

Iraq: EWARN & Disease Surveillance Bulletin

2016 Epidemiological Week: 1

Reporting Period: 4 — 10 January, 2016

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).

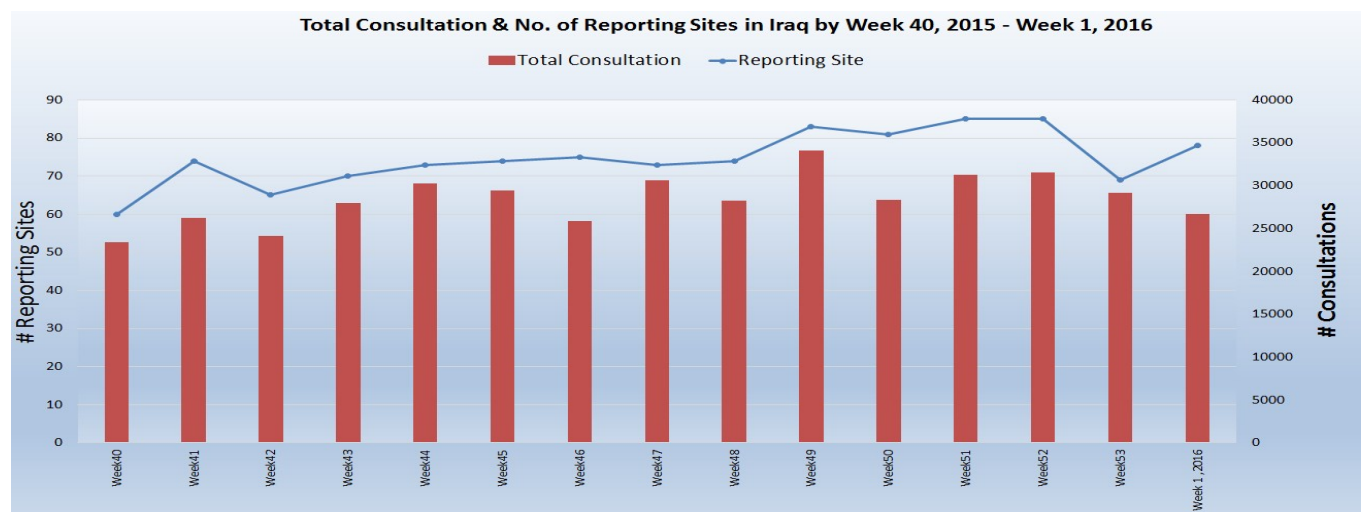
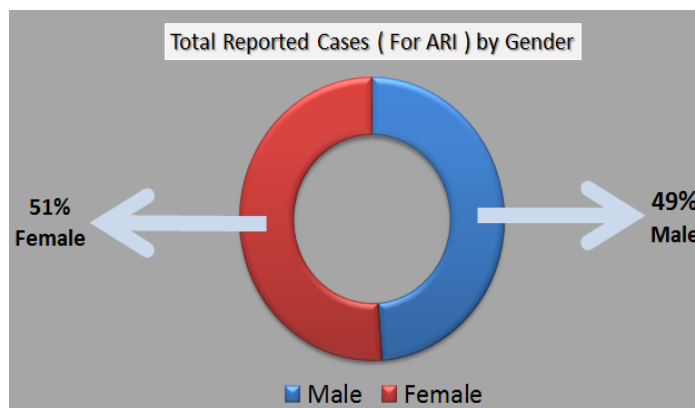
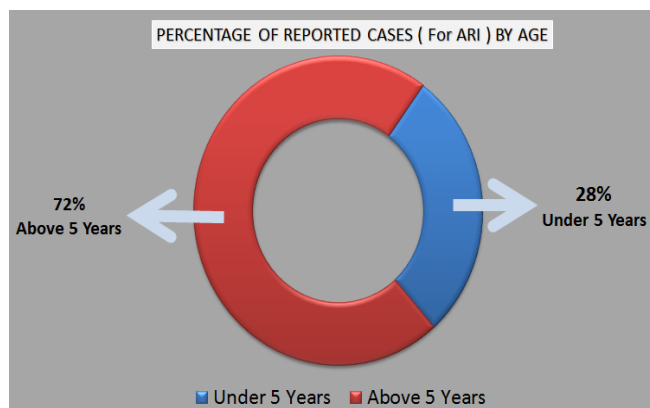


Figure I: Total consultations and proportion of reporting health facilities by week 40 2015 – week 1 2016
Consultations in the camps by age and gender (week 1)



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).

