GLOBAL TASK FORCE ON
CHOLERA CONTROL

WASH & IPC RESPONSE PACKAGE FOR CHOLERA IMST

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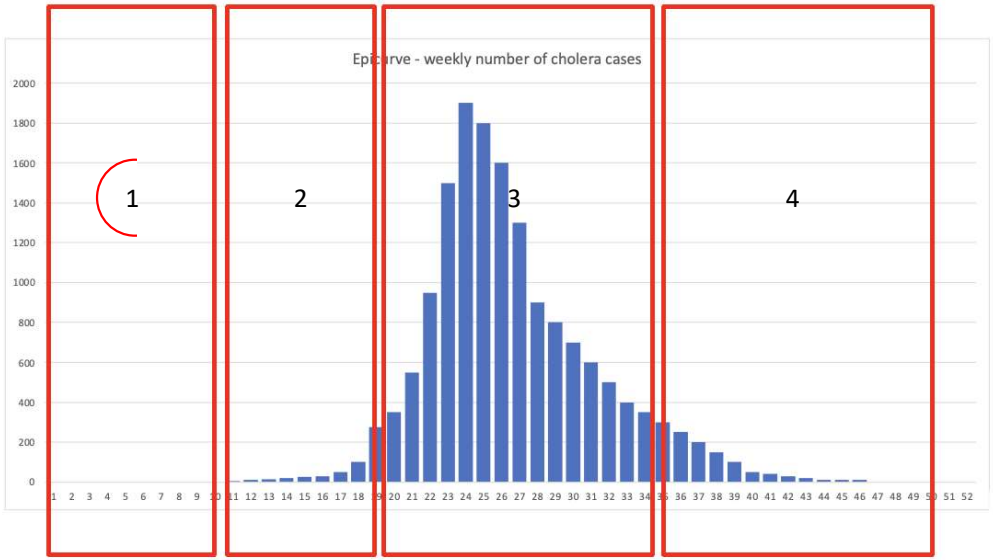
WASH & IPC response package for cholera

1. Observations – WASH & IPC during emergency response
2. Proposition to work on a WASH & IPC response package for the Cholera IMST
3. Expected outcome – the ideal scenario – being ready to respond “on time”

WASH & IPC response pack for cholera

Cholera outbreak cycle



Phase 1: Cholera preparedness / prevention (peace time, no cases or no cholera outbreak)

Phase 2: Readiness & early detection and response

Phase 3: Emergency response scale-up & outbreak control

Phase 4: End of outbreak, reaching the last mile, capitalization, evaluation, lessons learned, linking with future preparedness and with long-term cholera prevention efforts

NB: this idea of cholera outbreak cycle is valid at national level, but also at subnational / district level.

So while District A can be in emertency scale up phase, the neighboring District B could already be in the end of outbreak phase, while another District C could be in readiness phase.

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WASH & IPC response pack for cholera

- Why are we (so) slow to start responding ?
- Time to organize and agree on what to do
- No funding to kick start the response
- Lack of harmonized Guidance / Training / Tools
- Coordination > suboptimal response / gaps
- Poor Epi – RCCE - WASH collaboration
- Lack of systematic / centralized reporting
- Lack of real time monitoring & feedback to adapt & improve the response
- Supplies / logistics / transport !!!

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- Role of WHO in the cholera response WASH / IPC need to be clarified (added value, capacity, responsibility)
- Cholera readiness checklist (WASH/IPC) under development / field testing
- Lack of WASH IPC capacity (3 IPC people at regional level + 2 at global level, and 1 WASH AFR0, 1 WASH GVA + 1 WASH IMST) + ad hoc OSL support
- COs not always aware on how to mobilize surge support (and that some of the support is provided for free)
- No funding ready to kick start the response
- Lack of harmonized Guidance / Training / Tools and SOPs to respond to cholera (and need of a single place to find them)
- No reporting framework to report on
- Lack of replicability / quality insurance > lack of credibility > lack of funding

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Observation 1 – Coordination

Coordination confusing (duplication / overlap) with several coordination mecanisms and at the same time very difficult to have all information in one place

