The Health Press

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QUARTER 2, 2024

SPEAK OUT

"The damage caused by methanol poisoning is often irreversible"

Prof. Roma Chilengi

About the Health Press

The Health Press is an open-access and peer-reviewed public health bulletin published by Zambia National Public Health Institute (ZNPHI). It was founded with the mission of offering a forum for the exchange and dissemination of health-related research and knowledge in Zambia and around the world. Its goals include spreading information on Zambia's public health security status and guide policy direction on health security in the country. The issue of the Health Press typically includes a research article, outbreak investigation, field notes and epidemiological bulletin. A new issue is published quarterly online and can be accessed at https://thp.znphi.co.zm/index.php/the-healthpress.

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FOREWORD

Dear Readers,

I am delighted to present to you the second issue of the 2024 Health Press on behalf of the editorial team. During the second quarter of 2024, we focused our unwavering efforts on monitoring and putting to an end the cholera outbreak that affected our nation and other countries in the region. As the quarter came to a close, we noticed a rise in the number of cases of methanol poisoning scattered throughout the nation.

The current issue of the Health Press publication presents surveillance data for priority diseases for the second quarter of 2024. Notable highlights include an editorial that spoke out against the vice of methanol poisoning and an outbreak investigation that was conducted on a suspected case of Mpox in the North-western Province of the country.

My sincere appreciation goes to the authors, the editorial board, and the Surveillance and Disease Intelligence Cluster, whose invaluable assistance and contribution made this publication possible. I hope that this publication will inform the readers and encourage public health action for improved public health security in Zambia.

Dr. Cephas Sialubanje

Editor-in-Chief, The Health Press

EDITORIAL

"SPEAK OUT" – The ZNPHI speaks against Methanol Poisoning

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Given the recent reports of methanol poisoning, I thought we should dedicate this edition of 'SPEAK OUT' to inform and educate the public on this unfortunate situation. As of June 12th, 2024, multiple poisoning events linked to methanol had been reported in Zambia's Southern, Central, Northern, Lusaka, and Western Provinces. People from different communities in these regions have been consuming concoctions primarily made of water, methylated spirit, and a sweetener, usually diluted juices such as Jolly Juice. These concoctions have been given various names in different communities, including "Chimota", "D1 Kasosolo", and "Subilani" Beer. By that date, over 200 cases had been reported, with around 80 deaths, most of which occurred in May. By July 2024, the number of cases, deaths, and affected provinces continued to rise. Various health entities have been working to raise awareness and respond to these tragedies as best as they can, but they face significant challenges. Unfortunately, there is no easy fix for this type of poisoning, especially after the damage has been done.

Methanol poisoning, also known as methylated-spirit poisoning, occurs when a substance containing methanol is ingested. Methanol, sometimes referred to as methyl alcohol or wood spirit, is an organic chemical compound with the formula CH_3OH. This means it consists of a single carbon atom bonded to three hydrogen atoms (CH_3) and a hydroxyl group (OH). Methanol is a colourless liquid that easily catches fire, has a dis-

tinct alcoholic odour, and is volatile—meaning it readily evaporates from liquid to gas at room temperature.

Although methanol is colorless, it is often seen as a purple or blue liquid because it is dyed with methyl purple during manufacturing to help distinguish it from other alcohols, such as ethanol. This color change, along with the addition of a foul smell, is intended to make methanol appear unsafe to drink, thereby discouraging consumption. Methanol is readily available in shops and various convenience stores and is commonly referred to as 'Spirit.' Its volatility makes it a popular choice for starting fires.

Consuming methanol can have severe effects on the body, leading to cell failure and even nervous system damage. The toxic dose depends on the concentration and the timeliness of treatment. Unfortunately, treatment is difficult to obtain and, when available, is extremely costly; the damage caused by methanol poisoning is often irreversible. To give you an idea of the danger: as little as 30 ml (about a mouthful) is considered the minimum lethal dose for an adult of a certain weight, and just 10 ml (a tablespoon) can cause blindness. Some of the symptoms experienced by victims include

diarrhea, vomiting, blurred vision, restlessness, and in some cases, sudden onset blindness before succumbing to illness and organ failure. Once methanol enters the body, it is converted into formaldehyde and formic acid, both of which are highly toxic and potentially fatal in large amounts. This conversion can lead to metabolic acidosis, a condition where excess acid accumulates in the body.

Some of the information is drawn from how other communities have identified and dealt with methanol poisoning. Samples have been collected from various communities and sent to the University Teaching Hospital (UTH) for further investigation and guidance on the next steps. Drinking methanol is an uncommon form of poisoning that can cause severe metabolic disturbances, blindness, permanent neurological dysfunction, and death. While methanol itself may seem harmless, once inside the body, it is converted into formaldehyde and formic acid, both of which are highly toxic and potentially fatal in large amounts. This can lead to metabolic acidosis, a condition where excess acid builds up in the body. Factors contributing to this condition include the accumulation of body toxins, kidney failure, and the ingestion of certain drugs, such as large doses of aspirin. It can also be a rare complication of diabetes. Symptoms of metabolic acidosis include nausea, vomiting,

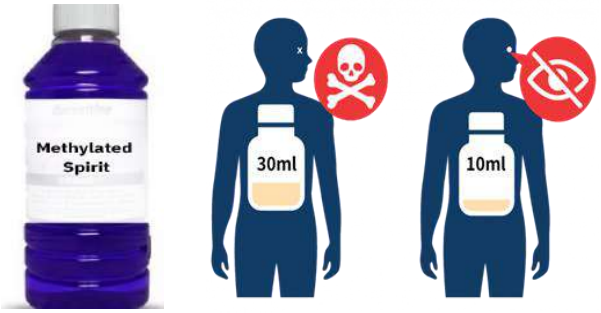
rapid breathing, and lethargy, which may explain some of the symptoms experienced by victims in our local communities.

