

WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 37: 8 - 14 September 2018
Data as reported by 17:00; 14 September 2018



World Health
Organization

REGIONAL OFFICE FOR
Africa
WHO Health Emergencies Programme

0

New events

52

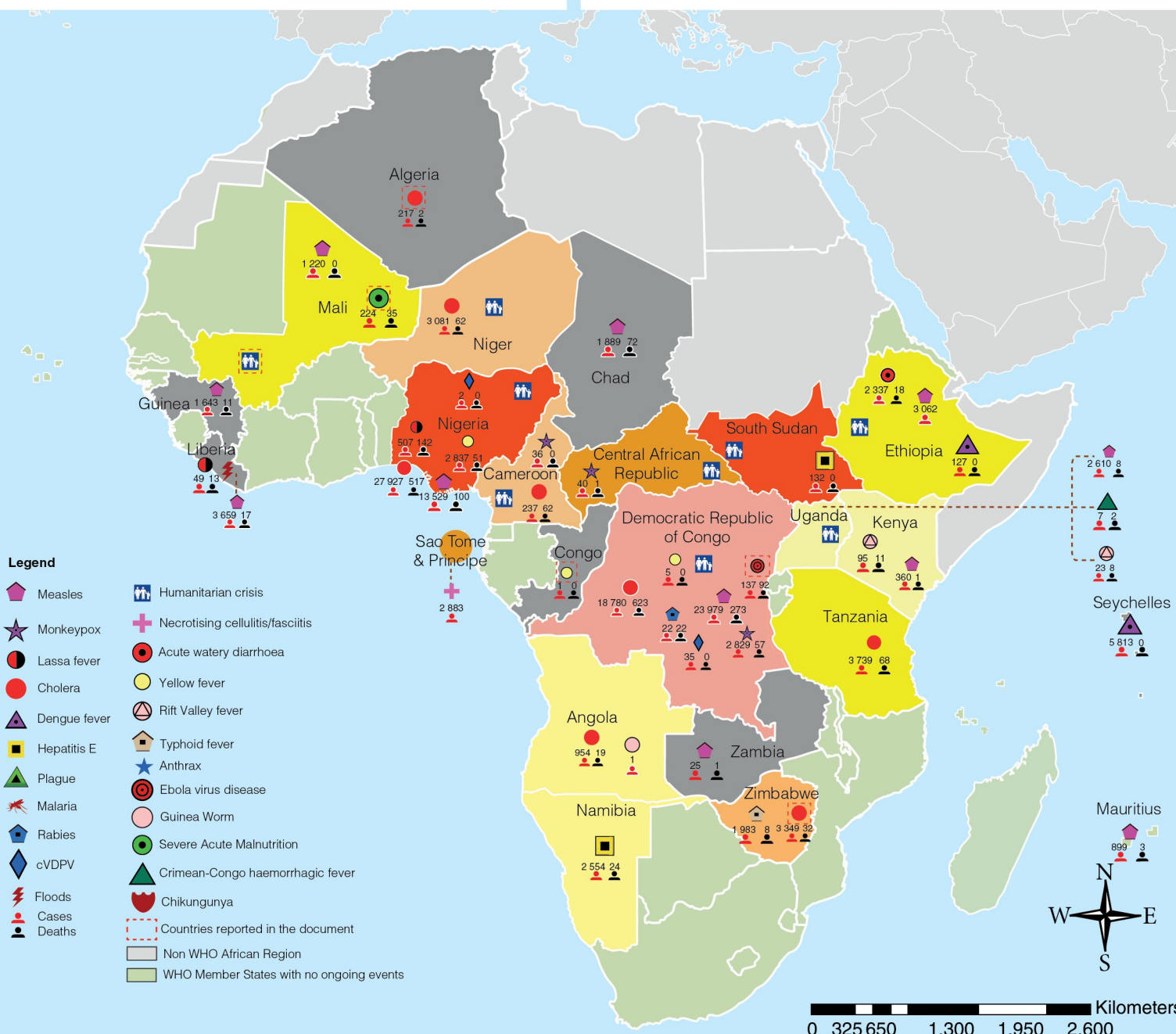
Ongoing events

41

Outbreaks

11

Humanitarian
crises



Graded events †

2

Grade 3 events

6

Grade 2 events

5

Grade 1 events

2

Protracted 3 events

2

Protracted 2 events

4

Protracted 1 events

30

Ungraded events

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

- [Ebola virus disease outbreak in the Democratic Republic of the Congo](#)
- [Cholera outbreak in Zimbabwe](#)
- [Cholera outbreak in Algeria](#)
- [Yellow fever outbreak in Republic of Congo](#)
- [Humanitarian crisis in Mali.](#)

- 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 recently declared cholera outbreak in Zimbabwe is of significant concern with the President of Zimbabwe declaring a state of disaster in Harare on 13 September 2018. The outbreak is rapidly escalating with hundreds of suspected cases being reported daily and the risk factors for cholera transmission ever present. The government have led the response from the front and the national and international public health community are being mobilised to support the strengthening of control activities.
- The incidence of acute malnutrition in Mali as a result of the insecurity presents a challenge. This has been brought about by communities unable to access their fields to cultivate crops due to the presence of improvised explosive devices and armed insurgents, resulting in a depletion of previous cereal stocks. Local authorities, with the support of partners reacted rapidly following notification of the situation. However, until the conflict driving the crises is curtailed by national and international governments the health and nutritional crisis will likely remain.

Ongoing events

Ebola virus disease

Democratic Republic of the Congo

137
Cases

92
Deaths

67.2%
CFR

EVENT DESCRIPTION

The Ebola virus disease (EVD) outbreak in North Kivu and Ituri provinces, Democratic Republic of the Congo continues to be closely monitored. Since our last report on 7 September 2018 (*Weekly Bulletin 36*), six new confirmed EVD cases and three new deaths have been reported. On 12 September 2018, 17 further suspected cases were under investigation to confirm or exclude EVD.

As of 12 September 2018, a total of 137 confirmed and probable EVD cases, including 92 deaths (case fatality ratio 67.2%), have been reported. Of the 137 cases, 106 are confirmed and 31 are probable. Of the 92 deaths, 61 occurred in confirmed cases. A total of 17 health workers have been affected, of which 16 are confirmed cases and three have died. Since the onset of the outbreak, 37 case-patients have recovered from the disease and were discharged and re-integrated into their communities. Of the 113 confirmed and probable cases with known age and sex, females account for 55% (n=62), and the largest proportion (26%, n=29) of cases were aged 35-44 years.

The Mabalako Health Zone, the epicentre of the outbreak, continues to record the majority of cumulative cases reported to date, accounting for 64.9% (89/137) of cases, followed by Beni with 18.2% (25/137) of cases. Of the 12 confirmed and probable cases reported since early September 2018, seven are from Beni Health Zone, while six other health zones (Butembo, Oicha, Musienene, Masereka, Kaluguta and Mandima) have reported confirmed and/or probable cases.

Five of the eight health zones reporting confirmed or probable cases have ongoing contacts: Mabalako, Beni, Mandima, Butembo and Masereka. As of 12 September 2018, a total of 1751 contacts were under follow up, of which 1589 (91%) were seen on the reporting day. This relatively low follow up can be explained by low monitoring observed in Butembo and Masereka health zones.

Alerts have been reported and investigated in several provinces of the Democratic Republic of the Congo as well as its neighbouring countries, namely Burundi, Central African Republic, Rwanda, and Uganda, and to date, EVD has been ruled out in all these alerts.

