

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 28: 8 – 14 July 2017

Data as reported by 17:00; 14 July 2017



World Health
Organization

REGIONAL OFFICE FOR

Africa

WHO Health Emergencies Programme

1

New event

36

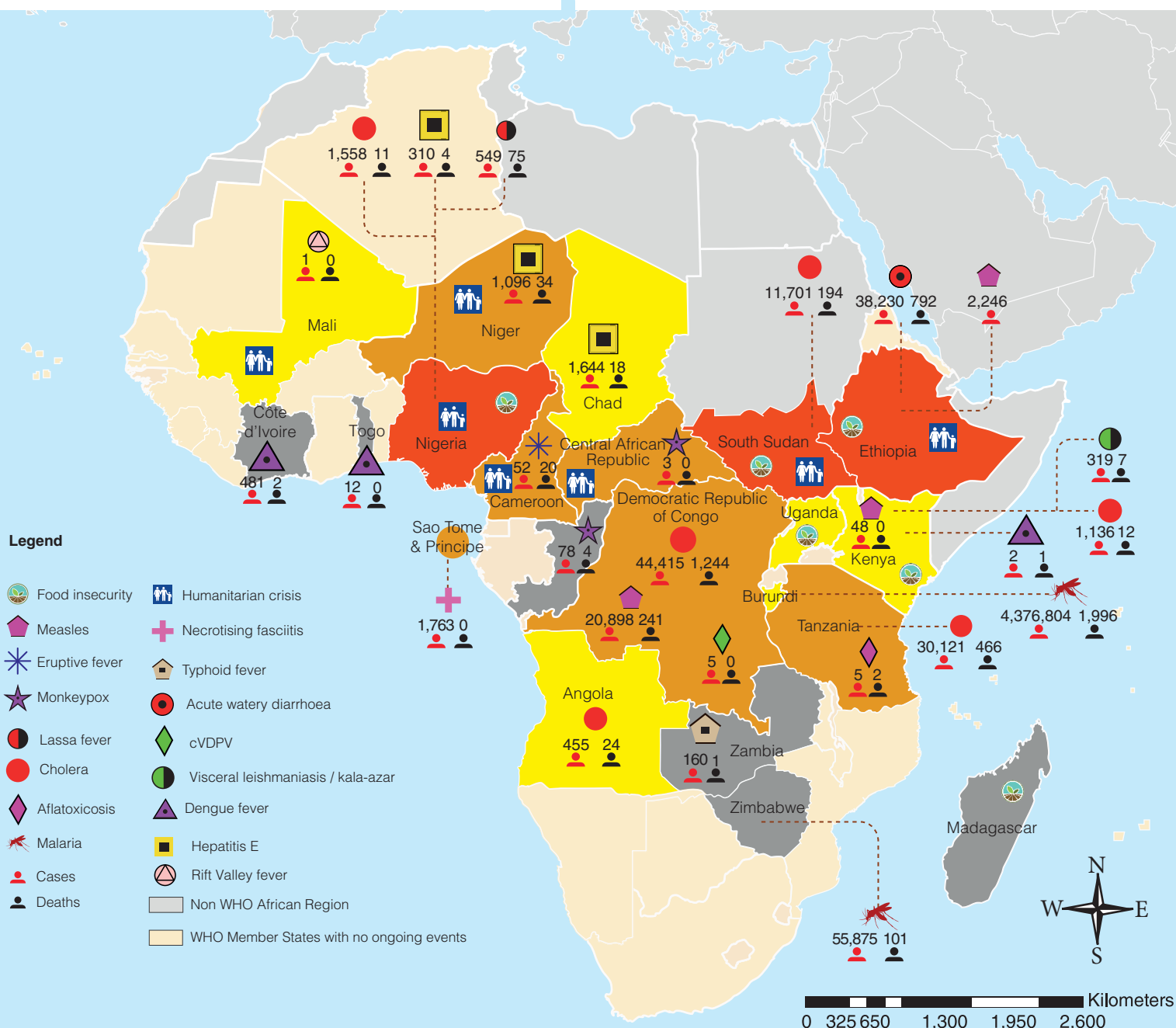
Ongoing events

27

Outbreaks

10

Humanitarian
crises



3

Grade 3 events
(including one protracted event)

6

Grade 2 events

7

Grade 1 events

21

Ungraded events

Overview

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- This weekly bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. WHO AFRO is currently monitoring 37 events: three Grade 3, six Grade 2, seven Grade 1, and 21 ungraded events.
- This week, one new event has been reported: an outbreak of Rift Valley fever in Mali. This week's edition also covers key ongoing events in the region, including the grade 3 humanitarian crises in Nigeria and Ethiopia, the grade 2 humanitarian crisis in the Central African Republic and outbreak of cholera in the Democratic Republic of the Congo, and outbreaks of Lassa fever in Nigeria and dengue fever 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 include:
 - The emerging scale of the severe acute malnutrition in the south-eastern part of Ethiopia calls for urgent multisectoral actions to alleviate the suffering and prevent avoidable morbidity and mortality in the vulnerable populations.
 - The deteriorating security situation in Central African Republic continues to affect the delivery of humanitarian assistance to the populations in need. In addition, the increasing trend of targeting humanitarian actors is worrying.

New event

Rift Valley fever

Mali

1
Case

0
Deaths

0%
CFR

Event description

A single case of Rift Valley fever (RVF) virus infection was detected in the Koulikoro Region in western Mali. This case was identified through laboratory investigations into three suspected yellow fever cases. All three samples tested negative for all arboviruses included on the molecular panel, namely: dengue, West Nile, RVF, chikungunya, Crimean-Congo haemorrhagic fever, and Ebola. However, one sample was anti-RVF virus IgM positive on serology testing by ELISA.

