Cholera platform

What do we do? Who are we?

Progress on roadmap

Success/challenges/advantages

Cholera platform WCA: www.plateformecholera.info
Julien Graveleau: jgraveleau@unicef.org

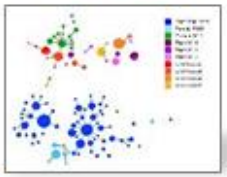
Cholera Platform: What do we do? – 4 pilars

Information and knowledge management

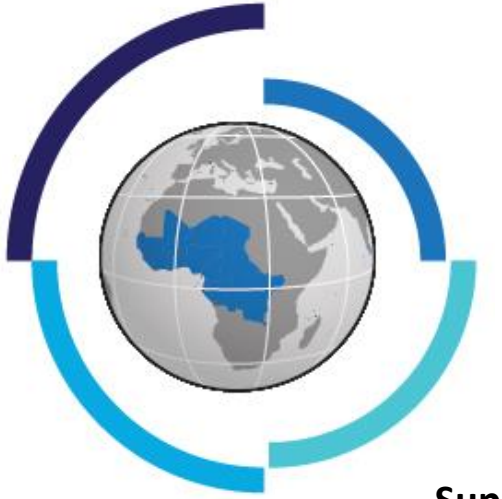
www.plateformecholera.info

Coordination

Support Research



Regional Cholera updates

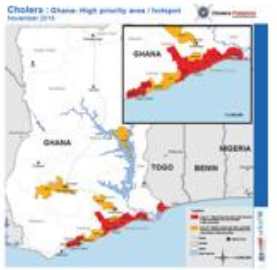


Reinforcing existing mechanisms (National cholera elimination plans)

Transborder workshops

Support National Strategic plan & Preparedness

Define hotspots areas



Advocacy and studies for long term prevention

Advocacy notes

Promote long-term solution

Develop investment plan in hotspot

Support response to cholera outbreaks

Support Preparedness: Plan, contingency, capacity-building

Emergency response and technical support

Cholera Platform: Who are we?

Objective: The cholera platform's objective is to **improve cholera control and prevention** across Africa

- Under UNICEF's leadership, the platform is a coordinating body comprised of WASH actors, epidemiologist, laboratory specialists, anthropologists and health actors in West and Central Africa (Extension to East- Southern Africa).

- Humanitarian and Development NGOs; Academics; UN agencies (IOM, WHO, OCHA, UNICEF); Donors (OFDA, ECHO…); IFRC/ICRC; National Red Cross; Ministries (Planning, Health, WASH, Civil protection); Intergovernmental organisations (OCAL, ECOWAS, CEEAS…)

- Bi-monthly communication to 460 people in 40 countries

- 26.141 visitors and 228.000 "clics" on webpage in 2017: www.plateformecholera.info

Platform: operational roadmap towards elimination of cholera

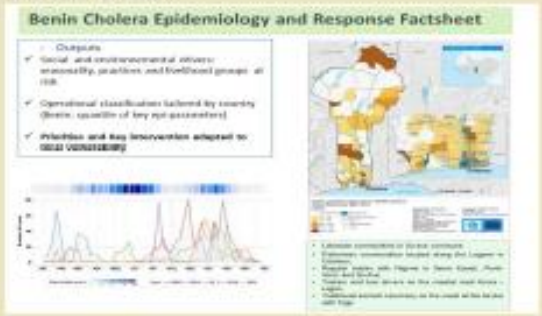
Ultimate Goal

Contribution to the rolling out of the *Global Ending Cholera Roadmap* 2030 in sub-Saharan African countries

Way Forward

Step 1

Evidence based studies to inform the risk: sub-regional & country level epidemiological tabletop studies for identification of cholera hot spots at district level



Step 2

- Field investigation at community for WASH+ diagnosis and in depth epidemiological study (risk assessment)

- Identification of programmatic response according to the context (tailor made)

Step 3

Develop an Investment Case for WASH in cholera hot spots (cost benefit analysis)

Step 4

Advocacy through presentation of evidence based studies to Humanitarian and Development Partners to target and leverage funding in cholera hot spots

