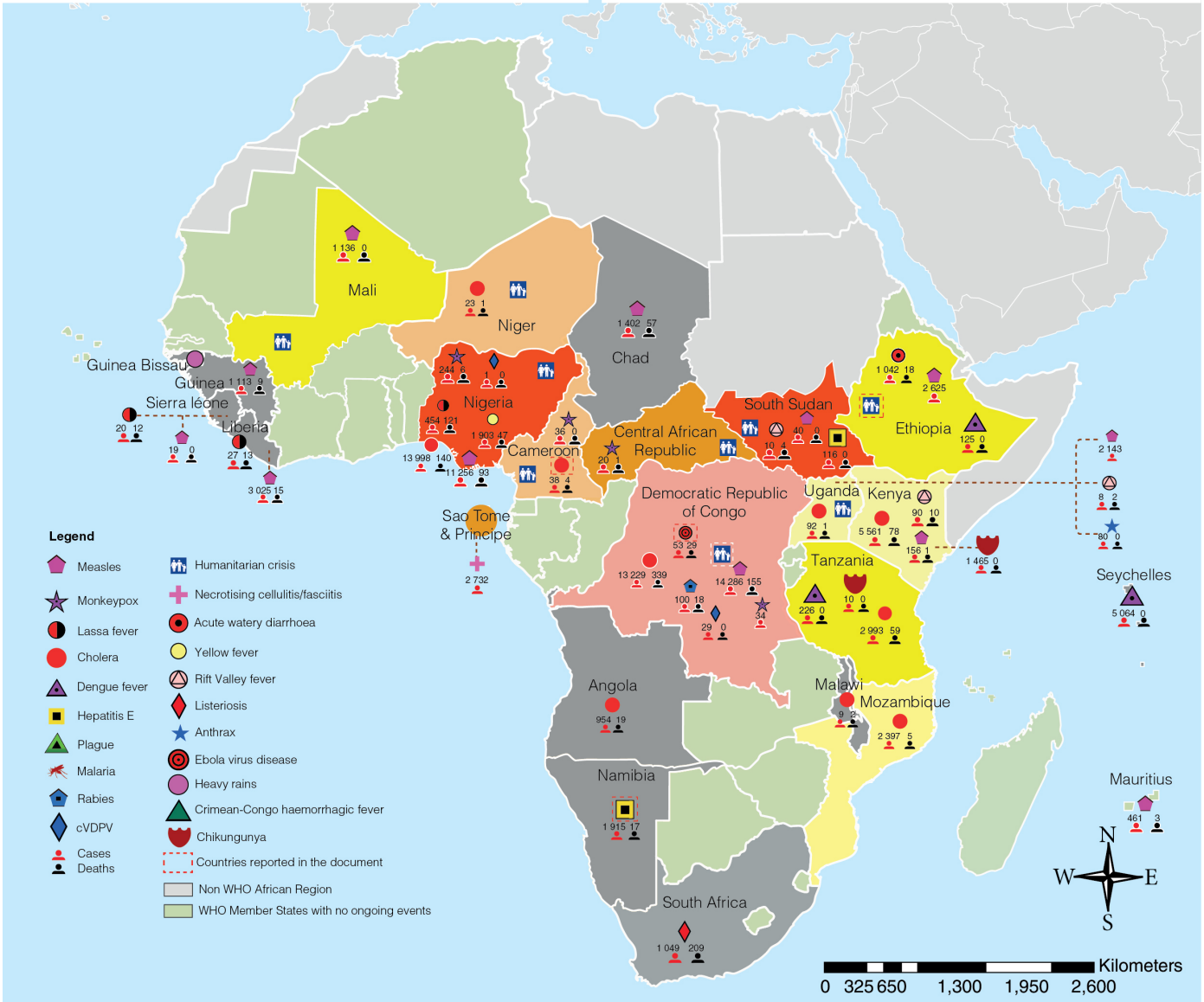
WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 28: 7 July - 13 July 2018
Data as reported by 17:00; 13 July 2018

World Health Organization
REGIONAL OFFICE FOR Africa
WHO Health Emergencies Programme

1	57	48	10
New event	Ongoing events	Outbreaks	Humanitarian crises



Graded events †

2 Grade 3 events	2 Grade 2 events	5 Grade 1 events	39 Ungraded events
2 Protracted 3 events	2 Protracted 2 events	3 Protracted 1 events	

Health Emergency Information and Risk Assessment

Overview

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9 All events currently being monitored

- This Weekly Bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 58 events in the region. This week's edition covers key new and ongoing events, including:

  - Humanitarian crisis in Ethiopia
  - Humanitarian crisis in in the Democratic Republic of the Congo
  - Hepatitis E outbreak in Namibia
  - Cholera outbreak in Cameroon
  - Ebola virus disease 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 issues and challenges include:**

  - The new wave of inter-communal violence within the ongoing humanitarian crisis in Ethiopia is of serious concern in terms of the population's health and wellbeing. IDP populations now exceed the size of host communities in some affected wordas with consequential poor conditions in overcrowded shelters, with limited access to water, sanitation and hygiene (WASH) facilities. Already inadequate health services are further overstretched and access to food is a major concern, with food security already an issue in the host communities, as well as an increase in disease outbreaks. The release of US$ 15 million from the UN Central Fund for Emergencies is a step in the right direction. However, substantially more funding will be required to meet the needs of the affected populations.

  - The ongoing outbreak of hepatitis E since September 2017 in Namibia is of concern. The decline in cases observed in the first quarter of the year has now been reversed and a recent increase in cases is occurring. Of note is that the vast majority of cases are linked to two informal settlements in Windhoek, the capital city. This outbreak has the potential to spread to other informal settlements in the capital as well as other regions of the country through population movement and response actions urgently need to be scaled up.

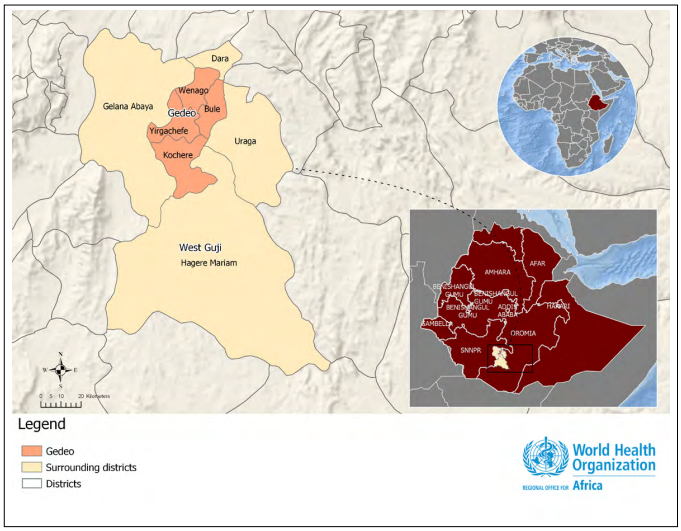
Ongoing events

Humanitarian crisis | Ethiopia

EVENT DESCRIPTION

The complex humanitarian emergency in Ethiopia continues, with a surge in numbers of internally displaced persons (IDPs) and continuing outbreaks of epidemic-prone diseases. There is currently a surge in IDPs following a new wave of inter-communal violence, which erupted in Kercha woreda, West Guji Zone in early June 2018. The conflict along the borders of Gedeao Zone in Southern Nations, Nationalities and People's Region (SNNP) and West Guji Zone in Oromia started in mid-April 2018 and has since resulted in the displacement of 818 250 individuals. The scale of recent displacements, with reports of more than 100 new IDPs arriving daily, has resulted in IDP populations exceeding the size of host communities in some affected wordas. The consequences of this are poor conditions in overcrowded shelters, with limited access to water, sanitation and hygiene (WASH) facilities. This surge in IDPs is in addition to the more than one million IDPs, located mainly in Somali and Oromia regions, initially displaced by conflict and drought. This is a substantial increase over the 720 000 IDPs reported over the same period of 2017. At present, there are a total of two million IDPs, in about 950 sites, across the region, mainly in Somali, Oromia and SNNP regions. As a result, already inadequate health services are further overstretched. Additionally, access to adequate food is a major concern, with food security already an issue in the host communities. Nutritional screening data from June 2018 indicates rapidly increasing levels of malnutrition with general acute malnutrition (GAM) exceeding 14% and an average of 32% of lactating and pregnant women malnourished.

Geographical location of humanitarian crisis in Ethiopia as of week 26, 2018



At present, the most reported diseases among current internally displaced persons (IDPs) are diarrhoea, pneumonia, and untreated wounds. The number of acute watery diarrhoea (AWD) cases reported from the ongoing outbreak in Afar continued to decrease in week 26 (week ending 29 June 2018), with 46 new cases reported from two woredas. Since the beginning of 2018, a total of 1 042 cases of AWD have been reported from Afar (811), Somali (151), Tigray (63) and Dire Dawa City Administration (17).

As of week 26, a total of 2 625 suspected measles cases were reported across the county, of which 699 were confirmed, with 56 new cases reported that week.

From weeks 1-26 of 2018, a total of 1 466 cases of severe acute malnutrition with medical complications (SAM-MC) cases were admitted to the 33 stablization centres (SCs) in Somali region. There has been a decrease in SAM-MC cases over the past three weeks, with 66 cases reported in week 26, compared to the 118 new cases reported in week 21 (week ending 25 May 2018).