The case-patient, a 10-year old son of a farmer from Ouléssébougou (80 km south of the capital Bamako) presented to a local health centre on 7 June 2017 with fever, jaundice, vomiting, and localised muscle pain. A rapid test for malaria was performed, which tested positive and antimalarial treatment (quinine) was started. Showing no signs of improvement and suspecting yellow fever, a blood sample was collected on 8 June 2017 and medical referral recommended. However, the child's parents opted to take him back to the village for traditional treatment. On 7 July 2017, the Institut Pasteur Dakar released the result confirming the diagnosis of RVF. On 9 July 2017, the child was re-admitted to the Centre de Santé de Référence d'Ouléssébougou, where he is currently receiving care.

On 7 July 2017, the district rapid response team was deployed to the affected village to conduct outbreak investigation. The team observed that the affected village is served by a large diameter well, with shepherds in transhumance (seasonal movement of people with their livestock) living nearby and regularly visiting the village. During active search, 60 villagers were examined, 32 blood samples were collected from febrile family and community members (some positive for malaria), and more than 100 blood samples collected from domestic animals. The laboratory results of these samples are still pending. No cases of icteric fever were detected and no cases of miscarriage in pregnant women or abortions or deaths in animals were reported.

Geographical distribution of Rift Valley fever cases in Mali, 7 June - 14 July 2017



Public health actions

- On 7 July 2017, the WHO Country Office and the National Directorate of Health convened a meeting to review the situation.
- The Ministry of Health held an emergency meeting on 8 July 2018 and promptly deployed the multidisciplinary national rapid response team of two epidemiologists, an infectious disease physician, two laboratory biologists (human health and animal health), a veterinarian, a communicator, and an entomologist.
- Further activities, including active case finding, animal health surveys, mapping and health promotion communications are planned.

Situation interpretation

The occurrence of a sporadic case of RVF in a village in Mali is not surprising. During August-November 2016, communities in the Tahoua Region, Niger (on the border with Mali) experienced an outbreak of RVF. And in January this year, OIE confirmed RVF virus as the cause of abortions in sheep and goats across the border in Menaka, Mali (some 1,700 km from the abovementioned outbreaks). Nevertheless, the detection of even a single case warrants an immediate emergency response, as such cases are often an early indication of widespread infection in livestock populations, associated with abortions with devastating economic impacts. Though the disease in humans is often subclinical or mild, 8-10% of cases develop severe symptoms, including ocular disease, encephalitis and/or haemorrhagic fever.

The differential diagnosis of this case was complicated by a probable malaria co-infection, with only serological evidence to suggest a recent RVF virus infection as the cause of his illness. At this stage, it is unclear how this child was infected. The virus may have been introduced to the area via nomadic livestock, with this child subsequently infected through direct exposure to these animals (e.g. during slaughter or birthing). Alternatively, transmission may have occurred via mosquitoes. Indeed, it is currently rainy season in Mali and RVF epizootics are known to occur during times of flooding and high rainfall, which stimulates the hatching of RVF-infected mosquito eggs, within which the virus may have remained viable for several years. This ultimately results in the emergence of RVF-infected mosquitos, which then infect ruminant animals and humans. The rainy season and transhumance increases the risk of spread to neighbouring communities and countries. Urgent investigations, under the One Health approach, are needed to determine if there is an ongoing RVF epizootic in the area, and implement prevention and control measures.

Ongoing events

Lassa fever

Nigeria

549
Cases

109
Deaths

19.9%
CFR

Event description

Nigeria has been experiencing resurgence of Lassa fever since early December 2016, with active transmission reported in five states in the last 3 weeks. During week 27 (week ending 9 July 2017), 13 new suspected cases including two deaths (case fatality rate 15.4%) were reported in Ondo (8) and Plateau (5) States. Five of the reported cases were confirmed: three in Plateau and two from Ondo. The three confirmed cases in Plateau State originated from a cluster of eight suspected cases investigated among students at a school in Langtang North Local Government Area. Two of the five confirmed cases died (one in Ondo and one in Plateau), giving a case fatality rate of 60% among the confirmed cases. Laboratory results of seven samples from Ondo are still pending.

As of 7 July 2017, a total of 549 Lassa fever cases have been reported in the country, including 196 confirmed and 14 probable cases. Of these, 109 cases have died, translating into an overall case fatality rate of 19.9%. A total of 77 deaths occurred among the confirmed and probable cases, reflecting a case fatality rate of 36.7% in this group.

Since the onset of this current outbreak in December 2016, 17 out of 36 states in Nigeria have reported at least one confirmed case. These states include: Ogun, Bauchi, Plateau, Ebonyi, Ondo, Edo, Taraba, Nasarawa, Rivers, Kaduna, Gombe, Cross-River, Borno, Kano, Kogi, Enugu, and Anambra. Meanwhile, five states, namely Anambra, Rivers, Ondo, Edo, and Plateau, have reported confirmed Lassa fever cases in the last 21 days.