Although different brands of methylated spirit are being used in the communities, they are all harmful to the body regardless. In Southern and Western Province, a new brand on the market called 'Beautiful' was used while a premium Quality methylated spirit is being used in Central Province. Whether it is a purple dyed spirit or colourless as its natural state, it should not be consumed. Efforts to manage the situation include:

- **Sensitization**: Local leadership and influential community members are raising awareness and encouraging safe drinking behaviors.
- **Intersectoral Collaboration**: Various sectors, including law enforcement, education, and community organizations, are working together to implement a comprehensive response.
- **Clinical Engagement**: Healthcare staff are being trained to raise the index of suspicion and identify potential cases more effectively.
- **Regulatory Measures**: Provinces are collaborating with local authorities to strengthen licensing requirements for alcohol vendors and increase monitoring to prevent the sale of unsafe products.

Given this information, we hope you understand why this is a serious issue. The best way to prevent methanol poisoning is to COMPLETELY AVOID CONSUMPTION. If you have or know anyone who has taken methanol, please go to the nearest health facility IMMEDIATELY. Do not wait to start experiencing symptoms.

We strongly advise everyone to completely avoid drinking substances containing methanol. It is extremely dangerous and can be deadly. Avoiding it at all costs is the best form of prevention. If you see something, say something, and help save a life. Thank you for considering our position on this matter. Should you require any further information or assistance, please do not hesitate to contact us at info@znphi.gov.zm.



As little as 30 ml of dyed methylated spirit shown on the left can be lethal dose.

Mpox Outbreak Investigation in Ikelenge District, 2024: A Single-Case Analysis

Geoffrey Mutiti[1] Kadolo Muntanga[2] Kizito Sampa[2] Marian Matipa Mulenga[1] Abiodun Kolapo[3] and Franklin Liamba[4]

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SUMMARY

On 30th May, 2024, the Ikelenge District Health Office in North Western Province alerted the Zambia National Public Health Institute of a suspected Mpox case at Jimbe Health Post. A case investigation was conducted involving interviews, review of medical records and contact tracing

One suspected case of Mpox was identified. A 13-year-old female presented with symptoms consistent with the case definition of suspected Mpox. Additionally, three contacts were identified of which none met the case definition for a suspected case. PCR and serological testing of crusts, collected from the primary case yielded negative results for Mpox.

The prompt detection of the alert demonstrates a functional early warning system. However, the strengthening laboratory systems is crucial to aid rapid detection and verification of potential cases.

INTRODUCTION

Monkeypox (now formally known as Mpox) is a zoonotic disease caused by the monkey pox virus (MPXV), which belongs to the Poxviridae family (Tiecco et al., 2022). It is endemic to central and western Africa (Gao et al., 2023). The disease was first discovered in 1958 and reported in humans in 1970. Before 2017, Mpox mainly occurred in central and western Africa, where the virus was sustained in local animal reservoirs, leading to occasional spillover into human populations, particularly in rural areas (Yu et al., 2023). Since 2017, ongoing human-to-human transmission has been reported in western Africa, resulting in occasional cases exported to other countries from 2018 to 2021(Gao et al.,

2023). The virus primarily spreads through direct contact with infected lesions and bodily fluids, though it can also be transmitted via respiratory droplets and contaminated surfaces. The ongoing outbreak of clade 1b which began in September 2023 has affected at least 12 countries, with over 17,000 suspected cases reported in 2024. The majority of these cases have been reported in the Democratic Republic of Congo (Adepoju , 2024; Africa CDC, 2024a). Zambia is on high alert due to its close proximity to the DRC.

On May 30, 2024, Ikelenge District Health Office in North Western Province, Zambia, alerted the Zambia National Health Institute (ZNPHI) of a suspected Mpox case from Lukuma Village under the Jimbe Health Post. This alert was triggered by a patient who presented with symptoms suggestive of Mpox. The date of onset for the patient's symptoms was May 23, 2024. The Jimbe Catchment Area under Ikelenge is situated along the border with Angola in Northwestern Province (see figure 1). It is characterized by cross-border activities including trade and serves as a point of entry. Ikelenge District is boarded by Angola on the Western and the Democratic republic of Congo on the north east. Given the district's geographic location, it is prone to importation of Mpox infection. Therefore, an outbreak investigation team comprised of Field Epidemiologists, Clinicians, and Public Health Officers from both ZNPHI and the Ministry of Health was deployed immediately. The aim of the investigation was to verify the alert and assess outbreak potential.

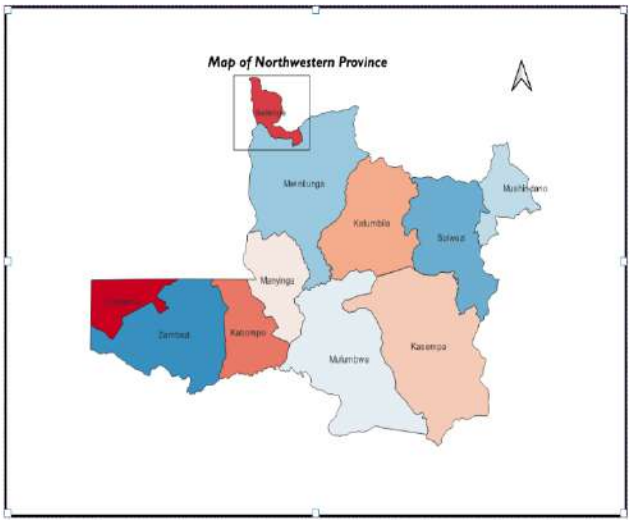

Figure 1 Geolocation of the case investigation site, Jimbe Catchment Area, and Lukuma Village.

