**B9.3 Interview with a community radio – Roleplay**

**Participant guide: Instructions for Director of Disease Control or the Ministry of Health/spokesperson**

**Instructions**

To prepare content items for communication about the disease you can use:

* Cholera Fact sheet (Annex 1)
* Press release 1 (Annex 2)
* Press release 2 (Annex 3)

Concentrate on the followings questions:

* Who?
* What?
* When?
* Where?
* How?
* Why?
* What are your three key messages?
* Which title would you like to see published in the newspapers?

**Annexes**

**Annex 1: Cholera Fact sheet**

Fact sheet N°107  
July 2015

**Key facts**

* Cholera is an acute diarrhoeal disease that can kill within hours if left untreated.
* Researchers have estimated that there are 1.4 to 4.3 million cases, and 28 000 to 142 000 deaths worldwide1 due to cholera every year.
* Up to 80% of cases can be successfully treated with oral rehydration salts.
* Provision of safe water and sanitation is critical to control cholera and other waterborne diseases.
* Oral cholera vaccines are an additional way to control cholera, but should not replace conventional control measures.

Cholera is an acute diarrhoeal infection caused by ingestion of food or water contaminated with the bacterium *Vibrio cholerae*. Researchers have estimated that every year, there are roughly 1.4 to 4.3 million cases, and 28 000 to 142 000 deaths per year worldwide1 due to cholera. The short incubation period of 2 hours to 5 days, is 1 factor that triggers the potentially explosive pattern of outbreaks.

**Symptoms**

Cholera is an extremely virulent disease. It affects both children and adults and can kill within hours.

About 80% of people infected with *V. cholerae*do not develop any symptoms, although the bacteria are present in their faeces for 1-10 days after infection and are shed back into the environment, potentially infecting other people.

Among people who develop symptoms, 80% have mild or moderate symptoms, while around 20% develop acute watery diarrhoea with severe dehydration. This can lead to death if left untreated.

**History**

During the 19th century, cholera spread across the world from its original reservoir in the Ganges delta in India. Six subsequent pandemics killed millions of people across all continents. The current (seventh) pandemic started in South Asia in 1961, and reached Africa in 1971 and the Americas in 1991. Cholera is now endemic in many countries.

***Vibrio cholerae*strains**

Two serogroups of *V. cholerae* – O1 and O139 – cause outbreaks. *V. cholerae*O1 causes the majority of outbreaks, while O139 – first identified in Bangladesh in 1992 – is confined to South-East Asia.

Non-O1 and non-O139 *V. cholerae* can cause mild diarrhoea but do not generate epidemics.

Recently, new variant strains have been detected in several parts of Asia and Africa. Observations suggest that these strains cause more severe cholera with higher case fatality rates. Careful epidemiological monitoring of circulating strains is recommended.

The main reservoirs of *V. cholerae* are people and aquatic sources such as brackish water and estuaries, often associated with algal blooms. Recent studies indicate that global warming creates a favourable environment for the bacteria.

**Risk factors and disease burden**

Cholera transmission is closely linked to inadequate environmental management. Typical at-risk areas include peri-urban slums, where basic infrastructure is not available, as well as camps for internally displaced persons or refugees, where minimum requirements of clean water and sanitation are not met.

The consequences of a humanitarian crisis – such as disruption of water and sanitation systems, or the displacement of populations to inadequate and overcrowded camps – can increase the risk of cholera transmission should the bacteria be present or introduced. Dead bodies have never been reported as the source of epidemics.

Cholera remains a global threat to public health and a key indicator of lack of social development.

The number of cholera cases reported to WHO continues to be high. During 2013, a total of 129 064 cases were notified from 47 countries, including 2102 deaths. The discrepancy between those figures and the estimated burden of the disease is due to the fact that many cases are not recorded for due to limitations in surveillance systems and fear of trade and travel sanctions.

**Prevention and control**

A multidisciplinary approach is key for reducing cholera outbreaks, controlling cholera in endemic areas and reducing deaths.

**Water and sanitation interventions**

The long-term solution for cholera control (which benefits all diseases spread by the fecal-oral route) lies in economic development and universal access to safe drinking water and adequate sanitation, which is key in preventing both epidemic and endemic cholera.

