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# REGIONAL FRAMEWORK FOR THE IMPLEMENTATION OF THE GLOBAL STRATEGY FOR CHOLERA PREVENTION AND CONTROL, 2018–2030

**Report of the Secretariat**

## EXECUTIVE SUMMARY

1. Cholera is an acute diarrhoeal infection caused by ingestion of food or water contaminated with the bacterium *Vibrio cholerae*. It has a short incubation period of two hours to five days. The infection is often mild or without symptoms but severe in 20% of cases. It affects both children and adults. In severe cases, cholera can rapidly lead to death by dehydration within hours, if left untreated.

2. Cholera mostly affects poor communities with low socioeconomic status. The most vulnerable populations are those residing in overcrowded areas with limited safe water and sanitation services, including unplanned mass urbanization. The 2017 WHO-UNICEF joint annual report on water and sanitation (based on 2015 data) indicates that globally, 663 million people lack access to safe drinking-water and over 2 billion people drink water from sources that have faecal contamination. In addition, displacements due to conflicts, natural disasters and extreme climatic changes are creating favourable conditions for cholera outbreaks in many settings across the globe.

3. Due to the above risk factors, cholera has remained a major public health problem. Globally, an estimated four million cholera cases and over 140 000 deaths are reported annually. In 2017 alone, over 150 000 cholera cases, including 3000 deaths, representing a case fatality rate (CFR) of 2.3%, were reported from 17 countries in the African Region. More than 90% of these cases were from six high-burden countries. This raises concern about the potential further increase of the cholera burden, including large-scale outbreaks in big cities.

4. Cholera is a recurrent outbreak with clear seasonality in most endemic areas. The persistence of cholera in these places reflects weaknesses in water and sanitation infrastructure and services, high-risk hygiene and social practices, gaps in surveillance and health care systems. In addition, insufficient political and financial commitments are contributing to prolonged recurrent outbreaks. More than 80% of affected countries report insufficient financing to meet their Water, Sanitation and Hygiene (WASH) targets.

5. Due to the high and increasing cholera burden and numerous challenges, the Global Task Force on Cholera Control (GTFCC) developed a global roadmap to end cholera by 2030. This Regional Implementation Framework with key milestones will guide the Member States to implement the global strategy to achieve the elimination of cholera by 2030.

6. The Framework proposes concrete actions which include, among others, enhancing epidemiological and laboratory surveillance, mapping cholera hotspots, improving access to timely treatment, strengthening partnerships and community engagement, increasing investments in clean water and sanitation for the most vulnerable communities, and promoting research. These will require increased political and financial commitments, coupled with meticulous monitoring and evaluation of implementation.

7. The Regional Committee is invited to examine and adopt the actions proposed in this Framework.

**CONTENTS**

**ABBREVIATIONS**

| | |
|---|---|
| CFR | Case Fatality Rate |
| CTC | Cholera Treatment Centre |
| CTU | Cholera Treatment Unit |
| EPR | Emergency Preparedness and Response |
| IDSR | Integrated Disease Surveillance and Response |
| IHR (2005) | International Health Regulations (2005) |
| IPC | Infection prevention and control measures |
| IV Fluids | Intravenous Fluids |
| GTFCC | Global Taskforce on Cholera Control |
| GDP | Gross Domestic Product |
| OCV | Oral Cholera Vaccine |
| ORS | Oral rehydration solution |
| RRT | Rapid Response Team |
| RC | Regional Committee |
| SDGs | Sustainable Development Goals |
| UAH | Universal access to health services |
| UHC | Universal Health Coverage |
| VRAM | Vulnerability Risk Assessment and Mapping |
| WASH | Water, Sanitation and Hygiene |
| WHO | World Health Organization |

## INTRODUCTION

1. Cholera is an acute diarrhoeal infection caused by ingestion of food or water contaminated with the bacterium *Vibrio cholerae*. It is a preventable and treatable disease caused by inadequate hygiene associated with poor socioeconomic status, insufficient water and sanitation. Cholera remains a major public health problem with about 1.3 to 4.3 million cases and 21 000 to 143 000 deaths occurring each year globally.[1]

2. The burden and impact of cholera epidemics are greatest in Africa, particularly in sub-Saharan Africa, where case fatality rates (CFRs) have exceeded the upper threshold of 1% since 2014. Between 2006 and 2015, approximately 752 000 cases, including 17 400 cholera-related deaths were reported in East and Southern Africa with an average CFR of 2.3 %.[2]

3. Cholera epidemics are intrinsically linked to development. The Gross Domestic Product (GDP) of an affected country can decrease by approximately 2.0 to 2.5% in the first year of an epidemic.[3] Cholera control measures contribute towards achieving the 2030 Sustainable Development Goals (SDGs) and universal access to basic health services.

