GLOBAL TASK FORCE ON
CHOLERA CONTROL

APPROACHES TO IMPROVING ACCESS TO CHOLERA CASE MANAGEMENT IN HUMANITARIAN SETTINGS – SOUTH SUDAN EXPERIENCE

South Sudan Experience
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BACKGROUND

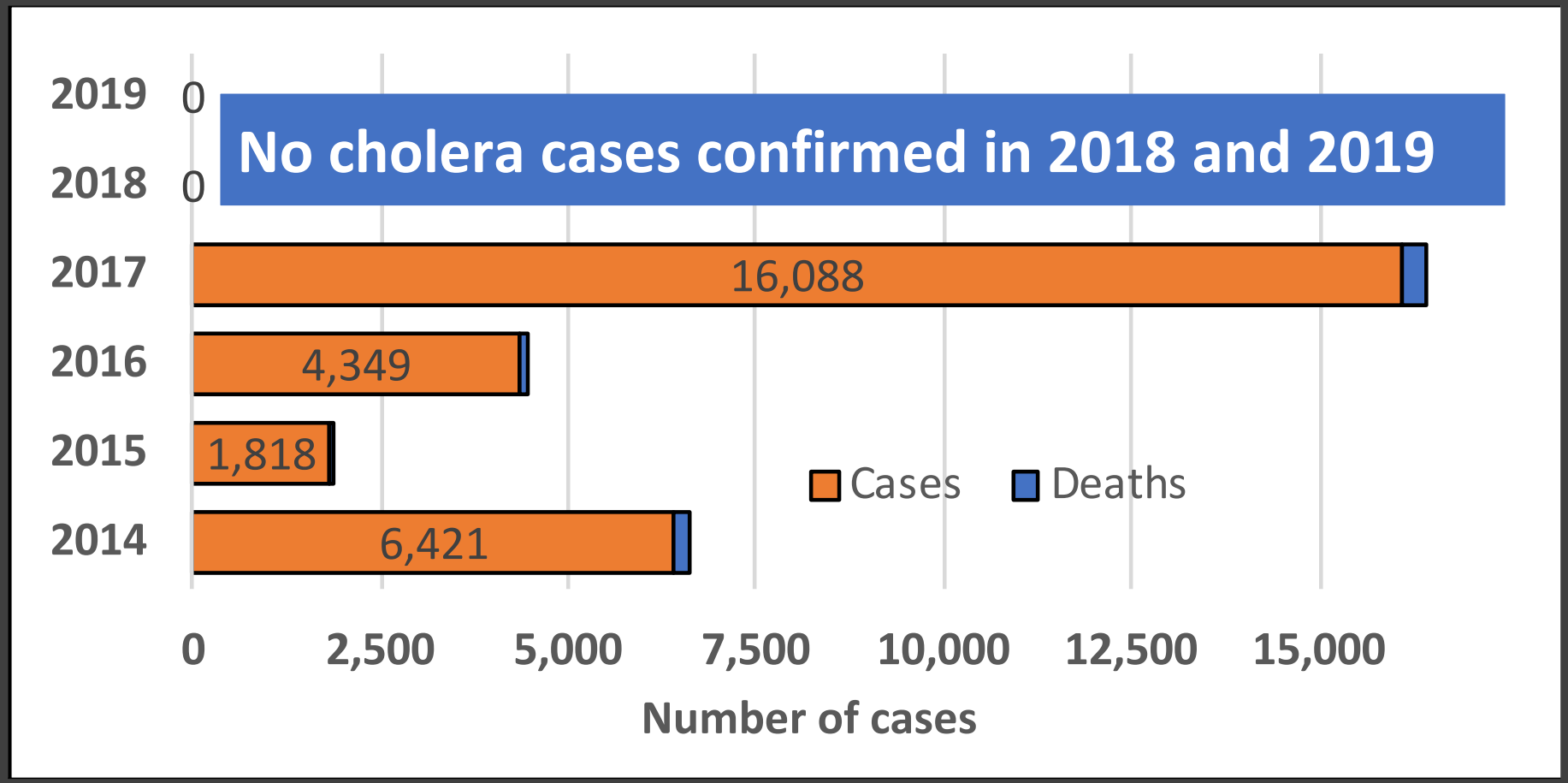
Years of conflict constrained social services - healthcare, education, safe water, sanitation, & other development indices

