



Highlights: week 4 (23-29 Jan 2012)

- 104 typhoid cases reported in Harare City
- Increase in malaria cases at national level
- 1 anthrax case reported in Gokwe North

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A. General Context

On-going typhoid outbreak reported in Harare City since 10 October 2011.

No report of outbreaks of malaria, cholera and measles this week countrywide.

No report of Pandemic Influenza A cases this year.

B. Epidemic prone diseases

Typhoid outbreak in Harare City

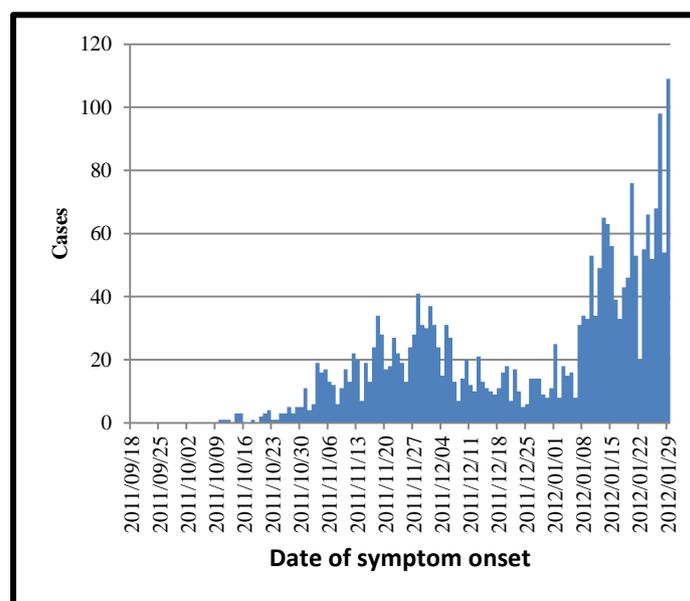
Since 10 October 2011, Harare City has been experiencing an outbreak of typhoid fever. This week, 502 cases were reported giving a total of 1320 cases since the beginning of 2012. The distribution of the week 4 cases by place of residence is shown in table 1. A total of 2412 cases were reported since beginning of the outbreak. The distribution of cumulative cases to date is shown in the map in Figure 2.

Table 1: Distribution of typhoid cases, Harare, 23-29 Jan 2012

Suburb	Cases	%
Kuwadzana	362	72.8
Crowborough	24	4.8
Waterfalls	12	2.4
Dzivaresekwa	12	2.4
Snake Park	8	1.6
Mbare	7	1.4
Mufakose	7	1.4
Tynwald	7	1.4
Warren Park	7	1.4
Grenara	7	1.4
Other Suburbs	49	8.9

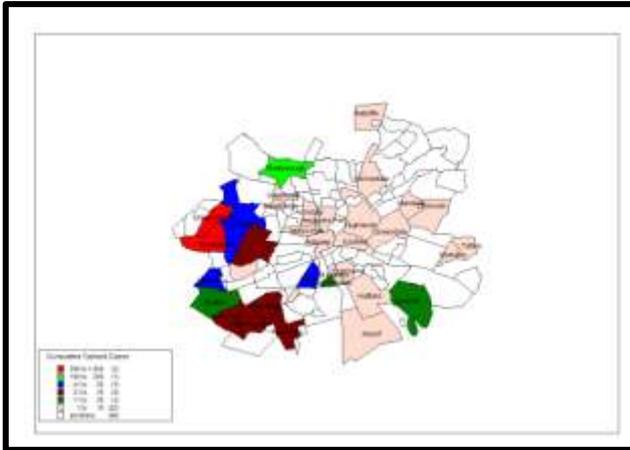
Other Areas: WhiteCliffe, Budiro, Belvedere, Sunningdale, Epworth, Glen View, Hatfield, Hopley, Westgate, Avenues, Avondale, Borrowdale, Greendale, Hatcliffe, Highfield, Kambuzuma, Mabelreign, Mt Pleasant, Ruwa, Mvurwi, Denview, Masasa Park

Figure 1: Harare Typhoid Epidemic Curve, 10 Oct 2011 - 29 Jan 2012



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Figure 2: Distribution of typhoid cases by place of residence, 10 Oct 2011- 29 Jan 2012