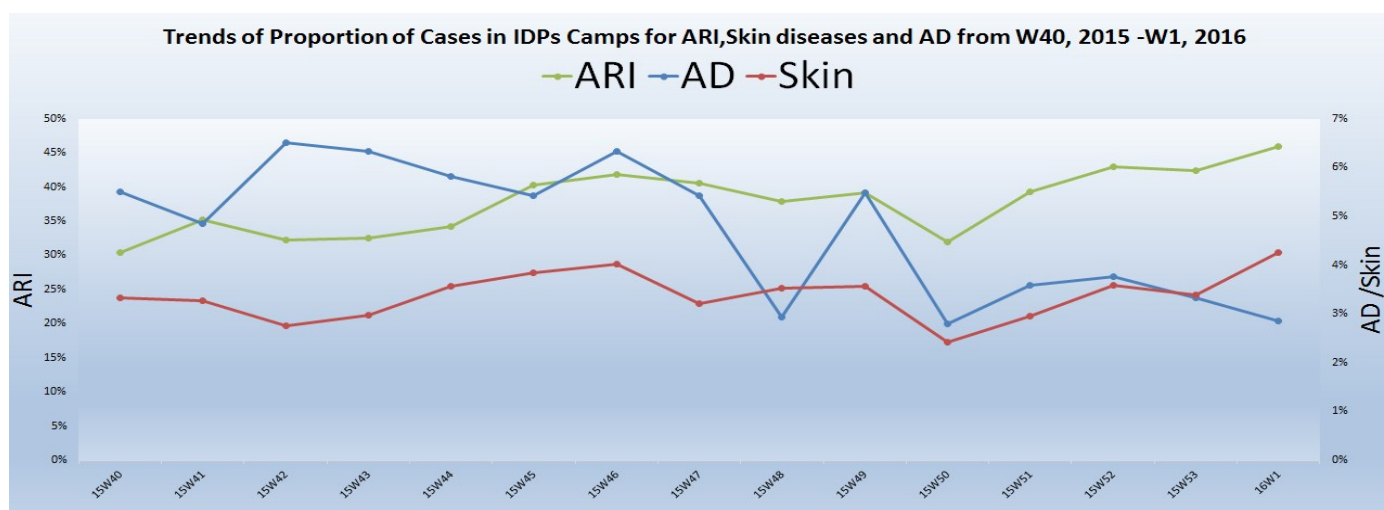


Figure II: Trend of proportion of cases of ARI, Scabies and AD in IDP camps week 40, 2015 –Week 1, 2016

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).

