

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 27: 1 – 7 July 2017
Data as reported by 17:00; 7 July 2017



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New event

39

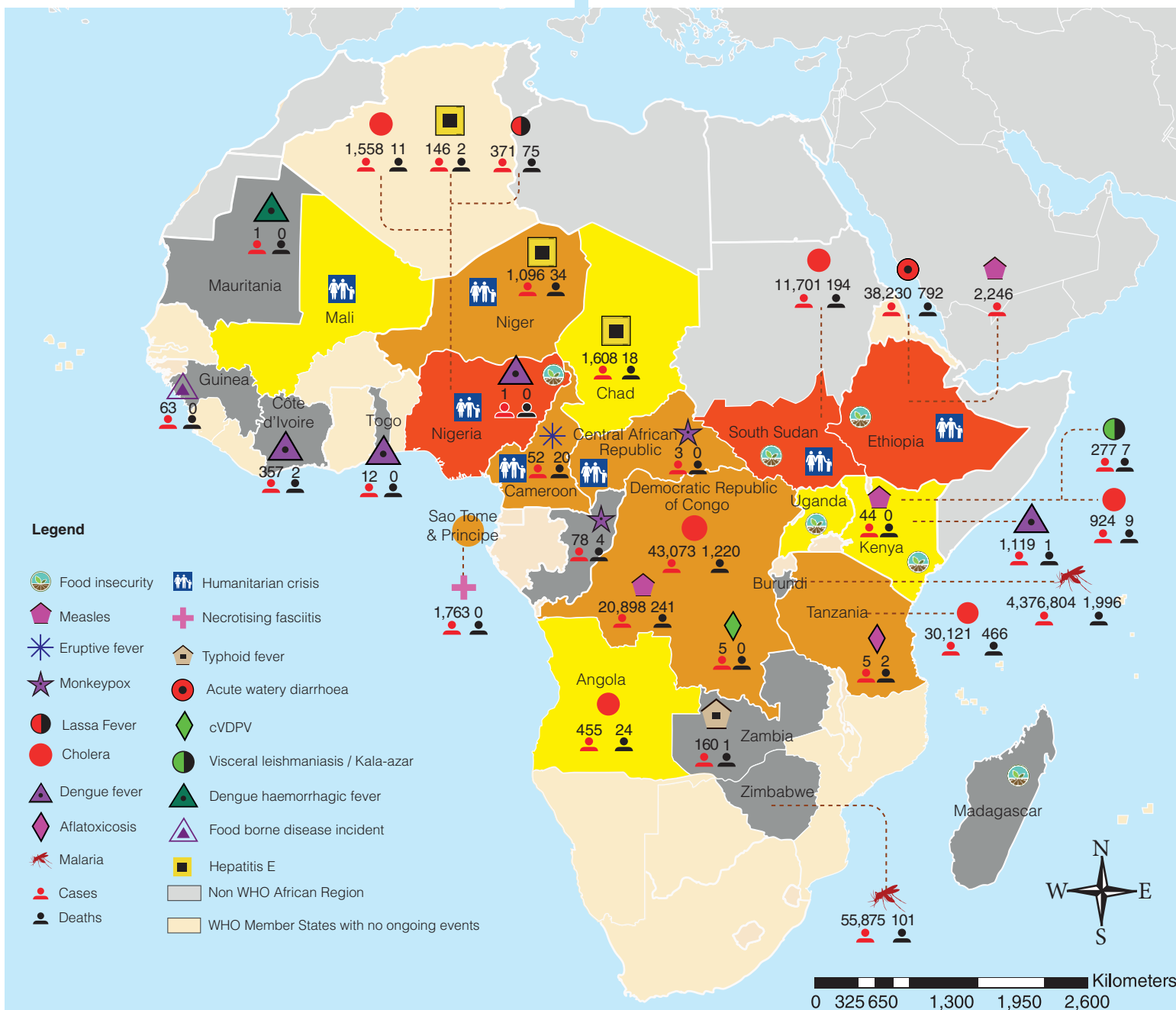
Ongoing events

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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 39 events: three Grade 3, six Grade 2, six Grade 1, and 24 ungraded events.
- This week's edition covers key ongoing events in the region, including the grade 3 humanitarian crises in South Sudan and Ethiopia and outbreaks of hepatitis E in the Lake Chad Basin (Chad, Niger and Nigeria), malaria in Burundi, dengue fever in Côte d'Ivoire, and visceral leishmaniasis in Kenya.
- For each of these events, a brief description followed by public health measures implemented and an interpretation of the situation is provided.
- A table is provided at the end of the bulletin with information on all public health events currently being monitored in the region.
- Major challenges to be addressed include:
 - The persistent and increasing incidence of malaria in Burundi, taking place within the context of humanitarian crisis, needs to be tackled more aggressively.
 - The number of countries in the African Region reporting dengue fever has been steadily growing. This could be an early indication of increasing endemicity of the disease in the region. Countries in the region need to strengthen their capacity for detection, confirmation and effective response to the disease.

Ongoing events

Malaria

Burundi

4,376,804
Cases

1,996
Deaths

0.05%
CFR

Event description

The malaria outbreak situation in Burundi continues unabated with intense transmission causing high morbidity and mortality. The disease trend has been increasing in the past 10 weeks. In week 25 (week ending 25 June 2017), 173,355 clinical cases of malaria including 102 deaths (case fatality rate 0.06%) have been reported, compared to 170,048 cases and 61 deaths (case fatality rate 0.04%) reported in week 24. Since the beginning of 2017, 4,376,804 cases including 1,996 deaths (case fatality rate 0.05%) have been reported, as of 25 June 2017. Meanwhile, a total of 8,169,484 cases and 3,826 deaths (case fatality rate 0.05%) were registered in 2016. While the entire country is reporting a high burden of malaria, the northern, central and eastern regions are most affected. Ten out of 18 provinces in the country have attained the epidemic threshold, namely Karusi, Gitega, Muyinga, Kirundo, Kayanza, Ngozi, Bubanza, Cankuzo, Cibitoke, and Ruyigi. The 10 provinces represent 63% of the population at risk. With an incidence rate of 51.9%, malaria has been the leading cause of morbidity and mortality in Burundi.