Platform roadmap towards elimination of cholera

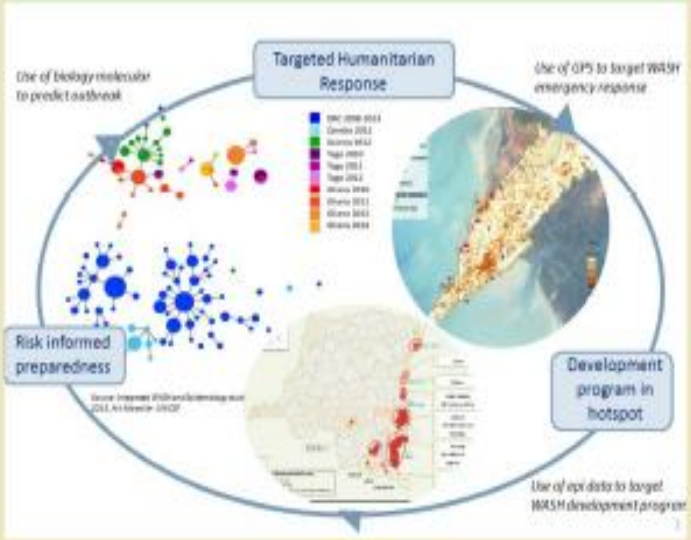
Step 5

- Carry out sustainable WASH+ intervention in communities regularly affected
- Oral Cholera Vaccination can bridge the gap between identification of needs and time to complete implementation of sustainable WASH Intervention

Step 6

- Sustainability check in cholera hot spots
- Impact study

Regional cholera strategy: an evidence based approach



European Commission

UKaid from the British people

unicef

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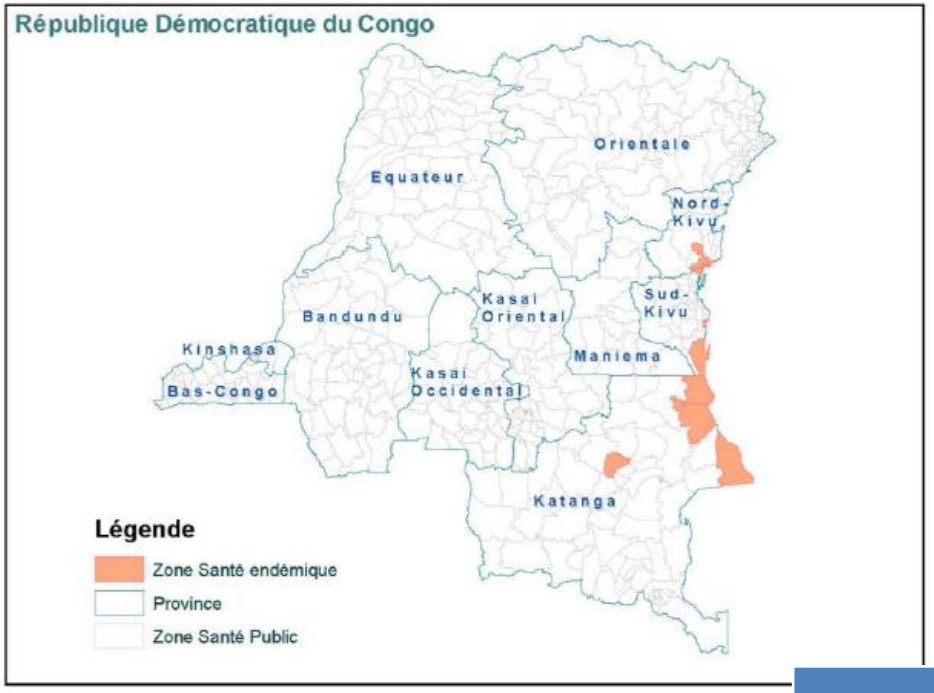
www.plateformecholera.info

Step 1: Studies to identify hotspots (22 countries)



What is a cholera hotspot?

A cholera hotspot is a geographically limited 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.

Hotspot studies have been conducted to date in twenty-two African countries (14 WCAR; 8 ESAR).