- OPD utilization/ capita/ year – 0.5 (WHO threshold: 5)
- Health Facility density per 10,000 - 1.4 (WHO threshold: 2)
- Core health workforce density per 10,000 – 6.3 (WHO threshold: 44.5)
- 80% of the health services are provided by NGOs.
- Basic use of improved water sources – 50% (48% rural; 60% urban);
- Basic use of improved sanitation facilities - 10% (6% rural; 28% urban)
- Open defecation: - 61% (70% rural; 22% urban)

These indicators favour endemic transmission of cholera

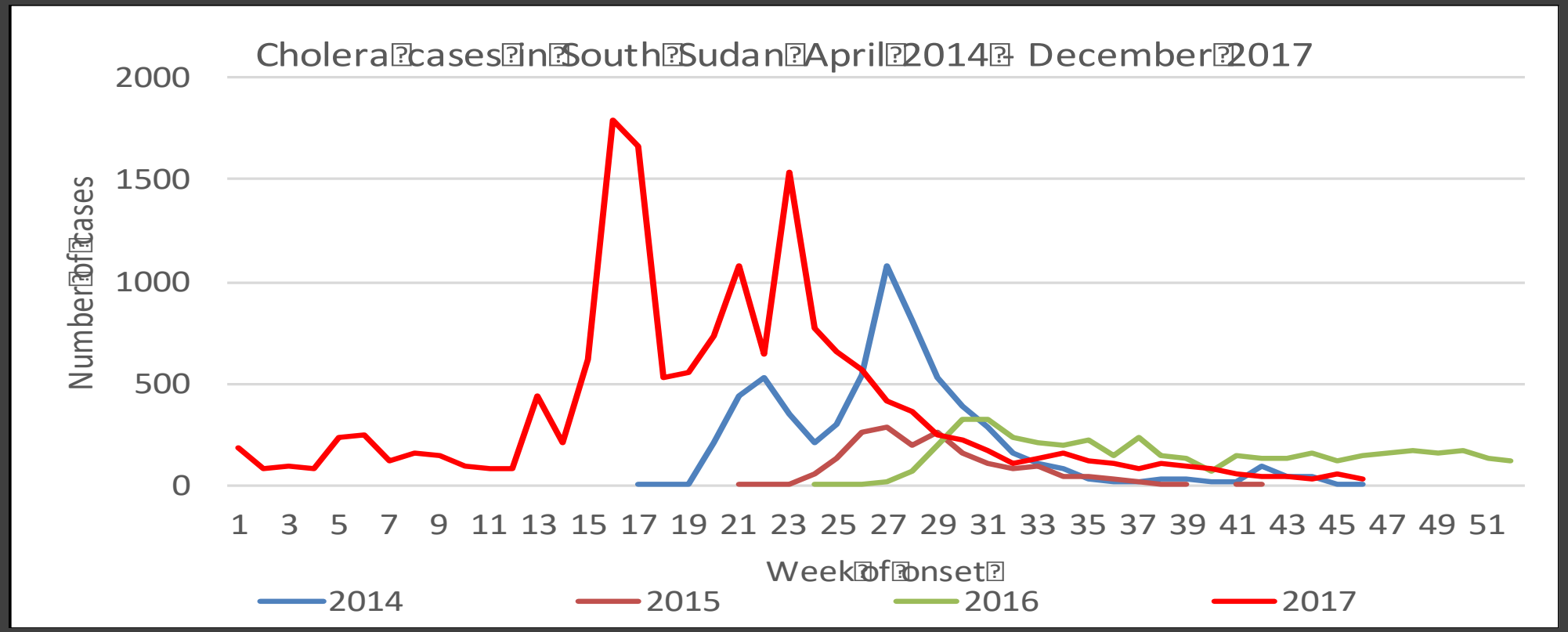
The most recent wave of cholera outbreaks 2014-2017 occurred in the context of a protracted crisis that started in 2013

Displacement of nearly 4 million people with constrained access to social amenities



Recent cholera outbreaks in South Sudan (2014-2017)

