**Discussion:** Transmission of Lassa virus is still largely due to low level of knowledge of the disease in these communities. Current awareness campaign strategy is not winning. There is need to seek for an effective method of Community health education such as mass production and distribution of information leaflets on lassa fever in the local language.

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**Yellow fever outbreak investigation and response, Darfur State, Sudan, September-November 2012**  
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**Background:** Sudan is in the yellow fever (YF) belt of Africa. In 2005 last outbreak of YF was detected in South Kordofan. In September 2012 Darfur States started to report the emerging of YF cases. The ongoing field investigation and management of YF outbreak was conducted to establish existence of outbreak, describe epidemiology of disease and to provide feedback for prevention and control.

**Methods & Materials:** A field based assessment was conducted by interviews, lab test, questionnaires and standard lab forms. Interviews conducted with key informants, patients, health personnel, family of deceased and nomads in the city and market. Blood samples taken. Quantitative and qualitative data analyzed using SPSS for interpretation of results.

**Results:** From Sep 1st thru 28th Nov 2012 a total of 578 cases reported to Federal Ministry of Health (FMOH) and resulted in 129 deaths, with CFR = 29%, AR 22.3. Common symptoms include: fever (98%), headache (71%), bleeding manifestation (50%), jaundice (39%). The most affected age group was 15-29.9 years (51%). All cases were notified from Darfur states, (Central 62%), East (0.5%), West (17%), North (11.5%) and South (9%), where 30 localities out of 57 were included. Male to female ratio 2:1. Similar sex and age distribution of exposure found among nomads and residents. Risk factors include: nomadic lifestyle, refugee camps, mountainous areas, presence of monkeys and vectors. Two samples out of first five were confirmed by IgM ELISA test and RT-PCR by the WHO reference laboratory for YF in Dakar, Senegal. Total of 67 samples from outbreak processed locally in National Public Health lab revealed 11 positive, 11 negative for YF, 2 negative 2 positive for flavivirus.

**Conclusion:** FMOH detected YF outbreak in Darfur states and the causes of the disease are declining after measures were taken to control and prevent further outbreak which include cases management and isolation. Mass vaccination Parallel direct control measures: environmental-vector control, health education and community mobilization. Lack of infrastructure and the poor security situation in the area certainly complicate situation. Recent report received about the circulation of the mosquito to several parts of the country risking further spread of the disease.

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**Management of Mycobacterium ulcerans disease (Buruli ulcer) in the Territory of Songololo, Democratic Republic of Congo: Outcomes, challenges and prospects**

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**Background:** Buruli ulcer is caused by infection with Mycobacterium ulcerans, an organism which belongs to the family of bacteria that causes tuberculosis and leprosy. Without treatment, the infection leads to destruction of skin and soft tissue with large ulcers usually on limbs, resulting to long-term functional disability. The General Reference Hospital of the “Institut Médical Evangélique” of Kimpese, located in the Territory of Songololo, known to be one of the main Buruli ulcer (BU) foci in the Democratic Republic of Congo, launched in 2004 a specialized BU program, offering inpatient treatment free-of-charge and supplementary aid. Although the number of BU cases admitted in the hospital was rising, a survey conducted in July-August 2008, in the Territory of Songololo, showed that only one in thirteen active BU cases was notified at the hospital at Kimpese in the 8 months prior to the survey.

**Methods & Materials:** We conducted a prospective observational study from 2009 through 2012 to assess the impact of decentralization and integration of BU control activities at the primary level of the health system in Songololo.

**Results:** The preliminary impact evaluation of the decentralization showed: (i) strong increase in case detection (3.6 times more cases detected), four years (2004-2007) before the Songololo survey conducted in 2008, 183 new cases have been reported, while 655 were detected after (2009-2012); (ii) the preponderance of category I lesions the last four years; (iii) around 50% of reported cases were confirmed by at least one laboratory test; (iv) three-quarters of reported cases have been treated in peripheral health centres; (v) increase in number of health areas reporting cases: On average, 15 out of 40 health areas before and 28 out of 40 after.

**Conclusion:** Decentralization and integration of BU control activities seem to be key ways of improvement of access to diagnosis and care at the most peripheral level of the health system. Partnership with health zones are of utmost importance for the implementation of a simple, functional, and efficient surveillance system in a resource-limited context, exportable in other BU endemic regions of the country. Meanwhile, sustaining the project’s impact remains a big challenge in the region.

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