Regional Health Working Group

8 November 2016

Dakar

Coordination
Agenda

• Follow up from last meeting
• Outbreak update
• Humanitarian update
• Reproductive health – mapping of who doing what
• Revitalizing the working group
• AOB
• Farewell to Dr Nkunku
Outbreak updates

- Rift Valley Fever: Niger
- Yellow Fever: Angola / DRC
- Cholera: Dosso (Niger) and Ghana
- Cerebro–spinal meningitis
- Measles: DRC
- Polio: Nigeria
RVF Outbreak Update - Niger
Between 02 August (week 31) and 31 October (week 43), a total of **162 cases** of fever, Rift Valley including **32 deaths** have been reported in Niger (CFR 19.7%)*

- The health districts of Tchintabaraden et de Tassara have registered the largest number of cases and deaths.

- The number of cases per week reached a peak in week 41 but now seems to be on the decline.

**History**
- The index case (02 August) occurred at the village of Egawane, Tchintabaraden DS, Tahoua Region
- Notification at central level on August 18, 2016.
- Declaration of the epidemic by national health authorities on September 20, 2016.

*latest data from Comité Nationale de Gestion des Epidémies (1/11/2016)
## RVF Outbreak in Niger

<table>
<thead>
<tr>
<th>District</th>
<th>Cases</th>
<th>%</th>
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<tbody>
<tr>
<td>Abalak</td>
<td>6</td>
<td>3.7</td>
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<tr>
<td>Keïta</td>
<td>9</td>
<td>5.5</td>
</tr>
<tr>
<td>Madaoua</td>
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<td>1.2</td>
</tr>
<tr>
<td>Tahoua</td>
<td>1</td>
<td>0.6</td>
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<tr>
<td>Tassara</td>
<td>35</td>
<td>21.6</td>
</tr>
<tr>
<td>Tchintabaraden</td>
<td>108</td>
<td>66.7</td>
</tr>
<tr>
<td>Tillia</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>162</strong></td>
<td><strong>100</strong></td>
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</table>
RVF Outbreak in Niger

Evolution hebdomadaire des cas et décès de S31 à S43
(02/08/2016 au 31/10/2016)
Suspected cases of Rift Valley Fever according to their profession weeks 31 to 42 2016 in districts of Abalak, Tilia, Tassara, Tchintabaraden and Keita (Tahoua Region) of Niger
RVF Outbreak Response

Laboratory/surveillance

- A total of 76 samples were collected and sent to the laboratory of the IPD and CERMES of Niamey, with the support of experts from the IPD. 74 were analyzed of which 12 were confirmed by IgM tests and/or PCR.
- Ongoing training of CERMES biomedical technicians on ELISA and PCR.

Actions taken:

- Continued support for patients - Ministry of Public Health in collaboration with BEFEN / ALIMA.
- Finalization and sharing with partners of RVF national response plan consolidated from plans developed at central, regional and departmental levels.
- Press conference held at the MOH on evolution of the RVF epidemic.
RVF Next Steps

Actions led by WHO country office and AFRO:

- Coordination committee meeting held for management of the outbreak with the participation of the IPD team
- Joint IPD / MSP entomological investigation to gather specific additional data for RVF
- Continuation of joint WHO / MSP investigation of RVF outbreaks in Keita Health District
- Finalization of the RVF response plan
- 21 October – visit to WHO country office, of FAO team consisting of four experts (epidemiologists and virologists)

Gaps

- Training of extra laboratory staff in ELISA and PCR for laboratory diagnosis of RVF

Next steps

- Continued medical care of hospitalised patients
- Organisation of a round table with donors to advocate for financing of the consolidated plan
- Proposed action as RHWG?
Cholera outbreaks
Cholera Outbreak Update

- Cholera regional update for week 40: Between January – week 40 2016, **24,335** cholera cases including **706** deaths (CFR: 2.9%) were reported from 19 WCARO countries.

- The most affected countries: DRC, Benin and Nigeria and CAR with by far the highest number of cumulative cases in DRC (22,558 cases, 649 deaths, CFR 2.9%). The number of cases per week has now sharply reduced in North and South Ubangi provinces of DRC and also in CAR.

- Cases from new outbreaks reported in Niger (Dosso – 20 October) and Ghana (Cape Coast District, Central region – 21 October) are not included in the above figures but are discussed below:
Cholera Outbreak Niger

Niger Alert: Dosso

- On 20 October, the authorities in Dosso received reports of ‘gastroenteritis’ in the village of Bella. Between **20 - 26 October**, **27** people were affected and **10** deaths reported. A joint team from the Ministry of Health, WHO and UNICEF was sent to monitor the situation and needs. Laboratory results confirmed cholera.

