1. Introduction

The aim of this bulletin is to provide information on public health events and emergencies to Member States, public health and health emergency professionals, health development partners and the wider audience on the status of outbreaks and health emergencies in the WHO African region.

This issue focuses on the Yellow fever, Cholera, Zika Virus Disease and Chikungunya outbreaks.

During the period under review, there have been protracted urban Yellow Fever (YF) outbreaks in Angola that have spread to the neighboring DR Congo and there have been exported cases to China and Kenya. Another outbreak of Yellow Fever was reported in Uganda but was not epidemiologically linked to the Angola or DR Congo outbreaks. The Uganda YF outbreak was rapidly and effectively contained.

Cholera outbreaks have been the most protracted public health events (PHEs) in the period under review affecting 15 countries. Tanzania, DR Congo and Kenya being the most affected. The cholera outbreak in DR Congo shows no signs of decline since the beginning of the outbreak.

Other major outbreaks that were reported during the period under review were: Chikungunya in Kenya and Dengue in Seychelles.

Moreover, protracted and escalated humanitarian crises in the Central African Republic, South Sudan and Burundi were associated with displacement of thousands of people and resulted in major health consequences.

Finally, floods and drought related to El Nino affected millions of people in Eastern and Southern Africa, including: Ethiopia, Zimbabwe, Malawi, Lesotho, South Africa, and Zambia. Consequently, food insecurity and severe acute malnutrition has significantly increased in the affected countries.
2. Overview of reported PHEs in WHO African Region

An overview of PHEs due to all hazards that occurred between January - June 2016 is provided in addition to summary of ongoing PHEs. 53 PHEs were reported to the WHO’s Event Management System (EMS*) of the Regional Office between January and June 2016, all of them due to infectious diseases. Twenty eight percent (28%) of the PHEs were of zoonotic origin, Cholera was the most frequent, accounting for 28%.

*EMS is a WHO web-based application that supports the process of epidemic intelligence detection, verification, risk assessment and monitoring.
3. Yellow Fever in the African Region

3.1 Angola

The Yellow Fever in Angola has become a protracted outbreak. Geographic expansion continues, as well as continuous transmission in Luanda. The trend of reduction in cases continues to be observed. As of 14 July 2016, only one confirmed case reported this week, the first and only one in July so far.

From 5 December 2015 to 14 July 2016, the Ministry of Health has reported a total of 3,674 suspected cases including 361 deaths of which 877 cases have been laboratory confirmed.

The WHO and partners are supporting the ministries of health in Angola in controlling the outbreaks. Surveillance system at provincial level has been strengthened. As of 14 June 2016, WHO has deployed 95 experts to Angola to support response operations of which 34 are currently in the field. WHO and partners have completed plans to scale-up the response by deploying additional staff at provincial and district level.

Reactive vaccination that started in Luanda has been expanded to cover most of the affected areas. Despite extensive vaccination efforts, circulation of the virus persists.

Mop-up vaccination in Luanda was launched on 15th July, 2016 by the Minister for Health and the Provincial Governor.

Preemptive vaccination has been planned to vaccinate northern districts of Angola and bordering districts of DR Congo.

3.2 DR Congo

As of 11 July 2016, DR Congo has reported 1,798 cases including 85 deaths. has reported 61 laboratory confirmed cases. Of the 68 confirmed cases, 59 were imported from Angola, 2 are sylvatic (not related to the outbreak) and 7 are indigenous.

Vaccination campaigns have conducted on affected health zones in Kinshasa and Kongo Central. Reactive vaccination campaigns will start on 20 July, in Kisengo health zone in Kinshasa province and in Kahemba, Kajiji and Kisandji health zones in Kwango province.

Preemptive vaccination is planed to vaccinate districts bordering Angola. So far, WHO has deployed 32 experts of which 26 are currently in the field.
3.3 Uganda

The outbreak in Uganda was fully controlled. As of 8 Jun 2016, a total of 91 cases including 3 deaths had been reported with 7 confirmed cases in Masaka (5), Rukungiri (1) and Kalangala (1)) districts. Sequencing showed a high similarity with the YF outbreak in 2010 in Northern Uganda. Of those tested negative for Yellow fever 10 has turned out to be positive for O’nyong’nyong mainly from Masaka few from other districts (6 from Masaka 1 each from Rukungiri, Bukomansimbi, Fort portal, and Kyenjonjo).

Uganda will continue to intensify it surveillance and preparation is underway to introduce Yellow fever vaccine into the routine immunization program. The country is preparing to conduct After Action Review to evaluate the response and improve preparedness.

3.4 Other countries

Guinea has reported 39 suspected cases since January 2016, including 8 probable cases. Two of these probable cases, tested in the Institute Pasteur Dakar (IPD), were IgM positive for yellow fever. Additional analyses are underway to confirm these two samples by serum neutralization.

The situation in Ghana remains the same. Ghana has reported four suspected cases from two regions: three in Brong-Ahafo region and one from Volta region. Investigations are ongoing to determine the vaccination status of the cases and to rule out a link with Angola or DRC. These are most likely sylvatic cases as these areas are known to be endemo-epidemic for yellow fever.
4. Cholera outbreaks

Between January - June 2016, a total of 31,543 cholera cases including 536 deaths (CFR: 1.7%) were reported from 15 out of 47 Member States. Three countries account for 84% of the cases: DR Congo (39%, with CFR: 2.3%), Tanzania (26%, with CFR: 0.8%), and Kenya (19% with CFR: 1.3%). Overall, cholera outbreaks increased, probably due to the heavy rains and the effect of El Niño in East and Southern Africa. The distribution of cholera cases and deaths is shown in Figures 4 and 5.

