

UNICEF Namibia – Cholera Outbreak Report #1

FOR EXTERNAL USE

14 January 2014

Highlights

As of 12 January 2014, the total cumulative reported cases were 287 and total number of cumulated deaths were 10 (5 died in community and 5 in hospital).

Government and partners (WHO, UNICEF, CDC and Namibia Red Cross) undertook assessment and response: i) Case Management; ii) Surveillance; iii) Logistics and iv) Social Mobilization.

Outbreak suspected to be linked to shortage of safe water sources following extended drought, combined with poor sanitation and hygiene practices.

I. Background

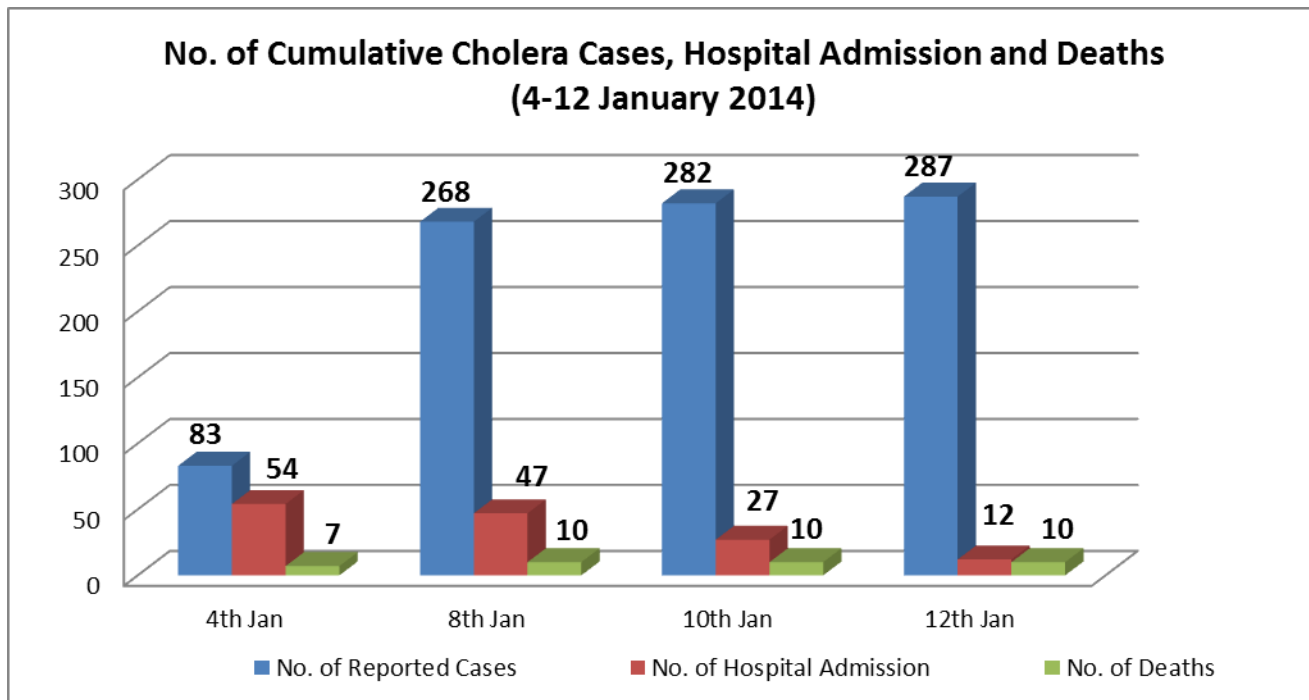
On 3rd January 2014, Opuwu District/Regional Health Team reported an outbreak of Cholera to Ministry of Health and Social Services. Cases have been detected since mid-December 2013 and stool samples tested positive for *Vibrio Cholerae* sero-group O1, sero-type Ogawa.

On 6th January 2014, Directorate of Primary Health Care called an emergency meeting on Cholera Outbreak Response and requests for technical assistance were sent to WHO, CDC and UNICEF to provide technical and other support for outbreak response.

Cholera Outbreak Response Team led by the Director of Primary Health Care, Deputy Director of Epidemiology, and Deputy Director of Family Health Division consists of members from MoHSS in Windhoek, Kunene Regional/District Health Team members, CDC, WHO and UNICEF. Outbreak Response Team met regularly and joined by the Honorable Regional Governor and his team on 10 January 2014. The Outbreak Response Team was divided into four working groups i) Case Management; ii) Surveillance; iii) Logistics and iv) Social Mobilisation.

II. Findings

As of 12 January 2014, the total cumulative reported cases were 287 of which 12 were still admitted at the hospital (cases were isolated in Cholera Treatment Tents right outside of Opuwu District Hospital) and total number of cumulated deaths were 10 (5 died in community and 5 in hospital). No more casualties reported since 9 January 2014. Please find below the number of cases, hospital admission and deaths reported over the period of time.



Active case finding through surveillance team has been carried out intensively since 6 January 2014, as a result more cases were identified early enough and received treatment. When case management and social mobilisation works were intensified from 7 January onwards, number of hospital admissions decreased as well as number of deaths reported.

Case Management and Social Mobilisation teams emphasized the health workers as well as community members on the importance of understanding the signs and symptoms of Cholera, early rehydration with ORS, and refer immediately to the nearest hospital or health centers/clinics. Those efforts were resulted as most of the referred cases to hospitals and health centers were in stable conditions when they reached the health facilities.

Number of reported cases suddenly increased during the last day of December and first few days of January 2014, where most of the festivities were on-going and many staff members were on leave.

Highest numbers of cases were reported from Etanga area as one particular source of unprotected surface water pond about 1 km from Etanga was identified as possible source of infection. And majority of reported cases were among children and women.

