event	Ongoing events	Outbreaks	Humanitarian crises



2	7	9	24
Grade 3 events	Grade 2 events	Grade 1 events	Ungraded events
2	0	1	
Protracted 3 events	Protracted 2 event	Protracted 1 event	

Health Emergency Information and Risk Assessment

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 46 events in the region. This week's edition covers key ongoing events, including:

  - Cholera in the Democratic Republic of the Congo
  - Cholera in Nigeria
  - Lassa fever in Nigeria
  - Yellow fever in Nigeria
  - Measles in Uganda
  - Floods/mudslide in Sierra Leone
  - Humanitarian crisis in the Democratic Republic of the Congo.

- 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 challenges include:

  - The high proportion of events occurring in countries such as the Democratic Republic of the Congo and Nigeria underscores the need to strengthen country's capacities and preparedness, and to continue to build capacity in these areas under the Country Business Model.

  - Access to potable water has remained an important underlying factor for multiple health emergencies in the African region. The multiple water-related health emergencies necessitate closer multisectoral work and political commitment redundant.

Ongoing events

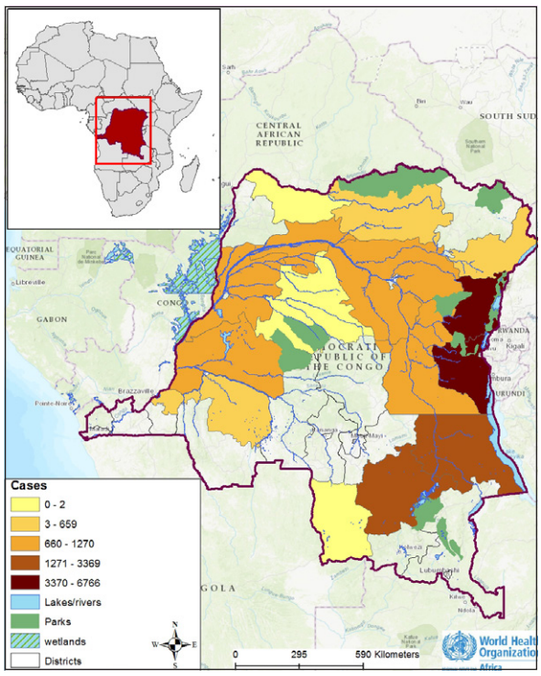
Cholera | **Democratic Republic of the Congo** | **27 881** Cases | **568** Deaths | **2.0%** CFR

Event description

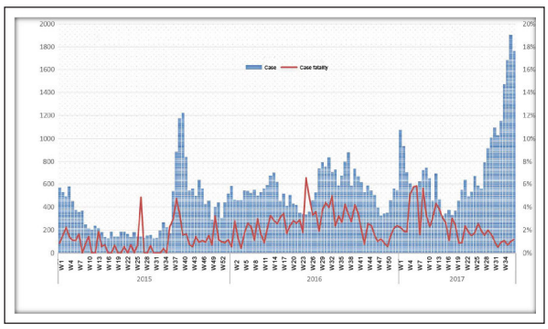
The cholera outbreak in the Democratic Republic of the Congo is still ongoing, with active transmission occurring in 10 provinces and new areas being affected. During week 36 (week ending 10 September 2017), a cumulative total of 1 761 new suspected cholera cases including 21 deaths (case fatality rate 1.2%) were reported from 10 provinces in the country, compared to 1 903 cases and 19 deaths (case fatality rate 1.0%) reported in week 35. The provinces that reported cases were Upper Katanga, Upper Lomami, Kongo Central, Kwilu, Maindombe, Maniema, Mongala, North Kivu, South Kivu, and Tanganyika. There has been geographical extension of the epidemic to new health zones during the reporting week, including Lubumbashi Health Zone in Upper Katanga Province; Bukama, Kabondo Dianda and Kabalo Health Zones in Upper Lomami Province and Ilebo Health Zone in Kasaï-Occidental Province. South Kivu and North Kivu are the most affected provinces, with 776 and 559 suspected cases during week 36, respectively.

Since the beginning of 2017, a total of 27 881 suspected/confirmed cholera cases including 568 deaths (case fatality rate 2.0%) were reported from 18 out of the 26 provinces in the country.

Geographical distribution of cholera cases in the Democratic Republic of the Congo, week 36, 2017



Weekly trend of cholera in the Democratic Republic of the Congo, week 1, 2015 - week 36, 2017



Public health actions

- The Ministry of Public Health has renewed high level commitment to controlling the ongoing cholera outbreak through the creation of a new and dedicated national authority – the National Program for the Elimination of Cholera and Control of Other Diarrheal Diseases (PNECHOL-MD).
- On 8 September 2017, the Minister of Health declared the cholera epidemic as a major health emergency and sent a letter of commitment to the governors for their involvement in the response.
- The national coordination platform for the response to the cholera epidemic has been strengthened by setting up seven subcommittees, including Surveillance and Laboratory, Management, Water Sanitation and Hygiene (WASH), Communication and Social Mobilization, Logistics, and Immunization. The terms of reference for the sub-committees and the main indicators to monitor the quality of the response to the epidemic are being finalized.
- WHO is providing technical, financial and logistical support to ensure effective functioning of the national coordination and response mechanisms.
- The Ministry of Health has deployed a total of 24 multidisciplinary national experts to the affected provinces to support the response. In addition, WHO is supporting the deployment of 40 other experts.
- The Ministry of Health, with the support of WHO, is finalizing a new national emergency plan for the response to the cholera epidemic. WHO committed an initial US$ 400 000 for field operations and additional US$ 1 million is being realised.
- WHO is establishing an incident management structure as well as developing a response plan to guide its support.
- Case management is being provided in the affected provinces with support from partners, including MSF.
- There is continued implementation of WASH activities including chlorination of water, establishing handwashing points, household disinfection, community outreaches, etc.

Situation interpretation

Cholera has become endemic in some provinces of the Democratic Republic of the Congo with seasonal peaks. The current cholera outbreak has been going on unabated, with new areas being affected. The trend is being exacerbated by the ongoing heavy rains and recent flooding, especially in South Kivu Province. Recently, there have been renewed commitments by the national authorities and partners to scale up efforts to control the outbreak. The establishment of a dedicated national authority to address the outbreak, the declaration of the cholera outbreak as a public health emergency and involvement of the regional and local political structures in the response are some of the examples. The partners have also shown commitment to controlling the protracted outbreak. It is anticipated that the current efforts will translate into improved implementation of cholera control interventions, especially at community level. Identification of clear indicators to benchmark the response is also commendable and will help to hold all stakeholders accountable.