PUBLIC HEALTH ACTIONS

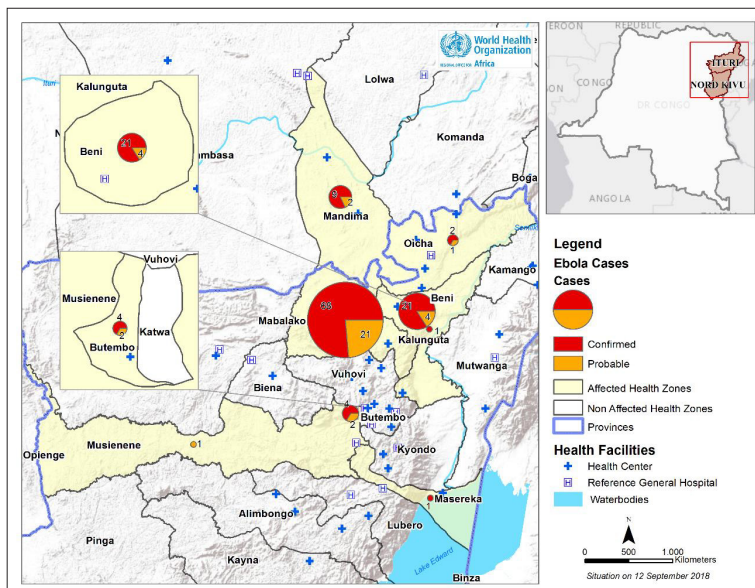
- All public health measures continue to be implemented in key areas of the response; coordination of response activities, surveillance, laboratory services, medical care, infection prevention and control, vaccination, communication, logistics and psychosocial care.
- Systematic monitoring and rapid investigation of all alerts continues in all provinces of the Democratic Republic of the Congo, and in neighbouring countries.
- As of 12 September 2018, all 37 points of entry in Democratic Republic of the Congo (Beni, Goma and Tshopo) are functional for health screening. A new checkpoint has been installed at Kyaghala in Butembo Health Zone. Since the beginning of the screening, over 2.9 million travellers have been screened, and 35 alerts have been reported, of which seven have been validated. Activities to strengthen capacity at points of entry in neighbouring countries as part of preparedness are on-going in collaboration with partners.
- As of 12 September 2018, a total of 8673 people have been vaccinated since the beginning of the vaccination exercise on 8 August 2018. The current vaccine stock available is 2750 doses.

SITUATION INTERPRETATION

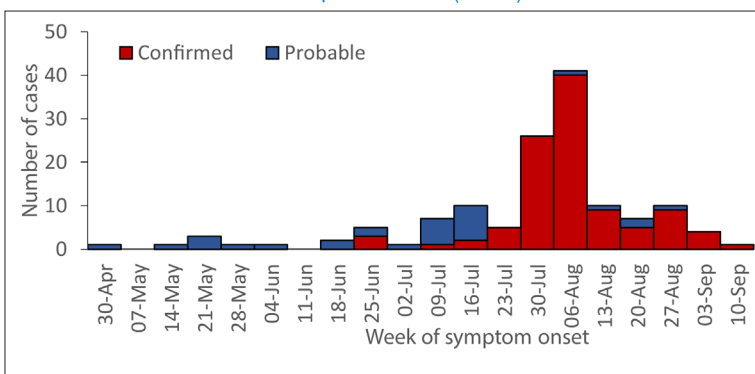
In the six weeks since the EVD outbreak in the Democratic Republic of the Congo was declared, progress is continuously being made to contain the disease. The situation in Mangina, the initial epi-centre of the outbreak, has stabilized, and focus has now shifted to Butembo and the new health areas that have reported confirmed EVD cases. Currently, the major issues of concern include potential undocumented chains of transmission, reluctance by some communities to adopt Ebola prevention behaviours, spread of the disease through healthcare facilities with poor infection prevention and control measures, delays in patients reaching Ebola treatment centres once they develop symptoms, and the potential spread of the virus into insecure areas with limited access.

The national authorities, WHO and partners are working with communities to ensure that they understand and adopt Ebola prevention behaviours, including the need for safe and dignified burials. Healthcare workers have also been involved in improving infection prevention and control practices in health facilities. While all other components of the response, as well as preparedness and readiness in the non-affected provinces of the Democratic Republic of the Congo and in the neighbouring countries, are being undertaken.

Geographical distribution of confirmed and probable Ebola virus disease cases, Democratic Republic of the Congo, 12 September 2018



Confirmed and probable Ebola virus disease cases by week of illness onset, data as of 12 September 2018 (n=137)



EVENT DESCRIPTION

On 6 September 2018, a cholera outbreak was declared in Harare by the Ministry of Health of Zimbabwe and notified to WHO on the same day. Twenty-five patients were admitted at an Infectious Disease Hospital in Harare presenting with diarrhoea and vomiting on 5 September 2018. Most cases came from Glenview 8 and 3, and Budiriro 1 and 2 suburbs. The alert case, a 25-year-old woman presented in a collapsed state and died on the same day, 5 September 2018. A sample from the woman was positive for *Vibrio cholerae*. All the patients had typical cholera symptoms, including excessive vomiting and diarrhoea with rice-water stools and dehydration. The Ministry of Health declared the outbreak after confirmation of 11 cases for cholera using rapid diagnostic test kits together with the clinical presentation. On the same day stool samples were taken for culture and sensitivity, and of the 39 samples taken, 17 were positive for *V. cholerae* Ogawa.

This outbreak is evolving rapidly and affecting mainly Harare city (98% of all cases). The main affected areas in Harare are Glenview and Budiriro. Cases epi-linked to this outbreak have been reported recently across the country in the following provinces: Chitungwiza City, Mashonaland Central province (Shamva District), Midlands province (Gokwe North), Manicaland province (Buhera District, Mutare City and Makoni District), Masvingo province and Epworth. Cholera data from the 1 September 2018 to date shows a rapid increase of suspected cases currently peaking on 9 September 2018, with 596 suspected cases notified. The Zimbabwean government have declared cholera as a disaster in Harare City.

Since the beginning of the outbreak on 1 September 2018, a total of 3349 suspected cases (71 confirmed) including 32 deaths have been reported (case fatality ratio 1.0%). The age group between 15-25 years old constitute 20.1% of the total cases affected, followed by the age group 0-5 (19.6%) and 25-35 (19.6%). Just over half (51%) of the reported cases are males.

Key risk factors for cholera in Zimbabwe are the deterioration of sanitary and health infrastructures and increasing rural-urban migration adding pressure to the water and sanitation infrastructure. In Harare, contaminated water from boreholes and wells are suspected to be the source of the outbreak. The water supply situation in Harare remains dire due to the high demand for drinking water that is not being met by the city supply.

PUBLIC HEALTH ACTIONS

- WHO is supporting the Ministry of Health to fight the outbreak by strengthening the coordination of the response and mobilizing both national and international health experts to form a cholera surge team.
- Outbreak coordination committees at the national and district levels have been established.
- WHO experts are helping authorities to track down cases, providing technical support to laboratories and improving diagnostics and strengthening infection, prevention and control in communities and health clinics.
- WHO is supporting the Ministry of Health in strengthening surveillance and scaling up response to the outbreak.
- The government is assessing the benefits of conducting an oral cholera vaccine (OCV) campaign and WHO is deploying an expert in OCV campaigns to Harare.
- A cholera treatment center was established by MSF in Glen View and it has provided extra nurses to support the response.
- WHO is providing cholera kits which contain oral rehydration solution, intravenous fluids and antibiotics for the treatment of cholera patients to Cholera Treatment Centers set up by partners.
- The recruitment of additional nurses to strengthen the response is ongoing.
- Door-to-door visits are being conducted and posters and pamphlets are being distributed in affected areas.
- Risk communication activities in affected and at-risk districts are being conducted by the government and health partners.

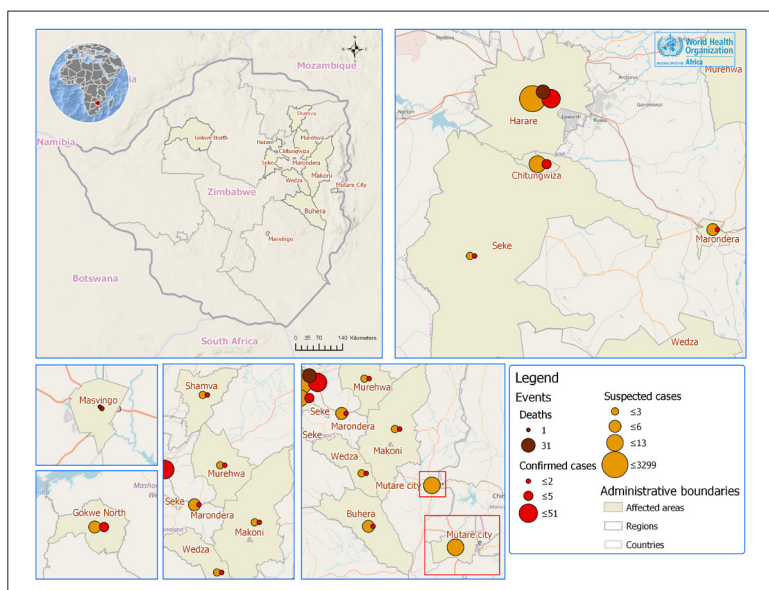
SITUATION INTERPRETATION

The cholera outbreak in Zimbabwe is rapidly evolving, with large number of new cases occurring, and new districts outside Harare being affected. The risk factors for cholera transmission are persistent in the capital city and in surroundings provinces. Sewer blockages are not yet repaired entirely in Harare and municipal water supply is sometimes interrupted during sewer repair and communities spend hours without clean water.

