

Joint Cholera Initiative for Southern Africa (JCISA) Sub-regional up-date on Cholera; 2017 – Week 6

Country name	2017 suspected cases						2017 Cumulative total			2016 total reported cases			Comments	
	W1	W2	W3	W4	W5	W6	Cases	Deaths	CFR	Cases	Deaths	CFR		
Angola	28	28	42	28	13	15	154	6	3.9%	78	4	***	Latest report 15/02/17: total of 269 cases officially reported with 12 deaths since 13 Dec. 2016: North West Zaire prov, (Soyo city), Cabinda & Luanda city	
Botswana														
Lesotho														
Malawi	0	0	0	0			0			1,792	46	2.6%		
Mozambique	2		4	210			216	1	0.5%	1,167	6	0.5%	Cases in Maputo and Matola cities and two districts in Nampula province - Monapo and Namialo	
Namibia														
South Africa														
Swaziland														
Tanzania	288	80	156	299	74	20	917	14	1.5%	14,928	202	1.4%	Considerable reduction from week 5. Report from 11 February 2017 only two cases - One each in Uvinza in the West and Morogoro.	
Zambia	0	0	0	0			0			1,379	32	2.3%		
Zimbabwe	0	0			0	0	0			10	1	***		
Total w/Tanzania	318	108	202	537	87	35	1,287	21		19,354	291			
Total sub region*	30	28	46	238	13	15	370	7		4,426	89			
* 10 Southern African countries			*** CFR no validity with so few cases.			0 - zero cases reported			nr - no report received					
Data source: Govt. reports, UNICEF, WHO, Buletim de Republica (Angola)														

The Joint Cholera Initiative for Southern Africa (JCISA) is a multi-agency technical partnership bringing together WHO, UNICEF, UNOCHA and OXFAM supporting national governments with the primary goal being to “strengthen regional capacity and collaboration in order to ensure more timely, integrated and effective technical support to countries in the areas of cholera preparedness, response and resilience”.

The Southern Africa sub-region consists of ten countries, five of which have been identified by the Initiative as priority countries – Angola, Malawi, Mozambique, Zambia and Zimbabwe. For the purposes of this IM process Tanzania is being included given its proximity to three of the priority countries and the possibility of cross border transmission. For further information contact Ben Henson, bhenson@unicef.org or Georges Tabbal, gtabbal@unicef.org.

Highlights

- Pleasing to report is the noticeable decline in cases in Tanzania – for week six, only 20 cases were reported and indeed, the daily bulletin for 19 February states that “No (0) new suspected cholera case was reported”. This is the first zero case report since the current outbreak started in August 2015!
- Mozambique Ministry of Health reports as at 16 February; 216 suspected cases from four sites: Maputo city, Matola city (neighbouring Maputo) and Namialo and Monapo districts located in Nampula province in the north of the country). The current outbreak in Maputo is the first in that city for three years.
- Meanwhile the outbreak in two cities in the north of Angola (Soyo and Cabinda) is declining, according to the Ministry of Health, but cases have been reported in the capital Angola – these are assumed to be linked with the Soyo outbreak.
- No cases are reported from the other southern African countries.

The focus of this bulletin is on the work carried out on behalf of the UNICEF regional office in 2016 – a **Desk Review of Knowledge, Attitudes and Practices (KAP) Related to WASH, cholera prevention and control & response Interventions in the JCISA Priority Countries**. The summary overleaf provides an overview and lists the key findings and recommendations of this important work. For further information, details of references cited, or indeed the full document, contact the author, Brian Maguranyanga, brian.maguranyanga@gmail.com or UNICEF RO Communication for Development specialist Charles Kakaire cnkakaire@unicef.org. In order to maintain the practice of keeping this bulletin to two pages the next page is unfortunately rather crowded, but the information given is important and indeed needs to be considered by all those involved in diarrhoeal disease prevention and response in the region.

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Desk Review summary: Knowledge, Attitudes and Practices (KAP) Related to WASH, Cholera Prevention and Control Response Interventions in the JCISA Priority Countries.

Introduction: Cholera remains a significant threat to public health, and a major cause of morbidity and mortality in Sub-Saharan Africa. Africa has the largest proportion of the cholera burden in the world, and deemed “cholera’s new homeland” due to the persistent cholera situation and annually reported cholera outbreaks since 1990. In several southern African countries, cyclical, seasonal, and annual cholera epidemics have been reported since 2000. The cholera outbreak in August 2008 in Zimbabwe resulted in approximately 98,424 suspected cases and 4,276 deaths (WHO 2009), the largest cholera epidemic ever recorded in Africa (Rebaudet *et al.*). Southern Africa experienced unprecedented cholera outbreaks in the past few years, and over 167,000 cases and 4,900 deaths recorded in nine countries across the sub-region during the period 2008/9.

