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REVIEW OF EPIDEMIOLOGICAL DATA AVAILABLE IN AFRO, OCEAC, OCCGE AND THE THREE EPIDEMIOLOGICAL ANTENNAE OF ICP/CDS/001 (NIAMEY, NAIROBI AND HARARE)

Report on a mission
8 September - 7 December 1985

by

Dr J. Bhageerutty, STC.

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1. INTRODUCTION AND OBJECTIVES

Within the context of AID/CCCD - WHO collaboration, a three month consultancy mission was planned in order to:

- review the epidemiological data available in AFRO, OCEAC, OCCGE and the three epidemiological antennae of ICP/CDS/001 (Niamey, Nairobi and Harare) and identify the sources used;

- examine the mechanisms for review of epidemiological situation and trends in respect of the six EPI target diseases, malaria and diarrhoeal diseases;

- outline proposal for streamlining the mechanism at regional level, identifying the minimum essential information and the indicators to be used for regional epidemiological review.

2. ACTIVITIES

2.1 The consultant arrived at AFRO on 8 September for briefing and interview of Regional Officers involved in data collection, processing, analysis and use thereof. He also looked into the different sources of information available at the Regional Office. He left AFRO on 10 October to pay visits of about one week each to OCEAC, OCCGE, and the epidemiological antennae at Niamey, Nairobi and Harare where he interviewed the relevant persons who were available (Annex 1).

2.2 It should be noted that the consultant was not able to meet the personnel of the epidemiological antenna at Niamey (both the epidemiologist and the technical officer were away on mission). He was fortunate enough to have a late three hour working session with the Epidemiologist of the Nairobi antenna on the day of his arrival as the Epidemiologist was leaving the next day to attend conference in Shri-Lanka. The Epidemiologist stationed at Harare was also absent on misssion.

2.3 During his stay in Niamey, Nairobi and Harare, the consultant also had useful exchange of views with a few nationals involved in the health information system.

3.1.2 It should be noted that in certain cases the data received at AFRO from different sources on the same subject rarely tally. In these circumstances, the highest figures are usually used.

3.1.3 Most of the routine epidemiological data received at AFRO are forwarded by the Registry to CDC (PHD) who after taking cognisance thereof reroutes them to PHS and CHS. The latter feeds the information in the computer of the Data Bank.

3.1.4 At the end of each month, the morbidity and mortality data in the computer are tabulated, in absolute numbers, by disease and by country and in March of each year country print-outs of the cumulated data for the preceding year are forwarded to each Member State through the WHO Coordinator for correction, completion and return. Most of the countries do make some corrections, and additions but very few fully complete all the columns. It was noted that the source of information was not recorded as the computer was not programmed for it. Other available information such as the demographic, immunization and manpower resources data are also stored in the computer.

3.1.5 The information stored in the computer are available to all regional officers, consultants and research workers on request. The data are analysed and utilized mainly for the preparation of the Biennal Report of the Regional Director and the Director General.

3.1.6 Some data received directly by Regional Officers through correspondence, visits or otherwise are analysed and interpreted by the relevant officers and feedback thereon to the source of such information. In some instances, these information are not forwarded to the Data Bank but are available, on request.

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3. FINDINDS

3.1 AFRO

3.1.1 At the Regional Office, epidemiological data are received from many sources, the main ones being:

(a) country epidemiological report/bulletin issued weekly/monthly. It is noted here that if a few countries forward their report/bulletin to the Regional Office on a regular basis, others forward theirs irregularly and a few do not send any, in spite of the constitutional obligation of the Member States to provide WHO with relevant information on their health status and development. Furthermore, not all countries report on the present 28 diseases under surveillance by AFRO. Also, the presentation of the data differs from country to country, some forward data on morbidity only, others morbidity and mortality, some by age of group, some by district/province etc;

(b) the half-yearly and yearly reports of the WPC/NWCs;

(c) telexes for action from Member States as well as copies of important epidemiological information received by HQ;

(d) epidemiological bulletin published by HQ;

(e) replies to questionnaires by the Member States on specific programmes;

(f) annual reports of the Ministry responsible for health in the Member States. It should be mentioned however that as most of the annual reports are published by the Member States with more than one year delay, practically no use is made thereof to update data stored at the Data Bank of AFRO. Furthermore, not all Member States publish annual report. The reports received are routed to PHD, PHP and PHS and other regional officers and are kept at the library.

(g) data in the Demographic Yearbook.

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3.2 OCEAC

3.2.1 Routine epidemiological data are collected by OCEAC from its Member States (Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea and Gabon). Its system of data collection was reinforced in 1980 on the basis of subdivision of each country into geographical sector, with a health officer in charge. All data from the health institutions in each sector are forwarded monthly, on a common form adopted by all the Member States (Annex 2), to the health officer in charge who after compilation and cursory analysis forwards them to the "Direction de la Médecine Préventive et des Grandes Endémies" or its equivalent at the Ministry of Health where the data are compiled on the same form for the whole country and forwarded to OCEAC and in some instances to AFRO or the relevant subregional epidemiological antenna. Epidemiological returns are also received from Angola and Rwanda at OCEAC. The data are fed in the OCEAC computer, cumulated with those of the past months of the year and published in its two monthly "Bulletin de Liaison et de Documentation" (Annex 3). AFRO receives a copy of this Bulletin which is kept in the library. However, the data published cannot be said to have come from the same institutions and over the same period of time.

