

The Council for Scientific and Industrial Research (CSIR)

**REGIONAL CHOLERA RESPONSE DISCUSSION**

*Proceedings*

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**Proceedings authors:**

*Funke, N., Jacobs, I., Said, M., Nienaber, S., and Steyn, M.*



## **EXECUTIVE SUMMARY**

The Water Resources Governance Group of the Council for Scientific and Industrial Research (CSIR) has a broad research focus which aims to explore the various elements that make up the political economy and social-ecological systems in relation to water. This involves the consideration of the relative fragility of states and societies in relation to environmental and livelihood security.

Out of these broad aims this research unit has developed a more specific area of interest which explores the relationship between water-borne disease and human security, particularly in terms of the transboundary nature, links and impacts of such diseases. The devastation of the 2008 cholera outbreak in Zimbabwe, and the resultant impact on neighbouring states provoked a particular interest and concern in relation to cholera.

Thus, in order more deeply understand the impacts of cholera within the SADC region the CSIR hosted a one-day workshop on Wednesday 30 September 2009. The workshop took the form of a multi-stakeholder engagement that sought to obtain expert input and insights on some potential research questions identified by the CSIR on cholera as a Transboundary (or cross-border) communicable disease that requires complex interventions in terms of preparedness and response, management, prevention and mitigation.

The workshop commenced with a presentation of preliminary findings on the status of regional responses and concerns about cholera in SADC member states. This was followed by a discussion about the presentation. The deliberations made it apparent that cholera is now endemic in the SADC region and should be addressed both from a health and a political point of view. Other important points that arose were the need for a regional response (with SADC playing an important coordinating role) to cholera, and the need to strengthen national healthcare systems. The strengths and

weaknesses related to the International Health Regulations (IHR) were also discussed.

Following the presentation, four research questions were posed:

**Question One:** “Is cholera prevention, preparedness and response a regional or national issue?”

**Question Two:** “What are the challenges at the global, regional, national and local level to cholera prevention, preparedness and response?”

**Question Three:** “How can we create an enabling environment for cholera prevention, preparedness and response in the region?”

**Question Four:** “What form can an effective regional coordinating mechanism take?”

Feedback and inputs elicited from the workshop participants are hereby presented in this report.

## INTRODUCTION

Cholera remains a latent health threat in Southern Africa. The most recent outbreak that originated in Zimbabwe in August 2008 resulted in 98 424 suspected cases and 4276 deaths in the country according to the Ministry of Health and Child Welfare in Zimbabwe (World Health Organization, 2009a). Ten countries in Southern Africa are currently affected by cholera either as a result of the Zimbabwe outbreak or independently of it. These countries are Angola, Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia, Zimbabwe (Kiem, 2009) and the Democratic Republic of the Congo (DRC). The table below illustrates the magnitude of the impact on other countries in the region at the time.

<b><u>Country</u></b>	<b><u>Predicted Cholera Cases</u></b>	<b><u>Recorded Deaths</u></b>	<b><u>Date of data record</u></b>
Malawi	-	104	20 March 2009 (Banda 2009)
Mozambique	9533	119	March 2009 (WHO 2009b)
South Africa	12000	59	10 March 2009 (AFP 2009)
Southern DRC	1596	14	10 Febraury 2009 (WHO 2009b)
Zambia	4354	55	10 Febraury 2009 (WHO 2009b)
Zimbabwe	98424	4276	30 May 2009 (WHO 2009a)

Cholera is an acute intestinal infection. It has a short incubation period and manifests itself as copious, watery, painless diarrhoea which results in extreme dehydration of the body. The infection can be fatal if treatment is not administered rapidly enough (World Health Organization, 2009c). Cholera is caused by the bacterium *Vibrio cholerae*; which is transmitted via faecally contaminated food and water (Easmon, 2005). This makes the spread of the disease more likely in countries

where access to safe drinking water and adequate sanitation cannot be guaranteed (World Health Organization, 2009c).

The world's population is vulnerable to the emerging and re-emerging threats of communicable diseases such as cholera. The recognition that communicable diseases do not respect geopolitical boundaries of nation states led to the inception of the International Health Regulations (IHR), in 1969 (Lee and Dodgson, 2000). Over the years, the IHR have undergone many revisions to the point of their adoption into international law in 2007; so as to provide the legal framework for international co-operation for the control of infectious diseases such as cholera (WHO, 2007). The IHR, amongst other things, obligates WHO Member States to notify WHO of any outbreaks of diseases in their countries that have the potential to cross borders and threaten public health worldwide, so as to monitor global outbreaks of diseases.

The World Health Organisation (WHO) recommends that in the event of a cholera outbreak in a region, neighbouring countries should improve on their preparedness to respond to such an outbreak and improve on their surveillance for the purpose of risk assessment, early detection and timely response (WHO, 2008). Such efforts could be more easily facilitated through international conventions that promote the importance of the need to multilaterally control cross-border spread of diseases.

