Highlights: week 49 (05 - 11 Dec 2011)

- Typhoid outbreak in Harare City
- Anthrax outbreak in Mash Central Province

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A. General Context

Typhoid outbreak in Harare City reported since 10 October 2011 and Mashonaland West Province has been affected this week.

No report of outbreaks of malaria, cholera and measles during week 49 countrywide.

No report of Pandemic Influenza A (H1N1) cases. A total of 1946 seasonal influenza cases were reported this week.

Several outbreaks reported in the Southern Africa Region: Meningococcal meningitis in South Africa, cholera in DRC and Malawi and suspected H1N1 cases in Namibia.

B. Epidemic prone diseases

Typhoid outbreak in Harare City

Harare City reported has been affected by an outbreak of Typhoid since 10 Oct 2011. This week, a total of 179 new typhoid cases were reported. Cases have been reported from Chitungwiza district (16) in Mashonaland West Province and Harare City (163).

As of week 49, a cumulative 781 cases and 1 death (CFR= 0.13%) reported. Northern-Western District of Harare City is the most affected with Dzivaresekwa 3 suburb reporting majority of cases.

Note: No available new updated Harare Typhoid Epidemic-curve, Graphs and Maps showing the distribution of the cases by date of onset; age and sex; and by place of residence respectively this week. May you please refer to previous epidemiological bulletins n° 139 and n° 140 for this information.

Anthrax outbreak in Mashonaland Central Province

Anthrax outbreak in Kanyemba area (Chapoto) in Mbire district
a. No new human cases reported this week
   - 1st cases reported on 17 Nov 2011
   - Total human cases= 43
   - Male = 18 (41.9%)
   - Females = 25 (58.1%)
   - Deaths = 0
b. Animal cases: several deaths of hippo and elephant reported at the beginning of the outbreak
   - Last hippo died on the 11th Dec 2011
   - 7 goats and 1 donkey affected

Anthrax outbreak in Mhakayakora village in Dotito area in Mt. Darwin District
- 1st Dec 2011: 1st case presented to the health facility on 1st Dec 2011
- 6th Dec 2011: outbreak reported
- Total human case of anthrax = 33
  a. Males = 17 (51.5%)
  b. Females = 16 (48.5%)
  c. Deaths= 0
- Animal cases: 72 cattle died in the area

Anthrax outbreak response activities

- Treatment of cases
- Provincial and District RRTs activated and composed of
  o MoHCW staff
  o Representatives from Veterinary Department; Civil Protection Committee; Parks and Wildlife; ZRP and IMC (NGO)
- Movement of animal stopped in the area
- Active cases finding and search of meat and skins of dead animals in the community
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- Intensified health education and community awareness campaigns
- Distribution of IEC materials in vernacular/local language
- Proper disposal of carcasses
- Disinfection of contaminated areas with using chloride of lime
- Cross border collaboration activities

RRTs visited the Zambian part of the country which borders with Kanyemba to
  - verify the diagnosis of the disease among wild animal in Zambia
  - record Zimbabwean cases seeking treatments on the Zambian side
  - assess control measures implemented on the Zambian side
  - share experiences and assess collaborative activities put in place to control the diseases

C. Completeness and timeliness of the National data

Completeness reported in week no 49 marginally increased from 54% to 59% whilst timeliness significantly increased from 48% to 57%.

Note: No report received from Masvingo Province this week.

D. Events of public health importance within SADC

1. No reports of new outbreaks or events
2. No update, on the following outbreaks cited in the epidemiological bulletin of week n°46, available this week:
   - Cholera outbreaks in DRC and Malawi
   - H1N1 in Namibia
   - Meningococcal disease in South Africa

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.

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.
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.
### Annex 2: Standard Case Definitions

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<thead>
<tr>
<th>Diseases</th>
<th>Standard Case Definitions</th>
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<tbody>
<tr>
<td><strong>Cholera</strong></td>
<td><strong>Suspected case</strong>&lt;br&gt;• 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&lt;br&gt;• 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</td>
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<td><strong>Note</strong>&lt;br&gt;• All suspected cases under the age of two years must be confirmed.&lt;br&gt;• 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.</td>
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<tr>
<td><strong>Malaria</strong></td>
<td><strong>Suspected uncomplicated malaria</strong>&lt;br&gt;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</td>
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<td><strong>Confirmed severe malaria</strong>&lt;br&gt;A patient hospitalized with <em>P. falciparum</em> asexual parasitaemia as confirmed by laboratory tests with accompanying symptoms of severe disease (vital organ dysfunction)</td>
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<tr>
<td><strong>Typhoid</strong></td>
<td><strong>Suspected case</strong>&lt;br&gt;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</td>
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<td><strong>Diarrhoeal</strong></td>
<td><strong>Suspected case</strong>&lt;br&gt;Passage of 3 or more loose or watery stools in the past 24 hours with&lt;br&gt;• or without dehydration <strong>or</strong>&lt;br&gt;• some dehydration and two or more of the following signs: restlessness, irritability, sunken eyes, thirsty, skin pinch goes back slowly, <strong>or</strong>&lt;br&gt;• 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</td>
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<td><strong>Note</strong>&lt;br&gt;<em>Laboratory confirmation of specific agent causing outbreak is not routinely recommended for surveillance purposes.</em></td>
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### Annex 3: Alert/Action Epidemic Thresholds for selected epidemic prone diseases and other diseases of public health importance in Zimbabwe

<table>
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<tr>
<th>Disease or condition</th>
<th>Alert Threshold</th>
<th>Action Threshold</th>
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| **Measles**          | 1 suspected case | **District level**
|                      |                 | 25 or more cases per 100,000 population |
|                      |                 | **Health facility**
|                      |                 | 3 or more cases in the same ward in 1 week |
|                      |                 | **Note:** In closed settings like Refugee camps, schools, inpatient ward within a health facility: 1 confirmed case |
| **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 | • 1 case in an area that is not endemic or
|                      |                 | • For endemic areas 3 cases per 100,000 |
| **Typhoid fever**    | 1 case          | • 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 | • 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 | • N\(^\text{th}\) of cases that exceed those in the 3\(^{\text{rd}}\) quartile (the upper limit) of the expected number of cases or
|                      |                 | • N\(^\text{th}\) 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

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)