PUBLIC HEALTH ACTIONS

- A joint Inter-Agency Mission visited Gedeo and West Guji zones between 25-29 June 2018 to gain a firsthand understanding of the IDP situation in both zones and to advocate for increasing partnership of humanitarian responders with regional authorities.
- On 12 July 2018 the United Nations Central Emergency Response Fund (CERF) released US$ 15 million to to enable humanitarian partners to scale up life-saving assistance in support of the Government-led response to people affected by the escalating intercommunal violence. More than 36 600 people will receive urgent nutrition assistance, 600 000 people will be supported with water, sanitation and hygiene service, 71 200 households will receive non-food item kits and 175 000 people will benefit from healthcare services.
- WHO deployed a surveillance officer, an environmental health officer, a medical nutritionist and two public health experts in Gedeo Zone and one environmental health officer, one surveillance officer and one public health expert to Guji Zone to provide technical support for the IDP response.
- WHO is supporting the surveillance, preparedness and response to diseases with epidemic potential at zonal and woreda level.
- Local authorities, through health extension workers, continue to sensitize communities by providing health education on WASH.
- WHO is co-leading the Health Cluster in coordinating the response activities for the AWD outbreak as well as the health response in IDP sites, along with coordination with Regional Health Boards through the Command Posts/Technical Working Group, guiding responses for measles and other notifiable diseases.
- Emergency supplies (IEHK modules and AWD kits) were dispatched to partners working across five regions in June 2018, to support the treatment of ongoing cases and create a small contingency stock in all high risk areas.

SITUATION INTERPRETATION

The upsurge in numbers of IDPs and their extremely poor living conditions creates a massively increased risk of major disease outbreaks such as pneumonia, measles, and diarrhoeal disease, along with increasing food insecurity. The situation for IDPs is likely to deteriorate further during the upcoming rainy season, into mid-September, with heavy rains likely to increase the risk of vector- and water-borne disease outbreaks. This situation requires a rapid up-scaling of preparedness, surveillance and case management capacity. While the release of the CERF is a crucial catalyst to scale up efforts, more funding is urgently needed to respond to all of the needs of those affected by the violence. The 2018 Ethiopia Humanitarian and Disaster Relief Plan requires US$ 1.6 billion to reach millions of people with food and non-food support. Sustainable funding to increase the necessary technical expertise and operational support to sustain an improved outcome is urgently required.

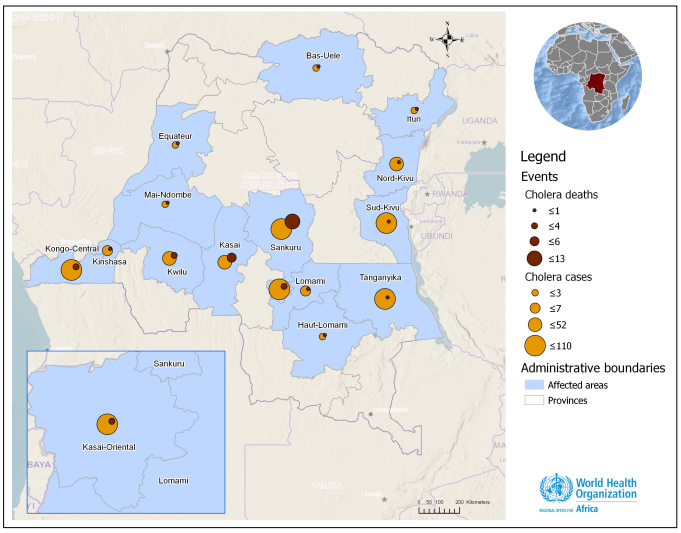
EVENT DESCRIPTION

The Democratic Republic of the Congo continues to experience a complex humanitarian crisis involving armed conflicts and inter-community tension exacerbating the numbers of those in need of humanitarian assistance as well as suffering from ongoing disease outbreaks.

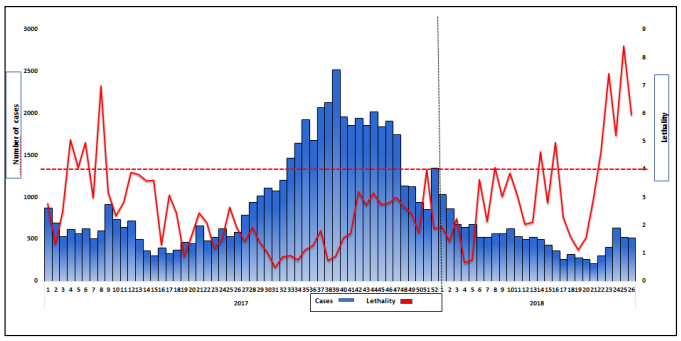
In South Kivu, the humanitarian situation continues to deteriorate in the Highlands of Bijombo (Uvira territory). New population movements have been reported since mid-June due to renewed clashes. In addition, the security situation in Maniema province remains volatile especially in Kabambare territory (Kabambare, Lusangi and Saramabila) where from time to time incursions of armed groups into villages are occurring. It is estimated that approximately 300 000 persons are internally displaced in the Kabambare and Kasongo territories. In Kasai, there is a current cessation of armed conflict, but humanitarian needs remain significant. In North Kivu, humanitarian assistance activities were suspended following a series of robberies against the teams of NGOs working in the Masisi area. This suspension deprives hundreds of patients of free outpatient care.

The cholera outbreak is ongoing, with 518 cases including 38 deaths (case fatality ratio 7.3%) reported in week 26, comparable to that reported the previous two weeks. Since the start of 2018, there have been a total of 13 229 cholera cases with 339 deaths (case fatality ratio 2.6%), as of 01 July 2018. Fourteen of 26 provinces reported at least one cholera case during the reporting week. The Kasai region remains the most affected, with 50% of cases reported in week 26. Among five provinces of this region, four are facing ongoing cholera outbreaks (Kasai Oriental, Kasai, Sankuru, and Lomami). The overall mortality remains critical, four provinces have a case fatality ratio higher than 5% at 2018 week 26 (Sankuru 20%, Kasai 12%, Kongo central 6% and Kiwulu 6%). There is generally increased trend in the number of cases across the country. Additionally, there is an increase in the number of cholera cases in Kinshasa, from the Islets of Gombe area.

Geographical distribution of cholera cases in Democratic Republic of the Congo, week 26, 2018



Cholera cases and deaths by epidemiological week in the Democratic Republic of Congo (DRC), 2017-2018



PUBLIC HEALTH ACTIONS

In response to the humanitarian crisis, the following activities are being undertaken:

- In Bas-Uele, Haut-Uele, North Ubangi, North and South Kivu provinces, UNHCR has strengthened basic services, particularly in the areas of health, education and the promotion of food self-sufficiency for refugees and the local population;
- Partners such as SANRU and MEDAIR, continue to implement the activities of the nutrition and development project in the 17 health zones of the province of Kasaï, in particular in the Mutena health zone.
- Doctors without Borders (Spain) continue their respective support to health centers in Kazimiya on the peninsula of Ubwari in South Kivu, in Salamabila health zone (Maniema) and in Kalole health zone (South Kivu) for displaced populations.
- The implementation of the Central Emergency Response Fund (CERF) Rapid Response to Outbreak Project is ongoing, with the support of WHO and partners, aiming to strengthen access to basic healthcare in 16 health zones in Haut-Lomami, Lomami, Kasai, Kasai Central, and South Kivu.

In response to the cholera outbreak, the following activities are being carried out

- WHO is strengthening the surveillance system and active search for cases in cholera affected areas.
- WHO is providing support for the management of cholera cases in different Cholera Treatment Units (CTU) through the provision of medicines and medical equipment.
- In Kasai Province, WHO is supporting the response to the cholera epidemic through active case finding in the health zones of Bulape, Dekese, Ilebo, Mikope and Mushenge.
- In Kwilu and Tanganyika provinces, WHO is supporting the management of cholera cases and implementation of community activities such as sensitization of the population against cholera and chlorination of water points.
- In the Province of Maniema, WHO continues to support the investigation of the cholera outbreak including collection and shipment of samples for suspected cholera cases to the laboratory.
- In Sankuru Province, WHO is supporting the Ministry of Health in providing free medical care for all cholera cases, as well as awareness campaigns on cholera prevention and water, sanitation and hygiene measures.

SITUATION INTERPRETATION

The Democratic Republic of the Congo is still facing a complex humanitarian crisis. The security situation remains volatile, resulting in continued population movements, and a huge number of persons requiring humanitarian assistance.

Although WHO and partners are working together to contain the cholera outbreak in Democratic Republic of Congo, we continue to observe the increase in cholera incidence. There is a need to adjust interventions in order to interrupt further transmission. Access to safe water, sanitation and hygienic practices to prevent cholera transmission has to be improved. Appropriate case management should be improved in the areas affected by the outbreak to decrease mortality.

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EVENT DESCRIPTION

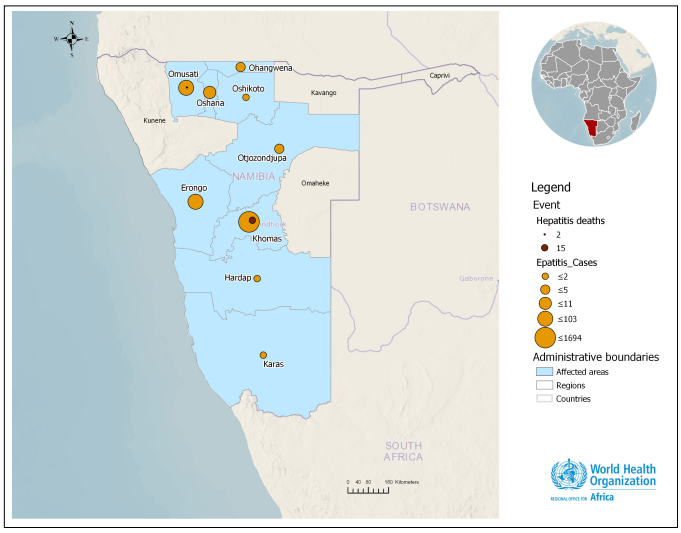
The outbreak of hepatitis E in Namibia which was first reported from Windhoek city, Khomas region in September 2017 continues to spread to other regions of the country. Three regions are currently experiencing outbreaks of hepatitis E including Khomas (containing the capital Windhoek), Omusati a northern region bordering Angola and more recently Erongo, in central-western Namibia. The latter two regions have been reporting cases since January 2018. Over 90% of cases reported are epidemiologically linked to the cases in Windhoek.