3.2.2 The progress made with the new system, though slow, is quite satisfactory as the number of health institutions participating as well as the number of returns received are on the increase.

3.2.3 The consultant made a few suggestions as regards a new format for an epidemiological return that was under discussions so that the present 28 diseases under surveillance by AFRO be included. The presentation of the data as published by OCEAC was also discussed so as to enable the Member States to follow better the trend of diseases under surveillance. The suggestions were well received. Furthermore, it was agreed that the data received from institutions on a regular basis will be analysed, interpreted and fedback to the Ministry of Health.

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3.2.4 Apart from collecting, compiling and publishing data from Member States, OCEAC also carries out on request special surveys as well as research work. The results of the surveys and research are also published in their Bulletin.

3.2.5 OCEAC may also play an important role, in collaboration with the Regional Office, to further strengthen the capacity of their common Member States to process, analyse and interpret the data collected for monitoring and evaluating their different programmes.

3.3 OCCGE

3.3.1 Epidemiological data are not collected on a regular basis at the Secretariat of the OCCGE. Any data, whenever received, from any of the Member States (Benin, Burkina-Faso, Ivory Coast, Mali, Mauritania, Niger, Senegal and Togo) are just filed and stored for use by research workers. It should be mentioned that the structure and functions of the Organization are presently being reviewed, specially as most of its technical activities have been decentralised.

3.3.2 AFRO is on the mailing list of OCCGE and receives regularly their two-monthly publication "OCCGE Informations" which is kept at the library. It contains mostly articles on the technical activities of the different institutes of OCCGE.

3.4 WHO Epidemiological Antennae

3.4.1 As previously mentioned, both officers of the WHO Epidemiological Antenna at Niamey were away during the visit of the consultant. According to the National WHO Programme Coordinator, the antenna at Niamey is not receiving any routine epidemiological data from countries of the Sub-Region, except Niger.

3.4.2 The Epidemiological Antennae of Nairobi and Harare receive from a few countries of their Sub-Regions the monthly/weekly epidemiological bulletins/reports. The data are analysed and interpreted and whenever the need arises, observations from the antennae are forwarded to the WHO Coordinator in the country for necessary action. Furthermore, each antenna, according to its functions, cooperates with the Member States in the Sub-Region, whenever requested, to develop: (i) epidemiological activities aiming at prevention and control of communicable diseases within the framework of implementing national strategies for Health for All by the Year 2000; (ii) mechanisms for collecting relevant information for the assessment of the health system, health situation and trends so as to provide sound basis for epidemiological surveillance.

3.4.3 Special surveys to evaluate country programmes are also carried out by the Antennae, whenever requested. The Antennae cooperate with the countries of the Sub-Regions in disease control and prevention activities as well as in research programme. Furthermore assistance, whenever requested, is provided by the antennae in any emergency situation. However, few countries take full advantage of expertise available at the Antennae, may be, because of lack of full information on their functions.

4. ANALYSIS OF DATA COLLECTED

4.1 It was noted that the data provided to the Regional office and Epidemiological Antennae by the Member States vary so substantially in the presentation and completeness that it is practically impossible to compare the effectiveness of different strategies adopted by Member States to combat the same diseases through use of the normal tools of epidemiology, i.e. rates.

4.2 Furthermore, there are many pitfalls in making any trend assessment on the endemic diseases reported by many Member States as the data forwarded do not come from the same health points at the different reporting time. However, these deficiences should not prevent the drawing of useful epidemiological conclusions on diseases of concern to the African Region and to the establishment of priority disease control activities.

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4.3 Presently, many Member States are faced with constraints and problems, some of which are mentioned below:

(i) a high percentage of the personnel at health points have had no training on the relevance and usefulness of data collection and analysis;

(ii) lack of cooperation on the part of some trained health personnel to submit returns;

(iii) no proper mechanism exist in certain Member States for the collection and processing of data;

(iv) no uniformity of reporting from the different provinces in certain countries;

(v) poor communication between the local, intermediate, central levels as regards the channelling of data, resulting in long delays for data to reach the relevant level;

(vi) little use is made of data collected at local and intermediate levels for monitoring and evaluating their activities;

(vii) shortage of trained manpower to process the data collected, to analyse and to interprete them in a way that can be easily understood by the decision makers.

4.4 Though the Member States of the Region are making efforts to strengthen their mechanisms of data collection and processing, without the active collaboration and support of WHO and other Agencies, it would take a long time for many Member States to have timely data with sufficient accuracy and completeness to provide the basis for effective disease control management.

4.5 Effective monitoring and evaluation of any programme depend on the synthesis of all the data derived from different sources which are relevant to the particular programme. Consequently, pertinent epidemiological data should be brought together to be correlated, analysed and interpreted thereby providing essential elements for efficiency and effectiveness of control programme management.

Feedback on data collected, correlated, analysed and interpreted is one of the most important aspects of monitoring and evaluating programmes. In Annex 4 is a concrete example where correlation of pertinent data coming from different sources on a particular country cast a poor picture on the efficiency and effectiveness of the measles prevention programme in a country.

