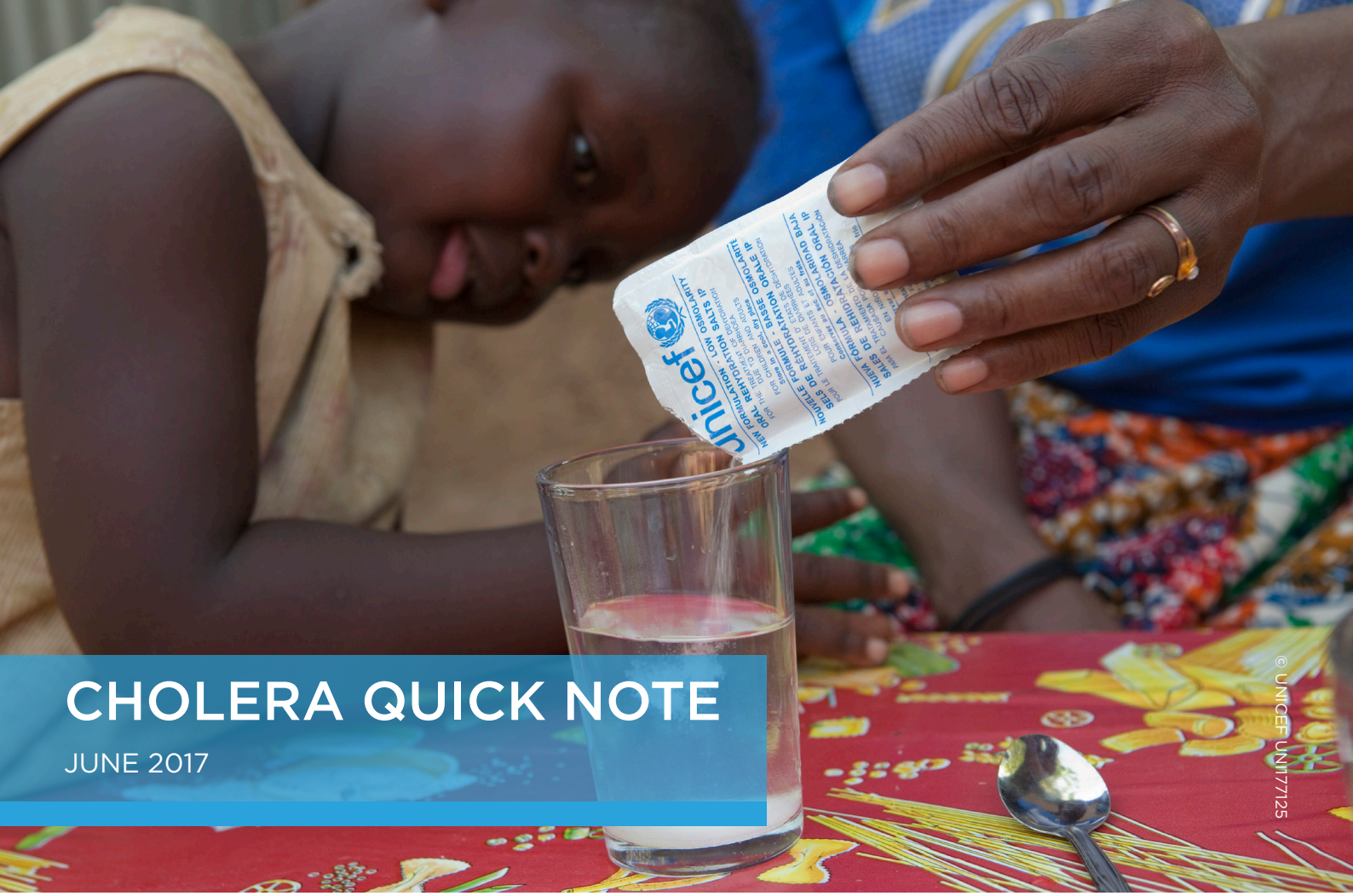

CHOLERA QUICK NOTE

JUNE 2017

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The purpose of this Quick Note is to provide key facts about cholera, and present a set of actions to guide decision making by senior management and program managers. Comprehensive phase and sector-specific response is elaborated separately in the *UNICEF Cholera Toolkit* (see last section on Where you can find sector information in the UNICEF Cholera Toolkit). Additional information can be found on the Cholera Teamsite.