The trigger of the most recent onset of cholera in Zimbabwe is not known for certain. In Zimbabwe, the sudden increase of cholera to epidemic proportions was facilitated by the breakdown of basic water and sanitation services. The subsequent movement of economic migrants from Zimbabwe into neighbouring countries, some of whom may already have had cases of cholera, played a significant role in the geographic spread of the epidemic.

The SADC countries are individually bound by international conventions (for example the International Health Regulations and SADC Health Protocol) to report a communicable disease such as cholera. In most instances, such information will

reach international organisations before it reaches the individual countries in a region. Thereafter epidemiological communiqués of epidemics such as cholera are then issued through world bodies such as the WHO and the CDC (Center for Disease Control). This information loop can be made more effective if disease related information is shared with all countries in a region immediately and simultaneously once an outbreak is confirmed so that these countries are given a head start in mobilising their resources in anticipation of outbreaks that may infiltrate their borders.

Out of this broad context and set of challenges facing the SADC region in relation to cholera, the CSIR water resources governance group, aims to deepen their understanding about the transboundary nature, links and impacts of cholera in the region. This process has been started by hosting a workshop to explore the nature of the transboundary challenge cholera poses to Southern Africa. In so doing it is the hope that eventual recommendations can be developed for creating a more co-ordinated and effective cholera response in SADC.

## **OBJECTIVES OF WORKSHOP**

The CSIR hosted workshop was held on 30 September 2009 at the CSIR Knowledge Commons in Pretoria. 16 participants engaged in this process (please see appendix 1 for the participant list).

The workshop had two objectives. The first objective was to elicit input from the workshop participants on a few important questions that had emerged out of preliminary research that CSIR had conducted on the notion of a regional response to cholera.

The second objective was to establish a network of actors, who are interested in taking forward collaborative discussion and research on a regional response to cholera. The participants invited to the workshop represented a variety of institutions namely; international organisations (WHO), international non-governmental

organisations (NGO) (Oxfam, MSF), research institutions (CSIR, University of Pretoria), local NGO's (Mvula Trust), and the National Department of Health (South Africa). The participants at the workshop were experts with varying degrees of experience in their respective fields.

This workshop sought to address the following overarching question, "Who takes responsibility for regional health emergencies in the instance of an outbreak of a cross-border disease such as cholera?" Related questions that were posed during the workshop and that arose from the discussion are the following:

- Is cholera response a regional or a national issue?
- What are the challenges at the global, regional, national and local level to cholera prevention, preparedness and response?
- How can we create an enabling environment for cholera prevention, preparedness and response?
- What form can an effective regional coordinating mechanism take?

## **WORKSHOP DISCUSSION**

The workshop began with a presentation by Maryam Said, from the CSIR, where she gave an overview of cholera in the SADC region (See appendix 2 to see the presentation slides). The presentation was followed by an initial discussion on the issues raised. Thereafter, the participants were asked to share their thoughts and offer inputs on the four questions posed above.

The general methodology for receiving the inputs to these questions was through the mode of interactive dialogue. Depending on the nature of the question, the mode of dialogue varied. This will be described in relation to each question.

Question one "Is cholera response a regional or a national issue?" was posed. On the basis of the resulting discussion it was rephrased to read: "Is cholera prevention, preparedness and response a regional or national issue?" It was decided that this issue was important at the global, regional, national and local levels. This dialogue

took the form of an unstructured conversation, where any participant could volunteer a thought or idea. This was mediated by a facilitator who ensured that as many participants as possible were given opportunity to speak within the designated time limit.

Question two was “What are the challenges at the global, national, regional (i.e. SADC) and local level to cholera prevention, preparedness and response?”. This dialogue took on a more structured form. Participants were requested to write down ideas on pieces of paper (using key words). These were then grouped on the wall of the workshop venue under the headings global, regional, national and local challenges. This ensured that an initial response from all participants in the room was gained. The clustered notes were then discussed at length using a similar dialogue process described for question 1.

Questions three and four were discussed in the same way. Question three was “How can we create an enabling environment for cholera prevention, preparedness and response?” Question four was “What form can an effective regional coordinating mechanism take?”. These questions were posed to the participants after which they were encouraged to freely contribute their ideas in a similar dialogue process used for question 1. The key points of the conversation were captured in bullet points on a board by the facilitator, who then gave a summary of the notes to conclude the conversation.

## **SUMMARY OF THE KEY POINTS RAISED DURING THE INTERACTIVE SESSIONS**

### *Summary of the key points of Maryam Said's presentation*

- A large part of Africa is afflicted by cholera, which is a re-emerging disease.
- The prevalence of cholera is closely related to the failure of basic services.
- Effective cholera response necessitates the need for short, medium and long terms actions plans to be in place.



- A complex web of actors from international, national and local levels of scale play a role in cholera response.
- Cholera is part of the biophysical environment in SADC and is aggravated by poor infrastructural development in large parts of the region, as well as the considerable occurrence of migration and refugees crossing state borders.
- Cholera has an explicitly regional nature and dimension in SADC. Thus, regional co-ordination of response is an important option to consider.
- It is necessary to decide who should co-ordinate a regional cholera response in SADC?