5. GENERAL PROPOSALS

5.1 At national level

There is an urgent need to strengthen the capacity of Member States to successfully implement their disease surveillance system, as well as their capacity to process, analyse and interpret data for management purpose. In particular, emphasis should be laid on the following:

(a) establishing/strengthening proper mechanisms for collecting, processing, analysing and interpreting epidemiological data;

(b) streamlining of the epidemiological data to be collected by the Member States and transmitted to the Regional Office for the assessment of regional health situation and trends of diseases under surveillance and also to allow the Regional Committee "to evaluate the action taken at national and regional levels for monitoring and evaluating the implementation of the strategies for Health for All by the Year 2000" (WHA36.35) in the context of the Seventh General Programme of Work 1984-89 in the field of disease prevention and control;

(c) the inclusion of the present 28 diseases under surveillance at the Regional level in the national list of diseases under surveillance. In the list chickenpox may be replaced by schistosomiasis, a major cause of morbidity in the African Region. It should however be noted that in some countries, some of the diseases do not exist except, may be, as imported cases. It is, however, important to submit a nil return on them rather than no return at all, for in the latter case, it may be taken that the country has no data thereon and thus creates ambiguity;

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(d) as regards countries where it is not yet possible to have total surveillance coverage, many health points, if they meet the laid down criteria, could be used as sentinel posts; the number of the population served by each sentinel post, if possible, by broad age groups, should be estimated to allow the calculation of basic epidemiological rates such as incidence, case fatality rates etc;

(e) the Ministries of Health of the Member States should be encouraged to make use of demographic and vital statistics that are available at their Central Statistical Offices to estimate the population catered by each health institution and to work out different rates so essential as epidemiological tools as well as to set out targets for their programmes at local level;

(f) the very important role of the WPC/NWC's Office in getting timely country data to be forwarded to the WHO Office regularly and channelling any feedback to the relevant local authorities for necessary action.

5.2 <u>At Sub-Regional level</u>

The collaboration existing between the present ICP and other sub-regional health or health related Organizations/Agencies and collaborating centres should be further strengthened through a free flow of information exchange, specially when the ICP is ~~well~~ integrated within the the WHO Sub-Regional Health Development Offices. It is proposed that the countries in each Sub-Region sent to the WHO Sub-Regional Health Development Office (SRHDO) their national surveillance data to be utilized for health situation and trend assessment at national and sub-regional levels. The assessment should be fedback through the relevant WPC/NWC for discussions with the relevant national authorities. The Sub-Regional Health Development Office may use this channel specially where weaknesses have been noticed to offer its cooperation to the Member States as regards strengthening the national mechanisms for data collection, processing, analysis and interpretation, the training of health personnel at local and intermediate levels on the relevance and use of information collected, special surveys, setting up of sentinel posts, selection of indicators, etc. It is understood that for the SRHDOs to be able to carry out these important functions efficiently, they must be provided with required qualified personnel as well as with adequate data

5.2.2 Special surveys, when requested by the Member States, may also be used to supplement data received from usual sources.

5.2.3 The degree of accuracy of any health situation and trend assessment is directly correlated to that of the data used. As previously stated, many of the data supplied by most the Member States are incomplete and no mention made as to whether the data relate to only a part or parts of the country or to sentinel posts. It is therefore proposed that action be initiated by the WPC and NWC, to encourage Member States to seek the cooperation of the SRHDO to sufficiently improve on the accuracy in data collection for their own use and to share them with WHO, after analysis and interpretation. This can often be done with relatively limited resources as most countries have an abundance of data collected at local and other levels and no full use made thereof.

5.3 <u>At Regional level</u>

The Regional office should continue to receive national epidemiological data either through the SRHDO's or direclty and make use of all sources of information available to it, as well as secondary data to assess the health situation and trends for the Region as a whole. It is to be reiterated that the data forwarded by the Member States should as far as possible be internationally comparable to enable AFRO to objectively process, analyse and interpret these data and to publish a reliable report on health situation in the African Region.

6. SPECIFIC PROPOSALS

6.1 A consultation with the participation of at least two senior officials (one of whom should be from the health information system) ~~of the~~ from each Member States should be held under the aegis of AFRO as soon as possible to work out a format for a monthly epidemiological report form, as this is the major source of information utilized by AFRO Data Bank. It is suggested that the form be divided into five parts. The first part should deal with the diseases subjected to the International Sanitary Regulations. This monthly reporting will in no way replace the obligations of the Member States under Part II of the International Sanitary Regulations. The second part should deal with diseases under global surveillance, the third with diseases of regional interest, (the present list may be discussed and proposal made for its amendement), the fourth with EPI target diseases and the fifth with other diseases of national importance. The morbidity and mortality data should be given according to the following age groups; under 1 year, 1 to 4 years, 5 to 9 years, 10 to 14 years, 15 to 64 and 65^{+} years. The form should specify whether the data relate to the totality of the country or only to parts thereof and in which case estimation of the population at risk should also be given. This consultation will be in line with resolution AFR/RC34/R9 which inter alia invites Member States to review current methods of epidemiological surveillance including the exchange of information so as to readapt and reactivate them in line with the need. Financial assistance for the printing of the first batches of the agreed form may ease their acceptance by the Member States.

6.2 The officers responsible at the Regional level for WHO programmes included in the Seventh Programme of Work covering the period 1984-1989 should get together to prepare a common yearly questionnaire embodying the minimum information they require for monitoring the progress of their programmes in the Member States. This common questionnaire will obviate the need of asking Member States information at different times of the year.

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6.3 Source/s of information should be recorded and must appear on the computer print-outs of the Data Bank.

6.4 The Data Bank should regularly transmit to each programme officer, in a tabulated form, as may be required, data for analysis, interpretation and feedback.

