OCHA United Nations Office for the Coordination of Humanitarian Affairs
Partnership for Humanity

# Regional Update No. 6 – Cholera/Acute Watery Diarrhoea Outbreaks in Southern Africa
## 06 March 2009

**HIGHLIGHTS / KEY PRIORITIES**

- ✓ **Cholera and acute watery diarrhoea cases (AWD) increased by 37,192 cases and 735 deaths (CFR 2.0%) since last report issued on 9 February 2009.**
- ✓ **The cholera epidemic is rapidly expanding to rural areas, such as in Malawi, Swaziland and Zimbabwe.**
- ✓ **Ms. Catherine Bragg, UN Assistant Secretary-General for Humanitarian Affairs and Deputy Emergency Relief Coordinator (ASG / DERC) led an inter-agency mission to Zimbabwe and finds the humanitarian situation grave.**
- ✓ **Overall, the region needs to scale-up public health outreach interventions at district and community levels.**

## REGIONAL CONTEXT

Regionally, the number of cholera cases has not only increased but has spread to infect more areas within the nine countries affected. An additional 37,192 cholera cases and 735 deaths (CFR 2.0%) were reported from 9 February to 4 March 2009. Those countries, reporting a significant increase in cholera are: Malawi (2,320 cases), Namibia (90 cases) South Africa (5,777 cases), Zambia (2,016 cases) and Zimbabwe (18,922 cases). Since the outbreak began, a cumulative total of 124,404 cases and 4,320 deaths (CFR 3.5%) have been recorded.

**Table 1: Regional Overview of Cholera / Acute Watery Diarrhoea (AWD)**

| Country | Reported Cases | Reported Deaths | Case Fatality Rate (CFR %) | Time Period |
|---|---|---|---|---|
| Angola | 5,368 | 60 | 1.1 | 01 Oct 08 - 04 Mar 09 |
| Botswana | 15 | 2 | 13.3 | 01 Nov 08 - 03 Mar 09 |
| Malawi | 4,171 | 95 | 2.3 | 15 Nov 08 - 01 Mar 09 |
| Mozambique* | 9,405 | 77 | 08 | 01 Jan 09 - 28 Feb 09 |
| Namibia** | 193 | 11 | 5.7 | 22 Oct 08 - 03 Mar 09 |
| South Africa | 11,979 | 59 | 0.5 | 15 Nov 08 - 02 Mar 09 |
| Swaziland*** | 643 | 0 | 0 | 15 Feb 09 - 21 Feb 09 |
| Zambia | 5,763 | 68 | 1.2 | 10 Sep 08 - 04 Mar 09 |
| Zimbabwe | 86,867 | 3,948 | 4.5 | 15 Aug 08 - 02 Mar 09 |
| **TOTAL** | **124,404** | **4,320** | **3.5** | |

Source: Ministries of Health, WHO
* Mozambique: Includes only 2009 figures. MoH is currently reconciling 2008 figures.
** Namibia: Includes cholera cases and Acute Watery Diarrhoea AWD cases.
** * Swaziland: No cases of cholera have been confirmed, only AWD. The total number of cases from December is being reconciled. Consequently, the report only includes figures for Epidemiological week 8.

**NOTE:** Given that countries were reporting on figures using different time periods and methods, OCHA ROSA has implemented a new methodology based on WHO epidemiological weeks for this report. Kindly note, that while great care has been taken to ensure the accuracy of these figures, there may be slight differences, as countries become accustomed to this reporting method.

In Zimbabwe, the epidemic appears to be stabilizing in urban areas, while outbreaks in rural areas remain high or are on the increase. Cholera has now spread to all parts of the country with Matabeleland North (bordering Botswana) being the last to be affected with 1,120 cases reported. Epidemiological data indicates a slight drop in cases from 7,458 to 5,443 respectively

for week seven (7-14 February 2009) and week eight (15-21 February 2009). However, the number of deaths increased from 217 to 234 deaths (CFR 4.3%). Community deaths remain a major concern. Shortages of health personnel and medical supplies remain a critical challenge in stemming the spread.

In South Africa, cholera has nearly doubled from 6, 202 cases to nearly 12,000 cases since 26 January to 2 March 2009. Limpopo and Mpumalanga provinces account for this rise. In Limpopo province, cholera has increased from 3,000 to 6,000 cases, with Mpulmalange showing a similar trend from 3,500 to 6,500 cases. The situation in Limpopo continues to present the greatest challenge with large numbers of vulnerable Zimbabweans continuing to cross into South Africa, with limited access to safe water, sanitation and shelter. A similar trend is observed for Namibia and Zambia, where cholera has almost doubled since the last report. This increase is likely due to the heavy rains received over the past few weeks.

