A. General context

Cholera cases were last reported in week 25 of 2011, having spilled over from 2010.

Since week 45 of 2010, no new confirmed measles cases have been reported. However, 38 suspected cases of measles were reported during week 31. Cumulative rebella positive cases from January to date is 121.

Within the region, Rift Valley Fever has been reported in Namibia and South Africa, Viral Haemorrhagic Fever and measles in DRC and cholera in Congo, DRC, Malawi, Mozambique and Zambia and suspected H1N1 cases in Namibia.

B. Epidemic prone diseases

Cholera

Ten out of the Zimbabwe’s 62 districts, namely: Bikita, Buhera, Chiradzulu, Chiredzi, Kadoma, Murewa, Mutare and Mutasa, reported cholera cases from January to June 2011. A total of 1,140 cases and 45 deaths were reported by the 26th June 2011, giving a crude case fatality rate of 4.0%. Of the total reported cases, 320 had been confirmed positive by laboratory tests. Majority of cases 870 (76%) were reported from Manicaland province where 697 (80%) of the cases were reported from Chiradzulu district.

The last cholera cases reported were from Chiredzi district in week 25. Surveillance continues in all districts.

Week 31 (1-7 August 2011)
No new cases of cholera were reported countrywide.

**Measles**

Thirty eight suspected cases of measles and twelve confirmed rubella cases were reported this week. However no cases of suspected measles were reported through the Case Based Surveillance System (CBSS). Cumulative rubella positive cases are now 133.

C. **Events of public health importance within SADC**

**Congo**

**Chikungunya**

As of July 04, a total of 9,424 cases were reported. No death was reported. Cases were reported from Brazzaville (8,880) and Pool (544). Preventive and control measures have been put in place.

**Cholera**

This is an update on the ongoing cholera outbreak in DRC which was first reported to WHO in late May 2011. As of July 28, a cumulative total of 4234 cases with 300 deaths were reported nationally. The four provinces affected are Bandundu, Equateur, Kinshasa and P. orientale. A WHO team is supporting national authorities to assess the public health risk of cholera, including carrying out a rapid logistics assessment.

**Mozambique**

Cholera cases have been reported since early January. Five provinces were affected namely: Nampula, Manhica, Cabo Delgado, Maputo Cidade and Maputo. As of 1st May 2011, a cumulative total of 1078 cases and 4 deaths (CFR= 0.4%) were reported. MOH distributed 18000 units of certza (water chlorination) in Maputo cidade. Surveillance and alert systems are being strengthened. Standard case management protocols are being implemented and control measures put into place. WHO and other partners supported national authorities in their efforts to control the outbreak. A multisectoral task force with members from the health cluster, WATSAN, education and NGOs has been established to support national efforts.

**Malawi**

The 2010-2011 cholera season in Malawi started on 1st November 2010. Since then six districts of Chikwawa, Nsanje, Blantyre, Chiradzulu and Rumphi have been affected. Stool samples collected from patients for laboratory confirmation, were found positive and Vibrio Cholerae was isolated. During the reporting week, 13th – 19th June 2011, no cases were reported. At national level the cumulative total cases reported is 60 and 4 deaths (CFR= 6.7%). At sub-national level, majority of cases were reported from Chikwawa (39) followed by Rumphi district (15) cases. Four death were reported from Rumphi district (CFR= 26.5%). Cholera mitigation activities including health education for community awareness, chlorination of water at household level, enhanced surveillance and case management are ongoing in the affected districts.

**Measles**

Mwanza district lies on the Southern Western part of Malawi and shares a common border with Mozambique (Zobue district, Tete Province).

Since 17 May 2011, Mwanza district has been reporting an increasing number of cases presenting with signs and symptoms similar to measles. These include generalized body rash, fever and cough. Six blood samples collected from patients for confirmation, at the Kamuzu Central Hospital National Measles laboratory, tested Measles IgM positive. This result surpassed the threshold for laboratory confirmed measles outbreak. As on 17 June 2011, a cumulative total of 26 cases and no deaths were reported from Mwanza district. Complicated cases have been admitted to Mwanza district hospital and an isolated ward has been opened.
The district has enhanced surveillance and conducted a mop vaccination in the affected villages. Affected villages are peri-urban locations around Mwanza Town close to the Malawi -Mozambique border. Mwanza town is a busy port of entry on the Malawi – Zimbabwe border via Mozambique Road. Six Nasopharyngeal swabs were collected for virus isolation and genotyping at the NICD in RSA.

