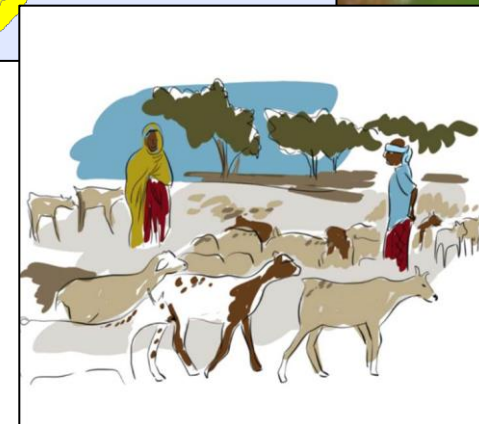
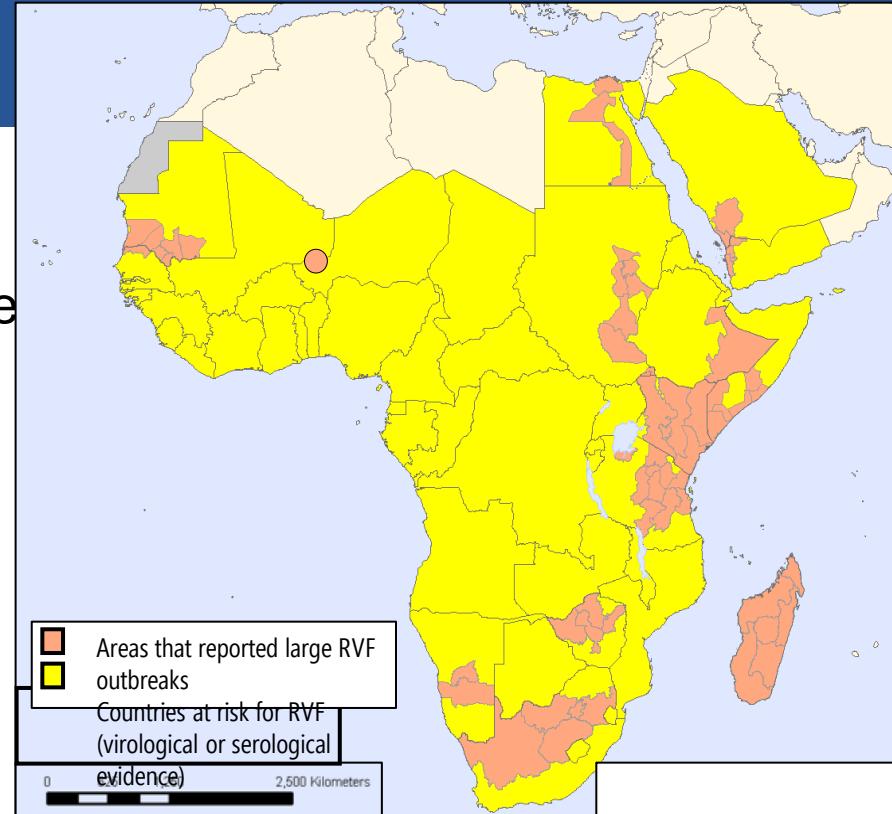