70% of cholera cases and high presency in 12 hotspots

[1] average weekly cholera cases over 5 years timeframe

[2] percentage of weeks with cholera over 5 years timeframe

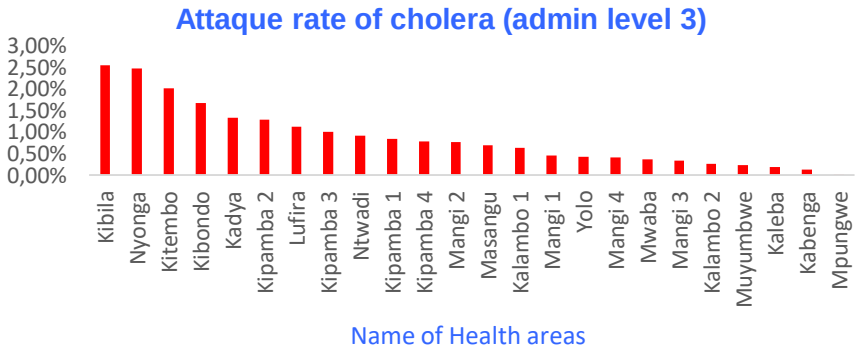
HEALTH ZONE		Epidemiological level[1]	Presency rate of cholera[2]
Katanga	KALEMIE	18	96%
	KINKONDJA	13	51%
	MOBA	10	70%
	NYEMBA	14	93%
Sud Kivu	FIZI	26	97%
	KADUTU	15	62%
	MINOVA	18	97%
	UVIRA	26	97%
Nord Kivu	GOMA	24	100%
	KARISIMBI	18	84%
	KIROTSHE	19	96%
	MWESO	18	89%

Step 2: Field investigation for diagnosis and identification of programmatic response (7 countries)

HEALTH ZONE OF KINKONDJA

Province : Katanga
District : Haut-Lomami

- Population: 234.000
- Moyenne épidémique: 13 cas/semaine
- Attaque rate: 1.38%
- Presency rate: 51%
- Typology: A (endemic)
- Water coverage : 20%
- Alternative water : lake
- Sanitation coverage : <5%




Field observations

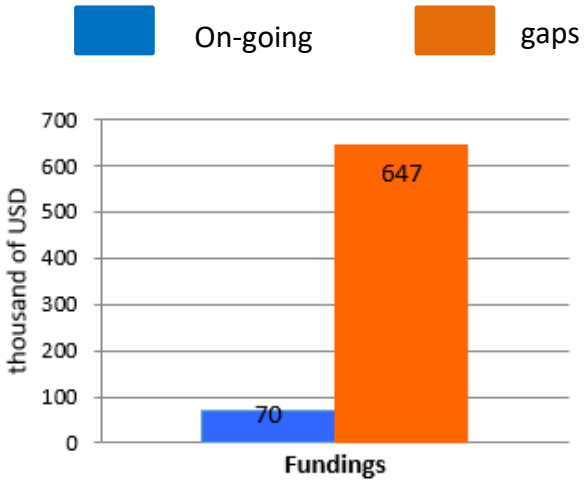
Group discussions + technical assessment

Features:

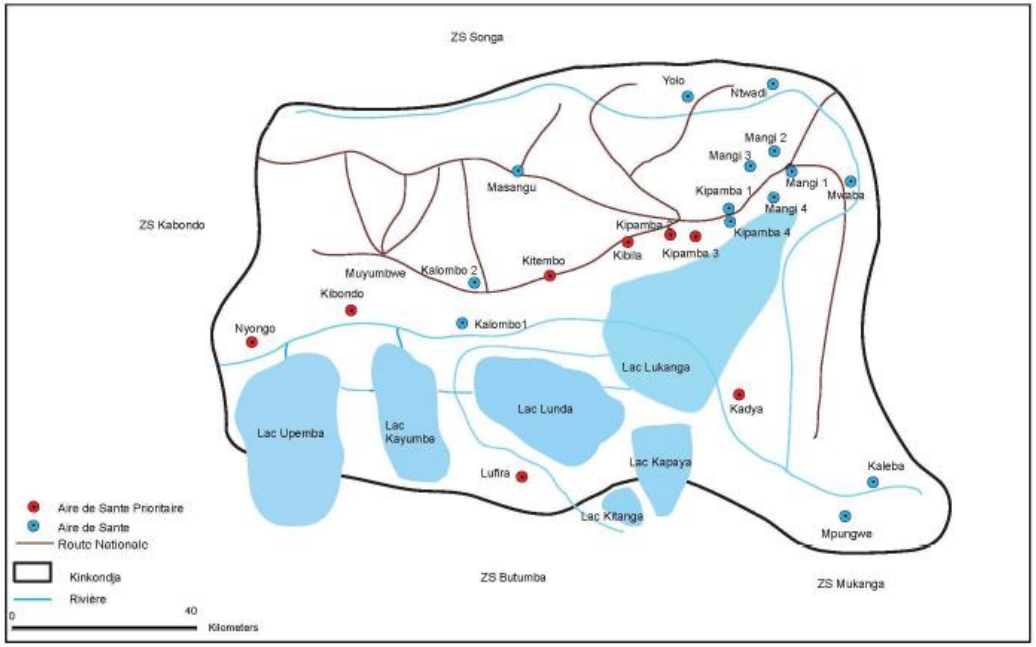
- Wetland / lakes
- Flood area
- Fish trade
- Islands populated
- Difficult road access
- Rural population
- Lack of NGOs / Capacity