Key Findings: The desk review findings highlighted key individual and societal WASH behaviors and practices, social norms, structural drivers and determinants of the cholera epidemic within the JCISA priority countries in Southern Africa:

- Across all the five countries, cholera outbreaks are largely a function of lack of access to safe water and improved sanitation facilities due to failure of urban water and sanitation systems, and cross contamination of water sources and sewage effluence. The urban and rural differentials / disparities in access to safe water and sanitation facilities exist, and stigma associated with poverty and cholera complicate the burden among the poor.
- In all the countries, poor hygienic behavioral practices and high proportion of rural population practicing open defecation, not treating water at point of use nor practicing handwashing with soap/ash at critical times heighten risks of cholera and other diarrheal conditions.
- Religious and socio-cultural beliefs and practices - objections to modern health services / medicines, sanitation taboos, handshaking, burial rituals, sharing utensils and food during funerals, and gender norms serve as barriers to cholera prevention and control especially during cholera outbreaks.
 - E.g., In Malawi and Zambia, ingrained cultural / social norms on latrine sharing among in-laws, parents and children, and discouraging pregnant women to use latrines ‘normalize’ open defecation, which increases risk to cholera and diarrheal diseases.
- The relatively high knowledge of cholera and optimal WASH behaviors (e.g., handwashing with soap/ash at critical time) has not necessarily translated into sustainable WASH practices that prevent cholera transmission.
- Weak health service delivery exists in all the countries, and hence limited capacity to deal with surges in cholera outbreaks and high number of cholera cases. These weaknesses include weak case management, limited skilled health personnel and logistical gaps, and thus contribute to poor responses to cholera prevention and control.
- The politics of cholera largely manifest in delays in declaring cholera emergency (Funke *et al.*) and this compromises cholera prevention, control and responses.
- The low investment in water and sanitation infrastructure in the five priority countries reflects lack of political will.
- Cross-border movement of people among neighboring communities in the different countries poses challenges for cholera responses, and require cross-border collaboration and cholera prevention, control and response interventions.

Conclusion: The desk review evidence highlighted the importance of multi-sectoral / multi-component interventions to address identified individual and societal behaviours and practices, social norms, and key drivers of cholera epidemics. Tackling WASH and cholera issues entails actions beyond provision of safe water, water and sanitation infrastructure and facilities to paying close attention to behaviour, hygiene practices, and socio-cultural conditions affecting WASH behaviours. *The “soft-side” of WASH remains the biggest challenge, and translating knowledge and benefits of water and sanitation provision into sustainable, optimal WASH behaviours and practices is critical in reducing diarrheal diseases or risks of cholera* (Aunger *et al.*).

Recommendations:

- **Accelerate investment in urban and rural water and sanitation infrastructure** in the priority countries to address disparities and control cholera
- **Increase investment in school water and sanitation infrastructure**, and improve WinS interventions given the youthful population in the priority countries
- **Scale up social and behaviour change communication interventions** to improve WASH practices and promote healthy behaviours including healthcare seeking behaviours. Expand local social mobilization and active engagement of local leaders (religious and traditional) and communities in WASH and cholera prevention, control and responses
- **Strengthen water treatment at point of use and hygiene promotion (including handwashing with soap) interventions**, and address socio-cultural and behavioural issues affecting water treatment and optimal hygiene practices. Sociological / anthropological issues - gender dynamics, ‘fishermen’s sub-culture’, religious and cultural practices - require due attention in order to reduce individual, household and communities’ vulnerability to cholera and other diarrheal diseases.
- **Strengthen cross-border collaboration and coordination mechanism** on cholera prevention, control and response, and **improve inter-country and regional sharing of cholera epidemic information** through enhanced information management and planning.
- **Health systems strengthening and multi-sectoral capacity building** of cholera prevention, control and response
- **Stakeholder engagement** involving community members, water vendors, religious and traditional leaders, local politicians and local authorities – in designing and implementing WASH and cholera prevention, control and response interventions
- **Strengthen capacity of local / national NGOs and structures, and sub-national coordination mechanisms** to improve preparedness, coordination and responses
- **Strengthen policy and advocacy** in terms of creating an enabling environment that improve policy frameworks, increased budgetary allocations and investments in water and sanitation infrastructure, and health system / service delivery in poor urban, peri-urban and rural communities.