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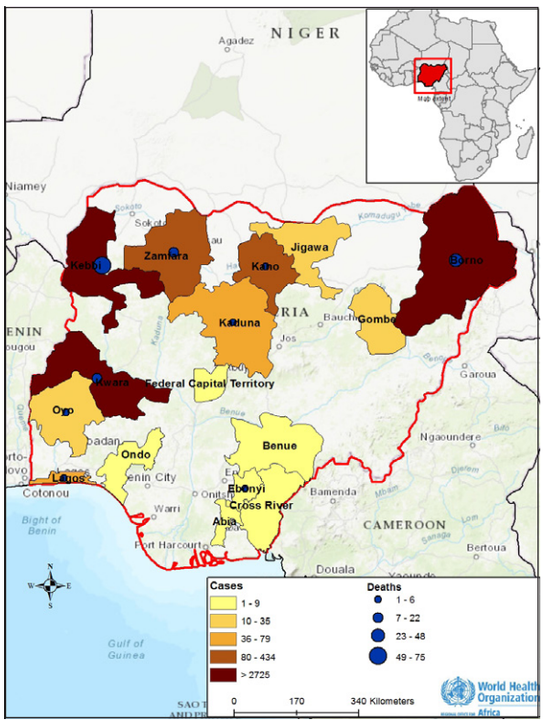
Event description

The cholera outbreak in Nigeria continues, with the situation being more precarious in Borno State, north-east Nigeria. In week 37 (week ending 17 September 2017), a total of 651 new suspected cholera cases were reported from five states, namely Borno, Kano, Kebbi, Oyo, and Zamfara. Since the beginning of the outbreak in the first week of May 2017, a total of 7 052 cases including 149 deaths (case fatality rate 2.1%) have been reported from eight states, namely Borno, Kaduna, Kano, Kebbi, Kwara, Lagos, Oyo, and Zamfara, as of 18 September 2017. Serotyping of isolates from Zamfara and Lagos States identified *Vibrio cholerae* O1 Ogawa as the causative agent.

In Borno State, the cholera outbreak began on 20 August 2017 in Muna corrido internally displaced persons (IDP) camp in Jere Local Government Area (LGA). As of 22 September 2017, a total of 3 498 cases including 53 deaths (case fatality rate 1.5%) have been reported from five LGAs, namely Dikwa, Jere, Konduga, Maidiguri, and Monguno. Jere LGA remains the worse affected, with 1 759 cases, followed by Monguno (1 099 cases) and Dikwa (640 cases). Out of the 131 stool samples taken, 82% (107) were positive for cholera on rapid diagnostic tests (RDT) and 74% (97) positive by culture.

Geographical distribution of cholera cases in Nigeria, week 18 - 37, 2017



Public health actions

- The Public Health Emergency Operations Centre (PHEOC) has been activated to coordinate the response to the outbreak.
- Active surveillance has been enhanced in the affected areas with case search being undertaken in hot spots and at-risk communities. A central hotline has been set up at the EOC for reporting of alerts.
- Case management is being provided at identified treatment/isolation facilities in the affected states. In Borno State, five cholera treatment centres (CTCs) and 12 oral rehydration points (ORP) are fully functional in the hot spots.
- The water, sanitation and hygiene (WASH) sector has intensified interventions, especially in Borno State where over 5 504 households have been reached with WASH services (hygiene promotion messages, hygiene kit distribution, and other water and sanitation activities). A total of 1 136 latrines have been cleaned and disinfected (636 in Muna, 411 in Monguno and 89 in Dikwa).
- On 18 September 2017, a 5-day oral cholera vaccine (OCV) campaign was launched in five local government areas in Borno State, targeting 915 005 people. By the fifth day (on 22 September 2017), a total of 844 305 people were vaccinated, giving an administrative coverage of 96% of the targeted population. A mop up exercise is being conducted in areas with low coverage.
- Risk communication has been intensified in the affected states. Cholera prevention messages are being aired on local radio stations in local languages. Hygiene promotion activities are being done in camps and schools through radio, community groups, posters, and other methods.
- Health education and community sensitization activities are being carried out in affected states.

Situation interpretation

TThe cholera outbreak in Nigeria, especially in Borno State, remains a concern. Borno State is currently home to over 5.5 million internally displaced persons (IDPs) and host communities, living in overcrowded conditions with limited social services. Potable water supplies, proper sanitation facilities and safe hygiene practices are inadequate. Recent flooding is also restricting access to several affected areas, which is also being compounded by the insecurity. The recent rainy season increased the risk of water-borne and sanitation-related diseases, including cholera. The current food insecurity and malnutrition exacerbates the impact of the environmental contamination on malnourished persons. Despite ongoing efforts by different partners on risk communication through hygiene promoters, posters, radio broadcasts and other platforms, behavioural change in communities is not at the required level and open defecation continues to be practiced widely.

It is anticipated that the ongoing interventions, augmented by the high uptake of the OCV campaign, will quickly bring the outbreak in Borno State to an end.

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Lassa fever | **Nigeria** | **854** Cases | **118** Deaths | **13.8%** CFR

Event description

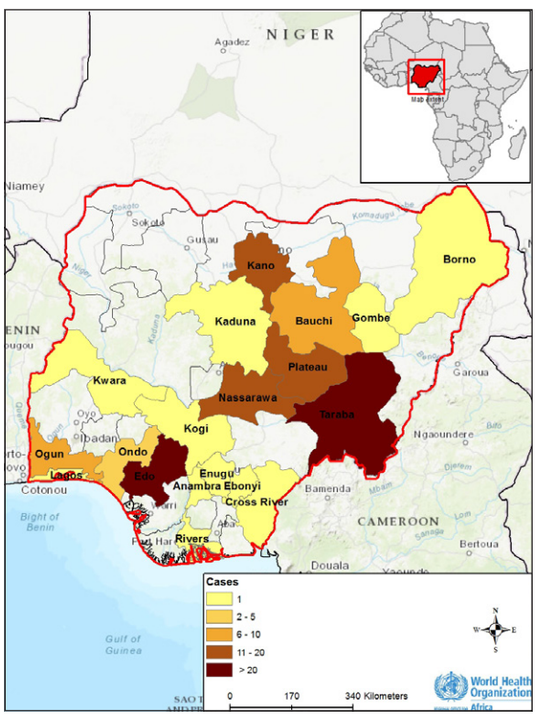
The incidence of Lassa fever cases in Nigeria has decreased in the last reporting week. During week 37 (week ending 17 September 2017), two new confirmed cases and no deaths were reported from Edo State. The results of 24 samples from Edo (19), Plateau (3), Ogun (1), and Kogi (1) states that were pending the previous weeks were all negative for Lassa fever. However, the outbreak is still being considered active in nine states (Ondo, Edo, Plateau, Bauchi, Lagos, Ogun, Kaduna, Kwara, and Kogi) that reported at least one confirmed case in the past 21 days.