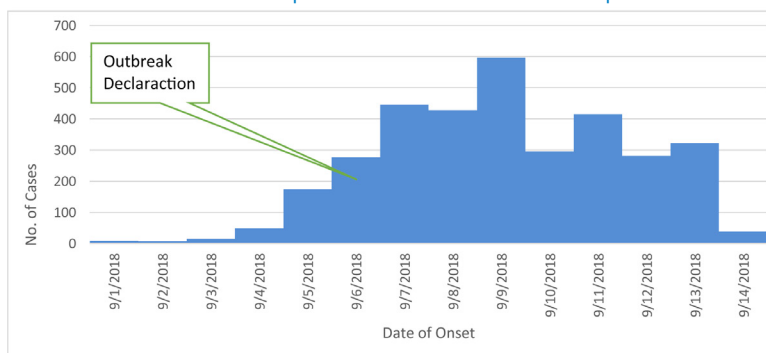
The ongoing outbreak control measures have not been able to halt the propagation of the disease. On 13 September 2018, seven days after the outbreak was declared, the president declared the outbreak of cholera as a state of disaster in Harare. The country's available response capacities are reduced as authorities are concurrently responding to a large typhoid outbreak which started in August 2018.

The national authorities and partners need to intensify and scale up implementation of conventional cholera control activities and consider the benefits of rapid initiation of a reactive cholera vaccination campaign.

Geographical distribution of cholera cases and deaths in Zimbabwe, 1 - 6 September 2018



Number of cholera cases reported in Zimbabwe from 1 - 14 September 2018



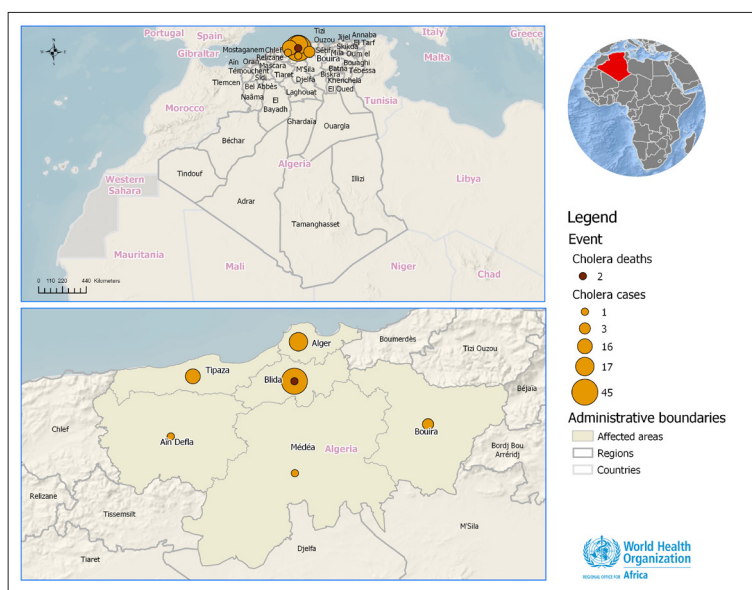
EVENT DESCRIPTION

The Ministry of Health of Algeria notified WHO of an outbreak of cholera on 23 August 2018 in the northern parts of the country, in and around the capital province Algiers. From 7 August 2018 to 6 September 2018, a total of 217 cases with cholera-like symptoms have been admitted to hospital and two have died (case fatality ratio 0.9%). Of these, 83 have been confirmed as *Vibrio cholerae* serogroup O1 Ogawa by the Institut Pasteur Algiers. Cases have been reported from seven provinces (wilayas). More than half the confirmed cases have been registered in Blida Province, followed by Algiers, Tipasa, Bouira, Médéa and Ain Defla.

The number of patients admitted peaked at 33 on 23 August 2018 and dropped to an average of six suspected cases a day by 31 August 2018. As of 4 September 2018, only ten patients remain hospitalized.

Twenty-one water sources, including three private sources, in the affected areas were tested for bacterial contamination and ten of these were found to be contaminated and not fit for human consumption. Two of the water sources tested positive for *V. cholerae* and were closed.

Geographical distribution of cholera cases and deaths in Algeria, 23 August - 6 September 2018



PUBLIC HEALTH ACTIONS

- The Ministry of Health immediately put a surveillance system in place in response to the outbreak and mobilized health teams to affected areas to identify the source of the disease.
- The Ministry of Health report that there is sufficient capacity within hospitals to treat cholera patients, who are being treated at two provincial hospitals in the affected areas.
- Water, sanitation and hygiene (WASH) activities were strengthened in affected areas and prevention activities reinforced and intensified.
- Communication around prevention measures was put in place.
- Case management took place in local hospitals in affected wilayas, with intensified surveillance and case finding around contacts of confirmed cases.
- The public water supply in Algeria is tested daily and has so far tested negative for enteric pathogens.
- Following a request from Institut Pasteur Algiers, WHO sent 5000 rapid diagnostic tests to Algeria.

SITUATION INTERPRETATION

Cholera is a rare event in Algeria, with the last outbreak recorded in 1996. The current outbreak developed rapidly, with 41 confirmed cases reported between 7-23 August 2018 and an average of four cases reported daily from 24-30 August 2018. The source of the outbreak and the mode of transmission is not yet known, but most cases appear to be clustered within a family group.

Cases are being reported in an urban setting where there is an increased risk of transmission, particularly as the source of the outbreak has not yet been identified and may still persist. This makes active surveillance, case finding, and reinforcement of communication of prevention measures key to limiting further spread and maintain the declining trend in cases.

EVENT DESCRIPTION

On 23 August 2018, the Ministry of Health and Population (MoHP) of the Republic of the Congo notified WHO of a yellow fever outbreak following the confirmation of one case in Pointe Noire.

On 4 July 2018, a 20-year-old male living in Bissongo, Pointe-Noire City, developed a fever. He visited a health centre in the Loandjili District of the City, on the following day. On 9 July 2018, due to persistent fever and the onset of jaundice, he returned to the same health center. The patient did not have a history of yellow fever vaccination or haemorrhagic symptoms. The patient had previously travelled to Ngoyo and Tchiamba Nzassi districts two weeks prior to symptom onset; Tchiamba Nzassi is a rural district in Pointe Noire located along the border with Angola. He was admitted at the health center for treatment of malaria. Due to the symptom and signs presented, yellow fever was suspected as a differential diagnosis, and a blood sample was collected on 10 July 2018 and sent to Institut National de Recherche Biomédicale (INRB) in Kinshasa, Democratic Republic of the Congo. Following the indeterminant results for yellow fever by serology, the sample was sent to Institut Pasteur in Dakar for confirmation. On 21 August 2018, the sample tested positive for yellow fever by seroneutralization with a high titre.

Following the confirmation of yellow fever, an investigation was conducted in August in the affected area. A retrospective search of 16 health centre registers in Pointe-Noire found 69 additional suspected cases that met the clinical case definition for yellow fever in 2018. Samples were collected sent to INRB and subsequently tested negative. Entomological surveys in the affected area were also conducted and high densities of mosquito vectors (*Aedes aegypti*) responsible for urban yellow fever transmission were found. Larval sites have been identified around the homes of suspected cases, and the situation could worsen with the arrival of the rainy season. These findings signal the potential for human-to-human transmission and rapid amplification of cases.

In week 36 (week ending on 9 September 2018), four new suspected cases were reported in Pointe Noire through the national surveillance system. These new cases were reported from Lumumba (1 case), Ngoyo (1 case) and Tié-tié (2 cases) districts. Blood samples were taken from all the new suspected cases and sent to the Institut Pasteur laboratory in Dakar for testing.