Rift Valley Fever and Community Protection: **Gaps, needs and priorities**

12 November 2025

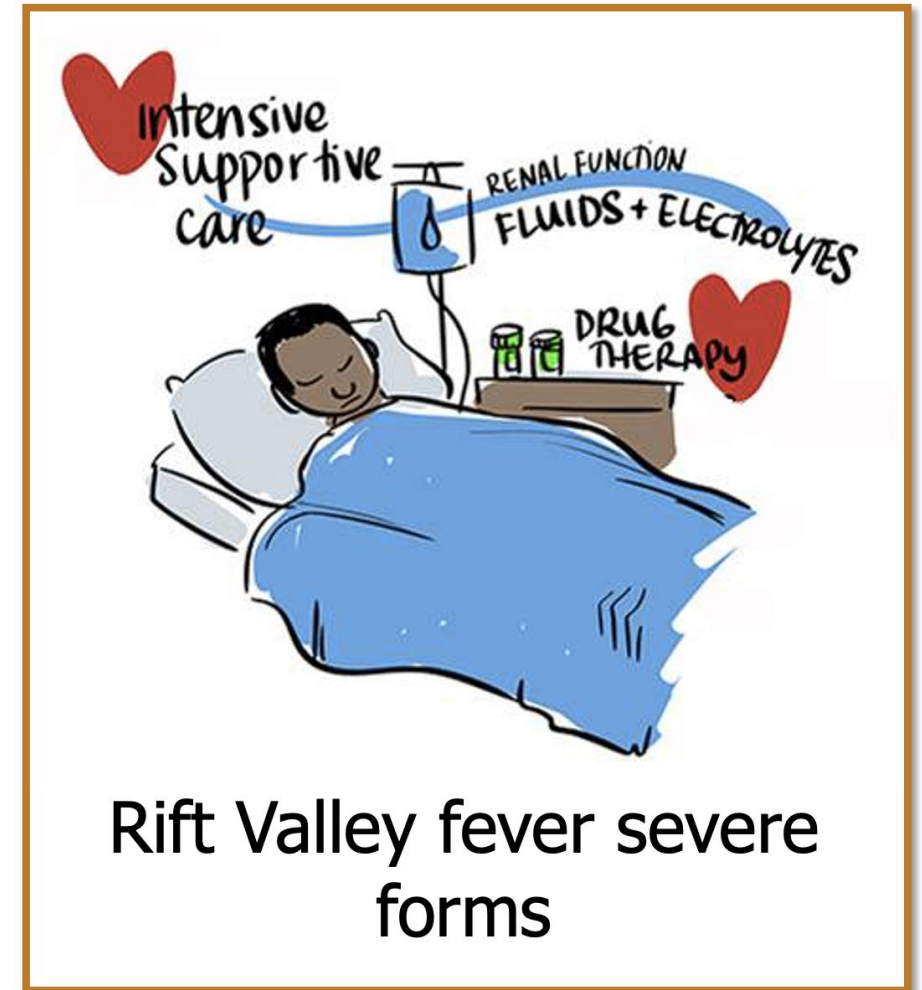
Rift Valley Fever

- RVF is a zoonotic viral disease spread mainly by mosquitoes and contact with infected animal tissues, with no confirmed human-to-human transmission.
- About 98% of human infections are asymptomatic or mild, while roughly 2% progress to severe illness such as ocular disease, meningoencephalitis, or hemorrhagic fever.
- The disease is endemic in sub-Saharan Africa and Egypt, placing nearly 1 billion people at risk.
- Early symptoms resemble influenza—including fever, muscle and joint pain, and headache—with an incubation period of 2–6 days.



Rift Valley Fever

- Diagnosis is difficult because symptoms overlap with other common illnesses like malaria, cholera, and meningitis.
- PCR and serologic tests (IgM, IgG) are the main diagnostic tools.
- No specific antiviral treatment exists, so care is primarily supportive.
- Prevention focuses on vector control, protective measures, avoiding contact with infected animal materials, and animal vaccination (human vaccines are unavailable).
- Surveillance is challenging due to many asymptomatic infections, significant economic losses in livestock, and risks of cross-border spread through animal trade.
- Current outbreaks include Senegal with 424 confirmed human cases and 30 deaths (CFR 7%) and Mauritania with 52 cases and 15 deaths, possibly worsened by co-infections.



