



FEDERAL REPUBLIC OF SOMALIA



MINISTRY OF HEALTH & HUMAN SERVICES

GENERAL OVERVIEW OF CHOLERA IN THE PAST 3-5 YEARS

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Somalia CCM Launching Ceremony.pdf



GLOBAL TASK FORCE ON
CHOLERA CONTROL



Somalia OCV Launching Ceremony in Mogadishu

LEAVING NO ONE BEHIND

ra Vaccination campaign

22 – 28 June 2019

Mogadishu, Somalia

rganized by

Health & Human Services

HO, UNICEF and GAVI.

DHAMEYNTA DAACUUN CALOOLAHA
IYADOO CIDNA LAGA TEGIN
OLOLAHA TALLAALKA DAACUUNKA

22 – 28 June 2019

MUQDISHO, SOOMAALIYA

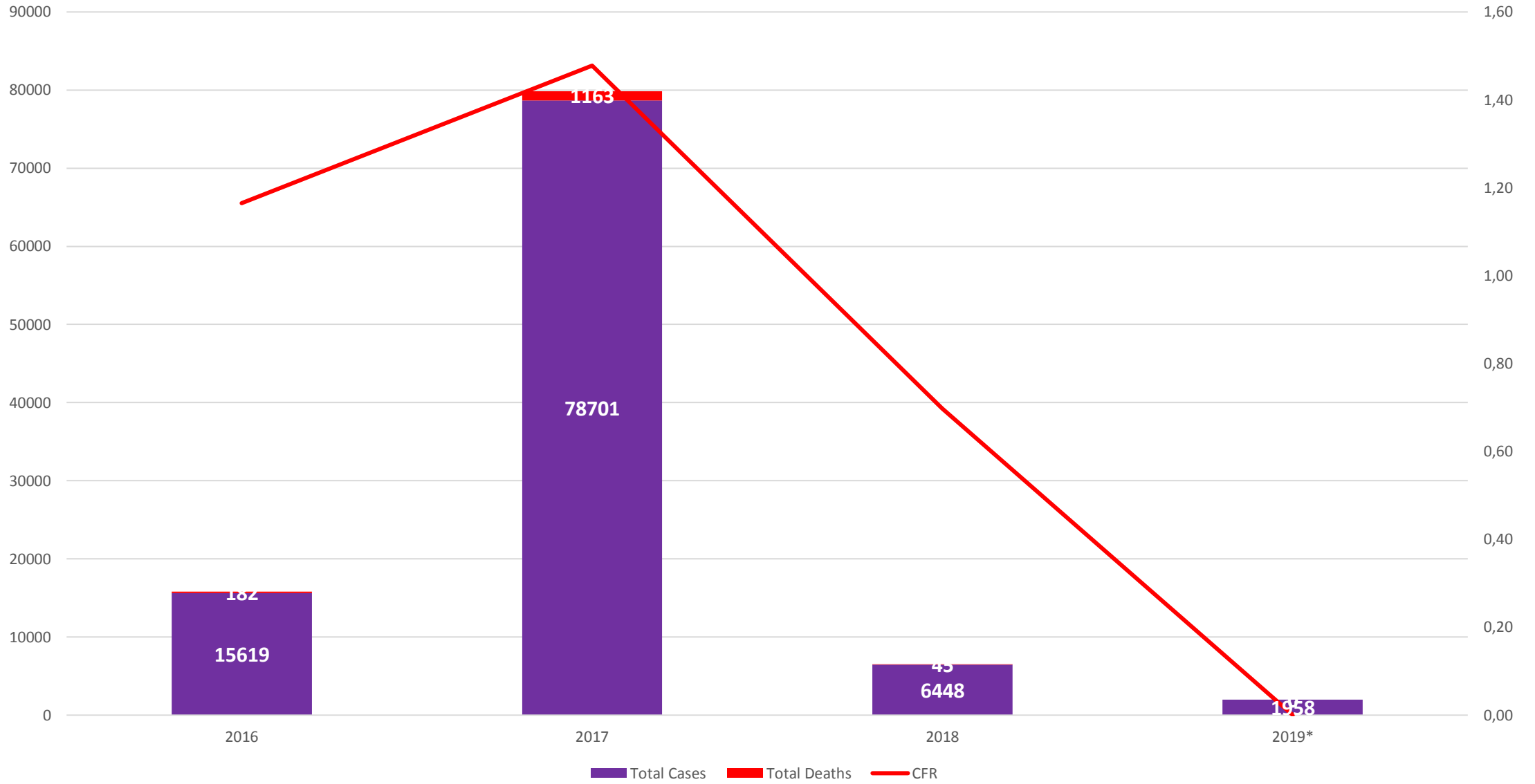
WAXAA QABANAYA WASAARADDA CAAFIMAADKA IYO
DARYEELKA BULSHADA IYADOO LA KAASHANAYSA
WHO, UNICEF & GAVI