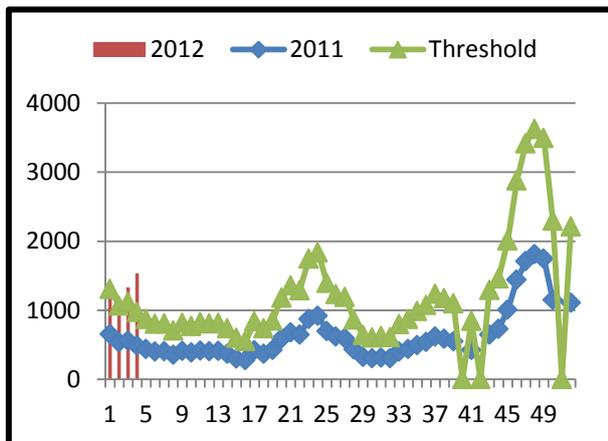
Anthrax

One new case of anthrax reported this week from Gokwe North. The national cumulative cases as of 29 January are six.

Diarrhoea outbreak

This week, a total of 7705 cases of diarrhoea were reported. The most affected areas were Harare 1537 (20%) followed by Chegutu 299 (3.8%) and Mutasa 269 (3.5%)

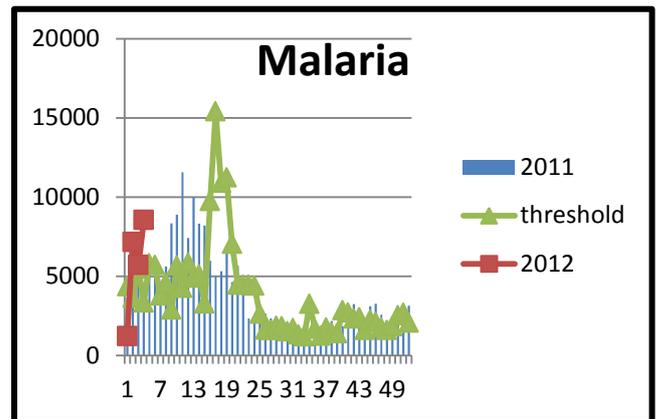
Figure 3: Comparison of weekly diarrhoeal cases of 2012 with those of 2011, Harare City, as of week 4



Malaria

This week, 8547 cases and 13 deaths were reported. The most affected areas were Mutasa 1321 (15%), Mutare 902 (11%), Chimanimani 843(10%), Mudzi 575 (7%) and Rushinga 520(6%). Since the beginning of 2012, a total of 23799 cases and 20 deaths (CFR= 0.08%) were reported.

Figure 4: Comparison of national malaria cases 2012 vs 2011 and epidemic threshold



C. Completeness and timeliness of the National data

National data completeness and timeliness reported this week n° 4 increased from 63% to 70% and from 46% to 50% respectively

D. Events of public health importance within SADC

Cholera

In Angola, a total of 400 case of which 26 deaths were reported (CFR=0.065%).

Anthrax

No update was received on the anthrax situation.

E. Acknowledgements

All health workers, operating at different levels of the health system, providing information are greatly acknowledged. In addition, special thanks to the members of Health and WASH clusters for sharing their data with our team.

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MOHCW is grateful to all Partners including UN family and NGOs for their support.

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: Classification of Events that may constitute a Public Health Emergency of International Concern

There are three groups of events if detected by the national surveillance system should trigger the use of the IHR (2005) Decision Instrument to be notified as they may constitute Public Health Emergencies of International Concern. These are:

1. A case of unusual or unexpected diseases which may have serious public health impact: smallpox, poliomyelitis due to wild-type poliovirus, human influenza caused by a new subtype and SARS.
2. Any events of potential international public health concern including events of unknown causes or sources and those involving other events or diseases:
 - environmental health emergencies (natural events, technological incidents, complex emergencies and deliberate events)
 - chemical risk in food (environmental or intentional pollution)
 - Zoonotic diseases or other infectious diseases.
3. Any of following diseases that have demonstrated the ability to cause serious public health impact and spread rapidly and 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.

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Annex 2: Standard Case Definitions

