Highlights

- **Number of reporting sites**: Seventy-nine (79) reporting sites including thirty-nine (39) in Internally Displaced People’s (IDP) camps, four (4) in refugee camps and thirty-seven (37) mobile clinics submitted their weekly reports timely and completely.

- **Total number of consultations**: 27,472 (Male=13,336 and Female=14,106) marking a decrease of 1,687 (6%) since last week.

- **Leading causes of morbidity in the camps**: Acute Respiratory Tract Infections (ARI) (n=12,868), skin diseases (n=1,142) and Acute Diarrhea (AD) (n=754) remained the leading causes of morbidity in all camps during this reporting week.

- **Number of alerts**: Eleven (11) alerts were generated through EWARN following the defined thresholds, of which ten were from IDP camps and one from a Refugee camp during this reporting week. All these alerts were investigated within 48 hours, of which eight were verified as true while the remaining three alerts were pending for further investigation and appropriate response by the respective Governorates Departments of Health, WHO and the relevant health cluster partners. (Details: see Alerts and Outbreaks Section).
Morbidity Patterns

**IDP camps:**

During week 1, the proportions of Acute Respiratory Tract Infections (ARI) are showing a slight increase from the previous 3 weeks. During this winter and as from week 1, the trend of the reporting cases of ARI showed overall slight increase, which is expected to increase during the coming weeks, in particular during the weeks of January 2016. The proportions of Acute Diarrhea in IDP camps have sharply decreased compared to last week (week 1, 2016 = 2.85% and week 53, 2015 = 3.35%). The proportion of skin diseases including scabies has shown a steady trend since week 46 (4.5%) due to the health and hygiene sessions in camps by the health cluster partners and Departments of Health. (See graph below).

**Refugee camps:**

During week 1, the proportion of Acute Respiratory Tract Infections (ARI) indicates a slight increase from 58% to 59% as expected during winter season. The proportions of Acute Diarrhea trend in refugee camps shows a steady decrease trend since last week, (week 52 = 2.3% and week 53 = 1.6%). Proportions of skin infestations including scabies have also decreased from 3% to 2.5% as winters are approaching and there is a need for extensive health promotion activities to be conducted in all camps. (See graph below).
Trends of Diseases by Proportion and location for IDP Camps

The graph below indicates the proportion of cases of Acute Respiratory Tract Infections, Acute Diarrhea and Skin Infestations, including scabies, which comprises the highest leading causes of morbidity in IDP camps for Week 1, 2016.

![Proportion of cases in IDPs Camps for ARI, Skin diseases and AD](image)

**Figure IV**: Proportion of cases of ARI, Scabies and AD in IDP camps for Week 1, 2016

Trends of Diseases by Proportion and location for Refugee Camps

The graph below indicates the proportion of Acute Respiratory Tract Infections cases, Acute Diarrhea and Skin Infestations, including scabies, which comprises the highest leading causes of morbidity in Refugee camps for week 1, 2016.

![Proportion of cases in Refugees Camps for ARI, Skin diseases and AD](image)

**Figure V**: Trend of proportions of cases of ARI, Scabies and AD in Refugee camps for Week 1, 2016
The graph below indicates the proportion of Acute Respiratory Tract Infections cases, Acute Diarrhea and Skin Infestations, including scabies, which comprises the highest leading causes of morbidity in off camp IDPs covered by mobile clinics for week 1, 2016.

Acute Respiratory Tract Infection (ARI) has been further divided into upper and lower respiratory tract infections since week 1, 2015. Compared to week 53, the proportion of upper ARI has increased by 2% from 93% to 95% while the Lower ARI proportion has decreased from 7% to 5% during the same time period. Furthermore, the below graph indicates the proportion of lower and upper ARI cases per each reporting site for week 1.