METHODS

We conducted a case investigation on the reported patient from 4th to 10th June, 2024. The team reviewed medical records and conducted contact tracing. A suspected case was defined as any resident of Lukuma Village presenting with an unexplained acute rash, mucosal lesions, or lymphadenopathy within a 21 days retrospective window. Specimens, including crusts, swabs, and blood, were collected for Real time polymerase chain reaction (PCR) testing in accordance with recom-

mended Africa CDC Mpox molecular diagnostic tests guidelines (Africa CDC, 2024b).

RESULTS

Case presentation

Review of medical records and examinations indicated that the reported patient met the case definition of suspected Mpox. The suspected case was identified as a 13-year-old female from Lukuma Village, Ikelenge District. She presented with a one-day history of rash and fever, preceded by abdominal discomfort. The fever persisted, and the generalized rash affected both upper and lower limbs bilaterally. Initially, the rash discharged clear fluid, which later turned to pus-like drainage, lasting 3-4 days before crusting over 7 days. Figure 1 shows lesions on the suspected case.

Further examination revealed malaise, lower backache, and a limping gait due to right thigh pain, with axillary, cervical, and inguinal lymphadenopathy. The suspected case did not report a cough, sore throat, diarrhea or vomiting and denied recent travel, or contact with symptomatic individuals. She had regular contact with domestic animals, including chickens, goats, dogs, and cats. Epidemiological assessments revealed no definitive link between the suspected case and individuals from endemic regions

Contact tracing

The investigation identified three household contacts, two adult females and a male child aged four years old. One of the adults who was the suspected case's mother had oral lesions treated as candidiasis but did not meet the Mpox suspected case definition. Likewise, two other contacts, an adult female neighbor and her four-year-old son did not meet the case definition for a suspected case upon examination.

Laboratory tests

The real-time polymerase chain reaction test of crusts did not detect monkey pox viral (MPXV) DNA.

Figure 2 Lesions in a suspected case of mpox, Jimbe, Northwestern Province, 2024

DISCUSSION

This investigation aimed to verify an alert received from Ikelenge District in North-Western Province concerning a patient with symptoms suggestive of Mpox. A review of medical records indicated that the patient, a

13-year-old female from Lukuma Village, presented symptoms consistent with the case definition for suspected Mpox. Consequently, contact tracing was initiated in line with the World Health Organization's interim guidance on surveillance, case investigation, and contact tracing for Mpox. This guidance recommends that contact identification and tracing should begin while further investigation of the suspected case is ongoing (World Health Organization, 2024). Three household contacts were identified; however, none met the case definition for suspected Mpox.

Since no additional suspected cases were identified, specimens for laboratory confirmation were collected only from the primary reported case. According to the WHO's interim guidance, confirmation of an Mpox case is determined by the detection of MPX viral DNA through real-time polymerase chain reaction (PCR) and/or sequencing (Moyo et al., 2022). PCR testing of crust samples collected from the suspected case did not detect MPX viral DNA. As a result, the investigation ruled out an Mpox outbreak based on these finding.

It is worth noting that Zambia has capacity to diagnose Mpox and the long turnaround time for laboratory confirmation observed in the present study was due to logistical challenges associated with sample collection and laboratory testing. For example, Lukuma Village is located in a remote part of Ikelenge District, over 341 km from the provincial health office and 921 km from Lusaka, where the designated lab is located. This distance posed a challenge in transporting samples for analysis, thus increasing the turnaround time. Similar issues were observed in other rural settings during the COVID-19 pandemic (Moyo et al. 2022). Moyo et al. (2022) also note that the lack of refrigeration or a reliable power supply in some health facilities to maintain specimen viability while awaiting transportation to diagnostic centers hampered laboratory diagnostic capability in most African countries during the COVID-18 pandemic. This is particularly problematic for remote areas lacking the necessary logistics for sample collection, handling, and dispatch.

While this investigation demonstrated a functional early warning system, it also highlights the need to strengthen laboratory systems for swift public health action. Studies indicate that weaknesses in testing capacity can lead to delays in outbreak identification, as evidenced in some African countries during previous COVID-19 and Ebola outbreaks (Afolabi et al., 2021).

Accelerating efforts to strengthen laboratory systems is crucial during the ongoing Mpox outbreak, particularly as cases are emerging in African countries that previously never reported human Mpox transmission (Bunge et al., 2022; WHO, 2022). For example, currently, the Ministry of Health in Zambia with support from the Global Fund is improving laboratory systems and diagnostics, as well as recruiting and building capacity of laboratory staff (The Global Fund, 2024). It is essential that these efforts be expedited to ensure that ZNPHI can respond to public health threats timely.

Finally, strengthening Mpox surveillance and case investigation is critical not only for the rapid identification of cases but also to inform implementation of control and prevention measures (WHO, 2024). It is crucial that public health actions be implemented immediately following an alert and not be delayed by laboratory confirmation.

CONCLUSION

We conducted a case investigation of Zambia's first suspected Mpox case reported in Ikelenge District, North Western Province. Using the case definition for a suspected case, only one individual met the criteria, and subsequent laboratory results were negative. The prompt detection and initiation of the investigation highlight the effectiveness of the existing early warning system. However, it is essential that preparedness efforts include plans to strengthen laboratory diagnosis and addressing logistical challenges especially associated with remote areas.

