World Health Organization

EWARN: EARLY WARNING AND RESPONSE NETWORK

Iraq: EWARN & Disease Surveillance Bulletin

2015 Epidemiological Week: 40 **Reporting Period: 28 Sep — 04 Oct, 2015**

Highlights

- **Number of reporting sites:** sixty (60) reporting sites including thirty six (36) Internally Displaced People's (IDP) camps, eight (8) refugee camps and sixteen (16) mobile clinics submitted their weekly reports timely and completely.
- **Total number of consultations:** 21,059 (male=9,432 and female=11,627) marking a increase of 7,573 (22%) since last week.
- **Leading causes of morbidity in the camps:** Acute Respiratory Tract Infections (ARI) (n=7,365), Acute Diarrhea (AD) (n=1,165) and skin diseases (n=778) remained the leading causes of morbidity in all camps during this reporting week.
- **Number of alerts:** Nine alerts were generated through EWARN following the case definition thresholds, of which Seven were from IDP camps and One from refugee camps and One from hospital during this reporting week. Nine of these alerts were investigated within 24-48 hours of which One were verified as true for further investigation and appropriate response by the respective Governorates Departments of Health, WHO and the relevant health cluster partners. (Details: see Alert and Outbreak Section).

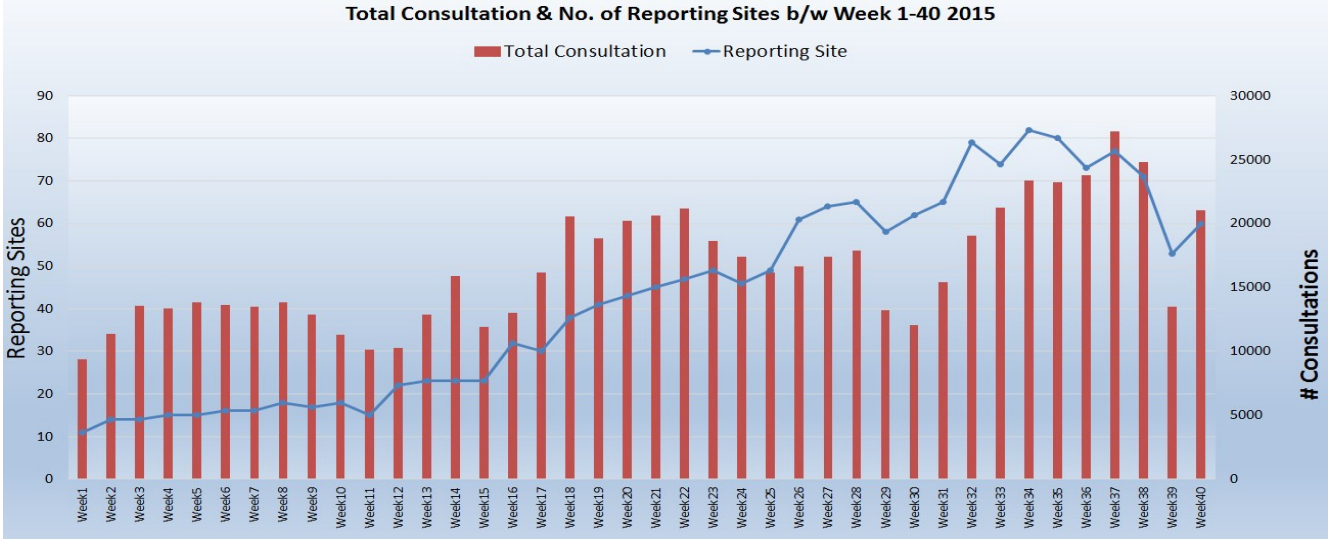
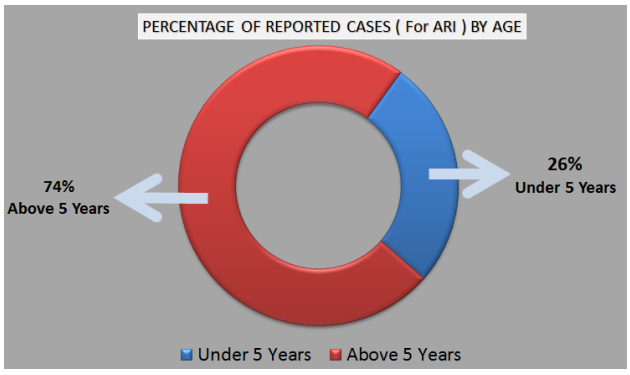
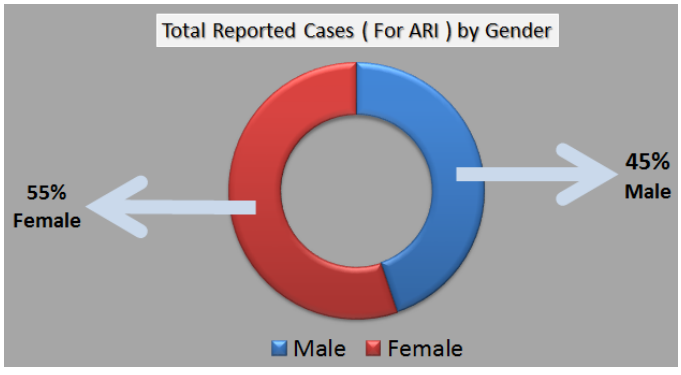


Figure I: Total consultations and proportion of reporting health facilities b/w week 1-40

Consultations in the camps by age and gender (week 40)





Morbidity Patterns

IDP camps:

During week 40, proportions of Acute Diarrhea in IDP camps has slightly increased since last week (week 39=5.10% and week 40=5.37%). The proportion of acute diarrhea has tripled from 3% in week 18 to 14% in week 26 due to the hot summers season. As a part of preparedness, Health and WASH cluster together continued the Cholera Task Force activities in the high risk governorates, due to which the trends of Acute Diarrhea has gradually decreased to 5.5% in week 34. The proportion of skin infestations including scabies has shown a steady trend since week 23 (6%) due to the lack of health and hygiene sessions in camps by the health cluster partners and Departments of Health. Proportion of Acute Respiratory Tract Infections (ARI) are showing a gradual steady downward trend between 30% - 35% since week 18. (See below graph).

