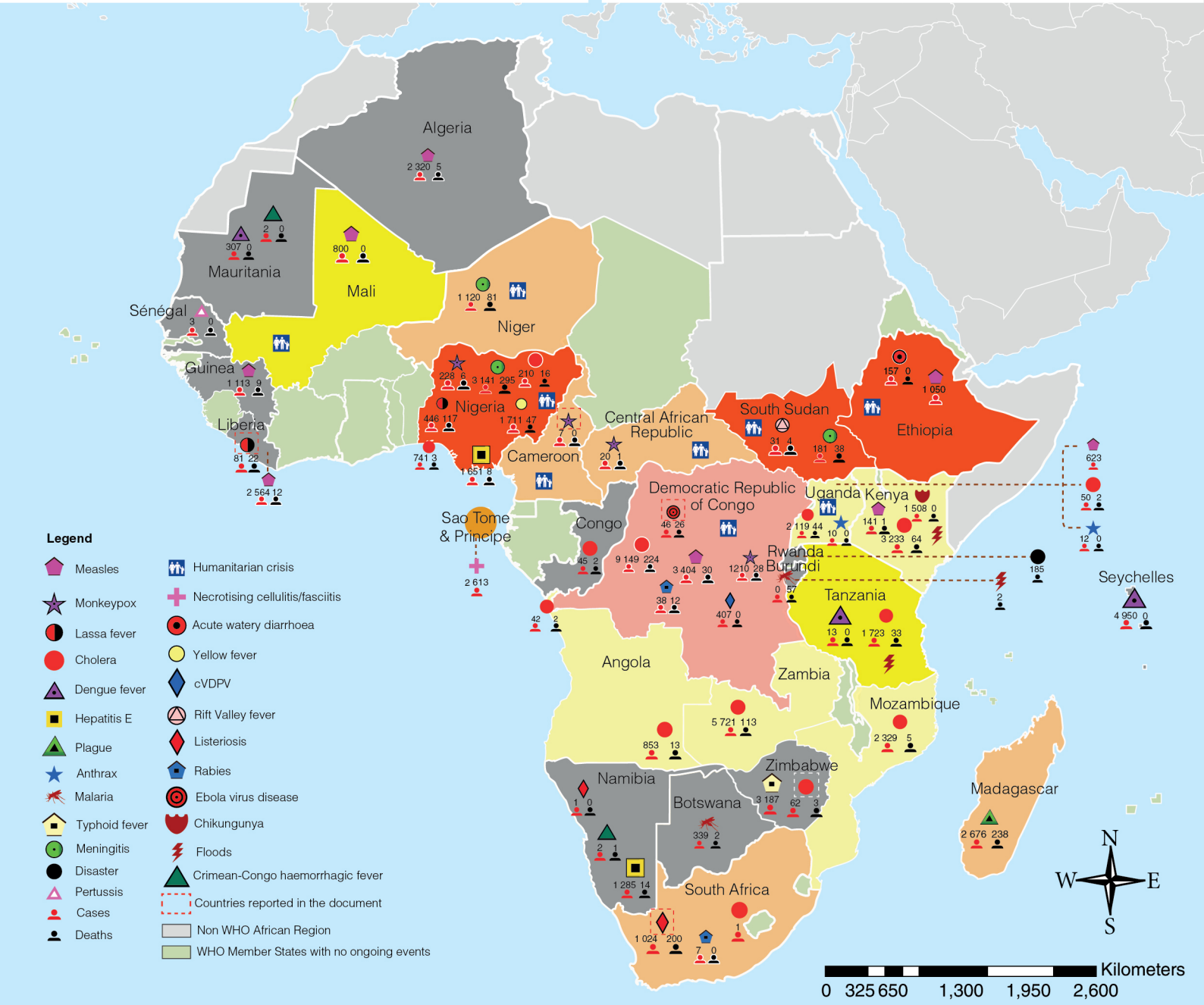
WEEKLY BULLETIN ON OUTBREAKS AND OTHER EMERGENCIES

Week 20: 12 - 18 May 2018
Data as reported by 17:00; 18 May 2018

World Health Organization
REGIONAL OFFICE FOR Africa
WHO Health Emergencies Programme

4	59	52	11
New events	Ongoing events	Outbreaks	Humanitarian crises



Graded events †

2	5	5	42
Grade 3 event	Grade 2 events	Grade 1 events	Ungraded events
3	1	2	
Protracted 3 events	Protracted 2 event	Protracted 1 event	

Overview

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- This Weekly Bulletin focuses on selected acute public health emergencies occurring in the WHO African Region. The WHO Health Emergencies Programme is currently monitoring 63 events in the region. This week's edition covers key new and ongoing events, including:

  - Monkeypox in Cameroon
  - Ebola virus disease in the Democratic Republic of the Congo
  - Lassa fever in Liberia
  - Listeriosis in South Africa
  - Cholera in Zimbabwe.

- 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 outbreak Ebola virus disease in the Democratic Republic of the Congo continues to draw public attention and concern globally. The occurrence of a confirmed case in Mbandaka City, the capital of Equateur Province, has brought a new dimension to the evolution of the outbreak. Rapid and robust response remains the only solution to this situation. However, this requires adequate and timely resources. WHO and partners are appealing to the global community to work together in order to quickly contain this outbreak.

  - A new outbreak of monkeypox has occurred in Cameroon, an event coming after nearly three decades since the last confirmed case in the country. The incidence of monkeypox has been increasing in the African Region recently, with six countries reporting outbreaks since 2016. As yet knowledge about the epidemiology and ecology of the virus remains limited, as well as surveillance for the disease. These gaps need to be addressed as a priority research agenda in order to design, recommend and implement needed prevention and control measures.

Statement of the first meeting of the International Health Regulations Emergency Committee regarding the Ebola virus disease outbreak in 2018

Geneva, 18 May 2018

Statement

The first meeting of the Emergency Committee convened by the WHO Director-General under the International Health Regulations (IHR) (2005) regarding the Ebola Virus Disease (EVD) outbreak in the Democratic Republic of the Congo took place on Friday 18 May 2018, from 11:00 to 14:00 Geneva time (CET).

Emergency Committee conclusion

It was the view of the Committee that the conditions for a Public Health Emergency of International Concern (PHEIC) have not currently been met.

Meeting

Members and advisors of the Emergency Committee met by teleconference. Presentations were made by representatives of the Democratic Republic of the Congo on the recent developments, including measures taken to implement rapid control strategies, and existing gaps and challenges in the outbreak response. During the informational session, the WHO Secretariat provided an update on and assessment of the Ebola outbreak.

The Committee's role was to provide the Director-General with their views and perspectives on:

- Whether the event constitutes a Public Health Emergency of International Concern (PHEIC)
- If the event constitutes a PHEIC, what Temporary Recommendations should be made.

Key Challenges

After discussion and deliberation on the information provided, the Committee concluded with these key challenges:

- The Ebola outbreak in the Democratic Republic of the Congo has several characteristics that are of particular concern: the risk of more rapid spread given that Ebola has now spread to an urban area; that there are several outbreaks in remote and hard to reach areas; and that healthcare staff have been infected, which may be a risk for further amplification.
- The risk of international spread is particularly high since the city of Mbandaka is in proximity to the Congo River, which has significant regional traffic across porous borders.
- There are huge logistical challenges given the poor infrastructure and remote location of most cases currently reported; these factors affect surveillance, case detection and confirmation, contact tracing, and access to vaccines and therapeutics.

However, the Committee also noted the following:

- The response by the government of the Democratic Republic of the Congo, WHO and partners has been rapid and comprehensive.
- Interventions underway provide strong reason to believe that the outbreak can be brought under control, including: enhanced surveillance, establishment of case management facilities, deployment of mobile laboratories, expanded engagement of community leaders, establishment of an air-bridge, and other planned interventions.
- In addition, the advanced preparations for use of the investigational vaccine provide further cause for

optimism for control

In conclusion, the Emergency Committee, while noting that the conditions for a PHEIC are not currently met, issued Public Health Advice as follows:

- Government of the Democratic Republic of the Congo, WHO, and partners remain engaged in a vigorous response – without this, the situation is likely to deteriorate significantly. This response should be supported by the entire international community.
- Global solidarity among the scientific community is critical and international data should be shared freely and regularly.
- It is particularly important that there are no international travel or trade restrictions.
- Nine neighbouring countries, including Congo-Brazzaville and Central African Republic, have been advised that they are at high risk of spread and have been supported with equipment and personnel. These neighbouring countries should strengthen preparedness and surveillance.
- During the response, safety and security of staff should be ensured, and protection of responders and national and international staff should be prioritised.
- Exit screening, including at airports and ports on the Congo River, is considered to be of great importance; however, entry screening, particularly in distant airports, is not considered to be of any public health or cost-benefit value.
- Robust risk communication (with real-time data), social mobilization, and community engagement are needed for a well-coordinated response and so that those affected understand what protection measures are being recommended.
- If the outbreak expands significantly or if there is international spread, the Emergency Committee will be reconvened.

The Committee emphasized the importance of continued support by WHO and other national and international partners towards the effective implementation and monitoring of this advice.

