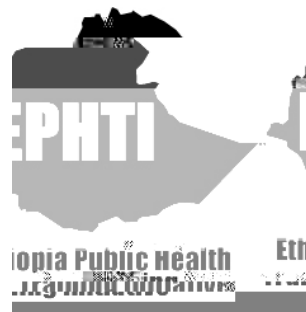


LECTURE NOTES

Epidemiology

For Health Extension Workers



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University of Gondar



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This material is intended for educational use only by practicing health care workers or students and faculty in a health care field.

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The development of this lecture note for training Health Extension workers is an arduous assignment for Dr. Yigzaw Kebede at Gondar University.

Essentially, it required the consolidation and merging of existing in depth training materials, examination of Health Extension Package manuals and the Curriculum.

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Finally the Federal Ministry of Health would like to express special

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Introduction

This lecture note will familiarize the students about the definition of words which are commonly used in Epidemiology, levels of prevention; Infectious diseases Epidemiology; measuring morbidity and mortality; sources and method of data collection; Epidemic investigation and management; and Surveillance.

The examples and exercises given in this lecture note will enable the health extension worker to better understand the concepts of Epidemiology.

The lecture note is not intended to replace standard textbooks. Hence, the reader is advised to read textbook when the need arises.



UNIT ONE

Introduction to Epidemiology

Learning Objectives:

At the end of this unit the student is expected to:

Define Epidemiology

Identify the main issues in the definition

Discuss the uses of Epidemiology

1.1. Definition

Epidemiology is the study of the *frequency, distribution* and *determinants* of diseases and other health related conditions in human populations, and the application of this study to the promotion of health, and to the prevention and control of health problems.

Major components of the definition

1. Population. The main focus of epidemiology is on the effect of disease on the population rather than individuals. For example malaria affects many people in Ethiopia but lung cancer is rare. If an individual develops lung cancer, it is more likely that he/she will die.

Even though lung cancer is more killer, epidemiology gives more emphasis to malaria since it affects many people.

2. Frequency. This shows that epidemiology is mainly a quantitative science. Epidemiology is concerned with the frequency (occurrence) of diseases and other health related conditions. Frequency of diseases is measured by morbidity and mortality rates.

3. Health related conditions. Epidemiology is concerned not only with disease but also with other health related conditions because every thing around us and what we do also affects our health. Health related conditions are conditions which directly or indirectly affect or influence health. These may be injuries, births, health related behaviors like smoking, unemployment, poverty etc.

4. Distribution. Distribution refers to the geographical distribution of diseases, the distribution in time, and distribution by type of persons affected.

5. Determinants. Determinants are factors which determine whether or not a person will get a disease.

1.2 History of Epidemiology

Although epidemiological thinking has been traced to the time of Hippocrates, who lived around 5th century B.C., the discipline did not flourish until 1940s.

Hippocrates displayed an extraordinary awareness of the impact of environment and behavior on personal well-being. Hippocrates therefore identified forces that epidemiologists today recognize as major determinants of human health.

There were many other scientists who contributed to the development of epidemiology. One of them was John Snow. In 1849, **John Snow**, an English physician, first identified the epidemiology of cholera in



those areas receiving water from the Southwark and Vauxhall Company. Finally, Snow concluded that the source of cholera outbreak was contaminated water.

1.3 Uses of Epidemiology

To make a community diagnosis. Epidemiology helps to identify and describe health problems in a community (for example, the prevalence of anaemia, or the nutrition status of children).

To monitor continuously over a period of time the change of health in a community. (for example, the effect of a vaccination programme, health education, nutritional supplementation).

To practice surveillance for a specific disease in order to be able to act quickly and so cut short any outbreak (example cholera).

To investigate an outbreak of a communicable disease, analyse the reasons for it, plan a feasible remedy and carry it out, and monitor the effects of the remedy on the outbreak.

Epidemiology

To plan effective health services. Effective services, interventions and remedies all depend on accurate community data.

Exercise

1. What is epidemiology?
2. "Fifty percent of malaria cases in North Gondar Zone occurred in Metema Woreda." This statement shows, please choose the best
 - a. the distribution of malaria
 - b. the causes of malaria
 - c. the time of the year when malaria is prevalent
3. Is epidemiology important to know the causes of malaria epidemic in your area?

UNIT TWO

Disease Causation

Learning Objectives

At the end of this unit the student is expected to:

Define cause of disease

Discuss the different risk factors for disease

Definition

Cause of disease: is an event, condition, characteristic or a combination of these factors which plays an important role in producing the disease.

The causes of disease can be classified in to two:

1. **Primary causes** – these are the factors which are necessary for a disease to occur, in whose absence the disease will not occur. The term **“etiologic agent”** can be used instead of primary cause for Infectious causes of diseases. For example “Mycobacterium tuberculosis” is the primary cause (etiologic agent) of pulmonary tuberculosis.



Epidemiology

The epidemiologic triangle, depicts the relationship among three key factors in the occurrence of disease or injury: **agent**, **environment**, and **host**.

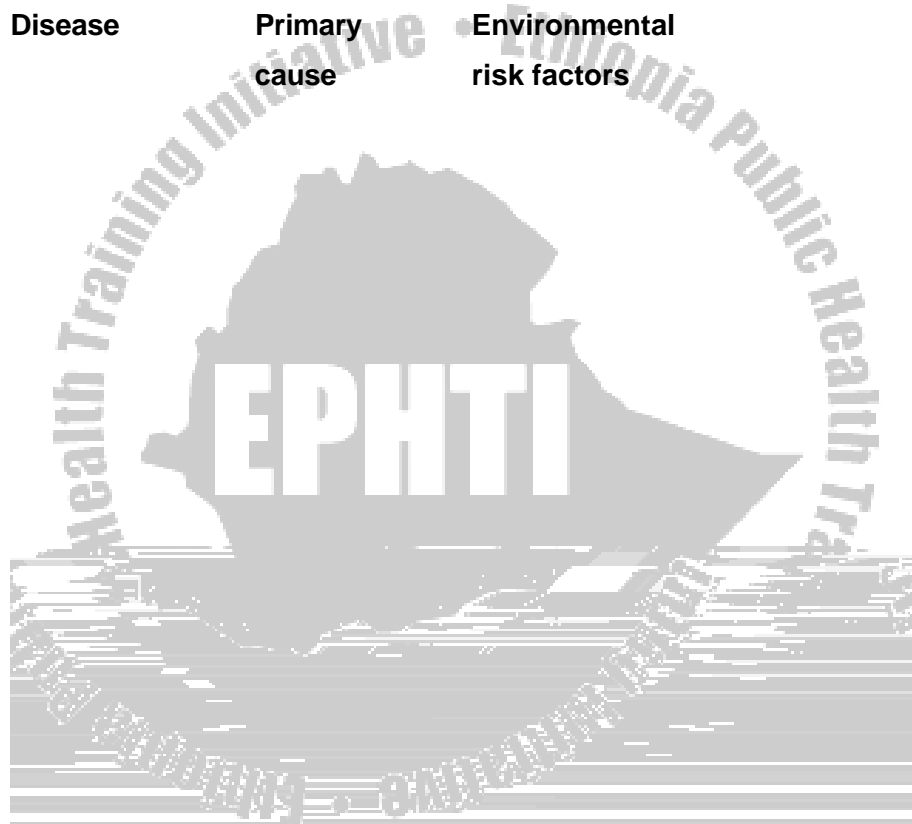
An **agent**



Exercise

Identify the primary causes and risk factors for the following diseases

Disease	Primary cause	Environmental risk factors
----------------	--------------------------	---------------------------------------



UNIT THREE

Levels of Prevention

Learning Objectives

At the end of this unit the student is expected to:

Define the natural history of disease and its different stages

Describe the levels of disease prevention

3.1 Natural history of disease



1. Stage of susceptibility

In this stage, disease has not yet developed, but the groundwork has been laid by the presence of factors that favor its occurrence.

Example: unvaccinated child is susceptible to measles.

2. Stage of Pre-symptomatic (sub-clinical) disease

In this stage there are no manifestations of the disease but pathologic changes (damages) have started to occur in the body. The disease can only be detected through special tests since the signs and symptoms of the disease are not present.

Examples:

- Detection of antibodies against HIV in an apparently healthy person.
- Ova of intestinal parasite in the stool of apparently healthy children.

The pre-symptomatic (sub-clinical) stage may lead to the clinical stage, or may sometimes end in recovery without development of any signs or symptoms.

3. The Clinical stage

At this stage the person has developed signs and symptoms of the disease. The clinical stage of different diseases differs in duration, severity and outcome. The outcomes of this stage may be recovery, disability or death.

Examples:

Common cold has a *short* and *mild* clinical stage and almost everyone **recovers** quickly.

Polio has a *severe* clinical stage and many patients develop paralysis becoming **disabled** for the rest of their lives.

Rabies has a *relatively short* but *severe* clinical stage and almost always results in **death**.