UNICEF's role and level of engagement will be adapted to the local context, in accordance with existing capacities and results of risk and needs assessments, to strengthen national *IHR core capacities*[1] through a cross sectoral approach and in line with the IHR M&E Framework and Joint External Evaluation tool (JEE)[2]:

KEY DISEASE FACTS[3] AND UNICEF PRIORITY ACTIONS – FOR SENIOR MANAGEMENT

• Cholera is an acute diarrheal disease that can kill within hours if left untreated.
• 1.3 – 4.0 million cases, and 21 000 to 143 000 deaths worldwide are due to cholera every year.
• Up to 80% of cases can be successfully treated with oral rehydration salts (ORS) if detected and treated early.
• Provision of safe drinking water and sanitation and hygiene promotion are critical to prevent and control cholera and other waterborne diseases.
• The oral cholera vaccine (OCV) is safe, effective and have proven to be acceptable to affected populations and should be considered an additional cholera control tool along with WASH, case management, risk communication and community engagement (RCCE) and surveillance.
• See the UNICEF Cholera Toolkit for guidance and tools on cholera across all of the sectors.
• More information can be found at the WHO website and in a short summary video WHO cholera brief.
• At the Global level the WHO leads the Global Taskforce for Cholera Control (GTFCC), convening experts on cholera. UNICEF leads the GTFCC's WASH working group.

UNICEF PRIORITY AREAS

UNICEF will focus advocacy and programme efforts on the following priority areas, according to context:

UNICEF will focus advocacy and programme efforts on the following priority areas, **selected according to context and in support of the government and WHO's comprehensive cholera control efforts:**

- Risk communication and community engagement
- Water, sanitation and hygiene for prevention and control
- Case management including oral rehydration points (ORP) and cholera treatment centers (CTC)
- Oral cholera vaccination (OCV) – campaigns (preventive and outbreak response)
- Epidemiological analysis – identify cholera hotspots, areas at risk and transmission pathways
- Supplies and logistics

Other areas of concern:

- Safe breastfeeding and co-management of cholera and severe acute malnutrition
- Safe delivery of education and prevention and control in schools
- Psychosocial support and stigma prevention

QUICK NOTE FOR PROGRAM MANAGERS

WHAT IS CHOLERA?

- Cholera is an acute diarrheal infection caused by ingestion of food or water contaminated with the bacterium Vibrio cholerae. Please see Chapter 2 and 3 of the UNICEF Cholera Toolkit.
- The short incubation period of a few hours to 5 days, is one factor that contributes to the potentially explosive pattern of outbreaks.
- Cholera has > 200 serogroups. O1 and O139 can cause outbreaks of cholera although currently there is little O139. O1 has two biotypes, El Tor (the dominant one since 1961) and Classical. Both biotypes have 2 serotypes, Inaba and Ogawa.
- **Endemic cholera** – An area where confirmed cholera cases, resulting from local transmission, have been detected in the last 3 years. An area can be defined as any subnational administrative unit including state, district or smaller localities. Note: Any country that contains one or more subnational administrative units that are endemic, as defined above, is considered a cholera-endemic country (definitions from WHO).
- A cholera **outbreak/epidemic** - A cholera outbreak is defined by the occurrence of at least one confirmed case of cholera and evidence of local transmission. Outbreaks can also occur in areas with sustained (year-round) transmission, and are defined as an unexpected increase (in magnitude or timing) of suspected cases over two consecutive weeks of which some are laboratory confirmed. Such increases should be investigated and responded to appropriately through additional outbreak response and control measures.
- A **"hot spot"** – A geographically limited area (e.g. city, administrative level or health district catchment area) where environmental, cultural and/or socioeconomic conditions facilitate the transmission of the disease and where cholera persists or re-appears regularly. Hotspots play a central role in the spread of the disease to other areas.
- Attack rates (AR) range from

    o 0.5-2%: low-medium risk settings (less crowded, open settings, rural, or may have better access to services)
    o 2-5%: higher risk settings (crowded places with poor water and sanitation, urban slums or camps)

o Greater than 5%: typically very high risk settings (high population density, poor water, sanitation and health services, low population immunity and high vulnerability).

• Factors such as population growth and globalization, may have contributed to larger and more frequent outbreaks. Extreme climate conditions, floods and droughts may lead to greater risk of cholera outbreaks.
• Prompt treatment should result in maintaining a case fatality rate of less than 1% (WHO).

WHERE IS CHOLERA OCCURRING?

• During 2015, a total of 172 454 cases were reported from 42 countries, including 1304 deaths. This is an underestimate of the true burden of disease, as many cases are not recorded due to limitations in surveillance systems, and many countries don't declare cholera outbreaks due to fear of negative impact on trade and travel.
• Cholera is endemic in many countries. Maps can be found on the WHO website. The latest information on outbreaks can be found at WHO Disease Outbreak News.
• Typical at-risk areas include peri-urban slums or camps for internally displaced persons or refugees with poor access to WASH and health services.
• Cholera has seasonal variability with increased spread during dry season with water shortages, or during rainy season with flooding and contamination of water sources.

WHO IS AT RISK OF GETTING CHOLERA?

• Risk factors include the following: areas where cholera is endemic, areas with poor water, sanitation, and hygiene, poor access to healthcare services (early detection and treatment can reduce spread), crowded settings and population movements.
• It affects both children and adults. In endemic areas, children <5 years old are at greater risk. Older children and adults are partially protected by acquired immunity. In epidemic settings, all age groups equally affected.
• Cholera infection provides short-term protection against reinfection, particularly by the same strain.

WHAT IS THE IMPACT ON CHILDREN?