Based on this advice, the reports made by the affected States' Parties, and the currently available information, the Director-General accepted the Committee's assessment and on 18 May 2018 did not declare the Ebola outbreak in the Democratic Republic of the Congo a PHEIC. In light of the advice of the Emergency Committee, WHO advises against the application of any travel or trade restrictions. The Director-General thanked the Committee Members and Advisors for their advice.

New event

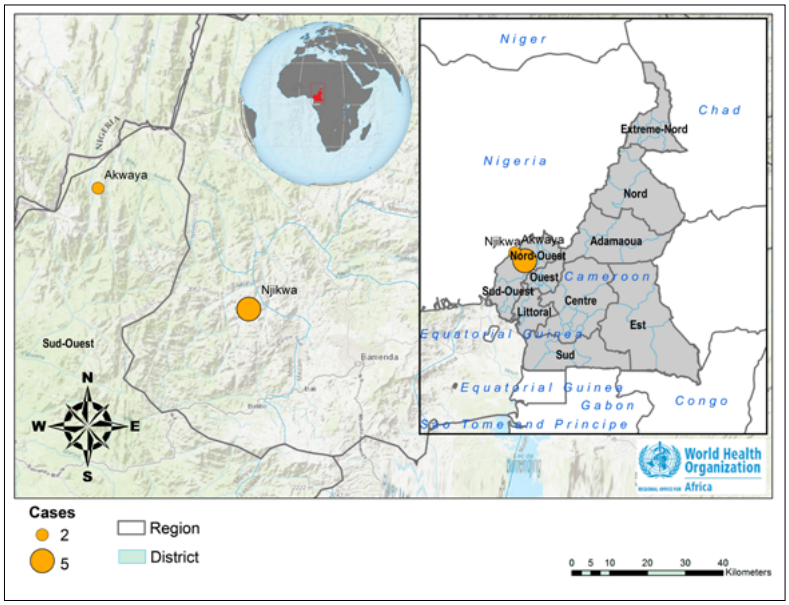
Monkeypox | **Cameroon** | 7 **Cases** | 0 **Deaths** | 0% **CFR**

EVENT DESCRIPTION

On 15 May 2018, the Ministry of Public Health of Cameroon notified WHO of an outbreak of monkeypox in Njikwa District in the north-west region of the country. The event was initially reported on 30 April 2018 when a cluster of two case-patients presented to a local health facility with fever, headache and lymphadenopathy, later followed by skin rashes. Biological specimens, including swabbing of the skin lesions and blood serum, were collected from the initial case-patients and shipped to the Centre Pasteur du Cameroun (CPC). Test results released by the CPC on 14 May 2018 showed that one of the two specimens was positive for orthopoxvirus by real-time polymerase chain reaction. Accordingly, the Ministry of Public Health formally declared an outbreak of monkeypox on 15 May 2018.

Active case search conducted by the rapid response team identified five additional suspected cases of monkeypox. As of 15 May 2018, a total of seven suspected cases have been reported, one of which has been confirmed. No deaths have so far been reported. Two districts have so far been affected, namely Njikwa (5 cases) in North-West Region and Akwaya (2 cases) in the South-east Region. A preliminary investigation (reportedly) established that the index case, a guard in a game park, handled a gorilla three weeks preceding his illness. Further epidemiologic investigations are being conducted.

Geographical distribution of monkeypox cases in Cameroon, 30 April - 15 May 2018



PUBLIC HEALTH ACTIONS

- The Ministry of Health convened an emergency coordination meeting to assess the outbreak situation and plan for response interventions. An incident management system has been activated at the sub-national level.
- An outbreak response plan is under development, articulating the control strategies and activities and detailing the required resources.
- Active epidemiological surveillance is being strengthened in the affected regions, including investigtions to identify the source of infection, active search for additional cases, follow up of contacts, and collection of laboratory specimens to facilitate confirmation.
- Infection prevention and control measures are being enhanced at the health facilities as well as capacity for case management.
- Health emergency information products, including situation reports and a press release have been prepared and disseminated to key stakeholders and the general public, respectively.

SITUATION INTERPRETATION

An outbreak of monkeypox has occurred in Cameroon, coming after about three decades since the last human case was reported in the country in 1989. Only three human cases of monkeypox had previously been reported in the country: the first case occurred in 1979 in the forest zone of South-East Region, the second case in 1980 in the East Region and the third case in the Central Region (in 1989). However, a monkeypox outbreak occurred among captive chimpanzees in 2014.

Since 2016, there has been an apparent increase in human monkeypox cases across the African Region, with outbreaks occurring in Central African Republic, Congo, Democratic Republic of the Congo, Liberia, Nigeria, and Sierra Leone. The cases are mostly being reported from rural areas where occupational activities such as farming and hunting are increasing the risk of animal-to-human transmission.

The potential for further spread and the lack of reliable surveillance remain a concern for this emerging zoonosis. The confirmation of monkeypox in Cameroon, therefore, underscores the need to maintain high level of vigilance and raise awareness of the disease among the local population. Communication and education for people on how to prevent the disease by avoiding contact with wild animals, particularly rodents and primates, are important. Healthcare workers also need to observe standard precautions when taking care of symptomatic patients and isolate them from others. Furthermore, gaps in knowledge about the epidemiology and ecology of the virus need to be addressed as a priority research agenda to design, recommend and implement needed prevention and control measures.

Go to overview

Go to map of the outbreaks

Ongoing events

Ebola virus disease | **Democratic Republic of the Congo** | 46 **Cases** | 26 **Deaths** | 56.5% **CFR**

EVENT DESCRIPTION

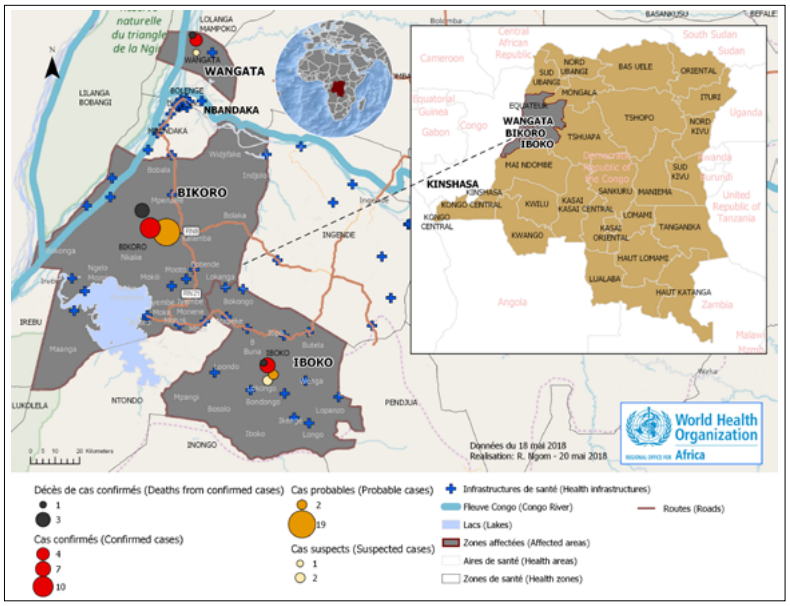
The Ebola virus disease in Equateur Province, Democratic Republic of the Congo continues to evolve. On 18 May 2018, three new suspected cases of Ebola virus disease have been reported in Iboko (2) and Wangata (1) health zones. One new death of a confirmed case from Bikoro has occurred on 18 May 2018. Four cases (reported previously) from Iboko were confirmed.

Since the beginning of the outbreak on 4 April 2018, a total of 46 suspected cases, including 26 deaths (case fatality rate 56.5%) have been four cases confirmed by laboratory test in Iboko, as of 18 May 2018. Of the 46 suspected cases, 21 have been confirmed, 21 probable and four remain suspected cases. Three healthcare workers have been affected, one of them has died.

Three health zones have so far been affected, namely: Bikoro (29 cases), Iboko (11 cases) and Wangata (6 cases). Bikoro Health Zone remains the epicentre of the outbreak, accounting for 67% of the total caseload. The majority (72%) of the cases in Bikoro come from the Ikoko-Impenge health area.

As of 18 May 2018, a total of 28 specimens have been collected and analyzed, either at the Institute National de Recherche Biomédicale (INRB) in Kinshasa or in a mobile laboratory in Bikoro. Of these, 21 tested positive for Zaire Ebolavirus species by polymerase chain reaction (PCR): Bikoro (10), Iboko (7) and Wangata (4).

Geographical distribution of Ebola virus disease in Democratic Republic of the Congo, 4 April - 18 May 2018



A total of 619 contacts have been listed and are being followed up, distributed as follows: Bikoro (330), Wangata (169) and Iboko (120) health zones.