Diabetes Mellitus has a *relatively longer* clinical stage and eventually results in **death** if the patient is not properly treated.

4. Stage of disability or death

Some diseases run their course and then resolve completely either spontaneously or by treatment. In others the disease may result in a

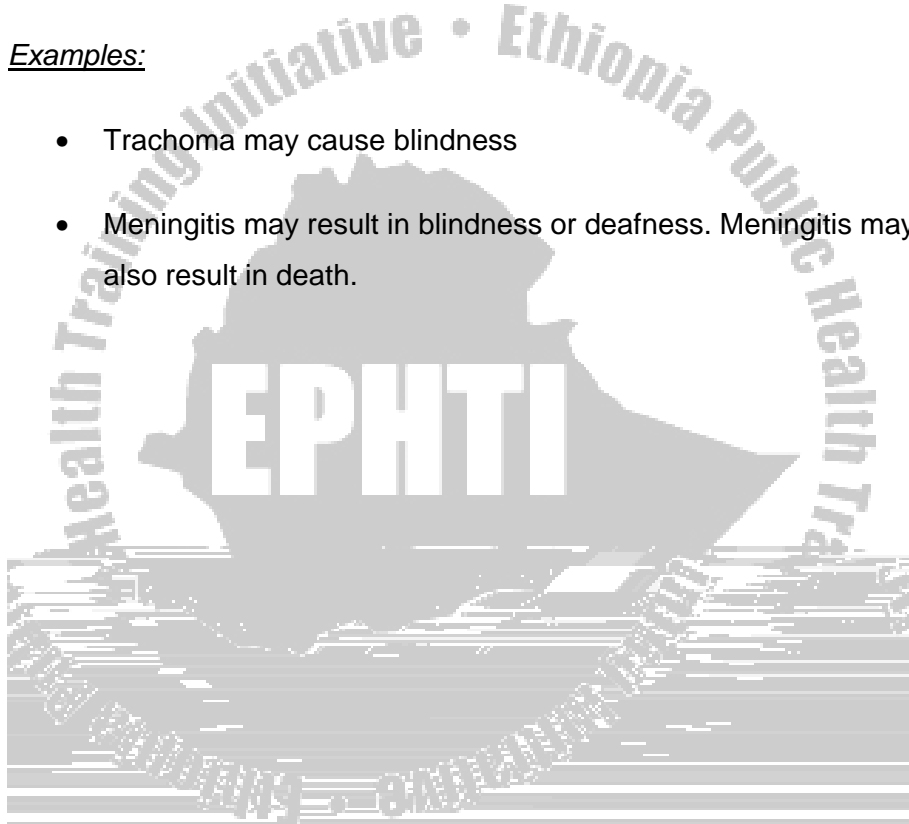
Epidemiology

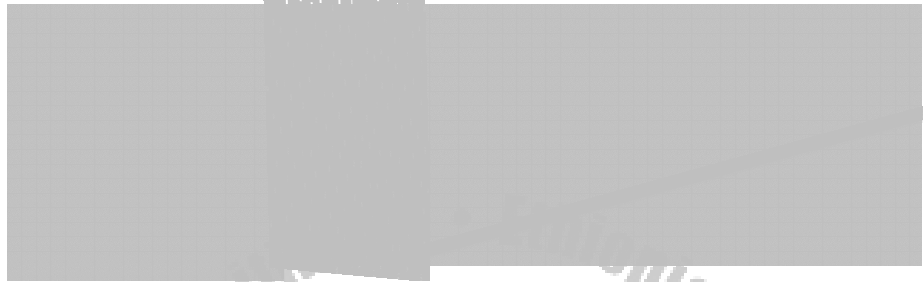
residual defect, leaving the person disabled for a short or longer duration. Still, other diseases will end in death.

Disability is limitation of a person's activities including his role as a parent, wage earner, etc

Examples:

- Trachoma may cause blindness
- Meningitis may result in blindness or deafness. Meningitis may also result in death.



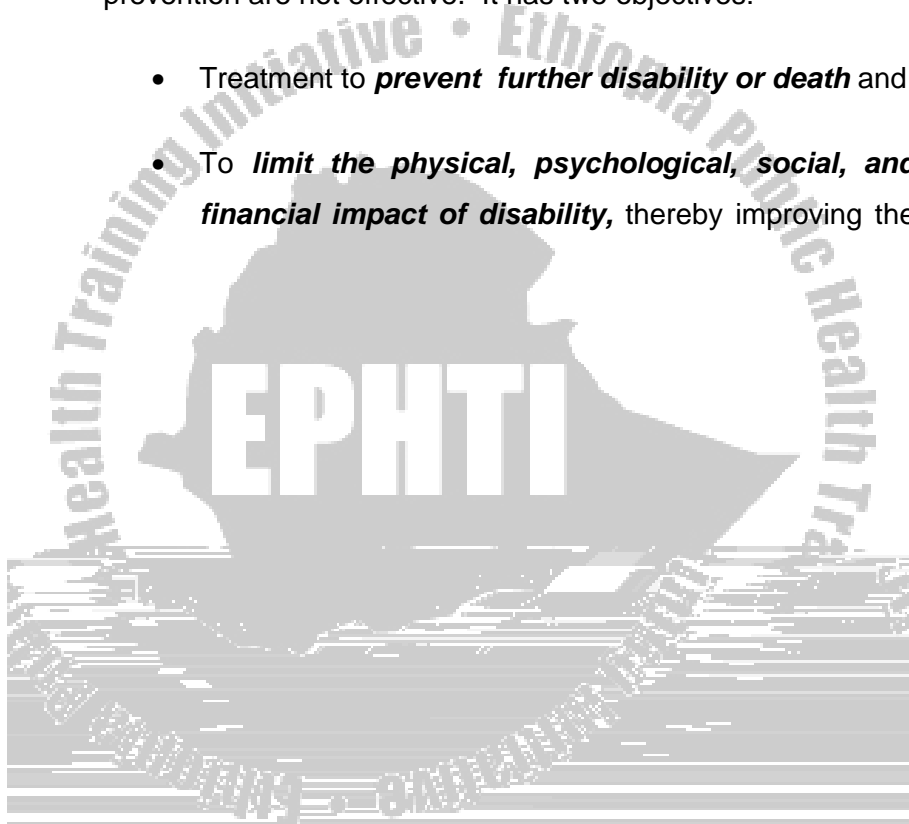






3) Tertiary prevention:– is targeted towards people with permanent damage or disability. Tertiary prevention is needed in some diseases because primary and secondary preventions have failed, and in others because primary and secondary prevention are not effective. It has two objectives:

- Treatment to **prevent further disability or death** and
- To **limit the physical, psychological, social, and financial impact of disability**, thereby improving the



Epidemiology

2. Write the primary, secondary, and tertiary prevention strategies for the diseases or conditions listed in the table below?

Disease	Primary prevention	Secondary prevention	Tertiary Prevention
Measles			
Pulmonary tuberculosis			
A person lost his leg by car accident			
Poliomyelitis			

UNIT FOUR

Infectious Diseases Epidemiology

Learning Objectives

At the end of this unit the student is expected to:

Define communicable/infectious disease

Discuss the components of infectious process

Describe different modes of disease transmission

4.1 Definition

Communicable disease (infectious disease) – is an illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

4.2 Components of the infectious process

The infectious process of a specific disease can be described by the following components, which constitute of the **chain of disease transmission**.

1. The Agent
2. Its reservoirs
3. Its portal of exits
4. Its mode of transmission
5. Its portals of entry
6. The human host

I. The Agents

The agents in the infectious process range from viral particles to complex multi-cellular organisms

II. Reservoirs

A reservoir is an organism or habitat, in which an infectious agent normally lives, transforms, develops and/or multiplies. Reservoirs for infectious agents may be humans, animals, plants or other inanimate objects.

Some diseases with human reservoirs are:

Most bacterial and viral respiratory diseases

HIV/AIDS/Sexually Transmitted Infections (STIs), measles, typhoid etc.

All infected humans, whether showing signs and symptoms of the disease or not, are potential sources of infection to others. A person who does not have apparent clinical disease, but is a potential source of infection to other people is called a *Carrier*. An example of carrier is a person infected with HIV. A person infected with HIV might not have the signs and symptoms but he/she is capable of transmitting the infection to others

Some diseases are transmitted to human beings from animals. These diseases are called **zoonoses**.

Examples: Rabies, anthrax, etc.