**General overview of cholera in the past 3-5 years – showing case fatality rates.
SOMALIA CHOLERA CASES FROM 2016 To Sept. 2019 BY YEAR**

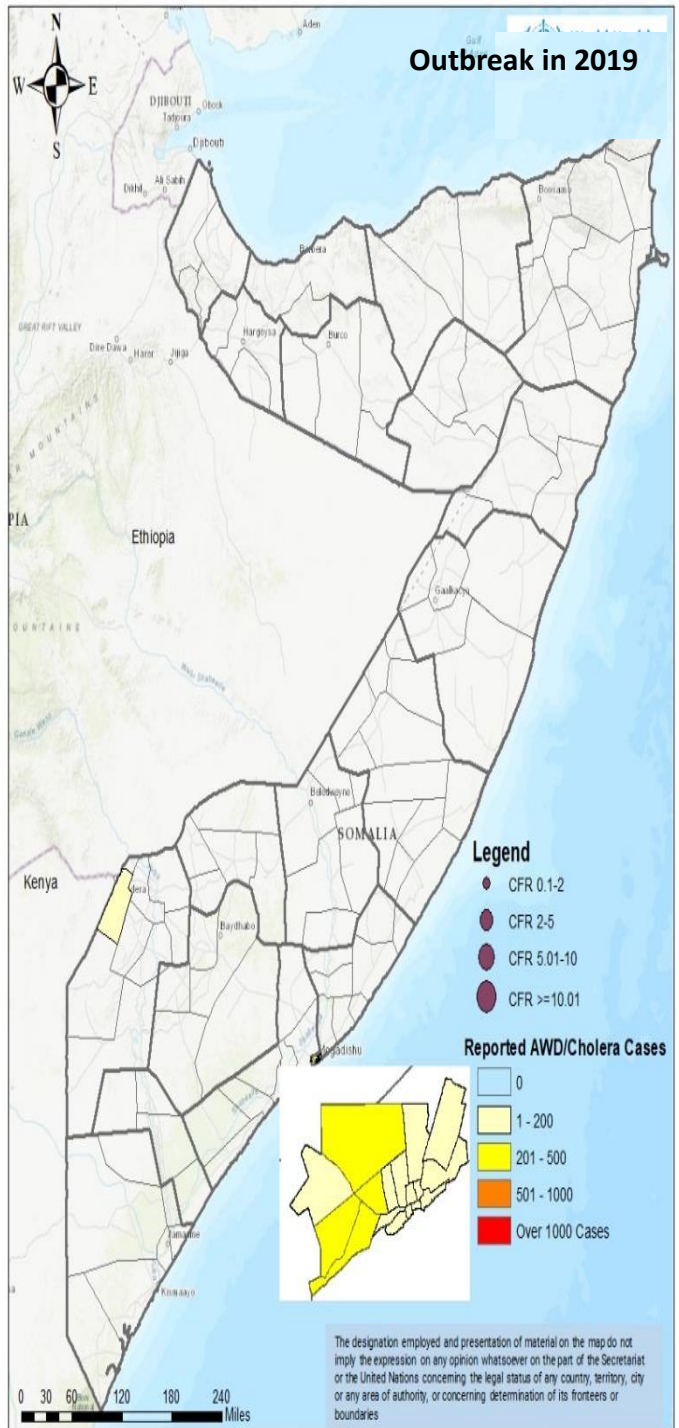