PUBLIC HEALTH ACTIONS

- On 18 May 2018, the National Coordinating Committee held a meeting, chaired by the Minister of Health, to review the outbreak situation and ongoing response.
- On 18 May 2018, the WHO Incident Management Team held a meeting with the Special Representative of the Secretary General of the United Nations, the Humanitarian Coordinator and officials from the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) MONUSCO officials.
- WHO, the GOARN partners (MSF, UNICEF and IFRC) and other partners are supporting the Ministry of Health and other national authorities through provision of technical, financial and logistical resources. WHO is also working closely with the UN agencies and other development partners to ensure appropriate support for the response.
- A total 7 560 doses of recombinant vesicular stomatitis virus–Zaire Ebola virus (rVSV-ZEBOV) vaccines arrived in Kinshasa by 19 May 2018. Targeted vaccination exercise is scheduled to start on 21 May 2018.
- WHO has released US$ 4 million from its Contingency Fund for Emergencies (CFE) to support rapid response and initial scale up of the operations in Democratic Republic of the Congo.
- A mobile laboratory deployed at Bikoro Referral Hospital on 12 May 2018 became fully operational on 16 May 2018, aimed to facilitate rapid confirmation of diagnosis for immediate decision making. A second mobile laboratory is being deployed in Mbandaka.
- As of 21 May 2018, WHO has deployed a total of 110 technical experts in various disciplines, distributed as follows: WHO AFRO (74) (including 34 vaccination technical staff from Guinea), WHO Headquarter (20) and WHO Country Office (16).
- On 18 May 2018, the AFRO Regional Emergencies Director had a call with donors in Geneva to update them on the evolution of the outbreak and solicit funding support.

SITUATION INTERPRETATION

The outbreak of Ebola virus disease in the Democratic Republic of the Congo continues to evolve, with a confirmed case in Mbandaka, the capital of Equateur Province. The occurrence of the disease in this urban setting brings a new dimension to the evolution of the outbreak. Mbandaka is connected to major cities in the country, such as Kinshasa, through water, air and land. Mbandaka is also located on the banks of the Congo River, which links both the capitals of the Republic of the Congo and the Central African Republic. This increases the population at risk of exposure to the disease. Accordingly, WHO reviewed its grading of the outbreak to Grade 3.

The Ministry of Health and other national authorities, WHO and partners continue to rapidly scale up implementation of control measures. To achieve this, WHO and partners are appealing for rapid funding of US$ 26 million. Of this, US$ 8 million is needed by WHO to support priority actions over the next three months.

WHO is also working with national authorities from nine neighbouring countries, namely Angola, Burundi, Central African Republic, Congo, Rwanda, South Sudan, Tanzania, Uganda, and Zambia to enhance preparedness and readiness for any likely spillage of infections to these countries. The key activities being implemented include assessments of country capacity and gaps, identification of priority activities and potential resources and sensitization of key stakeholders on Ebola virus disease prevention and control.

WHO does not recommend any restriction of travel or trade imposed on the Democratic Republic of the Congo, based on currently available information. WHO continues to monitor travel and trade measures in relation to this event.

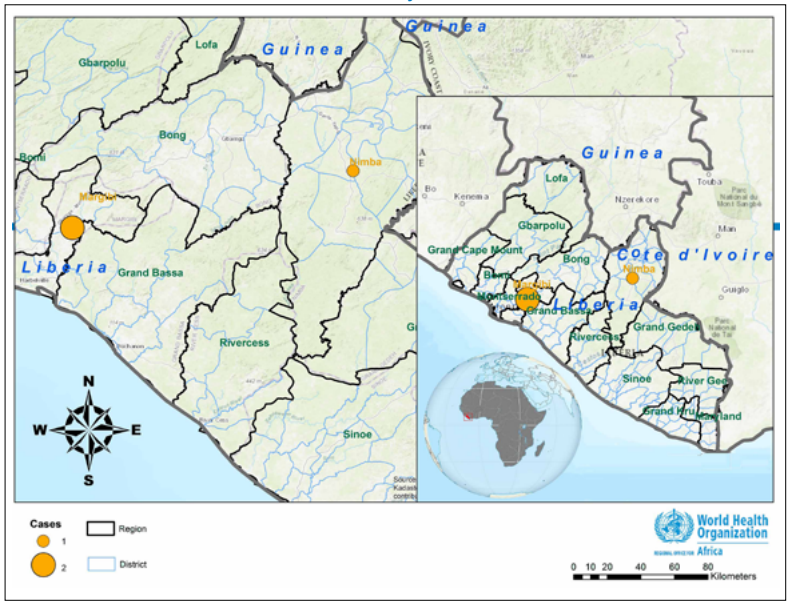
Lassa fever | Liberia | 84 Cases | 22 Deaths | 26.2% CFR

EVENT DESCRIPTION

Liberia continues to experience sporadic cases of Lassa fever, with three new confirmed cases reported between week 18 and week 19 of 2018. In week 19 (week ending 13 May 2018), one new confirmed case of Lassa fever was reported in Nimba County. The case-patient, a 10-year-old boy from Saclepea District, fell ill on 1 May 2018 and presented to a private hospital on 7 May 2018 with features of an acute abdomen. A surgical abdominal procedure was performed on 9 May 2018 and no evidence of an acute abdomen was seen. He later developed high fever post-operatively. A blood specimen was obtained on 10 May 2018 and shipped to the National Public Health Reference Laboratory (NPHRL). The test result released by the NPHRL on 11 May 2018 confirmed Lassa fever infection by real time polymerase chain reaction (RT-PCR).

In a similar, but unrelated event, two confirmed Lassa fever cases were reported in Margibi County during week 18 (week ending 6 May 2018). The first case was a 56-year-old male from Kakata District who developed illness on 25 April 2018. He presented to the district hospital on 3 May 2018 with fever, difficulty in swallowing, diarrhoea, and abdominal pain. He later developed respiratory distress, cough, and vomiting laced with blood, and died on 4 May 2018. A blood specimen collected and analysed at the NPHRL tested positive for Lassa virus infection by RT-PCR on 4 May 2018. The body was kept in a morgue for two days before a supervised burial on 6 May 2018.

Geographical distribution of Lassa fever cases in Liberia, 6 - 13 May 2018



The second case (in Margibi) was a 35-year-old pregnant woman from Kakata District who fell ill on 4 May 2018. She presented to the (same) district hospital on 7 May 2018 with lower abdominal pain, headache and difficulty in swallowing and breathing. The case-patient died shortly after admission and a supervised burial was conducted immediately. A blood specimen collected and tested at the NPHRL (on 7 May 2018) was positive for Lassa virus infection by rt-PCR,

There has been no epidemiological linkage established among the confirmed cases, so far.

From 1 January - 13 May 2018, a total of 84 suspected Lassa fever cases, including 22 deaths (case fatality rate 26.2%) have been reported across the country. Of these, 12 have been confirmed: Nimba (5), Montserrado (3), Margibi (2), Bong (1) and Grand Bassa (1). The overall case fatality rate among the confirmed cases is 83.3%. The majority (66.6%, 8) of confirmed cases are females. The age range of confirmed cases is from 1 year to 57 years, with a median age of 32 years.

A total of 138 contacts, including 65 healthcare workers, have been listed and are being followed up from the two affected counties: 54 from Nimba County (with 31 health workers) and 84 from Margibi County (including 34 health workers). As of 13 May 2018, no contacts have been found to be symptomatic.

PUBLIC HEALTH ACTIONS

- The county health team continues to coordinate outbreak response, with technical support from the Ministry of Health, the National Public Health Institute of Liberia (NPHIL), WHO, Médicines sans Frontièrs (MSF), and OXFAM.
- Active surveillance, including case search and contact tracing, are ongoing in the affected counties, who are sharing information to aid in this.
- The NPHRL continues to provide diagnostic laboratory services, with couriers stationed at designated points across the country for transport of specimens.
- A total of 45 health workers from 11 hospitals in Lassa fever endemic counties have been trained in Lassa fever case management and infection prevention and control (IPC) techniques. The training was conducted by the Ministry of Health and the NPHIL, with support from WHO. Antiviral medication (ribavirin) has been prepositioned at designated treatment facilities and is being provided as prophylaxis for high-risk contacts.
- Supplies for IPC (personal protective equipment, thermo-flash, hand washing soap and buckets) were distributed to one high priority healthcare facility. Safe and dignified burials have been conducted for the deceased in confirmed cases.
- Risk communication and community engagement is ongoing in affected communities, with rapid response teams visiting affected households and families to provide information. The Ministry of Health has produced radio jingles to be broadcast in the affected counties.

SITUATION INTERPRETATION

Liberia continues to experience sporadic Lassa fever cases as the disease is known to be endemic. However, the distribution of the disease appears to be widening as counties that were previously considered non-endemic are beginning to report cases. The national authorities and partners, therefore, need to maintain vigilance, as more cases are bound to occur and the case fatality rate remains high. Challenges around case detection, poor compliance with IPC practices among healthcare workers and hospital waste management need to be addressed urgently.