6.5 Print-outs on epidemiological data sent to each Member State for correction and completion in March of every year should also give the the following basic information as available in the Data Bank:

(i)	the estimated population as at ..../..../.... (day/month/year		
(ii)	birth rate	....	(year....)
(iii)	death rate	....	(" ....)
(iv)	rate of natural growth of population	....	(" ....)
(v)	population under one year	....	(" ....)
(vi)	" 1 to 4 years	....	(" ....)
(vii)	" 5 to 9 years	....	(" ....)
(viii)	" 10 to 14 years	....	(" ....)
(ix)	" 15 to 64 years	....	(" ....)
(x)	" 65+ years	....	(".....)
(xi)	Female population aged 15 to 49 years	....	(".....)
(xii)	Infant mortality rate	....	(".....)
(xiii)	Child (1-4 years) mortality rate	....	(".....)

6.6 Relevant data received independently by programme officers either through publications (OCEAC, OCCGE etc.) or through reports by WHO consultancy missions or special surveys or visits etc., should be transmitted to the CHS for entry into the computer.

6.7 Each regional programme officer should utilize maximally the information stored in the Data Bank at least once yearly to monitor the progress of his programme in each Member State and in the Region as a whole. Feedback to the Member States is of crucial importance. The analysis of the situation may also be published in the proposed AFRO quarterly epidemiological bulletin and used for the Biennal Report of the Regional Director as well as that of the Director-General.

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7. INDICATORS

7.1 However potentially useful an indicator may be to monitor progress at the Regional level, its selection depends on the capability of Member States to furnish sufficiently reliable information required for its calculation. Consequently, it would not be feasible, for the time being, to make use of incidence rate at Regional level to follow the trend in the field of communicable diseases control where disease reduction remains the fundamental objective.

7.2 Until such time that a majority of Member States would be in a position to provide sufficient accurate epidemiological data to work out incidence, and other relevant rates, the hereunder indicators may be utilized at the Regional level for monitoring progress:

A. General

(i) Number of countries where any of the diseases under surveillance in the Region, is of major public health importance.

(ii) Proportion of countries with control programme against any of the diseases of major public interest in the Region.

(iii) Case fatality rate of diseases under surveillance.

iv) The ranking (morbidity/mortality-wise) of the diseases at the Regional level worked out on the data supplied by the Member States.

B. Malaria

(i) Number of countries of the Region where malaria is endemic.

(ii) Number of countries, where malaria is endemic, with a malaria control programme.

(iii) Proportion of countries with control programme using chemoprophylaxis to protect pregnant women or other vulnerable group of their population.

(iv) Proportion of countries with vector control programme using (a) insecticide spraying; (b) general environmental control measures;

(v) Number of countries where malariometric surveys have been carried out.

(vi) (a) Number of countries with hypoendemic malaria.
(b) " " " mesoendemic "
(c) " " " hyperendemic "
(d) " " " holoendemic "

C. Diarrhoeal Diseases

(i) Number of countries in the Region with a diarrhoeal control programme.

(ii) Number of countries where ORS is available at local level in more than 50% of the health institutions.

(iii) Number of countries producing ORS;

(iv) Proportion of diarrhoeal cases receiving ORT in health institutions.

(v) Number of countries where the diarrhoeal disease control programme has been evaluated.

(vi) Proportion of the populations supplied with potable water.

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D. EPI

(i) Number of countries in the Region which has agreed to implement EPI;.

(ii) Number of countries where EPI is implemented.

(iii) Proportion of countries with EPI programme which have adopted the recommended schedule of immunizations.

(iv) Proportion of infants in the Region under one year of age fully immunized against the six target diseases.

(v) Proportion of infants in the Region fully immunized against each of the six target diseases.

(vi) Number of countries in the Region where:

(a) more than 75% of infants under 1 year are fully immunized against the six target diseases.
(b) between 60 to 75% " "
(c) " 40% to less than 60% "
(d) less than 40% of infants "
(e) more than 80% of infants under 1 year have received DPT1
(f) between 60 to 80% " "
(g) less than 60% of infants "
(h) more than 80% of infants under 1 year have received DPT3
(i) between 60 to 80% " "
(j) less than 60% " "

(vii) Proportion of pregnant women in the Region who have received ~~receiving~~ two doses or one booster dose of tetanus toxoid during ~~each~~ the year.

(viii) Number of countries where any of the EPI target diseases ranks amongst the ten major causes of morbidity or mortality.

8. SUMMARY

The problems faced by the Regional Office to fully utilize the epidemiological data supplied by Member States for health situation and trend assessment in the field of communicable diseases are discussed. Proposals are made to resolve as many of those problems as possible in order to enable the Regional Office to monitor and assess on a more accurate basis the trends of communicable diseases under surveillance. Certain indicators based on available data or on easily obtainable information from Member States are proposed.

9. ACKNOWLEDGEMENTS

The Consultant wishes to place on record his heartfelt appreciation and thanks to all WHO Officers as well as those of OCEAC and OCCGE who made themselves available, in spite their heavy schedule, to provide and discuss very valuable information. He is also most grateful to the WHO Coordinators and their staff for their kind assistance during his stay in the countries visited and not the least to USAID/CCCD Liaison Officer for his active help and collaboration.

