COMMUNICABLE DISEASE TOOLKIT

ANNEX

Angola

1. Health surveillance forms
2. Surveillance system guidelines and alert thresholds
3. **Case definitions**
4. Guidelines for outbreak control
5. Case management of epidemic-prone diseases
6. Guidelines for collection of specimens for laboratory testing
7. Outbreak investigation kit

WHO-RECOMMENDED CASE DEFINITIONS

ACUTE WATERY DIARRHOEA

Three or more abnormally loose or fluid stools in the past 24 hours with or without dehydration.

Suspected cholera case:

Person aged over 5 years with severe dehydration or death from acute watery diarrhoea with or without vomiting.

Person aged over 2 years with acute watery diarrhoea *in an area where there is a cholera outbreak.*

To confirm case:
Isolation of *Vibrio cholerae* O1 or O139 from diarrhoeal stool sample.

BLOODY DIARRHOEA

Person with acute diarrhoea with visible blood in the stool.

Suspected shigellosis case:
Any person with acute diarrhoea, visible blood in the stool and fever.

Confirmed shigellosis case:
Isolation of *Shigella dysenteriae* type 1 from stool culture and serology from a suspected case.

To confirm case of epidemic bacillary dysentery:
Take stool specimen for culture and blood for serology. Isolation of *Shigella dysenteriae*.

MEASLES

Person with fever **and** maculopapular rash (i.e. non-vesicular) **and** cough, coryza (i.e. runny nose) or conjunctivitis (i.e. red eyes)

or

Any person in whom a clinical health worker suspects measles infection.

To confirm case:
Presence of measles-specific IgM antibodies.

MENINGITIS

Suspected meningitis case:
Sudden onset of fever (>38.0 °C axillary) **and** one of the following:

- neck stiffness
- altered consciousness
- other meningeal sign **or** petechial/purpural rash

In children aged <1 year meningitis is suspected when fever is accompanied by a bulging fontanelle.

Confirmed meningitis case:
A suspected case with laboratory confirmation through positive cerebrospinal fluid antigen detection **or** positive cerebrospinal fluid culture **or** positive blood culture.

To confirm case:

Positive cerebrospinal fluid antigen detection **or** positive cerebrospinal fluid culture **or** positive blood culture.

ACUTE FLACCID PARALYSIS (SUSPECTED POLIOMYELITIS)

Acute flaccid paralysis (AFP) in a child aged <15 years, including Guillain–Barré syndrome **or** any paralytic illness in a person of any age.

Confirmed poliomyelitis case:
An AFP case with laboratory-confirmed wild poliovirus in stool sample.

EBOLA AND MARBURG VIRAL HAEMORRHAGIC FEVERS (VHF)

Suspected (clinical) case:
Any person ill or deceased who has or had a fever with acute clinical symptoms and signs of haemorrhage, such as bleeding of the gums, nose bleeds, conjunctival injection, red spots on the body, bloody stools and/or melena (black liquid stools), or vomiting blood (haematemesis). Documented prior contact with a case of VHF is **not** required.

Probable case (with or without bleeding):
Any person (living or dead) having had contact with a clinical case of EHF and with a history of acute fever.

Or

Any person (living or dead) with a history of acute fever and three or more of the following symptoms:
headache/vomiting/nausea/loss of appetite/diarrhoea/intense fatigue/abdominal pain/general muscular or articular pain/difficulty in swallowing/hiccoughs.

Or

Unexplained death:
The distinction between a suspected case and a probable case in practice is relatively unimportant as far as outbreak control is concerned.

Contact:
A person without any symptoms having had physical contact with a case or the body fluids of a case within the past 3 weeks. The notion of physical contact may be proven or highly suspected, such as having shared the same room/bed, cared for a patient, touched body fluids or closely participated in a burial (e.g. physical contact with a corpse).

To confirm case:
Laboratory confirmation of initial cases is necessary when an epidemic of VHF is suspected. Once the outbreak is confirmed, however, there is no need to collect specimens systematically from each patient, unless this can be done under perfectly safe conditions with appropriate laboratory support.

Confirmed diagnosis is based on ELISA for specific IgG and IgM antibodies, or Ebola-specific antigen detection. These tests are not commercially available and must be performed in specially equipped regional laboratories or shipped to WHO Collaborating Centres.

YELLOW FEVER

Suspected case:
Acute onset of fever followed by jaundice within 2 weeks of onset of first symptoms. Haemorrhagic manifestations and signs of renal failure may occur.

There are two disease phases for yellow fever.

Acute phase:

While some infections cause no symptoms whatsoever, this first phase is normally characterized by fever, muscle pain (with prominent backache), headache, shivers, loss of appetite, nausea and/or vomiting. Often, the high fever is paradoxically associated with a slow pulse (Faget's sign). Most patients improve after 3–4 days and their symptoms disappear, but 15% enter the toxic phase.

Toxic phase:

Fever reappears, the patient rapidly develops jaundice and complains of abdominal pain with vomiting. Bleeding can occur from the mouth, nose, eyes and/or stomach. Once this happens, blood appears in the vomit and faeces. Kidney function deteriorates; this can range from abnormal protein levels in the urine (albuminuria) to complete renal failure with no urine production (anuria). Half the patients in the "toxic phase" die within 10–14 days; the remainder recover without significant organ damage.

To confirm case:

Laboratory confirmation through:

- isolation of yellow fever virus, **or**
- presence of yellow fever specific IgM or a 4-fold or greater rise in serum IgG levels in paired sera (acute and convalescent), **or**
- positive post-mortem liver histopathology, **or**
- detection of yellow fever antigen in tissues by immunohistochemistry, **or**
- detection of yellow fever virus genomic sequences in blood or organs by PCR.