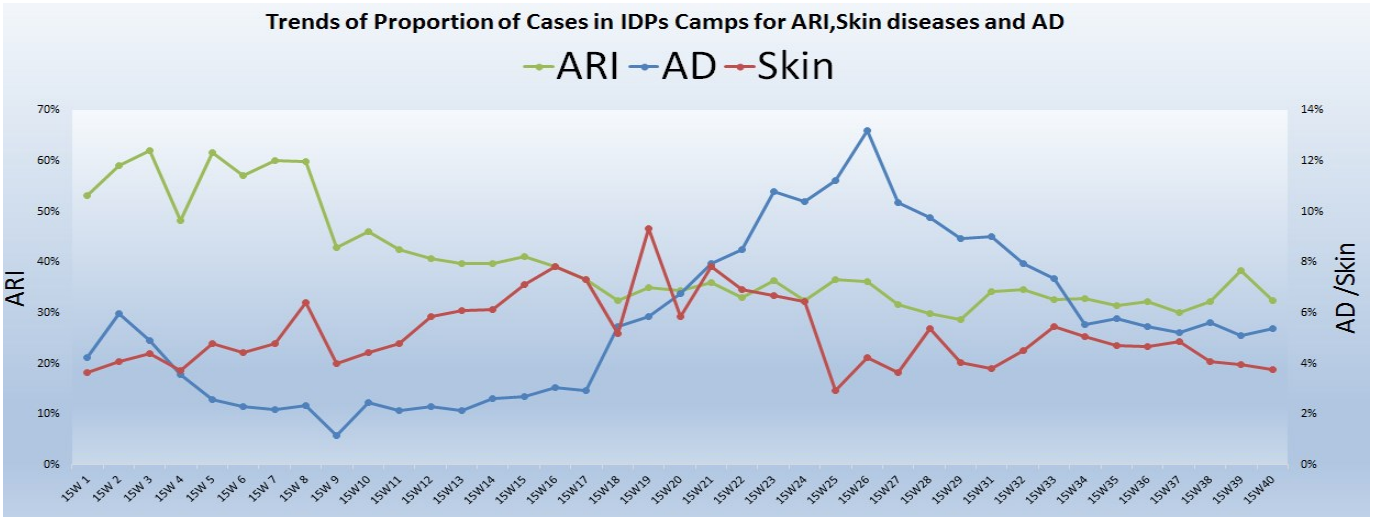


Figure II: Trend of proportion of cases of ARI, Scabies and AD in IDP camps (week 1 –40)

Refugee camps:

During week 40, proportions of Acute Diarrhea trend in refugee camps shows a steady trend since last week, (week 39=5.70% and week 40=6.36%). Proportion of Acute Respiratory Tract Infections (ARI) indicates a slow drop-down trend since the beginning of summer season, but currently shows a steady pattern since week 30, (week 30=41% and week 34=39%. Proportion of skin infestations including scabies have also dropped from 8% in week 30 to 4% in week 34 due to extensive health promotion activities conducted in all camps. (See below graph).

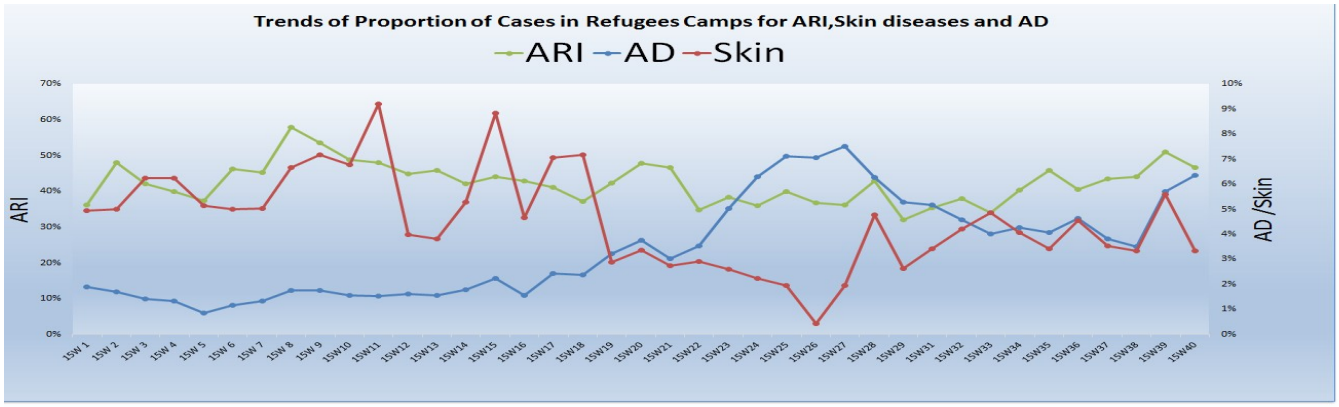


Figure III: Trend of proportion of cases of ARI, Scabies and AD in IDP camps (week 1 –40)

Trends of Diseases by Proportion and location for IDP Camps

The below graph indicates the proportion of cases of Acute Respiratory Tract Infections, Acute Diarrhea, and Skin Infestations including scabies which comprises the highest leading cause of morbidity in IDP camps for week 40, 2015.