Since 2014, the incidence of malaria in Burundi has been increasing. However, the epidemic threshold was reached in 2016. The outbreak was confirmed by a multidisciplinary investigation conducted in January 2017, which documented an increase in malaria incidence above the expected threshold. The Ministry of Health formally declared the outbreak on 13 March 2017.

The malaria outbreak in Burundi is taking place against the background of a worsening humanitarian crisis, characterised by insecurity, mass population movements and food insecurity. The International Organization for Migration estimated that 149,028 persons have been displaced internally and there are an additional 86,014 persons living with host communities.

Public health actions

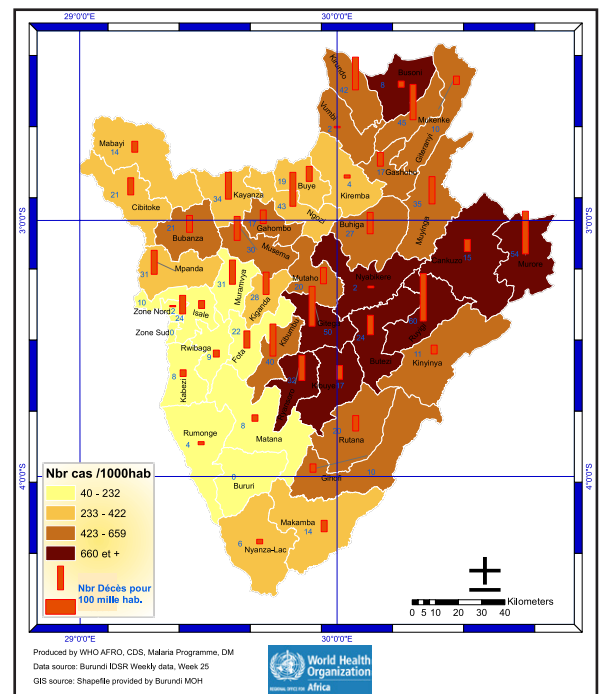
- The thematic response subgroups (monitoring, evaluation, prevention, and care) continue to hold regular coordination meetings. Weekly analysis and interpretation of data for trends is being conducted to monitor the evolution of the outbreak.
- A total of 75 medical officers and 200 paramedics (nurses and laboratory technicians) have been deployed in the most affected provinces to strengthen clinical management of malaria patients.
- Enumeration and distribution of vouchers in households in preparation for the national mass distribution of long-lasting insecticide-treated bed nets (LLITN) campaigns has been going on since June 2017. The national campaign is scheduled for 10-14 July 2017, and is expected to distribute 6,471,695 units of LLITN.
- Prepositioning of insecticides for the second round of indoor residual spraying in Cankuzo, Karusi and Rutana Provinces is in progress.
- A total of 126 healthcare workers have been mobilized and trained to operate mobile clinics in six provinces (Ngozi, Gitega, Kirundo, Muyinga, Kayanza, and Ruyigi), aimed to extend malaria case management to affected communities.
- WHO has strengthened its response capacity in Burundi through deployment of core personnel, including an incident manager, health information officer, epidemiologist, field coordinator, and logistician. The process to deploy additional medical professionals and public health experts is underway. A rapid risk assessment was undertaken and a 3-level grading call will be performed on Monday 10 July 2017.
- An integrated Mother-Child Health Week campaign was conducted from 19-23 June 2017, with a package of services including routine immunization, administration of vitamin A, deworming, antenatal care, distribution of soaps to pregnant women, and voluntary blood donation.

Situation interpretation

The malaria outbreak in Burundi has been increasing persistently despite ongoing response interventions. In the past 10 weeks the incidence of cases has increased. The main factors influencing the evolution of the outbreak include recurrence of floods and favourable climatic conditions, insufficient human, financial, logistical resources, and suboptimal multisectoral collaboration at various levels, leading to an inadequate response to the outbreak. These factors are being compounded by the ongoing humanitarian crisis and food insecurity, causing severe acute malnutrition that increases the vulnerability of children.

The response operations to this malaria outbreak need to be scaled up urgently, employing effective and known high-impact interventions. This is particularly critical as the rainy season approaches, which is a high-transmission period. WHO calls on all stakeholders, both government and partners, to mobilize the required resources and intensify implementation of effective control interventions at community level.

Geographical distribution of malaria cases in Burundi, week 25 of 2017



Event description

The general trend of the dengue fever outbreak in Côte d'Ivoire has been steadily increasing as new areas outside Abidjan are beginning to report cases. Between 20 and 27 June 2017, 87 new suspected dengue fever cases have been reported, of which 86 originated from Abidjan and one case from Issia (outside Abidjan).

Since the onset of the outbreak in April 2017, 444 suspected cases, including two deaths (case fatality rate 0.5%), have been reported, as of 27 June 2017. A total of 136 cases have been confirmed at the Institut Pasteur de Côte d'Ivoire (IPCI) laboratory. Seventy-one percent (96/136) of the positive samples isolated dengue virus serotype 2, while 32 samples were dengue type 3 and eight samples dengue type 1. The outbreak has been mainly limited to Abidjan, with Cocody, Abobo, Bingerville and Yopougon being the most affected townships. Cocody has remained the epicentre of the outbreak, accounting for 97% of the total caseload. Fifty-five percent of the affected people were aged 30 years and above and 28% were between 15 and 29 years. Women accounted for 57% of the cases.

The dengue fever outbreak in Côte d'Ivoire emerged on 22 April 2017 when the initial case, a 17-year-old boy from Deux-Plateau-Vallon in Cocody-Bengerville health district, presented to the local health facility with a febrile illness that was not responsive to a course of antimalarial treatment. Blood samples obtained from the case-patient on 23 April 2017 tested positive for dengue virus serotype 3 at the IPCI on 28 April 2017. The Ministry of Health and Public Hygiene notified WHO of the outbreak on 3 May 2017.