ACKNOWLEDGEMENTS

Acknowledgment to the Zambia National Public Health Institute for its invaluable technical and logistical support throughout the investigation and staff at the sub-national level in Northwestern Province for their significant contributions and support

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THE REPUBLIC OF ZAMBIA

Q2 **Public Health Bulletin** 1st April – 31th June 2024

Summary of outbreaks

Cholera

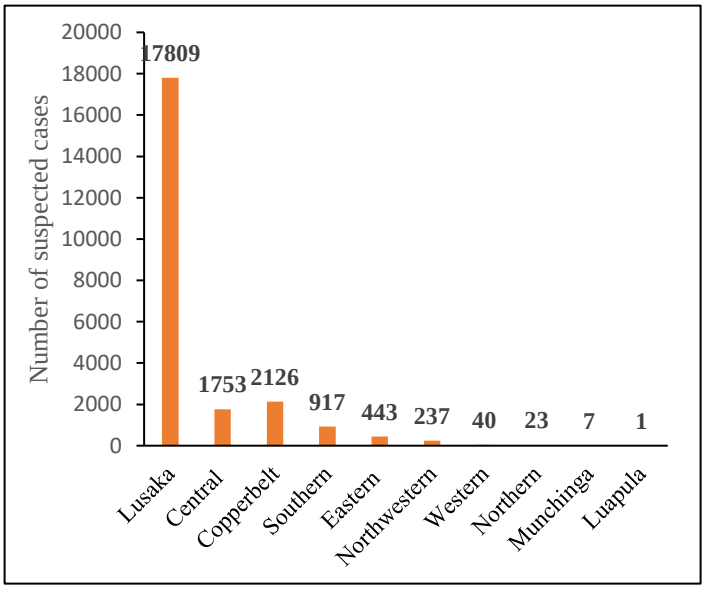

Figure 1 Cumulative suspected cholera cases by province as at 30th June, 2024 (Source: Cholera Situational Report)

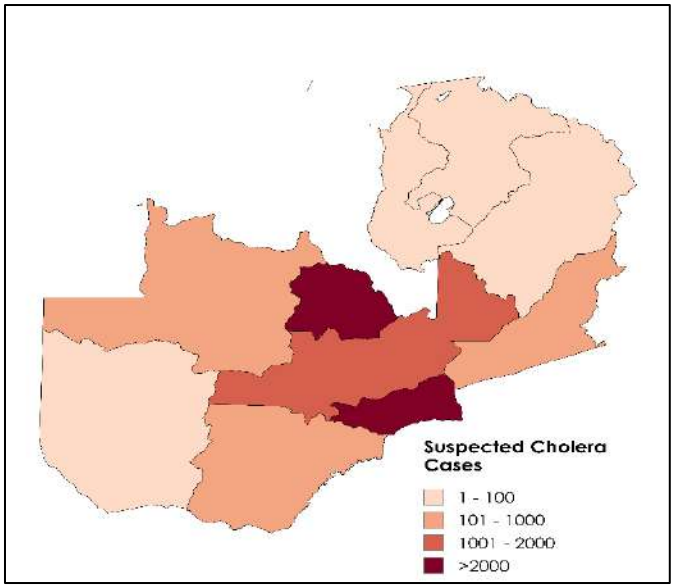

Figure 2 Map showing distribution of suspected cholera cases by province

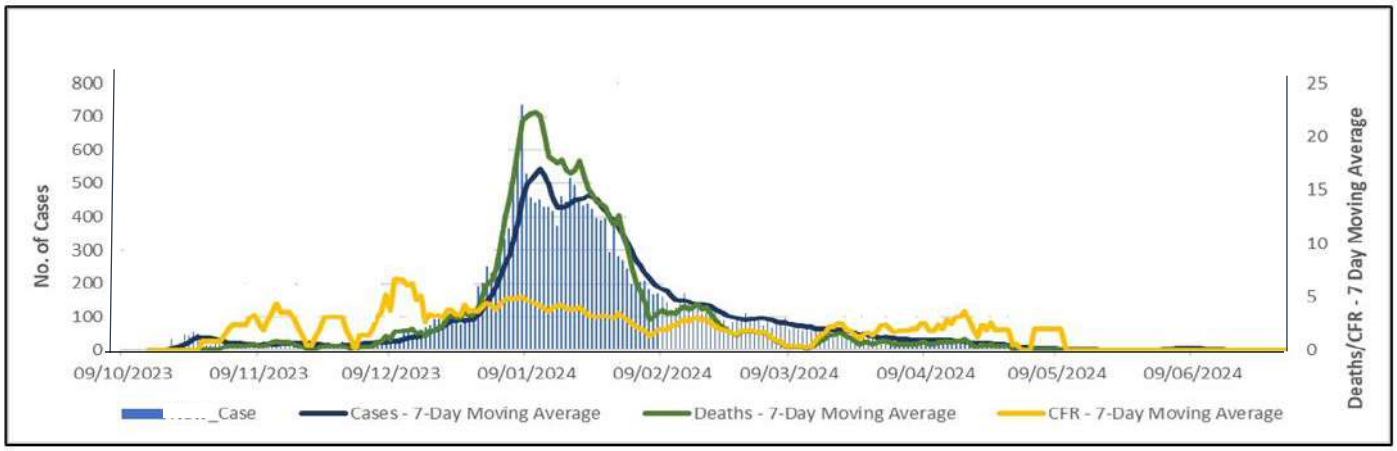

Figure 3 Epi curve of cholera cases in Zambia from October, 2023 to June, 30 2024. (Source: Cholera Sitrep, 30th June, 2024)

Zambia has been experiencing a Cholera outbreak since October 2023. By the end of Q2 2024, the cumulative number of suspected cases reached 23,381, up slightly from 22,481 in Q1. Lusaka and Copperbelt provinces reported the highest numbers, with 17,809 and 2,126 cumulative cases, respectively. The outbreak has resulted in 740 cumulative deaths, with a case fatality ratio of 3.17%. Over 80% of these deaths occurred in Lusaka province, mainly within the community. On a positive note, 22,617 discharges have been reported. For more information see cholera situational reports here.