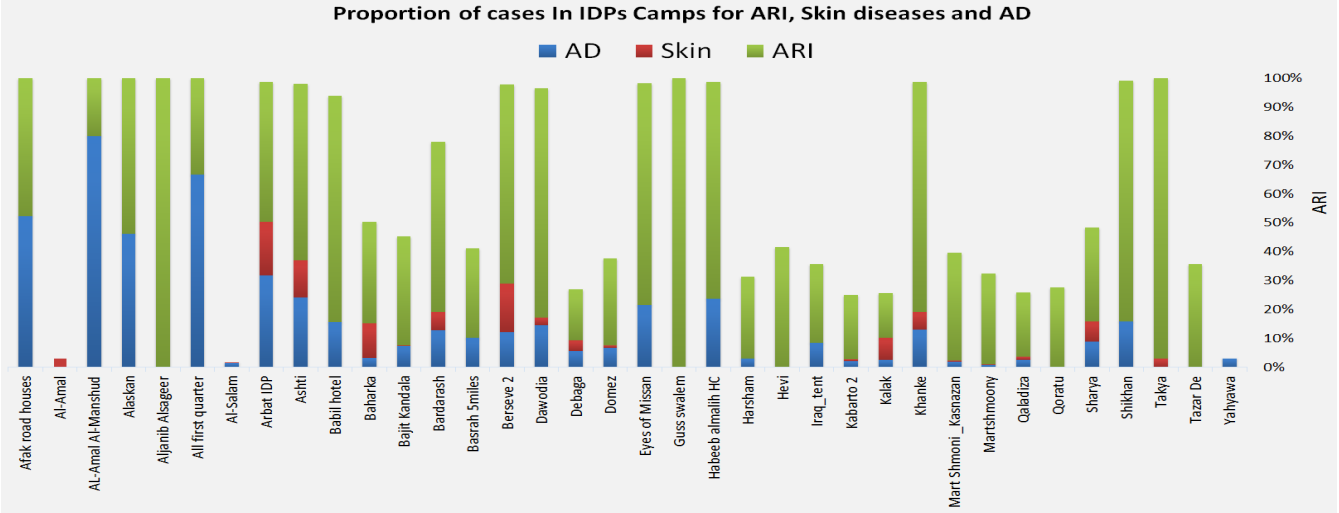


Figure IV: Proportion of cases of ARI, Scabies and AD in IDP camps for week 40

Trends of Diseases by Proportion and location for Refugee Camps

The below graph indicates the proportion of Acute Respiratory Tract Infections cases, Acute Diarrhea, and Skin Infestations including scabies which comprises the highest leading cause of morbidity in Refugee camps for week 40, 2015.

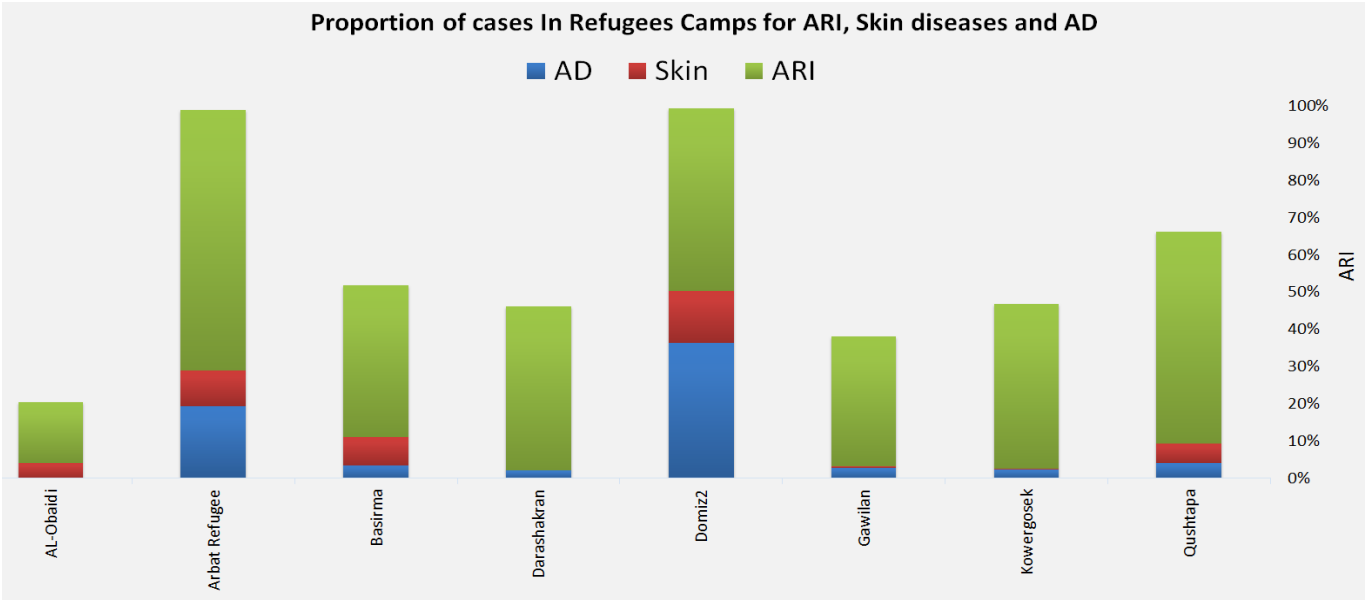


Figure V: Trend of proportions of cases of ARI, Scabies and AD in Refugee camps for week 40

Trend of Diseases by proportions for off camp IDPs covered by Mobile Clinics

The below graph indicates the proportion of Acute Respiratory Tract Infections cases, Acute Diarrhea, and Skin Infestations including scabies which comprises the highest leading cause of morbidity in off camp IDPs covered by mobile clinics for week 40, 2015.