From 2014-2017 at least 28,676 cases & 644 deaths were reported in SSD but there were no cholera cases confirmed in 2018 & 2019



Trends for cholera cases in SSD, Apr 2014 - Dec 2017

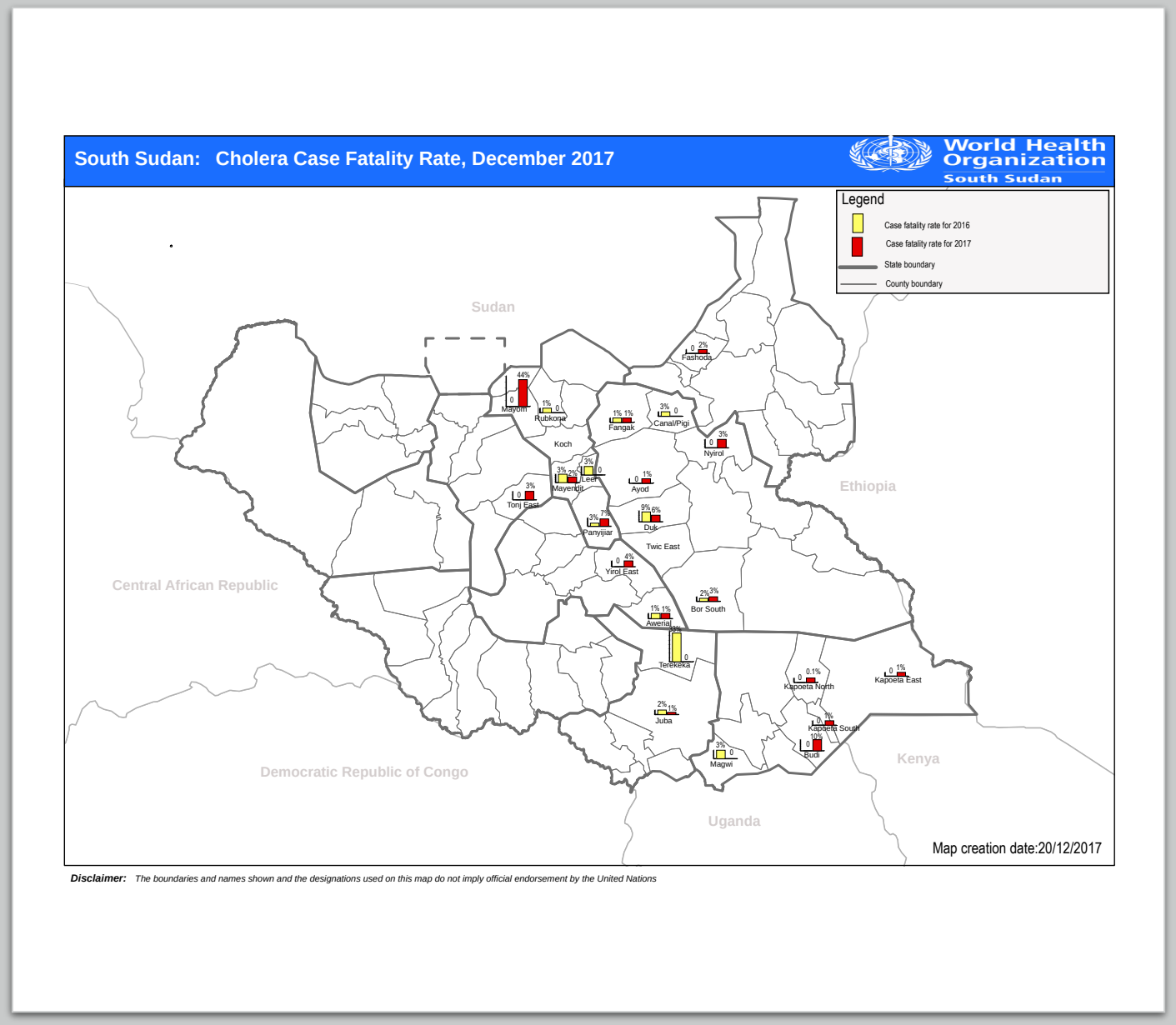
Since the onset of the crisis in 2013, cholera cases were reported every year since 2014 with the initial cases being reported in Juba during the 17th to 24th epidemiological weeks