- ❑ MoH coordination, WHO coordination with partners, WASH cluster coordination
- ❑ Not always a clear WASH / IPC Pillar plan
- ❑ Not every actor using the same strategy / set of activities
- ❑ Lack of harmonization on how to implement activities / tools
- ❑ No standardized WASH IPC logic / result framework / indicators
- ❑ Lack of centralized reporting & information sharing (and platform)
- ❑ Lack of sector vision of the overall response & gaps to do advocacy

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Observation 2 – Epi WASH RCCE analysis to guide the response

Response often lacking evidences to guide the action > not always the most efficient

- ❑ Difficulty to obtain real-time (and relevant) epi-analysis that can actually be used to guide the response
- ❑ Resistance to share epidemiological data to do our own analysis
- ❑ Geolocalisation of cases not systematic / or not shared and when exist, poorly analyzed to help guide the response
- ❑ Lack of documentation and sharing of investigation done at HH or community level, identification of main drivers of transmission, at-risk practices, risk factors
- ❑ Lack of post intervention monitoring and analysis to see if intervention has led to changes or identify what are the barriers to change

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Observation 3 – WASH & IPC in CTCs and HCFs

Lack of systematic monitoring / supervision and information sharing

- ❑ WASH & IPC in CTCs and HCFs often not reaching minimum standards
- ❑ Not enough partners supporting MoH with comprehensive WASH & IPC interventions
- ❑ Trainings yes, but lack of formative supervision / on the job training
- ❑ Lack of documentation of HAIs / sharing this information
- ❑ Waste management always a challenge
- ❑ IPC in HCFs non treating cholera patients often not considered (triage & referral)

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Observation 4 – WASH targeted interventions

Not systematic use of targeted interventions around cases (CATIs/ CLUSTIs / HBIs, etc.)

- ❑ Lack of GTFCC guideline promoting the use of targeted interventions as an efficient way to interrupt transmission
- ❑ Lack of harmonization of type of intervention / mode of delivery
- ❑ Focus on one-off disinfection (easy to do) rather than on education on how to protect the household in case a new person gets sick (and measure of secondary infection)
- ❑ Great way to have geolocalisation of cases
- ❑ Great opportunity to do more in depth investigation and identify main drivers of transmission, at-risk practices, risk factors
- ❑ Post intervention monitoring often not prioritized, while it is key to assess the effectiveness of the intervention

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Observation 5 – WASH protective interventions

WASH preventive activities not always guided by epi / RCCE analysis findings

- ❑ RCCE / WASH not always working hand in hand / duplication
- ❑ WASH actors not always guiding their interventions & messages based on epidemiological / risk factors identification / drivers of transmission
- ❑ No systematic chlorination of all water sources
- ❑ No systematic water quality monitoring
- ❑ Lack of emphasis on gatherings, social events, funerals, etc.
- ❑ Lack of emphasis on food hygiene
- ❑ Lack of post intervention monitoring and analysis to see if intervention has led to changes or identify what are the barriers to change

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Observation 6 – WASH & IPC supply and logistics

Logistical challenges / lack of anticipation

- ❑ Delays to have the required materials at the start of an outbreak
- ❑ Lots of imports, while maybe would be cheaper to procure locally
- ❑ Dispatch and requests system should be supported to avoid supply disruption
- ❑ Missing a centralized supply system

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WASH & IPC response package for the Cholera IMST

- ❑ Objectives / results framework (what we want to achieve)
- ❑ Activities / modalities / guidance / tools / SOPs
- ❑ Training modules
- ❑ Surge HR profiles / staffing / deployment modalities (cholera experts)
- ❑ Implementation teams (MoH & partners) – pre-establishement of PCAs
- ❑ Budget / emergency fund to kick start the response
- ❑ Equipment / consumables / logistics & supplies monitoring system
- ❑ Monitoring framework / indicators / reporting /quality insurance

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Overall objective of the WASH / IPC response :

To reduce cholera morbidity (and indirectly contribute to reduce mortality) by limiting transmission (environmental and direct transmission) and protecting at risk persons and populations from being exposed to cholera

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WASH IPC Pillar Leadership Coordination, Monitoring, Reporting, Advocacy