In Windhoek, 63 suspected cases were reported during week 26 (week ending 1 July 2018) comparable to the 64 cases reported during week 25 (week ending 24 June 2018), indicating that the upsurge of cases observed since week 22 is continuing. As of 1 July 2018, a cumulative total of 1 694 cases have been reported from Khomas region, of which 117 have been laboratory confirmed, 1 355 have epidemiological links to confirmed cases and 222 are suspected cases. A total of 15 deaths (case fatality ratio 0.9%) including six maternal deaths have been reported. The majority of cases (79%) in Khomas region have been reported from, or have a history of travelling to, Havana (n=926) and Goreangab (n=408), informal settlements in Windhoek. The most affected age group is between 20 and 39 years (76%), with 60% of cases being male.

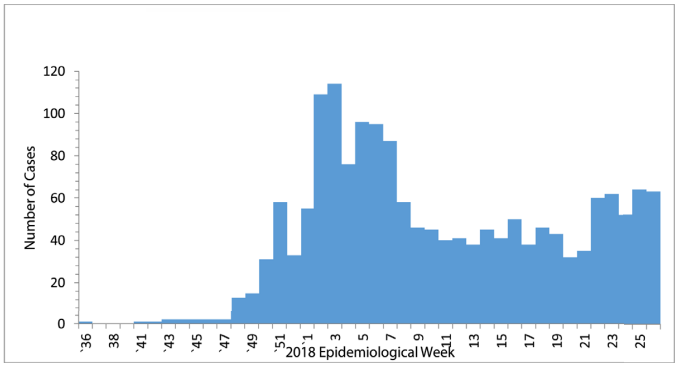
In Omusati region, from January to 5 July 2018, 103 suspected cases, with two maternal deaths (case fatality ratio 2.4%) have been reported. Out of the 103 suspected cases, 24 cases, including the two maternal deaths, have been laboratory confirmed as IgM positive. Forty-two results are pending. Seventy-nine percent (n=19) of the confirmed cases are in the age group 20-39 years, with males being the most affected (63%). In Erongo region, 93 suspected cases with no deaths have been reported from health facilities in Swakopmund district from January 2018 to 5 July 2018. Out of the 32 samples collected, 23 have been confirmed as IgM positive, including three maternal cases. Three samples results are pending. The majority of cases (n=63) in Swakopmund have been reported from the Democratic Resettlement community informal settlement. People aged between 21 and 30 years constitute the most affected group in Erongo (42%) with males representing 65% of reported cases.

From the beginning of the outbreak in week 36 of 2017 to 5 July 2018, a cumulative total of 1 915 cases including 17 deaths (case fatality ratio 0.9%) have been reported from Khomas (1 694), Omusati (103), Erongo (93) and seven other regions of Namibia (25). A total of 178 cases have been laboratory confirmed for genotype 2 hepatitis E virus, and eight maternal deaths have been notified.

Geographical distribution of hepatitis E cases in Namibia, September 2017 - July 2018



Hepatitis E cases by epidemiological week, Windhoek District, Namibia as of 1 July 2018 (n=1 694)



PUBLIC HEALTH ACTIONS

- The National Health Emergency Management committee with technical guidance from WHO, continues to lead the response activities under the thematic working groups (Coordination, Surveillance, Infection prevention and control/Case management, Water sanitation and hygiene (WASH) and Social mobilization), based on the response framework.
- Social mobilization has been conducted in affected regions, with support from Red Cross Volunteers and Health Extension workers of the Ministry of Health, by engaging community leaders (local political councillors).
- Environmental cleanliness campaigns have been conducted with participation of high government officials, including His Excellency the President, the honourable Minister of Health and Regional Governors.
- Installation of the reserve tanks and distribution points have been agreed upon, and 20 communal flush toilets have been put up during financial year ended June 2018; the remaining 200 communal toilets will be put up in the financial year starting July 2018, by the City of Windhoek.
- Repairs to 381 toilets have been made, however with little impact due to vandalism and theft in Windhoek informal settlements.
- Training of communities and health workers on the implementation of Community-Led Total Sanitation in affected communities is being planned.

SITUATION INTERPRETATION

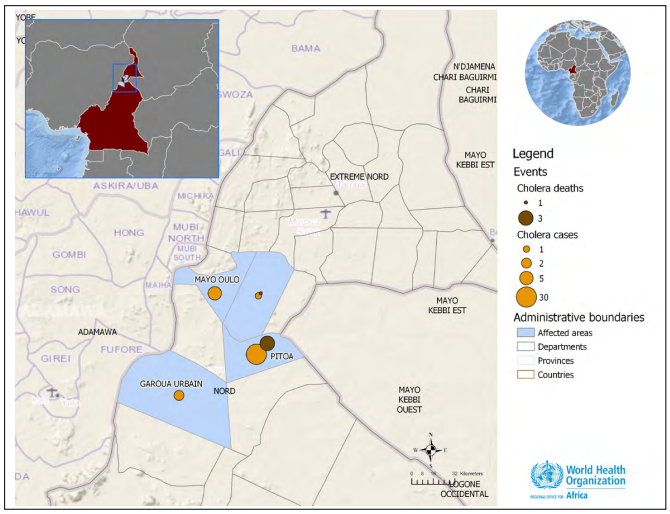
The upsurge of cases in Windhoek from 2018 week 22 to week 26 after the decline in disease trend observed in the preceding weeks is of concern, as is spread to other regions of the country. Vandalism of toilets repaired by the municipality may have contributed to the difficulty in containing the outbreak. There is an urgent need to scale up response activities to prevent a much wider disease outbreak, including speedy provision of safe water and sanitation, along with stronger social mobilization and community engagement to increase understanding of the transmission pathway and need for preventative measures.

Go to overview | Go to map of the outbreaks

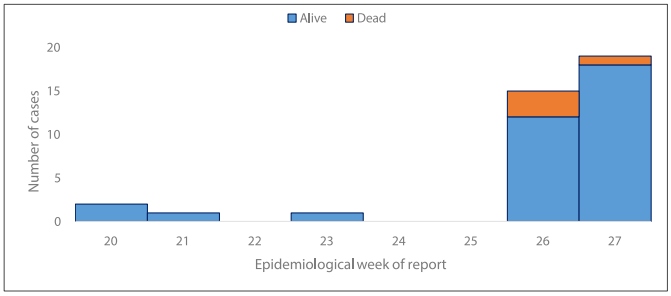
EVENT DESCRIPTION

The outbreak of cholera in Cameroon continues to evolve with new heath areas in northern Cameroon reporting cases. The initial two cases were reported in week 20 (week ending 20 May 2018) from Guirviza Health area in Mayo Oulo Zone on the border with Nigeria. The case-patients reportedly consumed food items from the Nigerian side of the border with subsequent onset of symptoms. One of the cases was confirmed for *Vibrio cholerae* at the Centre Pasteur du Cameroun in Garoua. Since then, five health areas in four zones in northern Cameroon have reported cases. In week 27 (week ending 8 July 2018), 19 new suspected cases including one death were reported from northern Cameroon. This is an increase in the number of suspected cases compared to the previous week when 15 suspected cases including three deaths were reported. As of 8 July 2018, a total of 38 suspected cases with four deaths (case fatality ratio 10.5%) have been reported from five health areas in four zones: Mayo Oulo Zone (5), Golombe Zone (30), Guider Zone (1), and Garoua II (2). Tchontchi health area in Golombe Zone is the most affected having reported a total of 30 cases with 3 deaths (CFR: 10%). Five cases have been confirmed by culture for *Vibrio cholerae*. The age of cases ranges from 1 to 80 years with a median of 26 years. Females are more affected compared to males with a ratio of 2 to 1.

Geographical distribution of cholera cases in Cameroon, 20 May - 8 July 2018



Cases of cholera by week of report, Cameroon, Week 20 - 27, 2018 (n=38)



PUBLIC HEALTH ACTIONS

- WHO and partners are supporting response activities to contain the outbreak.
  - The Ministry of Health of Cameroon has activated the incident management system (IMS) at both the central and regional levels to coordinate the response to the event with the involvement of the Regional Centre for the Prevention and Fight against the epidemics in the region of North Cameroon (CERPLE), WHO, UNICEF, CDC, and other partners.
  - A team from the regional level has been dispatched to support data management and epidemiological investigation of the outbreak.
  - Enhanced surveillance in affected districts is being carried out through active search for cases in the communities.
  - Cases are currently being isolated and managed at local health facilities and cholera kits have been dispatched to the Far North, North, and Adamawa Regions.
  - Communication and social mobilization activities are ongoing with dissemination of flyers, door-to-door outreach, community meetings, as well as media awareness in national and local languages.
  - Information dissemination is also being strengthened with production and dissemination of situation reports at the regional and central levels.
  - WASH activities are being scaled up with the provision of sanitary equipment in affected areas as well as disinfection of toilets. A total of 217 latrines have been chlorinated in three health districts.

SITUATION INTERPRETATION

The outbreak is occurring in the northern region of Cameroon close to the border with Nigeria where there is also an ongoing outbreak of cholera. The massive movement of people between the two countries in this region predisposes the population at risk to spread of the disease in an area already stricken by poor sanitary and hygienic conditions. Insecurity in the region with reports of frequent kidnappings and attacks by organized group of bandits may have implications on surveillance and response efforts. The authorities in both countries (Cameroon and Nigeria) will need to step up cross-border collaboration and information sharing in order to bring this outbreak under control and mitigate the risk of further spread. Reinforcement of surveillance, particularly at the community level, is advised. Appropriate case management should be implemented in the areas affected by the outbreak to decrease mortality. Ensuring national preparedness to rapidly detect and respond to the cholera outbreak will be needed to decrease the risk of spread to new areas.