*Dialogue emerging in response to Dr. Said's presentation*

- Cholera has become a permanent part of SADC
- There are many challenges facing cholera response:
  - Time is wasted in starting to respond to and treat outbreaks;
  - Governments are not uniformly good at declaring cholera outbreaks for various reasons;
  - Healthcare systems need strengthening in much of SADC
  - Cultural and religious factors, at times, undermine cholera response efforts.
- Regional co-ordination of cholera response is important. The UN may be able to play a supporting role in this regard.
- The 2005 revised IHRs are now internationally binding. The WHO is therefore now empowered to force governments to admit that they have cholera. This should be rigorously insisted upon.
- State sovereignty has an impact on the effectiveness of regional response and the implementation of WHO regulations. Without political will it is impossible to effectively respond to cholera.

*Dialogue about question 1: Is Cholera response a regional or a national issue?*

- It is not just reactively responding to cholera outbreaks, once they arise that is important, but also proactively attempting to address the problem more permanently through detailed vulnerability mapping that needs to be addressed.
- Cholera response requires preparedness at local, national, regional and international levels of scale
- Multi-sectoral meetings may be a good way to share understanding and knowledge across sectors
- Whilst all levels of scale are important, it is ultimately at local level where the suffering happens and thus where impact needs to be most targeted.

Dialogue about question 2:

*What are the challenges at global level to cholera preparedness, response and prevention?*

*What are the challenges at regional level to cholera preparedness, response and prevention?*

*What are the challenges at national level to cholera preparedness, response and prevention?*

*What are the challenges at local level to cholera preparedness, response and prevention?*

- At global level a number of challenges were considered. These included the impact of the wealth gap and inequalities in the world on cholera vulnerability, the powerful role that media plays in hyping certain diseases and outbreaks and not others, the importance of contingency planning for inevitable outbreaks in vulnerable areas, the struggle to enforce and implement the IHRs, the ongoing battle to access dedicated funding, lack of political will on the part of states, and weak coordination of international efforts to respond to cholera.
- At regional level a number of challenges were identified. These include concerns about weak political will in certain SADC states for dealing with cholera, limited state cooperation around cholera in the region, lack of clear leadership from SADC, the reality that cholera at times becomes overshadowed by other pressing issues in the region, and so on.

- At national level the concerns that were listed pertained to a crisis of political will, lack of coordination in times of crisis, the reality that there is a lack of information and capacity to deal with cholera particularly during large scale outbreaks, and concerns around inequitable distribution of resources from national governments and aid organisations assisting during outbreaks.
- At local level many concerns were raised. These included the challenge of mobilising sufficient funds for effective response, the challenge of coordination during crisis, the distorting role that media can play which results in certain outbreaks being flooded with resources whilst others are ignored, a lack of knowledge transfer about how to deal with these outbreaks and so on.

*Dialogue about question 3: How can we create an enabling environment for cholera response?*

- Capacity should come from the ground. The focus should not be regional but local.
- Whilst a set of regional principles should guide cholera response, action response plans need to be country specific.
- WASH infrastructure needs to be monitored.
- Whilst delaing with medium- and long-term enabling factors for cholera response, it is important to also focus on the short term and on what can be done when the next outbreak occurs.
- There is also a need for local political action to demand proper maintenance and operation of infrastructure.

*Question 4: What form can an effective regional coordinating mechanism take?*

- There is general agreement among the workshop participants that SADC has an important role to play in cholera response.
- Cross-border collaboration and health related exchange programmes might be a useful mechanism for improved regional coordination.
- Regional mechanisms does not necessarily have to be led by SADC, but instead could be led by another group or network.

- Regional coordination need not start on a formal, state indorsed basis,m but can begin to occur informally though networking.
- It is important to consider where the most relevant place to house information about cholera is, given the needs and limited access to technology in the SADC region.

## **WRAP UP AND WAY FORWARD**

Nikki Funke (CSIR) stated that the workshop proceedings would be compiled and distributed to the workshop participants present. Future research around the issue of regional cholera prevention, preparedness and response will have to be discussed and brainstormed within the CSIR team. There was also a suggestion for an annual meeting of the workshop participants should occur.

### **Issues to consider when developing future research projects on regional cholera prevention, preparedness and response**

The following significant points emerged from the workshop discussion:

1. More research is needed about health seeking behaviour. Why is it that some people go to hospital when ill and others do not, sometimes for religious and/or cultural reasons.
2. CSIR could attend multi-sectoral meetings (weekly ones take place during cholera outbreaks) and CSIR could collaborate with DOH's research unit as part of its partners looking at cholera responses.
3. Research should be done on the "CNN effect". What is the link between high intensity international media coverage and resources being deployed to emergency health situations? To what extent are health systems responding to the media, or is the media responding to health systems?