Step 3: Investissement plan (7 countries)

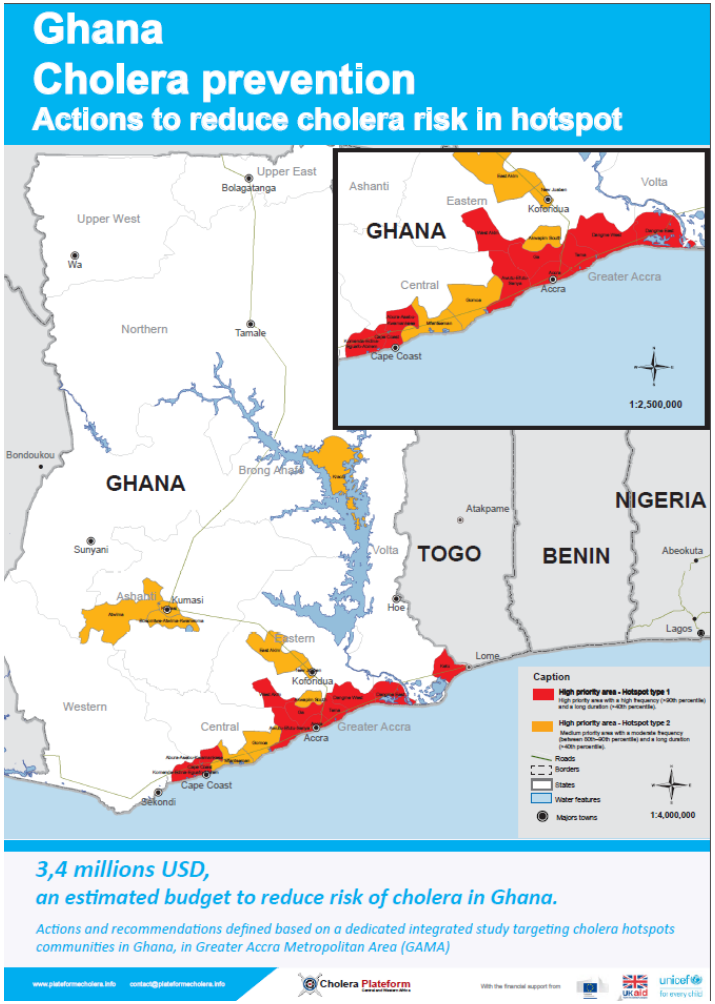
Targetted health Areas	GAPS	Budget
Nyonga	• Rehabilitation hand-pump • 11 new boreholes • CLTS	113.500 USD
Kibondo	• 10 new boreholes • CLTS	110.000 USD
Kibila	• Mini-gravity flow system • CLTS	60.000 USD
Kipamba 4	• 4 new boreholes • 1 solar elevated water tank • CLTS	80.000 USD
Lufira	• 2 solar elevated water tank • OCV on islands • CLTS	100.000 USD
Kadya	• Rehabilitation hand-pump • 2 solar elevated water tank • CLTS	83.500 USD
Kitembo	• OVC on islands • 1 solar elevated water tank • CLTS	100.000 USD



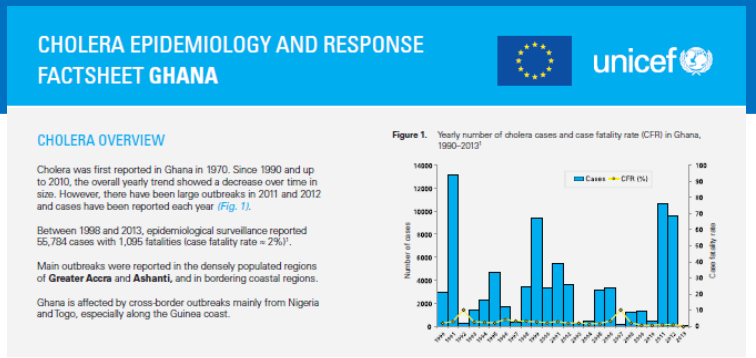
Total funding needs: 717.000 USD



Step 4: Advocacy (7 countries)