III. Portal of Exit

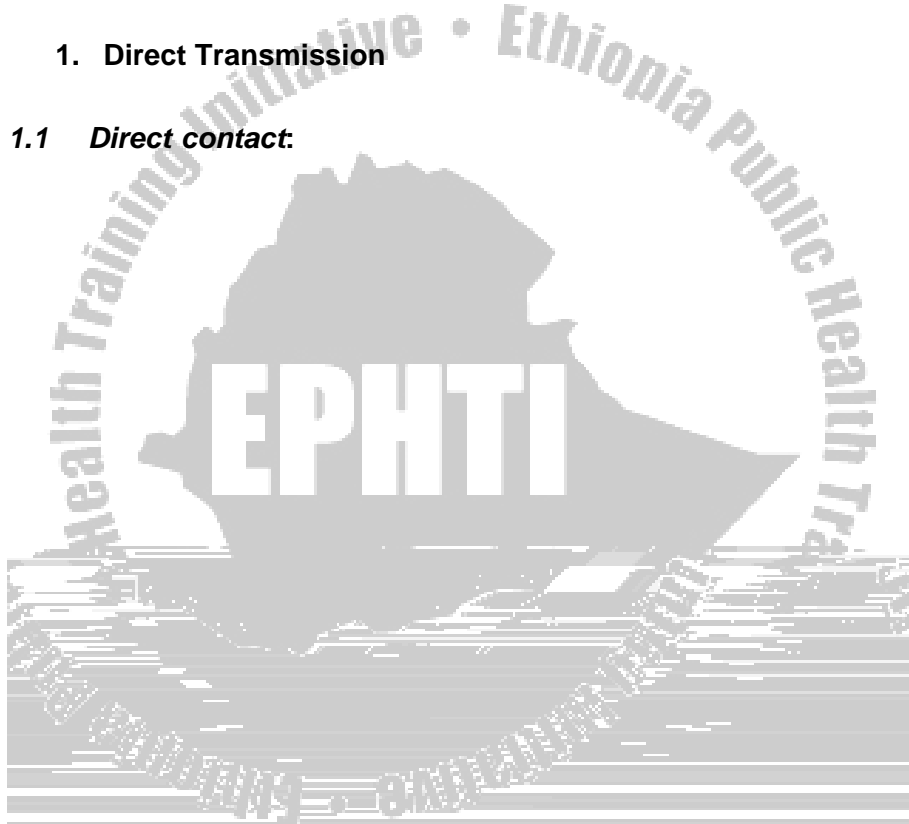
Portal of exit is the way the infectious agent leaves the reservoir. Possible portals of exit include all body secretions and discharges: Mucus, saliva, tears, breast milk, vaginal and cervical discharges, excretions (feces and urine), blood, and tissues. For example feces is the portal of exit for the eggs of hook worm.

IV. Mode of Transmission

Modes of transmission include the various mechanisms by which agents are conveyed to other susceptible hosts. Transmission may be direct or indirect.

1. Direct Transmission

1.1 *Direct contact:*



2.1 Vehicle-borne: Transmission occurs through indirect contact with inanimate objects fomites: bed sheets, towels, toys, or surgical instruments; as well as through contaminated food, water, IV fluids etc.

2.2 Vector-borne: The infectious agent is conveyed by an arthropod to a host. Vectors may be biological or mechanical.

Biological vector: A vector is called biological vector if the agent multiplies in the vector before transmission.

- Example: anopheles mosquito is a biological vector for malaria.

Mechanical vector: A vector is called mechanical vector if





individual members of the population, thereby lessening the likelihood of a person with a disease coming into contact with susceptibles.

Example - If 90 % of the children are vaccinated for measles, the remaining 10 % of the children who are not vaccinated might not become infected with measles because most of the children (90 %) are vaccinated. That means transmission from infected person to other susceptible children will not be easier.

Exercise:

Identify the components of the chain of transmission for the following diseases.

Chain of transmission	Malaria	Amoebiasis	Tuberculosis
i. Infectious agent			
ii. Reservoir			

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UNIT FIVE

Descriptive Epidemiology

Learning Objectives

At the end of this unit the student is expected to:

Define descriptive Epidemiology

Identify the most important Time, Place and personal variables in Descriptive Epidemiology

Describe cross sectional study (survey)

5.1 Definition

Descriptive epidemiology is one of the basic types of epidemiology, which is concerned with describing the frequency and distribution of diseases and other health related conditions by time, place, and person. The other branch of epidemiology which deals with the causes or determinants of diseases is called **Analytical Epidemiology**. It asks the questions: how? Why?

5.2 The major variables in Descriptive Epidemiology

The major variables in descriptive epidemiology can be classified under the headings: person, place and time. To describe the

occurrence of a disease fully, the following questions must be answered. **Who** is affected? **Where** and **When** do the cases occur?

5.2.1 Person

People can be categorized with respect to many variables. In Epidemiologic study it is common to specify three characteristics of a person – age, sex and ethnic group or race.

Age: Age is the most important determinant among the personal variables. Example: Measles affects children.

Sex: There are some diseases which are common among females. For example breast cancer is a disease of females.

Ethnic group and Race: Many diseases differ markedly in frequency, severity, or both in different racial or ethnic groups.

Other personal variables: There are also other personal variables that should be considered during epidemiologic studies. This includes social class, religion, occupation, marital status, environmental exposure etc.

5.2.2 Place

The frequency of disease is different in different places. These differences can occur because of the natural boundaries (e.g. mountain range, rivers, deserts). An area defined by natural boundaries may have a high or low frequency of certain diseases

because it is characterized by some particular environmental or climatic conditions, such as temperature, humidity, rainfall, altitude, mineral content of soil, or water supply. For example - Malaria is common in low lands but relapsing fever is common in highlands.

5.2.3 Time

Study of disease occurrence by time is a basic aspect of epidemiologic analysis. Occurrence is usually expressed on a monthly or annual basis.

Some diseases occur **periodically or cycles**. Cycles may be annual or have some other periodicity. The most common types of periodicity are in relation to seasonal changes, or in relation to changes in the number of susceptible persons in a population. Malaria is one of the example of diseases with seasonal periodicity, where high peaks occur in relation to the rainy season. Epidemic of malaria are common in October and November, when stagnant water bodies are convenient for the breeding of mosquitoes.

5.3 Cross sectional study design (Survey)

Cross sectional study is the major type of descriptive study designs. It is mainly concerned with the distribution of diseases with respect to time, place and person. By conducting survey, the magnitude of diseases or other health related condition will be known. They are useful for priority setting, resource allocation etc.

In cross sectional studies, information about the status of an individual with respect to the presence or absence of exposure and disease is assessed at a point in time. The point in time may be as short as few minutes or as long as two or three months. The time frame of "point in time" is based on the speed of data collection.

If somebody wants to conduct a survey, he/she can follow the following procedures:

Write the objectives of the survey

Identify the methods of data collection. Data can be collected by using questionnaire, interview, self-administered questionnaire, observation, applying laboratory tests etc.

Recruit and train data collectors

Calculate (determine) the number of people needed for the survey

Collect the data

Analyse the data

Disseminate the findings

Advantages of cross sectional studies:

are a one-stop, one-time collection of data

are less expensive & easier to conduct

provide much information useful for planning health services and medical programs

show relative distribution of conditions, disease, injury and disability in groups and populations. For example by conducting survey in different towns, it is possible to know which towns are highly affected by HIV/AIDS.

Exercises

1. Suppose you want to determine the prevalence of hypertension among adult population in your kebele. How do you conduct cross sectional studies for this purpose?

Choose the best answer for questions 2,3, and 4.

2. Malaria mainly affects children.

This is:

- a. Distribution by person
- b. Distribution by place
- c. Distribution by time

3. Pregnant women are highly affected by malaria.

This is:

- a. Distribution by person
- b. Distribution by place
- c. Distribution by time

4. Epidemic of malaria occurs in October, November and April.

This is:

- a. Distribution by person
- b. Distribution by place
- c. Distribution by time

UNIT SIX

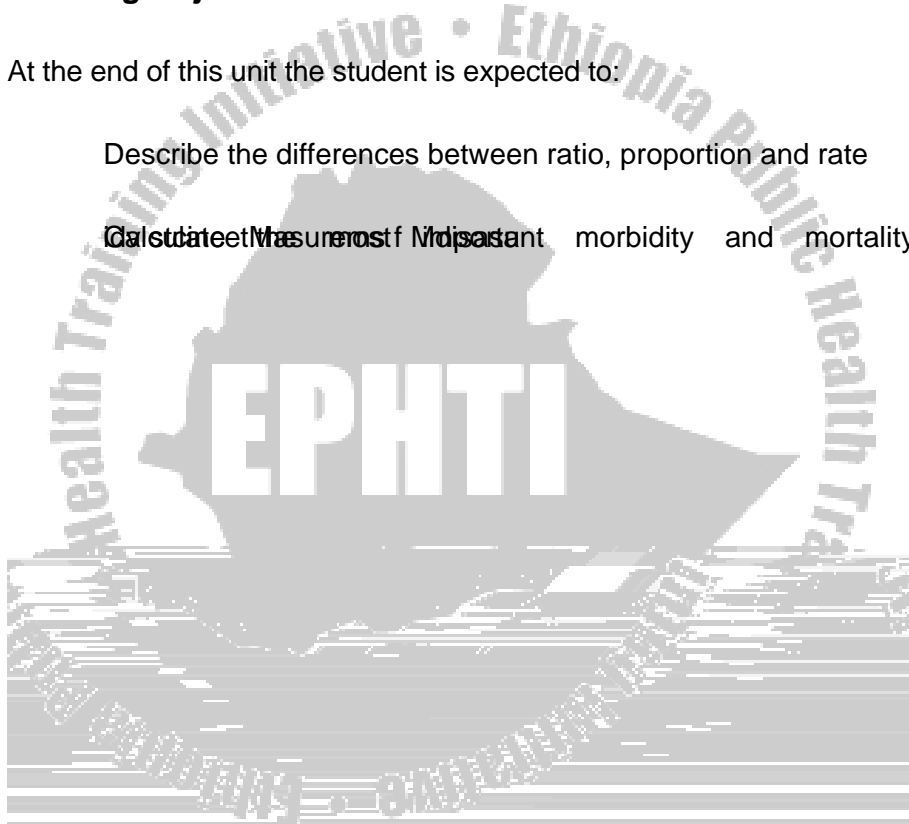
Measurements of Morbidity and Mortality

Learning Objectives

At the end of this unit the student is expected to:

Describe the differences between ratio, proportion and rate

Calculate measures of Morbidity and mortality



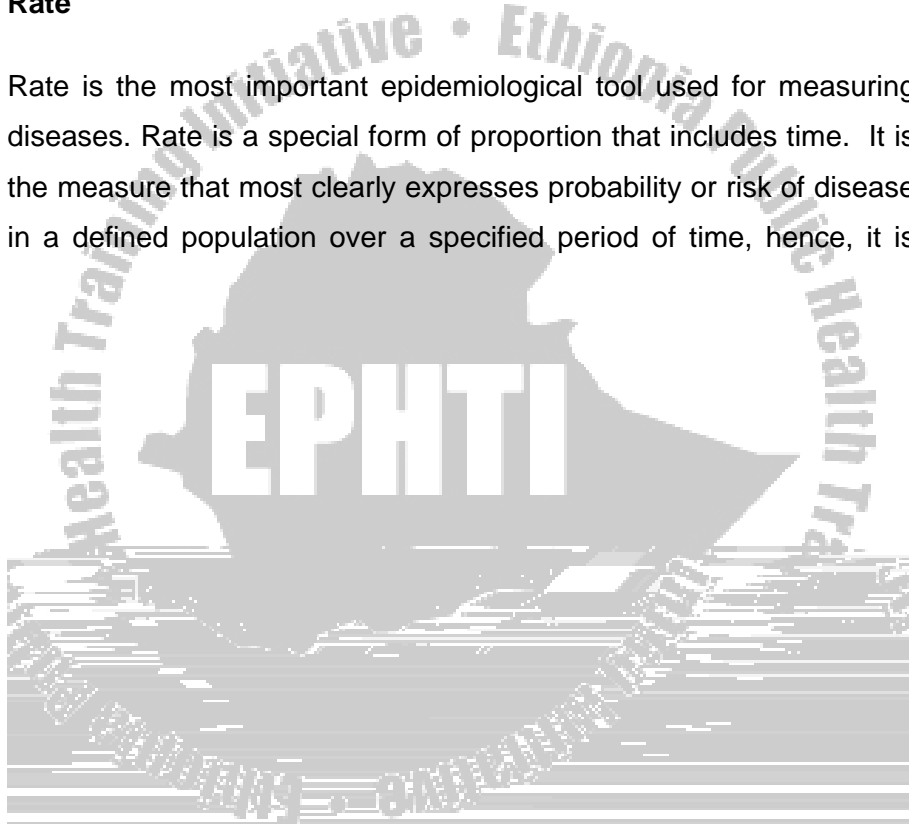


Example: The proportion of all births that was male

$$\frac{\text{Male births}}{\text{Male + Female births}} \times 100$$

Rate

Rate is the most important epidemiological tool used for measuring diseases. Rate is a special form of proportion that includes time. It is the measure that most clearly expresses probability or risk of disease in a defined population over a specified period of time, hence, it is



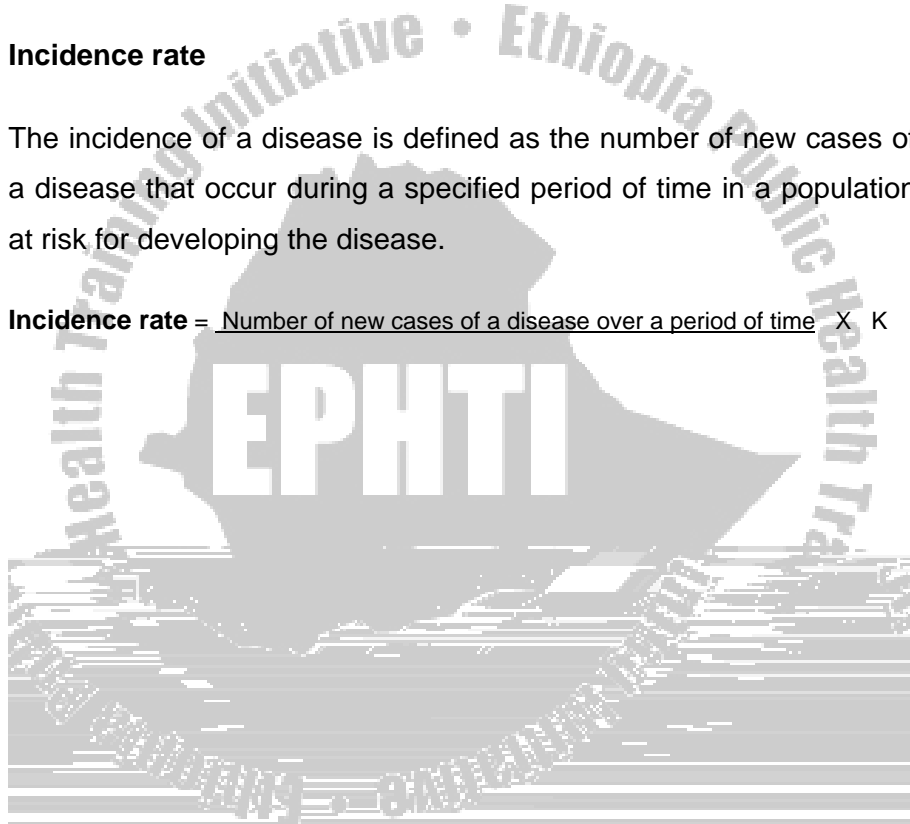
6.3 Measurements of morbidity

Morbidity rates are rates used to quantify the occurrence of disease. Measures of morbidity include incidence, period prevalence, and point prevalence rates.

Incidence rate

The incidence of a disease is defined as the number of new cases of a disease that occur during a specified period of time in a population at risk for developing the disease.

Incidence rate = $\frac{\text{Number of new cases of a disease over a period of time}}{\text{X K}}$



Epidemiology

used to make statements about the risk of disease. If the incidence rate of a certain disease is high in one area, then the risk of acquiring that disease by other healthy individuals will be high.

Example. In Ginbot 1995 there were 50 new cases of relapsing fever in “Kebele X”. The average total population of “Kebele X” was 5000. Calculate the incidence rate of relapsing fever in “Kebele X” in Ginbot 1995.

Answer- Incidence rate = $\frac{50}{5000} \times 1000 = 10$ new cases per 1000 population

That means out of every 1000 people living in “Kebele X”, 10 of them acquired relapsing fever in Ginbot 1995.

Another commonly used measure of morbidity is attack rate. Attack rate is a type of incidence rate which is mainly used during epidemics.

Attack rate = $\frac{\text{No. of new cases of a specific disease reported during an epidemic}}{\text{Total population at risk during the same time}} \times k$

On Tir 7, 1995, 100 people were invited by Ato Alemitegnaw for dinner. All of them ate the food that was served for dinner. The next day (Tir 8, 1995) 90 of the 100 people who ate that food developed diarrhea. Calculate the attack rate of diarrhea which occurred on Tir 8, 1995.

$$\text{Attack rate} = \frac{90}{100} \times 100 = 90 \text{ cases of diarrhea per 100 people}$$

That means out of 100 people who ate the food served by Ato Alemitegnaw, 90 of them developed diarrhea on Tir 8, 1995.

Uses incidence rate

Incidence rate is important as a fundamental tool for etiologic studies of diseases since it is a direct measure of risk. If the incidence rate is significantly higher in one area, then the cause of that disease can be systematically searched.

Prevalence rate

Prevalence rate measures the number of people in a population who have a disease at a given time. It includes both new and old cases. The major type of prevalence is point prevalence rate.

Point Prevalence rate: measures the proportion of a population with a certain condition at a given point in time. Point prevalence rate can be determined by conducting cross-sectional study.

6.4 Measurements of Mortality



Epidemiology

population (1995 health & health related indicators, MOH). That means out of 1000 total population about 13 people die each year.