4. To address the risk factors of the continued transmission of the cholera epidemic in the African Region, this Framework has been developed to facilitate the implementation of the Global Strategy for cholera prevention and control by Member States. The Framework describes the priority interventions, actions, targets and milestones for the reduction of morbidity and mortality associated with cholera.

## CURRENT SITUATION

5. The African Region has experienced further deterioration of humanitarian crises and disease outbreaks, including cholera. Persistent inadequate water and sanitation in some countries have contributed to protracted cholera outbreaks in recent years. These pose a serious challenge to public health and impact on development.

6. An estimated 159 million people still draw drinking-water directly from surface water sources, and 58% of them live in sub-Saharan Africa.[4] Despite efforts to reduce cholera transmission by increasing access to safe water, continued outbreaks have had a significant impact on the livelihoods of communities and affected the economies of the Member States. Over 80% of the affected countries report insufficient financing to meet their Water, Sanitation and Hygiene (WASH) targets to reach the Sustainable Development Goals (SDGs) in 2030.[5]

7. An analysis of 35 sub-Saharan African countries revealed that in urban areas and periurban slums, more than 90% of the richest quintile of the population uses improved sanitation and drinking-water and 60% have piped water on their premises. The poorest quintile of the population lives in

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1 World Health Organisation (2017); Cholera Fact Sheet (Accessed Feb 5 2018 at: http://www.who.int/mediacentre/factsheets)

2 World Health Organisation (2015); WHO (2015) Cholera case fatality rate (Accessed Feb 5 2018 at: http://www.who.int/gho/epidemic_diseases/cholera/case_fatality_rate_text/en/

3 Oxford Economic; Economic impact of a cholera epidemic on Mozambique and Bangladesh, 2010; (pp.4 – 5); (Accessed on Feb 10 2018 at: https://www.oxfordeconomics.com/publication/open/222590

4 World Health Organization, UNICEF. Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. World Health Organization; 2017. (pp.9-10); (Accessed on Feb 8 2018 at: http://www.who.int/mediacentre/news/releases/2017/launch-version-report-jmp-water-sanitation-hygiene.pdf

5 World Health Organisation (2018); Ending Cholera: A Global Roadmap To 2030; (Accessed on Feb 8 2018 at: http://www.who.int/cholera/publications/global-roadmap.pdf

rural areas where piped water is less available and open defecation is practised by more than 60% of households.[6]

8. Since 2015, cholera epidemics have been reported from seventeen (17) African countries. In 2017, a total of 150 167 suspected cases, including 3165 deaths (CFR 2.3%), were reported, twice as many as were reported in previous years. More than 90% of these cases were reported from six high-burden countries.[7] In 2017, WHO supported cholera response operations in 17 countries, focusing on multisectoral coordination, epidemiological surveillance, laboratory capacity, case management, Water, Sanitation and Hygiene (WASH) activities, risk communication and community engagement strategies for all graded emergencies.

9. With regard to enhancing surveillance, 44 countries (94%) out of 47 have adapted and are implementing the Integrated Disease Surveillance and Response (IDSR) technical guidelines. Furthermore, 64% (30 out of 47) of the countries have commenced community-based surveillance implementation, and 36 countries (76%) reported that they are implementing event-based surveillance.

10. From 2013 to 2017, WHO supported 65 Oral Cholera Vaccination (OCV) campaigns and supplied 16.2 million doses of vaccines to 18 countries globally. Eleven African countries[8] have successfully implemented OCV campaigns, most of them in the context of ongoing humanitarian crises or natural disasters. OCV is being rapidly integrated into cholera prevention and control plans; however, there are no clear linkages to WASH investments.

## ISSUES AND CHALLENGES

11. **Low-risk analysis and mapping to predict outbreaks:** There is inadequate availability of information to support the prediction of the outbreak seasonality. This has led to inadequate preparedness and limited pre-emptive response efforts for controlling cholera outbreaks in the Region.

12. **Low declaration of outbreaks and non-compliance with the International Health Regulations (IHR 2005):** A number of Member States have not always notified WHO in a timely manner in compliance with the IHR (2005). Under-reporting is also common in countries where tourism represents a good portion of the revenues, increasing the risk of international spread.

13. **Weak surveillance systems and under-reporting:** This is due to poor data quality, limited data use and inadequate national capacity. There is also inadequate availability of trained staff at the peripheral level, with limited or poor cross-border surveillance for early detection of cases.