Since the resurgence of the current wave of Lassa fever outbreak in December 2016 (week 49), a total of 854 suspected cases including 118 deaths (case fatality rate 13.8%) were reported, as of 15 September 2017. Of these, 258 cases were confirmed and 14 classified as probable. There were 86 deaths among the confirmed and probable case groups, collectively giving a case fatality rate of 31.6% in this group. During this outbreak, 19 out of 36 states have reported at least one confirmed Lassa fever case. Edo and Ondo States have accounted for over half of all the reported cases.

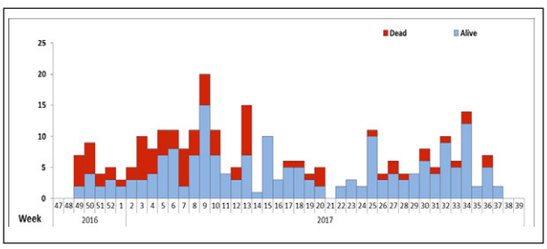
Public health actions

- The Nigeria Centres for Disease Control (NCDC) Lassa fever response working group is coordinating the response to the outbreak, in conjunction with partners (WHO, CDC, UMB, AFENET, etc.).
- Confirmed cases are being managed at identified treatment and isolation centres across the affected states with ribavirin and other supportive treatment.
- The NCDC distributed response materials for viral haemorrhagic fevers (VHF) to the affected states.
- The state surveillance teams continue to conduct enhanced surveillance and contact tracing activities in states with active outbreaks. Surveillance data is being collated nationally via the VHF management system. Reported cases continue to be classified based on the case definitions.
- Promotion of infection prevention and control measures (IPC) in health facilities is ongoing.
- A national Lassa fever outbreak review meeting was carried out with all the affected States and partners.

Geographical distribution of Lassa fever cases in Nigeria, December 2016 - 17 September 2017



Weekly trend of Lassa fever in Nigeria, week 49, 2016 - week 37, 2017



Situation interpretation

The trend of Lassa fever cases in Nigeria has been encouraging in recent weeks. It is widely anticipated that this current trend is leading to the final end of the outbreak. Nevertheless, it is important to sustain the current control interventions until the outbreak is ultimately contained. Active surveillance, laboratory confirmation and appropriate case management are critical interventions at this stage. The promotion of good hygiene practices in the community to reduce rodent activity through proven effective measures, as well as the use of standard IPC precautions when caring for patients in health facilities are equally important in controlling the outbreak.

The recently concluded national Lassa fever review and preparedness meeting should help to consolidating the ongoing response and strengthen preventive and preparedness measures, based on the lessons learned from this current epidemic.

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Yellow fever | Nigeria

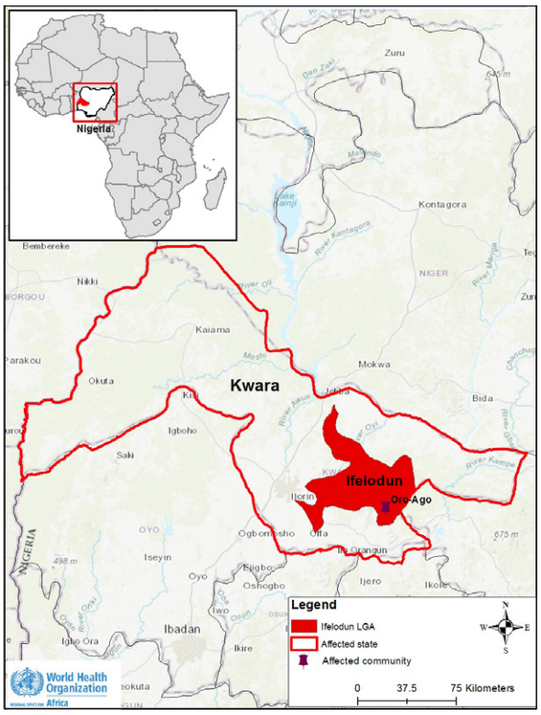
1 Case | **0** Death | **0%** CFR

Event description

On 15 September 2017, the Nigeria Federal Ministry of Health notified WHO of a confirmed yellow fever case in Ifelodun Local Government Area (LGA), Kwara State. The case-patient was a 7-year-old girl from Oro-Ago Community in Ifelodun LGA who developed symptoms, including fever, vomiting and abdominal pain on 16 August 2017. She had no previous history of yellow fever vaccination (according to her father) and no history of travel outside the state in the last 2 years prior to illness onset.

On 29 August 2017, a sample from the case-patient tested positive for yellow fever by polymerase chain reaction (PCR) at the Lagos University Teaching Hospital (LUTH). The specimens were subsequently referred to the Institute Pasteur Dakar (the regional reference laboratory) where a repeat PCR test was negative. However, yellow fever virus IgM was detected and plaque reduction neutralization test (PRNT) was positive (titre 1:320), showing serological evidence of recent infection. Other tests performed as part of the differential diagnoses, including dengue fever, West Nile fever, Rift Valley fever, chikungunya, Zika, and Crimean-Congo haemorrhagic fever were all negative. To date, there have been no reports of similar illness in the immediate family, local health centre or wider community. Further epidemiological and entomological investigations are underway to gain a deeper understanding and assess the risk of further amplification..

Geographical distribution of yellow fever case in Nigeria, 16 August – 22 September 2017



Public health actions

- A joint team from the Nigeria Centres for Disease Control (NCDC), the National Primary Health Care Development Agency and WHO have been deployed to support the State Government of Kwara in conducting a detailed investigation and risk assessment. An outbreak control team has also been put together to ensure coordinated decision-making and rapid response.
- Planning is underway for a reactive mass vaccination campaign in the affected LGA as well as neighbouring areas. Field teams are assessing the size and geographical extent of the target population.
- Local authorities are advocating for other preventive measures, including use of insect repellent, long-lasting insecticide-treated nets, proper sanitation and removing stagnant water and other mosquito breeding sites.

Situation interpretation

Yellow fever is endemic in Nigeria and routine vaccination against the disease was introduced to the Expanded Programme on Immunization (EPI) in 2004 as a single dose from 9 months of age. Vaccine coverage rates in Ifelodun LGA have substantially improved since then but the overall population herd immunity probably remains suboptimal. The last mass vaccination campaign in Kwara State was in 1987. Accordingly, a reactive vaccination campaign is warranted to prevent a larger outbreak. However, further investigations are needed to better define the target population for such as campaign.

Likewise, further investigations, including population movement and local vector density, will help to reveal the risk of further amplification. Based on the available information, the likelihood of further spread among the local population is moderate. As the affected area is over 250 km from the nearest international border (Benin), the risk of regional spread is currently low. This event, nevertheless, further drains an already stretched public health system in Nigeria. Kwara State is recovering from a large cholera outbreak (last cases reported in week 27 of 2017), while the country continues to respond to several concurrent public health emergencies in other states.