Context and Importance of Community Protection in RVF Response

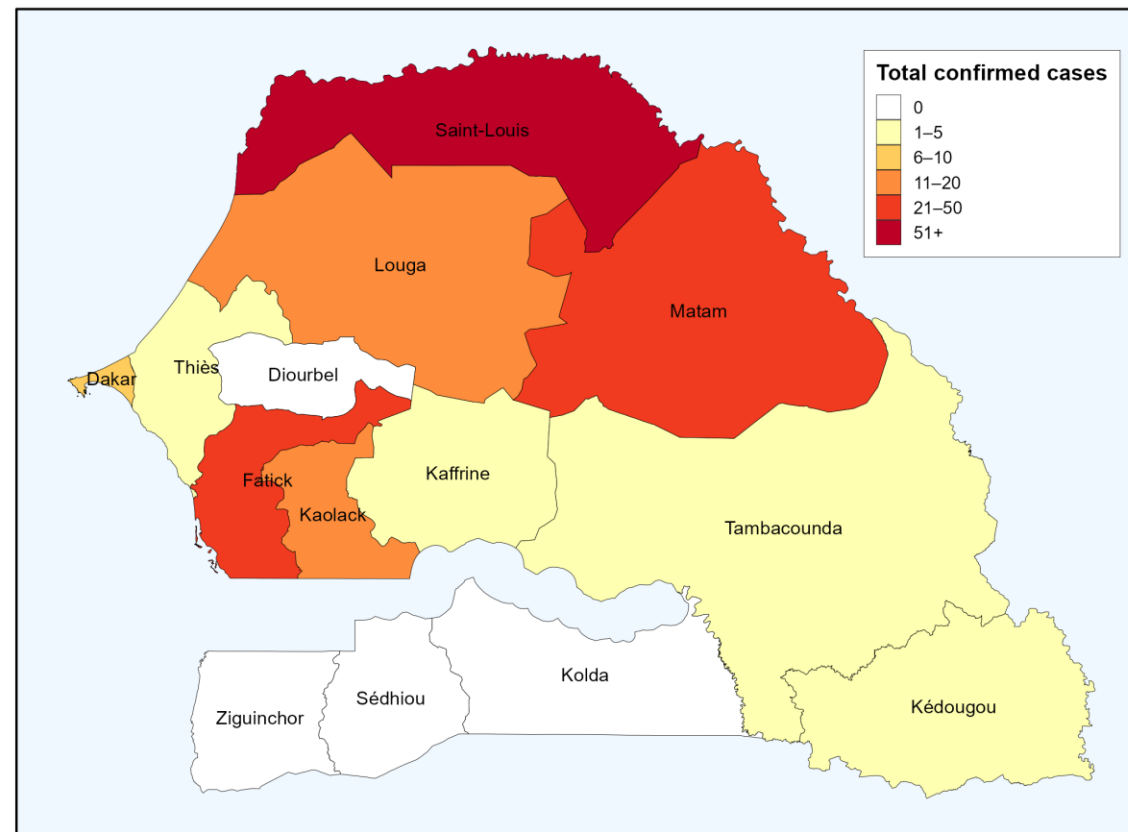
- RVF outbreaks are not only biological events but also deep economic crises that test community resilience and health systems.
- Communities heavily dependent on livestock face complex transmission dynamics linked to environment, behavior, and livelihood.
- Community protection is essential and extends beyond veterinary and laboratory capacities, integrating community perceptions, behaviors, and risks.
- WHO's community protection framework combines:
 - Community mobilization and communication
 - Community-based surveillance and early warning
 - Continuity and accessibility of health services
 - Livelihood and social protection
 - Local leadership and governance
- Data from communities is critical to understand perceptions, barriers, and socio-economic impacts of RVF. Without evidence from communities, technical interventions risk failure.
- The One Health approach is central, requiring coordination across human, animal, agricultural, and food sectors.

RVF in Senegal: Situation

- Senegal has recorded 424 confirmed human RVF cases across 32 departments, with St-Louis region accounting for 75.9% (322 cases).
- A total of 30 deaths have occurred, giving a 7.1% CFR, with adult males—especially breeders and housewives handling small ruminants—most affected.
- Human cases started in early September and show a decreasing trend since week 42, with CFR also declining due to better surveillance and case management.
- Animal infections include 302 confirmed cases from weeks 38–45, mainly in sheep (51%) and goats (41%), with 1,935 animal abortions reported.
- Animal cases span 11 regions, and notably, Kedougou reported human cases without corresponding animal cases.