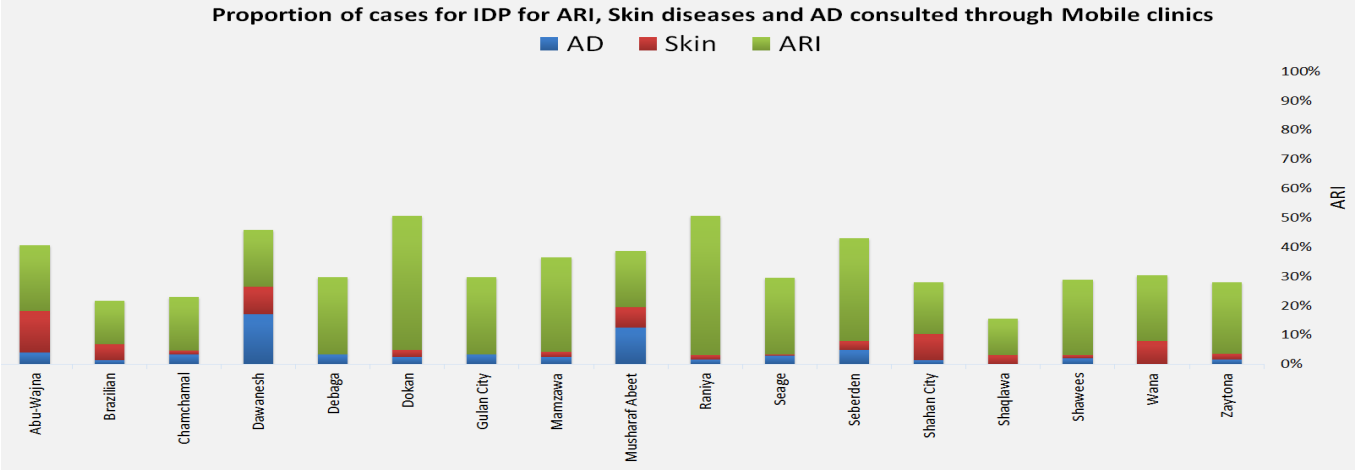
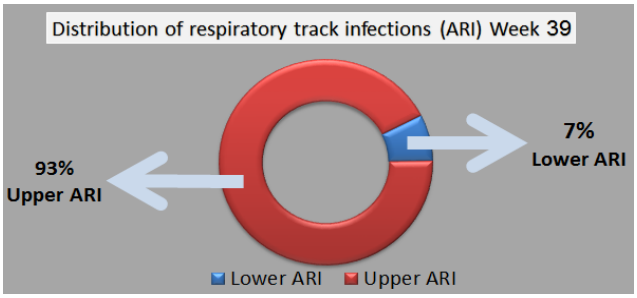
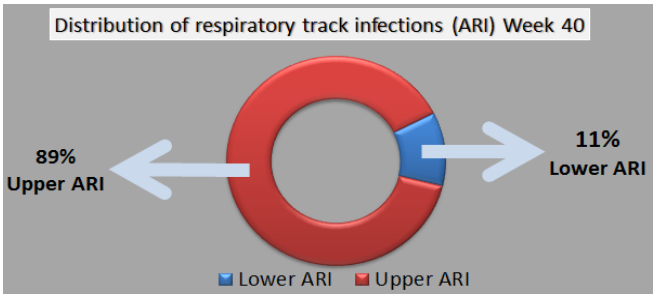


Figure VI: Trend of proportions of IDP cases for ARI, Scabies and AD covered by Mobile Clinics for week 40

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. According to EWARN data, the trend for lower ARI is increasing while that of the upper ARI is decreasing in summer. Compared to week 39, the proportion of upper ARI in week 40 has decreased by 4% while that for lower ARI has increased by 4%. Overall, the ARI trend is slowly decreasing in both IDP and Refugee camps as we go further into the summer months. Furthermore, the below graph indicates the proportion of lower and upper ARI cases per each reporting site for week 40. (Note start changing because of climate change)





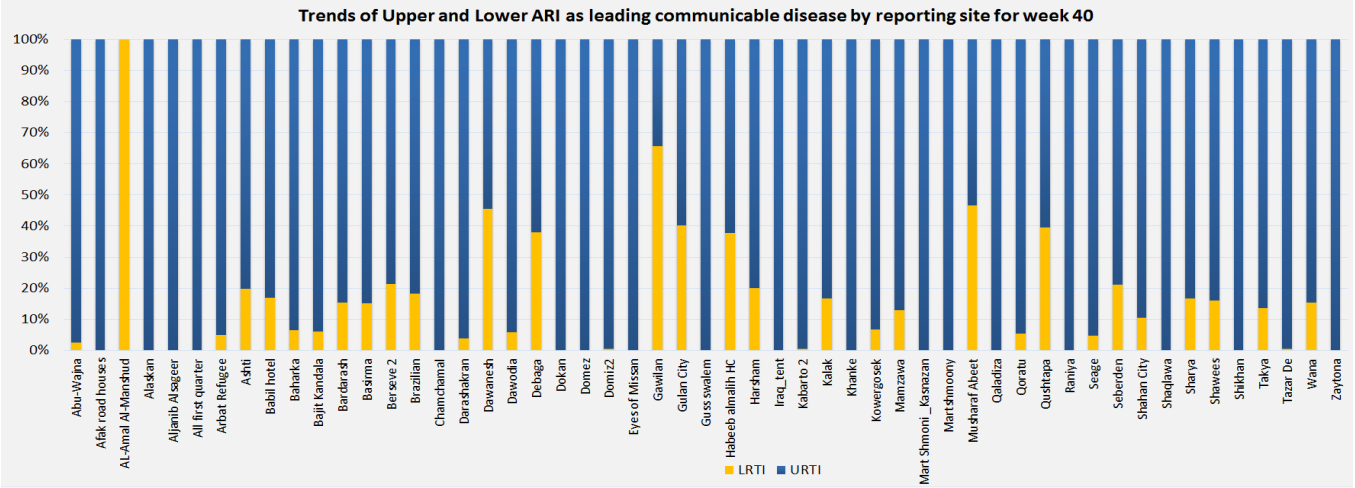


Figure VII: Trend of Upper and Lower ARI per reporting site for week 40

Trends of Water borne Diseases in IDP camps

The below graph shows the trends of waterborne diseases (Acute Diarrhea, Bloody Diarrhea and Acute Jaundice Syndrome) reported from IDP camps and which indicated a steady decrease in waterborne diseases from 14% in week 26 to 5.6% in week 40. (See below graph)