2. Age- specific mortality rate = No. of deaths in a specific age group

$$\frac{\text{during a given time}}{\text{Estimated mid interval population of specific age group}} \times 1000$$

Estimated mid interval population of specific age group



5. Neonatal Mortality Rate = No. of deaths under 28 days of age reported

$$\frac{\text{during a given time}}{\text{No. of live births reported during the same time}} \times 1000$$

No. of live births reported during the same time

Example: In 1996 there were a total of 5000 live births in “Zone B”. Two hundred of them died before 28 days after birth. Calculate the Neonatal Mortality Rate (NMR).

$$\text{NMR} = \frac{200}{5000} \times 1000 = 40 \text{ per 1000 live births}$$

That means out of 1000 live births in 1996, 40 of them died before 28 days after birth.

Death during the neonatal period is largely due to prematurity, malformations, accidents or injuries at birth, and lack of cleanliness and sterility during or after delivery. In addition, it reflects the inadequacy of antenatal care.

6. Infant Mortality Rate (IMR) = No. of deaths under 1 year of age

$$\frac{\text{during a given time}}{\text{No. of live births reported during the same time interval}} \times 1000$$

No. of live births reported during the

same time interval

Infant mortality rate reflects the health of the community in which the child is being brought up. Thus, it is high among people who have little health care, chiefly because infections, such as pneumonia, diarrhea and malaria, are common among their infants. Malnutrition is also one of the killer of infants in developing countries. The infant mortality rate in Ethiopia is one of the highest in the world (96.8 per 1000 live births). That means out of 1000 live births about 97 die before they celebrate their first birth day.

7. Under- five mortality rate = No. of deaths of 0-4 years of age
_____ during a given time _____ X 1000
Average (mid-year) population of
the same age at the same time

NB: The numerator says 0-4 years. 0-4 years in this formula means children from birth to less than five years of age i.e the upper age limit is not 4.

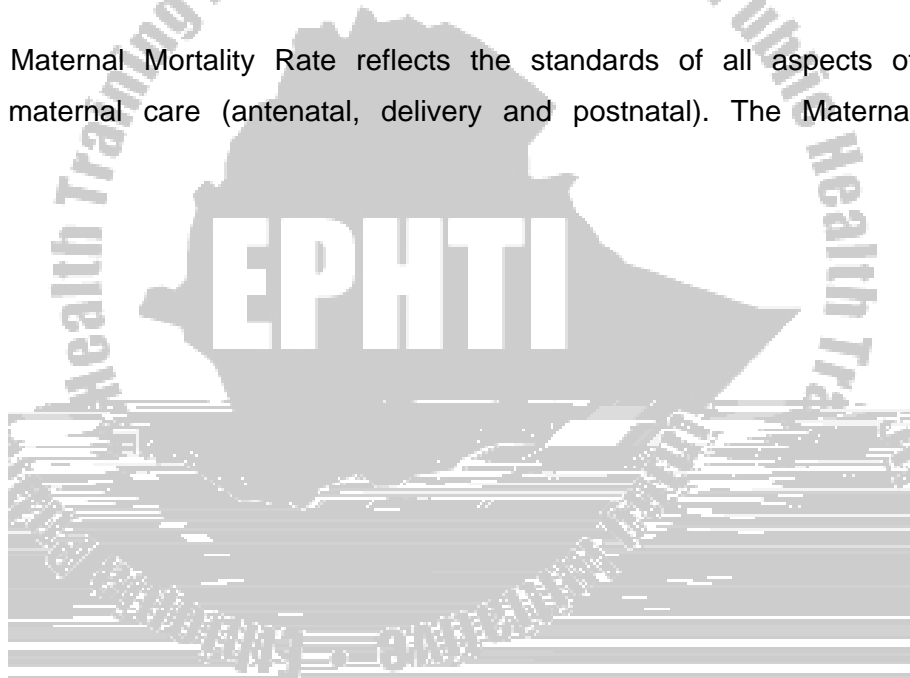
Example: In 1996 the total number of children under 5 years of age was 10,000 in "Zone C". In the same year 200 children under five years of age died. Calculate the under five-mortality rate (U5MR).

$$U5MR = \frac{200}{10,000} \times 1000 = 20 \text{ per 1000 under five children}$$

That means in “Zone C”, out of 1000 under five children, 20 died in 1996.

8. Maternal Mortality Rate = No. of pregnancy associated deaths of
$$\frac{\text{mothers in a given time}}{\text{No. of live births in the same time}} \times 100,000$$

Maternal Mortality Rate reflects the standards of all aspects of maternal care (antenatal, delivery and postnatal). The Maternal



- Total number of infant deaths = 200
- Number of women who died from pregnancy related causes = 160
- New cases of tuberculosis = 100
- All cases of tuberculosis = 300
- Deaths from tuberculosis = 60

Based on the above information calculate the following.

1. The incidence rate of tuberculosis.
2. The period prevalence rate of tuberculosis.
3. The case fatality rate of tuberculosis.
4. The Neonatal mortality rate.

UNIT SEVEN

Sources of Data and Methods of Data Collection

Learning Objectives:

At the end of this unit the student is expected to:

Identify the sources for health information

Describe the advantages and disadvantages of each source

Describe the methods of data collection

I. Sources of Data

There are different sources of data on health and health related conditions in the community. Each source has advantages and limitations. The information obtained from these sources is used for health planning, programming and evaluation of health services. The major sources are the following.

1. Census:

Census is defined as a periodic count or enumeration of a population. Census data are necessary for accurate description of population's health status and are principal source of denominator for rates of disease & death.

It provides information on:

Size and composition of a population

The trends anticipated in the future.

In Ethiopia census was conducted twice, i.e., in 1984 and 1994 (G.C).

Data was collected on:

Age, sex and size of the population

Mortality, fertility

Language, ethnicity

Housing

From these data different health indices could be calculated.

Crude birth rate, crude death rate, age specific mortality rate and sex specific mortality rate are some of the examples of the indicators that could be calculated.

Limitation

Conducting nationwide census is very expensive and it generates a large amount of data which takes a very long time to compile and analyze. .

It is carried in intervals of many years. Therefore it can't assess yearly changes.

2. Vital statistics:

This is a system by which all births and deaths occurring nationwide are registered, reported and compiled centrally. Certificate is issued for each birth and death. It is the source of information for the calculation of birth and death rates. There is no nationwide birth and death registration system in Ethiopia but the system should be established in the future.

The main characteristics of vital statistics are:

Comprehensive – all births and deaths should be registered.

Compulsory by law – should be enforced by law.

Compiled centrally so that it can serve as a source of information.

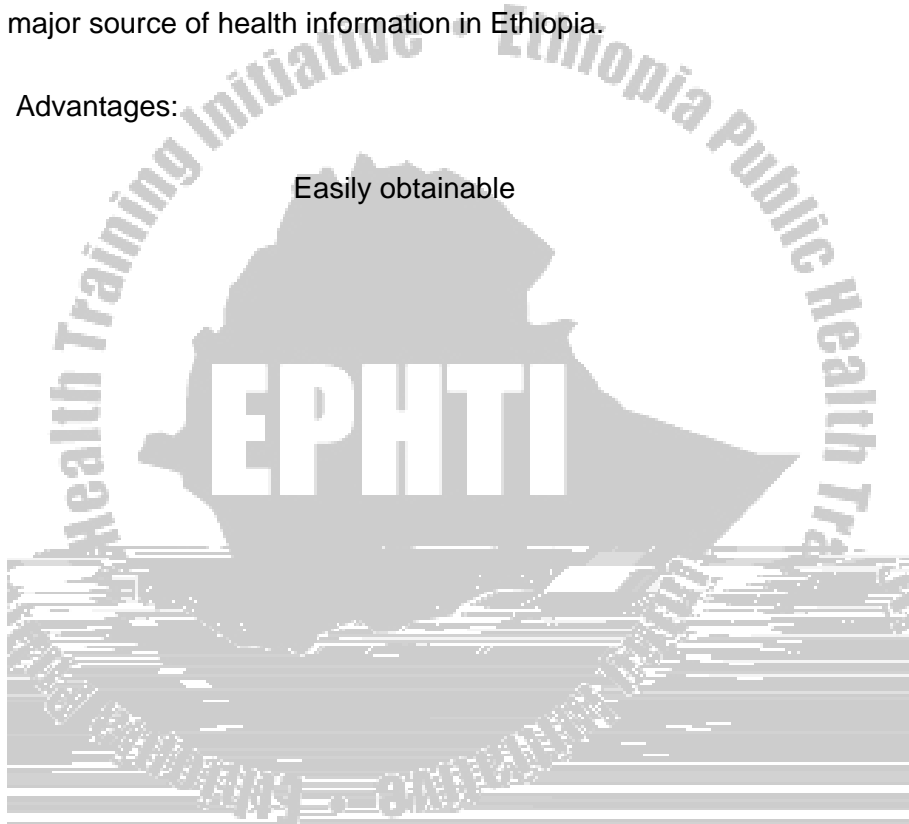
Continuous – it should be an ongoing process.