14. **Low access to WASH services:** The persistence of cholera outbreaks is predominantly due to inadequate access to safe water, poor sanitation infrastructure and unhealthy behavioural hygienic practices. Risk factors such as humanitarian crises, natural disasters (floods) and unplanned rapid urbanization have had a significant impact on the livelihoods of communities.

15. **Long-lasting conflict, poverty and famine:** Humanitarian crises, political instability, and poverty often result in displacement, especially of vulnerable populations, leading to overcrowded areas, such as camps for internally displaced persons or refugees and periurban slums. Such

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[6] UNICEF; Water, sanitation and hygiene; The case for support (Accessed 10 Feb 2018 at: https://www.unicef.org/publicpartnerships/files/WASHTheCaseForSupport.pdf

[7] Ethiopia, Democratic Republic of the Congo, Kenya, Nigeria, South Sudan and United Republic of Tanzania.

[8] Cameroon, Democratic Republic of the Congo, Ethiopia, Guinea, Malawi, Mozambique, Niger, Nigeria, Sierra Leone, United Republic of Tanzania and Zambia.

settlements frequently have limited safe water and sanitation services. Moreover, the latter is compounded by inadequate or absence of health care infrastructure. These factors increase the risk and severity of cholera outbreaks in the affected population.

16. **Low community-based interventions and risk communication:** Inadequate risk communication and insufficient community sensitization campaigns have contributed to the failure to control cholera outbreaks in the Region. There is low community adherence in the adoption of appropriate hygiene practices, safe food and water preparation, due to low promotion of risk communication campaigns and community engagement strategies in at-risk countries.

17. **Insufficient political commitment:** There is often inadequate involvement and political commitment at the highest levels of national governments to implement cholera prevention and control measures. This has contributed to delays in intervention thereby facilitating the spread.

18. **Ineffective coordination and weak multisectoral collaboration:** The limited or lack of collaboration and coordination with non-health partners and resources has contributed to ineffectiveness of the overall response to cholera outbreaks in the Region.

19. **Inadequate monitoring and evaluation:** Ineffective monitoring processes and the absence of monitoring and evaluation frameworks at the country level hamper the timely identification of response challenges or constraints and measures to address them. Additionally, irregular evaluation of response operations may hamper planning for future cholera preparedness and response.

20. **Insufficient Research:** Research is currently inadequate to find the root causes of the cholera outbreaks, their natural reservoir and mode of transmission to humans in order to improve prevention and control of cholera by Member States.

## THE REGIONAL IMPLEMENTATION FRAMEWORK

21. A strategic shift is needed to implement a comprehensive response to cholera outbreaks. This Framework outlines comprehensive, proactive and targeted measures to prevent cholera.

### Vision, Goals, Objectives, Targets and Milestones

### Vision

22. An African Region free of cholera epidemics by 2030.

### Goal

23. To reduce the morbidity, mortality and socioeconomic impact of cholera epidemics in the African Region.

### Objectives

24. The objectives are:

(1) To contribute to the global goal of eliminating predictable cholera epidemics by 2030.
(2) To reduce by 90% the magnitude of cholera outbreaks particularly among vulnerable populations and during humanitarian crises by 2030.

**Targets and Milestones:**

25. Targets

(1) Reduce by 100% the number of countries experiencing cholera outbreaks by 2030.

(2) Reduce the number of cholera cases to less than 50% of the current level by 2022.

(3) Reduce the case fatality rate for cholera to less than 1% by 2022.

26. Milestones

(1) Contribute to the global goal of eliminating predictable cholera epidemics**:** All Member States will have:

(a) Cholera focal points at the national level by 2019.

(b) Cholera outbreak Emergency Preparedness and Response (EPR) plans by 2019.

(c) Strengthened their national capacities for cholera preparedness and response by 2020.

(d) Established robust multisectoral and partner coordination mechanisms at the national and subnational levels by 2020.

(e) Mobilized the required technical and financial resources at all levels by 2022.

(f) Identified and mapped cholera hotspots in affected countries at all levels by 2022.

(g) Enhanced cross-border surveillance at all levels by 2025.

(h) Fully funded the long-term multisectoral cholera prevention and control plans by 2025.

(i) Implemented the multisectoral cholera prevention and control plans at all mapped hotspots and all levels by 2030.

(2) Reduce by 50% the magnitude of cholera outbreaks particularly among vulnerable populations and during humanitarian crises. All Member States will have:

(a) Conducted risk assessment and mapping by 2019.

(b) Established Rapid Response Teams (RRTs) for field investigation and risk evaluation by 2019.

(c) Established sufficient and specific capacity for cholera case management by 2020.

