REPORT ON CHOLERA SITUATION IN ESHOWE / NKANDLA, 18-20 APRIL 2001

As part of ongoing technical support for cholera control in KZN Province a working visit was made to Eshowe/Nkandla, one of the most affected districts.

A team comprising of Dr C. Mugero, Mrs N. Bonga – Coordinator district JOC, Sisters of Ekombe hospital visited some of the most affected areas of Mfongosi and Nhloshana in Ekombe areas.

Another team on 19th April 2001 with Dr C. Mugero and Mr N. Mbatha (EHO), the area Environmental Health Officer, some members of SAMHS visited other affected areas of Dloziyana, Nogajuka and locally based cholera treatment centres (St Marys Hospital, Melmoth; Dloziyana and Nogajuka Rehydration Centres)

OBJECTIVES OF THE MISSION:

- To review and discuss the ongoing cholera outbreak in the district with the health authorities and make appropriate recommendations.
- To review and follow up cholera control interventions at community level.

METHODOLOGY:

- Met and held discussions with District JOC members.
- Reviewed records and reports.
- Field visits to Cholera Treatment Centres (CTCs) and most affected Communities.
- Review cholera interventions in Communities.

CHARACTERISTICS OF THE EPIDEMIC

The district has been experiencing an outbreak since index case from Nkanini was confirmed in Eshowe hospital on 22 September 2000. The index case, a herdsman was originally from Nkandla. Samples from home and commonly used water source (river), were negative. Given the facts that an outbreak had earlier been reported in neighbouring Empangeni, a preparatory meeting involving EHOs of Eshowe/Nkandla & Lower Umfolozi had taken place as a part of preparedness for epidemic response. This included formation of a core team, Health Education and distribution of materials.

Following a slow increase in number of reported cases (mid November – 10th December 2000) there was a steady increase, reaching a peak in mid January 2001. With exception of an observed increase during week ending 4th February, there has been a steady decline.

When compared to other districts, besides Ulundi which has had 2 peaks (week ending 11th February & 18th March), the other 2 most affected districts Eshowe/Nkandla and Lower Umfolozi show almost similar trends.

There is an almost uniform increase during week ending 22nd April probably as results of gatherings/feasting during the concluded Easter festivities.

As of 20th April a cumulative case of 25 363 with 30 deaths giving a CFR of 0.12%.

Graph 1 shows trend of cholera epidemic in Eshowe/Nkandla in KZN.

ACHIEVEMENTS
Coordination of epidemic control;
Joint Operation Committees JOCs or District (Empangeni) meet on Mondays. Sub district (Eshowe?Nkandla, Lower Umfolozi) meet on Tuesdays.

The Committees manage daily running of cholera control activities, including monitoring statistics, water and sanitation especially in affected areas.

The technical team includes 5 EHOs from Gauteng Province and North West. A disaster management Committee with membership (District Council, NGOs, Municipal Councils, Provincial Disaster Management Team) meet monthly and provide strategic planning, allocation of funds.

Community Services Coordinator a Matron based at hospital and responsible for ; Community Health Centres, Clinics, Mobile Clinics, Community outreach programme (School Health Services, TB/AIDS and DOTs), Environmental Health Services and Community Health Workers (CHWs)/ Volunteers)

Have linkage with Community; held meetings with Traditional leaders (Amakhozi and Ndunas). Working groups within Ndunas include CHWs , Community facilitator (qualified trainer) and volunteers.

Evidence of data utilization at lower level for action.

Health personnel devoted, in working during weekends and after hours.

EPIDEMIOLOGICAL SURVEILLANCE AND CASE MANAGEMENT:
Forms of the problem lies in Ekhombe/Nkandla areas especially along Tugela river. These are vast areas with many Communities. Data is collected on a regular basis, basic analysis done and with effect from March, had started presentation of processed data during meetings. Further analysis od data and interpretation needed to facilitate in decision process.

The lack of feedback of information to Communities may be contributing to reason for their minimal/lack of participation, critical in effecting change at Community level.

Rehydration centres reporting more cases than hospitals and clinics (62 compared to 51). This desirable approach not only minimises congestion of hospitals but greatly improves accessibility to health services within the affected areas which in most cases have inadequate infrastructure. The spread of the disease is also minimised.

FINDINGS

- Rehydration/treatment Centre
- Standard treatment guidelines
- They were not available in both St Mary's and Dloziyana Rehydration Centre.
- The team discussed the importance of guidelines with the staff and Matron in charge of St Mary's Hospital. The draft photocopy was left with the Matron.

Infection Control Procedures

- The staff at ST Mary's Hospital (St Banabas Isolation Ward) didn't have protective clothing (aprons, shoe cover & gloves) despite the fact that they were supplied by Matrons.
- All the units didn't have the provision for disinfection at entrance/exit areas. (spray pumps or basins for foot bath)
- The team discussed the importance of strengthening the infection control measures and practicability of implementation.

Follow-up of discharged cases and contact case tracing

- These have not been happening with the exception of the EHOs outreach programme
- Based on information from the registers the staff were advised on the importance of follow-up and contact case tracing as one of the ways to quicken the epidemic control. Emphasis was placed on utilization of existing structures. (EHOs team, CHWs. trained volunteers and traditional leaders as well as councillors for advocacy).

Restriction of attendants/visitors to the treatment centre

- The team emphasised the restriction of unnecessary attendants/ visitors to treatment centre as the way of reducing the spread of the infection.

DATA MANAGEMENT

- The team discussed the importance of simple data analysis to be unit itself in addition to forwarding data to the district and feedback to the communities where patients. cases come from. At the community level this information could be used by the outreach team (EHOs, CHWs, trained volunteers, Traditional leaders and councillors)
- Draft tools to be developed for these activities.
- Activities with the communities to be planned in conjunction with the local leaders.

Follow-up of cholera control intervention in the Community

- Meeting was held with Induna Philip Zulu discuss issue of persisting cases from areas of Dloziyana & Nogajuga. The Indina was very pleased with the recognition of what the local leadership (Inkosi/Izinduma) as well as the community could play in active promotion of sanitation in a bid to bring the epidemic to a quick control.
- Induna suggested**:**
  - meeting with the tribal court during their next meeting to discuss the plan of action.

Possible risks factors for persistance in these areas.

- Poor sanitation (low latrine coverage about 10 %)
- Continous use of unsafe water (streams, rivers and unprotected springs)
- Slow behaviour change which is aggrevated by strong cultural beliefs.
- Irregular availability of Jik in most households (e.g. poverty)

RECOMMENDATIONS

- The District JOC should strengthen infection control procedures in all treatment centres.
- They should be continous supply of Jik to facilitate water chlorination at community level (chlorination of water at common collection points) to ensure the continous availability of safe water in the community.
- District JOC should strengthen cholera control strategies at the community level with the active involvement of the local leadership.