PUBLIC HEALTH ACTIONS

- The national committee for outbreak management was promptly activated.
- WHO has supported the country in the preparation of an emergency response plan.
- An International Coordinating Group (ICG) request for supplies for a reactive mass vaccination campaign targeting the Pointe-Noire area was approved and will take place by the end of September 2018.
- The Government is supporting resource mobilization activities for the operational costs of the mass reactive vaccination campaign and GAVI is supporting the funding of the vaccine purchase.
- WHO is supporting the MoHP in implementing targeted vector control activities for adult mosquitoes and larvae within a 200-metre perimeter of areas where the confirmed case-patient lives and works.
- WHO is also providing technical support to strengthen surveillance at points of entry, case management, and public awareness, as well as recommending the use of mosquito nets during the day time.
- Blood samples of suspected yellow fever cases are being sent to IP Dakar.

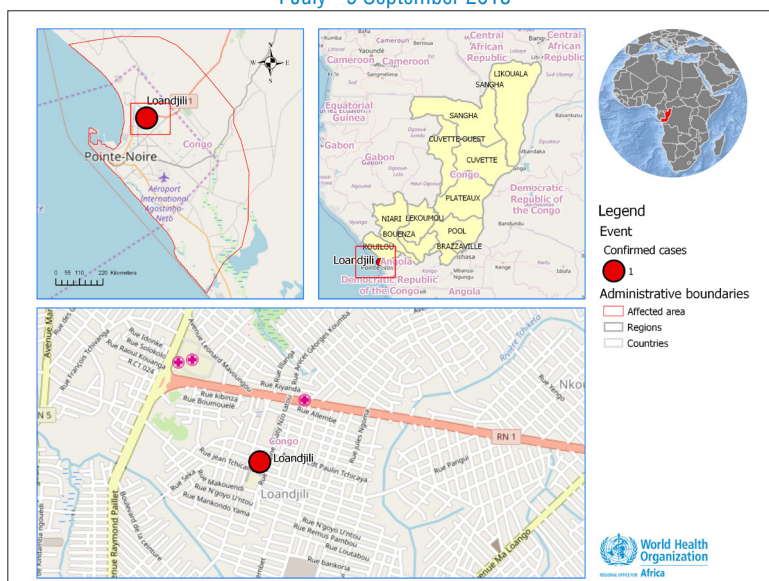
SITUATION INTERPRETATION

The Republic of Congo has recorded two yellow fever epidemics in the recent past: in 2009 and in 2012, both in the department of Cuvette West, Mamba district in the North Western part of Congo. The country is among the 40 high-risk countries targeted in the global strategy to Eliminate Yellow Fever Epidemics (EYE) by 2026.

Pointe-Noire is a port city and oil industry hub with an international airport and links to other large cities. Angola and the Democratic Republic of the Congo have recently conducted mass preventive and reactive yellow fever vaccination campaigns, respectively. However, population immunity levels remain low in the zones not targeted by the 2016 reactive campaigns, such as the areas neighbouring Pointe-Noire.

The potential for large epidemic amplification exists, as indicated by the large unprotected population, the presence of urban vectors and the soon approaching rainy season. Vaccination and vector control measures are the main means for prevention and control of the disease. The vaccine is safe, highly effective and provides life-long protection. Thus, the risk of an urban epidemic needs to be mitigated urgently, although currently there is no indication of active urban transmission based on the absence of fatalities or rapidly increasing incidence.

Geographical distribution of yellow fever case in Republic of the Congo, 4 July - 9 September 2018



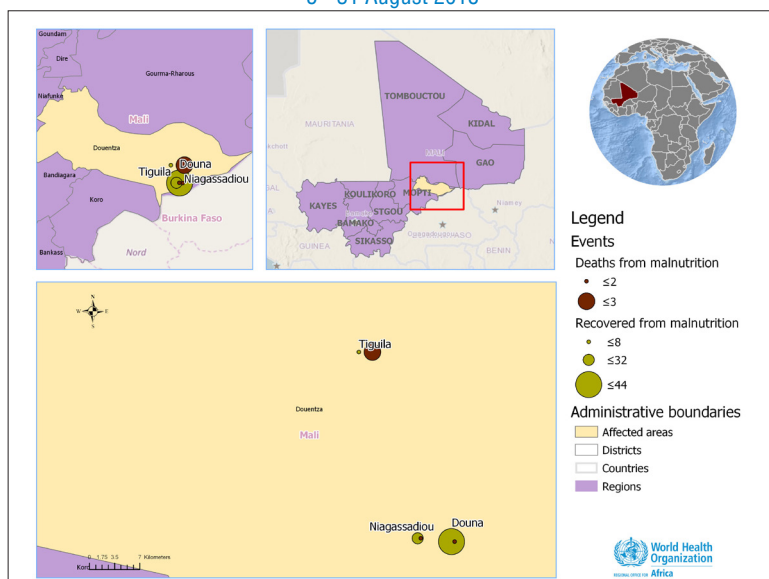
EVENT DESCRIPTION

There is no end in sight to the complex humanitarian crisis in Mali, precipitated by armed rebellion in 2012. Inter-communal conflict between Dogon and Fulani groups contributes to significant adverse effects on all aspects of the socio-economic situation, and the commune of Mondoro, Douentza District continues to experience insecurity as a result. Populations are not able to access their fields to cultivate crops, cereal stocks have been depleted and the populations of Douna, Niagassadiou and Tigula have been unable to obtain food for the past six months. In addition, humanitarian staff of the Centre de Santé Communautaire (CSCoM; community health centre) had to move to Douentza in January 2018, leaving vulnerable populations without intervention since then. People cannot move outside their villages because of the presence of improvised explosive devices and armed insurgents, who are essentially blockading the area. This has led to a food and nutrition crisis.

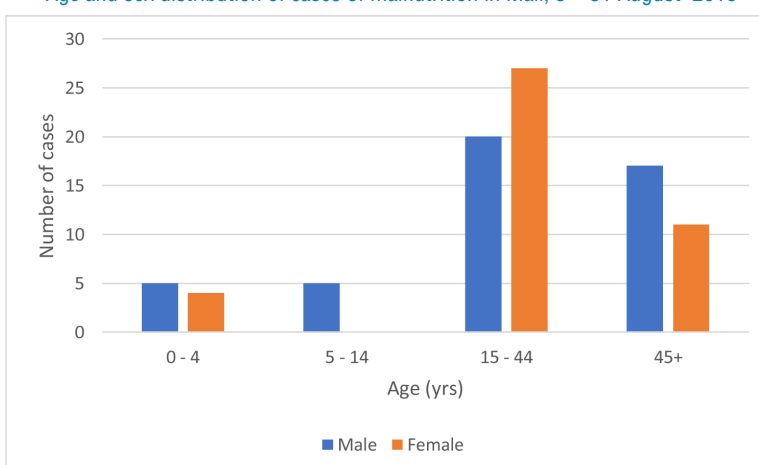
Reports of illness characterised by oedema of the lower limbs, myalgia, lameness, dyspnoea and sometimes death came from health workers dating back to 15 March 2018. From March to 5 August 2018, there were 224 cases of acute malnutrition, including 35 deaths (case fatality ratio 15.6%) recorded in Douna, Niagassadiou and Tigula. The first case, a 68-year-old man from Douna, was seen by a health worker in Niagassadiou on 14 June 2018. The Chief Medical Officer of the Douentza Health District was alerted to the growing problem by the CSCoM Technical Director of the affected health areas on 1 August 2018. The Regional Directorate of Health (DRS) received a detailed report on 2 August 2018, and an epidemiological investigation team, consisting of staff from WHO, the DRS, Mopti Regional Hospital, Douentza Health District and Mondoro City Hall, were deployed to the village of Mondoro (the capital of the commune) to see patients presenting at the health centre. The investigation reported a crisis of acute malnutrition due to lack of food resulting from constant inter-communal conflict, aggravated by a poor harvest in the previous year.

Samples analysed at the Institut National de Recherche en Santé Publique (INRSP), the reference laboratory in Bamako, showed iron deficiency anaemia, with no signs of infection, confirming the diagnosis of acute malnutrition. The age range most affected are those between 15-44 years, with slightly more women (27) than men (20) affected in this age group. In those aged 45 years and above, men (17) are more affected than women (11).