PERSONS MET/INTERVIEWED

AFRO

Dr A. H. Abdou, CDP

Mr K. E. Adidpeto, PHI

Dr J. C. Alary, PHD

Dr L. Arevshatian, CDI

Dr D. Barakamfitiye, PM3

Dr E. G. Beausoleil, CDM

Dr R. M. Boal, FHE

Dr D. Buriot, CDD

Mr G. S. Mounguengue, CHS

Mr C. V. G. Nair, PHS

Dr G. Ramanohisoa, HSD

Mr I. Ujoodha, CDT

Dr R. Yang, CDB

CCCD/Brazzaville

Mr D. Basset

Cameroun

Dr B. Ilunga, WPC/Cameroun

OCEAC/Yaoundé

Dr D. Kouka-Bemba, Secrétaire général

Dr L. Sentilhes, Secrétaire général honoraire

Dr V. Mouanda, Secrétaire général adjoint

Dr M. Merlin, Epidémiologiste

Mr J. J. Keuzeta, Ingénieur Statisticien

OCCGE/Bobo-Dioulasso

Dr E. Akinocho, Secrétaire général, a.i.

Mr Noungou, Administrateur

Mr Aguesse, Bibliothécaire, Centre de Documentation

Dr Roisin, Epidémiologiste

Dr Douchet, Directeur du Centre Muraz

Dr Hennequin, Chef de Service de Vaccinologie, Centre Muraz

Annexe 1

Niamey, Niger

Mr John Wright, NWC

Dr Daga Magagi, Secrétaire général/Ministère de la Santé et des Affaires sociales

Mr Mamoudou Soumeïla, Directeur des Etablissements des Soins

Mr Tini Inoussa, Directeur de la Division des Infrastructures & Statistiques

Nairobi, Kenya

Dr M. Davies, WPC

Dr Kalisa-Ruti, WHO Epidemiologist

Mr Christodoulou, WHO/TO

Mr E. M. Wafula, Coordinator of WHO supported ARI Project

Dr Kayo, Head of the Health Information System, MOH, Kenya

Dr D. M. Mutie, Manager KEPI/Diarrhoeal Diseases MOH Kenya

Dr T. K. A. Siongok, Director, Division of Communicable Diseases, MOH, Kenya

Harare, Zimbabwe

Dr Shehu, Sub-Regional Director

Dr G. T. Lema, WPC

Mr M. Mpayamaguvu, WHO/TO

Dr Munochiweyi, Head of the Health Information System, MOH, Zimbabwe

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ANNEX 2

MINISTERE DE .....

ANNÉE .....

DIRECTION DE .....

FICHE MENSUELLE OCEAC
D'ACTIVITÉS DE SURVEILLANCE ÉPIDÉMIOLOGIQUE

MOIS .....

I – NOTIFICATIONS PÉRIODIQUES DES MALADIES TRANSMISSIBLES	Mois actuel	Tot. depuis 1er Janvier	Total Année Précédente
Nombre de formations sanitaires participantes	.....	.....	.....
Notifications hebdomadaires			
* Nombre de bulletins attendus	.....	.....	.....
* Nombre de bulletins reçus	.....	.....	.....
Déclarations mensuelles			
* Nombre de fiches récapitulatives attendues	.....	.....	.....
* Nombre de fiches récapitulatives reçues	.....	.....	.....

Observations :

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II – ACTIVITÉS DE DÉPISTAGE			
Consultations externes des formations sanitaires			
* Nombre de consultants examinés	.....	.....	.....
* Nombre de consultations	.....	.....	.....
Examens systématiques			
* Nombre de personnes examinées, total	.....	.....	.....
dont – par équipes de prospection médicale	.....	.....	.....
dont – par équipes d'intervention épidémiologique ...	.....	.....	.....
dont – par équipes spécialisées (SMI, Hyg.sco.)	.....	.....	.....
* Population recensée des zones prospectées par les équipes de prospection (uniquement)	.....	.....	.....

Observations : zones prospectées, interventions effectuées, . . .