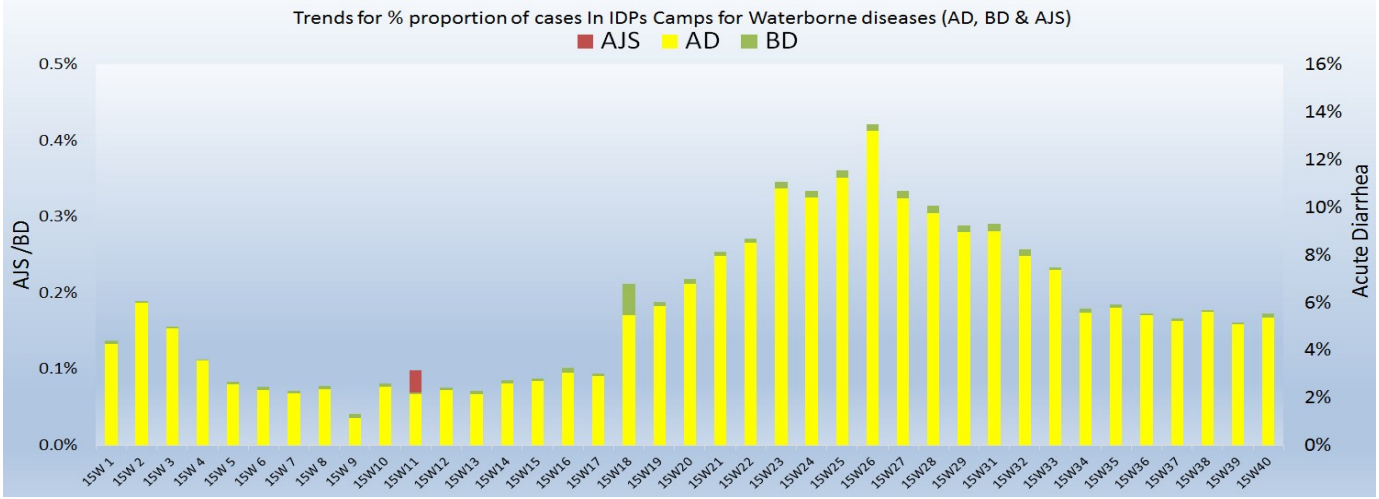


Figure VIII: Trend of Waterborne diseases from IDP camps, week 1 to 40—2015

Trends of Water borne diseases in Refugee camps

The below graph shows the trends of proportion of waterborne diseases (Acute Diarrhea, Bloody Diarrhea and Acute Jaundice Syndrome) from refugee camps indicating an decrease of the trend since week 30. Furthermore, no clustering has been reported for acute jaundice syndrome cases reported during the period.

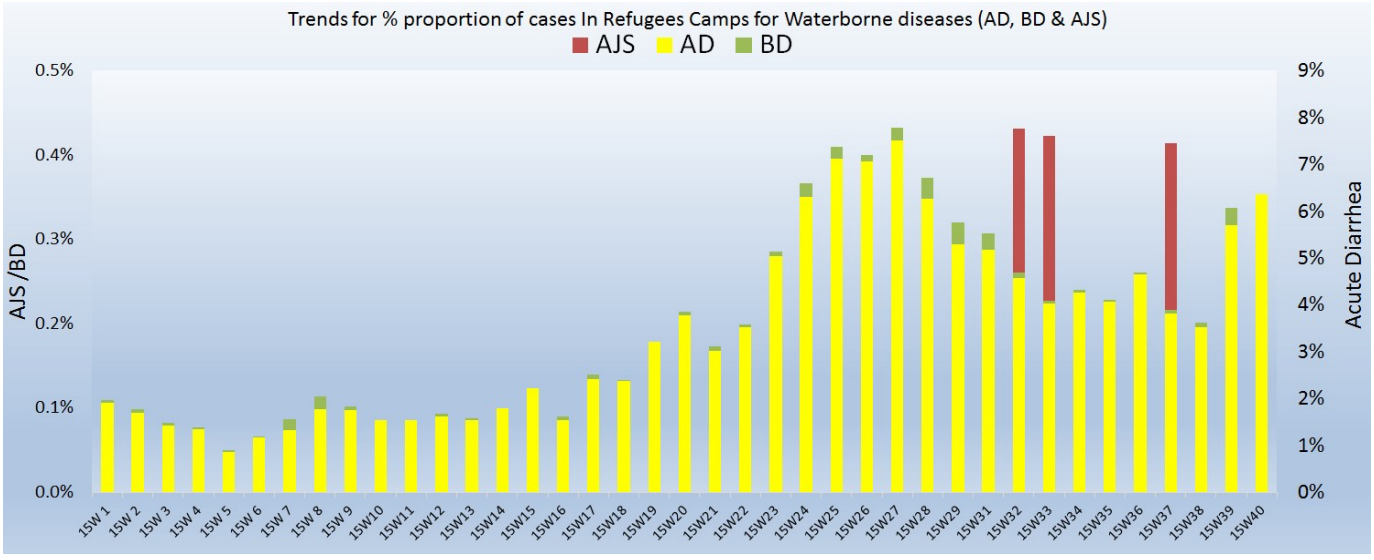


Figure IX: Trend of waterborne diseases from Refugee camps, week 1 to 40—2015

Alerts & Outbreaks

Nine alerts were generated through EWARN following the case definition thresholds, of which seven (7) were from IDP camps and One from refugees camps and One Hospital during this reporting week. Thirteen of these alerts were investigated within 24-48 hours of which Nine were verified as true for further investigation and appropriate response by the respective Governorates Departments of Health, WHO and the relevant health cluster partners. Blood and stool samples were collected from Six of these true alerts. Public health interventions were conducted effectively for all these One true alerts. 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 below table).