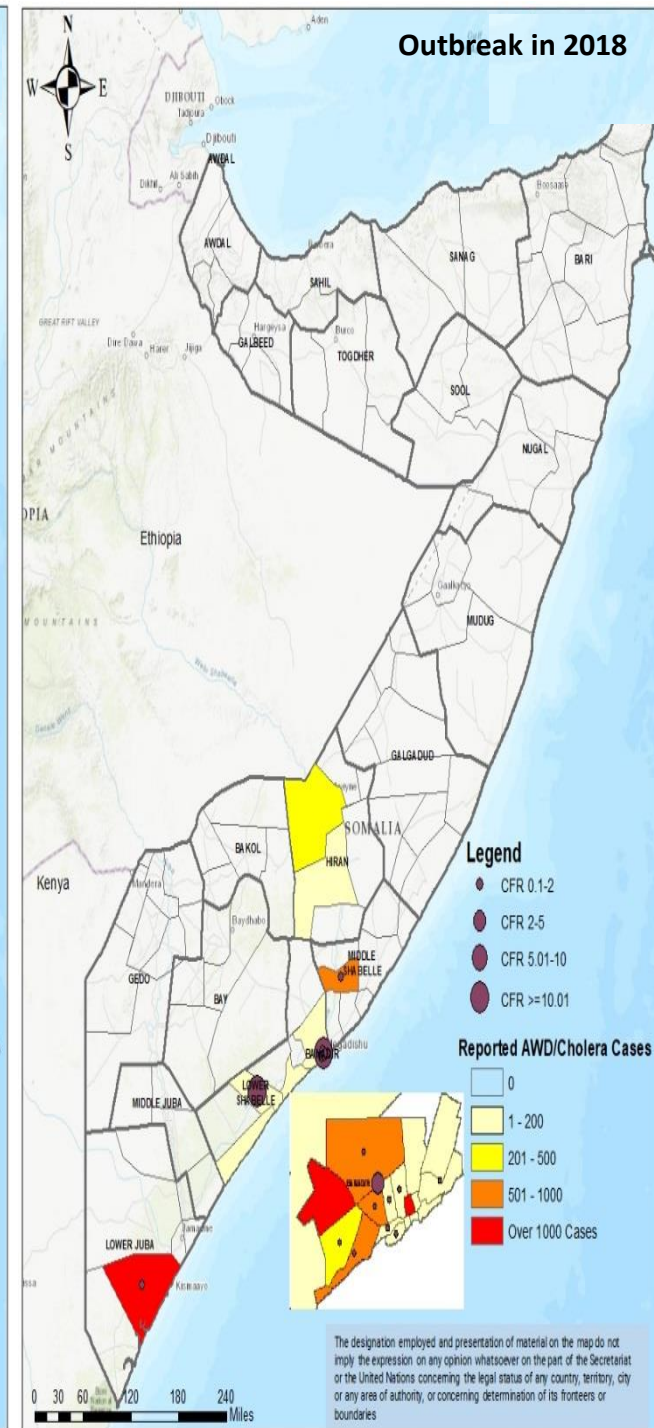
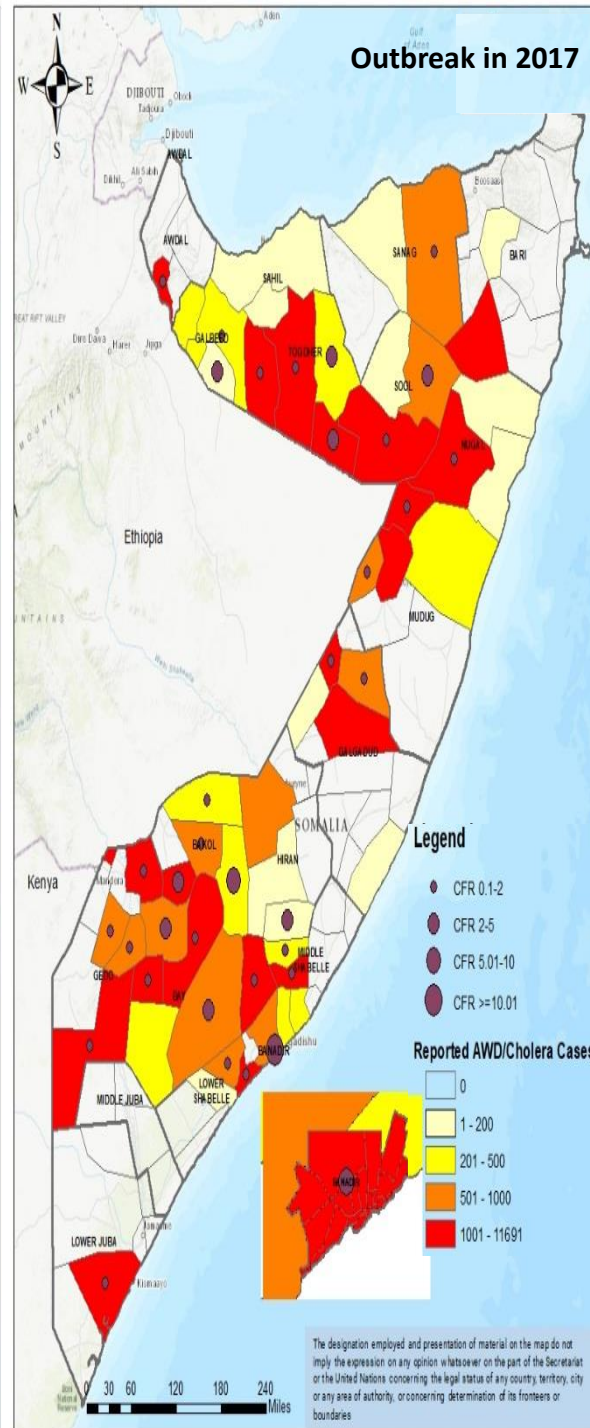
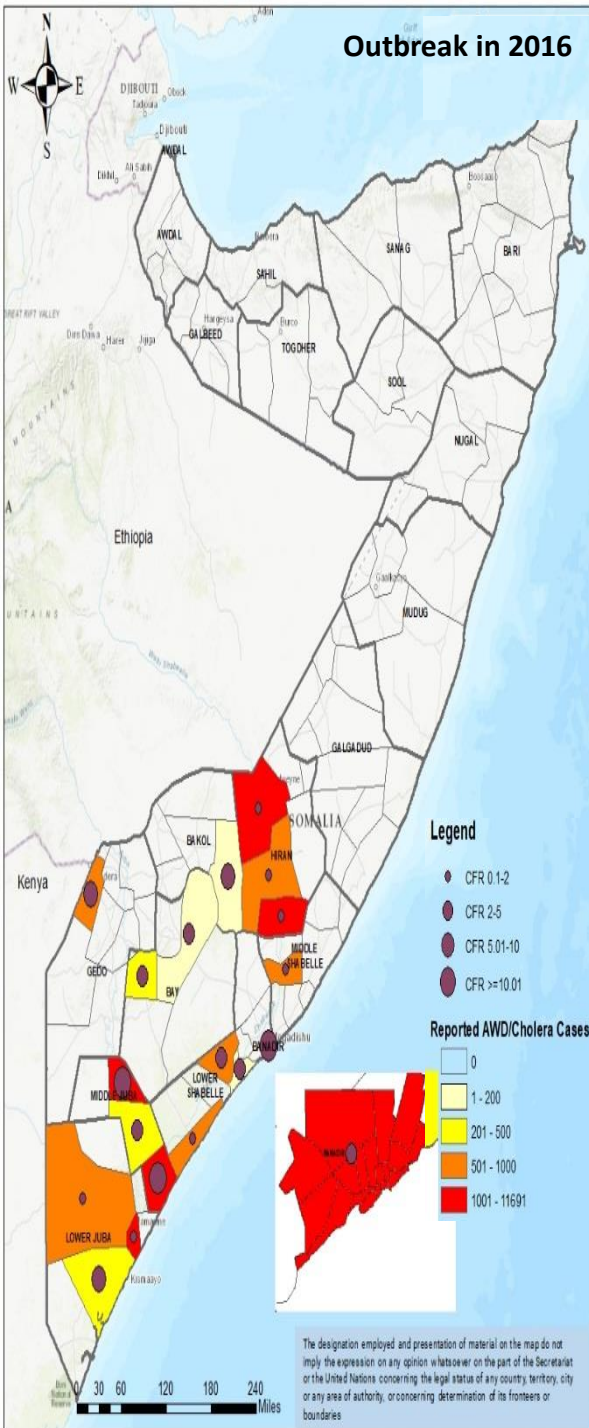
Year	Under 5 years	Over 5 years	Total Cases	Total Deaths	CFR
2016	8,780	6,839	15,619	182	1.17
2017	32,337	46,364	78,701	1,163	1.48
2018	3,792	2,656	6,448	45	0.70
2019*	1,296	662	1,958	0	0.00
TOTAL	46,205	56,521	102,726	1,390	1.35

