



Highlights

Cholera cases reported in Chimanimani and Chipinge

Week 17 Malaria statistics not yet available

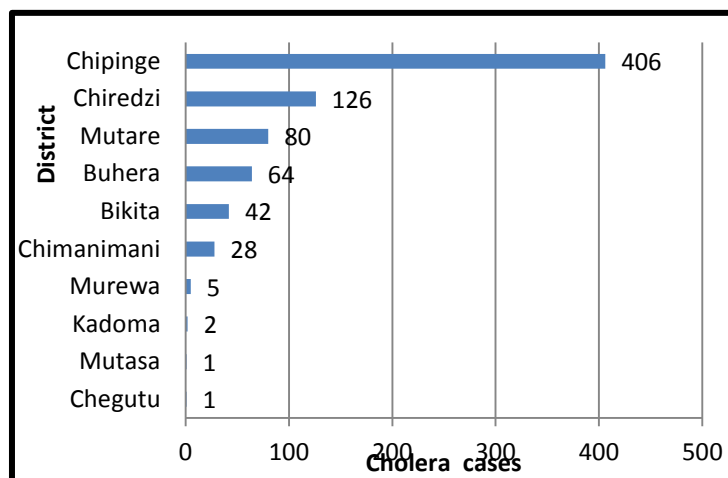
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Figure 1: 2011 Cumulative Cholera Cases



A. General context

Cholera continues to be reported in week 17 of 2011, having spilled over from 2010. Since week 45 of 2010, no new outbreaks of measles have been reported, although the situation is being closely monitored. Malaria outbreaks have been reported in 10 districts. Within the region, Rift Valley fever has been reported in South Africa, Viral Haemorrhagic Fever and measles in DRC and cholera in Zambia

B. Epidemic prone diseases

Cholera

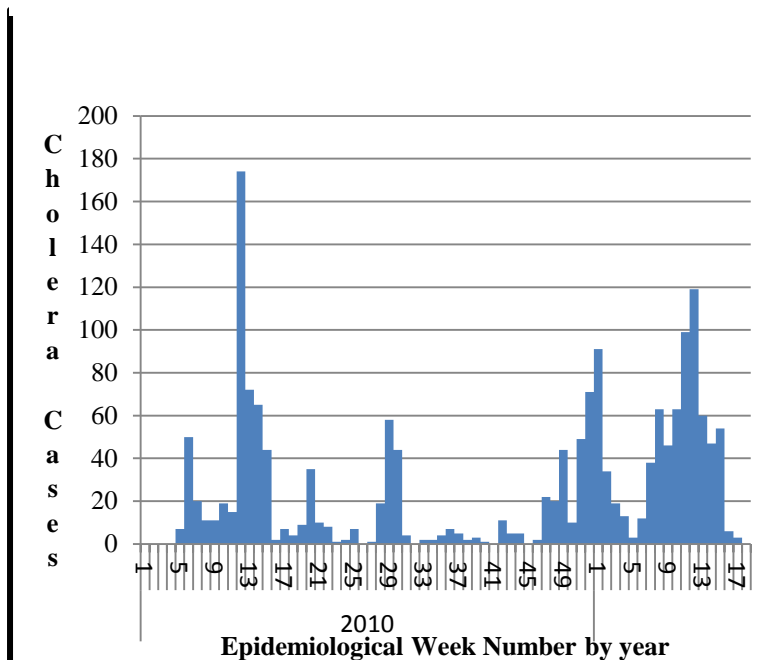
Ten out of the 62 districts, namely: Bikita, Buhera, Chimanimani, Chegutu, Chipinge, Chiredzi, Kadoma, Murewa, Mutare and Mutasa have reported cases since the beginning of 2011. There were 755 cumulative cases: 158 laboratory confirmed cases, 597 epilinked cases and 25 deaths reported by the 1st May 2011. The crude case fatality rate is 3.3%.

Week 17 (25 April – 1 May 2011)

Three cases were reported in week 17 from Chipinge. Surveillance continued in all districts, Chimanimani, Chiredzi and Chipinge districts have reported cholera cases in the last 3 weeks.

Malaria

Figure 2: Zimbabwe Cholera Epi-curve, Week 5, 2010 to Week 17, 2011



The cumulative cases and deaths of malaria in up to week 16 are 91 648 and 140 respectively, giving a case fatality rate of 0.2%. The cases have been reported from all provinces.

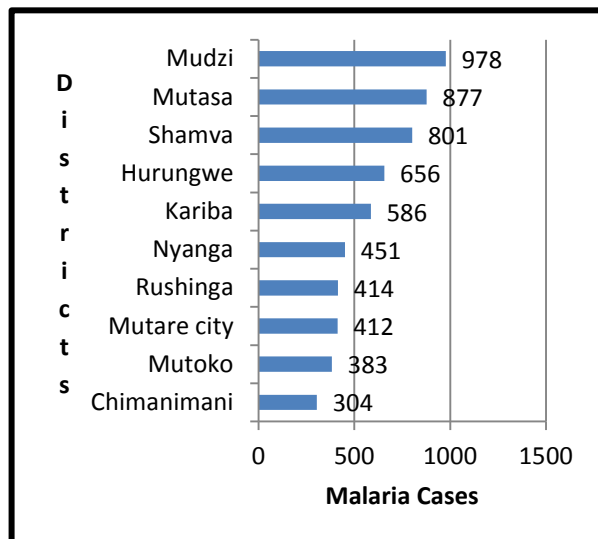
Week 16 (18-24 April 2011)

A total of 4 413 malaria cases and 10 deaths were reported. Out of the 705 cases reported in

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under 5 year olds there were no deaths. The highest number of malaria cases was reported from Mashonaland West (1,472) and Mashonaland Central (1,272).