• In endemic settings, children are less likely than adults to have been previously exposed, and due to this lack of acquired immunity, they are more vulnerable to symptomatic infection, severe illness and death.
• Children dehydrate more rapidly than adults (they have less body reserve, and they cannot rehydrate themselves), and they are also more susceptible to the effects of dehydration (they may go into hypovolemic shock, acute renal failure, and suffer from electrolyte imbalances sooner than adults). Children are also more prone to hypoglycemia from cholera.
• Children who are malnourished are at increased risk of severe illness and death. In addition, the diagnosis and treatment of a malnourished child is challenging, adding to this risk (see chapter 8 of the Cholera Toolkit).
• There is a high risk of fetal loss in pregnant women with cholera, associated with delays in seeking care, difficulties in the detection of dehydration and patient management.
• Depending on the size and context, a cholera outbreak can disrupt or overwhelm existing health facilities. This can divert staff and resources, reducing access to health and prevention services for common childhood killers. Cholera outbreaks can also lead to the closure of schools and other social services and social stigmatization.
• "According to research, immune factors against cholera are present in the breast milk of mothers who have contracted the disease. This means that breastfeeding boosts babies' immune systems while also eliminating the risks of consuming contaminated water, either directly or mixed with baby formula" (PAHO).

WHAT ARE THE SYMPTOMS OF CHOLERA? HOW IS IT DIAGNOSED?

• Cholera can kill within hours if untreated.
• About 75% of people infected do not develop any symptoms. However, the bacteria are present in their feces for 1-10 days after infection and are shed into the environment, potentially infecting other people.
• Of those who develop symptoms, around 20% develop severe disease and 80% mild to moderate disease.
• The first symptoms of cholera are usually acute profuse watery diarrhea, often with severe vomiting. Fever is not seen with cholera. The loss of copious fluids leads to dehydration,

with signs of severe dehydration including very poor skin turgor, weak or absent pulse, decreased or absent urine flow, sunken eyes, increased or gasping respirations, and altered mental status, and severe muscle cramps. It can lead to death if left untreated.

• Cholera needs to be confirmed by positive culture or PCRof stool specimens in reference laboratories. Once confirmed, patient diagnosis is based on clinical examination of suspected cholera cases.

• Rapid diagnostic tests (RDTs) are used to quickly identify cholera cases, while efforts to confirm the outbreak by culture and PCR continue (WHO 2016 Interim technical note for RDTs). RDTs are not for diagnosing individual cases - clinical management should be determined by symptoms and treated accordingly. The cost is $ 1/test.

HOW DO PEOPLE GET INFECTED WITH CHOLERA (HOW IS IT TRANSMITTED)?

• The predominant route for cholera transmission is fecal-oral. A person can become infected by drinking water or eating food contaminated with the bacterium Vibrio cholerae.

• In an epidemic (and endemic settings), the source of the contamination is usually the feces of an infected person.

• Cholera can spread rapidly in areas with inadequate treatment of sewage and drinking water.

• Cholera is not easily transmitted by casual contact, but by swallowing something (usually water or food) that has been contaminated with fecal matter or vomitus containing V. cholera. This can be intensified within households and crowded settings with poor access to clean water and adequate hygiene practices.

• The bacteria remain in the feces for about 1-7 days after infection, and are shed back into the environment. Antibiotics given early following symptom onset is known to decrease the duration of bacterial shedding. While intermittent shedding can persist for several months, chronic carriage is rare.

• The bodies of people who have died of cholera pose a risk of transmission, because they may leak fluids that contain high concentrations of cholera bacteria. In funerals, transmission may occur through consumption of food and beverages prepared by family members after they handled the corpse, because of poor hygiene and inadequate disinfection.

HOW CAN CHOLERA BE PREVENTED?

• Prevention of cholera includes access to adequate quantity and quality of safe water, food safety and hygiene, safe excreta disposal, systematic hand-washing with soap after defecation and before handling food or eating, safe handling of dead bodies, safe funeral practices, environmental hygiene in markets and public places, cholera vaccines (see Vaccines below), surveillance and early warning to detect cases and early access to case management (see UNICEF Cholera Toolkit chapter 9).

• Facilities treating patients should follow strict precautions for fecal and waste disposal, overall disinfection procedures, and provision of safe drinking water (UNICEF WASH Guidelines for Cholera Treatment Centers).

• Measures that inhibit or otherwise compromise the movement of people, foods or other goods are not epidemiologically justified and have never proven effective in controlling cholera (Heymann, 106).

• WHO does not advise routine screening or quarantining of travelers from cholera-affected areas, or the requirement of cholera vaccination as a condition for exit or entry into any country.

IS THERE A VACCINE AGAINST CHOLERA?

• Currently there are three WHO pre-qualified oral cholera vaccines (OCVs) (Dukoral®, Shanchol® and Euvichol®).

• OCVs are safe, effective and have been shown to be acceptable to populations where they have been introduced.

• Cholera vaccination campaigns are an additional public health tool to be used as part of a comprehensive cholera control program along with surveillance, WASH, case management and RCCE.