SOMALIA CHOLERA CASES FROM 2016 TO 2019 BY YEAR



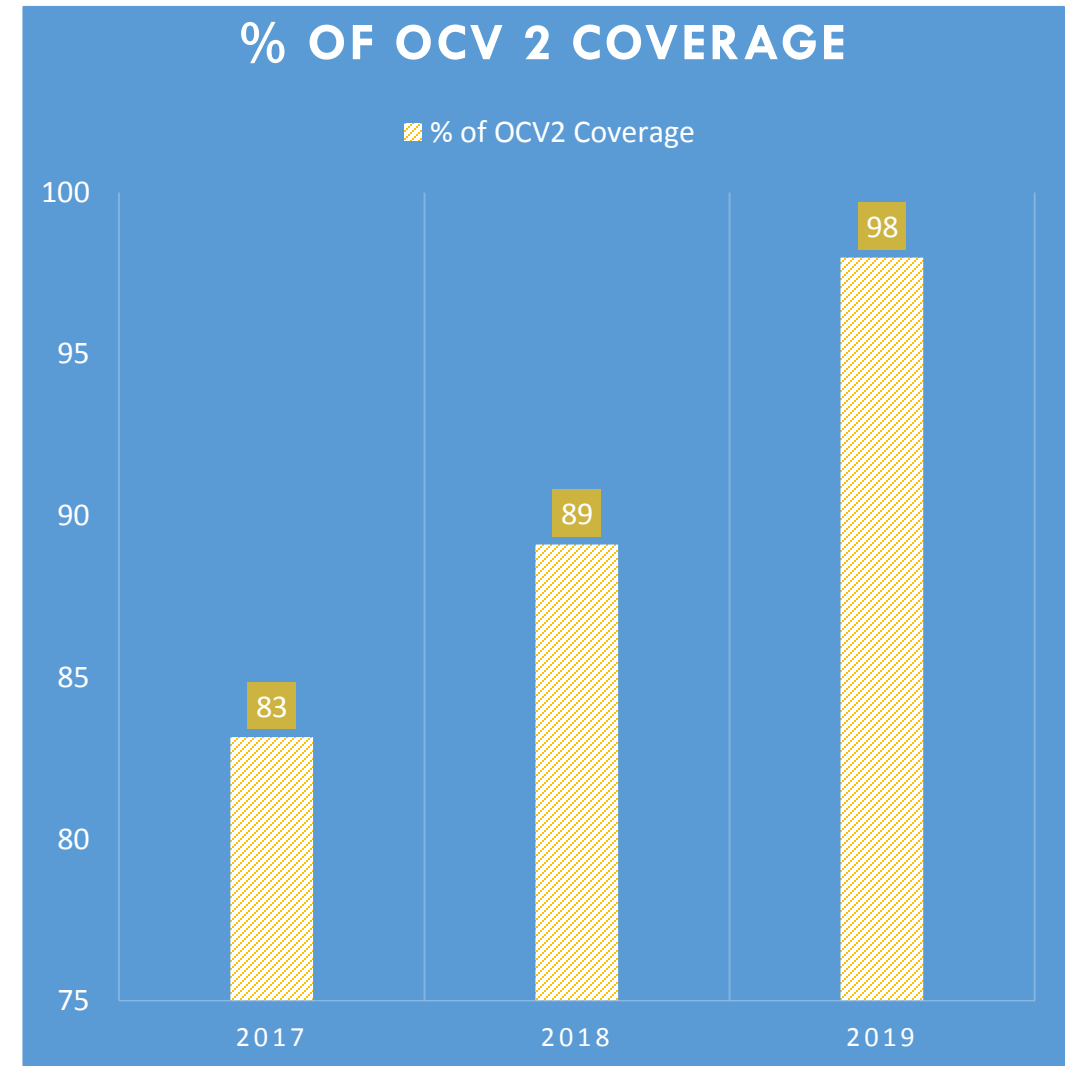
Somalia AWD/CHOLERA Drug Sensitivity from 2016 To Sept. 2019 by year