Public health actions

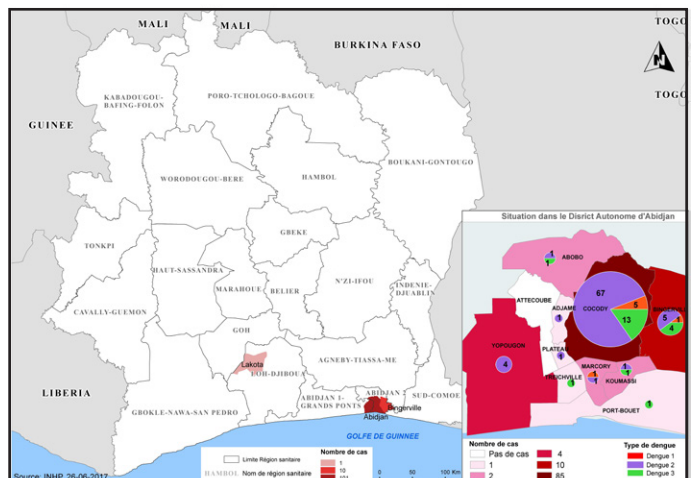
- The Ministry of Health, with support from WHO and partners, continues to implement outbreak control measures.
- Dissemination of case definition, active case search and collection of samples from suspected cases for laboratory confirmation, as well as field investigation, are ongoing.
- The capacity of private health centres in disease surveillance is being strengthened and weekly feedback on the disease is being provided.
- Vector control interventions are being implemented, including fumigation and destruction of mosquito breeding sites. A total of 985 households have been visited and 11,738 mosquito breeding sites destroyed. On average, 85% of the population have been engaged and are participating in sanitation improvement activities.
- Political, religious and community leaders are being sensitized on prevention and control of the disease. The Minister of Health has engaged the Town Mayors for their involvement in the control activities in their respective areas.

Situation interpretation

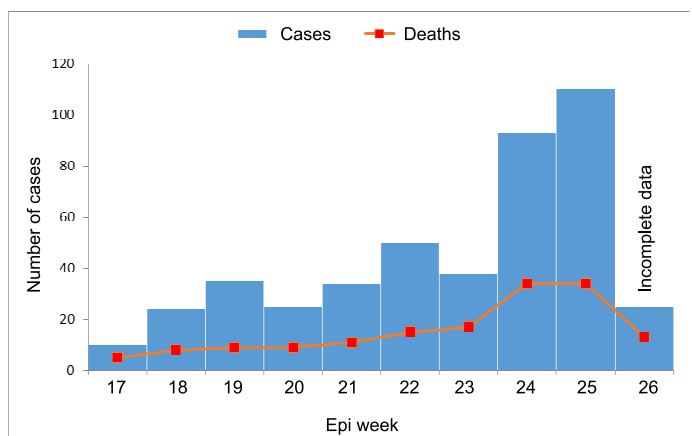
The ongoing dengue fever outbreak in Côte d'Ivoire was predictable. The coastal regions of the country, including Abidjan, are at high risk of dengue transmission, given the tropical climate with mixed urban and semi-urban settlements. The high entomological indices observed during the rapid assessment conducted at the beginning of the outbreak validated the potential risk for a dengue fever outbreak. The current rainy season and the high density of the mosquito vector in Abidjan and surrounding areas are maintaining the transmission of the disease.

Dengue fever transmission is currently taking place in many countries. In 2016/2017, outbreaks have occurred in Cape Verde, Burkina Faso, Kenya, Togo, etc. This is probably indicative of the widening endemicity of the disease in many sub-Saharan African countries. It is therefore important for countries in the African Region to strengthen capacity for early detection, rapid confirmation (including the use of rapid diagnostic tests), and appropriate response to the disease. To that effect, training of healthcare workers, strengthening laboratory networks, enhancing entomological surveillance, and promoting environmental and vector control activities are crucial.

Geographical distribution of dengue fever cases in Côte d'Ivoire, 22 April - 27 June 2017.



Weekly trend of dengue fever cases in Côte d'Ivoire, 22 April - 27 June 2017.



Event description

Three countries in the Lake Chad Basin, namely Chad, Niger and Nigeria, are experiencing concurrent outbreaks of hepatitis E. In Chad, the outbreak started in August 2016 in the Salamat Region where the disease remains active and confined. During week 26 (week ending 2 July 2017), 23 new suspected cases have been reported, against 19 cases the previous week. The cases came from four districts: Aboudeia (15), Amtiman North (5), Amtiman South (2), and Moraye (1). As of 2 July 2017, a total of 1,631 suspected/confirmed cases including 18 deaths (case fatality rate 1.1%) were reported. Of these, 77 cases have been hospitalized, including 20 pregnant women. To date, 98 samples have tested positive for hepatitis E virus.

In Niger, cases of hepatitis E were first detected on 2 January 2017. The outbreak appears to have peaked in week 19, with a staggered decline in the incidence of new cases since then. However, during week 25 (week ending 25 June 2017), 66 new suspected cases were reported. This reflects an increase in the number of cases, most especially in Diffa Region. As of 29 June 2017, a total of 1,096 suspected/confirmed cases including 34 deaths (case fatality rate 3.1%) have been reported in the country. The majority, 60%, of cases were from Diffa, followed by Bosso (21%) and N'Guigmi (18%). Meanwhile, Goudoumaria and Mainé Soroa Regions have reported sporadic cases. The most affected age group is older adolescents and young adults aged 15 to 39 years. Sixty percent of the cases are female, of which 85% are aged 15-49 years (women of childbearing age). Of 649 samples tested to date, hepatitis E virus was detected in 439 (68%) by PCR.

Nigeria is the latest country to report an outbreak of hepatitis E, with initial cases detected on 3 May 2017 in Damasak, a locality at the border of Niger. As of 30 June, 146 suspected/confirmed cases have been reported from three local government areas: Ngala (112 cases), Mobbar (19 cases) and Monguno (14 cases). Twenty-five women have been affected in Ngala, including two deaths (case fatality rate 8.0%). To date, hepatitis E virus has been confirmed in 21 samples. This outbreak has the potential to propagate rapidly due to the ongoing humanitarian crisis in the region, and population movements across the borders.