EVENT DESCRIPTION

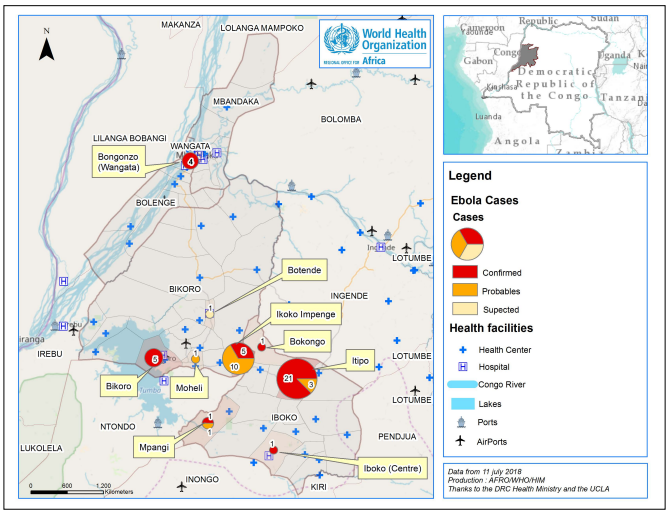
The Ministry of Health and WHO continue to closely monitor the outbreak of Ebola virus disease (EVD) in Équateur Province, the Democratic Republic of the Congo. Until the outbreak is declared over, intensive surveillance, survivor monitoring and other response activities are ongoing to prevent, promptly detect and respond to potential resurgences of the virus.

No new laboratory-confirmed EVD cases have been detected since the last case developed symptoms on 2 June 2018. Since the beginning of the outbreak (on 4 April 2018), a total of 38 laboratory confirmed and 15 probable cases (deaths for which it was not possible to collect laboratory specimens for testing) have been reported. Of these 53 cases, 29 died, giving a case fatality ratio of 54.7%. Twenty-eight (53%) cases were from Iboko, 21 (40%) from Bikoro and four (8%) from Wangata health zones. Five healthcare workers were affected, of which two died.

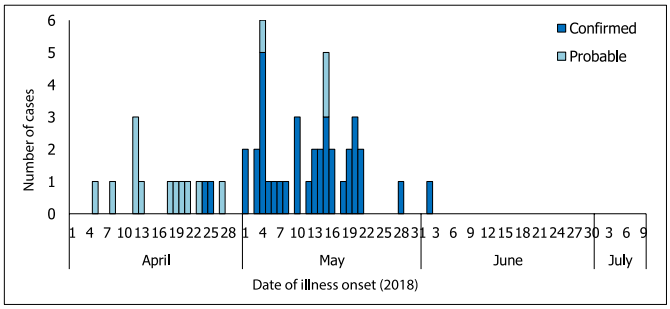
An additional eleven suspected EVD cases have been reported since our last report on 6 July 2018 *(Weekly Bulletin 27)*. As of 11 July all previously reported suspected cases have tested negative.

The last surviving confirmed EVD case was discharged from an Ebola treatment centre (ETC), following two negative tests on serial laboratory specimens, on 12 June 2018. Before the outbreak can be declared over, a period of 42 days (two incubation periods) following the last possible exposure to a confirmed case must elapse without any new confirmed cases being detected.

Geographical distribution of confirmed and probable Ebola virus disease cases, Democratic Republic of the Congo, 1 April – 9 July 2018 (n=53)



Confirmed and probable EVD cases by date of illness onset, Democratic Republic of the Congo, 1 April – 9 July 2018 (n=53)



PUBLIC HEALTH ACTIONS

- On 3-5 July 2018, the Ministry of Health, with support from WHO and partners, conducted a strategic operations review to assess the current epidemiological situation, evaluate progress against the EVD Strategic Response Plan, engage in lesson learning, and prioritize key activities and resources for continued vigilance in affected areas through to the end of the outbreak.
- A feedback meeting was held between 6-7 July 2018 to discuss the different strategies for surveillance and response to the EVD outbreak, which were adopted at the operational bases of Bikoro, Itipo, Iboko and Mbandaka.
- Daily coordination meetings continue at the national, sub-national and local levels to review the evolution of the outbreak, identify gaps in the response and propose key actions to accelerate the implementation of public health measures.
- Active surveillance activities are ongoing, including active case search at community and health facility levels, real-time investigation of alerts and collection of specimens from all suspected cases for laboratory confirmation and/or exclusion. From 13 May through 3 July 2018, 728 alerts were investigated and 387 individuals meeting the suspected case definition were tested.
- The vaccination teams remain on standby to rapidly respond to any new confirmed case. Since the launch of the vaccination exercise on 21 May 2018, a total of 3 330 people have been vaccinated in Iboko (1 530) Wangata (893), Bikoro (779), Ingende (107), and Kinshasa (21), as of 30 June 2018. Those identified for vaccination were front-line health professionals, people who were potentially exposed to confirmed EVD cases (contacts), and contacts of these contacts. A total of 2 020 vaccine doses are available in the central vaccine stores and 870 doses are in Mbandaka.
- A national laboratory strategy is being implemented, focusing on GeneXpert for confirmatory testing. Suspect deaths are tested with Oraquick (rapid diagnostic test).
- The ETCs in Bikoro, Itipo, Iboko and Mbandaka are operational and continue to provide clinical care to suspected EVD cases. MSF has transitioned the management of the ETCs in Mbandaka and Bikoro to the Ministry of Health.
- A clinic for EVD survivors has been established in Bikoro, operated by the Ministry of Health, INRB and MSF. WHO is supporting the Ministry of Health to establish a one-year programme for care to survivors, focusing on clinical follow-up, counselling, semen testing, and psychosocial support. A workshop to launch the project was held in Mbandaka from 6 to 7 July 2018.
- Risk communication, social mobilization and community engagement activities continue in Mbandaka, Itipo and Iboko, with the focus on identifying community-based alerts for epidemic-prone diseases, addressing rumours and misinformation, and reducing stigma against EVD survivors.

SITUATION INTERPRETATION

The current EVD outbreak has largely been contained. The last confirmed EVD case was notified on 6 June 2018, while all contacts completed 21-day follow-up on 27 June 2018. The 12 June 2018 marked the start of the countdown towards the end of the EVD outbreak, which requires 42 days (two maximum incubation periods) without notifying new confirmed EVD cases. Until this milestone is reached, it is critical to maintain all key response pillars. Strengthened surveillance mechanisms and a survivor monitoring programme are in place to mitigate, rapidly detect and respond to any resurgence.

The Ministry of Health, with support from WHO, conducted a strategic operations review from 3-5 July 2018 in order to guide prioritization of key activities through to the end of the outbreak, facilitate the development of a post-outbreak 90-day enhanced surveillance/response plan, and plan for the transition of EVD resources to enhance local and national response capacities to ongoing health emergencies across the Democratic Republic of the Congo. Similarly, preparation to conduct an after-action review has been initiated, aimed to document lessons learnt in order to inform preparedness and readiness for future outbreaks. Planning to improve the institutional capacity and resilience of the national health system is critical.

Go to overview | Go to map of the outbreaks

Summary of major issues challenges, and proposed actions

Issues and challenges

- The new wave of inter-communal violence within the ongoing humanitarian crisis in Ethiopia is of serious concern to the population's health and wellbeing. IDP populations now exceed the size of host communities in some affected wordas with consequential poor conditions in overcrowded shelters, and limited access to water, sanitation and hygiene (WASH) facilities. Already inadequate health services are further overstretched and access to adequate food is a major concern, with food security already an issue in the host communities, as well as an increase in disease outbreaks. Cases of severe acute malnutrition remain high, and the potential for large outbreaks of measles and acute watery diarhoea is ever present without immediate interventions. The situation is likely to deteriorate further with the upcoming rainy season.
- The outbreak of hepatitis E ongoing since September 2017 in Namibia is of concern. The decline in cases observed in the first quarter of the year has now been reversed with a recent increase in cases. Of note is that the vast majority of cases are linked to two informal settlements in Windhoek, the capital city. This outbreak has the potential to spread to other informal settlements in the capital as well as other regions of the country through population movement, and response actions urgently need to be scaled up.

Proposed actions

- In Ethiopia the situation requires a rapid up-scaling of preparedness, surveillance and case management capacity. While the release of US$ 15 million from the UN Central Fund for Emergencies is a step in the right direction, substantially more funding is urgently required to meet the needs of the affected populations.
- The national authorities and partners in Namibia need to scale up response activities to prevent a much wider disease outbreak. This should include quicker provision of safe water and sanitation facilities to affected communities, as well as stronger social mobilization and community engagement strategies. Interventions should also be targeted at risk groups, for example through the establishment of antenatal counselling for pregnant women.