Listeriosis | South Africa | 1 033 Cases | 204 Deaths | 19.8% CFR

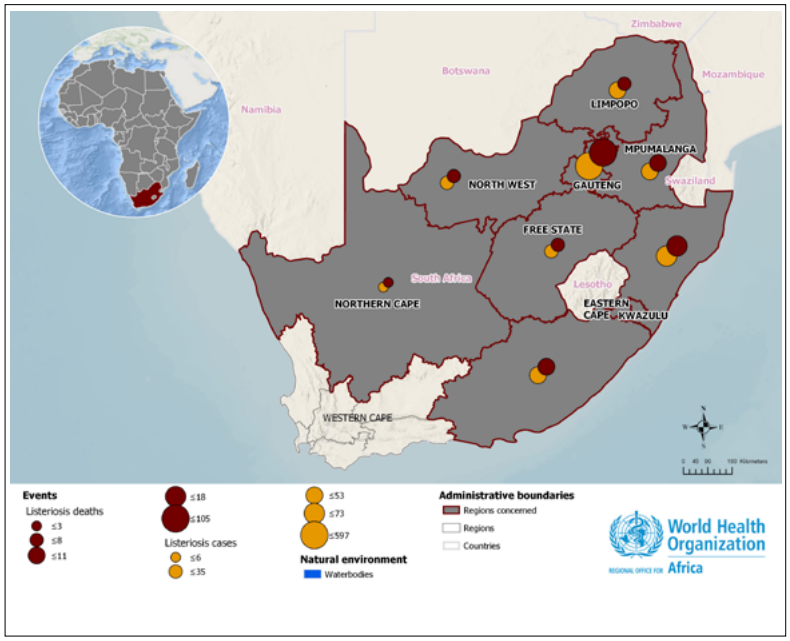
EVENT DESCRIPTION

The listeriosis outbreak in South Africa has improved remarkably, with the weekly incidence declining to fewer than five cases. Since our last report on 27 April 2018 (Weekly Bulletin 17), 14 additional confirmed cases and five deaths have been reported, as of 10 May 2018. Six of the cases occurred between 2 May and 10 May 2018. A total of 64 confirmed listeriosis cases have been reported since the implicated product recall was effected on 4 March 2018, translating into an average of 6.4 cases per week, compared to an average of 24.9 cases per week prior to the recall.

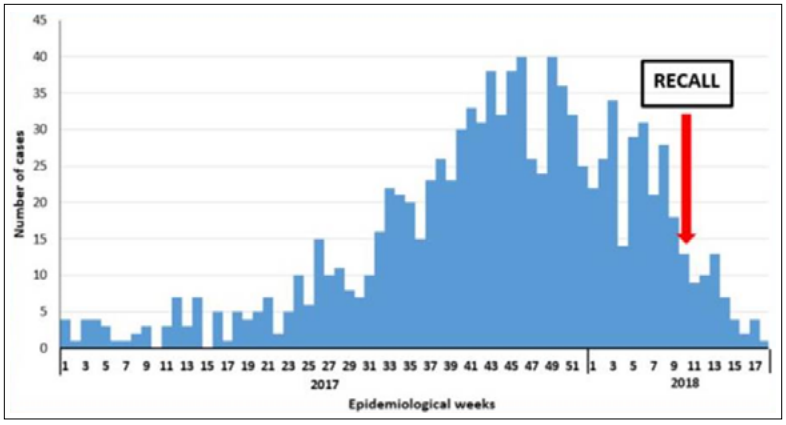
As of 10 May 2018, a total of 1 033 confirmed cases, including 204 deaths (case fatality rate 19.8%) have been reported from the nine provinces in the country. Gauteng Province has been the most affected, with 59% of the total caseload, followed by Western Cape at 13% and KwaZulu-Natal (7%). The proportion of cases in the remaining provinces ranges from 0.6% to 4.5%. Neonates aged 28 days and above remain the most affected age group, followed by adults aged 15-49 years of age.

All clinical isolates received at the National Institute for Communicable Diseases (NICD) are undergoing whole genome sequencing. Of the 64 cases received post recall, 39 isolates have been received for whole genome sequencing to date.

Geographical distribution ofl listeriosis cases in South Africa, 29 April - 29 May 2018



Weekly trend of listeriosis cases in South Africa, week 1, 2017 – week 18, 2018



PUBLIC HEALTH ACTIONS

- The Incident Management Team (IMT) continues to meet daily to coordinate response and preparedness activities, including continuous communication with stakeholders, sharing listeriosis response plan and recent situation reports. A matrix of key stakeholders has been finalized.
- Post recall, all new cases of laboratory confirmed cases are contacted by IMT members and a comprehensive food history obtained, to determine exposure to food products implicated in the outbreak. This involved 39 interviews of 64 people.
- A contract epidemiologist has been employed at the NICD specifically for listeriosis investigation. The NICD has deposited 10 representative ST6 sequences in the public GenBank – NCBI database to assess linkage of *Listeria monocytogenes* strains to the South African outbreak.
- The NHLS infection control services laboratory is receiving food samples for testing as of 14 May 2018 and the NHLS Laboratory Information system, TRAK, has been set up to capture all data from the final public health specimen request forms to allow tracing of food culture results from patient's homes. A system to allow environmental health practitioners to receive results from NHLS laboratories is being set up.
- Three provinces have submitted risk evaluation tools for 38 food processing facilities, and four factory visits and inspections were conducted by the IMT.
- The IMT members were trained in a new standard operating procedure for collecting food specimens for testing.
- Recalled products are being warehoused and destroyed at a rate of 80 tons per day.
- Food safety legislation is being reviewed by an expert committee of members of the Departments of Health, Trade and Industry, Agriculture, Forestry and Fisheries, and the National Regulator for Compulsory Specifications.
- Risk communication and engagement is ongoing, with a meeting of government communication officers on 9 May 2018 to plan and harmonize media strategy.

SITUATION INTERPRETATION

The listeriosis outbreak in South Africa continues to improve, with the weekly incidence of cases significantly declined since the product recall was implemented. New standard operating procedures are in place for collecting food specimens and food safety legislation is being reviewed, while food processing facilities and distributors are being inspected and monitored. However, challenges remain around provinces completing risk assessment profiles for all food production facilities, and continued training of environmental health practitioners, which has only just started. Given the wide geographical spread of the outbreak, the common occurrence of implicated products in people's diets and continued cases as late as 10 May 2018, authorities need to remain vigilant and ensure that new food safety standards are adhered to.

EVENT DESCRIPTION

The cholera outbreak in the suburbs of Harare, the capital city of Zimbabwe, is steadily improving, with only sporadic cases being reported. Since our last report on 20 April 2018 (Weekly Bulletin 16), 26 additional suspected cholera cases and zero deaths have been reported. On 16 May 2018, two new suspected cases were reported against zero cases reported on 15 May 2018. As of 16 May 2018, there were no patients admitted at any of the cholera treatment centres (CTCs) in the country.

Since the beginning of the outbreak on 23 March 2018, a total of 64 suspected cases with three deaths (case fatality rate 4.7%) have been reported, as of 16 May 2018. Of these, 22 cases have been confirmed, two cases classified as probable and 38 cases remained suspected. Of the three deaths, one occurred in a confirmed case and the other two were in probable cases. The outbreak has remained localized to three peri-urban areas: Chitungwiza City (44 cases), Stoneridge (18 cases) and Belvedere West (2 cases).

WHO was formally notified of the cholera outbreak in Harare on 7 April 2018 (by the Ministry of Health) following the death of the index case on 5 April 2018 and subsequent confirmation of *Vibrio cholerae* serotype Ogawa as the causative agent on 6 April 2018.

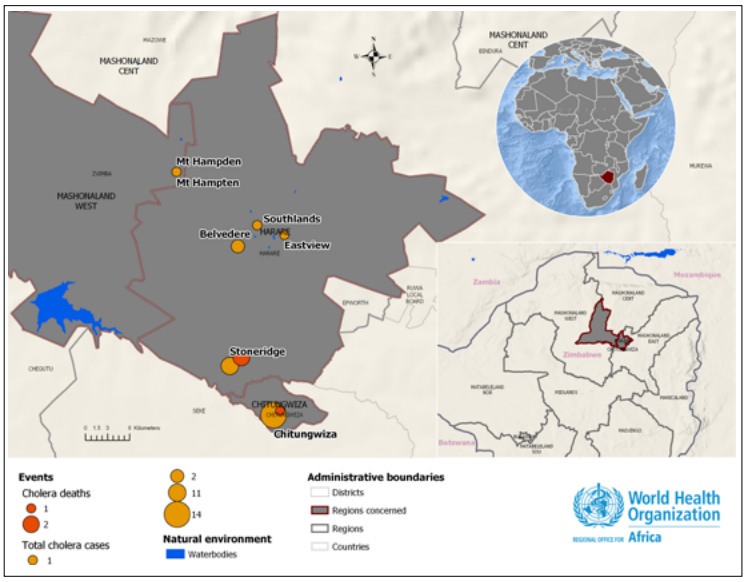
PUBLIC HEALTH ACTIONS

- The Ministry of Health and Child Care, Harare City local authorities and partners (including Oxfam, Médecins Sans Frontières (MSF), UNICEF, WHO, etc.) are responding to the cholera outbreak through the Inter Agency Coordination Committee on Health (IACCH).
- Active surveillance continues in the health facilities and communities. All suspected cases will have samples taken for laboratory testing. Line listing of cases and deaths are continuing at the health facilities.
- Cholera treatment centres remain operational.
- Social mobilization is taking place and information, education and communication (IEC) materials are being distributed, as well as door-to-door visits, education campaigns and road shows.