• They can be used for (please see chapter 4.3 in the English version of the Cholera Toolkit for more information)

  - o Reactive vaccination to reduce the spread and limit mortality of an outbreak that has already started.
  - o To prevent cholera from occurring during a humanitarian crises.
  - o To control the disease in areas where cholera is considered highly endemic and repeated outbreaks are reported.

• There are two mechanisms for release of OCV from the Global OCV Stockpile:

o ICG: An OCV stockpile of at least 2 million doses for use in outbreak and emergencies is managed by the International Coordinating Group (ICG) consisting of the IFRC, MSF, UNICEF, and WHO.
o GTFCC: Vaccines for use in endemic settings are managed by the OCV working group of the GTFCC, to be used as part of a longer-term comprehensive cholera control program.
o For more information, refer to WHO OCV Website and the global OCV stockpile, where technical documents needed to access the stockpile including M&E can be accessed.

• Two doses of OCV given at least 2 weeks apart provide an estimated 65% efficacy at 5 years of follow-up. The level of protection is lower in children less than 5 years[4].
• A single-dose of OCV is effective in response to outbreaks in populations who are at high risk of cholera, where the priority is to rapidly provide protection to populations at risk, particularly when vaccine supply is limited (Lancet 2016). Further studies are ongoing.
• In settings where polio vaccinations are also taking place, OCV should be given 2 weeks before or after oral polio vaccines (OPV), not at the same time. However, OCV can be given at the same time as measles and other vaccines.
• There is some evidence that OCV provides herd immunity[5].
• Shanchol/Euvichol can be administered to infants 1 year old and above, while Dukoral is for children above 2 years of age.
• The GTFCC notes that there are considerable benefits, and very few risks, from including pregnant women in the OCV vaccine campaign (please see the GTFCC technical note on OCV and pregnancy 2016).
• The OCV is not contraindicated for people with HIV.
• OCV requires a cold chain.
• No countries currently require vaccination as a prerequisite for entry. Please see the WHO technical note on OCV and OCV and international workers and travelers 2016.

IS THERE A TREATMENT FOR CHOLERA?

• Cholera is treatable. Appropriate treatment lowers the case fatality rate below 1%.
• Health facilities require a triage system, in order to rapidly categorize patients according to severity requiring immediate treatment.
• Up to 80% of people can be treated successfully through prompt administration of oral rehydration solution (ORS) (WHO/UNICEF ORS standard sachet) along with zinc. Please see chapter 8 of the UNICEF Cholera Toolkit.
• Setting up oral rehydration points (ORP) at the community level significantly increases access to ORS.
• Severely dehydrated patients, those who are unconscious, vomiting, or unable to drink sufficient ORS, require intravenous fluids that may be provided in a health facility or a specialized Cholera Treatment Center (CTC).
• Please see WHO technical note – organization of case management during a cholera outbreak.
• Appropriate antibiotics can diminish the duration of diarrhea, reduce the volume of rehydration fluids needed, and shorten the duration of V. cholerae excretion, and should be given to patients with severe dehydration or those with moderate dehydration and rapidly progressive fluid losses. Mass administration of antibiotics is not recommended, as it has no effect on the spread, and may lead to the emergence of antimicrobial resistance.
• The treatment of a child with severe acute malnutrition (SAM) should be managed very carefully using specific protocols (see chapter 8 of the Cholera Toolkit), for example ReSoMal that is used for management of SAM cannot be used to treat dehydration from cholera in a child with SAM.

UNICEF ACTIONS FOR CHOLERA PREPAREDNESS AND RESPONSE

UNICEF, across all of the sectors and services, will work with national governments in partnership with WHO, to support the following activities according to context through technical support, implementing partners, procurement of supplies, logistical support, communications and advocacy.

The **"Shield and Sword"** strategy (developed by UNICEF in West and Central Africa) is an integrated and targeted approach for cholera prevention and control. It is a risk-informed and evidence-based approach targeting high risk areas, population and practices. The "sword" is an intervention during an outbreak in affected areas, starting from the first suspected cases based on case investigation. The "shield" is characterized by sustainable preventive Water, Sanitation and Hygiene interventions outside of epidemic periods in the priority areas defined as being specifically at risk for cholera. The shield is also implemented during emergency situations, and its aim is to prevent the spread of outbreaks by protecting populations not yet affected.

BEFORE THE OUTBREAK: ACTIONS FOR PREVENTION, DETECTION, PREPAREDNESS

As this section will be informing Response – please review this section along with the section below on Response.

ADVOCACY

• In cholera endemic countries or those at risk, advocate to governments for the adoption of policies including allocation of resources for cholera prevention and control, focusing on equity:

- o Water, sanitation and hygiene services
- o Timely information and advice, diagnostics (including lab capacity), and treatment services for at-risk children and communities
- o Inclusion of OCV as part of the response strategy (including regulatory actions for cholera vaccine registration and use).