Cholera CFRs in SSD: 2016, 2017

Cholera CFRs were highest in counties with:

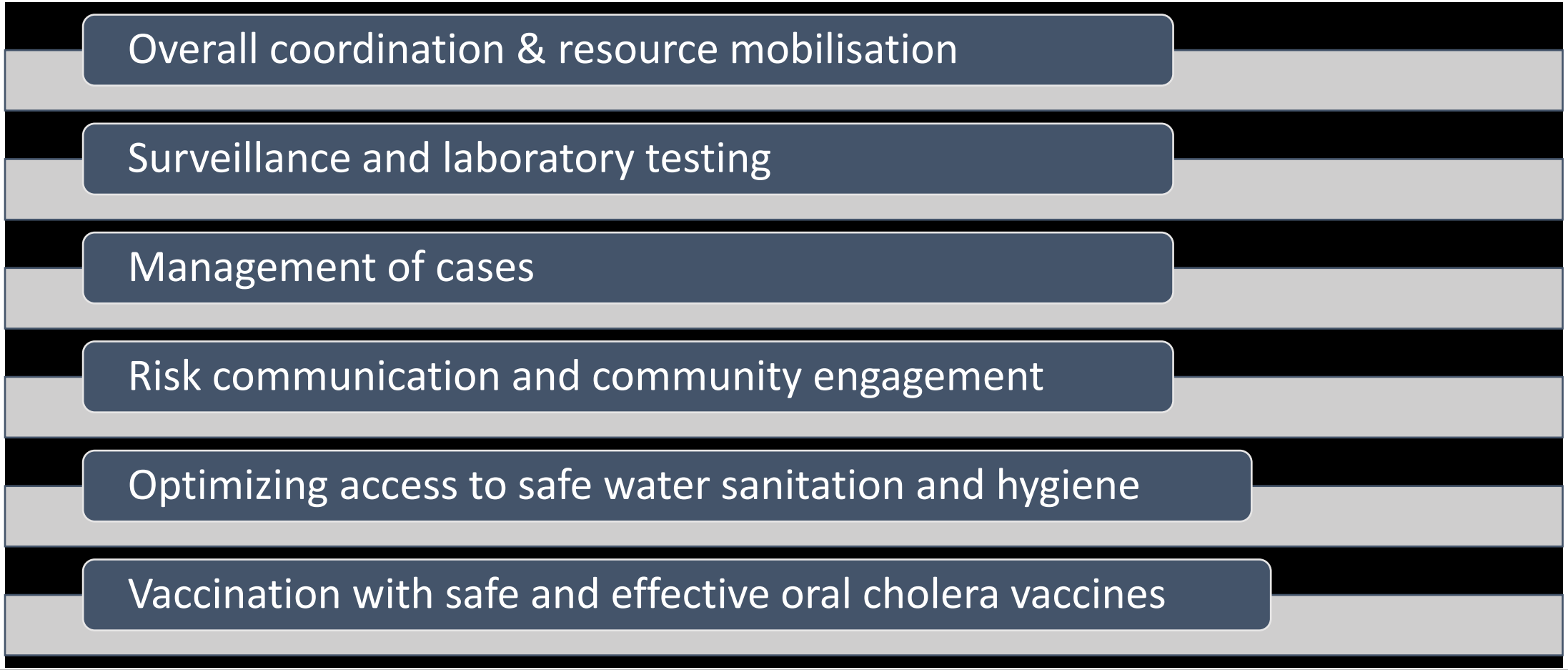
- Poor access to health care especially in populations living in the islands and cattle camps
- Security issues
- Ambulance challenges in the night
- Delayed initial response

Some strategies were developed to address these & are included in ongoing cholera preparedness activities



Cholera response strategy

- Comprehensive response led by the national cholera taskforce deployed the integrated approach for cholera interventions that included:



Objectives of cholera case management

- Prompt access to appropriate treatment to prevent cholera deaths through:
    1. Deploying adequate cholera treatment kits
    2. Availing cholera treatment facilities close to affected populations
    3. Availing apdated and adapted case management protocols
    4. Training health workers on cholera case management
    5. Empowering communities and households to initiate rehydration once cholera is suspected