Protracted drought in many parts of Opuwo district contributed to this Cholera as many boreholes dried up. And people are drinking from whatever water sources available and sharing the same water source with animals. Lack of personal hygiene and sanitation especially lack of hand washing practices created a rapid spread of Cholera even in a sparsely populated area. One surveillance team reported increasing number of Cholera cases after many people attended a funeral (died of suspected Cholera) where people showed up, shared food and drinks, and shook hands.

III. Discussion

3.1. Strengths

One of the major strengths of this response was the rapid action from the MoHSS and the health sector. Logistic team made sure that all the tents arrived on time, additional staff members deployed and ensured availability of sufficient supplies such as medicines, and ORS, etc. Six treatment tents at Opuwo District Hospital and two at Etanga Clinic were set up for isolation of Cholera cases and provision of adequate care by health staff. Engagement of Regional Governor, Regional Disaster Management Team and other sectors paid off as water tanks were deployed and water trucking is currently taking place between Opuwo and Etanga area. A Police Helicopter is available for 5 days to carry out surveillance as well as supply distribution to the most hard to reach areas in Etanga and other constituencies in Opuwo.

The role of Health Extension Workers was crucial in curtailing the outbreak at an early stage as they played an important part in linking the communities and health staff as well as providing health education, distribution and demonstration of water purification sachets, use of ORS, etc.

Namibian Red Cross Society is another active partner in Cholera Outbreak Response in Opuwo District. UNICEF and NRSC signed a project cooperation agreement in June 2013 to support drought affected regions on emergency preparedness and response focusing on WASH and nutrition activities. UNICEF provided N\$ 5,700,000 (US\$ 570,000) including the supplies of water purification tablets, water containers (collapsible jerry cans of 20 L), and most importantly training of 90 NRCS volunteers on WASH, hygiene and handwashing interventions. This preparedness has significant impact on stabilizing the outbreak as NRCS volunteers joined the social mobilisation team to educate the communities and distribute water purification sachets, water containers and ORS. They are also providing additional community education activities through soup kitchens and other food distribution interventions as part of the overall drought response.

3.2. Weaknesses

Coordination was a major challenge during the initial days of outbreak response. Regional Health Team was late in informing the MoHSS team in Windhoek. The engagement with the regional disaster management team took place only after the arrival of Outbreak Response Team from Windhoek. NRCS reported that they were not fully informed nor consulted throughout the process though they are the key stakeholders in terms of community and social mobilisation.

Social mobilisation is another area needing improvement as radio messages haven't been broadcasted to date though it was agreed as the very first intervention to be taken up. Opuwo has a very low coverage of sanitary latrines as well as low level of sanitation and hygiene practices. It will be an insurmountable task for community mobilisation efforts in convincing the communities to drink only safe and clean water; wash hands with soap and use/build sanitary latrines. Availability of IEC materials in local language is another weakness in community mobilisation.

3.3. Opportunities

Despite Cholera outbreaks in 2006 and 2009, the region did not take the opportunity to ensure sustainable behaviour change on sanitation and hygiene practices. MoHSS, NRCS and UNICEF must be working closely on i) household water treatment and safe storage ii) use of sanitary latrines and hand washing with soap and iii) availability of sanitation and hand washing facilities at public places including health centers and clinics.

3.4. Threats

Namibia is on its way to achieve MDG on water but this outbreak showed there are pockets of population without access to clean water. It reveals inequity in access to water in some parts of Namibia or among some population groups. Without available clean water, Cholera and other water borne diseases will continue to have negative impact on health outcomes of such population groups. Some other regions bordering Angola or with very low water and sanitation coverage are at risk for similar outbreaks.

IV. Way Forward

Current Cholera Outbreak happened in a sparsely populated area thus posing a low to medium risk compared to those outbreaks in densely populated urban areas or informal settlements. However distance to health centers/clinics, shortage of health staff and lack of knowledge/awareness among community members created challenges in terms of response and causing high case fatality during the initial days of outbreak.

As access to safe and clean water will be ongoing challenge in this area – household water treatment and safe storage become key areas of intervention. UNICEF will continue its support to MoHSS and NRCS with water purification sachets and water containers as well as community education on household water treatment and safe storage.

Hand washing with soap will be another key area of support through community education and distribution/demonstration of tippy taps (low tech low cost hand washing containers) and soap bars. Advocacy with regional council and private sector will take place to ensure all public places are equipped with hand washing as well as sanitation facilities.

UNICEF will be working closely with IEC Division of MoHSS, NRCS and WHO in mass media and interpersonal communication on Cholera prevention and ensuring communities practice safe hygiene and sanitation behaviours.

As medium and longer term response, community led total sanitation (CLTS) leading to behaviour change and demand creation of sanitary latrines must be one of the key interventions for 2014 onwards.

V. Immediate Next Steps

- Adaptation and broadcasting of “The Cholera Story”, a four minute video through NBC for nationwide awareness raising of Cholera (Action: UNICEF and IEC Division of MoHSS)
- Dubbing of that video in local languages for use by regional MoHSS teams and NRCS (Action: UNICEF to acquire high resolution copy for dubbing and share with IEC Division)
- Establishment of national level IEC taskforce to develop and distribute common messages for Cholera (Action: IEC Division to call a meeting)
- Key messages for local radio broadcasting in Opuwo (Action: UNICEF shared a draft message with social mobilisation team in Opuwo)
- Supplies needed for immediate and medium term action
 - Water Purification Sachets (Water Maker for MoHSS and NRCS)
 - ORS (For NRCS)
 - Water Containers (20 L collapsible Jerry Cans – For NRCS/MoHSS)
 - Hand Washing Basins (MoHSS/NRCS)
 - Soap Bars (MoHSS/NRCS)
 - IEC materials in local language (MoHSS/NRCS)

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