4. In terms of creating an enabling environment for effective cholera prevention, preparedness and response, the following recommendations emerged that could feed into future research:

- There is a need for a preparedness plan/plans at the national/local levels. These need to be reviewed periodically. They should be unique for each SADC member state, but should adhere to the same principles.
- While SADC is in the best position to coordinate the plans, each SADC member state should be responsible for its own plan
- There is a need for sharing of plans (and policy harmonisation) between countries. Is SADC the best mechanism to coordinate this?
- There should be support for national initiatives that are working well.

5. When discussing the possible form that a mechanism on regional cholera prevention, preparedness and response could take, the focus seemed to be very much on the local level. The following points emerged:

- In terms of mechanism for cross border health activities, local needs should be answered and this should be started through small initiatives (e.g. a forum or network of stakeholders on health responses)
- There was also agreement that information is needed around vulnerability. This information should be integrated and shared, and fed into the Water, Sanitation and Hygiene (WASH) cluster.
- Mention was made of the Humanitarian Assistance Network of South Africa (SA emergency.net) that could play an important part

6. Important points that came up related to the need for a networking capacity to respond to various informational needs (the working group present at this discussion could participate), and the importance of locating places in which to house information.

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## Appendix 1

### LIST OF WORKSHOP PARTICIPANTS

<b>NAME</b>	<b>AFFILIATION</b>	
<b>Sylvain Bertrand</b>	Oxfam GB	sbertrand@oxfam.org.uk
<b>Marianne Buenaventura Goldman</b>	Oxfam GB	mbuenaventura@oxfam.org.uk
<b>Abdijabar Dini</b>	UNICEF	ahdini@unicef.org
<b>Nicholas Eseko</b>	WHO	esekon@zw.afro.who.int
<b>Nikki Funke</b>	CSIR	nfunke@csir.co.za
<b>Inga Jacobs</b>	CSIR	ijacobs@csir.co.za
<b>Bheki Mdlovu</b>	NDOH	mdlovub@health.gov.za
<b>Tragedy Motswaire</b>	MSF	motswairetragedy@yahoo.com
<b>James Mwanzia</b>	WHO	mwanziaj@za.afro.who.int
<b>Shanna Nienaber</b>	CSIR	snienaber@csir.co.za
<b>Maryam Said</b>	CSIR	msaid@csir.co.za
<b>Maronel Steyn</b>	CSIR	msteyn@csir.co.za
<b>Jonathan Timm</b>	Mvula	jonathan@mvula.co.za
<b>Stephina Tshelane</b>	NDOH	tshelanes@health.gov.za
<b>Jaques van der Westhuizen</b>	NDOH	vandej@health.gov.za
<b>Fanus Venter</b>	UP	Fanus.venter@up.ac.za



## **Appendix 2**

To see the Maryam Said's powerpoint presentation please access the Groupwise shared folder.

Document Reference Number: 185021

## Appendix 3

Details of the discussions of the workshop:

<b>Presentation title: Overview of Position Paper on Regional Responses to Cholera in the SADC Region</b>	<b>Presenter: Maryam Said (Natural Resources and the Environment, CSIR)</b>
<b>1. Reporting notes</b>  <b>Summary of the presentation</b> <p>Maryam Said gave an informative presentation stating that cholera has been in the news frequently since last 2008. She indicated that, when looking at the map of the world, it becomes evident that a considerable part of Africa is afflicted by cholera. Cholera is a re-emerging disease, with millions of cases being reported from Africa, Asia and Latin America, and cholera often being linked to a failure of basic services. The risk of infection from cholera is also higher during man-made and natural disasters.</p> <p>It is important therefore to have a national response to cholera that caters for the short, medium and long-term. Short-term measures should include the provision of treated safe water to affected communities. In affected areas several measures should be taken e.g. the provision of latrines (at public gathering places), the promotion of safe refuse disposal, food handling practices and chlorine use (Jik) for water purification in homes. Medium-term measure should include preparedness for annual outbreaks, operational plans and disease surveillance. Long-term measures should include water, sanitation and hygiene (WASH) infrastructure, education, monitoring and surveillance.</p> <p>A complex web of actors is involved in a response to cholera in the Southern African Development Community (SADC) region. These include SADC, government agencies, humanitarian agencies (for example, local and international non-governmental organisations, community-based organisations)</p>	

and donors. All of these actors face challenges in terms of provision of WASH infrastructure, challenges to the health system and the various factors contributing to the spread of cholera.

Cholera in the SADC region is part of the biophysical environment and is aggravated by poor infrastructural development in large parts of the region, as well as the considerable occurrence of migration and refugees crossing state borders. Of particular concern is the annual percentage cholera case fatality rate (CFR) in the SADC region, which for many SADC countries sat well above one percent for the 2008/9 cholera outbreak. A CFR of greater than 1% indicates a problem with the health system in identifying and responding to outbreaks.