Cumulative Human RVF Cases by Region

As of 09 November 2025

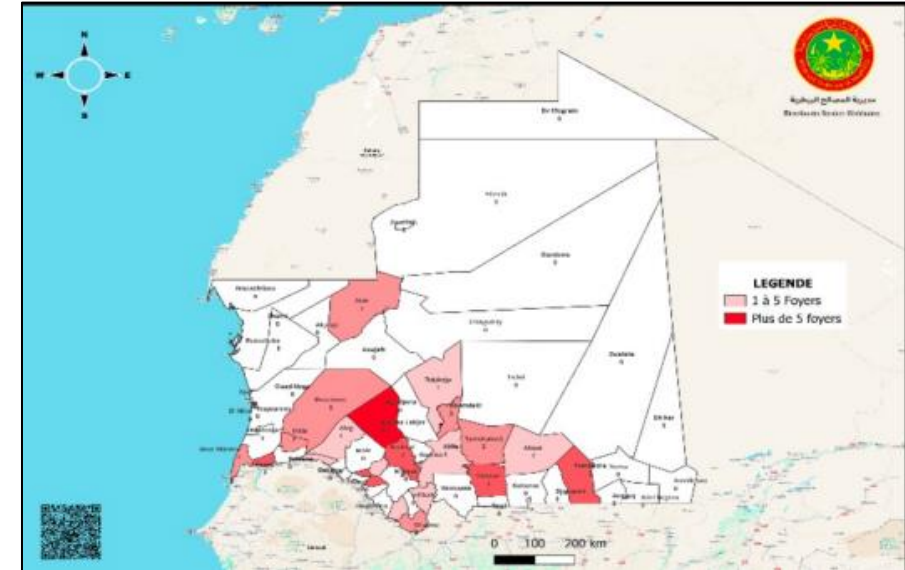


RVF in Senegal: Response

- Senegal activated its PHEOC, formed national and regional IMSTs, updated its RVF response plan, and convened a One Health Technical Working Group.
- Surveillance measures included active case search, investigations, deployment of SURGE teams and entomologists, and use of the RVF DHIS2 tracker.
- Laboratory capacity was strengthened through mobile labs deployed by national and partner institutions.
- Clinical care involved hospital management for severe cases and home-based care for mild infections.
- Response efforts included vector control, RCCE activities, logistics support with WHO assistance, and animal health actions such as surveillance, testing, and peri-focal vaccination.
- The Pasteur Institut Dakar supported community-based surveillance integrated into Senegal's national 4S system, training local actors to report suspected cases via the Redcap app for real-time verification.

Mauritania

- * Mauritania has reported 52 confirmed human RVF cases across 13 districts, with 15 deaths and a notably high CFR of 28.8%.
- * Most human cases occur in adult males (78% male, 73% adults), based on 237 samples tested with a 20.3% positivity rate using PCR only.
- * Co-infections include 49 dengue cases, with two patients infected with both dengue and RVF.
- * The country is concurrently facing a diphtheria outbreak with 258 confirmed cases in 2025, sharply increasing since epidemiological week 36.
- * Animal outbreaks total 63 across 25 districts, primarily affecting goats and camels, with 225 positives from 975 samples (23% positivity).
- * Most animal activity is concentrated in southern and central provinces, where high pastoral density and cross-border livestock movement facilitate transmission.



RVF cases in animals as of 4 November 2025

Mauritania

- Coordination efforts involve multi-sectoral meetings, One Health committees, development of a national response plan, and partner engagement including CDC and FAO.
- Surveillance includes enhanced monitoring in high-risk areas, active case searches, and joint outbreak investigations for RVF and diphtheria.
- Laboratory confirmation is conducted by PCR at the National Institute of Public Health Research, alongside isolation and treatment of severe cases supported by Emergency Medical Teams.
- Animal health actions include vigilance notices to veterinarians, distribution of pharmaceuticals and vector control tools, PPE supplies, and widespread community awareness materials.

Public Health Actions: WHO support in Senegal and Mauritania

- In both countries the **Incident Management System activated**, supported by a **joint WHO HQ and AFRO IMST**. Event graded **Grade 2** on 13 October, and a **CFE request approved on 20 October**. In both country, focus on :
 - **Support surveillance activities and expand diagnostic capacities** at district level (including trainings) in human and animal health sectors.
 - Scale up RCCE efforts significantly to focus on **meaningful engagement with the most affected groups** (e.g. herders, slaughterhouse workers) to raise awareness of transmission risks, preventive measures, care pathways, and access to trustworthy information.
 - **Organize targeted training** for healthcare worker, community health care workers and community-based animal health workers on RVF awareness and preventive measures, zoonotic and vector risks, case recognition and management as well as community engagement best practices.
 - **Improve capacities for clinical care** for severe patients through training, provision of supplies, and surge capacity as required.
 - **Procure** and distribute medical, IPC and laboratory supplies based on country needs.
 - Continue supporting **investigation of transmission patterns**, including examination of malaria circulation as well dual mapping of the human and animal outbreaks.
 - Scale up **vector-control** activities, for RVF but also importantly against malaria and dengue.
 - Continue **partner coordination** efforts with FAO, WOAHA and other key operational partners and sectors.