- All patients are being cared for in an isolation area with cholera kits that had been prepositioned by WHO in all districts. All efforts made to contain the disease, including community sensitization regarding prevention, symptoms, need for rapid treatment seeking, and free treatment available at the PHC centres.

Gaps

- Further support will be necessary to reinforce surveillance. Aim is to finalize as fast as possible the national emergency response plan which will help to estimate the full needs and mobilize resources.

- Any further information from group members?
Ghana

- An outbreak of cholera in Cape Coast district, Central region started on 21 October 2016
- The number of cholera cases has shown dramatic increase, rising from a cumulative caseload of 36 on 26 October to 172 on 2 November, notably with no fatality (CFR = 0%).
- The cholera cases are originating from adjoining peri-urban communities in Cape Coast Metropolitan. The exponential increase in the number of cases denotes high transmission potential of infections in the communities.

Response

- Detailed assessment is being conducted to establish the predisposing factors responsible for the current high attack rate in this outbreak.
- Emergency National Technical Coordination Committee (NTCC) meeting held 28 October 2016 and a multi-disciplinary national rapid response team (RRT) (including epidemiologist and logistician) deployed to Cape Coast 29 October 2016 to support regional and district response.
On 30 October, the national RRT conducted orientation of the regional and district response teams; and facilitated reactivation of the Regional Public Health Emergency Management Committee (PHEMC) including formation of technical sub-committees. It is envisaged that the alignment of the outbreak coordination structures will streamline and harmonize cholera control interventions.

For the moment, there remain some major gaps:

- Sub-optimal implementation of the WASH and risk communication/social mobilization interventions, but problems are expected to be addressed by improving functioning of the coordination structures.
- Vehicles to transport the various field teams have emerged to be inadequate.
- The discussion to designate proper cholera treatment centres has not been concluded. Infrastructural inadequacies thus persist including lack of appropriate cholera beds which poses a major challenge in the case-management of patients.
- Acute shortage of personal protective equipment (PPE) – leading to recycling of disposable PPE. Additionally, IPC practices in health facilities visited have shortcomings that need to be immediately addressed.
- With fully fledged interventions taking shape, the need for operational funds becomes critical.
Yellow Fever Outbreaks
From 5 December 2015 to 20 October 2016, 4347 suspected cases, with 377 deaths (case fatality rate, CFR: 8.7%); 884 cases have been laboratory confirmed, with 121 deaths (CFR: 13.7%).

Still no confirmed case since 23rd June. The majority of the probable cases in Angola have been ruled out as yellow fever cases by the Institut Pasteur in Dakar.

Two new probable cases without a history of yellow fever vaccination were reported from Kwanza Sul province in week of 24 October.

Of the forty-five probable cases that were reported in the four weeks to 13 October: 31 have been discarded, two are undergoing further testing and 12 await classification by the committee.
Yellow Fever Situation - Angola

National weekly number of confirmed, probable and negative yellow fever cases in Angola, 5 December 2015 to 13 October 2016

Data source: Yellow fever situation report 28 October 2016. Data for the past four weeks are subject to revision pending ongoing investigation.
Yellow Fever Outbreak - DRC

- From 1 January to 26 October 2016 2987 notified cases reported from all 26 provinces; 78 confirmed cases have been identified from 2800 suspected cases that have been laboratory tested, with 16 deaths (CFR: 21%)

- The last confirmed non-sylvatic case had symptom onset on 12 July.

- A new confirmed, sylvatic case was reported from Bominenge Health Zone in Sud Ubangui province (symptom onset probably 17 August).

- Fourteen probable cases remain under investigation (3 in Kinshasa, 8 in Kwango and one case each in Bas Uele, Kwilu, and Lualaba provinces).
National weekly number of confirmed and negative yellow fever cases in Democratic Republic of the Congo, 21 September 2015 to 26 October 2016*

Data are subject to revision pending ongoing investigation and reclassification. *Data where date of onset is unknown are not shown.
Yellow Fever Situation - DRC

Distribution of confirmed yellow fever cases in Democratic Republic of the Congo as of 26 October 2016
Yellow Fever Outbreak Response

**Angola**
- Phase two of the vaccination campaign targeting more than two million people in 12 districts in 10 provinces is ongoing.

**DRC**
- Reactive vaccination campaign completed in Feshi Health Zone in Kwango province: **152 492** people vaccinated against target of **146 449 (104.1%)**.
- Reactive vaccination campaign in Mushenge Health Zone in Kasai province (since 20 October) ongoing.
- Monitoring continues in the 62 Health Zones where the pre-emptive vaccination campaigns were conducted in August.