Anthrax

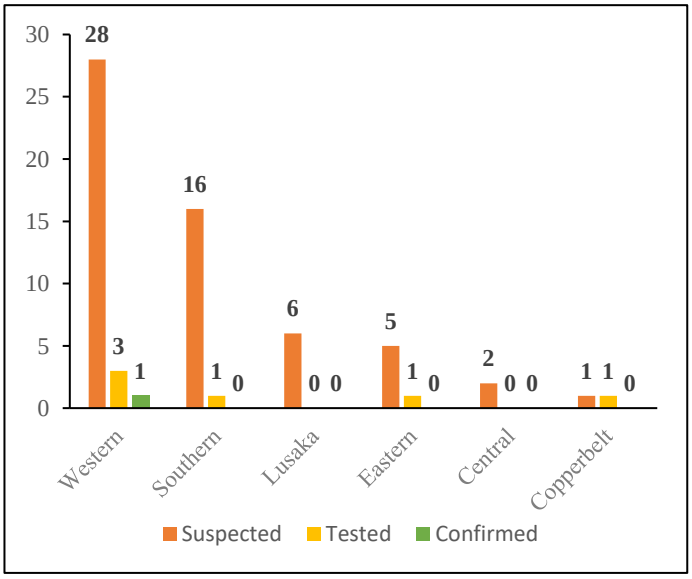

Figure 4 Quarter 2 suspected Anthrax cases by province (Source: eIDSR, 2024

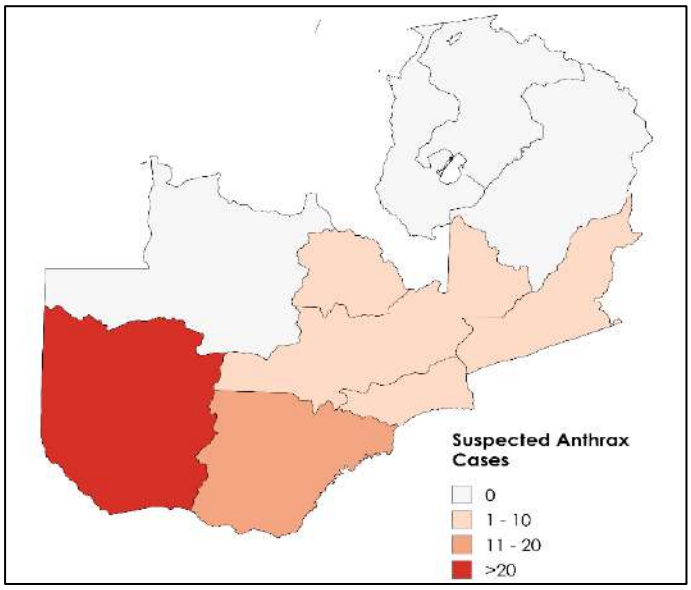

Figure 6 Map showing distribution of suspected Anthrax case by provinces

A total of 58 suspected Anthrax cases were reported across six provinces, excluding Luapula, Muchinga, Northern and Northwestern Provinces. This is a significant decrease from the 123 cases reported in quarter 1, 2024. This continued the downward trajectory in suspected Anthrax cases reported nationwide. Western province continues to report the highest number of cases with 28, followed by Southern Province with 16. However, despite the decrease, the 58 suspected cases in Q2 2024 remain significantly higher than the 7 cases reported in Q2 2023. It's also notable that cases spiked to 140 in Q3 2023. Given the current numbers and ongoing drought conditions, close monitoring, especially as the dry and hot season approaches, will be crucial.

Measles

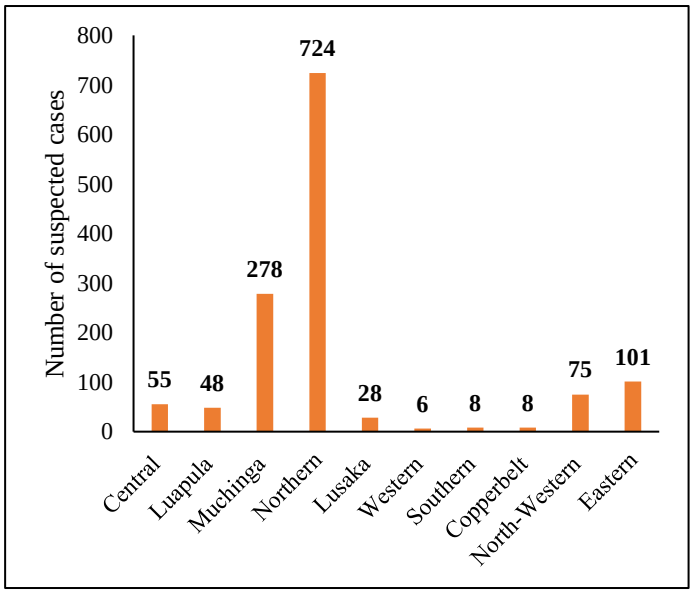

Figure 5 Quarter 2 Suspected Measles Cases (Source eIDSR, 2024)