EPI / WASH / RCCE – Analysis cell
Targeting and Tailoring the response

WASH IPC Supplies & Logistics

WASH IPC in CTCs, ORPs, HCFs

WASH targeted response around cases and deaths

WASH RCCE protective activities in affected and at risk communities

WASH & IPC Pillar Leadership, Coordination, Monitoring, Reporting, Advocacy

Objective: To ensure that overall WASH/IPC response is well coordinated among partners and follow best practices / GTFCC guidance on WASH IPC interventions in cholera outbreaks

Expected results:

- ☐ IPC WASH coordination mechanism at the national level is activated with MoH, Ministry of water and partners
- ☐ IPC WASH national response plan (with results, activities and indicators) exists
- ☐ IPC WASH SOPs exist, per activity
- ☐ IPC WASH training package exist, per activity
- ☐ IPC WASH partners mapping - who is doing what, where and when (4Ws matrix) updated
- ☐ IPC WASH monitoring framework exists and is known and agreed among partners
- ☐ IPC WASH reporting by all partners is ongoing
- ☐ IPC WASH information & knowledge management and dissemination is ongoing
- ☐ Gaps are identified & guide advocacy towards WASH IPC actors & donors to mobilize actors/resources

EPI / WASH – Analysis cell
Targeting and Tailoring the response

Objective: To ensure that the WASH IPC interventions are guided by the epidemiology, targeting at risk populations, making use of the understanding of the main drivers of transmission and key risk factors to develop relevant interventions, and monitor subsequent changes following interventions or identify barriers to change

Expected Results:

- ☐ Analysis of geolocalization of cases (identification of cholera hotspots / clusters of cases) is being done jointly by District Health teams & WASH actors
- ☐ Analysis of cholera cases demography to identify specific at-risk population groups (line list analysis)
- ☐ In-depth field investigation at household / community level to identify main drivers of transmission (contexts)
- ☐ Risk factors, practices, behaviors and perceptions are identified (investigation including elements on perception, behaviors and practices)
- ☐ Changes in risk factors, at risk practices, behaviors and perceptions following interventions is monitored and barriers to change identified (post intervention monitoring)

WASH & IPC in CTCs, ORPs, HCFs

Objective: To ensure WASH IPC minimum standards in health facilities receiving cholera patients and avoid the spread of the disease inside and outside health facilities

Expected Results:

- ☐ CTCs/CTUs, ORPs and HCFs are listed (by location) and mapped out
- ☐ WASH and IPC conditions in CTCs/CTUs, ORPs, and HCFs are evaluated at setup (initial assessment) and gaps / immediate needs for improvement are identified
- ☐ CTCs/CTUs and ORPs, and HCFs benefit from WHO or other partners support
- ☐ CTCs/CTUs and ORPs reach the minimum WASH IPC requirements
- ☐ SOPs for WASH IPC in CTCs / ORPs / HCFs are developed, disseminated, and implemented
- ☐ IPC focal persons in CTCs/ORPs/HCFs are trained and equipped
- ☐ Health workers are trained to safely care for patients with cholera
- ☐ Education training package exist and is given to visitors / caregivers on WASH IPC at the CTC/ORP
- ☐ Collection, storage and disposal of waste in CTCs/CTUs and HCFs is managed adequately
- ☐ HAI surveillance for health workers, caregivers and visitors in CTCs/CTUs/ORPs/ HCFs is in place
- ☐ Weekly supervision of WASH IPC in CTCs / ORPs / HCFs is implemented, with identification of supply needs and results are analyzed and shared at district and national level
- ☐ HCFs in affected areas have the capacity for screening, isolation, notification and transfer cholera cases to CTCs

WASH targeted response around cases and deaths

Objective: To ensure that the risk of transmission around cases is reduced

Expected Results:

- ☐ Information on cases (geolocalisation, physical address, contacts) is shared with rapid response teams in real time
- ☐ Analysis of geolocalisation is conducted to identify clustering
- ☐ Households of cholera cases receive a visit of a rapid response team with a standard package of activities aiming at reducing the risk of intra-household contamination
- ☐ 10-20 Neighboring households in a distance of 50m also receive a standard package of activities aiming at reducing the risk of contamination within the neighborhood (may differ from cholera cases household)
- ☐ Investigation at household / community level is conducted to give insights on drivers of transmission / risk factors
- ☐ Main drivers / risk factors identified are addressed through follow up intervention
- ☐ Post intervention monitoring (PIM) is conducted at household and community level to assess use of items and changes in in perceptions, behaviors and practices following intervention or barriers to behavior change
- ☐ If needed, response package is adapted following the results of monitoring