3. Health Service Records

All health institutions report their activities to the Ministry of Health through the regional health bureaus. The Ministry compiles, analyzes and publishes it in the health service directory. It is therefore the major source of health information in Ethiopia.

Advantages:

Easily obtainable

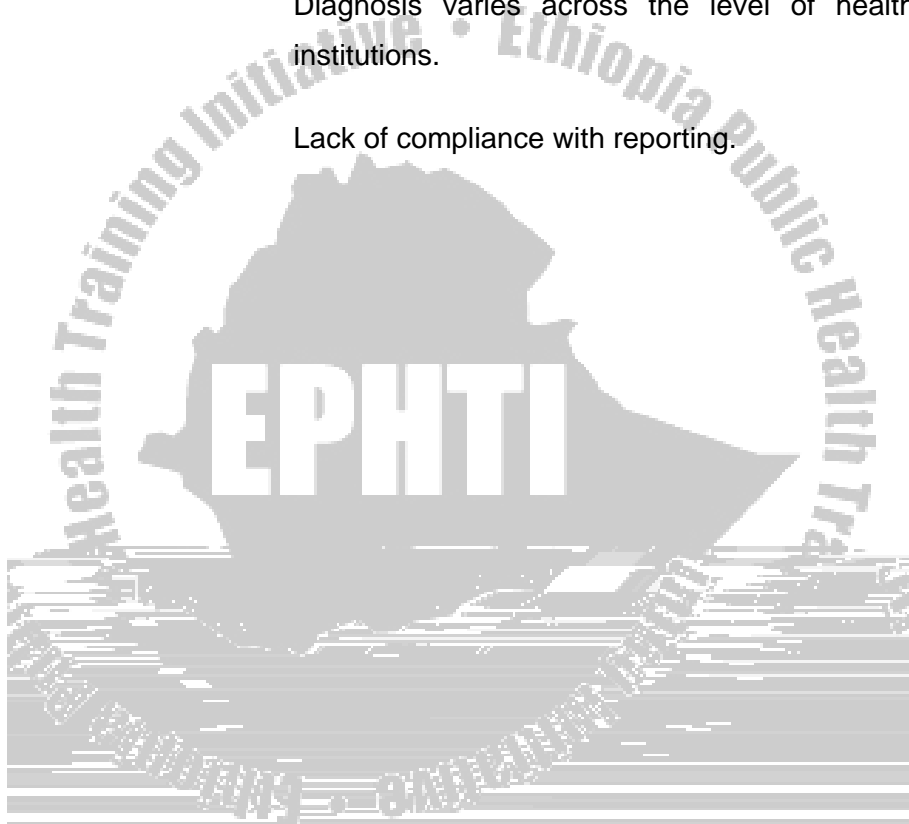


Lack of denominator – catchment area is not known in the majority of cases.

Lack of uniformity in quality.

Diagnosis varies across the level of health institutions.

Lack of compliance with reporting.





II. Methods of data collection

The main methods of collecting information are:

1. **Observation**
2. **Interview and questionnaires**
3. **Documentary sources** - Clinical records and other personal records, death certificates, publications etc.

Exercise

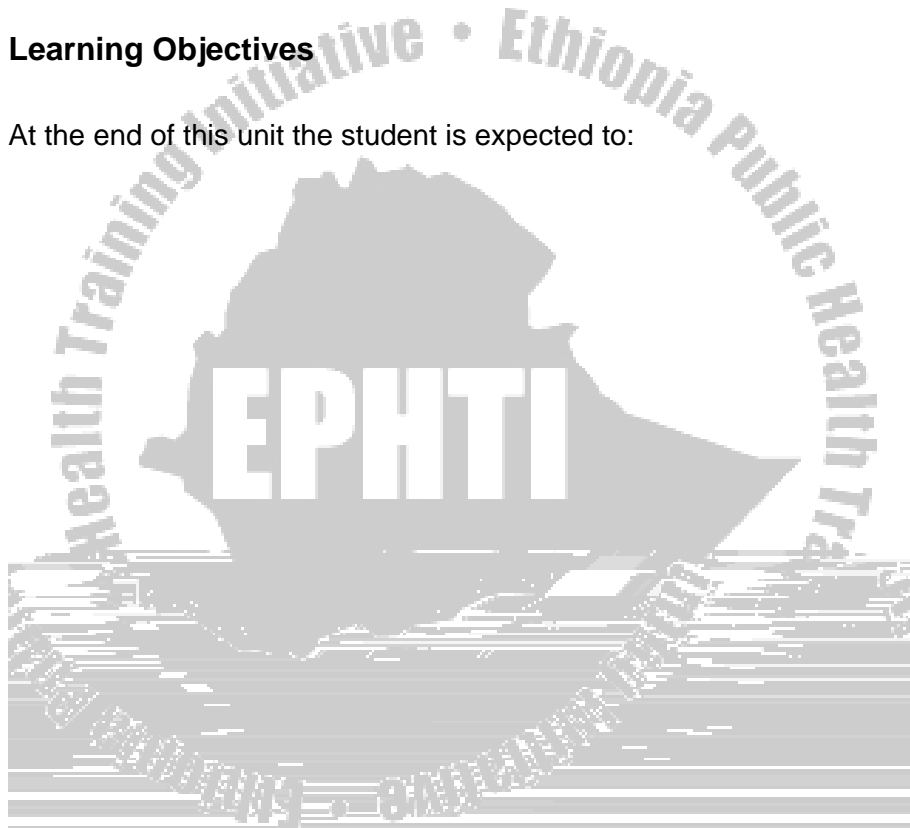
1. State the different sources of health information.
2. What is the major source of health information in Ethiopia?
3. Discuss the problems related to health service records as source of health data.
4. If you want to know the number of people in your kebele who are properly using latrines, which method of data collection would be appropriate?

UNIT EIGHT

Epidemic Investigation and Management

Learning Objectives

At the end of this unit the student is expected to:



Definition of terms related to the level of occurrence of disease

1. **Endemic:** Presence of a disease at more or less stable level.
Malaria is endemic in the lowland areas of Ethiopia.
2. **Hyper endemic:** Persistently high level of disease occurrence.
3. **Sporadic:** Occasional or irregular occurrence of a disease. When diseases occur sporadically they may occur as epidemic.
4. **Epidemic:** The occurrence of disease or other health related condition in excess of the usual frequency in a given area or among a specific group of people over a particular period of time.
5. **Outbreak:** Epidemics of shorter duration covering a more limited area.
6. **Pandemic:** An epidemic involving several countries or continents affecting a large number of people. For example the worldwide occurrence of HIV/AIDS is a pandemic.

The definition of epidemic indicates that the term can have a broad meaning. It may include any kind of disease or injury including non – infectious diseases. There is no general rule about the number of cases that must exist for a disease to be considered an epidemic. If the number of cases exceeds the expected level on the basis of the

past experience of the particular population, then it is an epidemic. It is important to note that this level varies for different diseases and different circumstances. An epidemic may cover a small area within a city, or an entire nation or may have a worldwide distribution. It may encompass any time period ranging from few hours (chemical intoxication, bacterial food poisoning), a few weeks (influenza, hepatitis) to several years (AIDS). A disease that remains epidemic over many years eventually may be considered endemic.

8.2 Types of epidemics

Epidemics (outbreaks) can be classified according to the method of spread or propagation, nature and length of exposure to the infectious agent, and duration.

1. Common Source Epidemics:- Disease occurs as a result of exposure of a group of susceptible persons to a common source of a pathogen, often at the same time or within a brief time period. When the exposure is simultaneous, the resulting cases develop within one incubation period of the disease and this is called a **point source epidemic**. The epidemic curve in a point source epidemic will commonly show a sharp rise and fall. Food borne epidemic following an event where the food was served to many people is a good example of point source epidemic. If the exposure to a common source continues over time it will result in a **continuous common source epidemic**. A waterborne outbreak that spreads through a

contaminated community water supply is an example of a common source epidemic with continuous exposure. The epidemic curve may have a wide peak because of the range of exposures and the range of incubation periods.

2. Propagated/ Progressive Epidemics:- The infectious agent is transferred from one host to another. It can occur through direct person to person transmission or it can involve more complex cycles in which the agent must pass through a vector as in malaria. Propagated spread usually results in an epidemic curve with a relatively gentle upslope and somewhat steeper tail. An outbreak of malaria is a good example of propagated epidemic.

When it is difficult to differentiate the two types of epidemics by the epidemic curve, spot map (studying the geographic distribution) can help.

3. Mixed Epidemics:- The epidemic begins with a single, common source of an infectious agent with subsequent propagated spread. Many food borne pathogens result in mixed epidemics.