Advocacy leaflet


CHOLERA EPIDEMIOLOGY AND RESPONSE
FACTSHEET **GHANA**

unicef

CHOLERA OVERVIEW

Cholera was first reported in Ghana in 1970. Since 1990 and up to 2010, the overall yearly trend showed a decrease over time in size. However, there have been large outbreaks in 2011 and 2012 and cases have been reported each year *(Fig. 1)*.

Between 1998 and 2013, epidemiological surveillance reported 55,784 cases with 1,095 fatalities (case fatality rate ≈ 2%)[1].

Main outbreaks were reported in the densely populated regions of **Greater Accra** and **Ashanti,** and in bordering coastal regions.

Ghana is affected by cross-border outbreaks mainly from Nigeria and Togo, especially along the Guinea coast.

Figure 1. Yearly number of cholera cases and case fatality rate (CFR) in Ghana, 1990–2013[1]

CHOLERA DISTRIBUTION

The four regions along the coast, **Greater Accra, Central, Western** and **Volta** represent over 70% of cholera cases between 1998 and 2013. This is driven by large outbreaks in **Greater Accra** region.

In the middle of the country, the main outbreaks were recorded in the densely populated **Ashanti** and **Eastern** regions which border **Greater Accra** region, with nearly 18% of registered cases.

In the North of the country, less than 10% of cholera cases were reported.

Outbreaks in **Greater Accra, Central** and **Eastern** occured at similar times-all-year round and were connected as a result of movement between these regions. Separate sporadic outbreaks in other regions appeared to be seasonal, emerging around June and September for **Ashanti** region and the northern part of the country. These seemed to coincide with rainy seasons and festivals when there was increased movement within and between regions.

Outbreaks in Ghana usually spread towards neighbouring countries from the south of Cameroon to Guinea Bissau through migrant fishermen and commercial trade.

Figure 2. Cumulative incidence of cholera by commune in Ghana, 1998-2013[2]

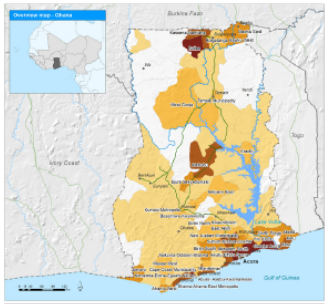
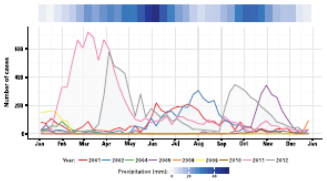


Table I. Epidemiological parameters of cholera outbreaks by main affected region in Ghana, 1998-2013[2]

Area	Cases / Deaths (N)	% of total cases	Number of outbreaks	Duration (a)
GREATER ACCRA	27353 / 120	53.4	8	65

Figure 3. Weekly number of cholera cases and median of estimated ten-day precipitation in Ghana, 2001–2013[2,3]