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III – TABLEAU RÉCAPITULATIF DES MALADIES TRANSMISSIBLES OBSERVÉES

Liste C.I.M. (O.M.S.)	MALADIES	Classement par âge des cas observés					Nbre de décès observés
		Moins de 1 an	1 à 4 ans	5 à 14 ans	15 ans et plus	Total	
001	CHOLÉRA	.....	.....	.....	.....	.....	.....
006	AMIBIASE	.....	.....	.....	.....	.....	.....
009	MALADIES D'IARRHÉIQUES ...	.....	.....	.....	.....	.....	.....
011	TUBERCULOSE PULMONAIRE	.....	.....	.....	.....	.....	.....
030	LEPRE	.....	.....	.....	.....	.....	.....
032	DIPHTÉRIE	.....	.....	.....	.....	.....	.....
033	COQUELUCHE	.....	.....	.....	.....	.....	.....
036-0	MÉNINGITE CÉRÉBROSPINALE	.....	.....	.....	.....	.....	.....
771-3	TÉTANOS DU NOUVEAU–NÉ	.....	.....	.....	.....	.....	.....
037-3	TÉTANOS (autres cas)	.....	.....	.....	.....	.....	.....
045	POLIOMYÉLITE AIGUE	.....	.....	.....	.....	.....	.....
138	SÉQUELLES DE POLIOMYÉLITE	.....	.....	.....	.....	.....	.....
057-9	MALADIES ÉRUPT. VARIOLIF.	.....	.....	.....	.....	.....	.....
052	VARICELLE	.....	.....	.....	.....	.....	.....
055	ROUGEOLE	.....	.....	.....	.....	.....	.....
060	FIEVRE JAUNE	.....	.....	.....	.....	.....	.....
070	HÉPATITE VIRALE	.....	.....	.....	.....	.....	.....
071	RAGE	.....	.....	.....	.....	.....	.....
076	TRACHOME	.....	.....	.....	.....	.....	.....
139-1	SÉQU. DE TRACH. (Trichiasis) ..	.....	.....	.....	.....	.....	.....
084	PALUDISME	.....	.....	.....	.....	.....	.....
085	LEISHMANIOSE	.....	.....	.....	.....	.....	.....
086-5	TRYPANO. H. AFRICAINE	.....	.....	.....	.....	.....	.....
090/097	SYPHILIS (toutes formes)	.....	.....	.....	.....	.....	.....
098-4	OPHTALMIE gono.du nouveau-né	.....	.....	.....	.....	.....	.....
098-0à8	Autres infections GONOCOCCIQUES	.....	.....	.....	.....	.....	.....
099	Autres maladies VÉNÉRIENNES	.....	.....	.....	.....	.....	.....
102	PIAN	.....	.....	.....	.....	.....	.....
120-0	SCHISTOSOMIASE (urin. ou vésic.)	.....	.....	.....	.....	.....	.....
121-1	SCHISTOSOMIASE intestinale ..	.....	.....	.....	.....	.....	.....
125-0	FILARIOSE à Wuchéréria Bancrofti	.....	.....	.....	.....	.....	.....
125-2	FILARIOSE à Loa Loa	.....	.....	.....	.....	.....	.....
125-3	ONCHOCERCOSE	.....	.....	.....	.....	.....	.....
125-7	DRACUNCULOSE	.....	.....	.....	.....	.....	.....
126	ANKYLOSTOMIASE	.....	.....	.....	.....	.....	.....
127/129	Autres HELMINT. intestinales ...	.....	.....	.....	.....	.....	.....

IV – ACTIVITÉS DE PRÉVENTION

VACCINATIONS	à titre individuel	Prospection Intervention	Total mois actuel	Total depuis 1 janv.	Total année précéd.
Antiamariles	.....	.....	.....	.....	.....
Antirougeoleuses	.....	.....	.....	.....	.....
Anticholériques	.....	.....	.....	.....	.....
B.C.G.	.....	.....	.....	.....	.....
Antitétanique *	.....	.....	.....	.....	.....
Antipoliomyélitiques * ..	.....	.....	.....	.....	.....
Antidiphtériques *	.....	.....	.....	.....	.....
Antirabiques	.....	.....	.....	.....	.....

* : Vaccinations complètes effectuées

V – MALADIES A NOTIFICATION HEBDOMADAIRE OBLIGATOIRE

Nombre de suspects ayant fait l'objet d'une investigation épidémiologique et / ou biologique :

* Porteurs d'une maladie éruptive varioliforme : .....
* Porteurs d'une maladie diarrhéique grave : .....
* Porteurs d'un ictère fébrile : .....
* Porteurs d'un syndrome fébrile hémorragique : .....

Résultats des examens de laboratoire (résultats reçus dans le mois) :

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.....

CHOLÉRA :

* Régions atteintes :

Département - Sous Préfecture - Canton	MALADES DÉPISTÉS		MALADES DÉCÉDÉS	
	Selles à V cholerae +	Diarrhée suspecte	Avant traitement	Après traitement
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
TOTAL :				

* Nombre de sujets soumis à chimioprophylaxie : .....

* Observations :

.....

POLIOMYÉLITE AIGUE :

* Cas reconnus, Total : ..... dont jeunes de moins de 15 ans : .....
* Observations (localisations géographiques, foyers éventuels, etc ...) :

.....

.....

Ex 2

ROUGEOLE

* Cas observés :

SELON LA TRANCHE D'AGE	Malades dépistés		Malades décédés	
	Antérieurement vaccinés	Non vaccinés	Vaccinés	Non vaccinés
De 0 à 9 mois	.....	.....	.....	.....
De 10 mois à 4 ans	.....	.....	.....	.....
de 5 ans et plus	.....	.....	.....	.....
Total :				

* Observations (bouffées épidémiques, complications, etc ...)

.....

.....

TÉTANOS

* Cas observés, total : ..... , dont cas de tétanos néonatal .....
* Observations :

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MÉNINGITE CÉRÉBROSPINALE

* Nbre de suspects ayant fait l'objet d'un examen bactériologique du LCR : _____
* Présence de méningocoque dans le LCR : _____
* Traitement spécifique utilisé :

Nombre de malades traités : _____ Nombre de malades décédés : _____

(dont DC avant traitement : _____ après traitement : _____)

* Observations :

.....

VI – AUTRES MALADIES A DÉCLARATION MENSUELLE (d'intérêt sous-régional)

A – TRYPANOSOMIASE (campagne nationale en cours)	Mois actuel	Tot. depuis le 1 janvier	Tot. année précédente
1. Nouveaux malades reconnus T + Total	.....	.....	.....
- dont LCR non altéré	.....	.....	.....
- dont dépistés par examens systématiques	.....	.....	.....
Déclarés suspects immunologiques (TO, IFI ++)	.....	.....	.....
Malades suspects cliniques (TO, LCR altéré)	.....	.....	.....
2. Total des trypanosomés existants (en compte)	.....	xxxxxxxx	.....
Déclarés guéris (et rayés des comptes)	.....	.....	.....
Déclarés décédés (et rayés des comptes)	.....	.....	.....
- dont décès au cours du traitement	.....	.....	.....
3. Échecs au traitement MÉLARSOPOL	.....	.....	.....
Rechutes et reprise de traitement	.....	.....	.....
4. Chimioprophylaxie, nombre de sujets protégés	.....	.....	.....