Public health actions

- The respective Ministries of Health, with the support of WHO and partners, continue to coordinate, investigate and respond to these outbreaks. In Chad, WHO has deployed one water, sanitation and hygiene (WASH) and one social mobilization expert. In Niger, a capacity building assessment has been conducted from 17-24 June 2017. In Nigeria, the NCDC, WHO and partners are providing technical, logistical and financial support to the state and federal governments, within the overall framework of humanitarian response.
- Implementation of WASH interventions continues in all the countries. In Chad, efforts to increase access to safe water continue, with the treatment and distribution of potable water. In Nigeria, tracking of safe drinking water, disinfection and chlorination of water points, distribution of chlorine tablets, and disinfection of household water storage containers are ongoing in refugee camps and villages in Sayam, Kindjandi, Assanga, and Kablewa.
- Case management, mainly supportive care, is being provided at the local health facilities with the support of partners. Symptomatic women (especially pregnant women) are receiving priority. In Chad, MSF continues to support Am Timam Hospital by supplying medicines and other commodities. In Nigeria, a unit has been set up by MSF in Ngala for the management of hepatitis E-infected women, in addition to the UNICEF clinic.
- Samples are being collected from suspected cases presenting with jaundice in all areas. In Nigeria, authorities are exploring mechanisms to boost laboratory testing capacities, including the potential deployment of mobile laboratories.
- Community sensitisation and risk communication activities continue to be strengthened in all countries through general community information sessions, the dissemination of preventive messages through multiple channels, and other mechanisms.

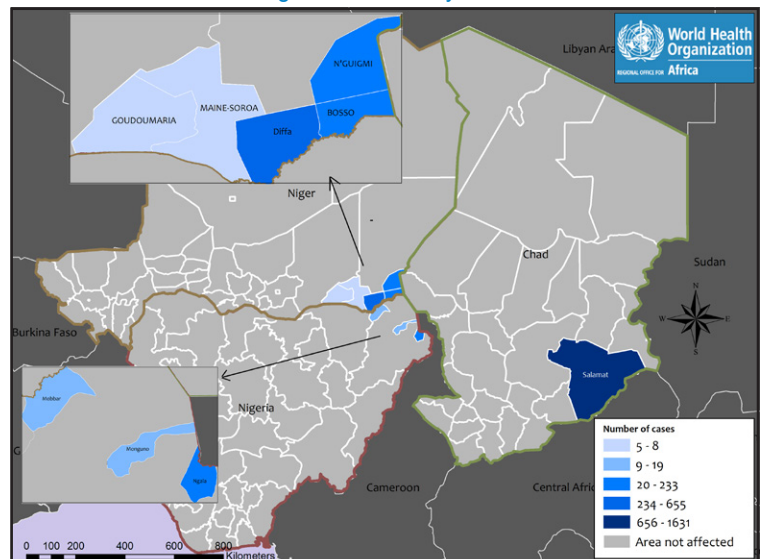
Situation interpretation

The concurrent occurrence of hepatitis E outbreaks in countries of the Lake Chad Basin is largely attributed to limited access to safe-drinking water (with the affected communities resorting to unsafe water sources) and inadequate sanitation facilities, perpetuating the faecal-oral transmission cycle. Hepatitis E is known to rapidly spread in internally displaced persons and refugee settings, and these outbreaks are indeed occurring within the context of humanitarian crises. The unstable security situation drives populations across the region. As free movement of displaced and returning populations facilitate the spread of the virus between countries, authorities must work rapidly to establish WASH interventions in all affected areas as the primary means of preventing new infections. For this, a strong technical and financial support is required from the international public health community, combined with strong cross-border collaboration between the countries.

In general, hepatitis E virus infections are self-limiting with a normally low case fatality rate (0.1 – 0.3%) in immunocompetent people. However, women in the third trimester of pregnancy are especially susceptible to fulminant disease. Although surveillance systems are likely underestimating the true extent of these outbreaks, the reported disproportionate burden of the disease in pregnant and other women of child-bearing is concerning. Hospitalization is required for people with fulminant hepatitis, and should also be considered for symptomatic pregnant women.

Strengthening laboratory capacity (most especially in Borno State, Nigeria) is also paramount as cases of hepatitis E are clinically indistinguishable from other forms of viral hepatitis.

Geographical distribution of hepatitis E cases in Lake Chad Basin, August 2016 - 2 July 2017.



Event description

Kenya has been experiencing an outbreak of visceral leishmaniasis (also known as kala-azar) since January 2017. The initial cases of the disease were reported on 4 January 2017 in Marsabit County in the mid-north of the country. One month later (on 4 February 2017), the disease was also detected in Wajir County in the east of Kenya. The outbreak remains active in both areas. In week 26 (week ending 2 July 2017), 22 new cases of kala-azar were reported from Marsabit County, while Wajir County reported the last cases on 17 June 2017.

As of 4 July 2017, a total of 277 cases, including seven deaths (case fatality rate 2.5%), have been reported from the two counties. Of these, 183 cases were confirmed by rapid diagnostic test (RDT) and 92 were probable cases. Marsabit County has reported a total of 162 cases and three deaths, coming from three sub-counties: Laisamis (101 cases), North Horr (52 cases) and Saku (9 cases), while Wajir County has reported a total of 115 cases including four deaths.