WASH & RCCE protective activities in affected and at risk communities

Objective: To ensure that affected and at-risk populations are protected through community level WASH interventions

Expected Results:

- ☐ Sources of water used by households in affected communities are mapped out
- ☐ Fecal waste management systems are assessed for potential risk (contamination of the environment)
- ☐ Households in affected / at-risk communities have access to sufficient water for all needs
- ☐ Households in affected / at-risk communities use chlorinated water (> FRC 0,2mg/L)
- ☐ Households in affected / at-risk communities use clean & safe storage containers
- ☐ Households in affected / at-risk communities know the safe food preparation measures
- ☐ Households in affected / at-risk communities know the importance of handwashing at key times
- ☐ Households in affected / at-risk communities have a handwashing station, with water & soap
- ☐ Handwashing is promoted and handwashing stations with soap / water are installed in markets and public places, schools, churches etc.
- ☐ Water quality monitoring & feedback to users / communities is in place in affected communities
- ☐ Households in affected / at-risk communities use safe sanitation systems / Open defecation is discouraged
- ☐ Solid waste management, collection, and disposal, is organized in particular around markets and other public spaces.
- ☐ Food safety laws and inspection of restaurants, food vendors and food processing are in place

WASH IPC Supplies & Logistics

Objective: To ensure the WASH IPC supplies availability in the right place in the right time

Expected Results:

- ☐ WASH IPC supply needs assessment for each CTCs/CTUs/ORPs (chlorine, soap, PPE, etc.) is done
- ☐ Forecast of all WASH IPC material is prepared (in collaboration with logistics, epi and case management) based on projections / scenarios for at least 3 months
- ☐ Local and international markets assessment is done
- ☐ Supply strategy is prepared (local, regional, international) based on zero shortage taking into consideration cost-efficient transport, including last mile delivery and warehousing
- ☐ Budget is prepared and sought for at least 3 months' supply
- ☐ Orders are prepared for at least 3 months
- ☐ Availability of IPC/WASH supplies in each CTCs/CTUs/ORPs is assessed on a regular basis to identify priority needs
- ☐ Regular update of stock, pipeline and consumption of all items and equipment is made and shared with the ministry of health and partners in real time
- ☐ Future supply needs are assessed taking into consideration the likelihood of different scenarios and consequences on supply, to enable pre-planning and pre- positioning.