- WHO has sent more than **30 million** vaccine doses to Angola, DRC and Uganda since the beginning of the outbreak through the International Coordinating Group (ICG) global stockpile, with additional doses from Bio-Manguinhos, Brazil.
- As of 25 October, 20 million vaccine approved for Angola and 9.4 million doses for DRC. The number of vaccine doses currently available in the ICG global stockpile for emergency response is 6.9 million.
Cerebro–spinal meningitis update

- During weeks 35 – 39 of this epidemic season (corresponding to September 2016) the situation remained calm, with only sporadic cases being reported by countries (total of 349 cases and 16 deaths across the region for the month).

- From week 1 - 39, a cumulative total of 20,129 suspected cases with 1,655 deaths have been recorded (CFR 8.3%).

- Among the 2,865 pathogens confirmed, the predominant are: S. pneumoniae (35.2%), followed by the serogroups of Neisseria meningitides: NmW (24.3%), NmC (13.1 %) and NmX (2.4 %).

- Countries should improve bacteriological confirmation of sporadic cases and notify where zero cases.
Measles Outbreak - DRC
Measles Outbreak - DRC

- A measles epidemic in the health districts of Nyunzu and Kongolo in the province of Tanganyika was officially declared by MONUSCO and the governor of Tanganyika on 25 October 2016.

- Between weeks 1 - 41, 2,087 cases have been registered, with 55 deaths (CFR: 2.64%) Of these, more than half the cases come from Nyunzu and Kongolo.

Source of information L’avenir newspaper (Kinshasa) 26 October 2016
Measles Outbreak Response

- With the support of WHO and UNICEF, the provincial health authorities announced a vaccination campaign in 11 health zones starting in November.

- In 9 of the health zones, the vaccination campaign will target solely children from 6 to 59 months, whilst in Nyunzu and Kongolo it will exceptionally target children from 6 months to 14 years.

- This is the 2nd vaccination campaign organized in the space of one year in the same health districts. The resurgence of the epidemic is believed to be mostly due to the refusal of some parents to vaccinate their children due to their beliefs and also due to low coverage due to population movement.
Polio outbreak - Nigeria
In August 2016, after more than two years without wild poliovirus being reported in Nigeria, the country reported two new cases of paralysis in Borno State, in an area newly liberated from Boko Haram Islamic extremists. In September a third case was confirmed by WHO and then a fourth case reported by the Minister of Health at the end of October 2016.

WHO has said the virus has been circulating undetected for five years in the area where Boko Haram began its Islamic uprising in 2009. More cases are expected to be discovered in these areas.

The Government of Nigeria is collaborating with WHO and other partners of the Global Polio Eradication Initiative to respond urgently and prevent more children from being paralyzed. These steps include conducting large-scale immunization campaigns and strengthening surveillance systems that help catch the virus early. These activities are also being strengthened in neighboring countries:
**Multi-country response**

- In the second week of October 2016, UNICEF and partners launched an emergency vaccination drive in **18 states in northern Nigeria and neighbouring Chad, Niger, Cameroon and Central African Republic**, to immunize more than **41 million children**.

- Nearly **39,000** health workers were deployed across the Lake Chad basin, where ongoing conflict with the insurgent group Boko Haram has forced 2.6 million people to flee their homes, leading to fears the virus could spread across borders.

- The four-day campaign was the third of five vaccination drives to contain the wild strain of the polio virus. **Two further campaigns are scheduled for November and December in Nigeria and neighbouring countries.**
Polio Outbreak Response - Nigeria

New vaccine combinations in Borno State

- With outbreaks of both WPV and cVDPVs in Nigeria this year, several vaccines are being used in combination to generate the highest level of immunity possible. In response to the detection of a strain of cVDPV2 in May in Borno, three vaccination rounds were using monovalent oral polio vaccine type 2. Giving OPV in monovalent form generates higher immunity against the virus type targeted.

- In addition, since July, children in Borno have been vaccinated with bivalent OPV and a vaccination campaign took place reaching children with the inactivated polio vaccine (IPV), which boosts immunity against all three strains of the virus.

- By using this combination of vaccines in Borno, these vulnerable children are being given the best chance at protection against polio, and the programme has the best chance of stopping the virus, this time for good. Yet any vaccine combination is only as good as the number of children it reaches; accessing children in currently inaccessible areas of Borno remains the topmost priority for the programme.

For more information: Global Polio Eradication Initiative (GPEI)
http://polioeradication.org/who-we-are/strategy/
THANK YOU!