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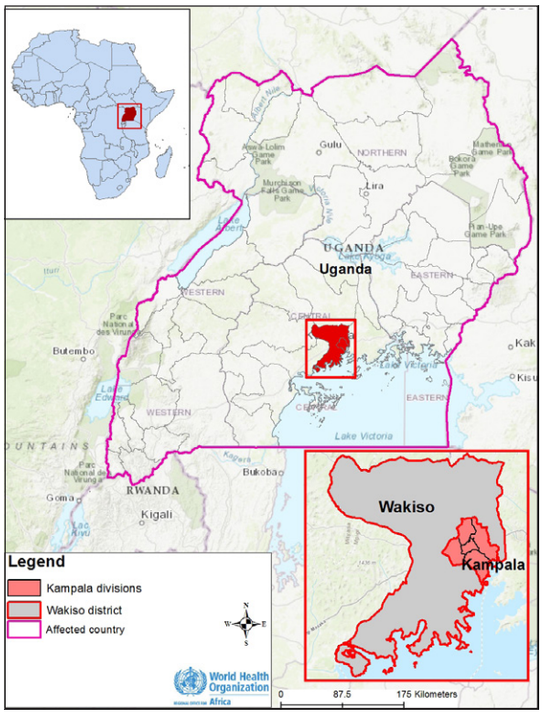
Event description

The measles outbreak in Uganda is still ongoing though the outbreak has remained limited to the urban districts of Kampala and Wakiso. In week 35 (week ending 3 September 2017), 20 out of 32 suspected cases in Kampala tested positive for measles virus infection at the Uganda Virus Research Institute. Similarly, 11 out of 41 suspected cases from Wakiso tested positive for the disease.

Since onset of the outbreak on 24 April 2017, a total of 552 measles cases including one death (case fatality rate 0.2%) have been reported in Kampala (309 casas and one death) and Wakiso (243 cases), as of 18 September 2017. Of the confirmed measles cases in both districts, 76% (26/34) had never been vaccinated with measles-containing vaccine (MCV). Children between 1 and 4 years were the most affected in both Kampala and Wakiso districts, although the attack rate among children aged less than 1 year was higher in Kampala District. All five divisions of Kampala District have been affected while 11 out of the 23 local government structures in Wakiso have reported cases.

The urban measles outbreak in Uganda was confirmed on 23 July 2017 and formally declared by the Ministry of Health on 8 August 2017.

Geographical distribution of measles case in Uganda, 24 April – 18 September 2017



Public health actions

- Coordination and monitoring of response interventions continue at the national and district levels through the respective task forces.
- The Ministry of Health has developed a measles response plan, which includes strengthening case management and case-based surveillance; reducing the numbers of measles-susceptible children and interrupting transmission by strengthening routine immunization services; ensuring a smooth flow of public information and effective social mobilization for appropriate community response behaviour; and effective coordination of epidemic response activities.
- A total of 392 vaccination outreach activities have been planned in the five divisions of Kampala. Kawempe, Rubaga, Nakawa, and Makindye Divisions will each conduct 80 outreaches while Central Division will undertake 72 outreaches. So far, 3 053 children have been immunized in Makindye and 2 766 children in Central Division.
- Periodic Intensified Routine Immunizations (PIRI) is being implemented in all five divisions of Kampala and all sub-counties of Wakiso District over a 3-month period, and never-vaccinated children will be identified and vaccinated.

Situation interpretation

Identified risk factors for this measles outbreak include populations not accessing immunization services, stock-outs of vaccines at the facility level, and inadequate routine vaccine services, including poor cold-chain management and inadequate supportive supervision. Overall, Kampala District is in the reach-every-district (RED) category 2, implying good access to, but poor utilization of routine immunization services, leading to increasing numbers of children susceptible to vaccine-preventable diseases, including measles. Reports show that health card retention among children in Kampala is suboptimal, at 43%, meaning that many children are missing essential routine vaccinations.

The current measles outbreak highlights the vulnerability of the poor urban populations, particularly under the prevailing economic constraints. Efforts are needed to achieve and sustain at least 95% coverage with two doses of MCV to control and prevent future outbreaks.

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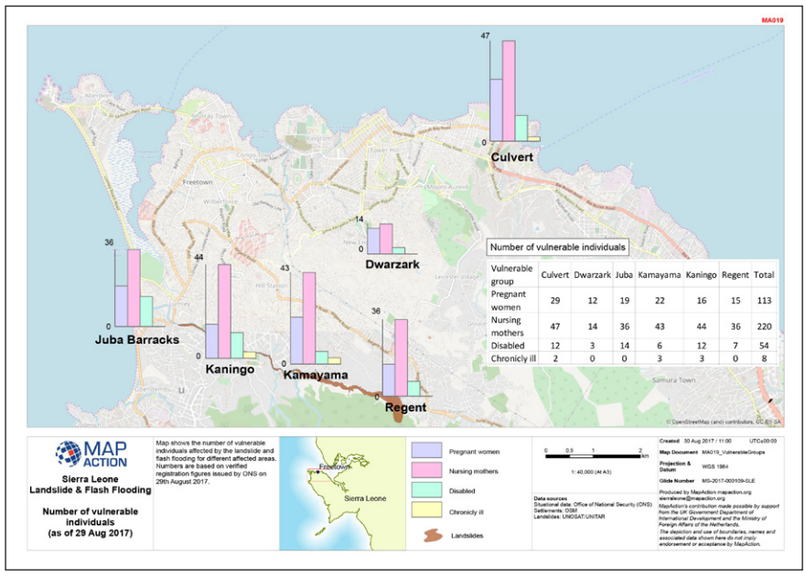
Event description

This is an update on the impact of the floods and mudslide which occurred in Freetown, Sierra Leone on 14 August 2017 and was last reported in this bulletin on 1 September 2017. The floods and mudslide resulted in loss of lives, as well as physical and psychological trauma to hundreds of people. The search for dead bodies has formally stopped; thus far, 502 burials have taken place and 500 people have been declared missing. In total, 1 247 households in six communities have been affected and nearly 6 000 people displaced. These numbers are subject to an ongoing verification process. Two camps have been established for the affected individuals as resettlement continues.

Number of vulnerable individuals in Sierra Leone landslide and flash floods, as of 29 Aug 2017



The mudslides and flooding damaged sanitation facilities and water pipes, thus contaminating communal water sources. The major public health concerns, therefore, included occurrence of epidemics that can be exacerbated by over-crowding, poor hygiene and inadequate access to clean and safe water. To that effect, the Ministry of Health and Sanitation (MoHS), in conjunction with health partners, undertook an emergency pre-emptive oral cholera vaccination (OCV) campaign in the Western Area Urban and Western Area Rural districts of Freetown in order to contribute to the prevention of a potential cholera outbreak. WHO supported MoHS in preparing for and undertaking the campaign. A target population of 500 000 at-risk persons were identified to receive a two-dose regimen of OCV. The first of the two rounds of the OCV campaign concluded on 21 September 2017 and preliminary data indicated an administrative coverage of over 96% of the targeted population.