COORDINATION, ASSESSMENTS AND PLANNING (SEE CHAPTER 5 AND 6 IN THE UNICEF CHOLERA TOOLKIT)

• Support the government and WHO to strengthen or establish an **emergency operation centre** engaging all relevant sectors/ministries.
• Participate in national **multi-sectoral outbreak risk analysis and mapping** for the following, and identify vulnerable populations at-risk:

- o Cholera endemicity/immunity including previous outbreaks
- o Seasonality, weather forecasting (storms, droughts)
- o Surveillance capacity, diagnostic/lab capacity
- o Identification of high risk areas - cholera "hot spots" or major epidemiological basins to guide local and cross-border control efforts
- o Coverage and quality of water, sanitation and hygiene services
- o History of previous cholera vaccination campaigns
- o Access to health services and case management capacity
- o Population movement
- o Displacement or urban slums resulting in crowding
- o Cultural/behavioral patterns

• **Develop preparedness and response plans** inclusive of scenario-based multi-sectoral contingency plans.

- o Reinforce preparedness activities ahead of the cholera season in endemic countries.
- o Establish and maintain response capacities in cholera hotspots – key for a rapid response.
- o Implement preparedness activities at various levels (i.e. central and subnational), and at cross-border areas in hot spots.

• Conduct **simulation exercises** to test response plans, clarify who does what where and when, capacity of partners across the sectors, and identify gaps.
• Develop an **integrated monitoring and evaluation plan**, and strengthen capacity to monitor the response.

CROSS-SECTORAL GUIDELINES AND TRAINING

• **Develop/update guidelines and training materials** as necessary, and **identify and train partners** at the national, district and local levels for:

- o cholera surveillance (including community-based surveillance)

o case management including setting up ORPs and CTCs
o infection prevention and control (IPC) in health care/ treatment facilities
o laboratory and RDT testing
o OCV vaccination campaigns
o WASH in the community
o risk communication and community engagement
o safe funeral practices during an outbreak
o safe breastfeeding
o cholera education, prevention and control in schools
o psychosocial support and reduction of stigma.

• In endemic countries where UNICEF has Integrated Management of Childhood Illness (IMCI)/Integrated community case management (iCCM) programs, train health care providers for cholera detection (knowing cholera case definitions[6] and using RDTs where indicated), reporting, case management and referral.

SURVEILLANCE, DETECTION AND EARLY WARNING SYSTEMS (see Chapter 3 in the UNICEF Cholera Toolkit and the WHO Interim guidance on cholera surveillance)

• Analyze cholera "hotspots" and areas at imminent risk for possible transmission routes to target prevention and response actions – as well as availability of WASH and other cholera control services in collaboration with MoH, WHO and partners.
• Support strengthening cholera surveillance, early warning and alert systems and outbreak investigations in country and across borders, integrate age categories and sex disaggregation.
• Through community-based programs engage and sensitize community leaders and members, networks, health volunteers to detect and report suspected cases of cholera (community-based disease surveillance).

PREVENTING OUTBREAKS - WATER SANITATION AND HYGIENE (WASH) AND OCV

•Target WASH activities to areas at risk (cholera "hot spots") - establish and maintain response capacities in hotspots for rapid response.
• Analyze hotspots and areas at risk for transmission routes and availability of WASH (and other cholera control) services.
• Define specific WASH prevention activities and prepare for an outbreak including:

o safe water supply - focus on chlorination at both collection sites and point of use, and appropriate water quality monitoring (esp. testing for residual chlorine)
o safe excreta disposal
o hygiene promotion at the community-level (markets, places of worship, schools, child protective spaces, therapeutic feeding centers etc.)

• Provide WASH services and IPC in health facilities that may be used for case management of cholera.
• Support the implementation of OCV vaccination campaigns before seasonal upsurges in endemic countries, prior to onset of outbreaks, in countries that have included it for routine use in their national strategy. Target high-risk groups only - preschool and school-aged children, pregnant women and HIV-infected individuals (based on risk assessment).
• Support the government in requesting OCV from the global stockpile if OCV is part of the response.

o Provide key resources to the government, so decision makers are familiar with the OCV procurement methods, risk assessments and request forms.
o Register OCV in the country through the National advisory committee on immunization (NITAG), or at minimum obtain waivers to import OCV, especially in cholera endemic or fragile/at risk countries.

SUPPLIES AND LOGISTICS

• Develop and maintain an inventory of essential cholera supplies for preventing spread (WASH) and case management (see WHO cholera kits) according to risk and needs assessments.
• Procure and distribute cholera supplies including local, regional, and global procurement, and support planning and implementation for shipping, storage and distribution of supplies in country for outbreak response.

RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT (RCCE) – see Chapter 7 in the UNICEF Cholera Toolkit

• **Conduct rapid Knowledge Attitudes and Practice (KAP) or qualitative studies** paying particular attention to socio-cultural and communication context, to understand baseline community knowledge and perceptions about cholera, its detection, prevention and control measures, and care seeking patterns.
• **Convene ministries and relevant UN and local partners engaged on RCCE** (media and risk communication, social mobilization and community engagement and behavior change expertise) and develop a RCCE **strategy and action plan**, including for community-based surveillance (where appropriate), prevention, and care seeking, using baseline data and by engaging key stakeholders, including affected/at-risk communities.

o **Conduct a social mapping of key stakeholders** (e.g. policy makers, program managers, communities, health providers), identify information and behavioral needs, and adapt key messages for action using C4D/RCCE resources for cholera.
o Using existing resources (UNICEF C4D networks and materials), **support preparation or adaptation of communication and media materials** (infographics, posters, video clips), as well as messages and actions for outreach through mass media, SMS and social media platforms (U-report, etc.).
o I**dentify rumor tracking and response system** such as traditional media and social media monitoring, local communication systems and networks.
o Develop **behavioral indicators** and **identify data collection plan**, in order to inform the RCCE response.

• Strengthen or establish a **system for community engagement** with partners and stakeholders at the national and provincial/ regional level. Pre-identify networks (community health workers, Red Cross volunteers, women and youth groups, etc.) for engagement and dissemination of messages for behavioral change.
• **Strengthen community consultation mechanisms** (hotlines, surveys) as part of feedback loop to inform decision-making and response actions.

OFFICE OPERATIONS

• **Pre-identify UNICEF cholera focal points in each sector** (e.g. health/immunization, C4D, WASH, education, child protection, media/external communications, supply and logistics, emergency operations, M&E) and update every year.
• **Pre-identify implementing partners** for cholera prevention and control. Consider options such as including emergency clauses[7] in existing PCAs (Programme Cooperation Agreement), developing contingency or standby PCAs[8].
• Identify potential **surge support requirements** according to sector and technical area (e.g. health, C4D/RCCE, WASH). Review the HR staff deployment guidance (link to rosters and staff safety guidelines).
• **Identify funding requirements** for prevention, preparedness, and response activities during an outbreak (i.e. re-programming existing funds).
• **Integrate epidemic risk** into the organization's preparedness platform and into existing sector programs.

CROSS-BORDER COLLABORATION

UNICEF will support coordination at the regional level for cross-border collaboration, with particular emphasis on epidemiological basins where there is risk of cross-border transmission, proactively engaging from the preparedness phase including for the following:
• Engage in existing regional mechanisms to identify potential synergies;
• Explore partnerships to identify and facilitate cross-border supply corridors and cross-border contracting, including with national and subnational authorities and the private sector;
• Explore and/or promote the creation of a regional or sub regional cholera coordination platform for information exchange (e.g. the Southern Africa (JICSA) and West and Central Africa cholera platforms);
• Conduct multi-country consultations for each epidemiological basin, for information sharing and strengthening of cross-border coordination and collaboration.

SUSPECTED / CONFIRMED OUTBREAK: ACTIONS FOR RESPONSE

As this section will be activating the prevention, detection preparedness section above – please review this section as well along with the Response.

Outbreak thresholds are determined by governments and ministries of health. A single case of cholera may indicate an outbreak.

COORDINATION, ASSESSMENTS AND PLANNING

• **Participate in national and inter-agency coordination mechanisms**, and support the enhancement of links among all sectors/clusters and coordination mechanisms for health, C4D/RCCE, WASH, nutrition, child protection, and education. UNICEF will act as Cluster Lead Agency (CLA) for WASH, nutrition, child protection, and education if these clusters are activated[9].
• **Participate in multi-sectoral rapid needs assessments, outbreak investigation and rapid response teams** (RRTs) with participation across all relevant sectors. Close coordination between countries is required for any cross-border investigations.
• **Review, update and implement integrated cross-sectoral cholera response and contingency plans** based on needs assessment.

SURVEILLANCE, ALERT, AND EARLY WARNING SYSTEM

• Intensify community-based surveillance, **analysis of "hot**

spots" and areas at risk and activate as necessary based on risk assessment, early warning alert and response systems in support of MoH and WHO. Please see WHO Interim guidance on cholera surveillance).

RISK COMMUNICATION & COMMUNITY ENGAGEMENT (RCCE)

• **Implement RCCE strategy and action plan** focusing on affected and the most at-risk populations.
• Work with the government, WHO and partners to **use the latest epidemiologic trends** (emerging hotspots, lessons from areas where there is a downtrend in cases) to inform RCCE activities.
• **Mobilize the media** and brief spokesperson (together with media communication teams) to address relevant cholera control, prevention and response plans of the government and partners in coordination with the government, WHO and civil society organization (CSO) partners.
• **Monitor behavioral change** (through KAP surveys, qualitative surveys, media monitoring, etc.) and results of rumor tracking, and **use results to inform proactive messaging and programming.**

WASH/INFECTION PREVENTION AND CONTROL (IPC)

Activate WASH component of the cross sectoral cholera response plan, RRT, WASH inter-sectoral coordination mechanisms and PCAs to:

o Participate in multi-disciplinary teams to identify cholera transmission routes (in the community, households, facilities) for targeted WASH response activities in communities, health facilities, gatherings or public places, funeral practices, inside social and livelihood groups, and at the household-level.
o ***Integrate safe drinking water and hand washing with soap as a priority of the Rapid Response Team (RRT).***

• **Safe water supply in affected areas**

o Provide adequate quantity of safe drinking water.
o Provide refresher training for water committees on chlorination at the source or on-site.
o Implement regular water quality testing to monitor free chlorine residual.
o Set up water storage capacity as needed (bladders, storage tanks) at the community level.
o Train CHW and hygiene promotors to distribute chlorine (Aquatabs or other products) to households and provide instructions on their use.
o Repair and rehabilitate water systems as needed.

