This weekly Epidemiological Bulletin is published jointly by the Ministry of Health and Child Welfare, Zimbabwe and the World Health Organization. For correspondence: Email: charimaril@zw.afro.who.int and shambared@zw.afro.who.int or call: +263772104257 or +263772277893

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### A. General context

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.

The last cholera cases were reported in week 25 of 2011, having spilled over from 2010.

A Typhoid outbreak started on the 10th October 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

#### 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.
Zimbabwe Weekly Epidemiological Bulletin

Week 42 (17– 23 October 2011)

No new cases of cholera were reported countrywide.

**Diarrhoea**

**Nationwide**

The number of diarrhoea cases reported nationwide increased from 6930 to 7069.

**Kadoma**

Kadoma diarrhoea outbreak is now under control.

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**Figure 3:** National Diarrhoea Epidemic curve, Zimbabwe, Week 1-40, 2011

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**Typhoid**

Harare city has declared a typhoid outbreak which started on the 10th of October. The outbreak has been attributed to lack of potable water in Dzivaresekwa 3. Detailed information on the outbreak is still coming.

C. Typhoid guidelines distributed

**Democratic Republic of Congo (DRC)**

**Cholera**

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 sensibilization 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 the WHO Country Office of Namibia received an investigation report from the Ministry of Health & Social Welfare. A case investigation was conducted by the MoH/WHO and CDC regarding a suspected outbreak of acute hemorrhagic fever in Windhoek, Namibia. The following were the major findings of the investigation: 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 etiology dated 28 September. Further investigation confirmed that the cause of death was due to bacterial meningitis.

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

26 October: 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.

Zambia

From 22 August to 14 September 2011, a total of 477 human cases of anthrax 5 community deaths (CFR = 1.05%) were reported. An estimated 60 to 80 hippo deaths was reported and the human cases were associated with the handling and consumption of the hippo meat. The outbreak is under control.

D. Preparedness and Response

E. Timeliness and completeness of data

National data completeness timeliness reported for week number 41 increased from 52% to 66% and timeliness decreased from 52% to 48% 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

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<th>District</th>
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<th>2010 Deaths</th>
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<th>2011 Deaths</th>
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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

**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.

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:
   - environmental health emergencies (natural events, technological incidents, complex emergencies and deliberate events);
   - chemical risk in food (environmental or intentional pollution) and
   - 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.