Case management consists of supplementation with Plumpynut, F75 milk and Plumpysup, as well as B-complex vitamins, anti-cardiac failure medications and antibiotics and anti-inflammatory drugs where necessary. As of 5 September 2018, out of 89 patients admitted at Mondoro CSCoM, 84 recovered and five died. There are currently no patients admitted, but more patients may be at other localities that have not been investigated.

Geographical distribution of malnutrition cases and deaths in Mali,
5 - 31 August 2018

Age and sex distribution of cases of malnutrition in Mali, 5 – 31 August 2018



PUBLIC HEALTH ACTIONS

- An emergency technical meeting between the WHO and the Mopti DRS team was held, during which the decision to conduct an investigative mission was taken, which was undertaken with the technical support of partners, WHO, UNICEF, OCHA, with logistical and security assistance from MINUSMA and FAMA.
- Six crisis management meetings were held between the DRS core team and partners (WHO, UNICEF, WFP, OCHA).
- Drugs and consumables were mobilized by DRS, WHO (one medical kit per 10 000 people for three months) and nutritional inputs by UNICEF and WFP.
- Four health workers were deployed to the Mondoro CSCoM (the DTCs of the affected health areas) and the nutritional focal point of the DRS.
- MINUSMA provided air logistics for transporting personnel, medication, consumables and nutrition to Mondoro.
- The seriously ill and those wounded by shooting were evacuated to Mopti Hospital.
- A joint livelihoods committee was established at village level, followed by a coordinating committee at Mondoro Town Hall.
- Food deliveries of 455 kg of legumes and oils were arranged for sick people and those accompanying then by PAM and MINUSMA.
- WFP provided 40 tonnes of food for the affected population, including 40 x 50 kg bags of beans and 10 x 5 litre cans of oil to Tigula; 30 x 50 kg bags of beans and 10 x 20 litre cans of oil to Douna; and 40 x 50 kg bags of beans and 20 x 20 litre cans of oil to Niagassadiou.

SITUATION INTERPRETATION

Continued insecurity brings major social and health consequences to affected populations and, in this instance, brought about a major incident of acute malnutrition resulting in illness and deaths in a vulnerable population. The risk factors for recurrence of this form of crisis remain, necessitating ongoing surveillance to activate early warning systems at community and regional level to prevent this. The combined response of all actors (state and humanitarian) was rapid and effective, once the situation was recognized. Urgent intervention is required at national and regional level to disseminate nutrition information, to carry out multi-sectoral needs assessment, coordinate the implementation of water, sanitation and hygiene activities and to develop and implement a response plan specific to this crisis. National and international governments need to act to bring about an end to the conflict driving this crisis.

Summary of major issues challenges, and proposed actions

Issues and challenges

- The cholera outbreak in Zimbabwe is of significant concern with hundreds of suspected cases being reported daily. The President of Zimbabwe declared a state of disaster in Harare city on 13 September 2018. The risk factors for cholera are ever present including deterioration of sanitary and health infrastructures and increasing rural-urban migration adding pressure on the water and sanitation infrastructure. The impending rainy season is also of concern given the potential to amplify transmission. There also remains a risk to the wider region if the outbreak is not brought rapidly under control.
- In Mali, the incidence of acute malnutrition as a result of the insecurity presents a challenge. This has been brought about by communities unable to access their fields to cultivate crops due to the presence of improvised explosive devices and armed insurgents, resulting in a depletion of previous cereal stocks. Additionally, population movement is limited due to the presence of improvised explosive devices and armed insurgents. The associate case fatality ratio of 15.6% is very worrisome.

Proposed actions

- WHO and partners should continue to support the government of Zimbabwe to address the cholera outbreak by implementing the national cholera response plan. The incident management structure should be established and the necessary personnel and resources to support the scale-up of all key pillars of the response addressed. The damage to the municipal water supply and sewer system needs to be rapidly fixed and safe, clean water supplied to the affected communities.
- Local authorities, with the support of partners, reacted rapidly to the acute malnutrition crisis in Mali, following notification of the situation. However, until the conflict driving the crisis is curtailed by national and international governments the health and nutritional crisis will likely remain. Urgent intervention is required at national and regional level to disseminate nutrition information, to carry out multi-sectoral needs assessment, coordinate the implementation of water, sanitation and hygiene activities and to develop and implement a response plan specific to this crisis.

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
Ongoing events										
Algeria	Cholera	Ungraded	25-Aug-18	7-Aug-18	6-Sep-18	217	83	2	0.9%	Detailed update given above.
Angola	Cholera	G1	2-Jan-18	21-Dec-17	29-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 neighbouring province of Luanda started reporting cases on 22 May 2018. From 22 May to 29 July 2018, 95 cases with seven deaths (CFR 7.4%) have been reported from fourteen districts in Luanda Province. Twelve cases have been confirmed for <i>Vibrio cholerae</i> . Fifty-seven percent of cases are males and 69% are aged five-year and above. The most affected district is Talatona having reported a total of 26 cases with five deaths (CFR 19%).
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	27-Aug-18	-	-	-	-	The humanitarian situation in Cameroon remains precarious with several regions of the country affected. In the Far North, the situation is marked by attacks linked to Boko Haram thus generating an influx of refugees from Nigeria including mass displacement of the local population. In the north-west and south-western regions, the crisis is marked by fighting between separatist militia and government forces leading to displacement of about 160 000 people in these regions. The regions of the North, Adamawa and East are also affected by the huge influx of refugees from neighboring Central African Republic thus placing pressure on the limited resources available to the local population. The humanitarian needs include food, shelter, access to basic health services including water, sanitation and hygiene.
Cameroon	Cholera	G1	24-May-18	18-May-18	29-Aug-18	237	22	17	7.2%	Between 18 May and 29 August 2018, a total of 237 suspected cases with 17 deaths (CFR 7.2%) have been reported from North and Central regions of Cameroon where there is an ongoing outbreak of cholera. Twenty-two cases have been confirmed for <i>Vibrio cholerae</i> by culture in the North (22) and Central (4) regions. So far, the peak of the outbreak was in week 32 (week ending 12 August 2018) in the Northern region and in week 29 in the central region. The age of cases ranges from 1 to 85 years and 58% were female.

Cameroon	Monkey-pox	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 management 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 suspected cases without active lesions. As of 13 June 2018, a total of 36 suspected cases have been reported from both North-west and South-west regions.
Central African Republic	Humanitarian crisis	Protracted 2	11-Dec-13	11-Dec-13	5-Sep-18	-	-	-	-	Despite the commitment of armed groups to the African initiative for peace in the country, the security and humanitarian situation remain precarious. This climate of insecurity continues to cause population displacement and disrupt the implementation of health sector activities in several localities. The situation is particularly volatile along Kaga Bandoro, Bocaranga-Paoua axis, and Alindao. About 2 500 new displaced people arrived at the Pk3 site in Bria following the clashes between armed groups on the Bria-Irabanda and Bria-Ippy routes since August 31. Testimonies mention several wounded and dead. Humanitarian workers have been targeted with eight deaths reported in 2018 including the latest fatality occurring on 1 August 2018. There are an estimated 90 000 vulnerable people in the localities of Paoua, Markounda, Bambari, and Zémio.
Central African Republic	Monkey-pox	Ungraded	20-Mar-18	2-Mar-18	22-Aug-18	40	13	1	2.5%	The outbreak was officially declared on 17 March 2018 in the sub-province of Ippy, Bambari district. Since the beginning of the outbreak, three districts have been affected, namely Bambari, Bangassou and Mbaiki districts. Cumulatively, 40 cases of monkeypox with one death (case fatality ratio 2.5%) have been reported from 2 March to 22 August 2018 in the country, and 13 cases have been laboratory confirmed out of 23 samples tested. No new cases notified in the three districts after the end of the epidemic.
Chad	Measles	Ungraded	24-May-18	1-Jan-18	9-Sep-18	2 734	650	78	2.9%	In week 36, 155 suspected cases with no deaths were reported. An increase in the number of cases compared to the previous week when 122 cases and 1 death were reported. Twelve districts: Faya, Mondo, Moussoro, Amzoer, Iriba, Kalait, Chadra, Oum Hadjer, Mangalme, Biltine, Isseriom and Ngouri have reported at least 5 suspected cases of measles during the last 4 weeks (week 31-35). The last 2 districts crossed the threshold for the first time. As of week 36, there are 2 734 suspected cases with 78 deaths (CFR 2.9%). A total of 650 cases have been confirmed (IgM-positive - 231, Epi-linked - 419, and clinically confirmed 30). Children aged 1 to 4 years are the most affected constituting 31% of cases reported.
Congo (Republic of)	Yellow fever	Ungraded	10-Jul-18	9-Jul-18	9-Sep-18	1	1	0	0.0%	Detailed update given above.