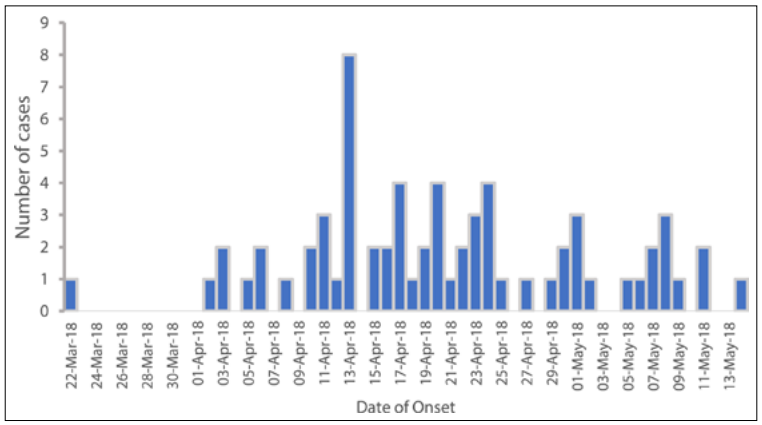
SITUATION INTERPRETATION

The cholera outbreak in the peri-urban suburbs of Harare, the capital city of Zimbabwe, has greatly improved. While the trend has been declining in recent days, there is a need to continue close monitoring of the situation to avoid any potential resurgence. There is also a need to continue implementation of preparedness and readiness activities across the country.

Geographical distribution ofl cholera cases in Zimbabwe, 5 April - 23 May 2018



Epidemic curve of cholera outbreak in Harare city, Zimbabwe, 22 March – 14 May 2018



Summary of major issues challenges, and proposed actions

Issues and challenges

- The outbreak Ebola virus disease in the Democratic Republic of the Congo continues to draw public attention and concern globally. The occurrence of the disease in an urban setting has brought a new dimension to the evolution of the outbreak. Mbandaka is connected to major cities in the country, such as Kinshasa, through water, air and land. Mbandaka is also located on the banks of the Congo River, which links both the capitals of the Republic of the Congo and the Central African Republic. This, therefore, increases the population at risk of exposure to the disease. This situation calls for rapid and effective implementation of control interventions, which require adequate technical, financial and logistical resources.
- A new outbreak of monkeypox has occurred in Cameroon, an event coming after nearly three decades since the last confirmed case in the country. The incidence of human monkeypox has been increasing in the African Region in recent times. Since 2016, outbreaks have occurred in six countries, namely: Central African Republic, Congo, Democratic Republic of the Congo, Liberia, Nigeria, and Sierra Leone. The cases are mostly being reported from rural areas where occupational activities such as farming and hunting are increasing the risk of animal-to-human transmission. As yet knowledge about the epidemiology and ecology of the virus remain limited, as well as surveillance for the disease.

Proposed actions

- The Ministry of Health and other national authorities in the Democratic Republic of the Congo, WHO and partners should rapidly scale up implementation of effective control interventions. All stakeholders, including the Government of the Democratic Republic of the Congo, technical, development and donor partners are urged to provide the necessary resources, urgently.
- The Ministry of Health and partners in Cameroon (and other African countries) should conduct in-depth epidemiological and ecological studies on monkeypox. Findings from these investigations should inform development of prevention and control strategies and interventions. In the meantime, surveillance for the disease needs strengthening as well as public health education in the communities. As part of the health system functioning, health facilities need to adhere to universal precautions and, where necessary, appropriate infection prevention and control measures.

All events currently being monitored by WHO AFRO

Country	Event	Grade†	WHO notified	Start of reporting period	End of reporting period	Total cases	Confirmed cases	Deaths	CFR	Comments
New events										
Cameroon	Monkeypox	Ungraded	16-May-18	30-Apr-18	16-May-18	7	1	0	0.0%	Detailed update given above.
Guinea	Measles	Ungraded	9-May-18	1-Jan-18	6-May-18	1 113	267	9	0.8%	A new measles outbreak was detected in epidemiological week 8, 2018. Measles was reported in all parts of the country since the beginning of the year. The most affected zones include Kankan, Conakry and Faraneh. Out of 522 samples tested, 267 samples tested IGM positive. Out of the positive cases, 76% were not vaccinated for measles despite vaccination campaign efforts in 2017 following a large epidemic.
Senegal	Pertussis	Ungraded	9-May-18	10-May-18	14-May-18	3	3	-	-	On 9 May 2018, a confirmed case of pertussis was reported to the Ministry of Health. In the last three months there have been 3 confirmed cases of pertussis in infants less than 6 weeks in Senegal districts of Touba, Darou-Mousty and Dakar-Nord. The cases were confirmed in Institut Pasteur Dakar and Bio24.
Uganda	Anthrax	Ungraded	9-May-18	11-May-18	29-Apr-18	12	3	0	0.0%	On 20 April 2018, 7 people were admitted to a hospital after eating a dead cow at Kaplopwoto village in Kween District. This is possibly a point source out break with a mixture of cutaneous, gastrointestinal, inhalation and meningeal anthrax forms associated with skinning, carrying, and eating a dead cow. As of 29 April 2018, 12 cases have been reported. Three samples sent to Uganda Virus Research Institute have tested positive for anthrax. A second set of samples have been shipped to UVRI for analysis.
Ongoing events										
Algeria	Measles	Ungraded	13-Mar-18	25-Jan-18	11-Mar-18	2 320	-	5	0.2%	A total of 2 320 cases including 5 deaths have been reported from 13 wilayas: El Oued, Ouargla, Illizi, Tamanrasset, Biskra, Tebessa, Relizane, Tiaret, Constantine,- Tissemsilt, Medea, Alger, and El-Bayadh.
Angola	Cholera	G1	2-Jan-18	21-Dec-17	8-Apr-18	853	5	13	1.5%	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). Cases are being reported from two districts of Uíge province (Uíge the seat of the provinces and the rural district of Son-go). A reduction of cases of cholera has been observed, from 22 cases of cholera in epi week 13, to 12 in epi week 14.

Angola (Cabinda province)	Cholera	Ungraded	8-Mar-18	18-Feb-18	25-Mar-18	42	-	2	4.8%	This outbreak began during week 7 of 2018. During week 12, Cabinda reported 7 cases and 0 deaths. The cases are restricted to five neighborhoods in poor suburban areas.
Botswana	Malaria	Ungraded	20-Apr-18	1-Jan-18	15-Apr-18	339	339	2	0.6%	In 2018, from epi week 1 up to epi week 15, there were 339 malaria confirmed cases and 2 deaths. The transmission peak is observed in EPI week 14 which is the traditional peak each year. Malaria normally occurs seasonally in Botswana. It occurs during the rainy season of October to May.
Burundi	Flooding	Ungraded	0-Jan-00	28-Apr-18	30-Apr-18	-	-	2	-	Torrential rains in Bujumbura have caused the diversion of the Mutimbizi river from its bed on 28 April 2018, leading to flooding in Buterere zone of Ntahangwa urban commune in Bujumbura Mayorship. As of 30 April 2018, two deaths have been reported, about 3 000 people have been internally displaced (more than 60% are children),and 216 houses have been destroyed. Buterere was also affected by flooding on 16 March 2018 (14 deaths), along with another zone, Gasenyi where 7 people died. There is the potential risk of cholera and malaria outbreaks in Bujumbura Mayorship.
Cameroon	Humanitarian crisis	G2	31-Dec-13	27-Jun-17	3-Nov-17	-	-	-	-	At the beginning of November 2017, the general security situation in the Far North Region worsened. Terrorist attacks and suicide bombings have continued and are causing displacement. Almost 10% of the population of Cameroon, particularly in the Far North, North, Adamaoua, and East Regions, is in need of humanitarian assistance as a result of the insecurity. To date, more than 58 838 refugees from Nigeria are present in Minawao Camp, and more than 21 000 other refugees have been identified outside of the camp. In addition, approximately 238 000 internally displaced people (IDPs) have been registered.

Central African Republic	Humanitarian crisis	G2	11-Dec-13	11-Dec-13	2-May-18	-	-	-	-	The security situation remains tense and precarious in many places across the country. On 1 April 2018, the armed group from the neighborhood of PK5 in Bangui, predominantly muslim attacked the Catholic Church of Our Lady of Fatima where 16 people were killed with around 100 wounded. That incident resulted in a series of violence and revenge where muslims were killed by angry christian groups. Two muslims were burned on the road and the other killed in Bangui Community Hospital.The provisional reports shows 185 wounded and 23 deaths from hospital sources. Currently, 2.5 million people are in need of humanitarian aid including 1.1 million people targeted for the health cluster partners. There are around 688 700 IDPs across the country, of which 70% are living with host families.
Central African Republic	Monkeypox	Ungraded	20-Mar-18	2-Mar-18	24-Apr-18	20	9	1	0.0%	The outbreak was officially declared on 17 March 2018 in the sub province of Ippy. In this reporting period, there is an increase in number of suspected monkey pox in Bangassou health district. As of 24 April, twenty cases including nine confirmed cases have been reported from Ippy (6) and Bangassou (3).
Congo (Republic of)	Cholera	Ungraded	21-Mar-18	n/a	10-Apr-18	45	3	2	4.4%	As of 10 April 2018, 45 suspected cases of cholera including 2 deaths were reported in the departments of Plateaux (33 suspected) and Likouala (12 suspected). The 3 confirmed cases were tested by RDT and/or culture.
Democratic Republic of the Congo	Humanitarian crisis	G3	20-Dec-16	17-Apr-17	26-Apr-18	-	-	-	-	The humanitarian and security situation remains very fragile in several provinces of the country, particularly in Ituri, North Kivu, South Kivu and Tanganyika. Insecurity is growing on the plain of Ruzizi, Kamanyora axis in Uvira. More than 1 300 people would have been affected by heavy rain and violent winds that fell in the localities of Makama, Yandale, Milanga, Nemba and Kaska from 21 to 23 April in the territory of FIZI, southern province Kivu.
Democratic Republic of the Congo	Cholera		16-Jan-15	1-Jan-18	15-Apr-18	9 149	0	224	2.4%	This is part of an ongoing outbreak. From week 1 to 15 of 2018, a total of 9 149 cases including 224 deaths (CFR: 2.4%) were reported from DRC. In week 15, there were 432 new cases with 12 deaths reported. Nationwide, a total of 61 680 cases including 1 327 deaths (CFR; 2.2%) have been reported since January 2017.
Democratic Republic of the Congo	Ebola virus disease	G3	7-May-18	4-Apr-18	14-May-18	46	3	26	56.5%	Detailed update given above.