• **Sanitation – excreta disposal** - despite a key objective, there is little chance for rapid impact on an outbreak through a massive programme of latrine construction, except in refugees or IDPs camps at the early stage of the outbreak.

o Provide latrines only in public places or institutions at high risk, such as health facilities, markets or prisons (apart from camp settings).
o Provide access to handwashing facilities in these locations.

• **Hygiene promotion and campaigns at the community level**

o Conduct hygiene promotion and awareness sessions in collaboration with health and RCCE actors.
o Print and disseminate education materials.
o Engage communities in WASH activities.
o Integrate hygiene promotion and WASH supplies with ORPs.

• Hygiene promotion at the household level

o Provide hygiene kits to families with cholera cases. Hygiene kits are context dependent but usually contain household water treatment, safe water storage, house disinfectant, soap and Information, Education and Communication (IEC) material. They can be distributed at the health facility level (to the care taker at admission) or by dedicated teams at household level. In both cases, practical demonstrations must be provided to ensure understanding of the key hygiene messages.
o Provide families with the messages and the knowledge to reduce household transmission.

• **Infection prevention and control (IPC) at health facilities and CTCs**

o Repair or rehabilitate WASH facilities in collaboration with health partners.
o Provide refresher training to strengthen IPC protocols.
o Provide hygiene kits to discharged patients.

• **Safe water supply in neighboring and not yet affected areas**

o Provide safe water (e.g. ensure chlorination of water networks, promote household water treatment, etc.) supported by mass communication on hygiene promotion and targeted preventive communication in public places at risk (e.g. markets, restaurants, etc.)

CASE MANAGEMENT

Activate Health component of the cross sectoral cholera response plan and PCA's to:

• **Disseminate cholera case definitions and treatment protocols and conduct refresher trainings** for primary health care providers at the facility and community levels to identify cholera patients, provide appropriate case management, and refer as needed. Refresher training should also include use of line listing and reporting.

• Reinforce capacities in the case management of SAM-cholera co-morbidity.

• Based on risk and needs assessments **set up treatment centers such as ORPs and CTCs** for early identification and access to treatment at the community and facility levels. CTC should have appropriate WASH facilities. Case management and IPC should be monitored daily and adjusted as needed. Please see the WHO technical note – organization of case management during a cholera outbreak.

VACCINATION

• Provide technical support to the MoH in collaboration with WHO, for **planning and risk assessments** with the engagement of UNICEF key sectors such as health, immunization, WASH and C4D.

• Conduct **macro and microplanning** and support the implementation of OCV vaccination campaigns to achieve adequate vaccination coverage (WHO OCV in mass immunization campaigns guidance for planning and use 2010 to be used along with the addendum.

• Activate the **communication and social mobilization component** of the vaccination campaign. Please see the UNICEF Framework for Developing an Integrated Communication Strategy for the Introduction of Oral Cholera Vaccines in Cholera Prevention and Control Programmes.

• **Integrate WASH** (with a focus on safe drinking water and hand washing with soap), use of ORS and early detection and care seeking and RCCE into the OCV campaign.

• **For outbreak response and prevention during a humanitarian crisis - procure vaccines** through the global stockpile (International Coordinating Group (ICG). Please see WHO OCV website for forms and resources. For eligible countries, the cost of vaccine and a portion of operational costs are provided by GAVI through the stockpile. Vaccination strategy should focus on targeting all age groups above 1 years of age in designated high-risk populations based on risk assessment.

OTHER UNICEF SUPPORTED SECTORS - SEE SECTION BELOW ON WHERE YOU CAN FIND SECTOR INFORMATION IN THE UNICEF CHOLERA TOOLKIT.

• Support the dissemination and implementation of **guidelines for breastfeeding** during outbreaks, and deliver messages to affected communities on safe breastfeeding.

• Dissemination and implementation of appropriate WASH facilities in feeding centres and school kitchens.

• Based on the assessment of the impact of the outbreak on the education system, support the dissemination and implementation of **guidelines for the safe operation of schools**.

• Engage with communities to assess for, and **address any potential stigmatization** of populations related to cholera. Support the delivery of **psychosocial support services** for affected children and communities according to context.

• Working with health and social services at the national and sub-national level, identify and deliver **protective services for children left without a caregiver**, due to the hospitalization or death of the parent or caregiver.