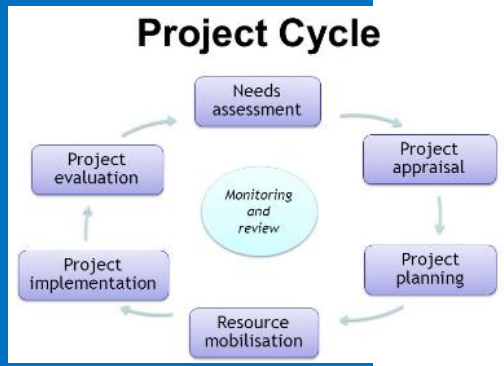


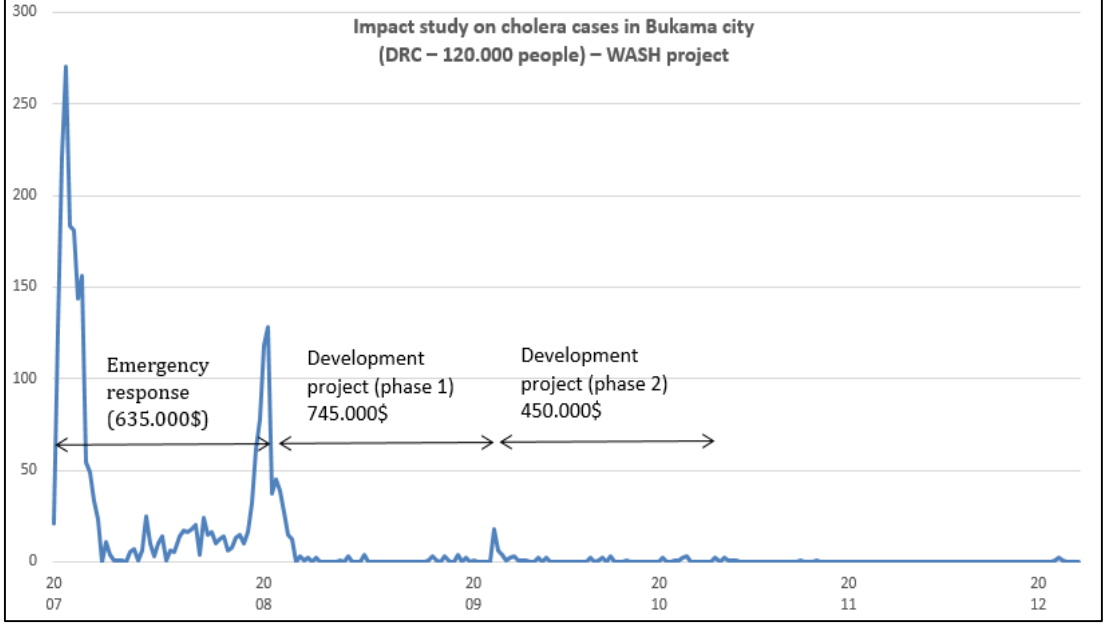
Factsheet

Country	Duration (years)	Beneficiaries	Budget (euro)
Ghana	3	1.000.000	3.400.000 €
Benin	3	85.000	1.329.000 €
Guinea	5	895.000	4.500.000 €
Niger	3	235.000	1.825.200 €
Chad	3	193.000	1.307.000 €
Togo	3	76.470	974.000 €
DR. Congo	5	3.933.000	34.600.000 €

Estimated budget

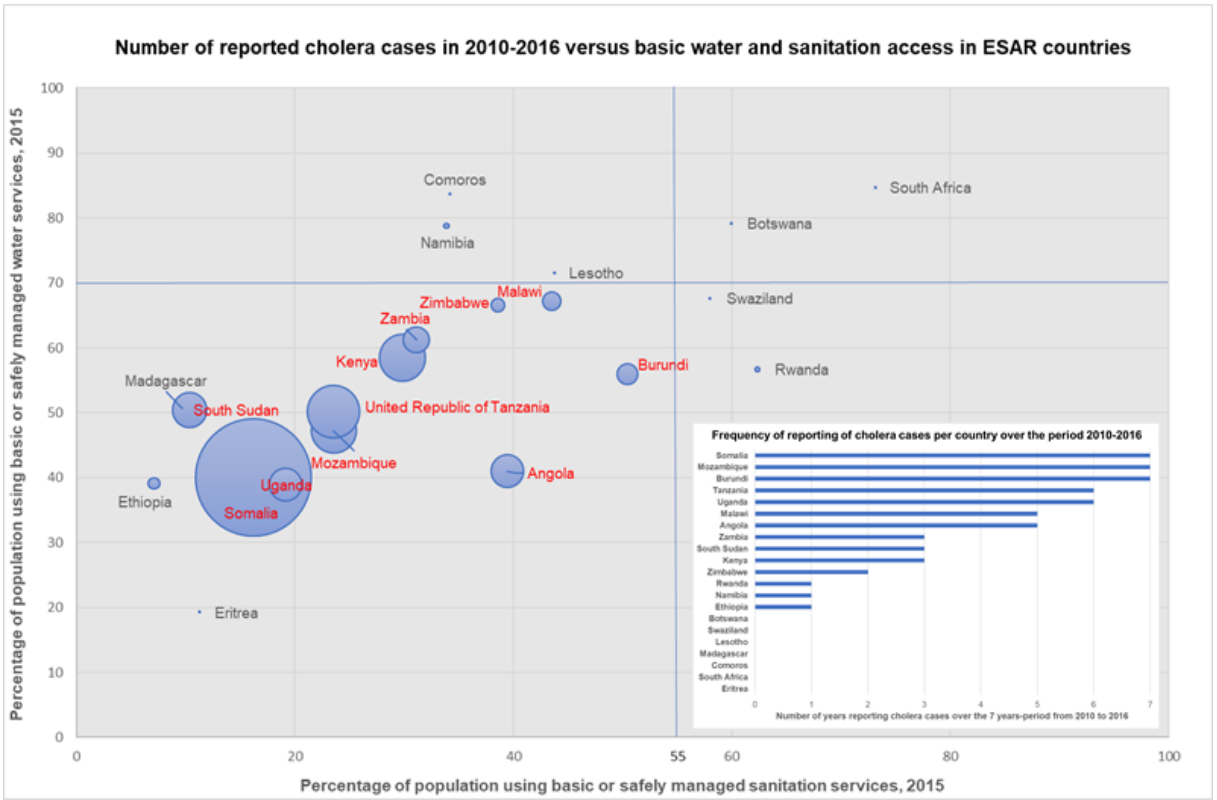
Step 5: Sustainable intervention (1 country)