Public health actions

- The Government of Sierra Leone continues to coordinate the overall humanitarian response while the Public Health National Emergency Operations Centre coordinates the public health component of the response.
- Surveillance for epidemic prone diseases has been enhanced and WHO is supporting the MoHS to conduct community-based surveillance in the two affected districts.
- On 20 September 2017, the MoHS with the support of WHO held an advocacy session at the Parliament to provide information on the OCV campaign.
- About 500 clinicians in over 120 facilities have been trained over the last month on cholera prevention and control.
- An assessment of cholera treatment units has been undertaken, with eight facilities ready for use in the event of an outbreak. Infection prevention and control (IPC) assessment teams, with the supported of WHO, identified gaps for some of the proposed isolation facilities and this has been communicated to the district leadership and partners.
- Prior to the OCV campaign, supervisors and vaccination teams at national, zonal and district levels were trained in OCV management. Community awareness-raising materials were printed and distributed, with extensive media engagement to improve uptake of the vaccine.
- The first round of the OCV campaign was undertaken from 15-20 September 2017, with a mop up done on 21 September 2017. The second round will be conducted in early October 2017.
- WHO provided a team of independent monitors during the OCV campaign. The team will also conduct post-OCV campaign monitoring to guide planning and implementation of the second round campaign.
- Daily review meetings were conducted in each district, chaired by District Medical Officers and involving officials from MoHS, WHO, UNICEF, MSF and other health partners.

Situation interpretation

The preparedness measures that have been undertaken in Freetown to mitigate the risk of occurrence of disease outbreaks, including cholera were commendable. The OCV campaign should be viewed as an additional tool to the conventional control measures, such as improving access to potable water and adequate sanitation, placing emphasis on food safety and hand hygiene practices and raising community awareness. All these interventions must be supported by high quality epidemiological surveillance for all epidemic prone diseases to facilitate early detection and effective response to any event.

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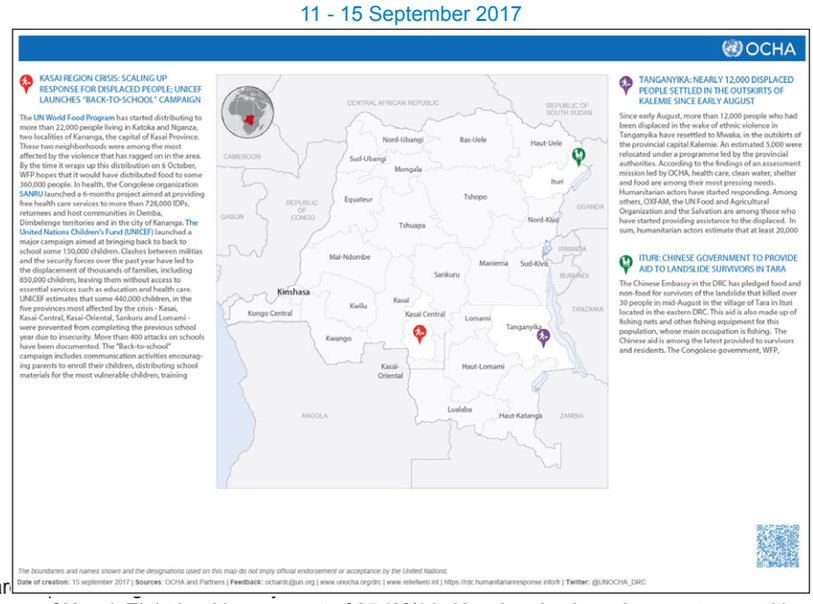
Event description

Since April 2016, the Democratic Republic of the Congo has experienced a humanitarian crisis in the Kasai Region, which arose from armed conflict between a local militia and the national government forces. The conflict started in Kasai Central Province and rapidly spread to the other four provinces of Kasai region (Kasai, Kasai Oriental, Lomami and Sankuru). The surrounding provinces of Lualaba, Tanganyika, Haut-Lomami and Kwilu are also bearing the burden of hosting internal displaced people (IDP). More than 1.3 million people have been displaced by the violence in the Kasai Region since August 2016, including 850 000 children. According to the UN Office for the Coordination of Humanitarian Affairs (OCHA), between July and September 2017, some refugees started to return to their homeland with 122 000 returnees in Kasai Central and 9 000 in Lomami. These returns are happening in villages that are in poor condition to receive them. The urgent needs of these returnees include food, essential household items, shelters, livelihood support, and psychosocial assistance.

Humanitarian situation in the Democratic Republic of the Congo, 11 - 15 September 2017



According to a recent World Food Programme survey, 42% of households in the Kasai Provinces ar[illegible] of severe acute malnutrition (SAM) in the five provinces of Kasai. Eight health zones out of 95 (8%) in Kasai region have been put on nutrition alert. The SAM rate is over 5% in some health zones of Kasai and Kasai Oriental.

During this crisis, a total of 58 health zones in the five Kasai provinces (61%), have been affected through the destruction or looting of health facilities, and disruption of health service delivery following the escape of health personnel. The crisis has also had a negative impact on health data transmission by health personnel, which means that there are no data available to analyse trends in the morbidity profiles of the affected provinces.

Public health actions

- Different partners in the field are providing primary healthcare services using fixed and mobile strategies, including functional rehabilitation of those injured, treatment of moderate and severe acute malnutrition, reproductive health services, medical and psychosocial support to victims of gender-based violence, vaccination, and water, sanitation and hygiene (WASH) activities.
- WHO, through the Central Emergency Response Fund (CERF), is implementing a project dedicated to providing primary healthcare services to affected populations, which include providing medicines for primary healthcare and organizing mobile clinics for areas lacking functional health facilities in 17 health zones in Tanganyika, Kasai, Kasai Central, and Kasai Oriental.
- WHO has developed an initial response plan to the humanitarian crisis, involving provision of primary healthcare to the affected populations as well as SAM care, improvement of national capacities in coordinating health response to the Kasai humanitarian crisis, and reinforcement of epidemiological surveillance and the overall preparedness and response to potential outbreaks, with a focus on cholera outbreaks.
- WHO has established an Incident Management Team at the three levels of the organization. The Incident Manager is already deployed in the country. Technical staff (field coordinators, an epidemiologist, and WASH experts) will be deployed in the four most affected provinces (Kasai, Kasai Central, Kasai Oriental and Lomami) within a week.
- WHO has procured emergency kits (3 trauma kits A, 3 trauma kits B, 15 severe acute malnutrition kits, 15 pneumonia kits, 60 basic interagency emergency health kits (IEHK) and 36 anti-malaria kits that will be delivered to affected provinces in the next few days.
- WHO is supporting the Minister of Health to organize a Partnership Forum dedicated to the health response. A joint WHO-Ministry of Health mission in the Kasai area will be conducted during the next 2 weeks to collect data on gaps in health emergency response and mapping partners' interventions.