<b>Country</b>	<b>Reported Cases</b>	<b>Reported Deaths</b>	<b>CFR (%)</b>	<b>Time Period</b>
<b>Angola</b>	<b>5 478</b>	<b>60</b>	<b>1.2</b>	<b>01/01/08 – 05/04/09</b>
<b>Botswana</b>		<b>2</b>	<b>13.3</b>	<b>01/11/08 – 17/04/09</b>
<b>Malawi</b>		<b>113</b>	<b>2.2</b>	<b>15/11/08 – 17/04/09</b>
<b>Mozambique</b>	<b>15 649</b>	<b>133</b>	<b>0.8</b>	<b>01/01/09 – 11/04/09</b>
<b>Namibia (Inc. AWD*)</b>	<b>203</b>	<b>9</b>	<b>4.4</b>	<b>22/10/08 – 14/04/09</b>
<b>South Africa</b>	<b>12 765</b>	<b>64</b>	<b>0.5</b>	<b>15/11/08 – 10/04/09</b>
<b>Swaziland (only AWD*)</b>	<b>13 278</b>	<b>0</b>	<b>0</b>	<b>22/12/08 – 28/03/09</b>
<b>Zambia</b>	<b>7 412</b>	<b>151</b>	<b>2.0</b>	<b>10/09/08 – 09/04/09</b>
<b>Zimbabwe</b>	<b>95 738</b>	<b>4154</b>	<b>4.3</b>	<b>15/08/08 – 10/04/09</b>

\* Acute water diarrhoea (AWD)

### **Concluding remarks**

Given the regional nature of the cholera crisis there clearly is a need for regional

co-ordination and response rather than the largely individualistic national responses that are mostly taking place at the moment.

Having sketched the cholera situation in the SADC region, the following question arises "Who should co-ordinate a regional cholera response?"

### **Comments/questions raised in relation to Maryam's presentation**

**James Mwanzia** (WHO) observed that Dr Said had delivered a good presentation that brings out a number of important issues. He pointed out that cholera is no longer the way it was before, in that there are no longer outbreaks that are a problem for a short time and then go away. Instead, cholera is now a permanent part of the SADC region.

As a result, a number of problems need to be addressed. Firstly, a considerable amount of time is lost in response to cholera. Secondly, often national governments do not want to declare that they have a cholera problem in their country (possibly out of fear of this having a negative impact on tourism, trade etc.). Instead, they refer to acute watery diarrhoea (AWD). This is problematic because valuable time is lost and because cholera and AWD are treated differently.

The issue of cholera thus has to be addressed not only from a public health, but also from a political point of view. This issue should be addressed through SADC, the African Union (AU) and other governing bodies of the continent. James Mwanzia was also of the opinion that health care systems need strengthening (from a diagnostic, human resources, and health promotion point of view), and that health department government officials are responsible for doing so.

Regional co-ordination in the humanitarian sector could also be strengthened. The United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) is doing a well in terms of coordination. Here questions arose as to the

role of national governments, and how humanitarian organisations can offer better support to national governments. The CFR also need to be looked into. Accurate daily reporting is a problem.

**Tragedy Motswaire** (Médecins Sans Frontières) spoke of the need for a regional response outbreak team as well as the need for a regional case definition of cholera that could be circulated and agreed/adhered to by all SADC countries.

**Bheki Mdlovu** (National Department of Health) said that while most countries have health systems in place, the important question is how those systems can be strengthened. Here, the CSIR could play a role through scientific research, for example, by asking where cholera comes from. While statistics are currently available, these only give us an idea of the disease. In terms of coordination there is a need for leadership, and that leadership should come from SADC instead of everyone distancing themselves from taking responsibility. At the same time, effective coordination should however also come from the member states. Member states need to control their ports of entry, their water system etc. Bheki Mdlovu suggested that a report from this meeting should be developed and that strong coordination is required within South Africa to begin with. He also expressed disappointment at the fact that other government departments were not present at the workshop and spoke of the need for a more coherent discussion between different government departments.

**Nicholas Eseko** (WHO) congratulated Maryam Said on a good presentation and added that the issue of cholera definitely has a regional link or implication. He mentioned Ethiopia, which does not want to label cholera for what it is but refers to it as AWD instead, possibly because it is considered to be a disease of the poor. Also because of economic and trade reasons, there is a fear and reluctance to own up to having the disease in the country.

**Nicholas Eseko** then spoke of the fact that there is now an opportunity to act

as a result of the IHRs which were revised in 2005; are now internationally binding. The WHO is therefore now empowered to force governments to admit that they have cholera. Integrated disease and surveillance response (IDSR) also needs to be strengthened because it is a very good tool both in terms of preparedness and response. Most countries in SADC have adopted this strategy.

Some issues need more research. Community challenges and deaths are often related to cultural and religious reasons, for example not going to hospital. Case fatality deaths are only applicable to people who come to hospitals and are treated there. But what about the people who do not?

**Tragedy Motswaire** (MSF) responded to the comments on Zimbabwe by saying that he thinks the President of Zimbabwe sees cholera as a “British” disease and that this view has more to do with people dying than community or religious reasons.