Year	Serotype		Sensitive to	Intermediate	Resistant
	Ogawa	Inapa			
2016	48	30	1-Tetracycline 2-Chloramphenicol 3-Cefuroxime	Not done	Not done
2017	134	0	1- Doxycycline 2- Erythromycine	Not done	Not done
2018	100	4	1- Doxycycline 2- Erythromycine	Not done	Not done
2019*	19	6	1- Doxycycline 2- Erythromycine	Ciprofloxin	1- Ampicilolin 2- Naldixic acid
TOTAL	319	173			



OCV IMPLEMENTATION COVERAGE 2017 TO 2019

Year	Target Pop.	Administrative coverage	
		OCV 2 Vacc. Coverage	% of OCV2 Coverage
2017	1,232,704	1,024,948	83
2018	189,775	169,120	89
2019	642,913	629,988	98
Total	2,065,392	1,8240,56	88



FOCUS ON CHOLERA MORTALITY

- ❑ Cholera Deaths in the community in remote areas are not recorded in the data as there is no professional health worker available to decide the cause of Death.
- ❑ Deaths due cholera is recorded only when it occurs at the treatment structures such as ctc/ctu or health facilities.
- ❑ Deaths occur more in the early of the outbreak and more at night or just upon arrival of the treatment structures.
- ❑ Contextual elements that might contribute to the mortality are **a)**. insecurity limiting movement. **b)**. People living inaccessible areas have to walk long distance to reach treatment facilities. **C)**. Lack of ambulance service and limited transport facilities at remote areas. **d)**. Limited staff capacity due frequent turn overs. **e)**. Supply shortage in remote treatment structures.
- ❑ Access to treatment may be difficult due to various reasons but people do know where they should go to get treatment.

FOCUS ON CHOLERA MORTALITY CONT...

- ❑ Issues that occur within treatment structures: **a).** Shortage of staff and limited capacity in case management. **b).** Occasional Shortage of supplies at treatment structures.
- ❑ Issues outside the treatment structures: Cases are poorly treated at Private pharmacy shops/conflict of interest
- ❑ In Somalia, AWD/Cholera affects all ages groups but more in < 5 children with an estimated percentage of 69% while 49% are women
- ❑ Cholera related deaths have decreased to less than 1% over the past 2 years
- ❑ A vast Rural areas in cholera hot spot districts are not accessible due to insecurity.

STRATEGIES BEING IMPLEMENTED TO TRY TO REDUCE MORTALITY:

- ❑ Development of National Cholera preparedness and Response plan for Somalia, from 2017 to 2022.
- ❑ Establishment of CTCs/CTU/ORP structures in all accessible Cholera hot spot regions and assigned a health partner.
- ❑ Supply prepositioning for Hot spot regions
- ❑ Expansion of EWARN for timely detection and response to cholera alerts especially in Remote areas
- ❑ Extensive community Awareness raising on cholera prevention and quick use of ORS available at CTU, ORS units and pharmacy shops
- ❑ Wide distribution of IEC materials on Cholera Prevention and control at community, Health facility, district, regional, state and National levels.
- ❑ WASH partners engagement at all levels.

STRATEGIES CONT....

- ❑ Distribution of updated case management protocols and guidelines to treatment structures.
- ❑ Training of health workers on proper cholera case management
- ❑ Training of Social mobilizers on cholera prevention at all levels
- ❑ Training of Lady health workers as Community Volunteers on cholera prevention and ORS distribution at household levels.
- ❑ Training and deployment of integrated emergency rapid response teams at National, state, regional and district levels, including members from key stakeholders.
- ❑ Promoting commitments of local authorities and communities at National, state, regional and district levels on Cholera prevention.
- ❑ Improving cholera Case Tracing and household disinfection services

SUCCESSSES:

- ❑ The case fatality rate has dramatically reduced in Cholera hot spot areas after OCV campaign.
- ❑ Local Authorities and communities appreciated the above strategies as the impact have clearly been seen by all.
- ❑ Implementation of 2 rounds of Oral cholera vaccination campaigns in each of the 19 high risk districts
- ❑ Over **1,8240,56** people have received 2 doses of OCV in 19 high risk districts
- ❑ Involvement of key political leaders at national, state, regional and district levels in the fight against cholera
- ❑ Financial and technical support from different partners and UN agencies
- ❑ Capacity building of health workforce in cholera case management, enhanced surveillance and diagnosis
- ❑ Early Warning Alert and Response Network provided real time information about cholera alerts that is useful to deploy Rapid Response Teams
- ❑ Dedicated Cholera Task Force with in MOH which works with other govt agencies and donors to conduct integrated response
- ❑ Development of cholera strategy is in advanced stages
- ❑ Deployment of Trained Integrated emergency Response teams in Cholera hot spot areas

CHALLENGES:

- ❑ The collapse of National health system in Somalia for decades due to the total collapse of the central Government in 1991.
- ❑ Limited funding towards cholera response, available donor funding is for emergency operations as opposed to sustained development projects such as WASH projects
- ❑ Ever increasing influx and over concentration of IDP camps in Major urban cities and towns of the country with very poor living conditions
- ❑ Limited access to safe drinking water together with poor hygiene and sanitation practices and facilities including practices of open defecation among IDP Population.
- ❑ Poor Geographical access for government and Humanitarian agencies to remote areas due to insecurity/Conflicts affects access to most vulnerable communities
- ❑ No cross border coordination with neighboring communities despite high population movement across borders

CHALLENGES CONT.....

- ❑ Un-controlled population movement with neighboring countries where there is no cross-border surveillance.
- ❑ Challenges in stool sample transportation from remote areas due to insecurity and limited transportation facilities.
- ❑ Less than 20% of the population in rural areas have access to basic health care services.
- ❑ A combination of multiple hazards (conflict, floods, drought) continue to contribute to the negative impacts on health services
- ❑ Inadequate coordination of preparedness and response activities among key partners
- ❑ High staff turn over of trained health workers in different locations and Health facilities.
- ❑ Lack of Cholera strategy document for Somalia

OPPORTUNITIES:

- ❑ Implementation of OCV campaign in cholera hot spot areas with support from GTFCC and GAVI.
- ❑ The development of Cholera strategy for Somalia is in its final stage with the support of WHO consultant.
- ❑ Some inaccessible areas are being made accessible and this will improve access for Humanitarian Response.
- ❑ Availability of good Number of Health partners in all Government controlled urban towns in Cholera hot spot areas.
- ❑ Good number of Federal states resume the coordination and implementation of cholera prevention and case management measures
- ❑ Enhanced surveillance using Early Warning Alert and Response network for early detection and response to alerts
- ❑ Training of community based volunteers in cholera high risk areas to support home based management of cholera using home made ORS.

PLANS AND WAY FORWARD:

- ❑ Finalization of National Cholera strategy document and government endorsement.
- ❑ Implement OCV campaign as deem necessary in cholera high risk areas.
- ❑ Strengthen EWARN system and extend it to district level and train CSR officers
- ❑ Explore opportunities to conduct training activities for community volunteers in Remote areas.
- ❑ Continue advocacy and resource mobilization for Cholera control and prevention aiming to the road map of ending cholera by 2030.
- ❑ Advocate for the Provision of safe water and proper sanitation to displaced communities
- ❑ Tracking population movements and displacements with the aim of early detection of outbreaks in vulnerable communities

Recommendations on the Use of Single Dose Antibiotics for Moderate AWD/Cholera in Fragile Health Systems

“A Strategy Pursued during the 2017 large Cholera Outbreak”

Category	Treatment	
	First-line drug choice (if local strain is sensitive)	Alternative drug choices
Adults including pregnant women	Doxycycline 300 mg in a single dose	Ciprofloxacin: 1 g orally as single dose or Azithromycin: 1 g orally as single dose
Children	Doxycycline 2-4 mg/kg in a single dose	Ciprofloxacin: 20 mg/kg (max 1g) orally as a single dose, or Azithromycin: 20 mg/kg (max 1g) orally as a single dose

This case management approach is also suggested for operational research

Thank you

Together we can
#endcholera



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