Figure 3: Top 10 Malaria Cases reported in week 17



C. Public Health Events of International Concern (PHEIC) within the region

Angola

Chemical Poisoning

Suspected cases of chemical poisoning have been reported from Kilamba Kiaksi Municipality of Luanda Province. A total of 118 cases of unknown cause were reported, affecting children in a medium level school complex. The main symptoms were nausea, throat irritation, dizziness and loss of consciousness. No deaths were reported and all cases recovered rapidly. Samples are now being sent for laboratory confirmation.

DRC

A suspected case of VHF was reported from Isiro district, Eastern province of DRC on 25th March. The patient, aged 36, developed fever on 18 March followed by hemorrhagic symptoms (melena, epistaxis, bleeding from eyes, and

hematuria). He died on March 28. Samples were taken on March 26 and shipped to INRB.

Measles

This is an update on the measles outbreak which started in Katanga and South Kivu in August 2010. From January to February 2011, a cumulative total of 16, 112 cases with 107 deaths have been reported from 11 provinces. The case fatality rate is 0.7%. The most affected provinces are Katanga (14 123 cases with 90 deaths, CFR 0.6%), South-Kivu (1 360 cases with 6 deaths, CFR: 0.4%), Kasai Oriental (210 cases and 3 deaths, CFR: 1.4%), and Kasai Occidental (103 cases with 6 deaths, CFR: 5.8%). The following actions are being taken by WHO: enhancement of surveillance, coordination of response activities and advocacy for resource mobilization. In 2010, the routine immunization coverage rate was estimated at 50%.

South Africa

Rift Valley Fever

From 1 January to 30 March 2011, a total of 16 lab-confirmed human RVF infections were reported in South Africa, with zero fatalities. Cases are primarily from the farming community (i.e. farmers, farm workers, farm managers) accounting for 88% (n=14) of the infections. Of the remainder, one case is a veterinary assistant and one case is unemployed. Of those with exposure information (n=15) currently available, all but one (14/15, 93%) reported direct contact with infected animal tissue and/or bodily fluids prior to onset of illness, 66% (10/15) reported mosquito-bites, 20% (3/15) consumption of unpasteurized milk, and 27% (4/15) acquisition and handling of meat not sourced from a retail outlet. The Department of Agriculture, Forestry and Fisheries has confirmed 21 animal RVF outbreaks so far this year, involving Western Cape, Eastern Cape and Northern Cape provinces.

Zambia

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Starting from week 45 of 2010, there has been a progressive increase in the weekly number of cholera cases reported from Zambia. So far, the country has reported a cumulative number of 63 cases in 2011 (up to what date?). From historical experience the epidemic is expected to peak around week 13 to 15 of 2011.

D. Preparedness

Cholera

National

Continued contact with PMDs offices checking on their stocks levels of cholera emergency stocks was maintained.

Chipinge

- Two EPR meetings were held in this week.
- MDM together with MoHCW continued to hold intensive sensitization sessions in both the South and the North.
- IEC materials and cholera guidelines were distributed to the clinics that did not have any.

Response actions this week

Cholera

Chipinge

MDM continued to support the MoHCW with both human resources and transport.

- Next EPR meeting planned for Tuesday 2nd May 2011.
- Community leaders and traditional leaders as well as religious leaders of

the apostolic sect members were also targeted in the sensitizations held in the week.

- Case management reinforcement was done in the health centers and good case management enforced.

Malaria

The National Pharmaceutical Company of Zimbabwe (NatPharm) has started distributing malaria drugs and RDTs procured through resources from the Global Fund and USAID.

E. Timeliness and completeness of data

The completeness and timeliness of this week's surveillance data was not yet available.

Acknowledgements

We are very grateful to health workers from facility to district and provincial 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 PHEIC occurring in the region is consolidated from the WHO daily summary of health events.

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Annex 1:

Table: Summary of cumulative current cholera outbreak cases by year as at week 17

District	2010		2011		Total Cases	Total Deaths
	Cases	Deaths	Cases	Deaths		
Beitbridge	17	0	0	0	17	0
Bikita	9	1	42	1	51	2
Bindura	2	0	0	0	2	0
Buhera	130	0	64	0	196	0
Chegutu	32	2	1	0	33	2
Chimanimani	66	0	28	9	94	9
Chipinge	39	2	406	7	445	9
Chiredzi	54	2	126	6	170	8
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	292	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	755	25	1690	47

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Annex 2: Standard case definitions and alert/action epidemic thresholds

1. Cholera Standard Case Definition

Suspected case:

In a patient age 5 years or more, severe dehydration or death from acute watery diarrhoea in an area where there is no cholera.

If there is a cholera epidemic, a suspected case is any person age 2 years or more with acute watery diarrhoea, with or without vomiting.

Confirmed case:

A suspected case in which *Vibrio cholerae* serogroups 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.)

D. Events of Public Health concern

There are three main categories of events that are notified under the International Health Regulations (IHR), these include:

- Conditions that must be notified to WHO: smallpox, poliomyelitis due to wild-type poliovirus, human influenza caused by a new subtype, SARS, cholera, plague, yellow fever, VHF, RVF and Meningococcal meningitis.
- “Any event of potential international public health concern including those of unknown cause or source, and those involving other events or diseases” than those listed above-
 - environmental health emergencies (natural events, technological incidents, complex emergencies and deliberate events);
 - chemical risk in food (environmental or intentional pollution) and
 - Zoonoses and infectious diseases.