Democrat-ic Republic of the Congo	Humani-tarian crisis	G3	20-Dec-16	17-Apr-17	2-Sep-18	-	-	-	-	The humanitarian crisis in the country remains volatile. Inter-communal conflicts and violence perpetrated by militias including the kidnapping of humanitarian staffs continue to contribute to mass population displacement and difficulty in access to humanitarian assistance in several localities in the east of the country.
Democrat-ic Republic of the Congo	Cholera		16-Jan-15	1-Jan-18	2-Sep-18	18 780	0	623	3.3%	In week 35, 888 cases with 26 deaths (CFR 2.9%) were reported from 13 out of 26 provinces. Five out of the total provinces that reported cases (East Kivu, South Kivu, Sankuru, Tanganyika and Kasai) reported more than 89% of the total cases and 92% of all cholera deaths. Since the beginning of 2018 to the week 35, a total of 18 710 cases were reported including 623 deaths (CFR 3.3%). The number of cases has been increasing since week 21, a similar trend was observed in 2017. Compared with 2017, an upward trend was also observed in the case fatality ratios.
Democrat-ic Republic of the Congo	Ebola virus disease	G3	31-Jul-18	11-May-18	9-Sep-18	137	106	92	67.2%	Detailed update given above.
Democrat-ic Republic of the Congo	Measles	Ungraded	10-Jan-17	1-Jan-18	2-Sep-18	23 979	505	273	1.1%	From 2018 week 1 to week 35 (week ending 2 September 2018), 23 979 cases with 273 deaths (CFR 1.1%) have been reported. During week 35, a total of 962 new cases were reported with nineteen deaths (CFR 1.98%). Epidemic zones are mainly focused in the eastern part of the country.
Democrat-ic Republic of Congo	Monkey-pox	Ungraded	n/a	1-Jan-18	2-Sep-18	2 829	-	57	2.0%	From week 1 to week 35 (week ending 2 September 2018), 2018, there have been 2 829 suspected cases of monkeypox including 57 deaths (CFR 2%). In week 35, a total of 87 suspected cases including six deaths have been reported. Suspected cases have been detected in 14 provinces. Sankuru Province has had an exceptionally high number of suspected cases this year.
Democrat-ic Republic of the Congo	Polio-myelitis (cVDPV2)	G2	15-Feb-18	n/a	14-Sep-18	35	35	0	0.0%	The latest case of cVDPV2 was reported from Yamaluka Health Zone, Mongala Province. As of 14 September 2018, a total of 35 cases with onset in 2017 (22 cases) and 2018 (13 cases) have been confirmed. Six provinces have been affected, namely Tanganyika (15 cases), Haut-Lomami (9 cases), Mongala (6 cases), Maniema (2 cases), Haut Katanga (2 cases), 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 poliovirus type 2.
Democrat-ic Republic of Congo	Rabies	Ungraded	19-Feb-18	1-Jan-18	2-Sep-18	22	0	22	100.0%	This outbreak began towards the end of October 2017 in Kibua health district, North Kivu province. In epi week 35 (week ending 2 September 2018), one new suspected case was reported. A total of 159 suspected cases with 22 deaths (CFR 13.8%) have been reported from week 1 to 35, 2018.

Democrat-ic Republic of Congo	Yellow fever	Ungraded	16-Aug-18	1-Jul-18	17-Aug-18	5	4	0	0.0%	Samples from four out of five suspected cases have been confirmed for Yellow fever by Plaque Reduction Neutralization Test (PRNT) at Institute Pasteur Dakar (IPD). One of the cases is a 29-year-old male from Ango District in Bas Uele Province and the other is a 42-year-old male from Yalifafu district in Tshuapa Province. The other 2 cases are from Tshuapa and Lualaba Province. Vaccination status of the cases are unknown and detailed investigation is ongoing.
Ethiopia	Humanitarian crisis	G2	15-Nov-15	n/a	26-Aug-18	-	-	-	-	As of July 2018, an estimated 860 056 displaced people have been reported from Gedeo zone (SSNP region) with an additional 188 747 IDPs estimated to be spread across six woredas in West Guji zone (Oromia region). Peace negotiations are still on going and succeeded in some of the Woredas like Hambela Wamena where all IDPs returned to their original villages.
Ethiopia	Acute watery diarrhoea (AWD)	Protracted 1	15-Nov-15	1-Jan-18	26-Aug-18	2 337	-	18	0.8%	This has been an ongoing outbreak since the beginning of 2017. In most parts of the country, the situation has stabilized except for two regions which continue to report cases. In weeks 33 and 34, a total of 850 AWD cases were reported from two regions, Dire Dawa (8), and Tigray (842). No new AWD cases have been reported from Afar and Somali regions since week 32 and week 25 respectively. From week 1 to 34 (week ending 26 August 2018) in 2018, a cumulative 2 337 AWD cases have been reported from Afar 1 004 (43%), Dire Dawa 103 (4%), Somali 116 (5%) and Tigray 1 114 (48%).
Ethiopia	Measles	Protracted 1	14-Jan-17	1-Jan-18	26-Aug-18	3 062	857	-	-	This has been an ongoing outbreak since the beginning of 2017. In 2018, a total of 3 062 suspected measles cases have been reported across the country. From the total suspected cases reported, 857 were confirmed cases (137 laboratory confirmed, 688 epi-linked and 52 clinically compatible). In week 34 (week ending 26 August 2018), no new suspected or confirmed cases were reported.
Ethiopia	Dengue fever	Ungraded	18-Jun-18	19-Jan-18	29-Jul-18	127	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. In week 30, two cases were reported from Liban Zone in Somali Region.
Guinea	Measles	Ungraded	9-May-18	1-Jan-18	12-Aug-18	1 643	418	11	0.7%	A measles outbreak was detected in epidemiological week 8, 2018. Cases has been reported in all parts of the country since the beginning of the year. The most affected zones include Kankan, Conakry and Faraneh. In week 32, 5 new suspected cases were reported and no samples sent to the laboratory. During the last 4 epidemiological weeks (week 29 to 30), 71 suspected cases were reported, 25 samples received at the laboratory, including 7 confirmed cases from 5 sub-prefectures. Since the beginning of the year, a total of 1 643 suspected cases were reported.

Kenya	Measles	Ungraded	19-Feb-18	19-Feb-18	10-Sep-18	360	20	1	0.3%	Since June 2018 the second wave of measles outbreak was reported in four counties, Mandera, Garissa, Nairobi and Kitui. Mandera County has reported a total of 164 cases including 9 confirmed cases from Mandera West and North sub counties. Garissa County reported a total of 35 cases and 9 confirmed cases from Garissa and Dadaab sub-counties. Nairobi county has reported 12 cases including 4 confirmed cases from Kamukunji sub county and 4 confirmed cases have been reported from Kitui East sub county, Kitui County. Initially, cases were reported from Wajir (39 cases and 7 confirmed) and Mandera County (102 cases with 4 confirmed cases and one death). The date of onset of the index case in Wajir County was on 15 December 2017 from Kajaja village.
Kenya	Rift Valley fever (RVF)	G1	6-Jun-18	11-May-18	13-Aug-18	95	21	11	11.6%	Following the initial confirmation of RVF by PCR on 7 June 2018, a total of 95 cases including 11 deaths (CFR 11%) have been reported from three counties in Kenya. Twenty-one samples submitted to the KEMRI tested positive by PCR for RVF. Wajir has reported 82 cases with six deaths, Marsabit reported 11 cases with three deaths and Siaya country reported 1 case with one death. The Eldas sub-county in Wajir has reported the highest number of cases (79) since the 11 May 2018. The last case was reported on 20 July 2018.
Liberia	Floods	Ungraded	14-Jul-18	14-Jul-18	27-Aug-18	-	-	-	-	Liberia is experiencing very heavy rainfall that has resulted in flooding in eight districts across five counties (Margibi, Montserrado, Grand Bassa, Sinoe, and Bomi) affecting about 54 687 people (57% women and 22% children) with one death in a 4-year-old child). The flood which started on 11 July 2018, has led to destruction of infrastructures and the water supply system forcing the people to look for alternative and unsafe water sources, thus increasing the risk for waterborne diseases. The affected people received humanitarian aid of food and nonfood items as well as treated for various illnesses by mobile medical teams.
Liberia	Lassa fever	Ungraded	14-Nov-17	1-Jan-18	2-Sep-18	49	20	13	26.5%	One suspected case was reported from Grand Kru County during week 35 (ending 2 September 2018) pending laboratory test. Cumulatively, since epi-week one, 160 suspected cases have been reported including 37 deaths. Of these, samples from 131 suspected cases have been tested by the laboratory with the following results: confirmed (20) and negative/not a case (111). Samples for 18 suspected cases are pending laboratory test. Case fatality ratio among confirmed cases is 65% (13/20).