Public health actions

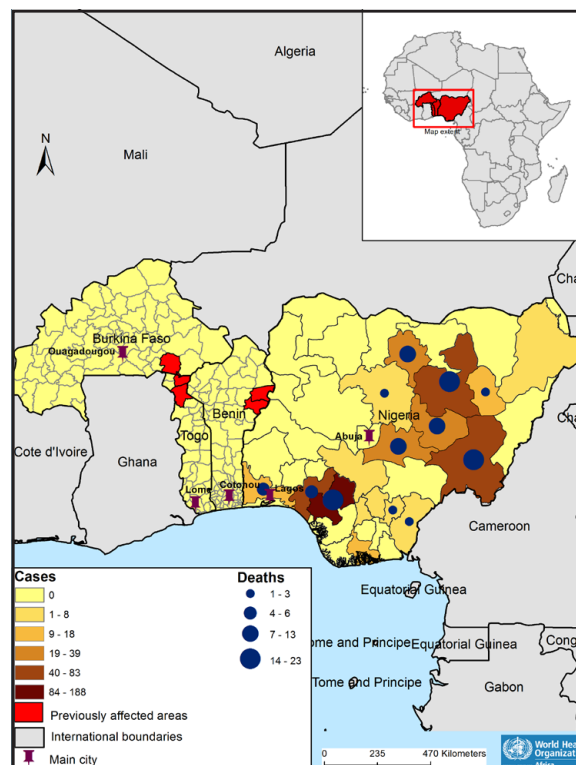
- The State Ministries of Health and the Nigerian Centres for Disease Control (NCDC) Lassa Fever Response Working Group continue to coordinate the response to the outbreak, with the support of partners (WHO, CDC, AFENET, University of Maryland, Baltimore, Jos University Teaching Hospital, etc.).
- State Surveillance Teams are continuing with enhanced surveillance and contact tracing activities in the states with active transmissions.
- In Plateau State, the rapid response team conducted outbreak investigation in the affected school; line listed cases, supported laboratory testing, and initiated contact identification and monitoring activities. The team plans to expand active search for additional cases to the other local hospitals and outreach stations.
- Case management and infection prevention and control activities have been prioritized in all the affected areas. In Ondo State, the NCDC teams supported the tracing of confirmed cases discharged against medical advice, facilitated expansion of the isolation and treatment centre, and undertook a data review. The team also advocated for the introduction of psychosocial and counselling services in the isolation unit and provision of funding to support the emergency operations centre (EOC) activities. In the Plateau State, an isolation ward has been established at the teaching hospital and equipped with personal protective equipment and injectable ribavirin. Staff training on the newly developed case management standard operating procedures is planned.
- Communication and social mobilization activities continue; media jingles have been developed and being disseminated; sensitization activities by the State Ministries of Health have been intensified in the community continuing; and sensitization of local government area authorities and health facilities is underway.
- Planning is underway for a 2016/2017 national Lassa fever outbreak review and preparedness meeting.

Situation interpretation

Lassa fever is known to be endemic in several West Africa countries. In Nigeria, seasonal outbreaks occur yearly between December and June. However, in recent years, cases have been reported at increased frequency from non-endemic areas and outside the usual season. In 2016, 273 suspected cases and 149 deaths (case fatality rate 55%) were reported from 23 states. Benin, Burkina Faso, Sierra Leone, and Togo have also reported outbreaks in 2017, which have since been controlled.

The current Lassa fever outbreak in Nigeria initially showed signs of easing following a peak in week 9 of 2017. However, the recent resurgence of cases, including the cluster of cases at a school, highlights the persistence of the outbreak. Notably, Nigeria is concurrently experiencing a protracted humanitarian crisis, as well as outbreaks of cholera and hepatitis E, which are collectively stretching the public health response capacity of the country and partners. Continued and enhanced efforts by the local governments and partners are crucial to bring this outbreak under control and minimize the impact of this often fatal viral infection. Communication and social mobilization efforts are a critical component of this response, aimed to promote early detection, isolation and treatment of cases; while engaging local communities to promote rodent prevention and control activities.

Geographical distribution of Lassa fever cases in Nigeria, December 2016 - 7 July 2017



Event description

Kenya has been experiencing an outbreak of dengue fever since March 2017. The outbreak was notified to WHO on 9 May 2017 by the Kenya Ministry of Health. Two counties, Mombasa (the coastal city) and Wajir in the east of Kenya have been affected. Retrospective investigation showed that the outbreak in Wajir County started on 23 March 2017. As of 11 July 2017, a total of 82 cases have been reported, all from Tarbaj sub-county. No new confirmed cases have been reported in Wajir since 20 June 2017.

Concurrently, Mombasa County has experienced a substantially larger outbreak since 31 March 2017. As of 11 July 2017, a total of 1,117 cases and one death have been reported. The outbreak has affected five sub-counties, including: Kisauni, Nyali, Mvitam, Likoni, and Jomvu. The last confirmed cases were reported on 2 July 2017.

As of 11 July 2017, the outbreak remains active in both counties, with a total of 1,199 cases and one death (case fatality rate <0.1%) reported. Of these, 672 cases have tested positive for dengue virus either by rapid diagnostic test (RDT) or serology (ELISA). Further subtyping of the circulating virus is not currently available.

Public health actions

- Enhanced disease surveillance is ongoing in the most affected areas including active case finding. WHO has finalized plans to re-orientate the rapid response teams on outbreak management and early warning as part of support to control of the outbreak.
- Case management for patients with dengue fever is ongoing in the health facilities in the affected areas.
- Vector control activities are ongoing, including inspection and identification of mosquito breeding sites, subsequent larviciding, targeted indoor residual spraying of households and institutions.
- Health promotion has been scaled up and additional efforts are being put in place by the Ministry of Health and partners to communicate the risk of the disease and the outbreak to the community.

Situation interpretation

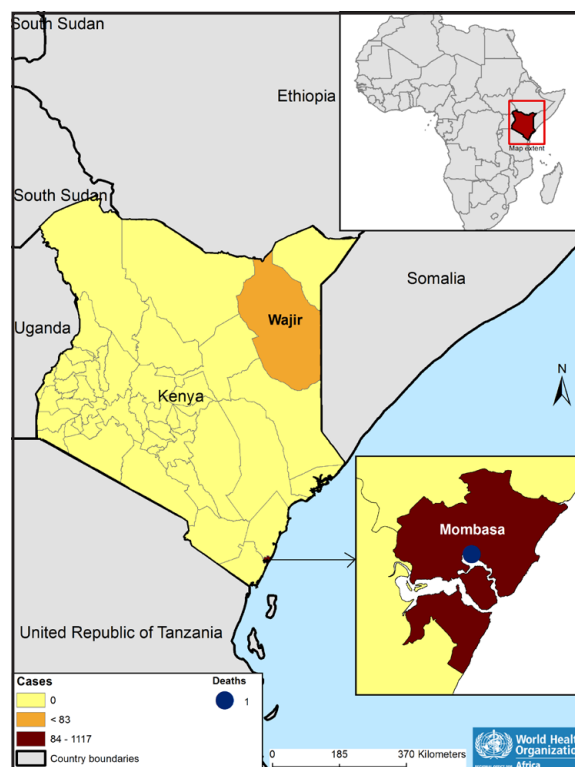
Kenya recorded the first dengue fever outbreak in 1982 in the coastal region. In 2011, a large outbreak occurred in Mandera town, bordering Somalia and Ethiopia in northern Kenya. The outbreak was associated with large population movements in the sub-region. In mid-2013 and mid-2014, large outbreaks recurred, coinciding with the long rainy seasons, which created favourable breeding grounds for the dengue mosquitoes. Dengue fever is mainly an urban and peri-urban disease, driven by human behaviours such as storing water in open containers inside or around homes. These are excellent breeding grounds and their close proximity to people increases the risk of transmission.