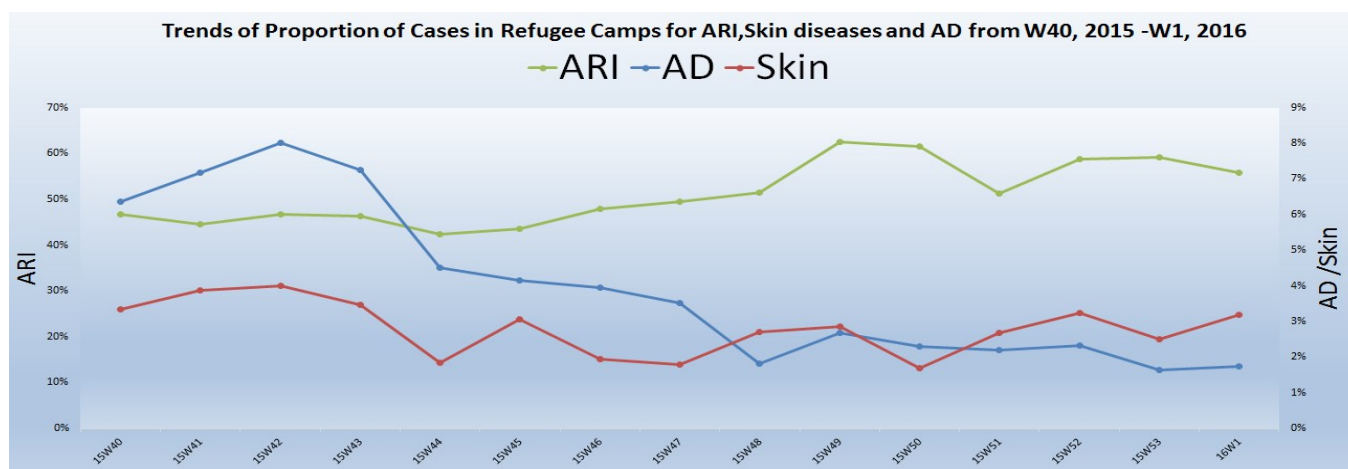


Figure III: Trend of proportion of cases of ARI, Scabies and AD in IDP camps Week 40, 2015—Week 1, 2016

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.

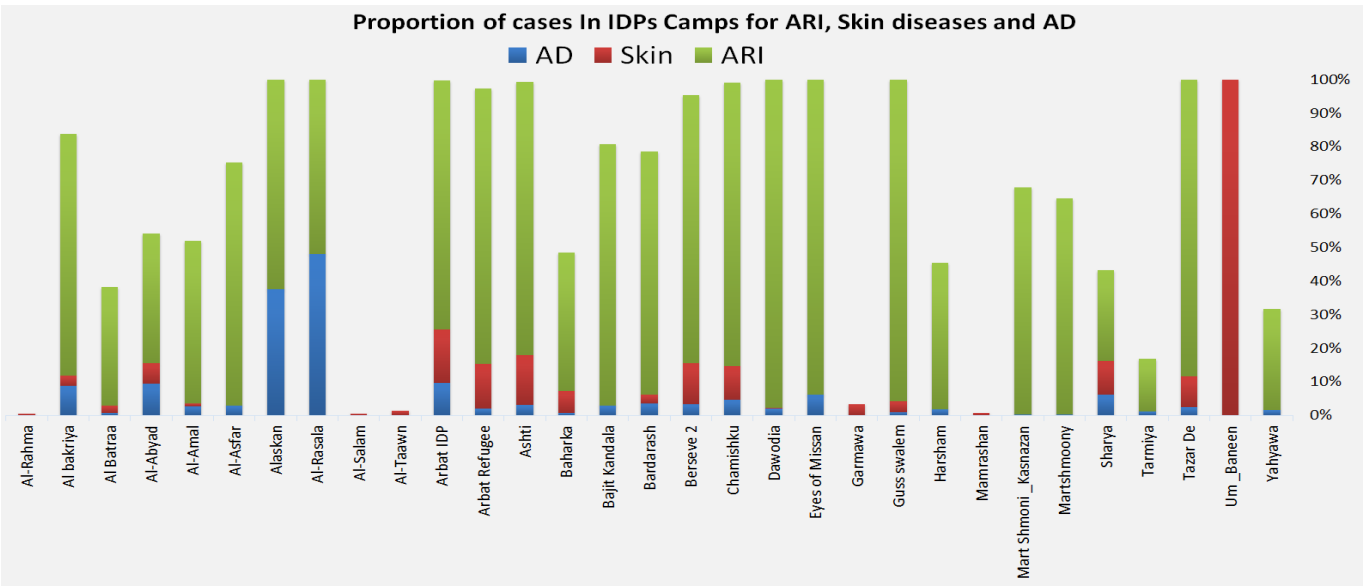


Figure IV: Proportion of cases of ARI, Scabies and AD in IDP camps for Week 1 2016

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.