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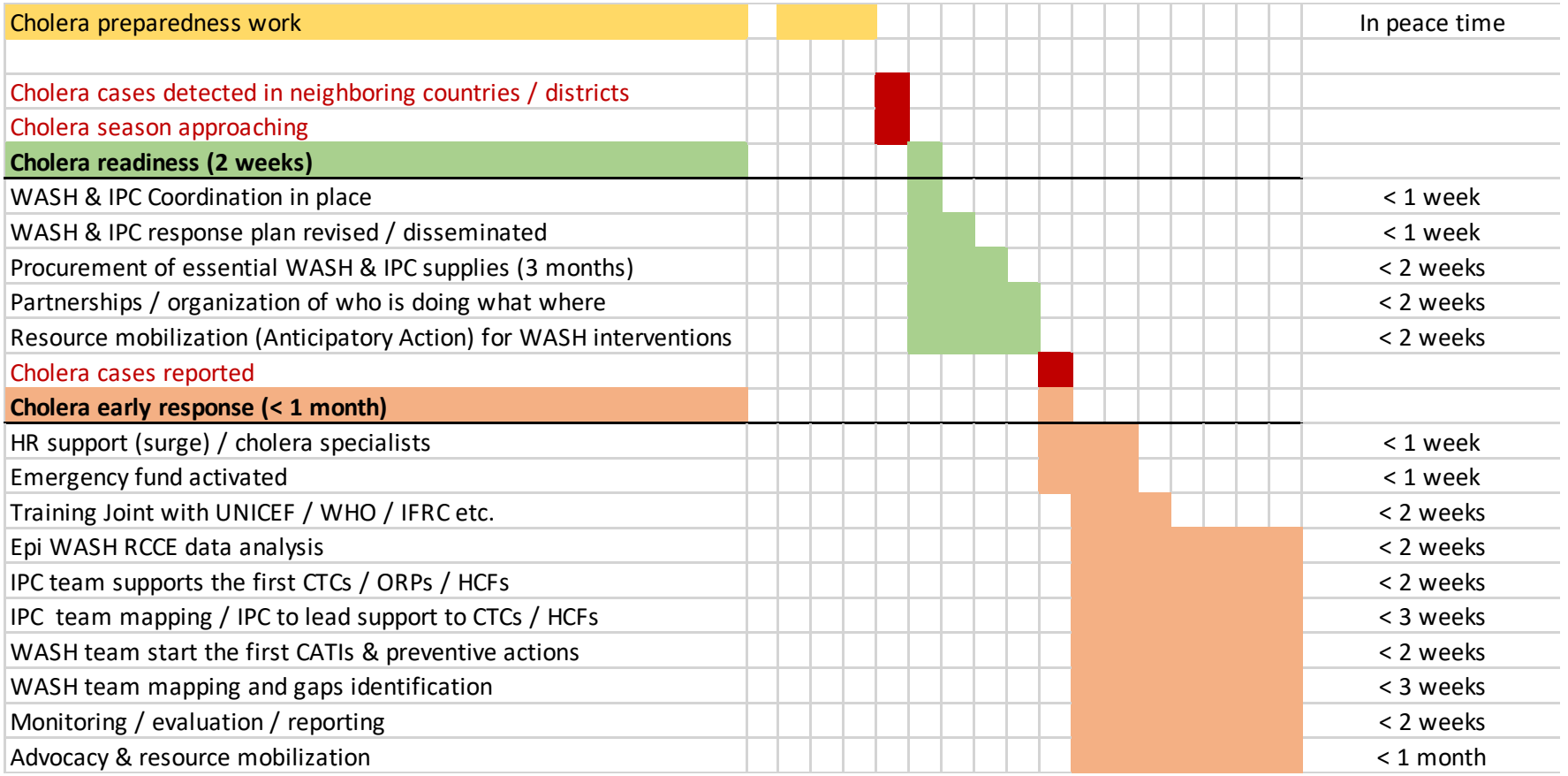
The ideal scenario



Cholera preparedness work	In peace time
Cholera cases detected in neighboring countries / districts	
Cholera season approaching	
Cholera readiness (2 weeks)	
WASH & IPC Coordination in place	< 1 week
WASH & IPC response plan revised / disseminated	< 1 week
Procurement of essential WASH & IPC supplies (3 months)	< 2 weeks
Partnerships / organization of who is doing what where	< 2 weeks
Resource mobilization (Anticipatory Action) for WASH interventions	< 2 weeks
Cholera cases reported	
Cholera early response (< 1 month)	
HR support (surge) / cholera specialists	< 1 week
Emergency fund activated	< 1 week
Training Joint with UNICEF / WHO / IFRC etc.	< 2 weeks
Epi WASH RCCE data analysis	< 2 weeks
IPC team supports the first CTCs / ORPs / HCFs	< 2 weeks
IPC team mapping / IPC to lead support to CTCs / HCFs	< 3 weeks
WASH team start the first CATIs & preventive actions	< 2 weeks
WASH team mapping and gaps identification	< 3 weeks
Monitoring / evaluation / reporting	< 2 weeks
Advocacy & resource mobilization	< 1 month

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The ideal scenario

- We have a short (2weeks) readiness phase to set up coordination / agree on how we will respond / mobilize some internal funds to kick start the readiness and order WASH & IPC supplies
- We have some form of anticipatory action / early action funding mecanism to support deployment & early action response package (1-3 months)
- This “early action” (1-3 month) is useful to set the “ideal response” as a precedent – “demonstration” of our capacity to respond
- It is then easier to request for more funding to expand the response if / when the situation deteriorates

THANK YOU!

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CHOLERA CONTROL