**Nicholas Eseko** (WHO) agreed.

**Shanna Nienaber** (CSIR) asked whether the reality of state sovereignty has an impact on the effectiveness of regional response, the implementation of WHO regulations etc. Some general discussion around this point followed. From the discussion it was observed that it is sometimes difficult to get international regulations pushed through into national legislation and practice. SADC may be able to generate political will and pressure to change the behaviour of certain states, and bilateral negotiations are also very important in terms of trust building etc.

**Nicholas Eseko** (WHO) specified that there is an implementation timeline for the IHRs and that core assessments will be conducted after a certain number of years to identify gaps. He also mentioned that SADC has a health desk and a forum for SADC Health Ministers as well as joint technical committees.

**Sylvain Bertrand** (Oxfam GB) asked about how many years and extensions it would take to implement the legislation, to which **Nicholas Eseko** replied that the target date is 2012. Sylvain Bertrand said that short-, medium- and long-term data should be used to feed into a regional response plan.

## **DISCUSSION ON QUESTIONS**

### **Question 1: Is Cholera response a regional or a national issue?**

**Fanus Venter** (University of Pretoria) said that vulnerability is a key factor to consider in terms of preparedness and response. We need to intervene not just reactively in cholera outbreaks, but need to look at modelling (scenarios) and also predicting vulnerability. There is a need for prevention and looking after vulnerable groups.

**Maronel Steyn** (CSIR) said that some vulnerability mapping and early detection activities are taking place at CSIR.

**Jonathan Timm** (Mvula) stressed the need for preparedness, response and prevention in terms of cholera. The issue is important at several scales: the local, national, regional and global. It is therefore important to build capacity at all levels.

**Stephina Tshelane** (NDOH) said that the department is expecting a cholera outbreak in the coming rainy season. She also asked whether there is evidence to compare the cholera response between different provinces. Why is the Western Cape better at containing the spread of cholera than other provinces? She said that the Department of Water Affairs (DWA) are working on WASH interventions and that there is a need to heighten intervention in the responsible departments. Stephina Tshelane said that not all research questions regarding cholera have been answered. She mentioned that weekly multi-sectoral meetings take place during cholera outbreaks and that there is a need for CSIR to be at

these meetings and that CSIR could collaborate with DOH's research unit as part of its partners looking at cholera responses.

**Maronel Steyn** (CSIR) agreed that this partnership would be excellent.

**Bheki Mdlovu** (NDOH) said that the recipients of regional and global challenges are the local people. He asked whether local capacity is currently being strengthened or addressed. He mentioned that there needs to be a focus on public health care (PHC) at the local (district) level with existing resources.

**James Mwanzia** (WHO) stated that if interventions do not make a difference at the local level, then there is a problem. A national as well as a regional response plan is needed. Cholera is a regional and national issue and there must be some impact on the local level. In the case of South Africa, one can learn quite a bit about the different provinces and what they are doing. Some provinces are further ahead in terms of public awareness than others. There needs to be process within the national system where all local actors are capacitated to take the required actions. In terms of testing for cholera, standardisation is important.

## **Question 2:**

**What are the challenges at global level to cholera preparedness, response and prevention?**

**What are the challenges at regional level to cholera preparedness, response and prevention?**

**What are the challenges at national level to cholera preparedness, response and prevention?**

**What are the challenges at local level to cholera preparedness, response and prevention?**

### *Global*

The following challenges were highlighted at the global level:



- **Need for technical plans**
- **Globalisation and the wealth gap:** there are fundamental inequalities in the system and this is the context in which political issues and colonialism and neo-colonialism are played out. It should therefore be understood.

In a case such as the HI-NI virus, developed world countries will be the first to order medicine and supplies, but developing countries will not be able to do so as easily. Pandemics do not discriminate; anyone can be affected by them. However, the severity of the impact is closely linked to the availability and accessibility of resources. (James Mwanzia – WHO and Jonathan Timm - Mvula)

- **The CNN effect:** in some cases cholera cases are documented and reported and in others not. This affects the flow of resources. An example is Zimbabwe, whose cholera outbreak was well documented and therefore received considerable resources to respond to the disease; as opposed to Angola, which also had a size-able outbreak but did not receive much international attention. (Sylvain Bertrand – Oxfam GB)

It might be interesting to do research on the impact of media coverage on the flow of resources. To what extent are health systems responding to the media, or is the media responding to health systems? (Jonathan Timm – Mvula)

- **Complexity:** cholera is a complex disease and a complex web of actors exists. Whose responsibility is it to address the crisis at the global level? How can the crisis be addressed at the regional, national and local level? (Inga Jacobs – CSIR)
- **Vulnerability:** how can vulnerable people in SADC be protected from

being exploited in research participation? People in Africa are often used as guinea pigs for drug testing, with the drugs subsequently being exported to developed countries. There is a need for benefit-sharing here to ensure that vulnerable people also benefit from research. There seems to be no initiative for conducting research in poor countries to, for example, develop vaccines themselves. They seem to be short of resources, expertise etc. (Bheki Mdllovu – NDOH)

