



Highlights

- No Cholera cases reported
- No Typhoid cases reported

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A. General context

In Zimbabwe, cholera cases were reported up to week 25 of 2011, having spilled over from 2010.

Since week 45 of 2010, no new confirmed measles cases have been reported, and the situation is being closely monitored.

Malaria outbreaks were reported in seven districts as at 12 April and malaria cases continue to be reported in some parts of the country. Malaria outbreaks are over.

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

From Week 1 to week 25, 2011, ten out of the 62 districts, namely: Bikita, Buhera, Chimanimani, Chegutu, Chipinge, Chiredzi, Kadoma, Murewa, Mutare and Mutasa, have reported cholera cases. A total of 1140 cholera

Figure 1: Cumulative Cholera cases, Jan – July 2011

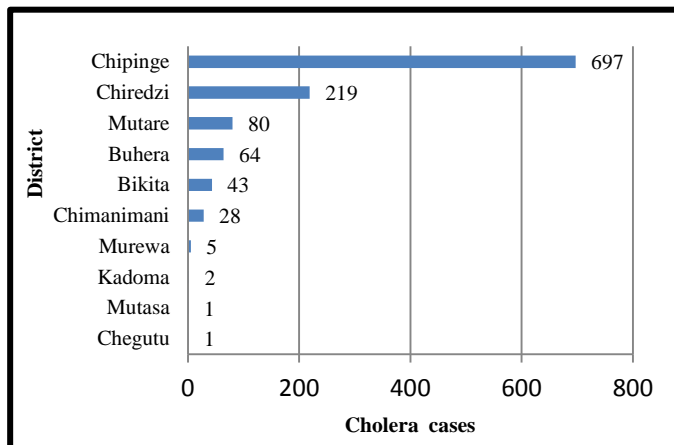
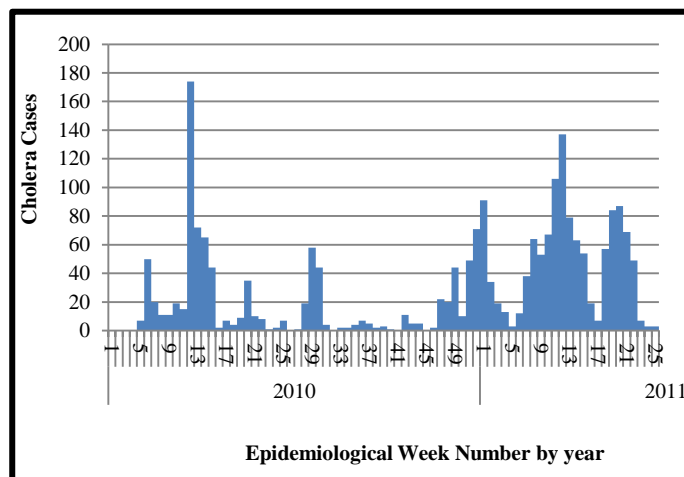


Figure 2: Cholera Epidemic curve, Zimbabwe, Week 5, 2010 to week 26, 2011



cases and 45 deaths were reported by the 17th July 2011, giving a crude case fatality rate of 4.0%. Of the total reported cases, 320 were confirmed positive by laboratory tests. Majority of cases 870 (76%) were reported from Manicaland province where 697 (80%) of the cases were reported from Chipinge.

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

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Antibiotic sensitivity

Antibiotic drug sensitivity tests done show that the following drugs: Tetracycline (doxycycline), ciprofloxacin and ceftriaxone are still effective on *Vibrio Cholerae*.

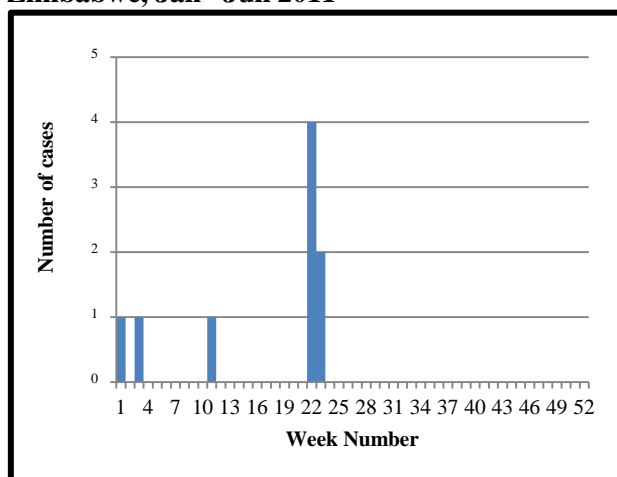
Week 28 (11 - 17 July 2011)

No new cases of cholera were reported countrywide.

Typhoid

No typhoid cases were reported this week. A total of nine suspected typhoid cases have been reported from Harare Central Paediatric Hospital since the beginning of the year. Last case was reported on 12 June

Figure 4: Typhoid epidemic curve, Harare, Zimbabwe, Jan –Jun 2011



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 13, a cumulative total of 3 441 cases with 225 deaths were reported from the following four provinces: Bandundu (1 274 cases and 73 deaths), Equateur (699 cases and 50 deaths), Kinshasa (57 cases and 06 deaths) and P.Orientale (1411 cases and 96 deaths). The overall case fatality rate is 7%. All the affected provinces are along the Congo River hence the risk of cross border transmission of the outbreak. A teleconference was held on 13 July between WHO Country Offices of Congo, and DRC and the WHO Regional Office to strategize coordinated response efforts. The World Health Organization is supporting government in enhancing surveillance, case management, setting of CTC and public health awareness campaigns.

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 has been 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).

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Since 17 May 2011, Mwanza district has been reported an increased 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.

H1N1

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.

D. Preparedness

Cholera

National

The Rapid Response Teams orientation training was held from 12 to 14 July 2011 in Bulawayo City

E. Timeliness and completeness of data

The completeness in data and timeliness of data reporting this week's surveillance is 80% and 62% 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 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.

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Annex 1

Table 1: Comparison of cholera cases and deaths of 2010 with those of 2011, Zimbabwe, as of week 28

District	2010		2011		Total Cases	Total Deaths
	Cases	Deaths	Cases	Deaths		
Beitbridge	17	0	0	0	17	0
Bikita	9	1	43	1	52	2
Bindura	2	0	0	0	2	0
Buhera	130	0	64	0	194	0
Chegutu	32	2	1	0	33	2
Chimanimani	66	0	28	13	94	13
Chipinge	39	2	697	20	736	22
Chiredzi	54	2	219	9	267	11
Chivi	13	0	0	0	13	0
Harare	4	0	0	0	4	0
Hurungwe	171	5	0	0	171	5
Kadoma	160	5	2	0	162	5
Makonde	3	0	0	0	3	0
Mangwe	1	0	0	0	1	0
Masvingo	10	1	0	0	10	1
Mt Darwin	11	1	0	0	11	1
Murewa	0	0	5	2	5	2
Mutare	206	2	80	0	286	2
Mutasa	0	0	1	0	1	0
Mwenezi	5	0	0	0	5	0
UMP	4	1	0	0	4	1
Total	937	22	1140	45	2071	67

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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, nausea 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, nausea 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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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:
 - 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.