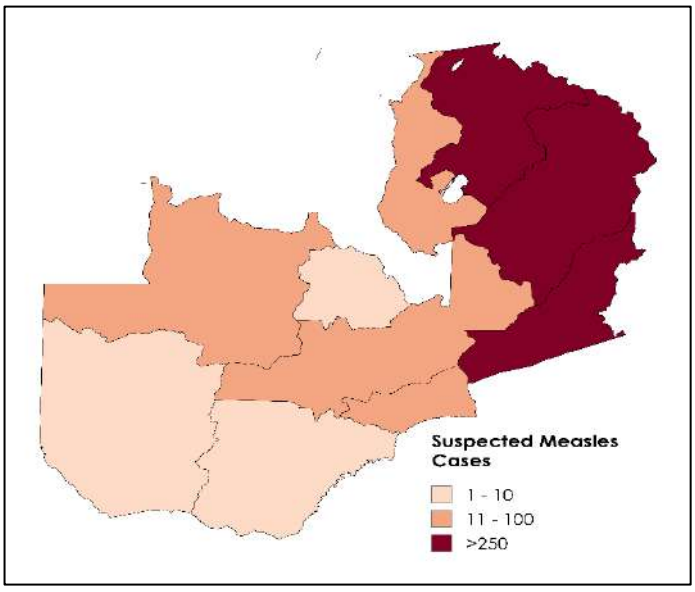

Figure 8 Map showing the distribution of Suspected Measles cases

A total of 1331 suspected measles cases were reported in quarter 2, 2024, representing a decrease from 2193 suspected cases reported in quarter 1, 2024. Northern Province reported the highest number of suspected cases with 724, followed by Muchinga and Eastern province with 278 and 101 suspected cases respectively. The remaining provinces reported less than 100 cases each with Southern Province (9) and Western Province (5) reporting the least number of suspected cases.

Biharzia

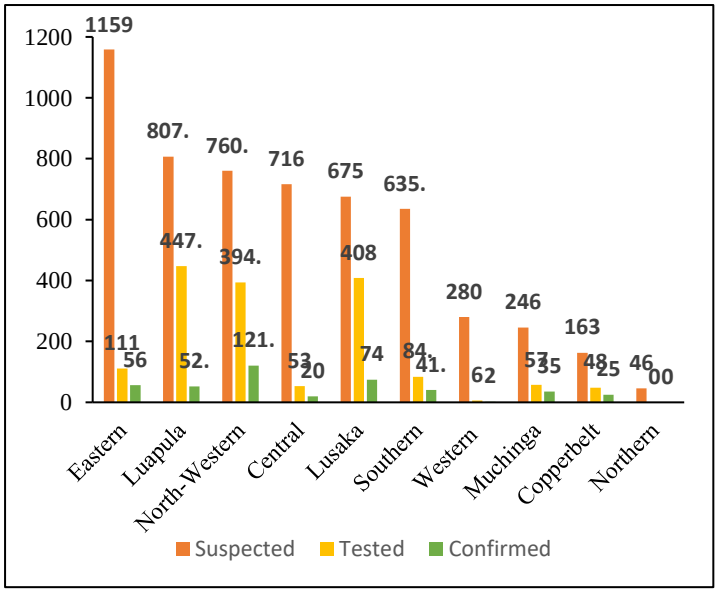

Figure 6 Quarter 2 suspected and tested Bilharzia cases (Source: eIDSR, 2024)

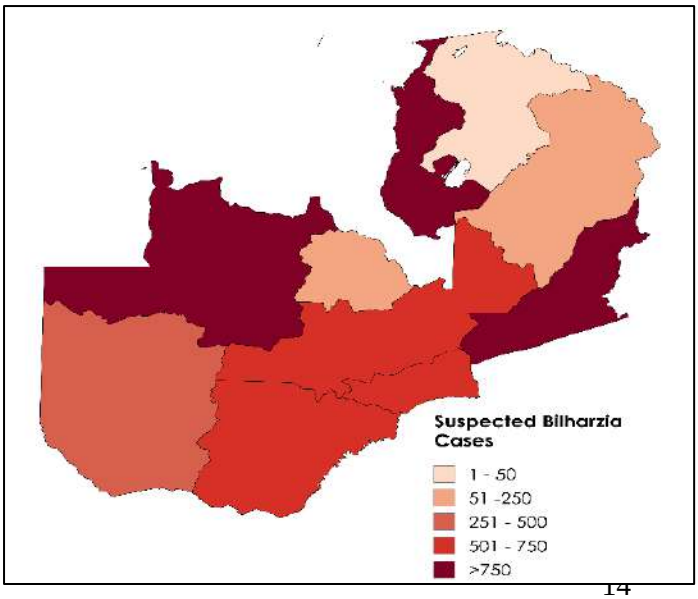

Figure 10 Map showing the distribution of suspected Bilharzia cases

A total of 5487 suspected Bilharzia cases were reported during the second quarter of 2024. This represents an increase from 4263 suspected cases reported in quarter 1, 2024. Eastern Province recorded the highest number of cases with 1159 followed by Luapula with 807 and North-Western with 760. Central (722), Lusaka (675), and Southern (635) Provinces each reported between 500 and 750 cases. Northern Province had the fewest suspected cases, with 46 reported. During Q2, 2023, a total of 4167 suspected Bilharzia cases were reported.