5. Observations :

.....

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B – LEPRE (campagne nationale en cours)

	Mois actuel	Tot. depuis le 1 janvier	Tot. année précédente
1 - Libérés des contrôles (déclarés guéris)			
2 - Nouveaux lépreux dépistés, total			
- dont formes lépromateuses			
- dont porteurs d'invalidité (2ème au 5ème degré)			
- dont formes infantiles			
3 - Total des lépreux existants (en compte)		xxxxxxx	
- dont Inactifs sans traitement (EOST)		xxxxxxx	
- dont Inactifs avec traitement (Blanchis)		xxxxxxx	
4 - Nombre de malades traités dans le mois		xxxxxxx	
- présents à plus de 50% des séances de traitement		xxxxxxx	
- en circuits de traitement		xxxxxxx	
- en autotraitement		xxxxxxx	

5 - Observations (traitements appliqués, réactions lépreuses, ...)

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C – TUBERCULOSE (campagne nationale en cours)

1 - Libérés des contrôles (déclarés guéris)			
2 - Nouveaux tuberculeux pulmonaires dépistés, total			
- dont formes bacillifères			
- dont dépistés par examens systématiques			
3 - Total des tuberculeux pulmonaires en compte		xxxxxxx	
4 - Nombre de malades traités dans le mois		xxxxxxx	
- dont hospitalisés depuis moins de 2 mois (Trt. Starter)		xxxxxxx	
- dont hospitalisés depuis plus de 2 mois		xxxxxxx	
- dont traitement ambulatoire		xxxxxxx	

5 - Observations (Échecs, rechutes observées, ...)

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Annex 2

D – TRÉPONÉMATOSES ET MALADIES A TRANSMISSION SEXUELLE

1. Urétrites aiguës reconnues dans le mois : ___ , avec présence de Gono + : ___
   Vaginites aiguës reconnues dans le mois : ____, avec présence de Gono + : ___
2. Cas de syphilis vénérienne dépistés dans le mois : ____
   - dont avec lésion clinique précoce (contagieuse) : ____
   - dont syphilis congénitale : ____
   - dont dépistage uniquement sérologique : ____
3. Nombre de contacts traités : ____

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.....

E – SCHISTOSOMIASE (mentionner les zones prospectées, la proportion relative de Sch. intestinales et urinaires, éventuellement des espèces parasitaires en cause) :

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F – ONCHOCERCOSE ET AUTRES FILARIOSES (mentionner les zones prospectées, le taux de porteurs de kystes, de lésions oculaires, et de cécité) :

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G – TRACHOME (donner la distribution des cas selon le stade clinique, le nombre de trichiasis traités, etc ...) :

.....

.....

.....

A ..... le .....

Signature :

INFORMATIONS EPIDEMIOLOGIQUES
ET STATISTIQUES

ACTIVITES DE SURVEILLANCE EPIDEMIOLOGIQUE
E N
REPUBLIQUE CENTRAFRICAINE

Source : Direction de la Médecine Préventive et des Grandes Endémies :
.Fiche mensuelle OCEAC des Activités de Surveillance épidémiologique.

	JAN/SEPT 1984	ANNEE 1983
1. POPULATION RECENSEE (estimation) :	2 400 000	2 400 000
dont moins de 5 ans :	16,5 %	16,5 %
âgés de 5 à 14 ans :	25,6 %	25,6 %
2. NOTIFICATIONS MENSUELLES		
- Secteurs et/ou formations participants à la Surveillance :	135	135
- Rapports attendus depuis Janvier :	1 370	1 620
- Rapports reçus depuis Janvier :	726	905
3. ACTIVITES DE DEPISTAGE		
- *CONSULTATIONS EXTERNES* des formations sanitaires :		
.Nombre de consultants examinés :	595 254	636 341
.Nombre de consultations :	1 065 842	1 244 904
- *EXAMENS SYSTEMATIQUES* :		
.par équipes de prospection médicale :	238 914	343 670
.par équipe d'intervention épidémiologique :	4 026	9 673
.par équipes spécialisées :	102 120	85 990
Total :	345 060	439 343
4. ACTIVITES DE PREVENTION : VACCINATIONS		
- Vaccinations antiamariles :	29 604	80 877
- Vaccinations antirougeoleuses :	63 413	95 813
- Vaccinations anticholériques :	1 629	2 552
- B.C.G. :	101 800	130 339
- Vaccinations antitétaniques* :	121 644	178 189
- DT.COQ* :	84 051	161 703
- Vaccinations antipoliomyélitiques* :	82 812	159 793
5. SURVEILLANCE DES MALADIES QUARANTENAIRES		
- Suspects porteurs d'une *maladie éruptive varioliforme*, ayant fait l'objet d'une investigation épidémiologique :	-	-