Public health actions

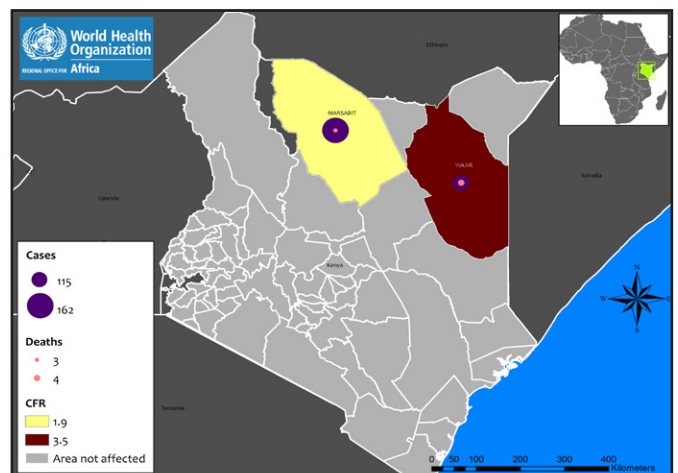
- The Ministry of Health continues to coordinate the response to the outbreak through a national task force supported by the WHO and several partners, including the University of Nairobi, the Drugs for Neglected Diseases Initiative and the Foundation for Innovative New Diagnostics.
- Case management for all infected patients is ongoing in the health facilities in the affected areas. During June 2017, WHO shipped a supply of anti-leishmanial medicines from its global buffer stocks to support treatment sites in Marsabit County.
- Between 18 and 21 June 2017, officials from the National Kala-azar Programme in Nairobi and WHO visited Marsabit County to provide on-the-ground support. The Ministry also dispatched testing kits and medical supplies to the kala-azar-affected counties in Wajir and Marsabit, as well as to Isiolo.
- Enhanced disease surveillance is also ongoing, including active case search in the most affected areas. WHO will be supporting the re-orientation of rapid response teams at county level on outbreak management, early warning and water quality testing to bolster the response to the concurrently occurring outbreaks of leishmaniasis, cholera, measles, and dengue in Kenya.
- Health promotion has been scaled up and additional efforts are being put in place by the Ministry of Health and partners to prevent further transmission of the disease.
- Vector control activities are ongoing, including inspection and identification of mosquitoes breeding sites with subsequent larviciding, and targeted indoor residual spraying of households and institutions in affected areas.

Situation interpretation

Leishmaniasis is caused by a protozoan parasite transmitted by the bite of infected phlebotomine sandflies, and often linked to environmental changes such as deforestation, building of dams, irrigation schemes, and urbanization. The disease is endemic in Kenya, with most cases presenting with a cutaneous form of the disease – causing facial ulcers, disfiguring scars and disability. The most severe form of the disease (visceral leishmaniasis) attacks the internal organs and, if left untreated, can be fatal in more than 95% of cases within 2 years of onset. There is, therefore, an urgent need to expand the number of screening, diagnostics and treatment sites to improve access to health services within affected communities.

The Ministry of Health and partners, however, face numerous challenges in responding to this outbreak. Some of the challenges include limited equipment and chemicals for vector control, inconsistent supply of commodities (anti-leishmanial drugs are mostly produced by a single manufacturer), limited capacity for laboratory diagnostics, inadequate number of trained personnel in the rapid response teams, and inadequate resources for health promotion and community engagement, outreach activities and mass education. Moreover, the response efforts are being stretched by the concurrent outbreaks of cholera, dengue and measles, as well as the ongoing drought-induced humanitarian crisis within the country.

Geographical distribution of visceral leishmaniasis cases in Kenya, 4 January - 4 July 2017



Event description

The impact of the drought-induced humanitarian crisis in the south-eastern part of Ethiopia continues. Internal displacement of people and their livestock, the arrival of refugees and their livestock from drought-affected Somalia and the recent influx of refugees from South Sudan further exacerbates the situation. To date, 4.3 million people are in need of health assistance, 800,000 people have been displaced and 300,000 people, mainly children, severely malnourished.

The acute watery diarrhoea (AWD) outbreak situation has continued to improve, with active transmission mainly ongoing in three out of the seven previously-affected regions. In week 26 (week ending 2 July 2017), 235 cases of AWD were reported from the three regions (Somali 156, Oromia 50 and Amhara 29), compared to 528 cases reported in week 25. Since the beginning of 2017, a total of 38,230 cases including 792 deaths (case fatality rate 2.1%) have been reported from seven regions, namely: Somali, Oromia, Amhara, Afar, SNNP, Tigray, and Benshangul Gumuz. Eighty-nine percent of these cases and 95% of the deaths were reported in Somali Region alone.

No new cases of measles were reported during reporting week 26. As of 2 July 2017, a total of 2,246 suspected measles cases have been reported from across the country since the beginning of the year. These include 989 confirmed cases (443 laboratory-confirmed, 490 epidemiologically-linked and 56 clinically-compatible). Oromia Region remains the most affected with 31% of the reported cases, followed by Amhara at 28%. Children below 5 years of age remain the most affected age group, accounting for 39% of the affected population, followed by the age group 5-14 years constituting 37%.

In week 25 (week ending 25 June 2017), 1,429 and 417 new cases of severe acute malnutrition (SAM) have been reported in Oromia and Amhara Regions respectively. Between weeks 1 and 25 of 2017, a total of 34,665 and 11,432 SAM cases were reported from the Oromia and Amhara Regions respectively.

Public health actions

- Continued engagement of religious, community and other opinion leaders to participate in risk communication and health promotion.
- A consultative meeting with the leaders of the Orthodox Church was convened to jointly address the emerging exposure issues responsible for the recent upsurge in AWD cases and strengthen preventive measures.
- The case management team continues to monitor and strengthen adherence to infection prevention and control (IPC) and case management protocols in the affected regions.
- Continued support is being provided to the Somali Regional Health Bureau and other community structures to provide services to the hard-to-reach communities.
- USD 2.3 million released from the Central Fund for Emergencies to support the scaling up of the current AWD response in Somali Region.
- Screening for immunization and nutritional status among displaced persons and refugees is being conducted at the Gambela and Benshangul Gumuz borders, targeting all children less than 14 years of age.
- A preliminary report of the phase 1 integrated measles campaign in Somali Region shows an administrative coverage of 97%. Meanwhile, independent monitoring has put the coverage at 95%, with Gashamo (attaining 85%) the only woreda with coverage of less than 90%.

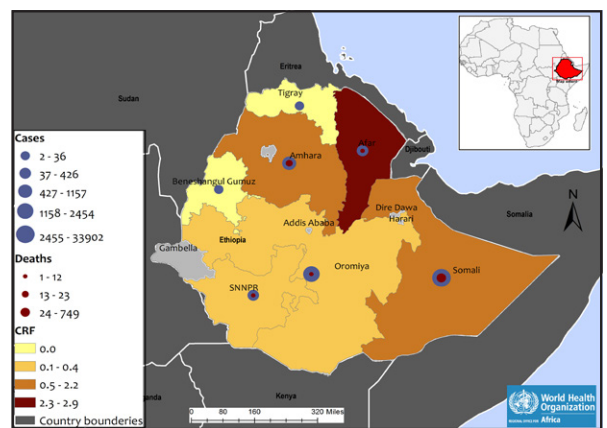
Situation interpretation

While the overall humanitarian situation in the south-east of Ethiopia still remains serious, the outbreak of AWD has improved markedly. The weekly AWD incidence has reduced from over 4,000 cases per week at the peak of the outbreak between weeks 13 and 15. This current decline in the trend is being attributed to the concerted efforts of the national authorities and humanitarian partners to scale up response interventions.