- **Need for contingency planning:** It is very important to look at contingency planning; and to influence actors to invest more resources in preparedness and prevention than only emergency responses. (Marianne Buenaventura Goldman – Oxfam GB)
- **A need to implement the International Health Regulations.**
- **A need for dedicated funding.**
- **Lack of political will.**
- **A need for coordination.**

### Regional

The following challenges emerged at the regional level:

- **A need for regional political will.**
- **A need for regional cooperation by all SADC governments:** a regional response is only as strong as its members are. An example is the European Union. (James Mwanzia - WHO)
- **A need to implement International Health Regulations:** questions arose around the IHRs. Why one might be able to use them to persuade member states and how can these be enforced? (Nikki Funke – CSIR)

Also, how legally binding are the IHRs and how static are they? Will they still be relevant by 2012 if they were already drafted in 2005? (Maronel Steyn – CSIR) To this it was replied that legislation should not be static

but should be revised. An expert committee is in place to revise the IHRs. (James Mwanzia – WHO)

SADC states include the International Protocol on Water Principles into their policies without the protocol being ratified by all member states and being binding. Ways have to be found for SADC to come up with effective solutions despite difficult circumstances. (Inga Jacobs – CSIR)

- **Need for leadership:** At the regional level there is not always a clear picture of who should lead. One often needs a passionate person to get things going. This is different from the national level, where government would automatically take on a leadership role. (Fanus Venter – University of Pretoria)

SADC is probably aware of the expectation for it to lead at the regional level, but its capacity needs to be strengthened, for example in terms of the Health Protocol. (Inga Jacobs – CSIR)

- **A need for clarity on the role of regional economic communities.**
- **A need for SADC coordination, funding and expertise:** A question was raised regarding the existing mechanisms in SADC and their effectiveness. (Nikki Funke – CSIR)

It seems that capacity is a problem in this regard. (Nicholas Eseko – WHO)

- **Immigration policies:** Immigration is well covered under the IHRs. (Nicholas Eseko – WHO)

Nonetheless, one of the problems of illegal immigration is that someone who is in a country illegally will not go to established health facilities to get treated. (Sylvain Bertrand – Oxfam GB)

There is a reality gap between what is happening and what should happen. Immigration policies do not match the reality of the region. (Jonathan Timm – Mvula)

There is a definite need for multi-sectoral collaboration. (Nicholas Eseko –

WHO)

All of South Africa's ports of entry need to be identified as part of early warning systems. (Stephina Tshelane – NDOH)

- **The nature of cholera:** cholera sometimes falls off the agenda because unlike HIV/AIDS, for example, it is not always a problem. The measures one needs to take to combat it are also typically different. Merely preventing waste from entering a river might not be sufficient. (Fanus Venter – UP)

### National

The following challenges emerged at the national level:

- **Need for political will:** there is a need for countries to admit that they have cholera. There is also a need for a national plan with an integrated disease surveillance system (South Africa does not have one) that can address implementation, preparedness and response, and to ensure that all provinces are equipped. (Nicholas Eseko – WHO)
- **A need for coordination.**
- **A need for health systems research.**
- **There is a difference between South Africa and other SADC countries in terms of water quality monitoring**
- **Need for information:** there is a need for a data exchange mechanism in the form of training guidelines. Are these distributed and indigenised? (Inga Jacobs – CSIR)

There is also a need for availability of accurate statistics (Maronel Steyn – CSIR)

There is perhaps a need for a central data management system (Maryam Said - CSIR)

Private and public facilities need to report when they suspect a case to the national DOH office. Getting information to flow from the district to the provincial and national level is difficult. A high staff turnover makes it very

difficult to maintain training. Data sharing is problematic. How do we build mutual relations in a multi-sectoral setting? There is a need for trust.

(Stephina Tshelane – NDOH)

- **Need for capacity:** this is a problem both in terms of human resources but also in terms of medical personnel being trained and willing to treat cholera patients. Some medical personnel prefer not to treat cholera patients (Tragedy Motswaire –MSF).
- **Equitable resource distribution at different levels of government.**
- **A lack of inter-sectoral communication.**

### Local

The following challenges emerged at the local level.

- **Finance:** There are budget constraints in particular provinces and water purification also seems to be a problem.
- **Capacity:** public health care was identified as a problem, as well as the need to ensure local action. There is a need for experts to assist at the district level. There is also a need for accessing knowledge and information. There seem to be a lack of materials and trained personnel (possibly due to the privatisation of skills), as well as unequal distribution of capacity and problems around the strength of the health system.
- **Management of the outbreak:** There was not enough support during the 2008/9 cholera outbreak.
- **Need for Coordination:** There are problems around the maintenance and operation of water infrastructure and operational coordination. Furthermore, there is only a weak early warning system in place.
- **Media distortion:** There was a distortion by the media during the last cholera outbreak of the areas which were in most need of a response.
- **Gender issues:** At the local level, women are the most affected by cholera. (Jaques van der Westhuizen – DOH)
- **Poor maintenance of local infrastructure:** The national response to poor operational response and maintenance is to build new infrastructure

instead. (Jonathan Timm – Mvula)

- **Privatisation of skills**
- **The lack of knowledge transfer**
- **There is a need to think globally and act locally** (James Mwanzia – WHO)

**Question 3: How can we create an enabling environment for cholera response?**

Jonathan Timm (Mvula) expressed that capacity building should come from the ground and should not start at the top in the hope that resources will be filter down.