Rwanda experience

- Discussed previous RVF outbreaks in Rwanda (2018 and 2022).
- 2018 outbreak was poorly managed due to **lack of community involvement**; low animal vaccination uptake despite awareness.
- 2022 outbreak was larger and involved the whole country, with improved multisectoral coordination through **district-level command posts** integrating community data.
- Emphasized the importance of community information flow to central authorities for timely decisions.
- Advocates for continued community engagement and digital platforms for ongoing surveillance and information sharing beyond outbreaks.
- Views communities as the **starting point of outbreak detection and response**, not just recipients.

WHO and other information on Rift Valley fever

中文 **English** Français Русский Español عربي

Rift Valley fever

World Organization for Animal health

- [Information on Rift Valley fever](#)
- [Manual of Diagnostic Tests and Vaccines for Terrestrial Animals](#)
- [Applying the One Health principles: a trans-sectoral coordination framework for preventing and responding to Rift Valley fever outbreaks.](#)

Food and Agriculture Organization

- [Rift Valley fever action framework](#)
- [Rift Valley fever surveillance manual](#)
- [What you need to know about Rift Valley fever](#)
- [Rift Valley fever \(RVF\) Early Warning Decision Support Tool \(RVF DST\)](#)

Emergencies

Rift Valley Fever



WHO/IP. Formerly

Rift Valley Fever (RVF) is caused by a virus transmitted by mosquitoes and blood feeding flies that usually affects animals (commonly cattle and sheep) but can also involve humans. In humans the disease ranges from a mild flu-like illness to severe haemorrhagic fever that can be lethal. When livestock are infected the disease can cause significant economic losses due to high mortality rate in young animals and waves of abortions in pregnant females.

The virus was first identified in 1931 during an epidemic among sheep on a farm in the Rift Valley of Kenya. Since then, outbreaks have been reported in sub-Saharan Africa, North Africa, and in 2000 Saudi Arabia and Yemen, marking the first reported occurrence of the disease outside the African continent, raising concerns that it could extend to other parts of Asia and Europe.

Causes

Symptoms

Diagnosis

Treatment

Prevention and control



The majority of human infections result from direct or indirect contact with the blood or organs of infected animals. The virus can be transmitted to humans through the handling of animal tissue during slaughtering or butchering, assisting with animal births, conducting veterinary procedures, or from the disposal of carcasses or fetuses. Certain occupational groups such as herders, farmers, slaughterhouse workers and veterinarians are therefore at higher risk of infection.

The virus infects humans through inoculation, for example via a wound from an infected knife or through contact with broken skin, or through inhalation of aerosols produced during the slaughter of infected animals.

There is some evidence that humans may also become infected with RVF by ingesting the unpasteurized or uncooked milk of infected animals. Human infections have also resulted from the bites of infected mosquitoes, most commonly the *Aedes* and *Culex* mosquitoes, as well as from bites of hematophagous (blood-feeding) flies.

Technical information

Disease outbreak news

Rift Valley fever – Gambia
26 February 2018

Rift Valley Fever in Niger
24 November 2016

Rift Valley fever in Niger
29 September 2016

Situation updates

↓ Rift Valley Fever in Niger, situation
update
pdf, 762kb
4 November 2016

↓ Rift Valley Fever in Niger, situation
update
pdf, 777kb

Related links



Pandemic and epidemic diseases (PED)



Risk communication



International Health Regulations (IHR)



Haemorrhagic fevers

EPI-WIN webinar

- View webinar “[Rift Valley Fever and Community Protection: Gaps, needs and priorities](#)”
- Speakers
 - Kai Von Harbou, Unit Head, Community Protection & Resilience, WHO
 - Nina Gobat, Community Protection and Resilience, WHO
 - Alejandro Costa, Scientist, Viral Hemorrhagic Fevers, WHO
 - Albert Gautier Ndione, COUS emergency response team in Senegal
 - Mame Yacine Mbodj, Institute Pasteur de Dakar, Senegal
 - Anselme Shyaka, One Health Specialist, University of Global Health Equity, Rwanda
 - Mathioro Fall, Head of the Animal Health Protection Division, Directorate of Veterinary Services, Senegal