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
New events										
Niger	Cholera	Ungraded	13-Jul-18	13-Jul-18	13-Jul-18	23	3	1	4.0%	An outbreak of cholera has been confirmed in Maradi Region on the border with Nigeria. Since 4 July 2018, a total of 23 cases with one death (CFR 4.3%) has been reported from Madarounfa district, Maradi Region. Three cases have been confirmed for *Vibrio cholerae* O1 inaba. Eight of the cases are reportedly from Ibiya (7) and Kwari (1) in Nigeria.
Ongoing events										
Angola	Cholera	G1	2-Jan-18	21-Dec-17	9-Jul-18	954	12	19	2.0%	On 21 December 2018, two suspected cholera cases were reported from Uíge district, Uíge province. Both of these cases had a history of travel to Kimpangu (DRC). From 21 December 2017 to 18 May 2018, a total of 895 cases were reported from two districts in Uíge province. The neighboring province of Luanda started reporting cases on 22 May 2018. From 22 May to 9 July 2018, 59 cases with 6 deaths (CFR 10.2%) have been reported from eight districts in Luanda Province. Seven cases have been confirmed for *Vibrio cholerae*. The most affected is Talatona having reported a total of 25 cases with 4 deaths (CFR 16%).
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	30-May-18	-	-	-	-	According to UNICEF's Humanitarian situation report on Cameroon as of May 2018, 160 000 Internally Displaced Persons (IDPs) in Meme and Manyu divisions in the South West, and Boyo, Momo, and Ngo-Ketunjia divisions in the North West are in need of assistance. The report noted the outbreaks of cholera and monkeypox in the regions during the month of May 2018 with the main response challenges been insecurity in the two regions due to the Anglophone crisis which forced many people to live in the bush, and geographically hard-to-reach health districts. In East region, there have been reported influx of refugees from the Central African Region fleeing the armed conflict in Bangui and along the borders. The general situation in the Far North has reportedly improved with decrease incidence of terrorist attacks and suicide bombings attributed to Boko Haram. However, returnees have been confronted with significant destruction in these areas due to previous attacks.
Cameroon	Cholera	Ungraded	24-May-18	18-May-18	9-Jul-18	38	5	4	10.5%	Detailed update given above.
Cameroon	Monkeypox	Ungraded	16-May-18	30-Apr-18	13-Jun-18	36	1	0	0.0%	On 30 April 2018, two suspected cases of monkeypox were reported to the Directorate of Control of Epidemic and Pandemic Diseases (DLMEP) by the Njikwa Health District in the North-west Region of Cameroon. On 14 May 2018, one of the suspected cases tested positive for Monkeypox virus by PCR. On 15 May 2018, the incident managment system was set up at the National Emergency Operations Center. An investigative mission to the North-west and South-west from 1 - 8 June 2018, found 21 new cases without active lesions. As of 13 June 2018, a total of 36 suspected cases have been reported from Njikwa Health district (7 including 1 confirmed), Akwaya Health District (6), Biyem-Assi health district (1), Bertoua Health District (1), and Fotokol Health District (1).

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	Protracted 2	11-Dec-13	11-Dec-13	1-Jul-18	-	-	-	-	The security situation remains tense and precarious in many places across the country. Humanitarian operations in many areas have been suspended due to increasing violence against aid workers. Humanitarian aid to Kaga Bandoro town has been suspended due to increasing violence against aid workers. In Kaga Bandoro town itself 60% of aid operations has been suspended. As of 31 May 2018, the number of estimated IDP has decreased by 2.5%. Currently, 2.5 million people are in need of humanitarian aid including 1.1 million people targeted for the health cluster partners. There are around 653 890 IDPs across the country, of which about 70% are living with host families and the remaining are located in 77 IDP sites.
Central African Republic	Monkeypox	Ungraded	20-Mar-18	2-Mar-18	30-Jun-18	20	9	1	0.0%	The outbreak was officially declared on 17 March 2018 in the sub province of Ippy. In this reporting period, there is an increase in number of suspected monkeypox in Bangassou health district. As of 24 April, twenty cases including nine confirmed cases have been reported from Ippy (6) and Bangassou (3). As of 30 June 2018, a new case from Bagandou (Mbaïki District) was confirmed by the the IPB laboratory.
Chad	Measles	Ungraded	24-May-18	1-Jan-18	13-Jul-18	1 402	92	57	4.1%	During week 27, 118 cases with 8 deaths were reported compared with 91 cases and 0 deaths last week. Between week 1 and week 27 of 2018, a total of 1 402 suspected cases with 57 deaths (CFR 4.1%) have been reported. The cases have been reported from 97 out of 117 health districts in the country. As of 13 July 2018, 92 cases have been laboratory confirmed, 376 confirmed by epidemiological link, and 23 clinically compatible. As of reporting date, 12 districts have had confirmed ongoing measles outbreak, these include: Bokoro, Gama, Amdam, Goz Beida, Haraze Mangueigne, Abeche, Arada, Ati, Mongo, Rig Rig, Tissi and Bardai.
Democratic Republic of the Congo	Humanitarian crisis	G3	20-Dec-16	17-Apr-17	5-Jul-18	534 108	-	-	-	Detailed update given above.
Democratic Republic of the Congo	Cholera		16-Jan-15	1-Jan-18	1-Jul-18	13 229	0	339	2.6%	The cholera outbreak in the Democratic Republic of the Congo continues with a total of 518 cases with 39 deaths (CFR 7.3%) reported during week 26, compared to 523 cases and 44 deaths (CFR 8.4%) reported during week 25. The cases have been reported from 14 out of 26 provinces. The provinces of Kasai Oriental, South Kivu, Kongo central, Sankuru and Tanganyika reported 71% of the suspected cases with 110 cases, 66 cases, 66 cases, 66 cases and 62 cases respectively. Case fatality rate was particularly high during week 26 in the provinces of Sankuru (19.7%), Kasai (12.5%), Kongo central (6.1%) and Kwilu (5.8%). From week 1 to 26 of 2018, a total of 13 229 cases of cholera including 339 deaths (CFR 2.6%) were reported. The persistent health workers strike in North Kivu impedes data collection from the cholera treatment centers and units in the province.
Democratic Republic of the Congo	Ebola virus disease	G3	7-May-18	4-Apr-18	9-Jul-18	53	38	29	54.7%	Detailed update given above.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Democratic Republic of the Congo	Measles	Ungraded	10-Jan-17	1-Jan-18	24-Jun-18	14 286	2 001	155	1.1%	In week 25 of 2018, 288 suspected cases with 7 deaths (CFR 2.4%) were notified across the country compared to 557 suspected cases with 9 deaths (CFR 1.6%) reported in the previous week 24. During week 25, the provinces of Haut Katanga, Sankuru, Tanganyika, Maniema and Haut Lomani notified 76.4% of all suspected cases. A total of 14 286 cases with 155 deaths (CFR 1.1%) has been reported from week 1 to 25, 2018.Two hundred and eighteen cases have been laboratory-confirmed and 1 783 epi-linked. Twenty-six health zones have had confirmed epidemics since week 1 of 2018.
Democratic Republic of Congo	Mon-keypox	Ungraded	n/a	1-Jan-18	24-Jun-18	34	34	-	-	From weeks 1-25 of 2018 there have been 2 924 suspected cases of monkeypox including 36 deaths (CFR 1.2%). Of the suspected cases, 34 cases have been confirmed. Suspected cases have been detected in 14 provinces. Sankuru Province has had an exceptionally high number of suspected cases this year.
Democratic Republic of the Congo	Polio-myelitis (cVD-PV2)	Ungraded	15-Feb-18	n/a	13-Jul-18	29	29	0	0.0%	The latest case of cVDPV2 was reported from Kambove, Haut Katanga Province from an AFP case with onset of paralysis on 14 May 2018. As of 13 July 2018, a total of 29 cases with onest in 2017 (22 cases) and 2018 (7 cases) have been confirmed. Six provinces have been affected, namely Haut-Lomami (9 cases), Maniema (2 cases), Tanganyika (14 cases), Haut Katanga (2 case), Mongala (1 case), and Ituri (1 case). The outbreak has been ongoing since February 2017. A public health emergency was officially declared by the Ministry of Health on 13 February 2018 when samples from 21 cases of acute flaccid paralysis were confirmed retrospectively for vaccine-derived polio virus type 2.
Democratic Republic of Congo	Rabies	Ungraded	19-Feb-18	1-Jan-18	24-Jun-18	100	0	18	18.0%	This outbreak began towards the end of October 2017 in Kibua health district, North Kivu province. A total of 100 cases with 18 deaths (CFR 18%) have been reported from week 1 to 25, 2018.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Ethiopia	Humanitarian crisis	Protracted 1	15-Nov-15	n/a	10-Jun-18	-	-	-	-	Detailed update given above.
Ethiopia	Acute watery diarrhoea (AWD)		15-Nov-15	1-Jan-18	1-Jul-18	1 042	-	18	1.7%	This has been an ongoing outbreak since the beginning of 2017. In most parts of the country, the situation has stabilized, however, Afar region is experiencing an increase in cases which began since week 18. In week 26, 49 cases were reported, all of which are from Afar region. From week 1 to 26 2018, a total of 1 042 cases with 18 deaths (CFR 1.7%) has been reported from the following regions: Somali (151 cases), Afar (811 cases with 18 deaths), Tigray (63 cases), and Dire Dawa City Administration (17 cases) . Between January and December 2017, a cumulative total of 48 814 cases and 880 deaths (CFR 1.8%) were reported from nine regions.
Ethiopia	Measles		14-Jan-17	1-Jan-18	1-Jul-18	2 244	555	-	-	This has been an ongoing outbreak since the beginning of 2017. In 2018, a total of 2 244 suspected measles cases have been reported across the country including 166 new suspected cases reported in week 23. From the total suspected cases reported, 555 are confirmed cases (72 lab confirmed, 453 epi-linked and 30 clinically compatible). A total of 14 laboratory confirmed measles outbreaks have been reported up to week 23 and two (Amhara and Somali regions) are currently active. So far, the outbreaks reported are from the regions of Amhara (3), SNNPR (1) and Somali (10). The age group mostly being affected remains under five (33%) and children 5 – 14 years (48%). The immunization status of the suspected cases shows that 10.2% of the cases are with "zero" previous doses and 57.4% of the cases with "unknown" immunization status. Between January and December 2017, a cumulative total of 4 011 suspected measles cases have been reported across the country.
Ethiopia	Dengue fever	Ungraded	18-Jun-18	19-Jan-18	1-Jul-18	125	52	-	-	An outbreak of Dengue fever which started on 8 June 2018 involving 52 cases in the flood affected Gode Zone of Somali Region has been confirmed by laboratory testing. Eighteen cases were reported in week 26 in Somali Region, this brings the total to 125 cases since 19 January 2018.
Guinea	Measles	Ungraded	9-May-18	1-Jan-18	6-May-18	1 113	267	9	0.8%	A new measles outbreak was detected in epidemiological week 8, 2018. Measles was reported in all parts of the country since the beginning of the year. The most affected zones include Kankan, Conakry and Faraneh. Out of 522 samples tested, 267 samples tested IGM positive. Out of the positive cases, 76% were not vaccinated for measles despite vaccination campaign efforts in 2017 following a large epidemic.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Guinea Bissau	Heavy rains	Ungraded	3-Jul-18	27-Jun-18	3-Jul-18	-	-	-	-	On 27 June 2018, strong winds of 80 to 100 Km/h and heavy rainfall hit Guinea Bissau, causing the death of three children and damages of 430 households. About 2 000 families and 11 000 people have been exposed to poor living conditions as a consequence of this disaster. Areas which suffered considerable damages include 6 settlements in the suburbs of Bissau, the capital town. Four other regions have been affected including Biombo, Quinara, Cacheu and Gabu. A humanitarian working group composed of UN agencies and other humanitarian stakeholders, among which Red Cross and MSF, are supporting the government in assessing the situation and responding to the affected populations needs. The development of a country contingency and mitigation plan against environmental disasters has been planned.
Kenya	Chikungunya	Ungraded	mid-December 2017	mid-December 2017	24-Jun-18	1 465	50	0	0.0%	The outbreak is still ongoing in Mombasa since December 2017. A total of 1 465 chikungunya cases with 50 being laboratory confirmed. The outbreak has affected 6 Sub Counties; Mvita (297 cases), Changamwe (499 cases), Jomvu (176 cases), Likoni (250 cases), Kisauni (153 cases) and Nyali (61cases).
Kenya	Cholera	G1	6-Mar-17	1-Jan-18	4-Jul-18	5 561	299	78	1.4%	The outbreak in Kenya is ongoing since December 2014. Between 1 January 2017 and 7 December 2017, a cumulative total of 4 079 cases with have been reported from 21 counties (data until 31 December 2017 not available). As of 4 July 2018, a total of 5 561 cases with 78 deaths have been reported since the 1 January 2018. During this outbreak 19 out of 47 counties in Kenya were affected. Currently, the outbreak is active in 8 counties: Garissa, Meru, Tana River, Turkana, West Pokot, Kelifi and Isiolo counties. The outbreak has been controlled in 11 counties: Elgeyo Marakwet, Kirinyaga, Busia, Mombasa, Siaya, Murang'a, Nairobi, Tharaka Nithi, Trans-Nzoia, Nakuru and Machakos. Garissa (1 538 cases and 18 deaths, CFR 1.2%) located on the border with Somalia is the most affected county and it hosts the Daadab refugee camp. Followed by Turkana county (942 cases and 11 deaths, CFR 1.3%) which is at the border with South Sudan and hosts refugees at the Kakuma camp.
Kenya	Measles	Ungraded	19-Feb-18	19-Feb-18	4-Jul-18	156	16	1	0.6%	The outbreak is located in two counties, namely Wajir and Mandera Counties. As of 7 May 2018, Wajir County has reported 39 cases with 7 confirmed cases; Mandera has reported 102 cases with 4 confirmed cases and one death. Date of onset of the index case in Wajir County was on 15 December 2017. The index case was traced to Kajaja 2 village from where the outbreak spread to 7 other villages: Ducey (18 cases), ICF (2), Godade (3), Kajaja(1), Konton(2), Kurtun (1) and Qarsa (12). As of 4 July 2018, Mandera County has reported a second wave of Measles outbreak from Takaba Sub county. A total of 15 cases with 5 confirmed have been reported.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Kenya	Rift Valley fever (RVF)	G1	6-Jun-18	11-May-18	8-Jul-18	90	18	10	11.1%	Following the initial confirmation of RVF by PCR on 4 June 2018, a total of 90 cases have been reported including 10 deaths (CFR 11%) from 3 counties in Kenya. Eighteen samples submitted to the KEMRI tested positive by PCR for RVF. Wajir has reported 78 cases and 6 deaths, Marsabit reported 11 cases and 3 deaths and Siaya country reported 1 case and 1 death. The Eldas sub-county in Wajir has reported the highest number of cases (72) since the 1 June 2018.
Liberia	Lassa fever	Ungraded	14-Nov-17	1-Jan-18	27-Jun-18	27	20	13	48.1%	Sporadic cases of Lassa fever have been reported since the beginning of the year. From 1 January to 27 June 2018, 130 suspected cases have been reported. As of 27 June 2018, only Nimba County remains in active outbreak phase with two new confirmed cases reported on 27 June 2018, while Bong, Margibi and Grand Bassa Counties have exited the outbreak phase. Test results by RT-PCR for 123 suspected cases showed 20 positive and 103 negative. Seven specimens were not tested due to poor quality. Thirteen deaths have been reported among 20 confirmed cases (CFR 65%). Females constitute 60% (12/20) of confirmed cases. The age range among confirmed cases was 1 to 65 years old with a median age of 32.5 years. Cumulatively, 27 confirmed and suspected cases (negative cases removed) have been reported with 13 deaths (CFR 61.79%). A total of 25 contacts are currently being monitored in Nimba county. All previous contacts (128) from Bong (71), Grand Bassa (24) and Nimba (33) have completed 21 days follow up.
Liberia	Measles	Ungraded	24-Sep-17	1-Jan-18	7-Jun-18	3 025	177	15	0.5%	During week 22 (week ending 3 June 2018), 72 suspected cases were reported from 11 counties: Maryland (17), Montserrado (16), Grand Kru (8), River Gee (8), Bomi (7), Margibi (6), Grand Gedeh (3), Nimba (2), Grand Bassa (2), Bong (2), and Sinoe (1). From week 1 to week 22 of 2018, 3 025 suspected cases have been reported including 15 deaths. Cases are epidemiologically classified as follows: 177 (5.9%) laboratory confirmed, 1 742 (57.6%) epi-linked, 544 (17.9%) clinically compatible, 156 (5.2%) discarded, and 406 (13.4%) pending. The cumulative number of suspected measles cases reported represents a 65.7% increase compared to the same period (week 1 – 22) in 2017, (1 037 in 2017 to 3 072 in 2018).