On 19 to 20 February 2009, the World Health Organisation (WHO), UNICEF and the Regional Office for the Coordination of Humanitarian Affairs for Southern Africa (OCHA ROSA) convened a regional cholera meeting in South Africa. Participants included health, water, sanitation, nutrition and other experts from the nine countries affected by the outbreak. The meeting concluded that the Southern Africa region is facing a public health crisis, which has exacerbated the outbreak. To address this, countries are working on developing a diagnostic of gaps, from which it is anticipated that a Regional cholera response and resource mobilisation plan will be developed.

Additionally, from 21 to 25 February 2009, a UN Inter-Agency Mission visited Zimbabwe. The mission was led by Ms. Catherine Bragg, UN Assistant Secretary-General for Humanitarian Affairs and Deputy Emergency Relief Coordinator (ASG / DERC). The UN inter-agency mission comprised OCHA, UNICEF, WHO and WFP. The mission met with President Mugabe, Prime Minister Morgan Tsvangirai, and seven cabinet Ministers from three different political parties. They also met with a broad spectrum of UN agencies, civil society, church-based organisations and representatives of the private sector. The Zimbabwean government acknowledged the humanitarian situation and assured the UN of their full cooperation with humanitarian partners. Current government priorities are health, food security, education, and the return of the Zimbabwean Diaspora. As the cholera epidemic is rapidly expanding to rural areas, the mission emphasized the need to scale-up public health outreach interventions at district and community levels. Early recovery, including the rehabilitation of basic infrastructures in health, water and sanitation needs further prioritisation. After leaving Zimbabwe, the mission travelled to South Africa on 26 February and met with the Government of South Africa, the UN Regional Directors' Team (RDT) and the Regional Inter-Agency Coordination Support Office (RIACSO) and held a press briefing with journalists.

## STATUS BY COUNTRY

### Angola

**Current Situation** – Since January 2008 to 4 March 2009, there were 5,368 cases and 60 deaths (CFR 1.1%). Provinces that remain the most affected include Huila (189 cases and 1 death) and Kwanza Norte (60 cases and 0 deaths). Uige province reported 146 cases and 0 deaths for the period 1 January 2009 to 4 March 2009. Information on cholera cases for the other provinces is unavailable at this time.

Inadequate public waste disposal and poor drainage raise concerns for the potential of larger scale outbreaks as the rainy season progresses. The density of the population provides an environment conducive to rapid transmission. The rainy season, is affecting some border provinces and has provoked floods and displacements. Although of limited scales to date, these displacements put populations at risk of drinking contaminated water and increase the spread of the epidemic.

**Response –** Cholera Treatment Centers (CTCs) remain active in main municipal hospitals and additional treatment supplies (especially ringer lactate) are ready for supplementary pre-positioning. During February 2009, 148 water points have been treated. To ensure continuing water treatment, a further 14,550 liters of calcium hypochlorite have been provided to community groups. In addition, 14,730,000 liters of safe drinking water were provided to at risk-communities at a rate of 2,104,286 liters a day. There is a need for increased strengthening of social mobilisation and communication activities as well as in supporting treatment of water at point of use with tablets and as an alternative to water trucking.

**Gap/s – Need for increase social mobilisation campaigns on hygiene and utilisation of sanitation facilities.**

## Botswana

**Current Situation –** Seven new cases and one death have been reported since 30 January 2009, bringing the total number to 15 cases and 2 deaths (CFR 13.3) for the period 15 November 2008 to 3 March 2009. Majority of the cases are due to trans-border infections. Of the 15 cases reported, 12 of these are reported to have contracted the infection from Zimbabwe. Tutume and Francistown district are the most affected with eight of these 15 cases. The other three cases include two locals that live in Francistown, near the border to Zimbabwe and another case was a traveller from Zambia to South Africa.

**Response –** The Ministry of Health (MoH) and Water Utility conducted more tests on the water quality of Shashe dam in the North East districts, which previously tested positive for Vibrio Cholera. The results were negative in two separate consecutive tests.

Due to the increased number of cases, the MoH has intensified monitoring and surveillance in all districts, especially in Tutume and Francistown districts. As part of its cholera preparedness activities, majority of the districts have revised their Emergency Preparedness Plans (EPR) along with establishing and improving the configuration of their District Emergency Management Committees (DEMC), and Rapid Response Teams (RRT) to strengthen response efforts.