Sn	Alert	Location	Governorate	IDP/Refugee Camp	# of cases	Run by	Investigation and Response within 48-72% DOH/WHO/NGO	Sample Taken Yes/No	Alerts Outcome True/False	Public Health Interventions Conducted
1	Suspected Meningitis	Hevi	Dahuk	Hospital	1	DOH	YES	YES	TRUE	YES
2	Acute Watery Diarrhea-(Suspected Cholera)	Bardarash	Dahuk	IDPs	3	PU-AMI	Yes	YES	No	Yes
3	Suspected Measles	Al-Salam	Anbar	IDPs	2	UIMS	Yes	Yes	No	Yes
4		Arbat IDP	Sulaymaniyah	IDPs	1	EMERGENCY	Yes	Yes	No	Yes
5		Iraq_tent	Baghdad	IDPs	17	DOH	Yes	Yes	No	Yes
6	Suspected Pertusis	Iraq_tent	Baghdad	IDPs	1	DOH	Yes	No	No	Yes
7	Bloody Diarrhea	Sharya	Dahuk	IDPs	10	Medair	Yes	Yes	No	Yes
8	Acute (Lower) Respiratory infections – (Suspected Pneumonia)	Berseve 2	Dahuk	IDPs	71	Malteser International	Yes	No	No	No
9		Qushtapa	Erbil	Refugees	137	DOH	Yes	No	No	No

Online EWARN Dashboard*

Surveillance of infectious diseases during emergencies is recognized as the cornerstone of public health decision-making and practice. Surveillance data are crucial for monitoring the health status of the population, detecting diseases and triggering action to prevent further illness, and to contain public health problems. Therefore; WHO-Iraq in coordination with Ministry of Health; is in process of developing a real-time online interactive interface for EWARNs showing the trends of the most leading communicable diseases monitored by location along with bi-monthly EWARN snapshot. (Details; click on the link)

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

* draft—Work in progress

Trends of Alerts

The below graph shows the number of alerts generated through EWARN system on weekly basis. All alerts are investigated and responded in a timely and coordinated manner through Ministry of Health, World Health Organization (WHO) and various health cluster partners.

NO outbreak has been declared since March, 2015. Now we have a lot of outbreak declared was of Measles & Acute Watery Diarrhea- (Suspected Cholera) from all governorate located in February And September, 2015

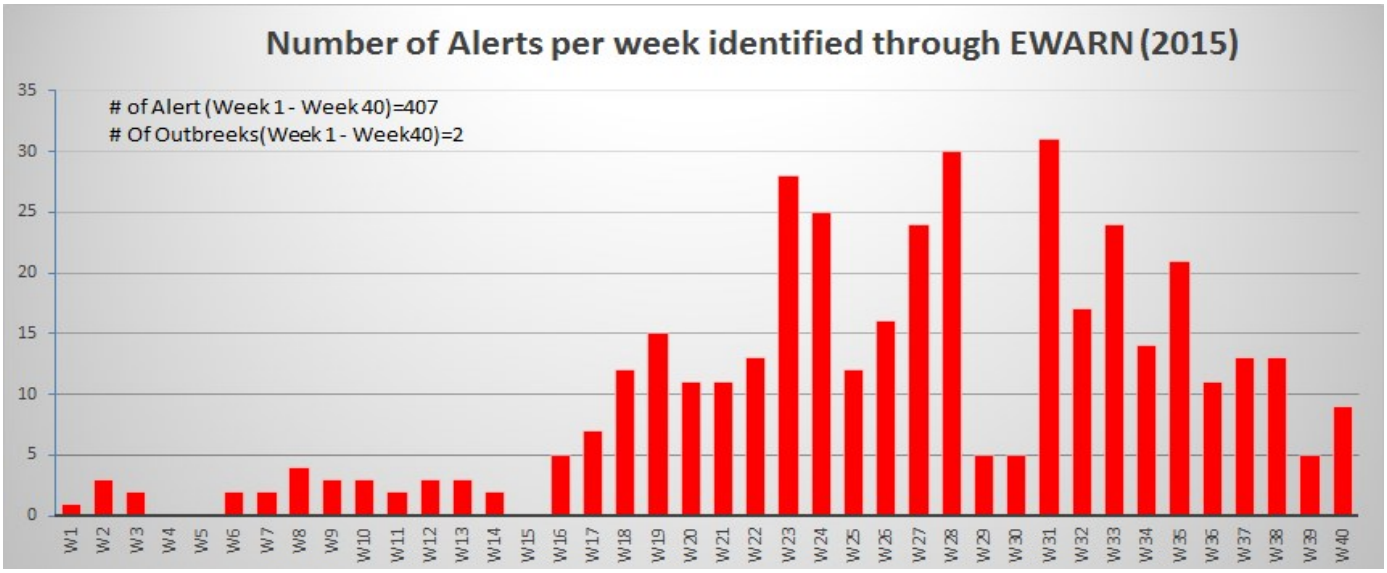


Figure X: Alerts generated through EWARN surveillance (week 1 to 40—2015)

Comments & Recommendations

- Cholera Task Force has continued their activities at Duhok, Erbil and Sulamaniyah governorates.
- As per the previous history of cholera outbreak in Iraq, WASH and health cluster has started working together for the implementation of the Cholera Contingency Plan.
- EWARN teams continued monitoring and evaluating missions of various health cluster partners across Kurdistan to strengthen the reporting mechanism.

For comments or questions, please contact

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Cholera Task Force-IRAQ

Update on Current Cholera Outbreak in Iraq.
SITREP – Situation Report 10 and 11
Summary
Full report on the site
http://www.emro.who.int/irq/iraq-infocus/situation-updates-2015.html

SITREP – Situation Report – N° 10
29.09.2015 (Epi Week 40)

SITREP focuses on outbreak overview of cholera as of September 29th, 2015 including geographical distribution, number of consultations on 29th, cumulative admissions and number of deaths since 8th September 2015.

Laboratory Confirmed cases:

The below table shows the cholera positive cases confirmed by the Central Public Health Laboratory by Ministry of Health – Baghdad as of 29th Sept, 2015.