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Malawi	Cholera	Ungraded	13-Jun-18	8-Jun-18	27-Jun-18	9	4	2	22.2%	Malawi is experiencing a new cholera outbreak in Salima district, in the Central Region Province. The last case of the previous outbreak in that district was reported on 1 April 2018. The new outbreak started on 8 June 2018 in Khombedza Health Centre catchment area, a rural area which was not targeted in the previous oral cholera vaccine campaign because it was considered a relatively low risk area. As of 27 June 2018, a total of 9 cases including 2 deaths (both died at health facility) have been reported in this new outbreak. The three villages where the cases came from, draw water from rivers. Unsafe water is therefore the risk factor. There is borehole in this community but the borehole water is very salty and people do not use it for drinking, cooking food, or bathing. They only use it for washing kitchen utensils. At least four for stool specimens were take taken and they were all positive on culture. *Vibro cholerae* 01 was isolated.
Mali	Humanitarian crisis	Protracted 1	n/a	n/a	30-Apr-18	-	-	-	-	More than 70 security incidents affecting humanitarians have been registered since the beginning of the year. Some 387 000 people were food insecure (crisis phase and emergency phase) from March to May 2018. During the lean season which spreads from June to August 2018, more than 4.3 million people, or more than one out of four Malians, will be food insecure and in need of humanitarian assistance, according to the regional analysis of the situation of food insecurity –harmonized framework- March 2018. Among these people, nearly 885 000 will be in a crisis phase (or phase 3) and about 48 000 in an emergency phase (or phase 4). The Ministry of Health, in collaboration with the nutrition cluster, has revised upwards the number of children at risk of acute malnutrition for reasons related, inter-alia, to the deterioration of the food security situation in certain localities. (Source: OCHA Humanitarian bulletin Mali March – April 2018)
Mali	Measles	Ungraded	20-Feb-18	1-Jan-18	8-Jul-18	1 136	265	0	0.0%	From Week 1 to Week 27 of 2018, a total of 1 136 suspected cases with zero deaths have been reported. The overall trend is decreasing in number of confirmed cases. Blood samples from 833 suspected cases have been tested of which 265 were confirmed (IgM-positive) at the National Reference Laboratory (INRSP). Five hundred and sixty eight tested negative. Over 55% of confirmed cases are below 5 years old. The affected health districts are Maciana, Bougouni, Kati, Koutiala, Kokolani, Kolondieba, Ouélessebougou, Sikasso, Douentza, Macina,Tombouctou, Dioila, Taoudenit and Kalabancoro. Reactive vaccination campaigns, enhancement of surveillance, and community sensitization activities are ongoing in the affected health districts.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Mauritius	Measles	Ungraded	23-May-18	19-Mar-18	12-Jul-18	461	461	3	0.7%	As of 12 July 2018, 416 confirmed cases of measles have been reported including three deaths (CFR 0.7%). All cases have been confirmed by the virology laboratory of Candos (IgM antibodies). No history of travel among measles cases. The onset of symptoms of the first cases was in week 12. The reported measles cases have increased since week 18 up to a peak in week 24, following that there has been a gradual decline in the number of cases. Forty-thee percent of the affected cases are between the age of 20-29 years. The three deaths were in women between the ages of 28 and 31 years. The most affected districts are Point Louis (172 cases) and Plaines Wilhems (98 cases) which accounts for 43% of all confirmed cases.
Mozambique	Cholera	G1	27-Oct-17	12-Aug-17	2-Jul-18	2 397	-	5	0.2%	Since the onset of the outbreak in mid-August 2017, a cumulative total of 2 397 cases including 5 deaths (case fatality rate = 0.2%) have been reported from the two provinces; Nampula (1 714 cases with 2 deaths) and Cabo Delgado (683 cases with 3 deaths). The last reported cases were in week 24 when Nacala Port District in Nampula Province reported 2 cases with zero deaths. Two weeks have passed without a case reported. The outbreak is being considered controlled in six districts and two cities in both provinces while Nacala Port District is still being monitored.
Namibia	Hepatitis E	Ungraded	18-Dec-17	8-Sep-17	5-Jul-18	1 915	178	17	0.9%	Detailed update given above.
Niger	Humanitarian crisis	G2	1-Feb-15	1-Feb-15	11-Jun-18	-	-	-	-	According to OCHA Weekly Humanitarian report for 5 – 11 June 2018, humanitarian missions to the south-eastern Diffa region have been suspended following a suicide attack in the regional capital Diffa on 4 June. At least six civilians were killed and 36 injured in three separate suicide blasts. A security assessment is to be conducted before the resumption of humanitarian missions. The region had seen a decline in attacks since the beginning of a military operation by the Multinational Joint Task Force in April.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Nigeria	Human-itarian crisis	Protract-ed 3	10-Oct-16	n/a	5-May-18	-	-	-	-	The security situation in north-east Nigeria remains volatile, with frequent incidents, often suicide attacks using person-borne improvised explosive devices (PBIED) and indiscriminate armed attacks on civilian and other targets. On 1 May 2018, an attack in Mubi town in Adamawa State resulted in 27 deaths and more than 50 injuries, while 13 people were killed in Zamfara State on 3 May 2018. In a related incident that took place on 5 May 2018, at least 45 people from Gwaska village in Kaduna State (outside north-east Nigeria) died in fighting between bandits and armed militia. Internal displacement continues across north-east Nigeria, especially in Borno, Adamawa and Yobe states, partly fuelled by deteriorating living conditions and the ongo-ing conflict. The number of internally displaced persons (IDPs) across the six states (Adamawa, Bauchi, Borno, Gombe, Taraba, and Yobe) in northeast Nigeria increased to over 1.88 million in April 2018, from 1.78 in February 2018. In addition, there are over 1.4 million returnees in the area. The communal conflicts between herd-ers and farmers, which has been taking place since January 2018 outside north-east Nigeria, also displaced approximately 130 000 people in Benue, Nasarawa, Kaduna, and Taraba States.
Nigeria	Cholera	G1	7-Jun-17	1-Jan-18	25-Jul-18	13 998	179	140	1.0%	As of 25 June 2018, a total of 13,998 cases including 140 deaths (CFR 1.0%) have been reported from 66 Local Government Areas across 16 States (Adamawa, Anambra, Bauchi, Borno, Federal Capital Territory, Gombe, Jigawa, Kano, Kaduna, Katsina, Kogi, Nasarawa, Niger, Plateau, Yobe and Zamfara) since the beginning of 2018. Bauchi, Adamawa, and Zamfara States constitute79.6% of the cholera cases reported. Bauchi LGA is the most critical recording close to 200 cases a day and being the LGA with the most protracted outbreak. Federal Capital Ter-ritory, Gombe, Jigawa, and Katsina are the latest to report outbreaks.Since the peak in week 21 when close to 1 400 cases were reported, there has been a steady decline in the number of cases on the overall. Since the last national update on 25 June 2018, Borno State has reported 26 new cases with zero deaths between 25 June and 1 July 2018. Adamawa State has also reported 172 new cases with zero deaths from 26 June 2018 to 5 July 2018.
Nigeria	Lassa fever	Ungraded	24-Mar-15	1-Jan-18	24-Jun-18	454	444	121	26.7%	In the reporting week 25, six new confirmed cases and two deaths were reported. From 1 January to 24 June 2018, a total of 2 042 sus-pected cases have been reported from 21 states. Eighteen states have exited the active phase of the outbreak while three, Edo, Ondo and Plateau states still remain active. Of the suspected cases, 444 were confirmed positive, 10 are probable, 1 588 negative (not a case). Thirty-nine health care workers have been affected since the onset of the outbreak in seven states Ebonyi (16), Edo (14), Ondo (4), Kogi (2), Nasarawa (1), Taraba (1), and Abia (1) with ten deaths in Ebonyi (6), Kogi (1), Abia (1), Ondo (1) and Edo (1). A total of 5 618 contacts have been identified from the 21 affected states. From week 49 of 2016 to week 51 of 2017, a total of 1 022 cases including 127 deaths were reported.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Nigeria	Measles	Ungraded	25-Sep-17	1-Jan-18	17-Jun-18	11 256	13	93	0.8%	In week 24 (week ending 17 June 2018), 188 suspected cases of measles were reported from 28 States. Since the beginning of the year, a total of 11 256 suspected measles cases with 13 laboratory confirmed cases and 93 deaths (CFR 0.8%) were reported from 36 States compared with 13 144 suspected cases with 77 laboratory confirmed cases and 76 deaths (CFR 0.6%) from 37 States during the same period in 2017.
Nigeria	Mon-keypox	Ungraded	26-Sep-17	24-Sep-17	30-Apr-18	244	101	6	2.5%	Suspected cases are geographically spread across 25 states and the Federal Capital Territory (FCT). One hundred and one laboratory-con-firmed and 3 probable cases have been reported from 15 states/territories (Akwa Ibom, Abia, Anambra, Bayelsa, Cross River, Delta, Edo, Ekiti, Enugu, Lagos, Imo, Nasarawa, Oyo, Rivers, and FCT).
Nigeria	Polio-myelitis (cVD-PV2)	Ungraded	1-Jun-18	1-Jan-18	27-May-18	1	1	0	0.0%	One new case of circulating vaccine-derived poliovirus type 2 (cVDPV2) has been confirmed in Nigeria this week, occurring in Kaugama dis-trict, Jigawa state, with onset on 15 April 2018.
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	3-Jun-18	1 903	46	47	2.5%	From the onset of this outbreak on 12 Septem-ber 2017, a total of 1 903 suspected yellow fever cases including 47 deaths have been reported as at week 22 (week ending on 3 June 2018), from all Nigerian states in 414 LGAs. The outbreak is currently active in the country. A total of 46 samples that were laboratory-confirmed at IP Dakar recorded from ten States (Edo, Ekiti, Katsina, Kebbi, Kwara, Kogi, Kano, Nasarawa, Niger and Zamfara). Yellow fever vaccination campaigns have been successfully completed in six states.
São Tomé and Principé	Necro-tising cellu-litis/ fasciitis	Protract-ed 2	10-Jan-17	25-Sep-16	24-Jun-18	2 732	0	0	0.0%	From week 40 in 2016 to week 26 in 2018, a total of 2 732 cases have been notified. In week 26, 11 cases were notified, 3 more than the previous week. Six out of seven districts reported a case, Mé-zochi (4), Agua Grande (3), Lobata (0), Cantagalo (1), Caue (1), Lemba (1) and Príncipe (1). The attack rate of necrotising cellulitis in Sao Tome and Príncipe is 13.8 cases per 1 000 inhabitants.