The ongoing dengue fever outbreak in Kenya (particularly in the coastal Mombasa County) is showing signs of easing. The decline observed during June and July may be due to onset of the cold season and lower rainfall, with environmental conditions less favourable to the mosquito vectors. Moreover, vector control activities may be contributing.

Continuous follow-up of the outbreak is required to ensure that control efforts are sustained and cases are detected in a timely manner. There is a strong likelihood of underestimating the actual burden of the disease since many people remain asymptomatic or have mild illness, and thus may not seek medical assistance. The affected counties are challenged by limited laboratory capacity and supply of essential medicines for dengue fever diagnosis, confirmation and treatment. In addition, both the affected counties are facing other competing outbreaks including measles, cholera and kala-azar, which rely on the same available health systems. There is also a need to strengthen the response capacity as most of the rapid response teams have limited training. A multidisciplinary team of experts is instrumental in mounting an effective response to this outbreak.

The global spread of dengue is worrying, being driven by world trade, climate change, rapid urbanization and poor environment management, mosquito habits, and insecticide resistance. The eggs of mosquitoes can survive long periods under dry conditions thus encouraging their transportation over great distances in ships, even across continents. Air transport enables infected persons to carry disease to areas infested with dengue mosquitoes, thus increasing local transmission of the disease. Africa is becoming rapidly urbanized, which is encouraging poor environmental sanitation, which in turn increases the breeding of dengue mosquitoes. Overpopulation encourages the rapid spread of the disease and the lack of access to health facilities increases the risk of severe outbreaks.

Geographical distribution of dengue fever cases in Kenya, 23 March 2017 - 11 July 2017



Event description

The cholera in the Democratic Republic of the Congo remains endemic over many years with seasonal transmission peaks. During week 26 (week ending 2 July 2017), 563 new cases including 11 deaths (case fatality rate 2.0%) were reported, compared to 585 cases and 15 deaths (case fatality rate 2.6%) registered the previous week. Between 1 January and 8 July 2017, a total of 15,063 cases including 427 deaths (case fatality rate 2.8%) have been reported across the country. Over 20% of these cases originated in Tanganyika Province where there are large numbers of internally displaced persons (IDPs) fleeing ongoing ethnic conflict. Since the beginning of the current outbreak in 2015, a total of 44,415 cases and 1,244 deaths (case fatality rate 2.8%) have been reported.

Eighteen out of the 26 provinces in the country have reported cholera cases in 2017. Cholera transmission dynamic across the provinces continues to exhibit a clear pattern. Of the 18 affected provinces, six are known to experience protracted propagation of cholera infections. These provinces are largely located along the lakes on the eastern side of the country, and along the River Congo to the west. The other 12 provinces are known to experience episodic/sporadic transmissions. While both groups have equally shared the disease burden, the provinces with episodic/sporadic disease pattern exhibited a much higher fatality rate of 3.8%, compared to 1.9% experienced in the other category. Kinshasa and Tshopo have recorded the highest case fatality rate of 6.8%.

Public health actions

- Implementation of enhanced surveillance has been strengthened along the landing sites and ports.
- Disinfection of boats at ports, homes and engagement of island communities in Kinshasa is ongoing.
- Continued field investigation of cases including collection and shipment of laboratory samples to the national reference laboratory, Institut National de Recherche Biomédicale.
- Establishment of free healthcare access for cholera cases by the Ministry of Health, with the support of MSF, ALIMA and other partners in all affected districts.
- Planning underway for a reactive oral cholera vaccine in the east of the country.
- The water, sanitation and hygiene (WASH) cluster continues to establish water chlorination points and hand washing stations in the affected provinces.
- Provision of information, education and communication material to all affected provinces including articles in local newspapers have continued.

