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. Typhoid outbreak has been reported in Dzivaresekwa 3 in Harare.

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

Typhoid

A total of 76 Typhoid cases have been reported this year. All of the cases were from Harare city. The recent typhoid outbreak started on the 10th of October. In Dzivaresekwa 3, the outbreak has been attributed to lack of potable water.

30 Typhoid cases reported in Harare
Diarrhoea outbreak in Kwekwe

Figure 1: Total National cumulative Typhoid Cases Jan-30 October

Figure 2: Typhoid Epidemic curve, Harare, 10 – 30 October 2011

Week 43 (24–30 October 2011)

30 cases were reported this week: 1 from Tynwald, 1 from Glen Norah, 3 from Kuwadzana, 4 from Marlborough (Including Good Hope and Westgate) and 21 from Dzivaresekwa.

Diarrhoea

Nationwide
Zimbabwe Weekly Epidemiological Bulletin

The number of diarrhoea cases reported nationwide decreased to 6875 from 7069.

Kwekwe Outbreak

Kwekwe District reported late a diarrhoea outbreak that started on 25 September. As of 30 October a total of 402 cases including 15 deaths of under five children had been reported. The case fatality rate is 3.7%.

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 continues in all districts.

Week 43 (24–30 October 2011)

No new cases of cholera were reported countrywide.

C. Events of public health importance within SADC

D. Democratic Republic of Congo (DRC)

The Ministry of Health of the DRC reports a total of 16 663 cases and 481 deaths (CFR 2.9%) as of 17 October 2011. The 04 provinces (out of 08 provinces) that are experiencing cholera outbreaks, report a total of 7 306 cases and 404 deaths (CFR 6%). These provinces are: Province Bandundu (CFR 6%), Equateur (CFR 5%), Kinshasa (CFR 5%) and Province Orientale (CFR 5%).

Interventions in the areas of epidemiologic surveillance, safe water and sanitation, management of CTCs and community sensitization are being implemented by the national authorities with support from WHO, UNICEF, MSF, COOPI, ALIMA, MDA, Oxfam, RC DRC and IFRC.

Namibia: Acute Haemorrhagic Fever

On 3 October A total of 2 suspected cases both of which were fatal were investigated, clarifying initial unofficial reports of 4 suspected cases. The cause of deaths of the 2 suspected cases were due to non-infectious etiologies. An additional case was included in this report since hospital records indicated an acute illness resulting in death without a clear aetiology dated 28 September. Further investigation confirmed that the cause of death was due to bacterial meningitis.

Food Poisoning

The WHO Country Office has provided a preliminary report regarding a suspected food
borne illness in 10 cases and 3 deaths occurring in Eenhana district, Ohangwena Region, Namibia since 13 October 2011.

A summary description of five cases which included signs, symptoms, treatment protocols, date of onset of illness, date of hospital admission and date of death or current status was provided. The symptoms reported are abdominal pain, vomiting and diarrhea with exposure history of consuming local fruits called omuani and omapwaka. Stool test samples were collected and sent for laboratory testing. Results are pending.

South Africa – Meningococcal disease

This is an update to the meningitis outbreak that is occurring in day care centres in Tshwane district, South Africa.

As of 21 October 2011, daily field visits have been conducted at the affected day care centres since additional 2 cases were detected. Environmental health department has been working with the management of the affected day care centres to improve the conditions.

In the interim, as these measures are being put in place, the affected centres will be monitored daily. Active surveillance activities will continue to be strengthened as well as collaboration with all stakeholders including the community to improve the condition at the day care centre.

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. 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 MoH will continue to monitor the situation. Public information activities are ongoing through the media and religious institutions.

E. Timeliness and completeness of data

National data completeness timeliness reported for week number 43 decreased from 68% to 57% and timeliness decreased from 51% to 43% 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.
Annex 1

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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<tr>
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<td>937</td>
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<td>1140</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 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.)

3. Typhoid Case Definition
Zimbabwe Weekly Epidemiological Bulletin

**Suspected case:** Any person with gradual onset of steadily increasing and then persistently high fever, chills, malaise, headache, sore throat, cough, and, sometimes, abdominal pain and constipation or diarrhoea.

**Confirmed case:** Suspected case confirmed by isolation of *Salmonella typhi* from blood, bone marrow, bowel fluid or stool.

4. **Diarrhoea Case Definition**

**Suspected case:**

Passage of 3 or more loose or watery stools in the past 24 hours with or without dehydration and:

*Some dehydration* -- two or more of the following signs: restlessness, irritability; sunken eyes; thirsty; skin pinch goes back slowly, or

*Severe dehydration* -- two or more of the following signs: lethargy or unconsciousness; sunken eyes; not able to drink or drinking poorly; skin pinch goes back very slowly.

**Confirmed case:**

Suspected case confirmed with stool culture for a known enteric pathogen. *Note:* Laboratory confirmation of specific agent causing outbreak is not routinely recommended for surveillance purposes.

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:

   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.