** Vaccinations complètes effectuées).*

ex. 3

	JAN/SEPT 1984	ANNEE 1983
- Suspects porteurs d'une *maladie diarrhéique grave*, ayant fait l'objet d'une investigation épidémiologique :	-	-
CHOLERA -Cas :	-	-
-Décès :	-	-
- Suspects porteurs d'un *ictère fébrile grave*, ayant fait l'objet d'une investigation épidémiologique...	-	-
6. CAMPAGNES NATIONALES EN COURS		
TRYPANOSOMIASE		
- *NOUVEAUX MALADES* pris en compte, total :	126	55
.avec diagnostic confirmé parasitologiquement (T+).	-	27
.suspects immunologiques (T0 et IFI+++) :	82	28
- Trypanosomés *EN COMPTE* :	644	571
- A.T. *RECONNUS GUERIS* et rayés des comptes :	19	22
- Trypanosomés *DECEDES* :	26	16
.dont décès au cours du traitement :	1	3
- *ECHECS ou RECHUTES* et reprise de traitement :	0	2
- Individus soumis à *CHIMIOPROPHYLAXIE* :	0	-
LEPRE		
- *NOUVEAUX LEPREUX* dépistés, total :	329	553
.présentant une forme lépromateuse :	36	65
.porteurs d'invalidités :	10	49
.âgés de moins de 15 ans :	14	28
- Lépreux *EN COMPTE* (au 30 Septembre) :	7 792	8 350
.en traitement :	6 776	-
.reconnus inactifs :	2 083	3 821
.inactifs sans traitement, sous contrôle :	1 016	1 239
- Malades *TRAITES* au cours du dernier mois :	4 191	5 274
.en autotraitement :	560	263
- Déclarés *GUERIS* et libérés des contrôles :	341	592
TUBERCULOSE		
- *NOUVEAUX TUBERCULEUX PULMONAIRES* dépistés, total...	248	906
.dont formes bacillifères :	193	815
.âgés de moins de 15 ans :	-	-
- Tuberculeux *EN COMPTE* (au 30 Septembre) :	1 834	1 686
- Malades *TRAITES* au cours du dernier mois :	1 246	1 296
.hospitalisés depuis moins de 2 mois :	33	144
.hospitalisés depuis plus de 2 mois :	7	19
.en traitement ambulatoire :	1 206	1 252
- Déclarés *GUERIS* et libérés des contrôles :	46	313

618

Annex 3

	JAN/SEPT 1984	ANNEE 1983
AUTRES MALADIES CIBLES DU PEV OBSERVEES	Cas /Décès	Cas /Décès
- Coqueluche :	1 123/ 3	452/ 2
- Diphtérie :	1/0	21/ 1
- Tétanos (y compris tétanos néo-natal) :	123/19	104/60
- Poliomyélite aiguë :	97/ 1	67/0
- Rougeole :	4 655/ 8	1 561/ 2
TREPONEMATOSES ET MALADIES A TRANSMISSION SEXUELLE		
- Ophtalmie gonococcique :	1 520	1 525
- Urétrites ou vaginites gonococciques :	17 813	13 898
- Syphilis vénérienne, toutes formes :	4 270	5 356
.avec lésion clinique précoce et contagieuse :	2 413	2 383
.dépistée uniquement par examen sérologique:	1 073	1 581
- Pian :	915	732
- Autres maladies vénériennes :	2 901	7 294
SCHISTOSOMIASES		
- Urinaires, à Sch. haematobium :	3 636	2 020
- Intestinales, à Sch. intercalatum :	-	-
à Sch. mansoni :	6 343	16 013
AUTRES MALADIES TRANSMISSIBLES		
- Rage :	1/ 1	19/ 7
- Amibiase :	5 590/0	8 055/ 10
- Méningite cérébro-spinale :	154/40	226/ 56
- Hépatite virale :	1 206/15	1 641/ 60
- Paludisme :	35 127/19	79 657/125
- Varicelle :	1 521/ 1	1 405/0
- Filariose à Loa Loa :	6 630	8 372
- Filariose à W. bancrofti :	410	1 788
- Onchocercose :	1 733	2 794
- Dracunculose :	81	3 359
- Leishmaniose :	0	10
- Trachome :	41	83
- Maladies diarrhéiques graves :	72 919/30	67 292/ 58

Measles immunization in country x on children aged between 9 to 35 months and cases of measles notified and deaths attributed thereto

Year	Estimated number of births	Number of children immunized (a)	Number of cases measles notified (d)	Number of deaths attributed (d) to measles
1978	...	...	33,012	389
1979	...	...	38,450	470
1980	...	475,192	35,568 (e)	235 (e)
1981	...	417,453	36,139	433
1982	290,200 (b)	549,548	39,526	486
1983	...	446,702	30,288	428
1984	...	587,193 (c)	30,478	487
1985	262,200 (a)	789,012 (d) (f)	9,828 (g)	128 (g)

(a) : Source : AFR/RC35/21.

(b) : Based on population estimate of 5,646,000 and a birth rate of 51.4 $^{0}/00$ (year 1975-80) as published in the Demographic Yearbook 1982.

(c) : AFRO Data Bank for first 11 months; the number for the whole year given to the consultant was 661,333.

(d) : AFRO Data Bank.

(e) : Preliminary figures.

(f) : Number for the first five months only.

(g) : Number for the month of January only.

A cursory analysis of the above data shows that it was impossible to have immunized the number of children in the target age group as mentioned unless same children are immunized and reimmunized. Furthermore, the programme did not seem to have had any effect on either measles morbidity or mortality. Periodic evaluation would have brought to light for remedial actions the dificiences in the programmes.