Situation interpretation

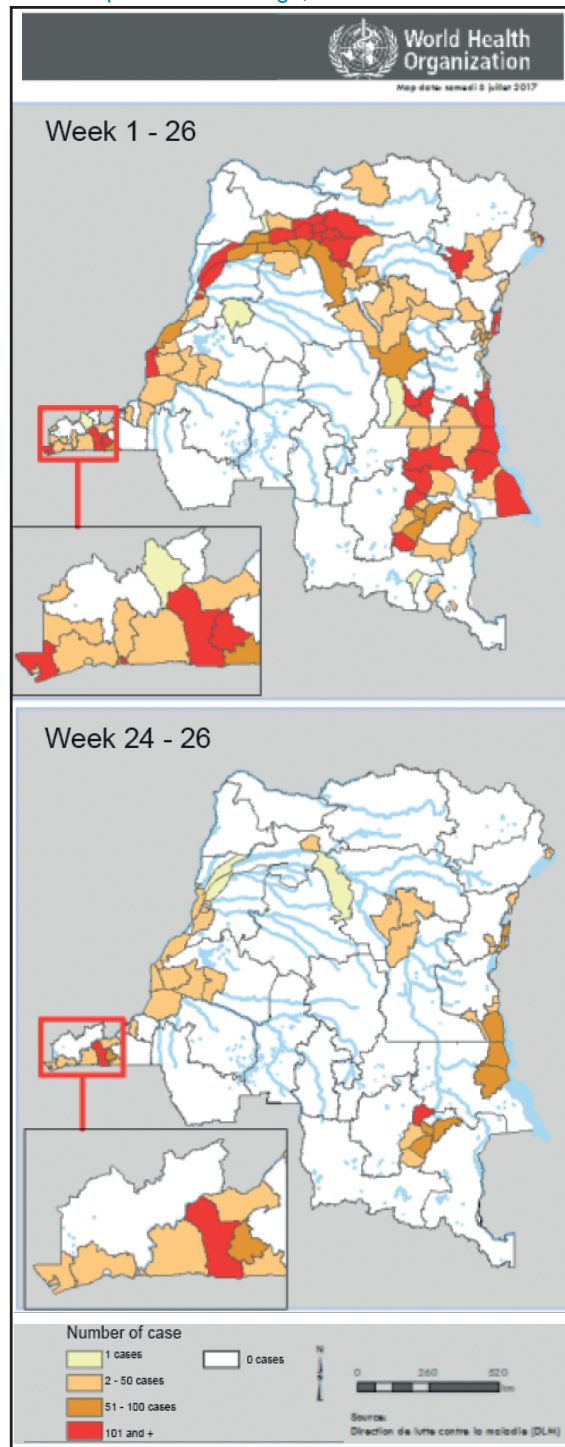
The outbreak of cholera in the Democratic Republic of the Congo is exacerbated by the decades of recurrent conflicts, which have destroyed social services including health facilities, water supply infrastructure and sanitation facilities. Consequently, there are large numbers of internally displaced persons and host communities facing a shortage of clean drinking water supplies, limited access to proper sanitation and resultant unsafe hygiene practices, which facilitate cholera transmissions.

The case fatality rate being recorded during the cholera outbreak in the Democratic Republic of the Congo has remained unacceptably high – averaging 2.8% overall and as high as 6.8% in some provinces. This could be an indication of inadequate healthcare service provision, in many forms. Generally, with proper and timely treatment, the cholera fatality rate should be maintained below 1%.

Taken together, multi-pronged approaches to address the pervasive socio-political instability as well as the dire health needs of the population need to be considered by the national authorities and global communities. Along with concerted efforts in peace building, cholera response pillars, including community engagement, WASH, case management, surveillance, and laboratory diagnostics, all need continuous strengthening.

WHO calls on partners to urgently increase their provision of technical and financial support to the Ministry of Health, particularly with the approaching heavy rainy season, generally lasting from September/October to May, increasing the risk of continued cholera transmission.

Geographical distribution of cholera cases in Democratic Republic of the Congo, week 1-26 of 2017



Event description

While the outbreak of acute watery diarrhoea (AWD) is subsiding in the south-eastern part of Ethiopia, the full extent of severe acute malnutrition (SAM) is emerging. The below-average rainfalls in the last consecutive seasons have caused severe drought across northern, eastern and central Ethiopia, leading to high levels of food insecurity – particularly in Oromia, Afar, and Amhara Regions. The majority of Ethiopia's refugee camps, hosting approximately 843,000 refugees from neighbouring countries, including about 375,000 from South Sudan, have reached full capacity. Overcrowding, malnutrition, and critical shortfalls in humanitarian aid are of concern. According to ACAPS, the number of people receiving humanitarian assistance has increased from 5.6 million to 7.78 million in the first quarter of 2017, and this number is expected to rise further in the second half of the year. About 8 million people currently receiving food assistance across the country are likely to face malnutrition as Ethiopia runs out of emergency food aid from July 2017, due to underfunding to maintain the supply pipeline.

During week 26 (week ending 2 July 2017), a total of 1,489 new cases of severe acute malnutrition (SAM) were reported in Oromia Region. Of these, 1,306 were managed at the outpatient therapeutic programmes (OTPs) and 183 were admitted to the stabilization centres (SCs). Between 1 January and 2 July 2017, 36,154 cases of SAM were reported in the region. These include 32,216 cases managed at the OTPs and 3,938 cases admitted to the SCs.

Meanwhile in Amhara Region, 515 new cases of SAM were reported in week 26 of 2017. Of these, 479 were managed at the OTP and 36 were admitted to the SCs. A total of 11,947 cases of SAM have been reported in the region between 1 January 2017 and 2 July 2017. These cases include 11,162 managed at the OTPs and 783 admitted to the SCs. Anecdotal nutrition surveillance data is currently showing high mortality rates, especially among children, attributed to severe malnutrition and its complications.

On the other hand, the AWD outbreak situation continues to improve. During week 27 (week ending 9 July 2017), 275 new AWD cases were reported from the three regions of Somali (149), Oromia (68) and Amhara (58). Since the beginning of 2017, 38,715 cases including 797 deaths (case fatality rate 2.1%) have been reported from the seven regions of Somali, Oromia, Amhara, Afar, SNNP, Tigray, and Benshangul Gumuz. Eighty-eight percent of the cases and 94% of the deaths were reported in Somali Region alone.

Public health actions

- A nutrition cluster, led by UNICEF, continues to coordinate the response to the acute malnutrition situation in the country. The cluster holds a weekly technical meeting, during which updates on ongoing activities are provided and technical issues discussed.
- The nutrition cluster 4W matrix has been updated to facilitate mapping of the partners and ensure equitable distribution and coverage of interventions in the countries.
- WHO has redefined and developed its strategy and plan to support and strengthen the response to the nutrition emergency in the Somali Region.
- WHO is deploying additional technical nutrition experts to enhance quality of care and support coordination of the response in the affected areas.
- WHO supported training of health workers on the management of SAM to improve on the quality of care for medically complicated malnutrition cases in the stabilization centres.
- WHO continues to provide technical support to the Ministry of Health on nutrition surveillance.
- WHO approved an additional US\$ 500,000 from its Contingency Funds for Emergencies (CFE) to support response operations to the humanitarian crisis, including the severe acute malnutrition.