In response to the cholera outbreaks, WHO and partners continue to provide support to the respective Ministries of Health in the areas of coordination, surveillance, laboratory, case management, WASH, and social mobilization. Reactive OCV campaigns have been conducted in South Sudan, Cameroon, Malawi and Tanzania.
5. Zika Virus Disease

In the African Region, Zika virus has been confirmed in Cabo Verde in October 2015 and Guinea Bissau in June 2016. The Cabo Verde Zika outbreak is linked to the Americas which was declared a PHEIC on 1 February 2016. As of 12 June 2016, 7,585 suspected cases of Zika including nine (9) microcephaly cases were reported among newborn babies of Zika infected mothers. As of 27 May 2016, 202 cases have been laboratory confirmed. There has been a decline in the number of reported cases in Cabo Verde.

Guinea Bissau has reported confirmed cases of Zika virus in the Island of Bijagos. The cases were confirmed by Institute Pasteur Dakar (IPD) on 29 June 2016. Three of 12 samples shipped to IPD tested positive for Zika virus by PCR. To facilitate genetic sequencing, additional serum were collected and sent to IPD on the 1st of July, 2016. Results are awaited. This will allow identify the origin of the outbreak.

Guidelines documents and information packages on preparedness and response to Zika virus disease were distributed widely to all the countries of the region.
6. Other ongoing outbreaks

6.1 Cholera in Democratic Republic of Congo

DR of Congo continue to experience Cholera outbreak. Between 01 January and 07 July 2016, a total of 12,514 cases including 300 deaths (CFR: 2.4%) were reported from 10 provinces out of 11 (Figure 4 and 5); with Katanga province being the most affected.

No decline observed in reported number of cases and deaths since the beginning of the year. On average, 450 cases and 12 deaths have been reported weekly.

The Ministry of Health with support from WHO and other partners continues to implement cholera preventive and control measures. These include strengthening of surveillance; implementation of water and sanitation activities; increased public health awareness and continued advocacy for resource mobilization. On 23 June 2016, WHO graded the cholera outbreak in DR Congo as level 2 in accordance with the WHO internal Emergency Response Framework (ERF). Incident Management System (IMS) is being established; staff needs has been identified and deployment plan is being prepared. Request for OCV has been sent to ICG and results are awaited.
6.2 Chikungunya in Kenya

On 28 May 2016, the Ministry of Health in Kenya reported to WHO of an outbreak of Chikungunya virus disease that started in the 1st week of May 2016. As of 14 June 2016, a total of 1,394 cases with 0 death had been reported from the Mandera County. Of the 82 samples tested, 25 were turned out to be positive for Chikungunya virus by KEMRI Arboviral laboratory in Nairobi.

WHO and partners are supporting the country in the areas of coordination, surveillance, case management, Laboratory capacity and vector control.
7. Discussion

Yellow Fever: This YF outbreak has been complex and challenging. WHO and other partners are dealing with the largest outbreak to-date of yellow fever in a dense, urban setting. Despite the challenges, WHO, partners, and the governments of Angola and DRC have managed within 6 months of the first reports of the outbreak to arrive at the situation where there have been no new confirmed cases in Angola for 6 weeks. During the same period, WHO also supported Uganda to stop transmission of a separate yellow fever outbreak that was not linked to the Angolan outbreak. Within 2 weeks of Angola notifying WHO of an outbreak of yellow fever in January this year, almost 2 million vaccines had been shipped to the country from the stockpile managed by the International Coordinating Group (ICG) for Vaccine Provision.

Cholera: During this reporting period, there have been reports of recurrent outbreaks of cholera in the eastern and southern Africa region mostly from areas previously affected in the DRC, Tanzania and Kenya. In the DRC, the outbreak continues to spread. Overall, in 2016 there has been a rise in reported cases of cholera compared to same period in 2014 and 2015. This rise is partly due to the spread of the infection to 7 non-endemic provinces in hard to reach areas along the river Congo. The risk of further spread of cholera within the provinces and beyond the borders is high because the predisposing factors still exist including: low latrine coverage, open defecation, and the use of unsafe water. The persistence of some risk factors in a number of areas lies outside the direct responsibility of the health sector. Therefore there is a need to for a multisectoral approach., including social services for communities in river shore regions and remote islands. It is also critical that a multisectoral long term approach be adopted to ensure effective control of cholera and other acute diarrhoea diseases of epidemic potential.

8. Conclusion

Outbreaks have major consequences when health systems are weak. During the Ebola outbreak, Senegal, Nigeria, and Mali had inadequate health systems but a high level of alert and preparedness. In addition strong leadership and coordinated support from partners allowed these 3 countries to defeat Ebola with little onward transmission. Weak health systems at all levels make us all vulnerable to the threat of epidemics and other health emergencies.

Moving forward, there is an urgent need to sensitize continental, national, and local governments to build robust health systems to prevent, detect, and respond to outbreaks. Further, there is a need to take advantage of existing and new opportunities such as : the GHSA, the African Union Commission, the African Centers for Disease Control and Prevention, the Regional Economic and Health Communities and country legislators and policy makers to ensure that Africa is better prepared.

Finally, there is a need to engage ministries of defense to propel the notion of national security. The greatest protection will come when all countries have fully complied with the IHR and achieved universal health coverage. Robust surveillance systems are critical to nip health emergencies in the bud. Moreover, Africa needs to build world class infrastructure to prevent, detect, and respond to outbreaks within a broader realm of strong health systems. The new WHO health emergency programme (WHEP) offers us an opportunity to collectively act now to limit the loss of lives from outbreaks and health emergencies.
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