Public education efforts have been intensified. Community mobilisation campaigns focusing on personal hygiene, food safety and sanitation have been initiated in all districts. Sensitization and training of health workers on the prevention and control of cholera cases is ongoing. Health workers at district levels are being trained in epidemic preparedness. WHO will provide technical assistance in the training of Laboratory technicians on 20 March 2009, for the investigation and identification of Vibrio Cholera.

**Gap/s – Increased technical capacity in laboratory testing.**

## Malawi

**Current Situation – T**he country reported 2,320 new cases and 41 deaths (CFR 1.7%) from 9 February to 1 March 2009. The cumulative number of cholera cases stands at 4,171, deaths and 95 deaths (2.2%). The country's case fatality rate (CFR) decreased from 2.8% to 2.2% for this period. All regions (Central, Southern and Northern) of the country are affected by cholera, with the number of affected districts increasing from 14 to 22. All the districts in the Central region are reporting cholera cases. In the Southern region, Phalombe is the only district with no confirmed cholera cases, as is the same for only Nkhatabay district in the Northern region.

The hardest hit district in the Central region remains Lilongwe, with 1,945 cases and 52 deaths (CFR 2.7%) reported since November 2008 to 1 March 2009. The outbreak peaked during Epidemiological week 5 (26 January to 1 February 2009), with 746 cases and 14 deaths registered. Since then, the trend emerging for the number of cholera cases reported per epidemiological week is showing a decline. Epidemiological week 9 showed a drop in the number of cases to 422 and seven deaths (reduction by 324 cases and 7 deaths).

**Response –** Due to the increasing number of districts and sites affected, the MoH is struggling to cope with the demand for additional resources. The Ministry of Health (MoH) made its second appeal for financial and material support on 18 February 2009. The first appeal was made on 12 December 2008. A number of partners responded and WHO was asked by MoH to coordinate the response from partners. The following are some of the partners that responded and are still supporting MoH: DFID; GTZ; Life Line Malawi; Malawi Red Cross Society; MSF-Belgium; MSF-France.; UNICEF; USAID; WFP (food for patients); WHO and World Vision Malawi.

**Gap/s – There is a need for financial, material or human support for outreach to district level.**

## Mozambique

**Current Situation –** During the period 1 January to 28 February 2009, a total of 9, 405 cases and 77 deaths (CFR 0.8%) was reported in ten provinces: Maputo province (120 cases and 1 death); Maputo city (963 cases and 4 deaths); Cabo Delgado (1,273 cases and 18 deaths); Manica (1,770 cases and 5 deaths); Tete (1,171 cases and 14 deaths); Zambezia (622 cases and 11 deaths); Nampula (2, 639 cases and 14 deaths); Niassa ( 293 cases and 6 deaths); Sofala (520 cases and 0 deaths) and Inhambane (34 cases and 4 deaths). Of the country's 144 districts, 45 districts are currently affected. During Epidemiological week eight (15 to 21 February 2009), a total of 1,373 cases and 9 deaths were notified. At present there is no evidence of a significant trans-border epidemic between Zimbabwe and Mozambique. Cholera is endemic in Mozambique and the situation is linked to poor environmental sanitation.

**Response –** The Ministry of Health (MoH) and WHO continue to carry out refresher training of Provincial Rapid Response Teams (RRT) and have conducted training of trainers (TOT) on cholera outbreak investigation and management. A total of 189 technicians in Manica, Zambezia, Tete, Nampula, Cabo Delgado,Sofala and Niassa Provinces were trained.

Cholera Task Forces, headed by MoH have been established to deliver a coordinated response (social mobilisation, water and sanitation, disinfection and primary prevention). Progress has been made in the revitalization of Provincial Technical Coordination Teams through the appointment of health authorities as the coordinator. The PTCTs have developed coordination work plans, as well as a scale-up of cholera prevention activities. Meetings are now taking place regularly with all partners to review actions and adjust the plan accordingly.

WHO provided financial support for the control of the cholera outbreak in Zavala district in Inhambane province and continues to support MoH in monitoring the evolution of the epidemic and strengthening epidemiological surveillance. Mapping of resources needed in the affected districts is ongoing. UNICEF continues to provide supplies (such as chlorine, plastic buckets, plastic basins, tents and other cholera protective equipment) to affected areas.

Currently, two UNICEF teams, each consisting of an emergency surge capacity staff and a WASH specialist, are providing technical assistance to improve coordination, response planning, surveillance and reporting as well as behaviour change communication initiatives. Both teams provided technical assistance and on-site monitoring to strengthen prevention activities and the organisation of treatment centers in the provinces of Manica and Nampula, Niassa and Sofala.