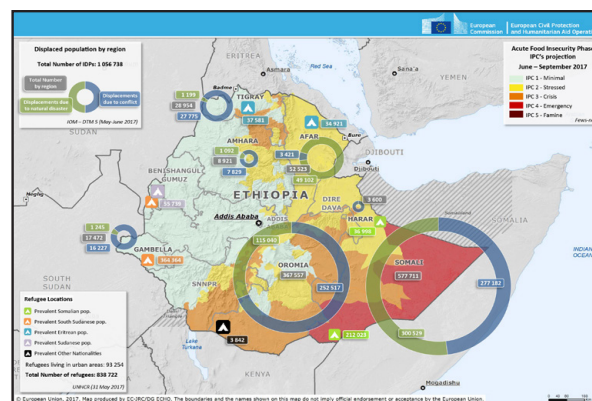
Situation interpretation

The impact of the prolonged drought and the subsequent food insecurity in the south-eastern part of Ethiopia has been severe. Analysis of recent surveillance data shows a rapid increase in admissions of severely malnourished children to the stabilization centres as well as high death rates. These are mainly attributed to shortage of food support at the community level, limited capacities in most stabilization centres and delayed arrival at the centres (due to many access issues). The full extent of the severe acute malnutrition situation is probably underestimated due to the suboptimal performance of the current surveillance system.

The response to the ongoing severe acute malnutrition is being challenged by many factors, including low coverage of services in priority areas – only 57% (38/67) of the hotspot priority woredas are being supported by non-governmental organizations. Most of the stabilization centres are functioning sub-optimally due to inadequate numbers of healthcare workers trained in the management of SAM and its complications, poor adherence to SAM management protocol, limited bed capacity, shortage of second-line medicines, and irregular supportive supervision.

There is an urgent need to clearly establish the magnitude of the malnutrition situation in the region and scale up preventive and management interventions. Rapid and detailed nutrition surveys should be promptly conducted to determine the true picture of this situation and facilitate the design of appropriate intervention strategies and actions. Multisectoral actions are therefore critical at this stage to ensure continuous treatment of severe and moderate malnutrition. On the broader perspective, adequate food aid should continue to be provided to the estimated 8 million people in need to avert further deterioration of the malnutrition situation.

Food insecurity, internally displaced persons and refugees in Ethiopia, July 2017

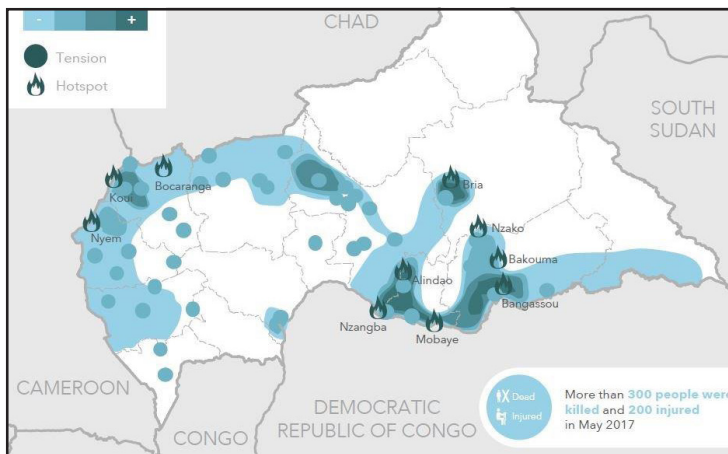


Event description

The security situation and the humanitarian crisis in the Central African Republic continue to deteriorate. Targeted attacks along communal and religious lines and human rights abuses have resulted in over 500,000 people internally displaced. Almost half of the population, 2.2 million people, is in need of humanitarian assistance and over 1 million people are food insecure. Protection, humanitarian access and food security are priority needs, yet needs continue to exceed available resources. Delivery of aid is expected to continue to decline due to low funding and restricted humanitarian access to large parts of the country.

Multiple security incidents have been reported in the last weeks. During the past week, 3-9 July 2017, new outbreaks of violence have resulted in deaths, injuries and displacement of people in the central, eastern and northwest regions of the country. In Zémio, factional fighting has led to an increase in the number of IDPs to 22,000, including 5,000 in the hospital grounds. A further 8,000 people have been displaced from villages close to Ngaoundaye in the northwest. Many other places have equally been affected.

Insecurity hotspots in Central African Republic, May 2017



Since the end of May 2017, at least 15 incidents targeting humanitarian actors have been reported. UNHCR and INTERSOS bases have been looted by armed men in Kaga-Bandoro, Nana Grébizi Prefecture. Due to violence at the hospital in Zémio, Haut-Mbomou Prefecture, MSF has withdrawn its staff to Bangui, leaving 20,000 people with limited access to healthcare. Earlier in the reporting week, most operational humanitarian organizations relocated their essential staff to Bangui (28 humanitarian workers in total).

Sporadic cases of monkeypox continue to be detected and investigated in Lobaye Prefecture (near the border with the Republic of Congo). During week 24 (week ending 18 June 2017), one new case was confirmed by the Institut Pasteur Bangui in a camp in Toma. Further investigations supported by the Ministry of Health and WHO revealed 24 of 26 (92.3%) of close contacts had antibodies (IgG) against monkeypox, and 4 against cowpox. This suggests a high level of circulation of the virus in the region, and may explain the low number of cases recorded during these outbreaks. Including this latest case, just 2 confirmed cases and 1 suspected case have been reported since the event was first notified to WHO on 14 April 2017.