Namibia

**Rift Valley Fever**

A case of Rift Valley Fever was reported in the Hardap region of Namibia on 9 June 2011. A team from the Ministry of Health and WHO country office conducted field investigations. More detailed information will be provided after the preliminary investigations.

**HIN1**

The Ministry of Health and Social Services indicated that eight suspected cases of H1N1 were reported from Wallis Bay district in Namibia on 14 June 2011.
Table 1: Comparison of cholera cases and deaths of 2010 with those of 2011, Zimbabwe, as of week 28

<table>
<thead>
<tr>
<th>District</th>
<th>2010 Cases</th>
<th>2010 Deaths</th>
<th>Total Cases</th>
<th>Total Deaths</th>
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<tbody>
<tr>
<td></td>
<td>2011 Cases</td>
<td>2011 Deaths</td>
<td></td>
<td></td>
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<tr>
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<td>1</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>937</strong></td>
<td><strong>22</strong></td>
<td><strong>1140</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>
Annex 2: Standard case definitions and alert/action epidemic thresholds

1. Cholera Standard Case Definition

Suspected case:

In an area where there is no cholera, any person aged five years or more, presenting severe dehydration or death from acute watery diarrhoea

In an area where there is a cholera epidemic, any person aged two years or more presenting with acute watery diarrhoea, with or without vomiting.

Confirmed case:

A suspected case in which *Vibrio cholerae* sero-groups O1 or O139 has been isolated in the stool.

NB: All suspected cases under the age of two years must be confirmed.

The inclusion of all ages in the case definition somewhat reduces specificity, that is, inclusion of more non-cholera childhood diarrhoea cases (mainly those below 5 years). It does not impede meaningful interpretation of trends. Teams should monitor any shift in the age distribution of cases, which might indicate a changing proportion of non-cholera cases among patients seen.

2. Malaria Standard Case Definition

Uncomplicated malaria

Any person living in area at risk of malaria or with a history of travel to a malaria prone area, with fever or history of fever within 24 hours; with headache, back pain, chills sweats, myalgia, nauseas and vomiting, without signs of severe disease (vital organ dysfunction) is diagnosed clinically as uncomplicated malaria.

Confirmed uncomplicated malaria

Any person with fever or history of fever within 24 hours; with headache, back pain, chills sweats, myalgia, nauseas and vomiting, without signs of severe disease and with laboratory confirmation of diagnosis by malaria blood film or rapid diagnostic test for malaria parasites.

Unconfirmed severe malaria

Any patient living in area at risk of malaria or with a history of travel to a malaria prone area, hospitalised with severe febrile disease with accompanying vital organ dysfunction diagnosed clinically

Confirmed Severe malaria

Any patient hospitalized with *P. falciparum* asexual parasitaemia as confirmed by laboratory tests with accompanying symptoms and signs of severe disease (vital organ dysfunction) diagnosed through laboratory.

Malaria with severe anaemia

Any child aged 2 months to 5 years with malaria and, if an outpatient with severe palmar pallor, or if an inpatient, with a laboratory test confirming severe anaemia. (NOTE: young infants less than 2 months are usually classified as serious bacterial infection and referred for further evaluation.)
D. Events of Public Health concern

There are three main categories of events, which if detected by the national surveillance system, should trigger the use of Annex 2 of the IHR (2005). Annex 2 is the Decision Instrument for the Assessment and Notification of Events that may constitute a Public Health Emergency of International Concern. These are:

i. A case of the following diseases, which are unusual or unexpected and may have serious public health impact and should be notified: smallpox, poliomyelitis due to wild-type poliovirus, human influenza caused by a new subtype and SARS.

ii. Any event of potential international public health concern including those of unknown causes or sources, and those involving other events or diseases (than those listed in i) above and iii) below). Such events may include:

   o environmental health emergencies (natural events, technological incidents, complex emergencies and deliberate events);
   o chemical risk in food (environmental or intentional pollution) and
   o Zoonotic diseases or other infectious diseases.

iii. An event involving the following diseases shall always lead to utilisation of the algorithm (i.e. Annex 2) because they have demonstrated the ability to cause serious public health impact and to spread rapidly internationally: Cholera, pneumonic plague, yellow fever, viral haemorrhagic fevers, West Nile Fever, other diseases that are of special national or regional concern e.g. dengue, RVF and meningococcal disease.