Democratic Republic of the Congo	Measles	Ungraded	10-Jan-17	1-Jan-18	4-Mar-18	3 404	-	30	0.9%	This outbreak is ongoing since the beginning of 2017. As of week 8 in 2018, a total of 48 326 cases including 563 deaths (CFR 1.2%) have been reported since the start of the outbreak. In 2018 only, 3 404 cases including 30 deaths (0.9%), were reported.
Democratic Republic of the Congo	Polio-myelitis (cVDPV2)	Ungraded	15-Feb-18	n/a	30-Mar-18	407	22	0	0.0%	On 13 February 2018, the Ministry of Health declared a public health emergency regarding 21 cases of vaccine-derived polio virus type 2. Three provinces have been affected, namely Haut-Lomami (8 cases), Maniema (2 cases) and Tanganyika (11 cases). The outbreak has been ongoing since February 2017.
Democratic Republic of Congo	Rabies	Ungraded	19-Feb-18	1-Jan-18	1-Apr-18	38	0	12	31.6%	This outbreak began towards the end of October 2017 in Kibua health district, North Kivu province. During Week 12 of 2018, seven new cases and two deaths were reported.
Democratic Republic of Congo	Monkeypox	Ungraded	n/a	1-Jan-18	26-Apr-18	1 210	34	28	2.3%	From weeks 1-16 of 2018 there have been 1 210 suspected cases of monkeypox including 28 deaths. Of the suspected cases, 34 cases have been confirmed. Suspected cases have been detected in 14 provinces. Sankuru Province has had an exceptionally high number of suspected cases this year (309 cases).

Ethiopia	Humanitarian crisis	Protracted 3 (combined)	15-Nov-15	n/a	8-Apr-18	-	-	-	-	The complex humanitarian crisis in Ethiopia continues into 2018. As of 8 April 2018, there were 1.74 million internally displaced people (IDP), of which 1.2 million are conficlit induced IDPs. The vast majoirty of IDPs are in Somali and Oromia regions. Almost 16% of the IDPs have no access to essential PHC services and another 30% have difficult access to health care. Only 37% of conflict IDPs have access to free medicines. Approximately 23 000 conflict IDPs have been resettled around 11 town administrations. While the security situation remains tense along the Oromia/ Somali border, there has been a slight ipmrovement in Hudet, Moyale, Bale, and Borena allowing for transportation of supplies.
Ethiopia	Acute watery diarrhoea (AWD)		15-Nov-15	1-Jan-18	8-Apr-18	157	-	0	0.0%	This is an ongoing outbreak since the beginning of 2017. In 2018 only, from 1 January 2018 to 10 April 2018, a total of 157 cases have been reported from three regions, Somali, Tigray and Dire Dawa regions with no death reported. In week 14, 4 cases were reported which is a reduction from 13 new cases in week 13. Between January and December 2017, a cumulative total of 48 814 cases and 880 deaths (CFR 1.8%) have been reported from 9 regions.
Ethiopia	Measles		14-Jan-17	1-Jan-18	8-Apr-18	1 050	399	-	-	This is an ongoing outbreak since the beginning of 2017. Between January and December 2017, a cumulative total of 4 011 suspected measles cases have been reported across the country. In 2018 only, a total of 1 050 suspected cases including 399 confirmed cases, have been reported from 5 regions (Addis Ababa, Amhara, Oromia, SNNPR, and Somali).
Kenya	Flooding	Ungraded	18-Apr-18	0-Jan-00	3-May-18	-	-	-	-	Large parts of Kenya have been experiencing floods following heavy rains, with 33 of the 47 counties in the country affected, especially those along the main rivers. The most affected counties are Tana River, Turkana, Mandera, and Kilifi. Figures from the Kenya Red Cross Society (KRCS) put the death toll at 80, with more than 33 injured. According to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), at least 244 407 people from 45 219 households across the country have been displaced, with more than 23 000 displaced in the last week. In Nandi County, 243 households were displaced following a mudslide, while landslides have been reported in Muranga County in the central region.

Kenya	Chikungunya	Ungraded	mid-December 2017	mid-December 2017	7-May-18	1 508	38	0	0.0%	The outbreak is still ongoing in three counties: Mombasa, Lamu and Kilifi. Since December 2017, Mombasa County has reported a total 1 302 Chikungunya cases with 32 being laboratory confirmed. The outbreak has affected 6 Sub Counties; Mvita (270 cases), Changamwe (445 cases), Jomvu (157 cases), Likoni (196 cases), Kisauni (153 cases) and Nyali (61cases). More 41samples awaiting results from KEMRI. Since 26 January 2018, Lamu also started reporting Chikungunya cases and so far, 199 cases have been line listed with 4 cases being laboratory confirmed. The new cases reported are from Lamu West, Mpeketoni. Kilifi County has reported 7 cases with 2 confirmed. One case was confirmed in Kakamega County linked to Kilifi outbreak.
Kenya	Cholera	G1	6-Mar-17	1-Jan-18	7-May-18	3 233	167	64	2.0%	The outbreak in Kenya is ongoing since 2017. Between 1 January 2017 and 07 December 2017, a cumulative total of 4 079 cases with have been reported from 21 counties (data until 31 December 2017 not available). In 2018, a total of 3 233 cases have been reported since the first of January. Currently, the outbreak is active in 6 counties: Garissa, Meru, Turkana, West Pokot, Machakos and Isiolo counties. The outbreak has been controlled in 10 counties: Kirinyaga, Busia, Mombasa, Tharaka-Nithi, Siaya, Murang'a, Tana River, Trans-Nzoia, Nakuru and Nairobi.
Kenya	Measles	Ungraded	19-Feb-18	19-Feb-18	7-May-18	141	11	1	0.7%	The outbreak is located in two counties, namely Wajir and Mandera Counties. As of 7 May 2018, Wajir County has reported 39 cases with 7 confirmed cases; Mandera has reported 102 cases with 4 confirmed cases and one death. Date of onset of the index case in Wajir County was on 15 December 2017. The index case was traced to Kajaja 2 village from where the outbreak spread to 7 other villages: Ducey (18 cases), ICF (2), Godade (3), Kajaja(1), Konton(2),Kurtun (1) and Qarsa (12). No new cases have been reported. Date of onset of the index case in Mandera County was on 15 February 2018.
Liberia	Measles	Ungraded	24-Sep-17	1-Jan-18	29-Apr-18	2 564	177	12	0.5%	From week 1 to week 48 of 2017, 1 607 cases were reported from 15 counties, including 225 laboratory confirmed, 336 clinically compatible and 199 epi-linked. From week 1 to week 17 of 2018, 2 564 cases have been reported including 12 deaths. Cases are epidemiologically classified as follows: 177 laboratory confirmed, 1 561 epi-linked, 31 clinically compatible, 128 discarded, and 384 pending.

Liberia	Lassa fever	Ungraded	14-Nov-17	1-Jan-18	13-May-18	84	11	22	26.2%	Detailed update given above..
Madagascar	Plague	Ungraded	13-Sep-17	13-Sep-17	29-Apr-18	2,676	558	238	8.9%	From 1 August 2017 to 29 April 2018, a total of 2 678 cases of plague were notified, including 559 confirmed, 828 probable and 1 291 suspected cases. Out of them 2 032 cases were of pulmonary, 437 were of bubonic, 1 was of septicaemic form and 208 cases unspecified. In week 17, 2 suspected cases were reported but tested negative.
Mali	Humanitarian crisis	Protracted 1	n/a	n/a	19-Nov-17	-	-	-	-	The security situation remains volatile in the north and centre of the country. At the last update, incidents of violence had been perpetrated against civilians, humanitarian workers, and political-administrative authorities.
Mali	Measles	Ungraded	20-Feb-18	1-Jan-18	29-Apr-18	800	246	0	0.0%	Health districts are affected by Measles in Bougouni, Koutiala, Kolondieba, Tombouctou, Dioila, Taoudenit and Kalabancoro. Reactive vaccination campaigns, enhancement of surveillance, and community sensitization activities are ongoing in the affected health districts. The national reference laboratory (INRSP) confirmed 246 cases by serology (IgM).
Mauritania	Crimean-Congo haemorrhagic Fever (CCHF)	Ungraded	26-Apr-18	22-Apr-18	8-May-18	2	1	0	0.0%	On 22 April 2018, one suspected case of haemorrhagic fever at Cheikh Zayed Hospital (CZ) was notified to the central department of the Ministry of Health. The case was a 58-year-old male cattle breeder in the locality of Elghabra, Assaba region. The onset of symptoms was on April 16, 2018 with high fever, arthralgia and headache. He reported being in contact with a dead cow, and no consumption of deceased animal meat was reported. The sample sent to the national reference laboratory confirmed the presence of Crimean Congo virus by serology (IgM positive). The case was discharged from the hospital on 27 April 2018. One new suspected case from the same area was notified on 30 April 2018 and tested negative for Crimean Congo virus by serology and PCR. As of 8 May 2018, 22 (69%) of the 32 identified contacts have completed follow up. No death has been reported.
Mauritania	Dengue fever	Ungraded	30-Nov-17	6-Dec-17	22-Feb-18	307	165	-	-	In November 2017, the MoH notified 3 cases of dengue fever including one hemorragic case (Dengue virus type 2) with a history of Dengue virus type 1 infection in 2016. As of 10 February, the national reference laboratory confirmed the diagnosis of 165 out of 307 RDT positive samples. Dengue type 1 and type 2 are circulating in the country with a higher proportion of subtype 2 (104/165).