The current response is being complicated by difficulties in reaching nomadic pastoralists who are dispersed and highly mobile, and yet at a high risk of contracting AWD due to limited access to safe water and sanitation. The increasing number and wide geographic distribution of IDPs (176 sites) further complicates the distribution of safe water. There is a need to continue monitoring the quality of water trucked by the private sector.

WHO and all the partners continue to work with the Federal Ministry of Health and the Regional Health Bureaus to ensure that the AWD outbreak is ultimately contained, as well as the measles outbreak and the malnutrition situation.

Geographical distribution of acute watery diarrhoea cases in Ethiopia, 1 January - 2 July 2017.



Event description

The security situation in South Sudan remains volatile with high tensions in many places. Threats against aid workers and contractors, by armed people, continue. Nine aid workers detained on 6 June 2017 in Guit County remain in detention as negotiations for their release are ongoing. In Upper Nile, fighting around Manthiang resulted in the relocation of humanitarian partners to Pagak by road. Relocation out of Pagak is under consideration, depending on further developments. In recent weeks, there have been increasing incidents of armed men entering Protection of Civilians (PoCs) camps and conducting robberies.

In the last weeks, inter-communal violence and cattle raids have been reported in many places, including the Lakes, and Northern and Southern Aerial Counties. About 102 deaths and 60 injuries were reported in June 2017. There are unconfirmed reports of nearly 6,000 people in the western part of Lakes fleeing to Unity as a result of inter-communal fighting in the past week.

There have been random population movements in many places, with people reportedly returning to different locations, depending on the security situation. Many internally displaced persons have begun returning to their homes during the day and use the PoCs for shelter at night. There are also reports of increasing incidences of gender-based violence, adolescent pregnancy, domestic violence, and violence against children, attributed to congestion and difficult living conditions in camps.

The cholera outbreak in South Sudan is ongoing. During week 26 (week ending 2 July 2017), 37 new cholera cases and one death (case fatality rate 2.6%) were reported. In the last 4 weeks, 2,044 cases and 44 deaths (case fatality rate 2.1%) have been reported. Since the onset of the current outbreak on 18 June 2016, 11,700 cases including 194 deaths (case fatality rate 1.6%) have been reported.

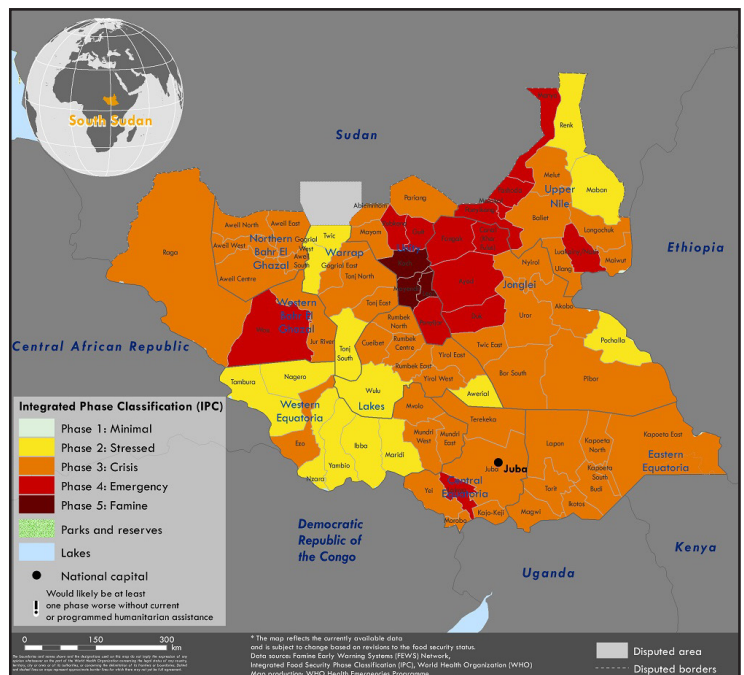
Public health actions

- The United Nations Humanitarian Air Service (UNHAS) has resumed regular flights to Pochalla after a month of cancellations as a result of the security situation.
- Training on Protection from Sexual Exploitation and Abuse (PSEA) and Adolescent Sexual and Reproductive Health, including reporting mechanisms, has been conducted for community health workers and outreach staff to enable them create community awareness.
- General food distribution is ongoing. During June 2017, a total of 3,103 metric tons of assorted food commodities were distributed to 841,183 beneficiaries in Northern Bahr el Ghazal. A total of 70,802 children under 5 years received Corn-Soya-Blend. In addition, 81,666 people received 53,752 South Sudan Pounds through Cash for Assets (CFA) programme.
- The registration and verification exercise in Rumbek North and Cueibet Counties is complete and 150,000 vulnerable people in the Lakes have been targeted for distribution.
- The National Cholera Taskforce continues to meet weekly in Juba. There are twice-weekly cholera coordination meetings at the Juba teaching hospital. At sub-national level, cholera taskforce committees are coordinating responses in areas with active transmission.
- A total of 15 cholera treatment facilities have been set up in Kapoeta State. In addition, the WHO/MoH team deployed in Kapoeta conducted on-the-job support and training on cholera case management, use of cholera RDT, and infection prevention and control for the health workers.
- On 28 June 2017, American Refugee Council (ARC) and WHO carried out training on community-based case detection and management for Cholera Response Supervisors for Kapoeta South and Kapoeta East.
- UNICEF Health Officers from all supported states have been trained by a WHO team in the use of cholera investigation kits, to allow laboratory confirmation of cholera at affected sites.
- Cholera vaccines have been deployed in Leer, Bor PoC, Malakal Town, Bentiu PoC, Bentiu PoC, Mingkaman IDP settlement, Aburoc IDPs, and Bentiu/Rubkona Town. In 2017, a total of 369,422 doses of the vaccine have been deployed targeting individuals aged one year and above. WHO has secured a total of 544,140 doses of oral cholera vaccines in 2017.