Situation interpretation

The armed conflict in Kasai has led to a severe humanitarian crisis in the region. The living condition of the IDPs is particularly alarming in the light of already poor health indicators in the provinces of Kasai, Kivu and Tanganyika. There were more than 200 reported attacks on health centres in Kasai and it is estimated that at least 25% of the health zones do not function due to lack of qualified medical personnel and disruption of the supply of medicines. The health services are already overwhelmed by the increased demand. At the same time, the Democratic Republic of the Congo is experiencing ongoing outbreaks of cholera, measles and type 2 circulating vaccine-derived poliovirus.

To avoid further deterioration of the humanitarian situation, the priority is to accelerate the implementation of life-saving interventions. The critical areas of interventions include nutrition, protection, health, food security, and WASH. There is also a need to strengthen the presence of partners on the ground to provide humanitarian aid.

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Summary of major challenges and proposed actions

Challenges

- Of the 46 events that are currently being monitored by the WHO Health Emergencies Programme in the African Region, 24% are occurring in the Democratic Republic of the Congo and Nigeria. Both countries have been experiencing protracted humanitarian crises. Response to the multiple concurrent public health emergencies is resource-intensive, in term of human capacity, finances and logistics; thus imposing serious strains on the national authorities and partners.

- Access to potable water has remained an important underlying factor for multiple health emergencies in the African Region, including several ongoing outbreaks of cholera and hepatitis E.

Proposed actions

- The high proportion of events occurring in countries such as the Democratic Republic of the Congo and Nigeria underscores the need to strengthen country's capacities and preparedness, and to continue to build capacity in these areas under the Country Business Model.

- The multiple water-related health emergencies necessitate closer multisectoral work and political commitment in countries.

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All events currently being monitored by WHO AFRO