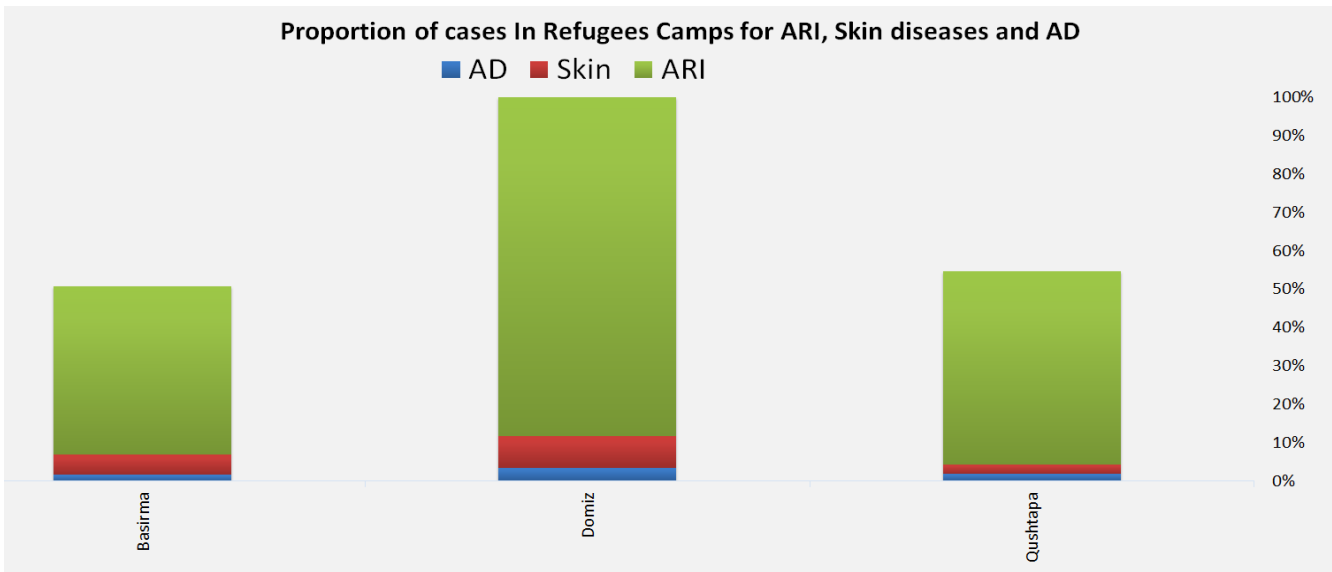


Figure V: Trend of proportions of cases of ARI, Scabies and AD in Refugee camps for Week 1, 2016

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

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.

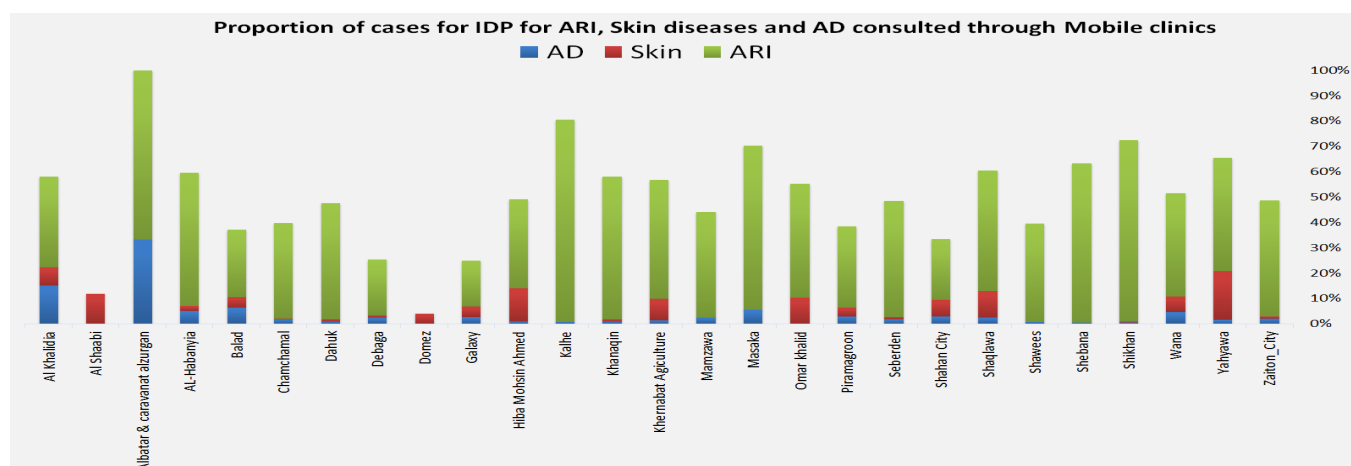


Figure VI: Trend of proportions of IDP cases for ARI, Scabies and AD covered by Mobile Clinics for week 1 - 2016