Public health actions

- Multiple humanitarian actors continue to provide emergency health services in most of the affected areas, despite the security constraints that reduce the access or presence of health partners.
- In Zémio, the town's hospital, AMIA private health centre and Congolese refugee camp health centre remain functional, but with reduced activities.
- The health sector response is being strengthened with the implementation of mobile clinics. Jeunesse Unie pour la Protection de l'Environnement et le Développement Communautaire (JUPEDEC) and MSF will deploy additional staff to Zémio, if the security situation improves. These groups will support the distribution of mosquito bed nets, and a measles vaccination campaign and will strengthen the early warning systems in place.
- The health partners in the western sector based in Bouar are preparing to carry out needs-assessment in the villages around Ngaoundaye.
- Africa Humanitarian Action (AHA) is using emergency medical kits provided by WHO to provide emergency healthcare to non-displaced people in the Zangba sub-prefecture.
- WHO donated emergency medical kits to JUPEDEC to strengthen their response capabilities in Zémio.
- MSF France will carry out an assessment mission in the Paoua-Bozoum area to assess needs and fill gaps in health structures affected by the recent armed attacks.
- Emergency health services are being provided in the hot spots areas, particularly Bria, Bangassou, Bakouma and Alindao, supported by MSF France, IMC (Bria), MSF Belgium, CORDAID and MVAS (Bangassou), CORDAID and CARITAS Centrafrique (Alindao) and CORDAID (Bakouma).
- WHO supported the national rapid response team to conduct outbreak investigations of the reported monkeypox case.

Situation interpretation

The security situation in Central African Republic remains unpredictable and volatile, with a significant increase in outbreaks of conflict in the eastern, central and western parts of the country. Protection of IDPs and enclaved Muslim communities, food security and humanitarian access remain critical in the country. This is putting strain on the financial and operational capacities of health sector partners. The health sector response plan for the remaining 6 months of 2017 requires US\$ 20 million to meet new humanitarian needs in both the health sector generally, and the cholera contingency plan specifically. In response to the financial difficulties faced by the humanitarian organizations in responding to the recent needs generated by the new crises, the Humanitarian Coordinator launched a Humanitarian Reserve Fund of US\$ 3 million.

Event description

The current humanitarian response in the north-east Nigeria has been obstructed by tense and volatile security situations resulting in restricted access to areas and vulnerable populations in need. There have been multiple security incidents in the past days in the forms of suicide attacks, as well as ambushes on military and civilian targets.

The uncontrolled movement of internally displaced persons (IDPs) and influx of returnees from Cameroon, Niger and Chad is still ongoing. The latest Displacement Tracking Matrix (DTM) reports a 3% increase in the number of IDPs and a 7% increase in the number of returnees. Bama, Gwoza and Kala Balge Local Government Areas (LGAs) are critically affected by shortages of adequate health, shelter, nutrition, and water, sanitation and hygiene (WASH) provisions.

The reported cases of hepatitis E continue to increase. As of 8 July 2017, 310 have been reported, including 42 confirmed cases. The number of reported cases from Ngala has doubled and women are disproportionately affected. The potential for the outbreak to spread to other LGAs, including Dikwa, remains high. The overall outlook of the food security situation is still poor with pockets of population severely affected by malnutrition. The hard-to-reach teams reported severe acute malnutrition (SAM) rates as high as 18%.

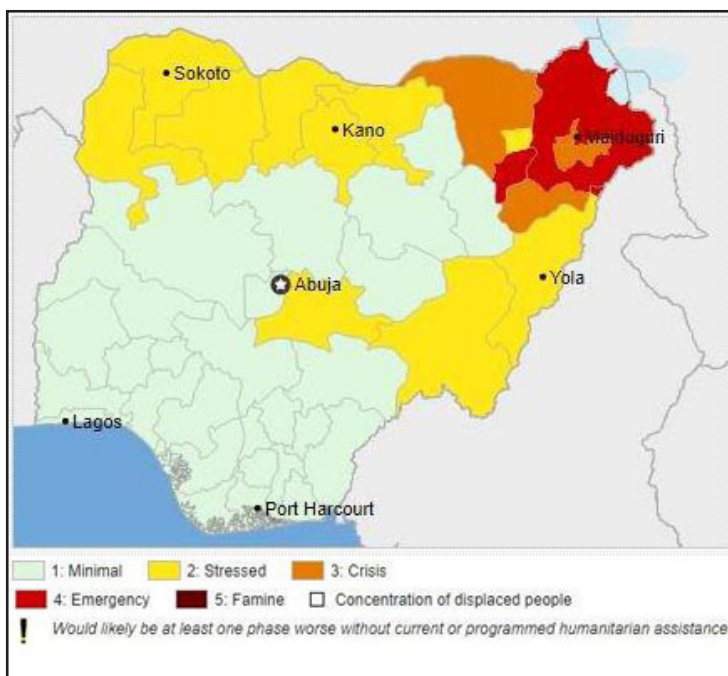
Public health actions

- The WHO mobile health teams have been scaled up to 58 teams, including three rapid response teams, which provide timely operational support.
- The response to the current hepatitis E outbreak, including WASH interventions, is being enhanced. Healthcare workers providing routine vaccinations and malnutrition screening have been sensitized on case identification and response.
- External support has been provided to build local laboratory capacity for timely confirmation of diseases.
- To reduce the burden of malaria, mass administration of malaria chemo-preventive drugs started on the 8 July 2017. Reports reveal high level of drug demand and acceptability among community members, and smooth implementation.
- WHO continues to provide preventive nutritional services and distribution of micro-nutrient products to malnourished patients. Interventions for malnutrition are undertaken in about 300 outpatient therapeutic programmes (OTPs) and 25 stabilization centres in Borno State. Thus far, 20 SAM kits have been distributed to about 20 LGAs. Plans are in place to scale up services to newly accessible LGAs, with emphasis on Banki and Guzamala, where SAM rates are the highest.

Situation interpretation

Although the status of humanitarian situation is still critical, there is a strong effort to coordinate responses to humanitarian, health, nutrition and WASH needs. Action by the Nigeria Centres for Disease Control (NCDC) has contributed immensely to the response to the hepatitis E outbreak, especially in surveillance and strengthening of laboratory capacities. WHO will continue to support the NCDC in these efforts. There is a need to mobilize additional funding for the subsequent rounds of seasonal malaria chemo-prevention. While a lot of progress has been made to secure funds (US\$ 2.35 million of the required US\$ 4.5 million have been provided), it is important to continue sourcing more funds for these crucial activities.