Typhoid

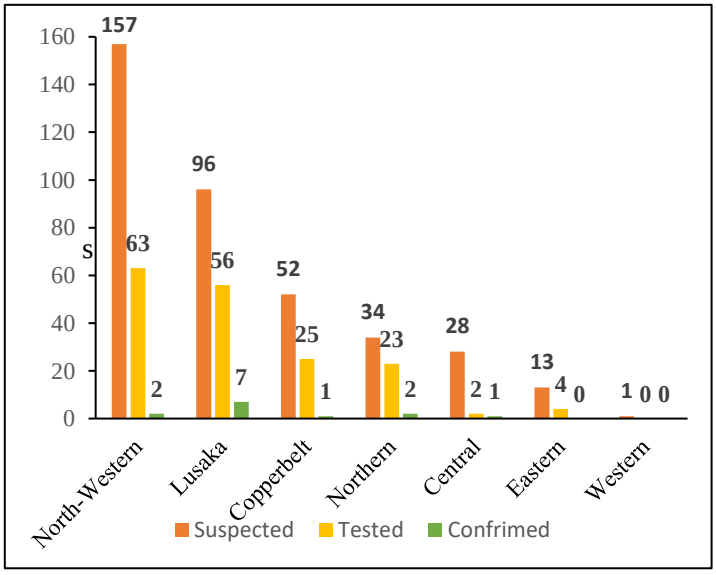

Figure 7 Quarter 2 suspected Typhoid cases per province (Source: eIDSR, 2024)

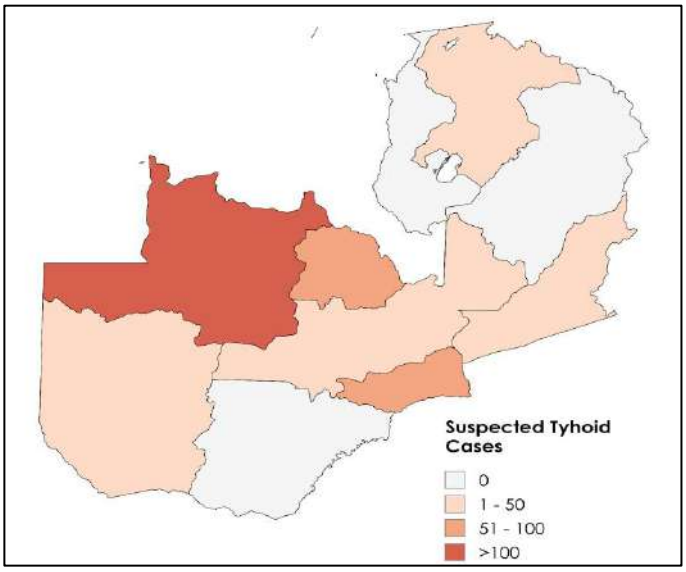

Figure 12 Map showing distribution of suspected Typhoid cases per province

A total of 381 suspected Typhoid cases were reported in Q2 2024, nearly doubling the 170 cases reported in Q1. Northwestern Province reported the highest number, with 157 cases—a dramatic increase from the 31 suspected cases reported in Q1. Lusaka (96) and Copperbelt (52) also experienced significant increases, ranking second and third, respectively. The lowest number of cases was in Western Province with 1, while Muchinga, Luapula, and Southern Provinces had no suspected cases. A similar upward trend was observed in 2023, where suspected cases increased from 397 in Q1 to 587 in Q2. Of note, between Q1 2023 and Q2 2024, Lusaka and Northwestern Provinces recorded the highest number of cases, with 578 and 575 respectively, accounting for approximately 62% of the total suspected cases reported during this period.

Maternal Mortality

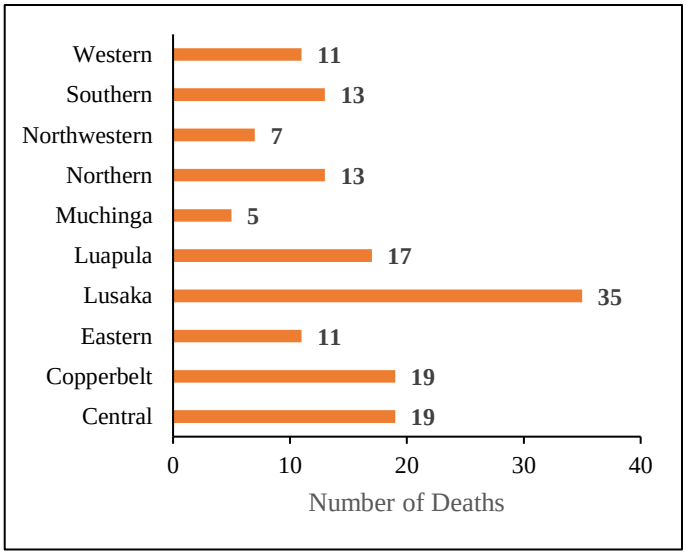

Figure 9 Quarter 1 reported maternal deaths per province (Source: Maternal Child Health Unit (Ministry of Health), 2024)