8.3 Investigation of an Epidemic

The purpose is to determine the specific cause or causes of the outbreak at the earliest time and to take appropriate measure directed at controlling the epidemic and preventing future occurrence. The

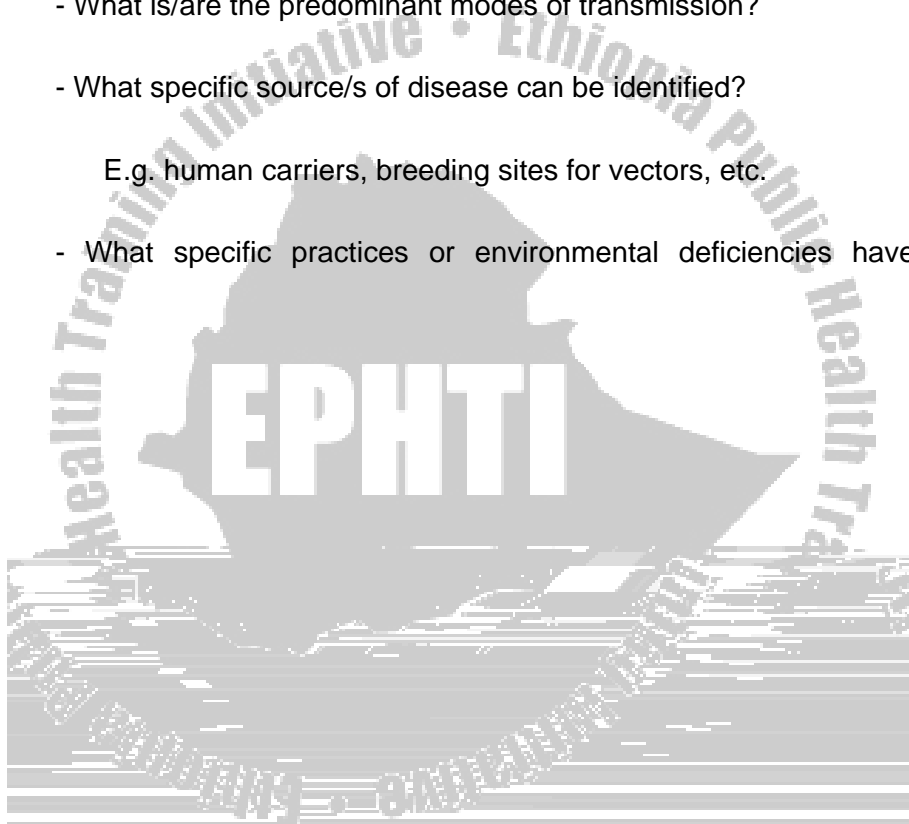
Epidemiology

following questions should be answered when investigating an epidemic.

- What is the etiological agent responsible for the epidemic?
- What is/are the predominant modes of transmission?
- What specific source/s of disease can be identified?

E.g. human carriers, breeding sites for vectors, etc.

- What specific practices or environmental deficiencies have



Steps in Epidemic Investigation

There is no fixed step in the investigation of epidemics but the following step can be considered as one option.

1. Prepare for fieldwork.

Before leaving for the field you should be well prepared to under take the investigation. Preparations can include:

Investigator must have the appropriate scientific knowledge, supplies, and equipment to carry out the investigation. It might be difficult for the health extension worker to fully investigate the epidemic, hence, he/she should inform and involve other high level health professionals from the outset.

collect sample questionnaire.

arrange transportation and organize personnel matters.

clarify your and your team role in the field. Arrange where and when to meet them.

2. Verify (confirm) the existence of an epidemic

This initial determination is often made on the basis of available data. Compare the number of cases with the past levels to identify whether the present occurrence is in excess of its usual frequency. Instead of

comparing absolute numbers it is advisable to compare rates like incidence rate

3. Verify (confirm the diagnosis).

Always consider whether initial reports are correct. Carry out clinical and laboratory investigations on the reported cases. For example the already collected blood film slides can be seen by laboratory experts to check whether the initial report was correct. It is important to investigate the index case (the first case that comes to the attention of health authorities) and other early cases. The importance of the index case and other early cases for diseases that are known to occur in epidemic form, such as relapsing fever, is as an indication to health authorities of the possible start of an outbreak. The sooner the index case and other early cases are investigated, the greater the opportunity to arrest the outbreak at earliest stage possible. The health extension worker requests support from the Woreda Health Office or the nearest Health Center for confirming the diagnosis.

4. Identify and count cases

Prepare “case definition” before starting identification of cases.

Case definition is defined as a standard set of criteria to differentiate between cases and non cases. Cases can be one of the following:

Confirmed / definite: A case with laboratory verification.

Probable: A case with typical clinical features but without laboratory confirmation.

Possible: A case with fewer of typical clinical features.

Cases can better be identified by active case detection using all available means including house to house visits. They can also be identified by stimulated passive case detection, for example by alerting the public about the epidemic and requesting them to report to the nearest health institution when they have signs and symptoms of that disease. The health extension worker can identify and count cases based on the sign and symptoms of the disease.

If there is effective drug for the treatment of that disease, cases can



Epidemic curve is an important tool for the investigation of disease outbreaks. In epidemic curve the distribution of cases is plotted over time, usually in the form of histogram, with the date of onset of cases on the horizontal axis, and the number of cases corresponding to each date of onset on the vertical axis.

Spot map is a map of locality where the outbreak has occurred, on which the location of cases is plotted. The spot map is often helpful in detecting the source of an outbreak. Mapping disease can be done at kebele, woreda, regional, and national level. One limitation of spot map is that it does not take into account underlying geographic differences in population density. Thus the spot map needs to be supplemented by calculation of place specific attack rates.

Person specific attack rates: The tool that is important for the analysis of disease outbreaks by personal characteristics is person specific attack rates like attack rates by age, sex, occupation, income, religion etc.

6. Identify the causes of the epidemic

All factors that can contribute to the occurrence of the epidemic should be assessed. The epidemic investigating team should try to answer questions like:

Why did this epidemic occur?

Are there many susceptible individuals?

Is the temperature favorable for the transmission of the diseases?

Are there breeding sites for the breeding of vectors? Etc

Confirmation of the diagnosis can be done by using additional tests which are more accurate. In addition to knowing the etiologic agent, more emphasis should be given to identify the risk factors. Investigate the environmental conditions such as food sanitation, suspected breeding sites, animal reservoirs, according to the type of disease outbreak being investigated.

7. Management of epidemic and follow up

Although it is discussed late, intervention must start as soon as possible depending on the specific circumstances. One might aim control measures at the specific agent, source, or reservoir. For example, an outbreak might be controlled by destroying contaminated foods, disinfecting contaminated water, or destroying mosquito breeding sites or an infectious food handler could be suspended from the job and treated.

General principles in the management of epidemics

Management of epidemics requires an urgent and intelligent use of appropriate measures against the spread of the disease. Action to be taken is dependent on the type of the disease as well as the source of

the outbreak. However, the actions can be generally categorized as presented below to facilitate easy understanding of the strategies.

A. Measures Directed Against the Reservoir

Understanding the nature of the reservoir is necessary in the selection of an appropriate control methods and their likelihood of success. The following are examples of control measures against diseases with various reservoirs:

Domestic animals as reservoir:

Immunization. Example – giving anti-rabies vaccine for dogs

Destruction of infected animals e.g anthrax

Wild animals as reservoir:

post-exposure prophylaxis for human beings- Example: rabies

Humans as reservoir

- a. Isolation of infected persons. This is separation of infected persons from non-infected for the period of communicability.

This is not suitable in the control of diseases in which a large proportion are inapparent infection (without signs and symptoms) or in which maximal infectivity precedes overt illness.

Actions to reduce transmission of respiratory infections

include ventilation of rooms.

In the case of diseases that involve an intermediate host for transmission, for example schistosomiasis, clearing irrigation farms from snails is an appropriate measure.

C. Measures that reduce host susceptibility

immunization (vaccination). Example vaccination for meningitis

Chemoprophylaxis: for example, use of chloroquine to persons traveling to malaria endemic areas.

After the epidemic is controlled, strict follow up mechanisms should be designed so as to prevent similar epidemics in the future.

8. Report of the investigation

At the end prepare a comprehensive report and submit to the appropriate/concerned bodies like the Woreda Health Office. The

Measures used for the control of the epidemic.

Recommendations for the prevention of similar episodes in the future.

Exercise

1. Hundred cases of malaria were seen in the health post which is found in your kebele in October 2000. Can you say there was epidemic of malaria in October 2000? Why?
2. Suppose epidemic of common cold occur in your area. What type of epidemic is this one?
 - a. Point source epidemic
 - b. Common source epidemic with continued

- a. Point source epidemic
 - b. Common source epidemic with continued exposure
 - c. Propagated epidemic
 - d. Mixed epidemic
4. Ten patients come to you to seek treatment because they have fever and severe headache. They also informed you that there are many other similar cases in their village. How do you investigate this epidemic?.
 5. Suppose malaria epidemic occur in your kebele. How do you control it?