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.

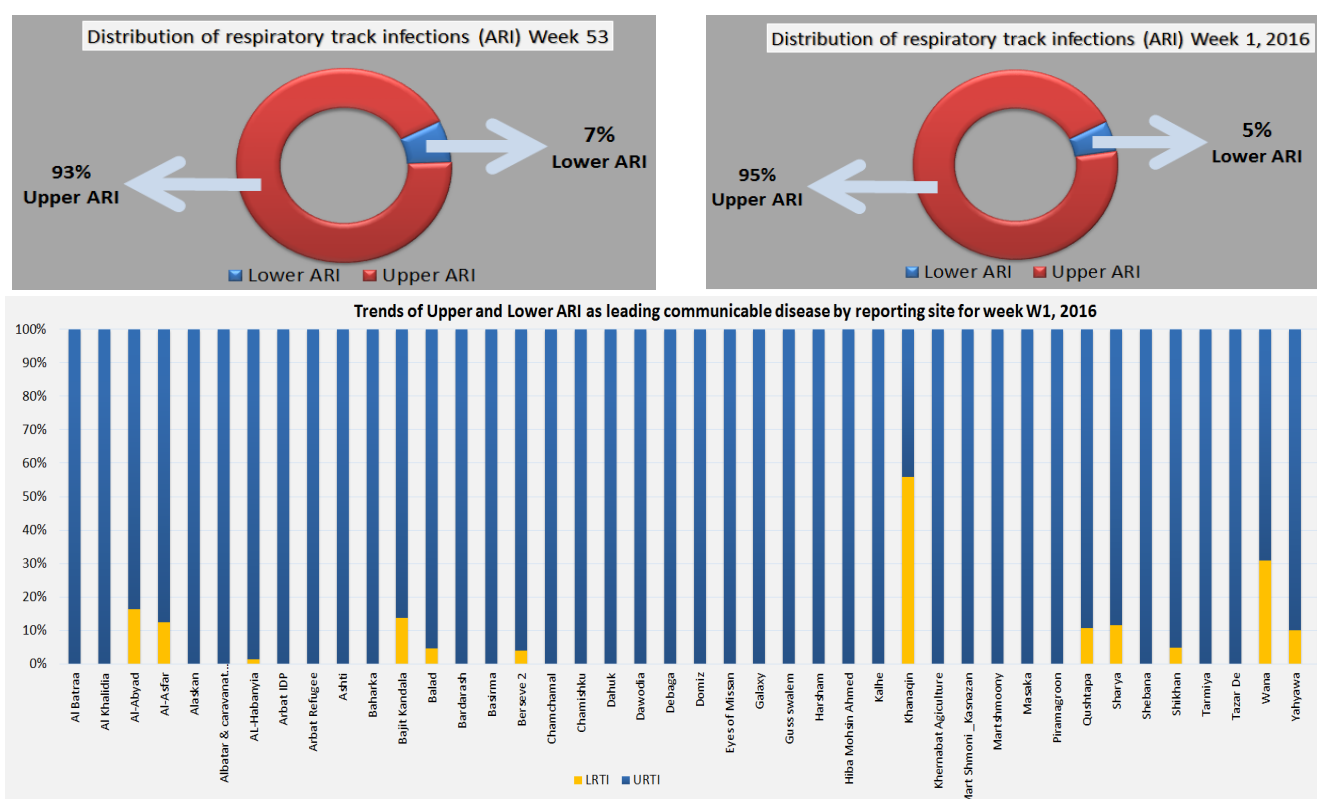


Figure VII: Trend of Upper and Lower ARI per reporting site for week 1 - 2016

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)