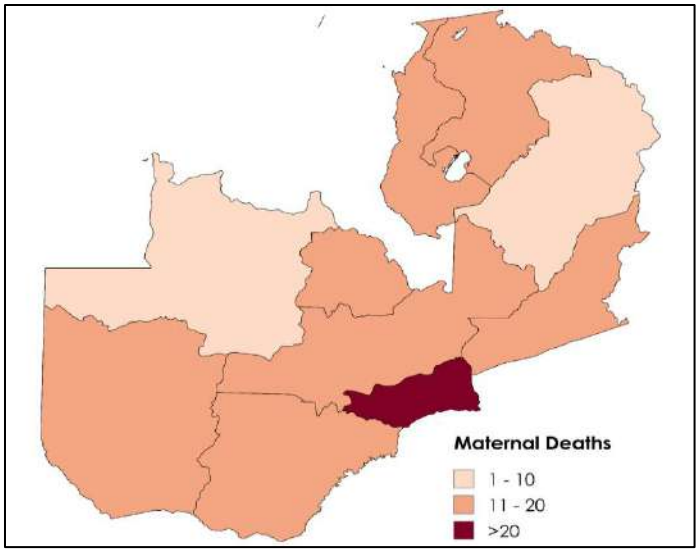

Figure 94 Map showing distribution of maternal deaths per

In the second quarter of 2024, a total of 150 maternal deaths were reported, a decrease from 177 deaths reported in the first quarter of 2024. Lusaka province continues to report the highest number of deaths with 35, followed by Copperbelt Province and Central province, both recording 19 cases each. Notably, Luapula Province experienced a significant increase from 6 deaths in quarter 1 to 17 deaths reported in quarter 2, 2024. Conversely, Muchinga and Northwestern provinces reported the least deaths with 5 and 7 deaths

Acute Flaccid Paralysis

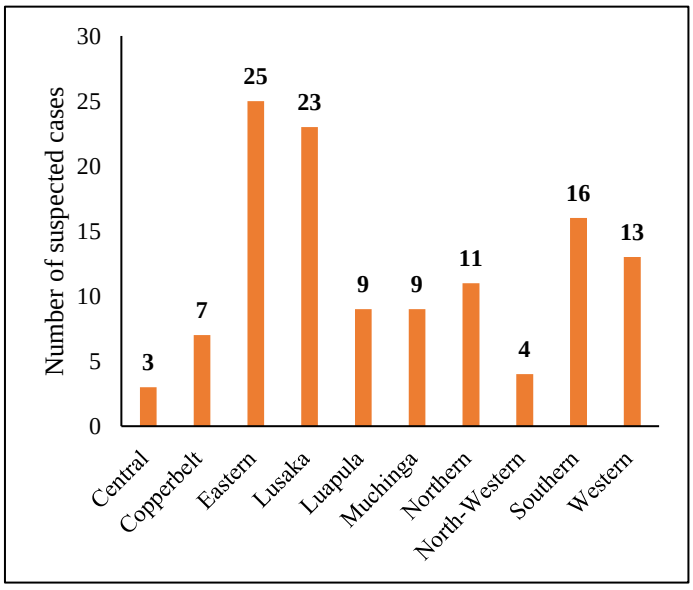

Figure 11 Quarter 2 suspected AFP cases by province (Source: eIDSR, 2024)

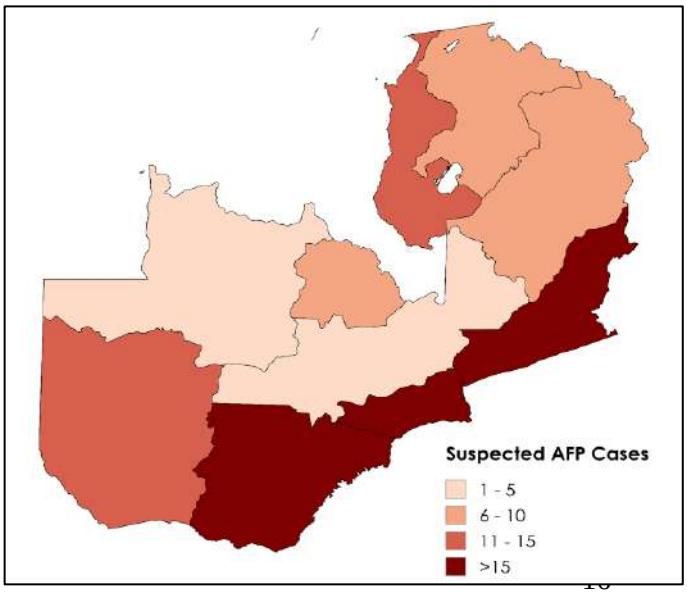

Figure 116 Map showing provincial distribution of AFP cases

A total of 120 suspected AFP cases were reported in Q2 2024. Lusaka and Eastern Provinces reported the highest number of suspected cases with 25 and 23 cases respectively. Lusaka experienced a dramatic increase from 4 cases reported in Q1, 2024. Conversely, Northwestern Province continues to report fewer cases with 4 while Central Province reported the least number of cases with 3. Overall, the 120 suspected cases reported in quarter 2 represent a decrease from the 133 suspected cases reported in quarter 1 2024.

Summary Report Priority Diseases, Conditions and Events

Disease/Event/Condition	Week 14 - 26		
	Suspected	Tested	Confirmed
AFP	120	120	0
Anthrax Suspected	58	6	1
Cholera	896	424	132
COVID-19	6,437	5,152	168
Dog Bite	5,769	0	5769.
Dysentery	12,606	569	136
HIV	779,490	753,262	16,544
Schistosomiasis (Bilharzia)	5,487	1,608	426
Malaria	3,1277,66.	293,2005.	149,0340.
Maternal Deaths*	150	0	150
Measles	1,331	373	260
Meningitis (Neisseria)	116	74	42
Monkey Pox	1	1	0
Tuberculosis	123,656	11,2504	5,361
Typhoid Fever	381	173	13

* Data not extracted from eIDSR

Data used was extracted from eIDSR on 29th August, 2024.

About eID0RS

The Electronic Integrated Disease Surveillance and Response System (eIDSR) is a disease surveillance system that is used to continuously and systematically collect, analyse, interpret, and visualize public health data. Data is collected at facility level and captured by district surveillance officers. The data reported in this bulletin was extracted from the system (except where indicated otherwise) on the aforementioned date.

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