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	20-May-18	5 064	1 429	-	-	As of week 26, a total of 5 411 suspected cases have been reported from all regions of the three main islands (Mahé, Praslin, and La Digue). A decreasing trend has been observed for the past 3 weeks. For week 26, thirty-seven suspected cases were reported; a 26 samples were tested for dengue of which One 1 was confirmed positive, 8 were probable and 17 were negative. No recent serotyping results and so far for this epidemic DENV1, DENV2 and DENV3 have been detected.
Sierra Leone	Lassa fever	Ungraded	8-Jun-18	1-Jan-18	1-Jul-18	20	20	12	60.0%	A total of 20 confirmed Lassa fever cases with 12 deaths have been reported since the beginning of the year, amounting to a case fatality rate (CFR) of 60 %. The cases have been reported from two districts, Bo (two cases with two deaths) and Kenema (18 cases with 10 deaths). The last confirmed case was reported during week 23 from Kenema district involving a 32 year-old female who died while in admission at Kenema Government Hospital.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Sierra Leone	Measles	Ungraded	14-Jun-18	4-Jun-18	14-Jun-18	19	19	-	0.0%	Koinadugu district on the border with Guinea has reported a total of 19 confirmed cases in two chiefdoms, Sulima (14 cases) and Mongo (5 cases) from 11 - 14 June 2018. These cases are reportedly from unvaccinated children in neighboring Guinea who have travelled with their parents to access services in nearby health facilities close to the border.
South Africa	Listeri-osis	Ungraded	6-Dec-17	1-Jan-17	21-May-18	1 034	1 034	204	19.7%	This outbreak is ongoing since the beginning of 2017. As of 21 May 2018, 1 034 cases have been reported in total. Around 80% of cases are reported from three provinces; Gauteng (59%, 606/1 034), Western Cape (13%, 130/1 034) and KwaZulu-Natal (7%, 73/1 034). The number of reported cases has decreased to 64 cases since the implicated products were recalled on 04 March 2018. Neonates ≤28 days of age are the most affected age group, followed by adults aged 15 – 49 years of age. All cases that have been identified after the recall are being fully investigated.
South Sudan	Human-itarian crisis	Protract-ed 3	15-Aug-16	n/a	15-Apr-18	-	-	-	-	The humanitarian situation in South Sudan remains volatile and unpredictable since the beginning of the crisis 4 years ago. The latest round of peace talks took place in Khartoum and permanent ceasefire agreement signed. However, despite this, it is apparent that the fighting leading to loss of lives has continued unabated. The economic crisis with hyperin-flation, food insecurity, and continued fighting has put lives of millions South Sudanese at risk. As of 8 july 2018, there are approximately 2.5 million refugees as a result of this crisis and 1.74 million IDPs.
South Sudan	Hepati-tis E	Ungraded	-	3-Jan-18	1-Jul-18	116	16	-	-	The number of hepatitis E (HEV) cases has increased in week 26. As of 1 July 2018, 116 suspect cases have been reported in 2018. Of the total suspect cases, 16 cases have been confirmed by PCR (15 in Bentiu PoC and 1 in Old Fangak). No new cases identified after active follow up in Fangak. Only 4 HEV cases have been admitted. At least 44% of the cases are 1-9 years of age; and 66% being male. Among the females, most cases have been reported in those aged 15 - 44 years (who are at risk of adverse outcomes if infected in the third trimester of pregnancy). Use of stag-nant water for domestic or recreation purposes is likely to be source of infection.
South Sudan	Measles	Ungraded	10-Jun-18	13-May-18	1-Jul-18	40	3	0	0.0%	Measles outbreak confirmed in Rumbek Center after 3 IgM positive cases were reported. As of 1 July 2018, a cumulative of 40 measles cases with no deaths have been line listed since week 19. Most cases are from Akuach village (2 km from Rumbek hospital) in Biir Payam. This is where the index cluster originated. Nearly 70% of the cases are under 5 years. Routine measles coverage for first quarter of 2018 for the county was 19%. As part of the response; outbreak investigation, line listing and vaccination micro plan targeting 44 049 children 6-59 months of age has been completed. A reactive response is planned by MedAir and CUAMM supported by WHO and UNICEF. Long-term strategy for improving routine immunization has been developed by EPI-MoH.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
South Sudan	Rift Valley fever (RVF)	Ungraded	28-Dec-17	7-Dec-17	1-Jul-18	10	6	4	40.0%	One new suspect RVF case was reported from Yirol East in week 27. As of 1 July 2018, a total of 10 cases of Rift Valley fever have been reported from Yirol East of the Eastern Lakes State, including six confirmed human cases (one IgG and IgM positive and five IgG only positive), three cases who died and were classified as probable cases with epidemiological links to 3 confirmed cases, 48 were classified as non-cases following negative laboratory results for RVF and other VHF's. One sample the suspected cases is pending laboratory testing. A total of four cases have died, including the three initial cases and one suspect case who tested positive for malaria (case fatality rate 40%).
Tanzania	Chikungunya	Ungraded	27-Jun-18	1-Jan-17	22-Jun-17	10	5	0	0.0%	Four cases of chikungunya have been reported from Holili Point of entry (POE) in Kilimanjaro following the traveller's screening. The travellers were coming from Kenya and presented with clinical symptoms of generalized body malaise and fever. Upon further laboratory investigations at the KCRI, samples tested positive by PCR. Other cases were confirmed early in 2018 travel history to Mombasa. From January to June 2018, a total of 10 suspected cases have been reported including 5 confirmed. All cases were captured in Tanzania through POE.
Tanzania	Cholera	Protracted 1	20-Aug-15	1-Jan-18	8-Jul-18	2 993	-	59	2.0%	During week 27, 109 new cases and 0 deaths were reported from Monduli DC (45 cases) and Ngorongoro DC (43 cases) in Arusha region; Sumbawanga DC (21 cases) in Rukwa region. As of week 27, a total of 2 993 cases with 59 deaths (CFR: 2%) were reported from Tanzania Mainland, no case was reported from Zanzibar. The last case reported from Zanzibar was on 11 July 2017. Cholera cases in 2018 increased and nearly doubled during the period of January – July 2018 (2 993 cases), when compared to the same period in 2017 (1 535 cases). From February to June 2018, 38 out of 45 specimen that were tested at the National Lab were positive for *Vibrio Cholerae* serotype 01 Ogawa. Since the start of the outbreak in August 2015, the country has reported a total of 36 288 cases including 597 deaths (CFR 1.6%).
Tanzania	Dengue fever	Ungraded	19-Mar-18	1-Dec-17	22-Jun-18	226	37	-	-	Dengue fever has been reported from Dar es Salaam since January 2018. As of 22 June 2018, a total of 226 cases with no death have been reported. The Tanzania National Health Laboratory and Quality Assurance and Training Centre (NHLQATC) has so far received a total of 92 samples of suspected dengue cases, of which 37 samples have tested positive for dengue fever and the circulating serotype is dengue type III.
Uganda	Humanitarian crisis - refugee	Ungraded	20-Jul-17	n/a	21-Jun-18	-	-	-	-	Uganda continued to receive new refugees precipitated by increased tensions mainly in the neighboring DRC and South Sudan. Despite responding to one of the largest refugee emergencies in Africa, humanitarian funding has remained low especially to the health sector. Current refugee caseload stands at almost 1.5 million refugees and asylum seekers from South Sudan, DRC, Burundi, Somalia and others countries. Daily arrival stands at approximately 250 – 500 per day. A total of 376 081 refugees and asylum seekers were received in 2017.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Uganda	Anthrax	Ungraded	-	12-Apr-18	19-Jun-18	80	4	-	-	Three districts in Uganda are affected by anthrax. As of 19 June 2018, a cumulative total of 80 suspected cases with zero deaths have been reported – Arua (10), Kween (48) and Kiruhura (22). One case has been confirmed in Arua district by polymerase chain reaction (PCR). The event was initially detected on 9 February 2018 in Arua district when a cluster of three case-patients presented to a local health facility with skin lesions, mainly localized to the forearms. Three blood samples collected from the case-patients on 9 February 2018 were shipped to the Uganda Virus Research Institute (UVRI). One tested positive for *Bacillus anthracis* by polymerase chain reaction (PCR) based on laboratory results released by the UVRI on 5 April 2018.
Uganda	Cholera	Ungraded	7-May-18	29-Apr-18	20-Jun-18	92	26	1	1.1%	On 29 April 2018, a 40 year-old female presented with vomiting, acute rice water diarrhoea at Kiruddu Hospital. She was attending to her sick child in Mulago hospital when symptoms of the disease manifested. A stool sample taken from the suspected case tested positive for *Vibrio cholerae* at the Central Public Health Laboratory (CPHL). Since then, patients with similar symptoms have been reported and out of 75 samples collected, 26 were positive for *Vibrio cholerae* on culture. Results released from the lab on 11 June indicate 9 positives cultures for *Vibrio cholerae* sero type Ogawa. As of 20 June 2018, a total of 92 cholera cases and one death were reported in Kampala Uganda (case fatality rate 1%). Seven new cases were admitted at the Mulago isolation center, this bring the total admissions to 16. Surveillance in hot spots as well as door to door community mobilization and media engagements is ongoing in the city. Other cholera outbreaks in the country that have been recorded this year include: Amudat, Kyegegwa, Kagadi, Mbale, Tororo and Hoima.
Uganda	Measles	Ungraded	8-Aug-17	24-Apr-17	30-Apr-18	2 143	610	-	-	As of 30 April 2018, a total 2 143 cases have been reported 610 cases have been confirmed either by epidemiological link or laboratory. Twenty-six districts have confirmed a measles outbreak, these include: Amuru, Butambala, Butebo, Buyende, Gomba, Hoima, Iganga Isingiro, Jinja, Kaliro, Kampala, Kamuli, Kamwenge, Kayunga, Kyegegwa, Kyotera, Kabarole, Kalungu, Luwero, Lwengo, Mbale, Mityana, Mpigi, Namutumba, Ngora and Wakiso. Two districts of Kayunga and Lwengo successfully controlled their outbreaks by intensifying the routine immunization. The main cause of the measles outbreaks is failure to vaccinate especially young children below the age of 5 years. The Ministry of Health has developed a measles response plan with an objective to rapidly interrupt measles transmission through intensified routine immunizations of susceptible children.