Mozambique	Cholera	G1	27-Oct-17	12-Aug-17	30-Apr-18	2 329	-	5	0.2%	The cholera outbreak is ongoing. From mid-August 2017 through 30 April 2018, 2329 cases have been reported from two provinces; Nampula (1 646 cases and 2 deaths) and Cabo Delgado (683 cases and 3 deaths) provinces. This outbreak started in mid-August 2017 from Memba district, Nampula Province and Cabo Delgado Province started reporting cases from week 1 of 2018. No new cases have been reported in the two provinces since Week 15. No cases have been reported from Erati and Nacrpoua districts since the beginning of the year.
Namibia	Crimean-Congo haemorrhagic fever	Ungraded	29-Mar-18	28-Mar-18	13-Apr-18	2	1	1	50.0%	A male subject from Keetmanshoop District became ill on 22 March 2018 after contact with a tick-infested cow. As of 28 March 2018 he was admitted to an isolation unit at Windhoek Central Hospital and PCR testing was confirmed positive on 31 March 2018. The patient died on 3 April 2018. An additional suspected case with a history of tick bite and vomiting has also been isolated as of 3 April 2018, but tested negative for CCHF on 7 April 2018.
Namibia	Hepatitis E	Ungraded	18-Dec-17	8-Sep-17	6-Mar-18	1 285	104	14	1.1%	This is an ongoing outbreak since 2017. The majority of cases have been reported from informal settlements in the capital district Windhoek. The most affected settlement is Havana, accounting for about 573 (56%) of the total cases, followed by Goreagab settlements with 256 (25%) cases. The most affected age group is between 20 and 39 years old representing 76% of total cases.
Niger	Humanitarian crisis	G2	1-Feb-15	1-Feb-15	11-Apr-18	-	-	-	-	The humanitarian situation in Niger remains complex. The state of emergency has been effective in Tillabéry and Tahoua Regions since 3 March 2017. Security incidents continue to be reported in the south-east and north-west part of the country. This has disrupted humanitarian access in several localities in the region, leading to the suspension of relief activities, including mobile clinics.

Niger	Meningitis	Ungraded	26-Apr-18	1-Jan-18	6-May-18	1 120	69	91	8.1%	In 2018, week 18 (from 30 April to 6 May), there were 69 new confirmed meningitis cases, including 9 death (CFR 13%) reported in Niger. There are no health districts that passed the epidemic treshold of 10 cases per 100 000 inhabitants. One district is under alert with an attack rate of 4.2 cases per 100 000 inhabitants. From epi week 1 up to epi week 17, there were 1 120 cases and 91 deaths notified (CFR 8.1%). As of 29 April 2018, 733 samples were analysed by CERMES and among them, 327 tested positives (45%): 153 NmC (46,8%), 109 NmX (33,3%), 53 Sp (16,2%), 8 Hi (2,4%), 1NmW135 (0,3%), 1 Nm underfined (0,3%), and 2 others (0,6%).
Nigeria	Humanitarian crisis	Protracted 3	10-Oct-16	n/a	31-Jan-18	-	-	-	-	Conflict and insecurity in the north east of Nigeria remain a concern and resulted in a large scale of displacement. Most affected areas recently are along the axis from Monguno to Maiduguri, namely in Gasarwa, Gajiram, Gajigana, Tungushe, and Tungushe Ngor towns. Initial estimates for the number of IDPs in recent months is between 20 000 and 36 000; many are in dire need of humanitarian services.
Nigeria	Cholera	Ungraded	7-Jun-17	1-Jan-18	3-Mar-18	210	2	16	7.6%	There is an ongoing outbreak since the beginning of 2017. Between 1 January and 31 December 2017, a cumulative total of 4 221 suspected cholera cases and 107 deaths (CFR 2.5%), including 60 laboratory-confirmed were reported from 87 LGAs in 20 states. Between weeks 1 and 9 of 2018, 210 suspected cases including two laboratory-confirmed case and 16 deaths (CFR 7.6%), have been reported from 28 LGAs in 9 states. Most recently, cases have also been reported from Yobe and Bauchi states. During 28 March to 8 May 2018, Yobe State reported 402 cases including 15 deaths (CFR 3.7%).

Nigeria	Lassa fever	G2	24-Mar-15	1-Jan-18	13-May-18	446	428	117	26.2%	In the reporting Week 19 (7-13 May 2018) five new confirmed cases were reported from three states -Edo (1), Ebonyi (1) and Ondo (3) with one new death in Ondo state. From 1 January to 13 May 2018, a total of 1 914 suspected cases and 157 deaths have been reported from 21 states. Seventeen states have exited the active phase of the outbreak while four- Edo, Ondo, and Ebonyi, Taraba States remain active. Of the suspected cases, 428 were confirmed positive, 10 are probable, 1 468 negative (not a case) and 8 samples are awaiting laboratory result (pending). Thirty-eight healthcare workers have been affected since the onset of the outbreak in eight states – Ebonyi (16), Edo (12), Ondo (4), Kogi (2), Benue (1), Nasarawa (1), Taraba (1), and Abia (1) with nine deaths in Ebonyi (6), Kogi (1), Abia (1) and Ondo (1). A total of 1 022 cases including 127 deaths were reported from week 49 of 2016 to week 51 of 2017.
Nigeria	Hepatitis E	Ungraded	18-Jun-17	1-May-17	31-Dec-17	1 651	182	8	0.6%	The number of cases has been decreasing since week 51 of 2017. Forty-three new cases were reported in Kala/Balge LGA in week 52 (ending 31 December 2017).
Nigeria	Yellow fever	Ungraded	14-Sep-17	7-Sep-17	15-Apr-18	1 711	41	47	2.7%	A total of 1 771 cases have been reported from all Nigerian states in 396 LGAs. Forty one samples have been laboratory-confirmed at IP Dakar.
Nigeria	Monkeypox	Ungraded	26-Sep-17	24-Sep-17	25-Feb-18	228	89	6	2.6%	Suspected cases are geographically spread across 24 states and the Federal Capital Territory (FCT). Eighty-nine laboratory-confirmed cases have been reported from 15 states/territories (Akwa Ibom, Abia, Bayelsa, Benue, Cross River, Delta, Edo, Ekiti, Enugu, Lagos, Imo, Nasarawa, Rivers, and FCT).
Nigeria	Meningitis	Ungraded	26-Dec-17	1-Sep-17	23-Apr-18	3 141	292	295	9.4%	From 1 September 2017 to 23 April 2018, 3 141 suspected cases have been reported from fifteen States: Katsina (1 133), Zamfara (1 039), Sokoto (363), Jigawa (162), Kano (107), Kebbi (95), Niger (70), Yobe (65), Bauchi (31), Cross River (28), Adamawa (23), Borno (17), Plateau (4), Gombe (3) and Kaduna (1). Of the 728 samples tested, 292 (40.1 %) were positive for bacterial meningitis. *Neisseria meningitides* C (NmC) accounted for 63.4% (185) of the positive cases.

