A. General context

The last cholera cases were reported in week 25 of 2011, having spilled over from 2010. This year, 1104 suspected cases of measles have been reported. Of the 628 samples collected and sent for measles confirmation, no positive measles cases were found while 303 positive cases of rubella were found. There are no malaria outbreaks being reported in the country.

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

B. Epidemic prone diseases

Cholera

From January to June 2011, ten out of the Zimbabwe’s 62 districts, namely: Bikita, Buhera, Chimanimani, Chegutu, Chipinge, Chiredzi, Kadoma, Murewa, Mutare and Mutasa, reported cholera cases. By the 26th June 2011, a total of 1140 cases and 45 deaths were reported, giving a crude case fatality rate of 4.0%. Of the total reported cases, 320 were confirmed positive by laboratory tests. Majority 870 (76%) of cases was reported from Manicaland province among which 697 (80%) cases were reported from Chipinge.

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

Week 40 (3–9 October 2011)

No new cases of cholera were reported countrywide.

Suspected Measles
Three suspected cases of measles were reported this week from Mutare.

**Diarrhoea**

Kadoma city declared an outbreak of diarrhea on the 28th Sept 2011. The first cases were recorded on the 5th September 2011 (in week 37). Children under five years old were the most affected group specifically those under the age of two years. E. Coli and Rotavirus were isolated from stool samples. Ngezi suburb reported the highest attack rate of 9 per 100 000. A total of 718 cases were reported of which 238 were reported in week 40. Thirty percent of the cases were treated at FCH (in full since its not a familiar abbreviation). 3 deaths were reported in September.

Figure 3: Diarrhoea Epidemic curve, Zimbabwe, Week 1-40, 2011

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

**Democratic Republic of Congo (DRC)**

**Acute Flaccid Paralysis**

A case of AFP has been reported from Bas-Congo on the 19th August 2011. A mass vaccination campaign was conducted in the area on 8th September 2011. DRC has interrupted polio transmission between 2001 and 2006. A number of AFP cases have started being reported since 2006. A total of 41 cases have been reported in 2007, 5 cases in 2008 and 3 cases in 2009. In 2010 a total of 100 AFP cases were reported.

**Cholera**

As of 30 August 2011, 5 666 cases of which 330 deaths (CFR=5.8%) were reported. Four provinces were affected, namely: Equateur (1 935 cases and 112 deaths, CFR= 5.7%), Bandundu (1 751 cases and 109 deaths, CFR=6.2%), Kinshasa (386 cases and 25 deaths, CFR=6.4%) and Province Orientale (1 594 cases and 84 deaths, CFR=5.2%).

**Tanzania**

An outbreak of measles was reported in West District of Urban West Region in Zanzibar. The outbreak started on the 15th August 2011 in West District. A National Task Force was set up including health staff from immunization, epidemiology and health education units. The response team conducted a reactive campaign in the areas from the 27th to 28th August 2011. By the end of the vaccination campaign, a total of 5,477 children aged between 6 and 59 months were vaccinated and the vaccination coverage was 83.3%. The team from MoHCW will continue to monitor the situation. Public information activities are on-going through the media and religious institutions.
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Zambia

From 22 August to 14 September 2011, a total of 477 human cases of anthrax among which 5 community deaths (CFR = 1.05%) were reported. An estimated 60 to 80 hippo deaths was reported. Available information on the magnitude of the epizootic is limited. Cross border spread of anthrax to the neighboring districts in Malawi is a high possibility. Need to share updated information and situation reports with Malawi. Joint cross-border implementation of activities between Zambia and Malawi are priority. The multi-sector national Epidemic Management Committee consisting of human and animal health departments (including Zambia Wild Life Authority and the University of Zambia, School of veterinary department) has been reactivated and meets on regular basis. Guidelines on control of anthrax have been distributed to the districts to enhance surveillance, case management, health education and enforce regulations for disease prevention.

D. Preparedness and Response
Kadoma Diarrhoeal Outbreak

Water deliveries have remained as the cornerstone intervention. 14 107 households covered by health promotion activities. 5 out of 23 water samples had faecal contamination. 46 sewer blockages were attended to.

E. Timeliness and completeness of data
National data completeness and timeliness reported for week number 39 decreased from 63 to 52% and from 52% to 40% respectively.

F. Acknowledgements

We are very grateful to health workers from facility to district, provincial level and national level for sharing surveillance data. In particular, we recognise those who share complete data on time.

We also acknowledge members of the Health and WASH clusters who share their data with our team. MoHCW recognizes the efforts made by NGOs and other partners that are providing support to them. Information on events of public health importance occurring within SADC is consolidated from the WHO daily summary of health events.
Table 1: Comparison of cholera cases and deaths of 2010 with those of 2011, Zimbabwe, as of week 36

<table>
<thead>
<tr>
<th>District</th>
<th>2010 Cases</th>
<th>2010 Deaths</th>
<th>2011 Cases</th>
<th>2011 Deaths</th>
<th>Total Cases</th>
<th>Total Deaths</th>
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<td><strong>1140</strong></td>
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<td><strong>2071</strong></td>
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</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 5years). 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.)
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E. 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:
   - environmental health emergencies (natural events, technological incidents, complex emergencies and deliberate events);
   - chemical risk in food (environmental or intentional pollution) and
   - 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.