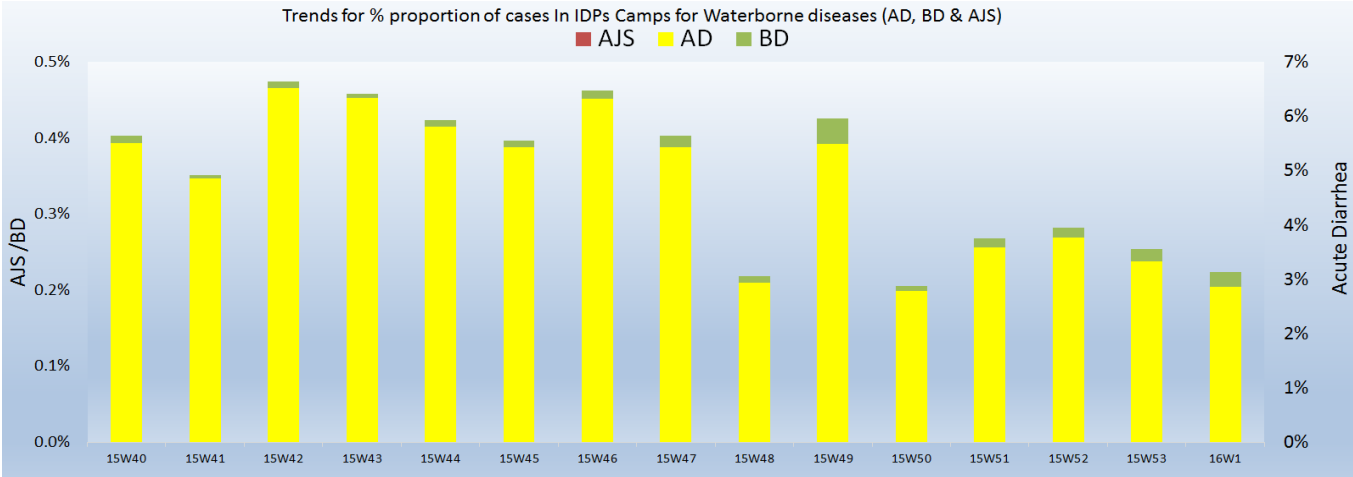


Figure VIII: Trend of Waterborne diseases from IDP camps, week 40, 2015—Week 1, 2016

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.