Nigeria (Borno State)	Cholera	Ungraded	n/a	13-Feb-18	6-May-18	741	32	3	0.4%	From 13 February to 6 May 2018, 741 cases of cholera including 3 deaths (case fatality rate: 0.4%) were reported in Borno State, Nigeria. In the period between 24 April and 6 May 2018, 30 suspected cases have been reported from Kukawa LGA (21), and Banki LGA (9). No death was reported. Eighty (79%) of the 101 samples tested using rapid diagnostic tests (RDTs) were positive while 32 (47%) of 67 samples were culture positive for *Vibrio cholerae*. Since the beginning of the outbreak, the majority of suspected cases (706; 95%) and all deaths have been reported from Kukawa LGA. The number of cases reported for epi-week 18 (ending 6th May 2018) compared to the previous week shows a twofold increase and resurgence of cases in Kukawa LGA.
São Tomé and Príncipé	Necrotising cellulitis/ fasciitis	Protracted 2	10-Jan-17	25-Sep-16	22-Apr-18	2 613	0	0	0.0%	From week 40 in 2016 to week 16 in 2018, a total of 2 613 cases have been notified. In week 16, 17 cases were notified, the same number as the previous week, 7 cases less than 14 weeks. Six (6) out of seven districts (7) reported. The attack rate of necrotising cellulitis in São Tomé and Príncipé is 13.2 cases per 1 000 inhabitants. The most affected district are Caue (attack rate: 20.1 cases per 1 000 inhabitants) and Cantagalo (19.4 cases per 1 000 inhabitants).
Seychelles	Dengue fever	Ungraded	20-Jul-17	18-Dec-15	22-Apr-18	4 950	1 429	-	-	A total of 4 459 cases have been reported from all regions of the three main islands (Mahé, Praslin, and La Digue). A total of 4 950 suspected cases reported by end of week 16, 2018. Significant increase in reported suspected cases for week 16 compared with week 15, a total of thirty-four (34) suspected cases. Twenty-four (24) samples tested amongst which five (5) were positive, nineteen (19) negative. Of note nine (9) suspected cases were admitted at Baie St Anne Praslin Hospital but unfortunately not tested. So far for this epidemic the serotypes DENV1, DENV2 and DENV3 have been detected.
South Africa	Listeriosis	G2	6-Dec-17	1-Jan-17	24-Apr-18	1 024	1 024	200	19.5%	Detailed update given above.

South Africa	Rabies	Ungraded	-	1-Jan-18	17-Apr-18	7	6	0	0.0%	From Jan 2018 to date, a total of six human cases of rabies have been laboratory confirmed. Cases were reported from KwaZulu-Natal Province (4) where a resurgence of rabies has been reported. The remaining cases were reported from the Eastern Cape Province. For all of the cases, exposures to either rabid domestic dogs or cats were reported. Another probable case of rabies was reported from the Eastern Cape, but a sample for laboratory investigation for rabies was not available. The case did however present with a clinical disease compatible with a diagnosis of rabies and had a history of exposure to a potentially rabid dog before falling ill.During 2017, a total of six cases were reported for the year.
South Sudan	Humanitarian crisis	Protracted 3	15-Aug-16	n/a	15-Apr-18	-	-	-	-	Following the conflict in December 2013, about 4 million people have fled their homes, 1.9 million people are internally displaced, 2.1 million are refugees, and 7 million people are in need of humanitarian assistance. The country is currently facing a severe economic crisis and high inflation making health emergency operations expensive and hence difficult for delivering humanitarian assistance. As of 15 April 2018, the security situation remains volatile with reported incidents of cattle raiding and revenge killings between communities in various locations hampering humanitarian service delivery. The security situation remains tense along the border between Unity state and Gogrial East and Tonj North counties due to cattle raiding.
South Sudan	Rift Valley fever (RVF)	Ungraded	28-Dec-17	7-Dec-17	6-May-18	31	6	4	12.9%	As of 6 May 2018, a total of 31 cases of Rift Valley fever have been reported from Yirol East of the Eastern Lakes State, including six confirmed human cases (one IgG and IgM positive and five IgG only positive), three cases who died and were classified as probable cases with epidemiological links to the three confirmed cases, 26 were classified as non-cases following negative laboratory results for RVF (serology), and samples from 20 suspected cases are pending complete laboratory testing. A total of four cases have died, including the three initial cases and one suspect case who tested positive for malaria (case fatality rate: 12.9%).

Tanzania	Floods	Ungraded	18-Apr-18	15-Apr-18	17-Apr-18	-	-	-	-	Heavy rains and poor drainage systems have led to intense flooding in Dar es Salaam affecting the districts of Ilala, Kinondoni, Temeke, Kigamboni. As of 17 April 2018, 15 have died and another 10 have been injured. Response teams are mobilizing.
Tanzania	Cholera	Protracted 1	20-Aug-15	1-Jan-18	13-May-18	1 856	-	36	1.9%	This is part of an ongoing outbreak. During epidemiological week 19, 44 new cases were reported from Longido DC of Arusha region, and Songwe DC of Songwe region. As of week 19 ending 13 May 2018, a total of 1 856 cases with 36 deaths (CFR: 1.9%) were reported from Tanzania Mainland, no case was reported from Zanzibar. The last case reported from Zanzibar was on 11 July 2017. Since the start of the outbreak on 15 August 2015, Tanzania mainland reported 30 462 cases including 502 deaths (CFR 1.65%) and Zanzibar reported 4 688 cases including 72 deaths (CFR 1.54%). In total, 35 150 cases including 574 deaths (CFR 1.63%) were reported for the United Republic of Tanzania.
Tanzania	Dengue fever	Ungraded	19-Mar-18	n/a	21-Mar-18	13	11	-	-	An outbreak of Dengue fever is ongoing in Dar es Salaam. Further information will be provided when it becomes available.
Uganda	Humanitarian crisis - refugee	Ungraded	20-Jul-17	n/a	2-Mar-18	-	-	-	-	The influx of refugees to Uganda has continued as the security situation in the neighbouring countries remains fragile. Approximately 75% of the refugees are from South Sudan and 17% are from DRC. An increased trend of refugees coming from DRC was observed recently. Landing sites in Hoima district, particularly Sebarogo have been temporarily overcrowded. The number of new arrivals per day peaked at 3 875 people in mid-February 2018.
Uganda	Cholera	G1	15-Feb-18	12-Feb-18	30-Apr-18	2 119	24	44	2.1%	The outbreak of cholera in Hoima District continues to evolve. The epidemic has affected 4 sub-counties: Kyangwali, Kabwoya, Buseruka, Bugambe and Kahoora division in Hoima municipality. Most of the new cases are from newly arrived refugees from DRC. No new deaths have been reported since 9 April 2018.

Uganda	Cholera	Ungraded	1-May-18	1-May-18	10-May-18	50	3	2	4.0%	From 15 April to 10 May 2018, 50 cases of cholera including 2 deaths (case fatality rate: 4%) were reported in Amudat district, Uganda. One (25%) of the 4 samples tested using rapid diagnostic tests (RDTs) were positive and 3 (27%) of 11 samples tested for *Vibrio cholerae* by culture were positive for strain Ogawa. The first cases including the index case were coming from Kasei parish in Kenya and the majority of suspected cases (25; 54%) have been reported in Loroo sub-county.
Uganda	Anthrax	Ungraded	-	12-Apr-18	16-Apr-18	10	1	-	-	On 9 February 2018, three cases of suspected cutaneous anthrax were identified in a refugee camp of Arua District. Blood samples taken off the three suspected cases were transported to the Central Public Health Laboratory. On 5 April 2018, blood samples were tested by PCR by the Uganda Virus Research Institute. *Bacillus anthracis* was confirmed in one of three samples tested, by PCR.
Uganda	Measles	Ungraded	8-Aug-17	24-Apr-17	3-Oct-17	623	34	-	-	The outbreak is occurring in two urban districts: Kampala (310 cases) and Wakiso (313 cases).
Zambia	Cholera	G1	4-Oct-17	4-Oct-17	15-Apr-18	5 721	565	113	2.0%	As of 15 April 2018, 5 243 cases and 96 deaths have been reported in Lusaka district. From other districts outside Lusaksa, 478 cases and 17 deaths have been reported. Since the begining of the outbreak, Zambia has reported a cumulative total of 5 721 cases including 113 deaths.
Zimbabwe	Cholera	Ungraded	7-Apr-18	5-Apr-18	15-May-18	62	23	3	4.8%	Detailed update given above.

Recently closed events										
Malawi	Cholera	Ungraded	28-Nov-17	20-Nov-17	29-Apr-18	929	195	30	3.2%	No new cases of cholera have been reported for more than 14 days in Malawi. Since the outbreak started on 24 November 2018, a total of 929 cases and 30 deaths (case fatality rate 3.2%), had been reported from 13 districts as of 13 May 2018. In total 13 districts were affected including Lilongwe. Initial cases by district and by location within the district were laboratory confirmed by stool culture at the nearest designated laboratories with capacity to do culture. Positive samples were sent to National Reference Lab for serotyping. A total of 84 (13%) stool specimens were taken for culture of which 78 (93%) were positive for *Vibro cholerae* 01. The first round of OCV campaign, targeting half million people in selected hot spot areas was conducted 17-21 April 2018. The second round will be conducted 21-25 May 2018. Surveillance and raising public awareness activities are continuing. The country has sent a report to close the event.

†Grading is an internal WHO process, based on the Emergency Response Framework. For further information, please see the Emergency Response Framework: http://www.who.int/hac/about/erf/en/.
Data are taken from the most recently available situation reports sent to WHO AFRO. Numbers are subject to change as the situations are dynamic.

Correspondence on this publication may be directed to:
Dr Benido Impouma
Programme Area Manager, Health Information & Risk Assessment
WHO Health Emergencies Programme
WHO Regional Office for Africa
P O Box. 06 Cité du Djoué, Brazzaville, Congo
Email: afrooutbreak@who.int

Contributors
E. Douba (Cameroon)
K. Yealue (Liberia)
M. Groepe (South Africa)
S. Maphosa (Zimbabwe)
F. Mboussou (Democratic Republic of the Congo)

Graphic design
Mr. A. Moussongo

Editorial Team
Dr. B. Impouma
Dr. C. Okot
Dr. E. Hamblion
Dr. B. Farham
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Data sources
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