Trends of Upper and Lower ARI as leading communicable disease

Acute Respiratory Tract Infection (ARI) has been further divided into upper and lower respiratory tract infections since week 1, 2015. Compared to week 53, the proportion of upper ARI has increased by 2% from 93% to 95% while the Lower ARI proportion has decreased from 7% to 5% during the same time period. Furthermore, the below graph indicates the proportion of lower and upper ARI cases per each reporting site for week 1.
**Trends of Waterborne Diseases in IDP camps**

The graph below shows the trends of waterborne diseases (Acute Diarrhea, Bloody Diarrhea and Acute Jaundice Syndrome) reported from IDP camps and which indicated a sharp decrease in waterborne diseases from 6% in week 47, 2015 to 3.13% in week 1, 2016. (See graph below)

![Graph showing trends for % proportion of cases in IDPs Camps for Waterborne diseases (AD, BD & AJS)](image)

Figure VIII: Trend of Waterborne diseases from IDP camps, week 40, 2015—Week 1, 2016

**Trends of Waterborne diseases in Refugee camps**

The graph below shows the trends of proportion of waterborne diseases (Acute Diarrhea, Bloody Diarrhea and Acute Jaundice Syndrome) from refugee camps which indicates a decrease of the trend since week 42. Furthermore, no clustering has been reported for acute jaundice syndrome cases during this period.

![Graph showing trends for % proportion of cases in Refugee Camps for Waterborne diseases (AD, BD & AJS)](image)

Figure IX: Trend of waterborne diseases from Refugee camps, week 40, 2015—Week 1, 2016
Eleven alerts were generated through EWARN following the case definition thresholds, of which ten were from IDP camps and one from Refugee camps during this reporting week. All these alerts were investigated within 48 hours, of which eight were verified as true, while the remaining are pending further investigation and appropriate response by the respective Governorate Department of Health, WHO and the relevant health cluster partners. A Cerebrospinal Fluid sample has been taken from the suspected case of meningitis and waiting for the lab result. The trends of epidemic-prone diseases for each reporting site is being monitored through a detailed monitoring matrix maintained at WHO EWARN department. (Details: see table)

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<th>District</th>
<th>IDPs/Refugee Camp</th>
<th>Ref cases</th>
<th>Run by</th>
<th>Investigative and Response</th>
<th>Sample Taken</th>
<th>Alerts/Outcome</th>
<th>Public Health Intervention Conducted</th>
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**Trends of Alerts**

Measles outbreak was declared in Arbat camp in Sulaymaniyyah in March 2015, which was responded and controlled.

On September 15, 2015, a cholera outbreak was officially declared by the Ministry of Health (MoH) of Iraq following laboratory confirmation of a suspected cholera case from Al-Shamiya District in Diwaniya Governorate by the Central Public Health Laboratory (CPHL). Within few weeks, the outbreak had spread to other central, southern governorates along the Euphrates River. The source of cholera infection was linked to the contaminated water supplies due to limited water and sewage treatment facilities because of chronic electricity shortages and lack of maintenance.

The Ministry of Health led the coordination of a multisectoral response to the cholera outbreak through activation of the National Cholera Task Force headed by the highest level of the government in their stewardship role. By mid-October 2015, the outbreak had rapidly spread to 17 of the 19 governorates in Iraq. A total of 119,983 suspected cholera cases were tested for cholera, and 4,915 cases were laboratory-confirmed for Vibrio cholera subtype “Inaba”. Seventy-five percent of all cases were recorded from ten districts within Baghdad, Babylon, Diwaniya and Muthanna governorates. Very few cases were reported from northern governorates, particularly Sulaymaniyyah, Erbil and Dohuk. Furthermore, several neighbouring countries (Bahrain, Kuwait, Iran and Oman) reported imported cases linked to recent travel history to Iraq, but none of these countries had experienced a full-blown outbreak.

**Number of Alerts per week identified through EWARN**

For comments or questions, please contact

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Link for EWARN Dashboard: http://who-iraq-ewarn.github.io/