(d) Developed a comprehensive cholera social mobilization strategy and community-based interventions by 2020.

(e) Strengthened or set up functional epidemiological and laboratory surveillance systems at all levels by 2022.

(f) Ensured water quality interventions in affected cholera hotspots and at-risk communities by 2025.

(g) Maintained WASH investment and operation costs at all affected hotspots and communities by 2030.

(3) **Ensure regular monitoring, evaluation and adaptation of the regional cholera framework:** All Member States will have**:**

(a) Identified monitoring and performance indicators and defined quality control mechanisms for planned interventions by 2019.

(b) In collaboration with WHO, developed investment case(s) for cholera control by 2020.

(c) Documented challenges and lessons learnt, and utilized this information for decision-making by 2022.
(d) In collaboration with WHO, defined integrated quality control mechanisms for assessing the implementation of the Framework by 2025.

## 27. GUIDING PRINCIPLES

(a) **Government ownership, leadership and accountability:** Elimination of predictable cholera epidemics requires strong government leadership, ownership, investment and accountability at all levels.

(b) **Human rights, gender equity and equality:** All cholera prevention and control interventions should be based on promoting human rights, gender equality and equity in accessing health care, and basic water, hygiene and sanitation services.

(c) **Evidence-based and forward-looking actions:** This Framework will promote the use of evidence-based policies, services and interventions, to ensure that high-quality and effective interventions are used.

(d) **Community engagement and participation:** Member States are urged to emphasize community-based interventions, ensure active community participation and ownership of local governments, civil society, local leaders, religious leaders and individual citizens.

(e) **Multisectoral and multidisciplinary approaches:** Broad partnerships, multisectoral and multidisciplinary coordination mechanisms are critical for success.

(f) **Domestic financing:** Sustaining interventions requires mobilization and proper allocation of domestic resources. For long-term sustainability, the financing of cholera interventions should be supported from domestic resources.

(g) **Regional integration and cross-border collaboration:** responding to public health risks requires a multisectoral and coordinated approach within countries and cross-border collaboration with neighbouring countries.

## PRIORITY INTERVENTIONS AND ACTIONS

28. This Framework proposes priority interventions that should be aligned with strategies for achieving universal health coverage (UHC2030) and all the SDGs. These priority interventions cut across three specific SDGs, namely SDG 6 to “ensure availability and sustainable management of water and sanitation for all”, SDG 3 to “ensure healthy lives and promote well-being for all at all ages” and SDG 11 to “make cities and human settlements inclusive, safe, resilient, and sustainable”

**Member States are urged to undertake the following actions:**

***Information for focused action***

29. **Conduct risk analysis, mapping and profiling:** Conducting systematic cholera Vulnerability Risk Assessment and Mapping (VRAM) will enable Member States to characterize the risks and identify coping capacities. This will provide a clearer picture of the epidemiology of cholera at local levels including mapping of cholera hotspots.

30. **Strengthen cross-border surveillance, improve notification and compliance** to facilitate cross-border surveillance and real-time information sharing, including nominating cholera focal points in at-risk countries and agreeing on cross-border activities. The cholera focal point should collaborate with the national IHR (2005) focal point to ensure timely and regular sharing of information with neighbouring countries in case of outbreaks.

***Interventions for impact***

31. **Strengthen capacities to anticipate cholera epidemics:** Comprehensive implementation of IDSR at health facilities and community levels will facilitate early detection, reporting and control of cholera outbreaks. Epidemiological surveillance for timely detection of suspected cholera cases should be complemented by additional investments in laboratory capacity for rapid confirmation of suspected cases. This should be complemented by setting up early warning surveillance systems and cross-border surveillance.

32. **Promote safe water and proper sanitation services** by investing in improving access to clean potable water, adequate sanitation and promotion of hygiene practices as the mainstay of prevention of both endemic cholera and outbreaks. Local leaders in rural areas and municipalities (including mayors) should be empowered to enforce and monitor standards of household and community-level hygiene practices such as availability of latrines, protected water sources and handwashing facilities.

33. **Strengthen case management** in order to establish adequate capacities to provide access for prompt and effective treatment of cholera patients. This should include quick access to the life-saving Oral Rehydration Solution (ORS) therapy. Case management materials should be stocked and pre-positioned in high risk areas. Other interventions should include adequate training of health workers, improving health infrastructure, services and medical technologies, providing clear treatment guidelines, and ensuring prompt patient referral.