Diseases	Standard Case Definitions
Cholera	<p>Suspected case</p> <ul style="list-style-type: none"> In an area where there is no cholera outbreak, any person aged five years or more, presenting with severe dehydration or death from acute watery diarrhoea In an area where there is a cholera outbreak, any person aged two years or more presenting with acute watery diarrhoea, with or without vomiting
	<p>Confirmed case A suspected case in which <i>Vibrio cholerae</i> sero-groups O1 or O139 has been isolated in the stool.</p>
	<p>Note</p> <ul style="list-style-type: none"> 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.
Malaria	<p>Suspected uncomplicated malaria Any person living in a malaria area or history of travelling in a malaria area within the last 6 weeks, presenting with fever, malaise, chills, and rigors, without signs of severe disease such as vital organ dysfunction</p>
	<p>Confirmed uncomplicated malaria Is suspected uncomplicated malaria with laboratory diagnosis by malaria blood slide or RDT for malaria parasites</p>
	<p>Confirmed severe malaria A patient hospitalized with <i>P. falciparum</i> asexual parasitaemia as confirmed by laboratory tests with accompanying symptoms of severe disease (vital organ dysfunction)</p>
Typhoid	<p>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</p>
	<p>Confirmed case A suspected case confirmed by isolation of <i>Salmonella typhi</i> from blood, bone marrow, bowel fluid or stool</p>
Diarrhoea	<p>Suspected case Passage of 3 or more loose or watery stools in the past 24 hours with</p> <ul style="list-style-type: none"> or without dehydration or some dehydration and two or more of the following signs: restlessness, irritability, sunken eyes, thirsty, skin pinch goes back slowly, or severe dehydration and 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
	<p>Confirmed case Suspected case confirmed with stool culture for a known enteric pathogen.</p>
	<p>Note <i>Laboratory confirmation of specific agent causing outbreak is not routinely recommended for surveillance purposes.</i></p>

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Annex 3: Alert/Action Epidemic Thresholds for selected epidemic prone diseases and other diseases of public health importance in Zimbabwe

Disease or condition	Alert Threshold	Action Threshold
Measles	5 suspected cases within a district in a month	1 measles IgM confirmed case <i>Note: This also applies to closed settings like Refugee camps, schools, or health facilities</i>
Meningococcal meningitis	1 suspected case	1 confirmed case
Plague	1 suspected case	1 confirmed case
Rabies (suspected rabid bites)	1 case of a bite from suspected rabid animal	1 case of a bite from suspected rabid animal
Trypanosomiasis	1 suspected case	<ul style="list-style-type: none"> 1 case in an area that is not endemic or For endemic areas 3 cases per 100,000
Typhoid fever	1 case	<ul style="list-style-type: none"> 5 suspected cases per 50,000 population or 20 suspected cases per District's catchment area or any 1 confirmed case by blood culture
Viral Haemorrhagic Fever	1 suspected case	1 confirmed case
Outbreak of unknown cause	3-5 cases or deaths with similar symptoms that don't fit most case definitions	Any cluster of cases or deaths that had similar symptoms over a short period of time and fail to respond to treatment for the usual causes of the symptoms
Acute Flaccid paralysis (AFP) / Polio	1 AFP case	1 confirmed case of polio (virus isolated).
Dysentery	5 cases or more per reporting site per week	<ul style="list-style-type: none"> A 2-fold increase in the number of cases compared to an expected number usually seen in previous season – specific time period Any increase in number of deaths due to bloody diarrhoea
Cholera	1 suspected case	1 confirmed case (where it has not been reported before)
Diarrhoea under five	Increasing number of cases in a short time	Doubling of no of cases as compared to the same time period of a previous year.
Malaria	Increasing cases above the median	<ul style="list-style-type: none"> N^o of cases that exceed those in the 3rd quartile (the upper limit) of the expected number of cases or N^o of cases that exceed the mean plus 1.5 x Standard Deviations (Mean + 1.5 SD).
Neonatal Tetanus (NNT)	1 suspected case	1 confirmed case
Human influenza caused by a new Subtype	1 suspected case	1 confirmed case
Severe Acute Respiratory Syndrome (SARS)	1 suspected case	1 confirmed case
Adverse Events Following Immunisation (AEFI)	1 suspected case	1 confirmed case
Acute Viral Hepatitis	1 suspected case	1 confirmed case
Anthrax	1 suspected case	1 confirmed case

Notes

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An *alert threshold* suggests to health workers that further investigation is needed. Health workers respond to an alert threshold by:

- Reporting the suspected problem to the next level
- Reviewing data from the past
- Requesting laboratory confirmation to see if the problem is one that fits a case definition
- Being more alert to new data and the resulting trends in the disease or condition
- Investigating the case or condition
- Alerting the appropriate disease-specific programme manager and district epidemic response team to a potential problem.

An *epidemic/action threshold* triggers a definite response. Possible actions include communicating laboratory confirmation to affected health centres, implementing an emergency response, community awareness campaign, or improved infection control practices in the health care setting.

Reporting

- T1 for notification of an infectious notifiable disease (used for up to five cases after which line lists must be filled)
- Weekly Rapid Disease Notification Form
- Reporting is to the next level (health facility to district to province to national level)