Or epidemiologically linked to a confirmed case or outbreak.

ACUTE LOWER RESPIRATORY TRACT INFECTION / PNEUMONIA IN CHILDREN AGED LESS THAN 5 YEARS

Cough or difficult breathing

and

Breathing 50 or more times per minute for infants aged 2 months to 1 year

Breathing 40 or more times per minute for children aged 1–5 years

and

No chest indrawing, no stridor, no general danger signs.

Note: **Severe pneumonia** = Cough or difficult breathing **plus** any general danger sign (unable to drink or breastfeed, vomits everything, convulsions, lethargic or unconscious) or chest indrawing or stridor in a calm child.

MALARIA

Clinical case definition:

Uncomplicated malaria

Patient with fever or history of fever within the past 48 hours (with or without other symptoms such as nausea, vomiting and diarrhoea, headache, back pain, chills, myalgia) in whom other obvious causes of fever have been excluded.

Severe malaria

Patient with symptoms as for uncomplicated malaria, as well as drowsiness with extreme weakness and associated signs and symptoms related to organ failure such as disorientation, loss of consciousness, convulsions, severe anaemia, jaundice, haemoglobinuria, spontaneous bleeding, pulmonary oedema and shock.

Confirmed malaria case (uncomplicated or severe):
Patient with uncomplicated or severe malaria with laboratory confirmation of diagnosis by malaria blood film or other diagnostic test for malaria parasites.

To confirm case:

Demonstration of malaria parasites in blood film by examining thick or thin smears, or by rapid diagnostic test kit for *Plasmodium falciparum.*

NEONATAL TETANUS

Suspected case:
Any neonatal death between 3 and 28 days of age in which the cause of death is unknown

or

Any neonate reported as having suffered from neonatal tetanus between 3 and 28 days of age but not investigated.

Confirmed case:

Any newborn with normal ability to suck and cry during the first 2 days of life but who, between 3 and 28 days of age, can no longer suck normally and becomes stiff or has convulsions (i.e. jerking of the muscles) or both.

Hospital-reported cases are considered as confirmed cases.

The diagnosis is entirely clinical and does not depend on bacteriological confirmation.

SEXUALLY-TRANSMITTED INFECTIONS

Genital ulcer syndrome
Ulcer on penis or scrotum in men and on labia, vagina or cervix in women with or without inguinal adenopathy.

Urethral discharge syndrome
Urethral discharge in men, with or without dysuria.

Vaginal discharge syndrome
Abnormal vaginal discharge (amount, colour and odour), with or without lower abdominal pain or specific symptoms or specific risk factors

Lower abdominal pain
Symptoms of lower abdominal pain and pain during sexual relations, with examination showing vaginal discharge, lower abdominal tenderness on palpation, or temperature >38 °C.

TUBERCULOSIS (TB)

Suspected TB case:
Any person who presents with symptoms or signs suggestive of pulmonary TB, in particular cough of long duration (>2 weeks, *or in accordance to current Angola National Tuberculosis Control Programme recommendation*).

May also be coughing blood, have chest pain, shortness of breath, fever/night sweats, tiredness, loss of appetite and significant weight loss.

All TB suspects should have three sputum samples examined by light microscopy. Early morning samples are more likely to contain the TB organism than a sample taken later in the day.

Pulmonary TB smear-positive (PTB+)

Diagnostic criteria should include:

- At least two sputum smear specimens positive for acid fast bacilli (AFB)

or

- One sputum smear specimen positive for AFB and radiographic abnormalities consistent with active pulmonary TB

or

- One sputum smear specimen positive for AFB and a culture positive for *Mycobacterium tuberculosis*.

Pulmonary TB smear-negative **(PTB-)**

A case of pulmonary TB that does not meet the above definition for smear-positive TB. Diagnostic criteria should include:

- At least three sputum smear specimens negative for AFB

and

- Radiographic abnormalities consistent with active pulmonary TB

and

- No response to a course of broad-spectrum antibiotics

and

- Decision by a clinician to treat with a full course of anti-TB chemotherapy.

FEVER OF UNKNOWN ORIGIN

Person with fever (>38 °C axillary) in whom all obvious causes of fever have been excluded.

OTHER COMMUNICABLE DISEASES

TYPHOID FEVER

Person with fever of ≥38 °C for 3 or more days is considered suspect if the epidemiological context is conducive.

Clinical diagnosis is difficult as typhoid may vary from a mild illness with low grade fever and malaise to a severe picture of sustained fever, diarrhoea or constipation, anorexia, severe headache and intestinal perforation.

To confirm case:
Isolation of *S.* Typhi from blood or stool cultures.

SEVERE MALNUTRITION

In children aged 6–59 months (65−110 cm in height):

- Weight-for-height (W/H) index <-3 Z-scores (less than minus 3 Z scores on table of NCHS/WHO normalized reference values of weight-for-height by sex) **or**
- Bilateral pitting oedema irrespective of W/H, in absence of other causes.

TRAUMA/ INJURY

Any person who has sustained, either directly or indirectly, a fatal or non-fatal injury which may be:

- war-related: caused by any weapons or explosion of a landmine or other unexploded ordnance (UXO).

- other: road traffic accidents, domestic violence, burns.

Note: Landmine injuries relate to buried mines (e.g. antipersonnel and/or antivehicle mines). UXO injuries arise from explosive objects/devices that are typically above ground at the time of detonation, such as cluster munitions that did not detonate on impact.

MATERNAL DEATH

Death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management.

NEONATAL DEATH

Death of liveborn infant during the first 28 days of life. It is a classification by age, not cause.