Fanus Venter (UP) said that cholera is not seen on a regular basis in the same areas. This makes it difficult to formulate a national response.

Shanna Nienaber (CSIR) asked about who has the necessary resources and where these should be housed. Fanus Venter (UP) replied that very little is needed to treat cholera, although, as Sylvain Bertrand (Oxfam GB) pointed out that access by road during the rainy seasons is a problem in many African countries and usually hamper delivery of medical supplies.

Maronel Steyn (CSIR) and Nicholas Eseko (WHO) both agreed that epidemic preparedness and response plans are critical; they should also be country specific, although the same principles could apply across the region, according to Bheki Mdlovu (NDOH). SADC could play a coordinating role here.

The issue of coordination came up and both Nicholas Eseko (WHO) and James Mwanzia (WHO) made the point that the sharing of expertise in countries and between provinces is very important and that good coordination is always helpful.

Stephina Tshelane (NDOH) talked about the need to monitor progress in terms of water supply and sanitation infrastructure. Inter sectoral coordination is very important, even in times when there are no outbreaks, according to James Mwanzia (WHO).

Jonathan Timm (Mvula) stated that existing initiatives such as the blue drop/green drop process, which are city specific, should be supported. It is important that users understand what is happening to their water.

Shanna Nienaber (CSIR) said that while the focus of the discussion seems to have been on medium- and long-term enabling factors, it is important to also focus on the short term and on what can be done when the next outbreak occurs.

#### SUMMARY

- There is a need to build capacity on the ground. This could take the form of surveillance systems.
- South Africa does not see cholera on a regular basis.
- It is very important to retain local capacity and knowledge at the local level.
- Equitable distribution of resources is needed.
- There is a need for preparedness plan/plans at the national/local levels. There is also a need to be reviewed periodically. They should be unique for each SADC member state, but should adhere to the same principles.
- While SADC is in the best position to coordinate the plans, each SADC member state should be responsible for its own plan.
- There is also a need for sharing of plans (and policy harmonisation) between countries. Is SADC the best mechanism to coordinate this?
- WASH infrastructure needs to be monitored. Vulnerability also needs to be taken into account and needs to be integrated into research.

- How can intra-country coordination between different sectors be improved? There should be support for national initiatives that are working well.
- There needs to be a mechanism or a responsible actor for inter sectoral interaction or coordination at the local level. This should happen not only in times of crisis. Community advisory boards, which are currently being launched in South Africa, should be involved here.
- There is also a need for local political action to demand proper maintenance and operation of infrastructure.

**Question 4: What form can an effective regional coordinating mechanism take?**

Nikki Funke (CSIR) observed that there seemed to be agreement among the workshop participants that SADC has an important role to play.

Jonathan Timm (Mvula) said that he would like to challenge the idea that SADC should be the responsible party. He said that what may be needed is a demand-driven approach, not a supply driven approach, which SADC might provide. Could SADC adopt a demand-driven approach?

James Mwanzia (WHO) focused on the need for cross-border collaboration and said that health related exchange programmes might be useful.

Inga Jacobs (CSIR) said that a regional mechanism does not necessarily have to be led by SADC, but that it could be a group or networkers focused on a health response. Also, not all countries would need to be involved from the start, and starting small can be a good thing.

In response, Fanus Venter (UP) raised the question of whether such cross border activities require bureaucratic permission from states, or whether they could start less formally. He said that it might be easier to apologise later than to go



through the lengthy and complex process of asking for and attaining permission.

Jonathan Timm (Mvula) made the point that there is an informational need around mapping and modelling vulnerability, the results of which could be fed to society. He used the WASH cluster forum as an example. He also mentioned the Humanitarian Assistance Network of South Africa (HANSA-SA emergency.net), an online network that is functions on the basis of peer-to-peer interactions and is demand driven.

Shanna Nienaber (CSIR) raised a question here regarding whether this would be the most relevant place to house information given the needs and limited access to technology in the SADC region.

Bheki Mdlovu (NDOH) thought that the network sounded interesting and promising.

### **Summary**

- Do we want a centralised top down approach?
- How do we build the required capacity at the bottom/local level?
- In terms of mechanism for cross border health activities, there was a focus on answering local needs and starting through small initiatives (e.g. a forum or network of stakeholders on health responses).
- There was also agreement that information is needed around vulnerability. This information should be integrated and shared, and fed into the WASH cluster.
- There is a need for evidence-based approaches.
- Mention was made of the Humanitarian Assistance Network of South Africa (SA emergency.net) that could play an important part.
- Important points that came up related to the need for a networking capacity to respond to various informational needs (the working group present at this discussion could participate), and the importance of

locating places in which to house information.