Food insecurity crisis in Nigeria
The Integrated Food Security Phase Classification (IPC)
projection for June - September 2017



Summary of major challenges and proposed actions

Challenges

- Surveillance information coming from services provision centres and other anecdotal sources indicate that the magnitude of the acute severe malnutrition in the south-eastern part of Ethiopia is much higher and the situation more serious than previously realised. The number of new admissions of SAM cases to the therapeutic feeding centres continues to rise as well as fatalities attributed to complications of malnutrition. The current response capacities to the malnutrition situation are being challenged by many factors, including low coverage of services in hotspots priority areas.
- The deteriorating security situation in Central African Republic continues to obstruct delivery of humanitarian assistance to the populations in need. This situation is being complicated by the increasing incidents targeting humanitarian actors, which is worrying.

Proposed actions

- All stakeholders, both government and partners, to urgently mobilize the required resources and rapidly scale up response to the severe acute malnutrition, especially at the community level. Rapid and detailed nutrition surveys should be promptly conducted to establish the true extent of this situation and guide planning and implementation of effective intervention strategies and actions. The nutrition cluster should provide strong leadership to coordinate all the actors and ensure that the situation is responded to effectively.
- Continuous advocacy for concerted peace building efforts to address the pervasive security and socio-political instabilities. The humanitarian community to continue providing assistance including healthcare to the population in need in the given circumstances.

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								
Rift Valley fever	Mali	Ungraded	10-Jul-17	1 (1)	-	-	Single case, 10 year-old male from a village in Ouélesse-bougou Health district, Koulikoro region. Onset 4 July 2017, presented to healthcare 8 July 2017. Tested suspected yellow fever, but found positive for anti-RVVF IgM by the Institut Pasteur in Dakar.	10-Jul-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	-	-	-	-	Detailed update given above.	30-Jun-17
Humanitarian crisis	Niger	G2 extension	Beginning 2015	-	-	-	-	-
Cholera	Democratic Republic of Congo	G2	02-Jan-15	44,415	1,244	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 Caue-South, Lembá and Lobata-North.	28-Jun-17
Drought/food insecurity	Kenya	G1	-	-	-	-	SMART surveys highlighted the rates of Global Acute Malnutrition rates increases 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	1,644 (98)	18	1.1%	During the past reporting week, 13 new suspected cases, 0 deaths and 0 hospitalized were reported from four areas: Amtiman North (n=4), Amtiman South (n=1), Amsinéné (n=1) and Aboudeia (n=7). Active case detection and WASH activities continue in affected areas.	09-Jul-17
Cholera	Kenya	G1	10-Oct-16	1,136 (175)*	12*	1.1%	*Counts reported are for 2017 YTD only. Outbreaks remain active in Garissa, Nairobi, Murang'a, Turkana and Wajir counties. 54 new cases were reported this past reporting week, all from Garissa and Nairobi counties.	11-Jul-17
Cholera	Angola	G1	04-Jan-17	455	24	5.3%	Since early December 2016, cases have been detected in Cabinda (225), Soyo (225) and Luanda (5).	28-Jun-17
Malaria	Burundi	Newly graded G1	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	549 (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 IDSR.	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	48 (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. Two new cases were reported in Mandera this past week, where the outbreak remains active. No new cases have been identified in Garissa since the last case was reported on 4 June 2017.	11-Jul-17
Hepatitis E	Niger	Ungraded	06-Apr-17	1,096 (439)	34	3.1%	Detailed update given above.	30-Jun-17
Monkeypox	Central African Republic	Ungraded	14-Apr-17	(3)	0	0.0%	During week 24, one confirmed case of Monkeypox was reported from Mbaiki Health District. Investigations carried out with the support of WHO resulted in the collection of samples from 20 contacts, 16 of which were also positive (without symptoms).	30-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 / ka-la-azar	Kenya	Ungraded	05-May-17	319 (201)	7	2.2%	Two counties, Marsabit (n=200) and Wajir (n=119) have been affected by outbreaks since early 2017. Outbreaks remain active in both areas, with the last cases reported on 9 July and 17 June 2017 within the two counties, respectively. 24 new cases were reported in Marsabit in the past week.	11-Jul-17
Dengue	Cote d'Ivoire	Ungraded	06-May-17	481 (224)	2	0.4%	Three of the four dengue virus (DENV) subtypes have been identified: DENV-2 (102 cases), DENV-3 (36 cases) and DENV-1 (9 cases). During the week of 27 June to 4 July 2017, 37 new suspected cases were reported; all from Abidjan where the majority of cases have occurred. Mosquito control and awareness raising campaigns continue.	04-Jul-17
Dengue	Kenya	Ungraded	09-May-17	2	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.	11-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 cVFPV1. No new cases have been reported since the original cluster.	31-May-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	310 (39)	4	1.3%	The outbreak is currently active in Ngala (n=256), Damasak (n=35) and Monguno (n=15). In Ngala, the number of infected pregnant women was 38 (12%) as of 8 July, including four deaths (CFR = 11%). Of 164 samples tested to date, 66 (64%) were positive for HEV.	08-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
Aflatoxicosis	Tanzania	Ungraded	28-Jun-17	5	2	40.0%	MoH notified the event may be ongoing in Partimbo village, Kiteto 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
Recently closed events								
Dengue haemorrhagic fever	Mauritania	Ungraded	07-Jun-17	1 (1)	0	0.0%	Single confirmed in a traveller from Angola presented with symptoms of haemorrhaging to healthcare on 31 May 2017. The case later tested positive for dengue virus infection. Follow-up completed for 10 close contacts and 10 healthcare staff, nil develop symptoms during 21 days of follow-up. No additional cases registered to date.	07-Jul-17
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
Dengue	Nigeria	Ungraded	22-Jun-17	0	0	0.0%	Neg labs	22-Jun-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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