Strategies for Improving access to cholera case management

Coordination of cholera case management

- **Multisectoral taskforce** – national and sub-national level
- Case management sub-committee charged with improving access to recommended case management
- There are ongoing cholera preparedness activities
- **Sub committee structure**
  - Chaired by Government technical officers
  - Co-chaired by partner agencies – WHO, Unicef, MSF, and other frontline health cluster partners
- **MoH Rapid response teams –** that included case management experts deployed to support case management including setting up cholera treatment facilities in Government controlled areas
- **Emergency Responding health cluster partners** deployed to support case management in Opposition controlled areas and location sub-optimal government presence

Coordination of cholera case management cont..

- **Emergency Mobile Medical Teams** –
  - WHO teams to support emergency response to cholera and other PH emergencies
  - Constituted by Medical Officers; Public Health Officers; Nurses; WASH officers; and logisticians
  - Deployed to support cholera investigations including case management in locations with sub-optimal government and partner presence (provider of last resort)
- **Routine Primary Health Care (PHC) partners** were also engaged to support case management for outbreaks in their respective county of designation and eventually – emergency funds were curved out of the routine PHC funds to support cholera control
- **Unicef contracted national NGOs** to operate ORPs and CTCs/CTUs to improve access to cholera case management in affected populations
- **International NGOs** like MSF; MedAir; Save the Children etc. setup cholera treatment facilities to improve access to cholera treatment

Role of households and communities

- Community health workers deployed to empower communities to prevent cholera; identify; and manage suspect cholera cases
- Dissemination of cholera community case definition to facilitate early case identification at household level
- Educating & empowering households to start cholera treatment at home:
  - Preparing and giving ORS immediately to people with watery diarrhoea and continue drinking while travelling to nearest health facility
  - People with watery diarrhoea should immediately go to the nearest health facility or CTC/CTU
  - Demonstration on mixing the standard and homemade oral rehydration solution
  - Provision of 3-5 ORS sachets per household during the house-to-house visits

Cholera case management at designated oral rehydration points (ORPs)

- ORPs setup close to affected areas for ready access to timely rehydration
- ORPs primarily managed suspect cases with no or mild/some dehydration
- ORPs initiated treatment and refer suspect cases with severe dehydration, to designated CTC/CTU
- ORS corners set up at HF in locations without ORPs
- Active house-to-house case search by CHWs to identify and initiate rehydration for suspect cases
- Mobile ORS teams; backpacks; in hard-to-reach locations for example in nomadic communities, areas with conflict and populations displaced to the bush or secluded islands, or in settings where flooding prevents proper access to the population and setting up an ORP facility

Cholera case management at designated cholera treatment centers or units (CTCs/CTUs)

- CTCs/CTUs established close as possible to the affected populations
- CTCs/CTUs zoned to manage cholera cases with no dehydration, some, and severe dehydration
- CTCs/CTUs made accessible to distant affected locations using an established ambulance network
- Military ambulances deployed in the night in insecure urban settings
- CTCs/CTUs had ample and well-trained staff including medical doctors, clinical officers, nurses, public health officers, and support staff
- CTCs/CTUs provided IV rehydration with ringer's lactate, antibiotics to severe cases, managed cholera complications & malnourished children with cholera

Challenges

- Delays in deploying comprehensive initial responding teams leading to high CFR rates when new locations report outbreaks
- Insecurity
- Poor physical access – especially during the rainy season, floods
- Poor adherence to treatment protocols
- Overuse of IV fluids even for patients with no or mild/some dehydration
- Shortage of supplies like cholera beds

Way forward

- Improving access to basic healthcare services
- Optimal outbreaks and cholera preparedness
  - Comprehensive cholera preparedness and control – There are ongoing preparedness activities
    – updated plan and emergency funds
  - Trained rapid response teams for prompt response
  - Optimal cholera case management kit prepositioning – underway as part of cholera & floods preparedness planning
  - Updated and disseminated cholera outbreak manual that includes case management
  - Training health care workers on cholera case management protocols – as part of the IDSR training
  - Ongoing efforts to empower communities for prompt initiation of rehydration of new suspect cases

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