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
Uganda	Rift Valley fever (RVF)	Ungraded	29-Jun-18	20-Jun-18	9-Jul-18	8	4	2	25.0%	Following the confirmation of confirmed cases of RVF in Isingiro district on 28 June 2018, WHO was notified of RVF in Uganda on 29 June 2018. As of 9 July 2018, a total of 8 cases (4 confirmed and 4 suspected cases) including 2 deaths (CFR 25%) were reported from 3 districts (Kasese, Isingiro and Ibanda). Two case-patients are currently admitted at the Isolation unit in Mbarara Regional Referral Hospital. All cases were confirmed by PCR at UVRI.
Recently closed events										
Côte d'Ivoire	Floods	Ungraded	20-Jun-18	18-Jun-18	1-Jul-18	-	-	20	-	From 18 to 19 June 2018, almost all of Côte d'Ivoire suffered heavy rains which led to a great deal of material damage and loss of life. The resulting floods in several neighborhoods in Abidjan and other cities led to collapse of buildings and bridges. A total of 21 deaths has been reported, including 18 in Abidjan in Cocody. In the most affected district of Riviera in Abidjan, 115 wounded people were receiving care. A total of 136 people has also been reportedly rescued in affected areas by the rapid intervention system put in place. On 20 June 2018, the Public Health Emergency Operations Center (COUSP) was activated to respond to the health consequences of this crisis. Rapid Intervention teams have been in the field to assess health risks, health services, to collect information for the response planning and decision making.

†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. Bategereza (Ethiopia)
F. Banza-Mutoka & G. Folefack (Democratic Republic of the Congo)
P. Mhata (Namibia)
E. Douba (Cameroon).

Graphic design
Mr. A. Moussongo

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

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