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR %	Comments
Newly reported events										
South Sudan	Floods	Ungraded	12-Sep-17	13-Sep-17	19-Sep-17	-	-	-		On 12 September 2017 the Sudanese Ministry of Health reported that floods caused by heavy rains have affected 119 000 people in Aweil North and Aweil West of former Northern Bahr el Ghazal State. It has caused some deaths and injuries, and deeply affected the daily lives of over 650 households in eight villages of Maban County, Upper Nile State. The floods have also destroyed roads, schools, homes, crops and vegetables in all the affected areas.
Ongoing events										
Angola	Cholera	G1	15-Dec-16	13-Dec-16	6-Aug-17	468	-	21	4.5%	Since 13 December 2016, cases have been detected in Cabinda (236), Soyo (227) and Luanda (5). Soyo reported zero cases since epidemiological week 26 and Cabinda reported the same since epidemiologic week 29. Luanda has not reported any cases since week 5. The high transmission areas are linked to the cholera outbreak in Kongo Central Province in DRC.
Benin	Flood	Ungraded	10-Sep-17	18-Sep-17	18-Sep-17	-	-	-		On 10 September 2017, the WHO Country Office in Benin was informed of flooding in the north of the country, especially Malanville and Karimama health zones. At least 544 households with 6 635 inhabitants, 367 pregnant women, and 2 688 children under 5 years of age were affected. About 172 households with 1 032 inhabitants are displaced or homeless. Most of the displaced persons have sought refuge with their parents in non-disaster areas, on farms or in the tents offered by the Red Cross. There is widespread damage to crops and livestock. No loss of human life has been reported and no particular increase in diarrhoea or malaria cases has been noted.
Burundi	Malaria	G1	22-Mar-17	1-Jan-17	25-Aug-17	5 787 490	-	2 580	0.04%	Weekly case counts are exceeding 2016 rates and on the rise. North-west and central provinces reported the highest incidence of disease in week 36.
Burundi	Cholera	Ungraded	20-Aug-17	20-Aug-17	12-Sep-17	32	4	0	0.0%	Cases have been reported from four districts: Nyanza-Lac (27), Cibitoke (1), Bubanza (1) and Mpanda (3).
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	23-Jul-17	-	-	-	-	Conflict in both north-east Nigeria and Central African Republic has led to mass population movement to Cameroon. 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. A detailed update was provided in the week 31 bulletin.
Cape Verde	Malaria	G2	26-Jul-17	27-Jan-17	17-Sep-17	225	-	1	0.4%	The incidence of new cases continues to increase with 35 new cases reported in the past 7 days. All indigenous cases to date have been reported from the city of Praia. Cases reported from São Vicente (6), Sal (1) and Porto Novo (1) likely all acquired the infection during travel to Praia or overseas, and there is currently no evidence of indigenous transmission within these locations. One death was reported this week in an indigenous case.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR %	Comments
Central African Republic	Humanitarian crisis	G2	11-Dec-13	11-Dec-13	9-Sep-17	-	-	-	-	The security situation in the country remains precarious with several security incidents recorded in different areas. From 24-25 August 2017, clashes were reported in and around the city of Kongbo resulting in several deaths and injuries. NGOs continue to be targeted by elements of armed groups – most recently the Catholic sisters of Bangassou were attacked on 25 August 2017. A detailed description of the case was provided in the week 36 bulletin.
Central African Republic	Pertussis	Ungraded	6-Sep-17	29-Jul-17	1-Sep-17	272	0	11	4.0%	Cases have been reported from Boda and Boganagone health districts. Investigations are ongoing to determine the cause and the extent of the problem.
Chad	Hepatitis E	G1	20-Dec-16	1-Aug-16	3-Sep-17	1 783	98	19	1.1%	Outbreaks are ongoing in the Salamat Region predominantly affecting North and South Am Timan, Amsinéné, South Am Timan, Mouraye, Foulonga and Aboudeia. Of the 64 cases occurring in pregnant women, five died (case fatality rate 7.8%) and 20 were hospitalized.
Chad	Cholera	Revised G1	19-Aug-17	14-Aug-17	17-Sep-17	370	6	52	14.1%	Cases have been reported from Koukou Health District (293) and Goz Beida Health District (68) in the Sila Region, as well as Am Timan Health District (9) in the Salamat Region.
Cote d'Ivoire	Dengue fever	Ungraded	3-May-17	3-May-17	29-Aug-17	1 231	311	2	0.2%	Abidjan city remains the epicentre of this outbreak, accounting for 97% of the total reported cases. The main health districts affected include Cocody, Abobo, Bingerville and Yopougon. Of the cases confirmed, 181 were dengue virus serotype 2 (DENV-2), 78 were DENV-3 and 13 were DENV-1. In addition, 39 samples were confirmed IgM positive by serology.
Democratic Republic of the Congo	Cholera	G2	16-Jan-15	24-Feb-15	26-Aug-17	23 959	-	528	2.2%	Detailed update given above.
Democratic Republic of the Congo	Humanitarian crisis	G3	20-Dec-16	17-Apr-17	30-Aug-17	-	-	-	-	Detailed update given above.
Democratic Republic of the Congo	Measles	Ungraded	10-Jan-17	2-Jan-17	22-Aug-17	30 211	449	370	1.2%	The incidence of new cases has declined since the current outbreak peaked in early 2017.
Democratic Republic of the Congo	Landslide	Ungraded	18-Aug-17	18-Aug-17	25-Aug-17	-	-	-	-	On the evening of 15-16 August 2017, torrential rains caused a landslide which destroyed almost all of the small, remote fishing village of Tara in the Djugu Territory, Ituri Province in the northeast of the country. Some 174 people are presumed dead; however, only 34 bodies were recovered. Eight seriously injured people were transferred to the Tchomia Health Centre. According to the OHCA, around 280 children were orphaned by the disaster and are being sheltered in a neighbouring village.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR %	Comments
Ethiopia	Acute watery diarrhoea (AWD)	Protracted 3	15-Nov-15	1-Jan-17	12-Sep-17	44 218	-	832	1.9%	534 new cases reported in week 36. The recent resurgence is predominantly occurring in the north-west regions of Amhara (222 cases), Tigray (167), and Afar (110) regions this past week.
Ethiopia	Humanitarian crisis		15-Nov-15	n/a	24-Aug-17	-	-	-	-	This complex emergency includes outbreaks of AWD and measles (reported separately below) and El Niño-related drought and food insecurity affecting the Horn of Africa.
Ethiopia	Measles		14-Jan-17	1-Jan-17	31-Jul-17	2 607	-	-	-	There have been 58 separate laboratory-confirmed measles outbreaks in the country. A detailed update was provided in the week 32 bulletin.
Ethiopia	Undiagnosed acute jaundice syndrome (AJS)		23-Aug-17	23-Aug-17	7-Sep-17	203	0	5	2.5%	Cases of AJS of unknown aetiology have surged in Dollo zone, Somali region since July. The cause remains unknown. A detailed update was provided in the week 37 bulletin.
Kenya	Cholera	G1	6-Mar-17	1-Jan-17	21-Sep-17	2 857	557	50	1.8%	Nationally case numbers continue to decrease. Six countries are currently reporting active outbreaks: Nairobi, Nakuru, Machakos, Vihiga, Kajiado and Kilifi.
Kenya	Drought/food insecurity	G1	10-Feb-17	n/a	24-Aug-17	-	-	-	-	As of 24 August, SMART surveys estimated the (low-medium-high) prevalence GAM in Kenya at 2.6-22.9-32.8, and SAM at 0.2-4.0-9.8%.
Kenya	Leishmaniasis, visceral (kala-azar)	Ungraded	7-Jun-17	4-Jan-17	26-Aug-17	457	362	7	1.5%	Marsabit (n=338) and Wajir (n=119) counties have been affected by outbreaks since early 2017. The outbreak remains active in Marsabit, where the last reported case was reported on 26 August 2017. The outbreak has been controlled in Wajir, where the last reported case was reported on 17 June 2017. No new cases were reported in the past week.
Madagascar	Plague (pneumonic)	Ungraded	13-Sep-17	13-Sep-17	15-Sep-17	32	2	5	15.6%	Activities have been scaled up to response to the ongoing outbreak of pneumonic plague, predominantly affecting the districts of Faratshiho, Antananarivo (and surrounds) and Toamasina. Investigations revealed the outbreak was linked to a case that died on 27 August during transit in a shared bush-taxi from Ankazobe district (a plague-endemic area) to Toamasina via Antananarivo. In addition, 25 other cases of plague (mainly bubonic) have been identified but are not directly linked to the outbreak. A detailed report was provided in the week 37 bulletin.
Madagascar	Food insecurity	Ungraded	23-Feb-17	n/a	15-Jul-17	-	-	-	-	Food insecurity continues in the south parts of the island. A recent food security assessment showed that from June to September 2017, an estimated 409 000 people (25% of the affected area population) will be in need of humanitarian assistance. A detailed update was provided in the week 30 bulletin.
Mali	Humanitarian crisis	G1	-	n/a	3-May-17	-	-	-	-	Limited information is available on this event. At the last update (3 May), the security situation remained unstable, and incidents of violence and inter-ethnic conflicts were increasingly spreading.
Mali	Dengue fever	Ungraded	4-Sep-17	1-Aug-17	14-Sep-17	212	16	0	0.0%	Active case search activities completed following detection of a case during a study has identified a total of 16 confirmed case from 212 samples tested to date.
Mauritania	Undiagnosed diarrhoeal disease	Ungraded	27-Jul-17	16-Jul-17	27-Jul-17	79	-	0	0.0%	Limited information is available on this event. At the last report, viral gastroenteritis was suspected in two clusters detected in Nouakchott.
Mauritania	Crimean-Congo haemorrhagic fever (CCHF)	Ungraded	25-Aug-17	20-Aug-17	25-Aug-17	1	1	0	0.0%	Single confirmed case in a shepherd from Boutilimit Prefecture. A detailed description of the case was provided in the week 34 bulletin.