Step 6: Impact study/ sustainability check / Evaluation of project cycle

(0 country)



Success and challenges of the platform

Success and achievements

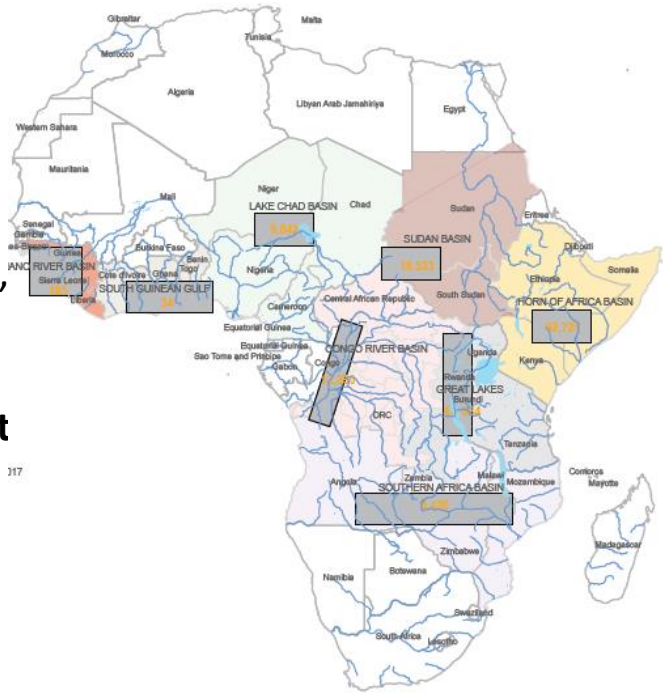
- **Extend** the West and Central platform and its strategy to Eastern and Southern Africa **for a global African approach** on cholera per basin
- 5 years since creation with **increasing number of actors** and recognition
- Support long term engagement by "national multisectorial elimination plan" (12 countries);
- Identify hotspots (14 countries in WCAR + 8 countries in ESAR)
- Field investigations and investment plans (7 countries)
- Compendium of 34 cholera studies in WCAR available on website

Challenges

- **Funding gaps** to support the platforms
- **Mobilize resources** for cholera control in **hotspots as a long-term investment** and/or prioritize hotspots as part of SDGs
- **Decentralize** through sub-platform per epidemiological basin.
- No official agreement between the platform and GTFCC despite being an operational actors of the roadmap.
- **Lack of impact studies to leverage funds**
- Lack of monitoring indicators towards "elimination of cholera"

Advantages of the Regional platform

- **Better communication and alert between countries** (not limited to cholera)
- **Approach cholera per basin** and not only per country (e.g: Lake Chad Basin or Great Lake Basin) for a global impact towards elimination of cholera.
- The platform acts as an **operation body of the GTFCC roadmap**
- **Exchange** of experiences **between countries** (website, workshops, coordination meetings, capacity building…).
- Develop a regional analysis on vulnerability to cholera for **efficient use of funds** (e.g: in the definition of hotspots)
- **Develop technical tools adapted to regional context** (training modules, communication messages, anthropological studies…).
- Promote **harmonized approach** between partners
- **Leverage regional organization** (OCAL, ECOWAS, CEEAS…) **and countries** in the implementation of roadmap



Any questions?

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