UNIT NINE

Epidemiological Surveillance

Learning Objectives

At the end of this unit the student is expected to:

Define surveillance

Describe the types of surveillance

Discuss the activities of surveillance

Identify public health important diseases that are under surveillance in Ethiopia

9.1 Definition

Surveillance is defined as the *continuous (ongoing)* scrutiny of the

To provide scientific baseline data and information for priority setting, planning, implementing and evaluating disease control program for both communicable and non-communicable health problems.

To define the magnitude and distribution of diseases by time, person and place dimension.

9.3 Types of surveillance

The two common types of surveillance are passive and active surveillance.

Passive surveillance

Passive surveillance may be defined as a mechanism for routine surveillance based on passive case detection and on the routine recording and reporting system. The information provider comes to the health institutions for help, be it medical or other preventive and promotive health services. It involves collection of data as part of routine provision of health services.

Advantages of passive surveillance

covers a wide range of problems

does not require special *arrangement*

it is relatively cheap

covers a wider area

The disadvantages of passive surveillance

The information generated is to a large extent unreliable, incomplete and inaccurate

Most of the time, data from passive surveillance is not available on time

Most of the time, you may not get the kind of information you desire

It lacks representativeness of the whole population since passive surveillance is mainly based on health institution reports

Active surveillance

Active surveillance is defined as a method of data collection usually on a specific disease, for relatively limited period of time. It involves collection of data from communities such as in house-to-house surveys or mobilizing communities to some central point where data can be collected. This can be arranged by assigning health personnel to collect information on presence or absence of new cases of a particular disease at regular intervals.

Example: investigation of out-breaks

The advantages of active surveillance

the collected data is complete and accurate
information collected is timely.

The disadvantages of active surveillance

it requires good organization,
it is expensive
it requires skilled human power
it is for short period of time(not a continuous process)
it is directed towards specific disease conditions

Conditions in which active surveillance is appropriate

Active surveillance has limited scope. Unlike passive surveillance, it cannot be used for routine purposes. There are certain conditions where active surveillance is appropriate. These conditions are:

For periodic evaluation of an ongoing program

For programs with limited time of operation such as eradication program

In unusual situations such as:

New disease discovery

New mode of transmission

When a disease is found to affect a new subgroup of the population.

When a previously eradicated disease reappears.

9.4 Activities in Surveillance

The different activities carried out under surveillance are:

1. Data collection and recording
2. Data compilation, analysis and interpretation
3. Reporting and notification
4. Dissemination of information

9.5 Features of a good surveillance system

Using a combination of both active and passive surveillance techniques

Timely notification

Timely and comprehensive action taken in response to notification

Availability of a strong laboratory service for accurate diagnoses of cases

9.6 The integrated disease surveillance system

The integrated disease surveillance system is a relatively new strategy, which is being implemented in Ethiopia. In this strategy several activities from the different vertical programs are coordinated and streamlined in order to make best use of scarce resources. The activities are combined taking advantage of similar surveillance functions, skills, resources, and target population.

Integrated disease surveillance strategy recommends coordination and integration of surveillance activities for diseases of public health importance.

Diseases included in the integrated disease surveillance system

Among the most prevalent health problems 21 (twenty one) communicable diseases and conditions are selected for integrated disease surveillance to be implemented in Ethiopia. The diseases are

recommended because they fall into one or more of the following categories:

Are top causes of high morbidity and mortality in Ethiopia (for example, malaria, pneumonia, diarrheal diseases, tuberculosis, and HIV/AIDS)

Have epidemic potential (for example yellow fever and cholera)

Surveillance required internationally (for example plague, yellow fever and cholera)

Have available effective control and prevention interventions for addressing the public health problem they pose (for example schistosomiasis, onchocerciasis, trypanosomiasis)

Can easily be identified using simple case definition; and

Have intervention programs for prevention, control, eradication or elimination of the diseases (for example EPI and Integrated Management of Childhood Illness Strategy (IMCI))

List of Priority Disease in Ethiopia

A. Epidemic-Prone Diseases

Cholera
Diarrhea with blood (Shigella)
Yellow fever
Measles
Meningitis
Plague
Viral hemorrhagic fevers***
Typhoid fever
Relapsing fever
Epidemic typhus
Malaria

B. Diseases Targeted for Eradication and Elimination

Acute flaccid paralysis (AFP)/ polio
Dracunculiasis (Guinea worm)
Leprosy
Neonatal tetanus

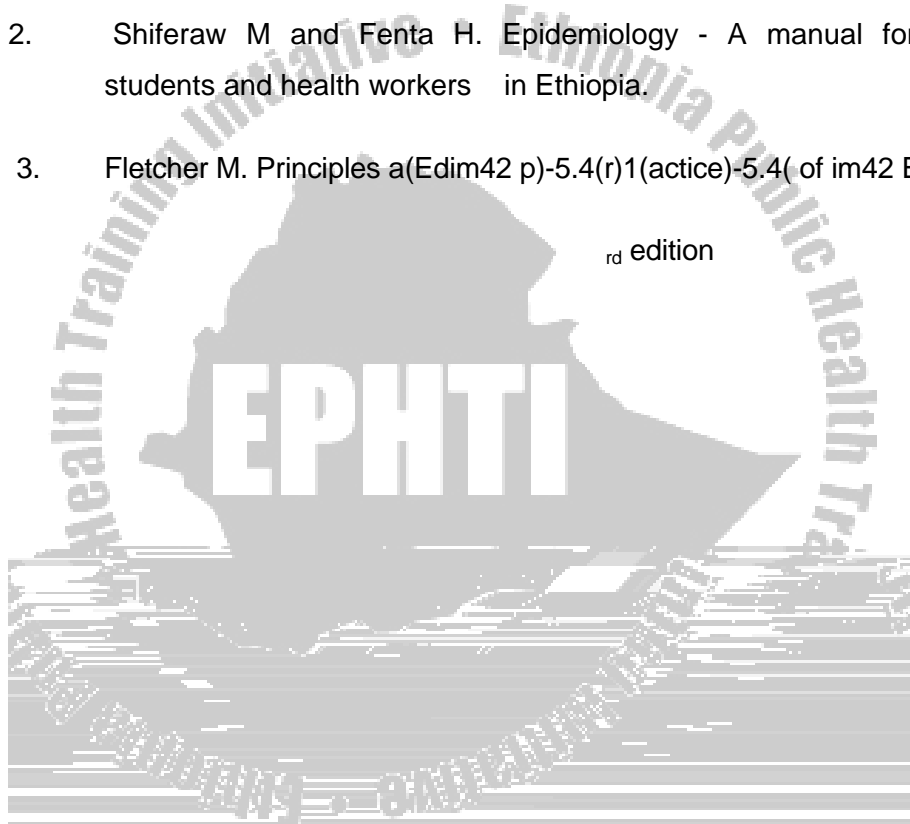
C. Other Diseases of Public Health Importance

Pneumonia in children less than 5 years of age
Diarrhea in children less than 5 years of age



Reference

1. Mausner and Bahn. Introductory text of epidemiology. Second Edition. W. B. Saunders.
2. Shiferaw M and Fenta H. Epidemiology - A manual for students and health workers in Ethiopia.
3. Fletcher M. Principles of Epidemiology and Public Health. 3rd edition.



10. Berhane Y. Principle of Epidemiology. Lecture Note. Department of Community Health, faculty of Medicine, Addis Ababa University, 1997.
11. Rockett IRH. Population and Health: An Introduction to Epidemiology. A publication of the Population reference Bureau. Second Edition, December 1999, 54 (4).
12. Hennekens CH and Buring JE. Epidemiology in Medicine. Little, Brown and Company Boston/Toronto. USA, First Edition, 1987.
13. Teutsch SM, Churchill RE. Principles and Practice of Public Health Surveillance, second edition, Oxford University Press, Oxford, 2000.
14. Leon Gordis. Epidemiology. W.B. Saunders Company, 1996.
15. Beaglehole R. Bonita R. Kjellstrom. Basic Epidemiology. World Health Organization, Geneva, 1993.
16. Vaughan JP. Morrow RH. Manual of Epidemiology for District Health Management. World Health Organization (WHO), Geneva, 1989.
17. McCusker J. Epidemiology in Community Health. AMREF. Rural Health Series No. 9, 2001.

18. Disease Prevention and Control Department, MOH. National Technical Guideline for Integrated Disease Surveillance and Response (IDSR); 2003.
19. Kishore J. A. Dictionary of Public Health, 2002.
20. John M. Last. A Dictionary of Epidemiology, Forth Edition. Oxford University Press, 2001.
21. Spasoff RA. Epidemiologic Methods for Health Policy. New York, Oxford University Press, 1999.
22. Ministry of Health, Federal Democratic Republic of Ethiopia. Health and Health Related Indicators. 1995