Situation interpretation

The intense conflict in South Sudan since mid-2016 has resulted in unprecedented levels of human suffering, with a staggering 6 million people facing severe food insecurity during June and July 2017. Ongoing violence, market disruption and crop failures have resulted in soaring food prices, leading to instability in areas that were previously stable. In addition, civilians are regularly subjected to human rights violations, including sexual violence. The crisis continues to trigger major public health risks and disease outbreaks, of which cholera is currently the most severe. Malaria and measles continue to be a concern. WHO and other partners continue to provide humanitarian assistance to the populations in need.

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 malaria outbreak in Burundi has been persisting since 2016 and is not showing any signs of alleviating despite the ongoing response. The outbreak is taking place within the context of a humanitarian crisis. Effective response to the outbreak has been challenged by insufficient resources and capacity, in addition to other factors. The outbreak is likely to escalate with the coming second rainy season, which will accentuate malaria transmission. This outbreak needs to be tackled more aggressively and comprehensively.
- The number of countries in the African Region reporting dengue fever has been steadily growing. In 2016/2017 alone, five countries have experienced dengue fever outbreaks, namely Burkina Faso (2,736 cases and 22 deaths), Cape Verde (128 cases), Kenya (153 cases), Togo (12 cases), and Côte d'Ivoire (357 cases and 2 deaths). This picture could be an early indication of increasing endemicity of the disease in the African region.

Proposed actions

- All stakeholders, both government and partners, to urgently mobilize the required resources and scale up implementation of effective control interventions at community level. The interventions should comprehensively cover all the affected provinces, including the other parts of the country.
- Member States in the African Region, with support from partners, to strengthen capacities to detect, confirm and effectively respond to dengue fever. Particular attention should be put on enhancing epidemiological and entomological surveillance, laboratory diagnostic capacity and integrated vector control.

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								
Foodborne disease incident	Guinea	Ungraded	02-Jul-17	63	0	0.0%	Isolated incident of foodborne illness in guest attending a wedding. 63 developed symptoms of gastroenteritis 5-6 hours following consumption of the meal, 19 were admitted to hospital. Cholera was excluded on 5 specimens, further laboratory investigations are pending.	02-Jul-17
Aflatoxicosis	Tanzania	Ungraded	28-Jun-17	5	2	40.0%	MoH notified the event may be ongoing in Partimbo village, Kiteo District, Manyara region. From 15 to 16 June 2017, 5 children aged 3-9 years from the same family presenting with vomiting, abdominal pains, jaundice and ascites. Their illness was attributed to aflatoxicosis due to improper storage/damage of maize following harvest.	28-Jun-17
Ongoing events								
Humanitarian crisis	Nigeria	Protracted 3	-	-	-	-	A detailed update on this protracted event will be provided every second week. See also below an update on ongoing outbreaks.	06-Jul-17
Humanitarian crisis	South Sudan	G3 extension	-	-	-	-	A detailed update on this protracted event will be provided every second week. See also below an update on the ongoing cholera outbreak.	03-Jul-17
Humanitarian crisis/AWD	Ethiopia	Upgraded to G3	15-Nov-15	38,230*	792*	2.1%	This complex emergency includes outbreaks of AWD and measles (reported separately below). *Counts reported are AWD cases and deaths for 2017 YTD only. A detailed update on the protracted event will be provided every second week.	02-Jul-17
Humanitarian crisis	Cameroon	G2 extension	-	-	-	-	-	29-Jun-17
Humanitarian crisis	Central African Republic	Downgraded to G2	-	-	-	-	-	-
Humanitarian crisis	Niger	G2 extension	Beginning 2015	-	-	-	-	-
Cholera	Democratic Republic of Congo	G2	02-Jan-15	43,073	1,220	2.8%	Since the beginning of 2017, 13,721 suspected/confirmed cholera cases including 403 deaths (case fatality rate 2.9%) have been reported, up to 24 June 2017. Six provinces have been the worst affected during 2017, including Tanganyika, Sud-Kivu, Kongo Central, Mongala, Maniema, and Equateur.	24-Jun-17
Cholera	Tanzania	G2	04-Apr-15	30,121	466	1.5%	Since the outbreak started in August 2015: 25,478 cases including 393 deaths on the Tanzania mainland, and 4,643 including 73 deaths from Zanzibar. A sudden increase in suspected cholera cases was observed on the Tanzanian mainland this past week.	25-Jun-17
Necrotising cellulitis/ fasciitis	Sao Tome & Principe	G2	10-Jan-17	1,763	0	0.0%	There has been a steady decline in the disease trend since the beginning of 2017; however, this trend has stagnated in recent weeks, with an average of 20 cases being reported every week. The most affected districts are Caeue-South, Lembá and Lobata-North.	28-Jun-17
Drought/ food insecurity	Kenya	G1	-	-	-	-	SMART surveys highlighted that the rates of Global Acute Malnutrition rates increased across the country. An estimated 7.8 million population are in IPC3-5 during May/June 2017.	06-Jul-17
Drought/ food insecurity	Uganda	G1	-	-	-	-	6 July update - 200-900 individuals arriving daily (compared to 400-1,200) last week. June 2017 update - Refugee population: 1,277,476 individuals (74% of refugees are from South Sudan). Crude mortality: 0.1/10,000. Under 5 mortality: 0.3/10,000. No major outbreaks, except for the 11 districts in northern Uganda experiencing malaria outbreaks. Minimum required rates of investigating suspected meals cases attained (2.57/100,000) - 12% of cases IgM positive. 1 suspected case of bacterial meningitis reported.	06-Jul-17
Humanitarian crisis	Mali	G1	-	-	-	-	-	-
Hepatitis E	Chad	G1	01-Sep-16	1,631 (98)	18	1.1%	Detailed update given above.	02-Jul-17
Cholera	Kenya	G1	10-Oct-16	1,072 (141)*	12*	1.1%	*Counts reported are for 2017 YTD only. Outbreaks remain active in Garissa, Nairobi, Murang'a, Turkana and Wajir counties, all reporting 2 or more cases in the most recent reporting week. The majority of new cases this week were from Garissa County.	04-Jul-17
Cholera	Angola	G1	04-Jan-17	455	24	5.3%	Since early December 2016, cases have been detected in Cabina (225), Soyo (225) and Luanda (5).	28-Jun-17
Malaria	Burundi	Ungraded	01-Jan-17	4,376,804*	1,996*	0.05%	*Counts include cases notified during 2017 YTD only. Detailed update given above.	30-Jun-17
Lassa fever	Nigeria	Ungraded	01-Dec-16	371 (175)	75	20.2%	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. 7 states are currently reporting active outbreaks.	30-Jun-17
Measles	Ethiopia	Ungraded	14-Jan-17	2,246 (989)	-	-	No new cases were reported in week 26/2017.	02-Jul-17
Cholera	South Sudan	Ungraded	20-Feb-17	11,701*	194*	1.6%	*Counts reported in total suspected cholera cases reported on IDRS from weeks 1-25 (ending 25 June) of 2017 only. During the same period, 334,958 cases and 256 deaths from acute watery diarrhoea have been notified through IDRS.	02-Jul-17
Measles	Democratic Republic of Congo	Ungraded	10-Jan-17	20,898 (312)	241	1.2%	The incidence of new cases has declined since the current outbreak peaked in early 2017.	11-Jun-17
Monkeypox	Congo (Republic of)	Ungraded	01-Feb-17	78 (7)	4	5.1%	Since 27 Jan 2017, suspected cases of monkeypox have been reported in the department of Likouala and the department of Cuvette (unconfirmed). Suspected cases have been reported from Bétou, Enyelle, Dongou, Impfondo and Owando districts.	14-May-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