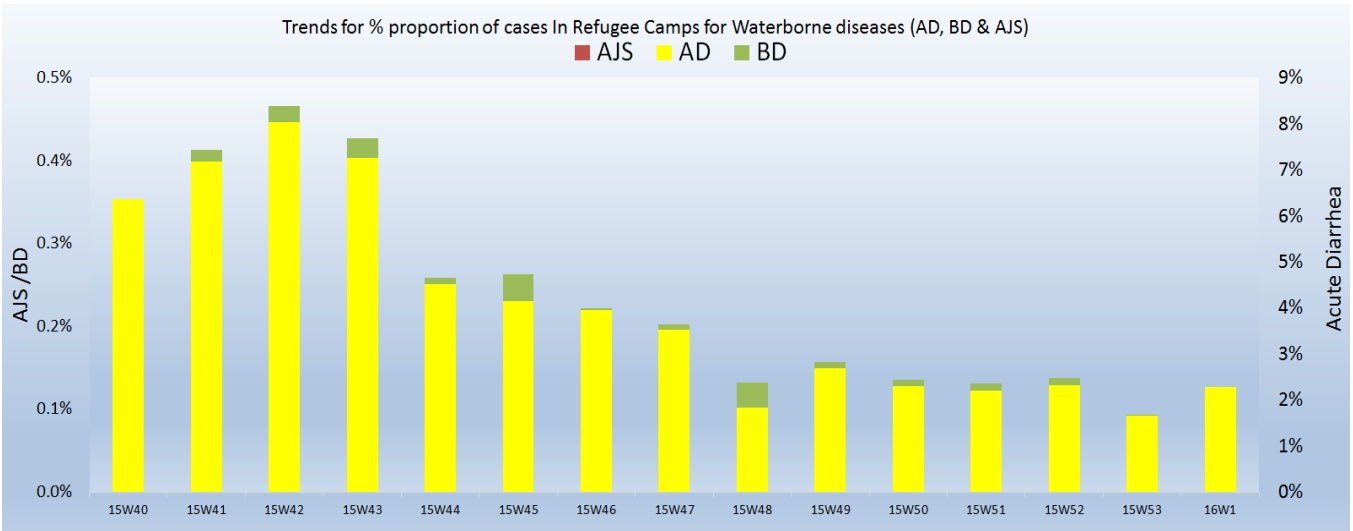


Figure IX: Trend of waterborne diseases from Refugee camps, week 40, 2015—Week 1, 2016

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

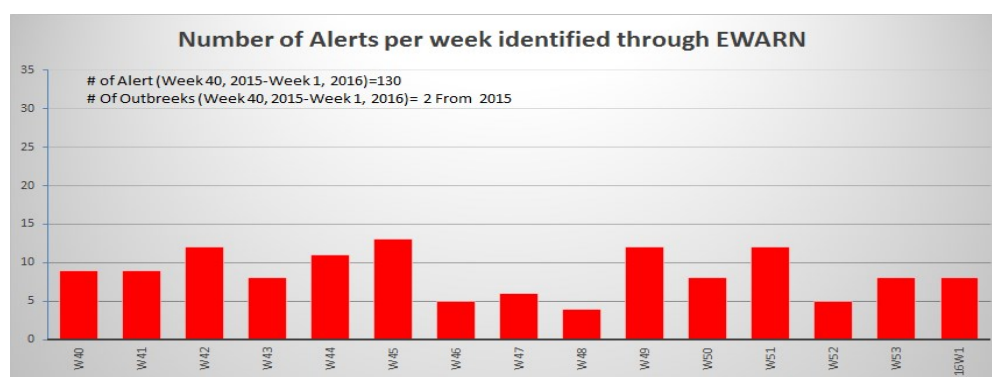
Sn	Alert	Location	Governorate	District	IDP/Refugee Camp	# of cases	Run by	Investigation and Response within 48-72% DOH/WHO/NGO	Sample Taken Yes/No	Alerts Outcome True/False	Public Health Interventions Conducted
1	Suspected Leishmaniasis	Al-Salam	Anbar	Ameriyat Al-Fallujah	IDPs	2	UIMS	Yes	No	TRUE	Yes
2		Al-Amal	Anbar	Al-Nakheeb	IDPs	4	UIMS	yes	No	TRUE	Yes
3		Al-Taawun	Salah al-Din	Al-Mutasem	IDPs	1	UIMS	yes	No	TRUE	Yes
4		Al-Rahma	Salah al-Din	Dijlah	IDPs	21	UIMS	yes	No	TRUE	Yes
5		Zaition City	Erbil	Erbil	IDPs	1	MC-IMC	Yes	Yes	TRUE	Yes
6		Ashti	Sulaymaniyah	Sulaymaniyah	IDPs	1	EMERGENCY	Yes	Pending	Pending	Pending
7		Soryia	Dahuk	Dahuk	IDPs	2	PU-AMI	Yes	No	TRUE	Yes
8	Suspected Meningitis	Seage	Dahuk	Zakho	IDPs	1	IMC	Yes	No	TRUE	Yes
9	Suspected Measles	Ashti	Sulaymaniyah	Sulaymaniyah	IDPs	1	EMERGENCY	Yes	Pending	Pending	Pending
10		Al Batraa	Anbar	Anbar	IDPs	2	DOH	Yes	Yes	TRUE	Yes
11		Arbat	Sulaymaniyah	Arbat	Refugee	1	EMERGENCY	Yes	Pending	Pending	Pending

Trends of Alerts

Measles outbreak was declared in Arbat camp in Sulaymaniyah 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 Sulaymaniyah, 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.



For comments or questions, please contact

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