Serial	Governorate	Cities	Confirmed cases
1	Baghdad	Abu Ghraib, Zaafaranyeh, Karrada, Mahmoudia, Al-Khadraa, Al-Ghazalia, Al-Sihha, Aldoora	80
2	Babylon	Hilla, Mahawil	169
3	Najaf	Manthera	20
4	Qadisiyyah / Diwaniya	Diwaniya	52
5	Muthanna	Samawa Center	75
6	Wassit	Wassit	6
7	Kerbala	Kerbala	8
8	Basrah	Basrah City	4
Total			**414**

Immediate Priority Action:

WASH:

1. Ensuring availability of safe drinking water (chlorine treated) and use of HWT option (aqua-tabs) at a household level (for cholera affected and vulnerable/highly at risk IDP populations)
2. Ensuring critical chlorine/aluminium sulphate stocks in country, and continuous monitoring and chlorination of water supply

3. Ensuring availability and use of ORS, soap at household level (for cholera affected and vulnerable/highly at risk IDP populations)

HEALTH:

1. Focusing on the case definition and to avoid under reporting – daily line lists form the hospitals are necessary
2. Proper case management and to avoid over burdening of tertiary hospitals, the case management has to be decentralization from the tertiary hospitals to community level health care by establishing Cholera treatment centers and Oral rehydration Therapy centers
3. Extensive, aggressive promotion of health/WASH messages on Cholera prevention and health seeking behaviors
4. Prophylactic Cholera Vaccination - vulnerable population (Pilgrimage season – Najaf, Kerbala; IDP & Refugee settlements)
5. Addressing gaps in sanitation (treatment of hospital and household waste/sewerage)

Cholera Taskforce Activities:

Coordination: Cholera Command and Control Centre (C4) established at MoH with an effective inter sectoral coordination mechanism established with WASH cluster.

Health Response: Although with the current health response across the governorates through MoH, DoH and health cluster partners like IMC, PU-AMI and MSF, Ministry of Health has drafted a comprehensive Cholera Response Plan with the technical input from WHO with seven defined strategies to response effectively to the current outbreak in the affected Governorates focusing on the Case management strengthening including ORTs and Cholera Treatment Centres, Enhancing active and passive surveillance, Public health laboratory strengthening, Community and public health awareness improving, Logistic and supply supporting, Coordination and management improvement, Water quality monitoring strengthening and Vaccination of population in high risky areas

Proposed Vaccination Plan:

With regards to the Oral Cholera Vaccine and release of the vaccines–

1. The release of OCV (Shancol) is managed by the ICG – International Coordinating Group of which WHO is one of many members
2. A Tentative 500,000 doses of Shancol are kept a part of the global stock as priority for Iraq at this stage

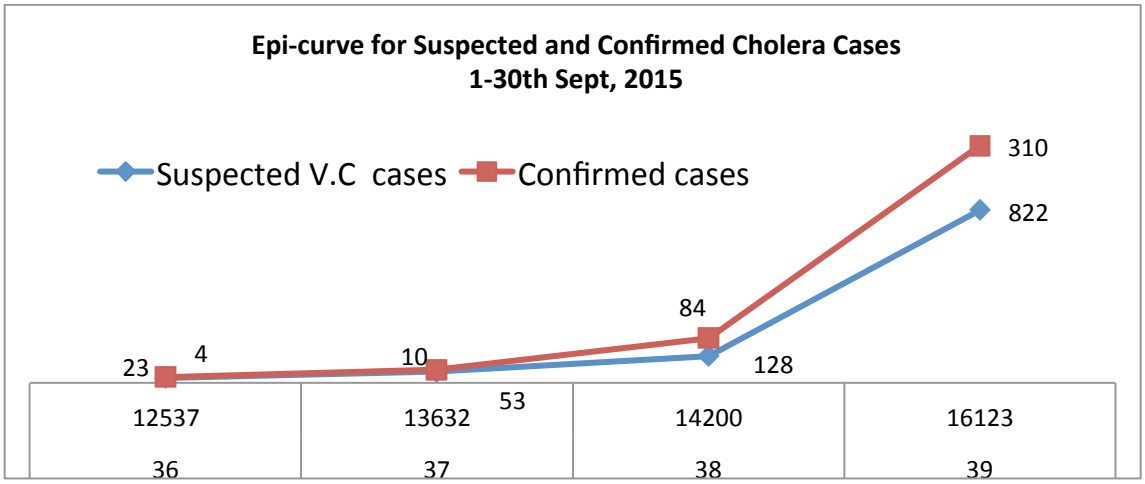
WASH Response: WASH partners continue with their efforts to support the ongoing cholera response in the Central and Southern Governorates of Iraq. The following actors are providing (or planning to provide response actions, including dissemination of key messages through their networks) with are WASH Cluster Partners: WHO, UNICEF, UNICEF IMPLEMENTING PARTNERS (RIRP, UMIS, JANNAT AL-FRDAWS); DRC, NRC, ACTED, Government Partners: Directorate of Water; Baghdad Governorate Office; Najaf DoH and Al Ataba foundation, UNDP, UNICEF C4D, CCM, Protection partners (UNFPA), Mercy Corps, NCCI, UNOPS.

SITREP – Situation Report – N° 11
01.10.2015 (Epi Week 40)

In continuation of **SITREP** 10 dated 29th Sept, Today **SITREP** focuses on outbreak overview of cholera as of October 1st, 2015 including geographical distribution and Epi-curve for suspected and confirmed Cholera cases since 8th September 2015 and consideration of Oral Cholera Vaccine (OCV) for the most at risk population.