Social mobilisation campaigns via radio programmes and debates, multimedia mobile units and theatre activities is being scaled up in cholera affected areas, particularly in Tete, Cabo Delgado, Zambezia, Manica and Sofala. MoH and health partners have allocated funds for strengthening surveillance, preparedness and community mobilisation, using their own internal funds.

**Gap/s – Additional funds is needed to strengthen surveillance, preparedness and response, particularly in districts with high transmission risk and border districts to countries affected by cholera.**

## Namibia

**Current Situation** – Since last report issued, cholera has almost doubled. The country has reported 90 new cases and five deaths (CFR 5.6%) since 9 February to 3 March 2009. The cumulative number of cases stands at 193 cases and 11 deaths (CFR5.7). All cases are reported in the Opuwo District in the Kunene Region. The main cause of the outbreak is due to a lack of proper sanitation facilities and potable water.

The heavy rains in the Caprivi and Kunene region may exacerbate the cholera outbreak. The Regional Emergency Committee has emphasized the need for health workers to remain vigilant.

**Response –** The Regional Emergency Committee, activated by the Regional Health Committee continues to monitor the situation and meets regularly. It has also intensified social mobilisation campaigns on a continuous basis and is distributing water purification tablets. The construction of VIP latrines has commenced, and surveillance of affected areas has been intensified. Adequate supplies for the treatment of cholera have been provided and Information, Education and Communication (IEC) material on cholera produced.

**Gap/s – None**

## South Africa

**Current Situation** – Cholera has nearly doubled with 5,777 new cases and 15 deaths (CFR 0.2%) reported from 23 January to 2 March 2009. In total, there are 11,979 cases and 59 deaths (CFR 0.4%) reported since the onset of the outbreak on 15 November 2008 to 2 March 2009 in all nine provinces of the country. Mpumalanga (bordering Mozambique and Swaziland) and Limpopo provinces (bordering Zimbabwe) have the highest concentration of cholera cases with 6,585 cases and 30 deaths (CFR 0.46) and 5,088 cases and 24 deaths (CFR 1.44%) respectively. Cholera continues to spread to the more central parts of the country, Gauteng province, the economic hub of the country, has recorded 278 cases and 4 deaths (CFR 1.44%). Most of the suspected cases are people who have a travel history to either Zimbabwe or Musina. Other suspected cases were found to have been in contact with persons who travelled to these areas.

**Response** – Throughout the country the Department of Health along with partners is strengthening surveillance as well as scaling-up social mobilisation campaigns aimed at hygiene promotion, food hygiene, etc. The provision of clean water and sanitation facilities remains a priority.

In Limpopo province, the Government has provided R18m (US$ 1.7m) for the installation of a mobile water purification plant in the affected areas. However, R6 billion (US$ 570m) is needed for water infrastructure and sanitation facilities for to contain and prevent a further spread of the outbreak. The municipality had distributed awareness pamphlets to the affected villages, provided bleach and conducted roadshows.

Given that the cholera epidemic is largely due to trans-border infections, a multi-sectoral meeting was held with the Department of Home Affairs: Immigration, Department of Labour and Department of Agriculture to discuss efforts to contain and prevent the further spread of the outbreak. Training has been conducted for hospitals and clinic staff with an emphasis on surveillance and preparedness.

**Gaps - Need to intensify health campaigns.**

## Swaziland

**Current Situation** – During Epidemiological week eight (15 – 21 February 2009), the country reported 643 Acute Watery Diarrhoea (AWD) cases and zero deaths. AWD has now spread to all four regions of the country, with Manzini region being the latest to be affected. The country's 2009 figures are being reconciled, and a cumulative total since the onset of the outbreak on 22 December 2008 is unavailable. The situation is of particular concern due to the geographic location of Swaziland as it borders the affected South African province of Mpumalanga.

**Response –** A cholera contingency plan has been drafted and is being implemented. Preparedness activities have been accelerated. The Government has established a Cholera Task Team to prepare guidelines for health workers. Training of health workers is also being planned. Assessments of health facilities are being undertaken.

**Gaps – There is inadequate information, education communication (EC) materials as well as a shortage of cholera treatment kits. There is a need to mobilize funding.**

## Zambia

**Current Situation –** From 10 September 2008 to 4 March 2009, the country recorded a cumulative total of 5,763 cases and 120 deaths in 29 districts in eight provinces of the country. This is an increase of 2,016 cases and 70 deaths (3.4%) compared to the last report issued on 9 February 2009. Rainfall has increased around Lusaka in the past week and this might further worsen the situation.