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	11-Aug-17	-	-	-	-	The security situation remains precarious and unpredictable. On 28 June 2017, 16 000 people were displaced after a suicide attack on an IDP camp in Kablewa. In another attack on 2 July 2017, 39 people from Ngalewa village, many of them children, were abducted. The onset of the rainy season is impeding the movements of armed forces around the region.
Niger	Hepatitis E	Ungraded	2-Apr-17	2-Jan-17	13-Aug-17	1 610	441	38	2.4%	The majority of cases have been reported from the Diffa (912), N'Guigmi (286) and Bosso (235) health districts. Case incidence continues to decline.
Nigeria	Humanitarian crisis	Protracted 3	10-Oct-16	n/a	11-Aug-17	-	-	-	-	Since April 2017 about 15 000 Nigerian refugees have returned from Cameroon after the Tripartite commission began implementing the agreement on the voluntary return of Nigerian refugees. Living conditions in areas of return are difficult, as the influx has overwhelmed resources such water. On 28 July 2017, a suicide attack on a newly established camp in Dikwa LGA killed 14 people and wounded 24 others, mostly women and children.
Nigeria	Cholera (Borno State)		20-Aug-17	14-Aug-17	22-Sep-17	3 498	97	53	1.5%	Detailed update given above.
Nigeria	Lassa Fever	Ungraded	24-Mar-15	19-Feb-17	15-Sep-17	853	258	118	13.8%	Detailed update given above.
Nigeria	Cholera (nationwide)	Ungraded	7-Jun-17	1-Jan-17	18-Sep-17	7 052	145	149	2.1%	Confirmed outbreaks have been reported from 7 states: Borno, Kebbi, Zamfara, Kano, Lagos, Oyo, Kwara and Kaduna States. The outbreak was recently confirmed in Kaduna State (40 cases, 2 confirmed). Apart from Kwara where the outbreak has been controlled for an extended period, outbreaks are continuing on or being sustained at low levels in other states.
Nigeria	Hepatitis E	Ungraded	18-Jun-17	3-May-17	28-Aug-17	874	42	5	0.6%	The outbreak is concentrated in Borno State, with incidence steadily declining after peaking in week 26. The majority of cases have been reported Ngala (697), Mobbar (71) and Monguno (62).
Nigeria	Floods	Ungraded	3-Sep-17	27-Aug-17	11-Aug-17	-	-	-	-	On 27 August 2017, following a heavy rains and failure of the drainage system across the city a flooding disaster occurred in Makurdi. After initial assessment of the town, the state Governor announced the setting up of two IDP camps at the Makurdi International Market and Agan town at the outskirt of the city. As of 2 September 2017, 450 households have been registered; the exact population of the households is yet to be determined as registration is still ongoing.
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	21-Sep-17	1	1	0	0.0%	Detailed update given above.
São Tomé and Principé	Necrotising cellulitis/fasciitis	G2	10-Jan-17	25-Sep-16	21-Sep-17	2 031	-	0	0.0%	Case numbers continue to fluctuate at low-moderate levels. During week 37, 34 new cases were reported.
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	10-Sep-17	3 878	1,295	-	-	Dengue virus serotype 2 (DEN-2) is predominating. Cases have been reported from all regions of the three main islands (Mahé, Praslin and La Digue). A detailed update was provided in the week 32 bulletin.
Sierra Leone	Flooding/ mudslide	G1	14-Aug-17	14-Aug-17	14-Sep-17	-	-	-	-	Detailed update given above.
South Sudan	Humanitarian crisis	G3	15-Aug-16	n/a	14-Sep-17	-	-	-	-	As of week 36, 1.87 million people are internally displaced, about two millions people are refugees in neighbouring countries, and six million people are food insecure. OCV campaigns are ongoing.
South Sudan	Cholera	Ungraded	25-Aug-16	18-Jun-17	10-Sep-17	19 889	-	355	1.8%	Cholera transmission is on the decline countrywide. During August, five counties (Budi, Juba, Kapoeta East, Kapoeta South, and Nyirol) reported cholera transmission. The interruption of transmission is attributed to coordinated interventions in WASH, case management and OCV.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR %	Comments
Uganda	Drought/food insecurity	G1	1-Jul-17	n/a	24-Aug-17	-	-	-	-	This event forms part of a larger food insecurity crisis in the Horn of Africa. The northern and eastern regions are predominantly affected.
Uganda	Humanitarian crisis - refugee	Ungraded	20-Jul-17	n/a	30-Aug-17	-	-	-	-	The influx of refugees to Uganda has continued as the security situation in the neighbouring countries remains fragile. According to UNHCR, the total number of registered refugee and asylum seekers in Uganda stands at 1 326 750, as of 1 August 2017. More than 75% of the refugees are from South Sudan. Detailed update given in the week 35 bulletin.
Uganda	Measles	Ungraded	8-Aug-17	24-Apr-17	18-Sep-17	552	-	-	-	Detailed update given above.
Uganda	Crimean-Congo haemorrhagic fever (CCHF)	Ungraded	21-Aug-17	10-Jul-17	24-Aug-17	11	2	3	27.3%	No additional cases have been reported. A detailed description of this event was provided in the week 35 bulletin.
United Republic of Tanzania	Cholera	G1	20-Aug-15	1-Jan-17	10-Sep-17	2 852	-	48	1.7%	The outbreak is trending upward with 158 new cases and 1 death in week 36. During this week, cases were reported from Mbeya (76), Tanga (56), Kigoma (15), Njombe (10) and Katavi (1). Zanzibar has reported zero cases since 11 July 2017.
Congo (Republic of)	Monkeypox	Ungraded	1-Feb-17	18-Jan-17	14-May-17	78	7	4	5.1%	Limited information is available on this event. No new cases have been reported to WHO since the last reported cases May 2017.
Democratic Republic of the Congo	Circulating vaccine-derived polio virus (cVDPV)	Ungraded	17-May-17	20-Feb-17	13-Sep-17	8	8	0	0.0%	An outbreak of a circulating vaccine-derived poliovirus type 2 (cVDPV) have been confirmed in Upper Lomami and Maniema. The date of the onset of paralysis of the last case 20 June 2017, bringing the total to 8 cases this year. The outbreak response included three rounds of mOPV2 vaccinations implemented on 27-29 June (in the 2 affected provinces), 13-15 July in Haut Lomami and 20-22 July 2017 in Maniema, and 31 August to 2 September in both affected provinces.
Recently closed events										
Central African Republic	Monkeypox	Ungraded	9-Feb-17	7-Feb-17	13-Jul-17	5	2	0	0.0%	Limited information is available on this event. No new cases have been reported to WHO since the last reported case in week 24.
Kenya	Dengue fever	Ungraded	8-May-17	23-Mar-17	6-Sep-17	1 537	806	1	0.1%	Outbreak in the Mombasa (1 455 cases) and Wajir (82 cases) counties have been successfully controlled. The last cases reported on 30 July and 20 June 2017 within the two counties, respectively.
United Republic of Tanzania	Aflatoxicosis	Ungraded	17-Jun-17	15-Jun-17	6-Aug-17	8	-	4	50.0%	Between 15 June and 13 July 2017, two unrelated clusters of suspected acute aflatoxicosis, affecting two families in separate towns in Kiteto District, Manyara Region in the northern part of Tanzania. No further cases have been reported to date. 30 blood samples collected during community investigations have been submitted for aflatoxin testing, and 28 blood samples for pesticide poisoning; results pending.

†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
A. Bakainaga (Uganda)
R. Musoke (Sierra Leone)
M Stephen (Nigeria)

Graphic design
Mr. A. Moussongo

Editorial Team
Dr. B. Impouma
Dr. C. Okot
Dr. E. Hamblion
Dr. B. Farham
Dr. V. Sodjinou
Ms. C. Machingaidze
Mr. B. Archer
Dr. D. Kpandja
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Production Team
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Mr. C. Massidi

Editorial Advisory Group
Dr. I. Soce-Fall, *Regional Emergency Director*
Dr. B. Impouma
Dr. Z. Yoti
Dr. Y. Ali Ahmed
Dr. F. Nguessan
Dr. M. Djingarey

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

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