Epidemiological Curve:

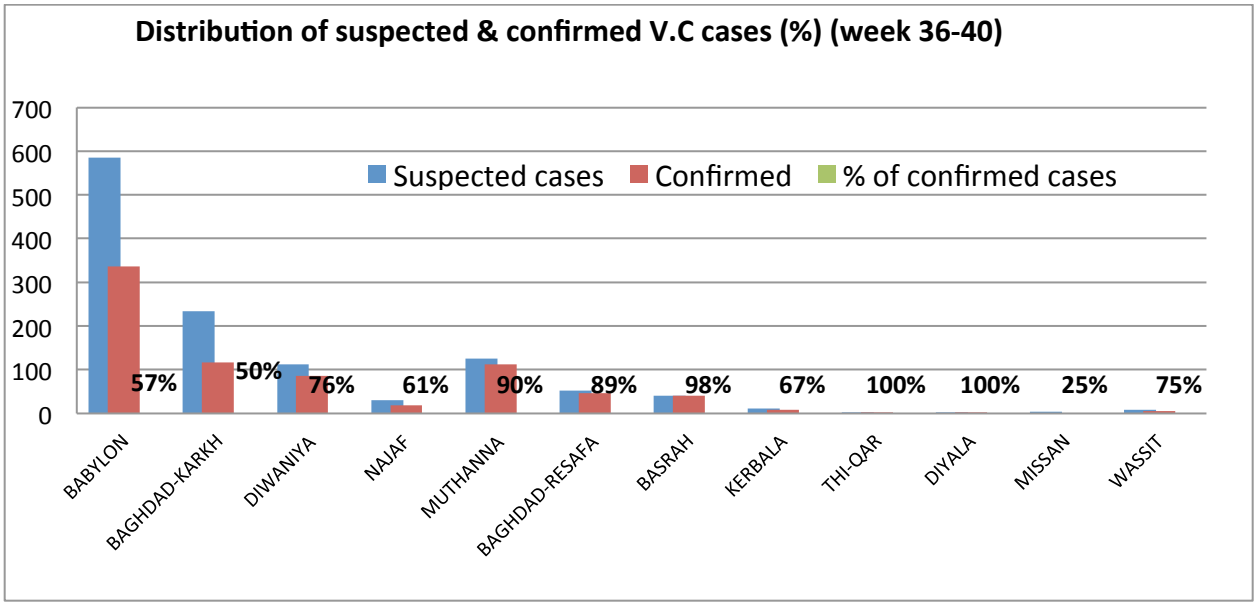
The data received from the Ministry of Health (MoH) indicates that during the week of 36 (31st August – 6th September, 2015), out of 12,537 acute diarrheal cases, there were 23 suspected cholera cases reported through the disease surveillance mechanism out of which four cases were laboratory positive. The number of suspected cases gradually increased in week 37 (7-13 Sept) to 53 out of which 10 were confirmed for VC, followed by 128 suspected VC cases and 84 were positive in week 38 (14-20 Sept, 2015). In week 39 (21-28 Sept) the suspected cases increased to 822 and out of which 310 were tested positive for Vibrio Cholera.



Graph 1: Epi-curve for cholera outbreak between weeks 36-39 (1st - 30th Sept, 2015)

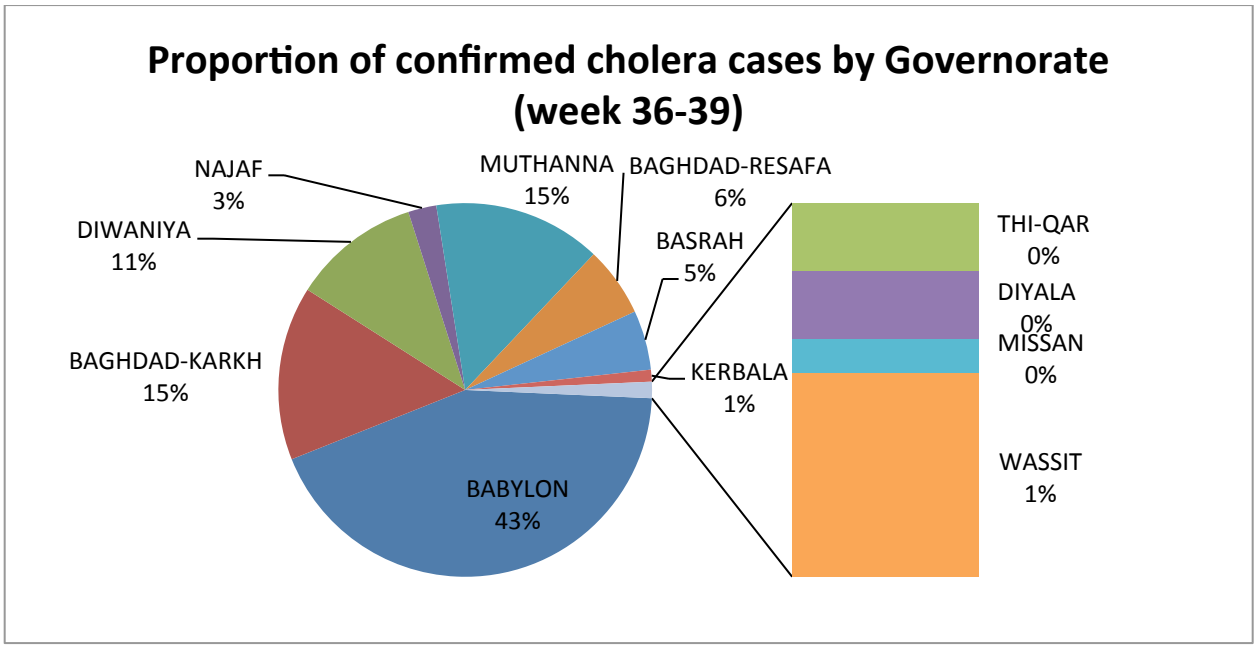
Distribution of cases by Governorate:

The data received from Ministry of Health indicates that the highest numbers of suspected cases are from Babylon, followed by Baghdad – Karkh, Muthanna, Qadissiya – Diwaniya, Baghdad- Resafa, Barsrah and Najaf.



Graph 2: Distribution of suspected & confirmed Cholera Cases by Governorate b/w weeks 36-39

The below pie chart indicates the proportion of confirmed cases by Governorate.



Graph 3: Proportion of confirmed cases by governorate b/w weeks 36-39 (1st - 30th Sept, 2015)