According to the National Epidemic Preparedness Committee (NEPC), the distribution of cases among children is cross-cutting all age groups between one and 14 years; compared to previous trends where more children under five-years were affected.

**Response** - The government with assistance from limited partners such as MSF continue to respond to the cholera situation which by and large has been brought under control. In addition, other Government institutions such as department of water affairs, Lusaka Water and Sewerage Company (LWSC) have joined the fight against the cholera situation. The NEPC has called for strengthening the provision of suitable sanitary facilities, along with social mobilisation campaigns focused on hygiene and utilisation in areas with inadequate toilet coverage. Strong community involvement is needed as utilisation is linked to behaviour change.

Gap/s – **A comprehensive cholera mitigation plan from MoH has yet to be presented. Additionally, MoH is requesting for more technical and financial assistance for improved cholera prevention communication tools.**

## Zimbabwe

**Current Situation** – From 4 February to 2 March 2009, 18, 922 new cases and 577 deaths (CFR 3.0) were reported in ten provinces of the country. Epidemiological data for week seven (7-14 February 2009) and week eight (15-21 February 2009), shows that new cholera cases and deaths is on the decrease. Week eight in comparison to week seven noted a 25% decrease in cases and a 42% decrease in cholera deaths. However, it is hoped that figures in the next coming weeks may confirm this trend. The institutional Case Fatality Rate (CFR) came down from 1.7% to 1.4%, whereas the crude CFR dropped from 4.3% to 3.3%. Over 60% of all new cases in week eight came from three provinces: Masvingo, Midlands and Mashonaland Central, and 54% of all new deaths for the same week came from the other provinces: Manicaland, Mashonaland West and Harare.

Cholera cases in urban areas have reduced, but the outbreak is continuing to make inroads into rural areas. The number of community deaths is still disproportionately high and continues to be a major concern. WHO forecasts that if the epidemic continues to spread at current rates, more than 123,000 people could be infected by May 2009, compared to previous estimates of 92,000 cases. Thirty cholera strains have been found in the country's water, according to findings released by the International Centre for Diarrhoeal Disease Research (ICDDR) mission to the country in January, with the support of the World Health Organisation (WHO). The mission tested borehole, tap water, drain water, and shallow wells for the virus as well visited health centres.

The Assistant Secretary-General for Humanitarian Affairs and Deputy Emergency Relief Coordinator, Ms. Catherine Bragg led a UN inter-agency mission to Zimbabwe from 21 to 25 February 2009. As the cholera epidemic is rapidly expanding to rural areas, the mission called for scaling up public health outreach interventions at district and community levels. Early recovery, including the rehabilitation of basic infrastructures in health, water and sanitation needs further prioritisation.

**Response –** Of the total of 448 Cholera Treatment Centres/Units (CTC/U) that have been in existence since the start of the current cholera outbreak in August 2008, some 119 CTC/Us have closed, while the remaining 329 CTC/Us are still operating, most of which are located in Manicaland, Mashonaland West and Masvingo.

The Education and Water, Sanitation and Hygience (WASH) Clusters joined forces and established a technical working group to develop a cholera strategy for schools. The group developed a Cholera Education Strategy, IEC materials and basic hygiene materials (kits). Distribution of these materials will be done prior to, or soon after opening of schools. The WASH cluster continues to rehabilitate water points; however a recent survey of six rehabilitated water points showed that half had become re-infected, underscoring the need to continue monitoring of water sources and water points.

**Challenges -** Significant delays in the procurement and logistics of essential medical and non-food-items (NFIs) is being experienced. Delays are due to the large amounts of NFIs required within the region. Several organisations report that while producers in South Africa are working hard to meet the demand for NFIs, their capacity is being overstretched. In addition there is a bottleneck at Beitbridge border between South Africa and Zimbabwe, which can result in delays of up to three weeks.

Despite the delays, UNICEF-procured NFI stocks are now arriving in the country and will, with assistance from WFP, be transported to five warehouses around the country for allocation to UNICEF implementing partners for distribution to beneficiaries in priority areas.

Human traffic between high incidence locations of Bulawayo and Beitbridge, through Gwanda district is a likely transmission route for the spread of cholera and preparedness and response interventions need strengthening.

Gap/s – **There are shortages of ORS (Oral Rehydration Salts) needed to treat cholera. Need for NFIs, as South Africa (regional supplier) has a backlog. Additional capacity needed for strengthening response in rural communities.**

For more information refer to: http://ochaonline.un.org/zimbabwe.

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