***Communication for behavioural change***

34. **Strengthen community-based interventions and implement risk communication strategies** to ensure that effective public health preparedness and response measures are in place by strengthening proactive communication through continuous messaging before and during cholera outbreaks. Mechanisms for ensuring active participation and involvement of local governments, civil society, local/traditional leaders and individual citizens should be developed and implemented. Engaging community structures in establishing, monitoring and maintaining water and sanitation infrastructure will be the main cornerstone for eliminating cholera.

***Financing for sustainability***

35. **Strengthen leadership and political commitment** by prioritizing cholera prevention and control, starting with the involvement at the highest levels of government to ensure that all relevant national ministries (beyond the health sector) are adequately involved. To achieve elimination targets, cholera should be given greater prominence through its inclusion in national policies and plans either as a stand-alone plan or embedded within broader disease control initiatives or within national health, WASH and development, and SDG implementation plans where relevant.

36. **Commit to develop an investment case and increase domestic funding** to ensure long-term sustainability of the national cholera control programme, as well as guarantee the continuation and strengthening of the current funding streams to sectors, departments, ministries, subnational levels and agencies involved in the implementation of national cholera control plans.

37. **Strengthen partnerships and multisectoral collaboration** to coordinate cholera activities with a broad range of partners, at the national, regional and global levels. Strong coordination mechanisms and forums should be established to facilitate a multisectoral, collaborative approach, given the risk factors for cholera that lie outside the health sector.

***New innovative tools for an old disease***

38. **Promote the use of Oral Cholera Vaccine (OCV)** as part of a multisectoral cholera control plan to complement other cholera control measures. When indicated, OCV should be administered in a timely manner to control outbreaks and prevent further spread as indicated in the guidelines.[9]

39. **Promote research and development:** Invest in research and development in order to improve knowledge for prevention and control of cholera. Operational research should be undertaken on local issues, including effectiveness of sociocultural interventions, how to maximize the use of existing tools (technologies, drugs, vaccines, biomolecular technologies) and how to monitor drug susceptibility.

***Monitoring for quality and accountability***

40. **Strengthen mechanisms for monitoring and mutual accountability:** Ensure that systems and tools are developed for multisector monitoring of targets towards achieving the milestones and objectives. Regular joint multisector monitoring and evaluation of the status of framework implementation should be conducted to learn lessons for improvement.

**WHO and Partners are urged to undertake the following actions:**

***Shared responsibility, collective accountability***

41. **Ensure partnership and multisectoral collaboration:** WHO, in collaboration with Member States, will cooperate and coordinate its activities with a broad range of partners at the national, regional and global levels. Responding to public health risks requires a multisectoral and multiagency coordinated approach. WHO and UNICEF will continue to spearhead their joint work in supporting Member States in addressing the situation of water, sanitation and hygiene in the Region.

42. **Effectively coordinate interventions:** WHO commits to convene and ensure global coordination of cholera control initiatives and increase the visibility of cholera as a major public health threat. Through the Global Taskforce on Cholera Control (GTFCC), WHO will play a coordinating role in bringing on board external partners and providing adapted technical expertise to Member States.

43. **Facilitate use of OCV:** WHO will facilitate the registration and stockpiling of OCV in Member States to ensure prompt vaccine deployment and provide support for effective vaccine delivery strategies. WHO and partners will continue to encourage Member States to use OCV as a complement to the standard cholera intervention package especially in high-risk countries.

44. **Strengthen Member States' capacities to anticipate cholera epidemics (readiness):** WHO and partners will work with Member States to build capacity in all aspects to eliminate cholera. These include cholera prevention, preparedness, operational readiness and response.

45. **Compliance monitoring:** WHO will strengthen monitoring and improve compliance of Member States with IHR (2005) requirements, especially timely and mandatory reporting.

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[9] World Health Organization (WHO) Guidelines on Use of Oral Cholera Vaccines, 2017 (Accessed on Apr 16, 2018 at: http://www.who.int/cholera/vaccines/en/

46. **Promote research and development:** WHO will coordinate and facilitate the efforts of Member States and partners to undertake research in order to build evidence and improve on cholera interventions. Under the leadership of Member States, WHO will set the research agenda and strengthen mechanisms for the necessary ethics approvals to facilitate operational research and long-term scientific studies to document and better understand issues pertaining to cholera.

47. **Monitoring and evaluation:** WHO shall continuously monitor long-term cholera control and elimination programmes at the country and regional levels. WHO and partners will produce and disseminate regular reports on cholera and conduct analyses of risk factors to enable timely remedial actions.

48. The WHO Regional Director shall report to the Seventieth session of the Regional Committee for Africa, and on a regular basis thereafter, on the implementation of the Framework.

## ACTIONS PROPOSED

49. The Regional Committee is invited to examine and adopt the actions proposed in this Framework.