Liberia	Measles	Ungraded	24-Sep-17	1-Jan-18	2-Sep-18	3 659	3 394	17	0.5%	There has been a gradual decline in the number of suspected cases since the peak in week 14 when approximately 230 suspected cases were reported. Eleven (11) suspected cases of measles were reported across the country in week 35 (ending 2 September 2018). Cumulatively, since epi-week one, 3 659 suspected cases including 17 deaths have been reported. Of these, 539 have been tested by the laboratory. Epi-classification are as follows: lab confirmed 258 (7.1%), epi-linked 434 (11.9%), clinically confirmed 2,702 (73.8%), discarded 258 (7.1%), pending 7 (0.2%).
Mali	Humanitarian crisis	Protracted 1	n/a	n/a	20-Jul-18	-	-	-	-	The complex humanitarian crisis exacerbated by the political-security crisis and intercommunity conflicts continue in Mali. More than four million people (nearly a quarter of the population) are affected by the humanitarian crisis, including 61 404 who are internally displaced and nearly 140 000 who are refugees in neighbouring countries such as Niger, Mauritania and Burkina Faso (data from CMP report, 7 June 2018). The health system is still weak, while the health need is increasing. The departure of health system personnel and incidents targeting health infrastructure, personnel and health equipment are worsening the existing health system. There are 1.7 million people in need of health assistance in the face of inadequate numbers of health care workers (3.1 per 10 000 people, compared to the WHO recommended 17 per 10 000). The security incidents are increasing in Mopti and Menaka.
Mali	Severe acute malnutrition	Ungraded	1-Aug-18	15-Mar-18	5-Aug-18	224	0	35	15.6%	Detailed update given above.
Mali	Measles	Ungraded	20-Feb-18	1-Jan-18	26-Aug-18	1 220	312	0	0.0%	From Week 1 to Week 34 of 2018, a total of 1 220 suspected cases with zero deaths have been reported. The cumulative blood samples from 914 suspected cases have been tested of which 312 were confirmed (IgM-positive) at the National Reference Laboratory (INRSP). Over 66% of confirmed cases are below 5 years old. The affected health districts are Maciana, Bougouni, Kati, Koutiala, Kokolani, Kolondieba, Ouélessebouyou, 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.
Mauritius	Measles	Ungraded	23-May-18	19-Mar-18	9-Sep-18	899	899	3	0.3%	As of 9 September 2018, 899 confirmed cases of measles have been reported including three deaths (CFR 0.3%). All cases have been confirmed by the virology laboratory of Candos (IgM antibodies). The onset of symptoms of the first cases was in week 12. The incidence is highest in the age groups 0 - 4 and 25 - 34 years of age. The three deaths were in women between the ages of 28 and 31 years. The most affected districts are Port Louis and Black River. A single genotype of measles virus, D8, was detected in 13 samples. The source of infection of measles is most likely an imported case.

Namibia	Hepatitis E	G1	18-Dec-17	8-Sep-17	29-Jul-18	2 554	395	24	0.9%	As of 29 July 2018, four out of 14 regions in Namibia have been affected by the HEV outbreak namely, Khomas, Omusati, Erongo and Oshana regions. From week 36 of 2017 (week ending 10 September 2017) to 29 July 2018, a total of 2 554 cases with 24 deaths (CFR 0.9%) have been reported in Khomas, Omusati, Erongo, Oshana and six other regions of Namibia. A total of 395 cases have been laboratory confirmed (IgM ELISA) and ten maternal deaths (probable and confirmed cases) have been notified. Over 80% of reported cases are epidemiologically linked to cases reported in Windhoek, the epi-centre of the epidemic.
Niger	Humanitarian crisis	G2	1-Feb-15	1-Feb-15	2-Aug-18	-	-	-	-	The security situation in Niger's Diffa Region remains precarious. According to USAID's Lake Chad Basin complex emergency report dated 2 August 2018, Boko Haram-related insecurity continues to restrict food access and livelihood activities for displaced populations in Diffa Region, Southeast Niger. Limited access to pasture is also undermining livestock activities in Diffa's pastoral zones, reducing herders' purchasing power. According to the report, crisis levels of acute food insecurity may persist in parts of Diffa through January 2019, although food security in many areas could improve to Stressed levels beginning in October. UNHCR's June 2018 report indicated around 104 288 internally displaced people in the Diffa Region. From January–June, relief actors admitted nearly 7 000 children ages five years and younger experiencing severe acute malnutrition for treatment in Diffa, including nearly 650 patients with medical complications, according to the UN Children's Fund (UNICEF).
Niger	Cholera	G2	13-Jul-18	13-Jul-18	13-Sep-18	3 081	19	62	2.0%	As of 13 September 2018, a total of 3 081 cases with 62 deaths (CFR 2%) have been reported from seven health districts, namely, Madarounfa, Maradi Commune, Guidan Roumdji, Gaya, Damagram Takaya, Malbaza and Birni Konni in Maradi, Dosso, Tahoua and Zinder regions. Seventy-nine percent of cases are age 5 and above and females constitute 56.2% of the cases reported. A total of 19 samples have tested positive by culture for <i>Vibrio cholerae</i> O1 inaba. Ninety percent (455) of cases reported in Madarounfa district originated from Nigeria.

Nigeria	Humanitarian crisis	Protracted 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 ongoing 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 herders 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	9-Sep-18	27 927	45	517	1.9%	In week 36 (week ending 9 September 2018), 1 306 suspected cases including 24 deaths (CFR: 1.8%) were reported from five states: Zamfara (588 cases with 12 deaths), Katsina (377 cases with 12 deaths), Borno (280 cases), Adamawa (55 cases), and Kano (6 cases). As of 9 September 2018, a total of 27 927 suspected cases including 517 deaths (CFR 1.9%) have been reported from 19 States since the beginning of 2018. There is an overall increasing trend in the number of reported cases. No new cases were reported in the last three or more weeks from Anambra, Bauchi, Ebonyi, FCT, Gombe, Jigawa, Kaduna, Kogi, Nasarawa, Niger, Plateau, Sokoto and Yobe states. There is an almost equal proportion of males and females affected.
Nigeria	Lassa fever	Ungraded	24-Mar-15	1-Jan-18	2-Sep-18	507	497	142	28.0%	In week 35 (week ending 2 September 2018), five new confirmed cases with one death were reported from Edo state. From 1 January to 2 September 2018, a total of 2 466 suspected cases have been reported from 22 states. Of the suspected cases, 497 were confirmed, 10 were probable, and 1 959 were negative (not a case). Thirty-nine health care workers have been affected in seven states since the onset of the outbreak, with ten deaths. Eighteen states have exited the active phase of the outbreak while four- Edo, Ondo, Ebonyi, and Bauchi states remain active.