SUPPLIES AND LOGISTICS

• Implement the supply plan and distribution strategy based on identified gaps, including procurement of cholera essential supplies (including RDTs as indicated, see WHO cholera supply list), shipping, storage and distribution of supplies in country.

• Distribute supplies to hot spots and areas at imminent risk, as close to the community as possible.

MONITORING AND EVALUATION

• Implement an integrated monitoring and evaluation plan, including data collection and analysis to inform program decision-making.

OFFICE OPERATIONS

• Upon declaration of an outbreak, **set up a cross-sectoral cholera** team in the office with a minimum health, immunizations, WASH and C4D for information sharing and internal coordination.

• **Activate emergency clauses in existing PCAs, contingency or standby PCAs.** Develop as necessary **PCAs and contracts[10] with partners** to deliver services for cholera prevention, control and community engagement.

• Access the internal roster of technical and operational experts and standby partners. Review the HR staff deployment guidance (see staff safety guidelines).

• Mobilize funds internally through emergency funds or external funding sources such as CERF (see Funding appeal checklist), or re-programing of existing program funds.

WHERE CAN YOU FIND SECTOR INFORMATION IN THE UNICEF CHOLERA TOOLKIT?

- **NUTRITION**
  - o Breastfeeding recommendations – Section 8.3.9
  - o IYCF and cholera Q&A – Annex 8D
  - o Management of malnutrition and cholera – Section 8.3.9
  - o Prevention of cholera in feeding centers (cholera in institutions and public settings) – Section 9.10 and Annex 9E
- **EDUCATION**
  - o Cholera in schools (cholera in institutions and public settings) – Section 9.10 and Annex 9E
  - o Kitchen and Cooking Recommendations for Schools and Children Centres for Cholera Response – Section 9.10
- **PROTECTION**
  - o Psychosocial support and protection - Section 8.5.3
  - o Mainstreaming protection into cholera response – Annex 8J
  - o Cholera in child protection centers (cholera in institutions and public settings) – Section 9.10 and Annex 9E
  - o Rapid assessment of protection issues, Zimbabwe – Key resources 8.5.4
- **WASH**
  - o Chapter 7 – community based interventions
  - o Chapter 4 – prevention
- **HEALTH**
  - o Alert and response – Chapter 3
  - o Case management – Chapter 8
  - o Community case management – Section 9.11
  - o OCV – Section 4.3 (there is a full chapter that is updated that will be available shortly)
- **RCCE**
  - o Communicating for cholera preparedness and response - Chapter 7
- **SUPPLIES AND LOGISTICS**
  - o Section 6.5 and 10.4
  - o Note – the DDK have been updated now as a revised Cholera Kit
- **HIV – SECTION 8.3.10**
- **ALL SECTORS/EMERGENCIES/SUPPLIES**
  - o UNICEFs roles and responsibilities – Chapter 1
  - o Cholera basics – Chapter 2
  - o Coordination – Chapter 5
  - o Preparedness actions – Chapter 6
  - o UNICEF operations – Chapter 10
  - o Incorporation into existing programs: – Section 4.4
- **GENDER**
  - o Cholera considerations by Gender and Age - Section 2.3.4
  - o A gendered approach to cholera in Haiti – Key resources Section 8.5.4
- **DISABILITY** – excreta control for physically vulnerable section – Key resources Section 9.4

NOTES

[1] IHR core capacities[1] include: 1) National legislation, policy and financing; 2) Coordination and National Focal Point communications; 3) Surveillance; 4) Response; 5) Preparedness; 6) Risk communication; 7) Human resources; and 8) Laboratory. All 196 State Parties are required to have or develop IHR core capacities. Basics of IHR are further elaborated in the Overarching document.

[2] IHR Monitoring and Evaluation Framework

[3] The information has been sourced from WHO and CDC websites 2017.

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3378723/

[5] Herd protection works by reducing shedding of V. cholera and reduces the risk of transmission in both vaccinated and unvaccinated individuals living within vaccinated communities.

[6] Refer to Chapter 3 in Cholera toolkit for examples of case definition during an epidemic (page 33 in English version)

[7] Allows partners to divert and utilize non-emergency resources for immediate response that are later covered by emergency funds when they become available

[8] Pre-defined dormant PCAs to be activated upon mutual agreement between UNICEF and the partner when an emergency is declared

[9] Clusters may be activated under the IASC system, and/or cluster-like mechanisms for specific disease control activities (RCCE, WASH, etc.) Refer to IASC Level 3 Activation Procedures for Infectious Disease Events. The UNICEF representative is responsible for proactively engaging in UNCT/HCT discussions and decision-making in all phases of the response, including the initial assessment (potential scale and risks, including wider secondary impact of the outbreak - humanitarian, social, economic, security), and the activation of clusters.

[10] Other options include SSFA (Small Scale Funding Agreement), Special Service Agreement (SSA). Note there are simplified procedures for Level 2 and 3 Emergencies. Refer to UNICEF Simplified Procedures in Emergencies.