Event	Country	Grade	Date of notification to WHO	No. of cases / suspected (confirmed)	No. of deaths	CFR (suspected) / %	Comments	Date of last sitrep
Food insecurity	Madagascar	Ungraded	23-Feb-17	-	-	-	March-April marked the peak of the hunger gap (lean season) in the south of the country. As of May 2017, some 850,000 people were in need of humanitarian assistance, and 5,000 children were affected by SAM. Food assistance has been received by 685,160 people. A national IPC exercise will be conducted in June 2017.	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	44 (12)	0	0.0%	The outbreak has been reported in Dagahaley, Dadaab and IFO refugee camps in Garissa County since 21 March 2017, and from communities in Mandera County since 8 June 2017. While no new cases were reported in the most recent reporting week (last case onset 4 June), outbreaks remain active in both areas.	04-Jul-17
Hepatitis E	Niger	Ungraded	06-Apr-17	1096 (439)	34	3.1%	Detailed update given above.	30-Jun-17
Monkeypox	Central African Republic	Ungraded	14-Apr-17	3 (1)	0	0.0%	During week 22, 1 new suspected case was reported from Mbaiki near the border of the Republic of Congo. A previously reported suspect case (onset during week 20) was PCR negative. 10 case contacts are currently under observation.	02-Jun-17
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
Visceral leishmaniasis / kala-azar	Kenya	Ungraded	05-May-17	277 (183)	7	2.5%	Two counties, Marsabit (n=162) and Wajir (n=115) have been affected by outbreaks since early 2017, and remain active. Detailed updated given above.	04-Jul-17
Dengue	Cote d'Ivoire	Ungraded	06-May-17	444 (136)	2	0.5%	Detailed update given above.	20-Jun-17
Dengue	Kenya	Ungraded	09-May-17	1,119 (672)	1	0.1%	The outbreak has been reported in Mombasa County (n=1,117) and Wajir County (n=82). Outbreaks remain active in both areas, with the last cases reported on 2 July and 20 June 2017 within the two counties, respectively.	04-Jul-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
Dengue haemorrhagic fever	Mauritania	Ungraded	07-Jun-17	1 (1)	0	0.0%	Single confirmation in a traveller from Angola presenting with symptoms of haemorrhaging to healthcare on 31 May 2017. The case later tested positive for dengue virus infection. No additional cases have been reported to date.	16-Jun-17
Cholera	Nigeria	Ungraded	07-Jun-17	1,558 (13)	11	0.7%	Since the onset of the outbreak on 1 May 2017, suspected cases have been reported from 5 LGAs in the Kwara State: Asa (18), Moro (50), Ilorin South (215), Ilorin East (450) and Ilorin West (780).	30-Jun-17
Hepatitis E	Nigeria	Ungraded	18-Jun-17	146 (21)	2	1.4%	Detailed update given above.	02-Jul-17
Dengue	Togo	Ungraded	18-Jun-17	12 (12)	0	0.0%	12 confirmed cases reported. WHO awaits further information on this event.	18-Jun-17
Dengue	Nigeria	Ungraded	22-Jun-17	1 (1)	0	0.0%	Single confirmed case reported. WHO awaits further on this event.	22-Jun-17
Recently closed events								
Ebola Virus Disease	Democratic Republic of Congo	G2	08-Mar-17	8 (5)	4	50.0%	On 2 July 2017, WHO declared the end of this outbreak. See the week 26 Bulletin for a full summary of the declaration.	02-Jul-17
Malaria	South Africa	Ungraded	03-Apr-17	12,113*	-	-	Malaria is seasonal in South Africa with peaks occurring during the rainy months from September to May. Annual (end of season) reviews are underway in Limpopo and Mpumalanga provinces.	30-Jun-17
Anthrax	Zimbabwe	Ungraded	15-Apr-17	11	1	7.1%	In total 11 suspected cases of cutaneous anthrax were identified in Binga district following community exposure to 14 hippos carcasses that were subsequently skinned and butchered for meat. <i>Bacillus anthracis</i> was isolated from one hippo carcass.	05-Jul-17
Yellow fever	Nigeria	Ungraded	23-Jun-17	0	0	0.0%	Yellow fever has been excluded through retesting (performed by IP Dakar) of samples collected from 2 cases that were previously identified as PCR positive for the virus by the national laboratory. Hepatitis E was confirmed as the cause of illness in both individuals.	07-Jul-17

Data are 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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