Nigeria	Measles	Ungraded	25-Sep-17	1-Jan-18	26-Aug-18	13 529	901	100	0.7%	In week 34 (week ending 26 August 2018), 154 suspected cases of measles were reported from 24 States. Since the beginning of the year, a total of 13 529 suspected measles cases with 901 laboratory confirmed cases and 100 deaths (CFR 0.74%) were reported from 36 States compared with 17 177 suspected cases with 108 laboratory confirmed and 105 deaths (CFR 0.61%) from 37 States during the same period in 2017.
Nigeria	Polio-myelitis (cVDPV2)	Ungraded	1-Jun-18	1-Jan-18	8-Aug-18	2	2	0	0.0%	Circulating vaccine-derived polio virus type 2 (cVDPV2) was confirmed in a stool sample from a case of acute flaccid paralysis (AFP) with symptom onset on 16 June 2018 in Yobe State. This is the second AFP case since the beginning of 2018 with a confirmed cVDPV2. The first was an AFP case in Kaugama district, Jigawa state, with onset on 15 April 2018.
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	2-Sep-18	2 837	47	51	1.8%	From the onset of this outbreak on 12 September 2017, a total of 2 837 suspected yellow fever cases including 51 deaths have been reported as at week 35 (week ending on 2 September 2018), from 543 LGAs in all Nigerian states. No new in-country presumptive positive case in the reporting week and the last case confirmed by IP Dakar was on 6 June 2018 from River State. A total of 47 out of 126 presumptive positive samples were laboratory confirmed at IP Dakar.
São Tomé and Príncipe	Necrotising cellulitis/fasciitis	Protracted 2	10-Jan-17	25-Sep-16	26-Aug-18	2 883	0	0	0.0%	A total of 2 883 cases have been notified from week 40 in 2016 to week 34 in 2018 (week ending 26 August 2018). It should be noted that 55% of the cases notified during the last 3 weeks come from the district of Me-zochi. The case-fatality rate of cellulitis in São Tomé and Príncipe is 14.6 cases per 1000 inhabitants.
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	2-Sep-18	5 813	1 511	-	-	As of week 35 (2 September 2018) a total of 5813 cases of Dengue have been reported, and 1 511 cases have been confirmed since the last week of 2015. There is a general decreasing trend since week 23. For week 35, a total of 22 suspected cases were reported. The number of confirmed cases have been on a decline, with 791 Currently in circulation are the serotypes DENV1, DENV2 and DENV3. The suspected cases were distributed in 14 districts on Mahe Island for week 35. No suspected cases are reported from the inner islands. The number of confirmed cases report has been on a decline, from 791 cases in 2016, 595 cases in 2017, to 124 cases confirmed thus far in 2018.
South Sudan	Humanitarian crisis	Protracted 3	15-Aug-16	n/a	26-Aug-18	-	-	-	-	The humanitarian situation in South Sudan has remained volatile and unpredictable since the beginning of the crisis four years ago. Inter-communal violence continues in spite of peace efforts and humanitarian workers are often targeted by militia factions. The humanitarian situation is characterized by mass displacement of the population, economic crisis with hyperinflation, food insecurity, and frequent disease outbreaks.

South Sudan	Hepatitis E	Ungraded	-	3-Jan-18	9-Sep-18	132	16	-	-	No new case of hepatitis E was reported in week 36. As of 9 September 2018, 132 suspect cases have been reported since the beginning of the year. 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 Old Fangak county. Six HEV cases have been admitted. Forty-four percent of the cases are 1-9 years of age, 62% 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).
Tanzania	Cholera	Protracted 1	20-Aug-15	1-Jan-18	9-Sep-18	3 739	50	68	1.8%	During week 36, 69 new cases with one death were reported from Ngorongoro DC in Arusha Region. As of week 36, a total of 3 739 cases with 68 deaths (CFR: 1.8%) were reported from Tanzania Mainland since the beginning of 2018. No case was reported from Zanzibar (the last case was reported on 11 July 2017). Cholera cases in 2018 increased and nearly doubled during the period of January – August 2018 (3 739 cases), when compared to the same period in 2017 (2 466 cases).
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.
Uganda	Crimean-Congo haemorrhagic fever (CCHF)	Ungraded	24-May-18	-	17-Jul-18	7	3	2	28.6%	On 23 May 2018, a 35-year-old male suspected of having a viral haemorrhagic fever died at a hospital in Mubende. Test result released on 24 May 2018, confirmed the case as positive for Crimean-Congo haemorrhagic fever (CCHF) by PCR at Uganda Virus Research Institute. As of 18 June 2018, there were a total of five cases (one confirmed and four suspected) and two deaths (CFR 40%). Three of the suspected cases were identified from the same household as the confirmed case in Nkooko sub-county. Samples taken from the suspected cases were negative for CCHF. As of 17 July 2018, two new CCHF cases were confirmed from Mbarara RRH. The cases are a couple from Nakivale Refugee settlement from Isingiro district. Contact tracing is ongoing in the district and 42 out of 57 contacts were under follow up on day of report.
Uganda	Measles	Ungraded	8-Aug-17	1-Jan-17	11-Sep-18	2 610	651	1	0.0%	As of 11 September 2018, a total of 2 610 cases have been reported of which 651 cases have been confirmed either by epidemiological link or laboratory testing since the beginning of the year. Four hundred forty-one (441) cases were laboratory confirmed by IgM. One death has been reported among the confirmed cases. Fifty-three districts in the country have reported a measles outbreak. Ninety-nine percent of the confirmed cases are from rural areas.

Uganda	Rift Valley fever (RVF)	Ungraded	29-Jun-18	20-Jun-18	14-Aug-18	23	19	8	34.8%	One new case from Kiruhura district has been confirmed for Rift Valley fever by PCR at Uganda Virus Research Institute on 14 August 2018. From 18 June to 14 August 2018, a total of 23 suspected cases with eight deaths (CFR 34.8%) have been reported from 11 districts in Western Uganda. Nineteen(19) cases have been confirmed by PCR at the Uganda Virus Research Institute (UVRI). The most affected district is Insingiro having reported 11 cases with two deaths (CFR 18.2%). Ninety-six percent (96%) of cases reported are males, the majority of whom are herdsman and butchers.
Zambia	Measles	Ungraded	2-Aug-18	6-Jul-18	28-Aug-18	25	6	1	4.0%	On 1 August 2018, an outbreak of measles was reported in the Paul Mambilima catchment area of Mansa District in Luapula Province, Zambia. The affected community lies astride the international border with the Democratic Republic of the Congo. The first case has been traced to a one-year-old child who died in Lukanga Village in the Paul Mambilima catchment area after presenting with fever, conjunctivitis, and rash. As of 28 August 2018, a total of 25 cases with one death (CFR 4%) have been reported. The last case was reported on 17 August 2018. Age of cases range from four months to 42 years. Six out of eight samples collected have tested IgM-positive.
Zimbabwe	Cholera	G2	6-Sep-18	6-Sep-18	11-Sep-18	3 349	58	32	1%	Detailed update given above.
Zimbabwe	Typhoid fever	Ungraded	7-Aug-18	6-Jul-18	10-Sep-18	1 983	16	8	0.4%	On 7 August 2018, WHO was notified by the Ministry of Health and Child Care of Zimbabwe of a suspected outbreak of Typhoid fever in Gweru City, Midland Province of Zimbabwe. A total of 1 983 cases with eight deaths (CFR 0.4%) have been reported as of 10 September 2018. Sixteen cases have been confirmed. There is a decline in the daily number of cases reported since the peak on 8 August 2018 when 186 cases were reported.
Recently closed events										
Kenya	Cholera	G1	6-Mar-17	1-Jan-18	3-Sep-18	5 756	332	78	1.4%	The cholera outbreak in Kenya is considered controlled by the Ministry of Health. No new cases have been reported since 19 August 2018. As of 3 September 2018, a total of 5 756 cases including 78 deaths (CFR 1.4%) have been reported since the 1 January 2018. During this outbreak 19 out of 47 counties in Kenya were affected. The last affected county was Garissa located in the eastern part of the country.
Sierra Leone	Lassa fever	Ungraded	8-Jun-18	1-Jan-18	19-Aug-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 ratio (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. No new Lassa fever case has been confirmed since 5 June 2018.

†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.

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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

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Contributors

S. Maphosa (Zimbabwe)
H. Khelifi (Algeria)
E. Ndinga, D. Bompangue, (Congo)
F. Mboussou, F. Banza-Mutoka (Democratic Republic of the Congo)
M. Sacko (Mali).

Graphic design

Mr. A. Moussongo

Editorial Team

Dr. B. Impouma
Dr. C. Okot
Dr. E. Hamblion
Dr. B. Farham
Mr. G. Williams
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Dr. P. Ndumbi
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Mrs. M. Teklemariam

Editorial Advisory Group

Dr. I. Soce-Fall, *Regional Emergency Director*
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Dr. Z. Yoti
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Dr. M. Djingarey

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.