Actions targeting environmental conditions include:

* the development of piped water systems with water treatment facilities (chlorination);
* interventions at the household level (water filtration, water chemical or solar disinfection, safe water storage containers); and
* as well as the construction of systems for sewage disposal and latrines.

Most of those interventions require substantial long term investments and high maintenance costs which are difficult to fund and sustain by the least developed countries, where they are also most needed.

**Treatment**

Cholera is an easily treatable disease. Up to 80% of people can be treated successfully through prompt administration of oral rehydration salts (WHO/UNICEF ORS standard sachet). Very severely dehydrated patients require the administration of intravenous fluids. These patients also need appropriate antibiotics to diminish the duration of diarrhoea, reduce the volume of rehydration fluids needed, and shorten the duration of V. cholerae excretion. Mass administration of antibiotics is not recommended, as it has no effect on the spread of cholera and contributes to increasing antimicrobial resistance.

In order to ensure timely access to treatment, cholera treatment centres (CTCs) should be set up within the affected communities. With proper treatment, the case fatality rate should remain below 1%.

**Surveillance**

Under the International Health Regulations, notification of all cases of cholera is no longer mandatory. However, public health events involving cholera must always be assessed against the criteria provided in the Regulations to determine whether there is a need for official notification.

Local capacities for improving diagnosis, and for collecting, compiling and analysing data, need to be strengthened so that vulnerable populations living in high-risk areas can be identified in order to benefit from comprehensive control activities. Cholera surveillance should be part of an integrated disease surveillance system that includes feedback at the local level and information-sharing at the global level.

**Social mobilisation**

Health education campaigns, adapted to local culture and beliefs, should promote the adoption of appropriate hygiene practices such as hand-washing with soap, safe preparation and storage of food and breastfeeding.

Awareness campaigns during outbreaks also encourage people with symptoms to seek immediate health care. The campaigns should use modern communication channels (mobile phones, smartphones, social media, etc.) and adapted to local cultures. The use of qualitative methods of analysis, to help adapt messages to local culture and beliefs, is also encouraged.

**Oral cholera vaccines**

Currently there are 2 WHO pre-qualified oral cholera vaccines (OCVs) (Dukoral® and Shanchol®). Both vaccines have been used in mass vaccination campaigns with WHO support. Their use has enabled evidence to be collected on the effectiveness and feasibility on implementation of oral cholera vaccination campaigns as a public health tool in protecting populations at high risk of cholera.

Dukoral® is administered to adults and children aged >6 years in 2 doses; and to children aged >2 years and <6 years in 3 doses. Protection can be expected 1 week after the last dose. Field trials in Bangladesh and Peru have shown that this vaccine is safe and confers 85% protection for 4–6 months in all age groups. This vaccine is not licensed for use in children aged <2 years.

Shanchol’s immunization schedule is 2 doses given at an interval of 2 weeks for those aged >1 year. Shanchol® has provided longer term protection than Dukoral® in children aged <5 years, and therefore does not require a booster dose after 6 months in this age group, unlike Dukoral®. Shanchol® provided 67% protection against clinically significant *V. cholerae* O1 cholera in an endemic area for at least 2 years after vaccination. A field trial in Kolkata, India obtained protective efficacy (65%) of the vaccine up to 5 years.

An OCV stockpile of 2 million doses was formally established mid-2013 for outbreak control and emergencies. The OCV stockpile was created on the principle that vaccines have a role in the prevention and control of cholera when used in conjunction with accessible healthcare and improvements in water and sanitation.

In November 2013, the GAVI board approved a contribution to the global cholera vaccine stockpile for epidemic and endemic settings, for 2014-2018. The objectives of the GAVI investment are to:

1. break the current cycle of low demand–low supply, significantly increasing global OCV production and availability;
2. reduce the impact of cholera outbreaks; and
3. strengthen the evidence base for periodic pre-emptive campaigns.

As of June 2015, about 2 million doses of OCV have been shipped from the stockpile in various settings, either in the form of reactive campaigns in areas experiencing an outbreak or pre-emptive vaccination campaigns among populations at elevated risk for cholera (“hotspots”), or at heightened vulnerability during an humanitarian crisis.

Impact on cholera burden or transmission was significant in all endemic, outbreak and emergency settings. Furthermore, contrary to earlier concerns, the communities readily accepted the vaccines and high vaccine coverage were reported. No serious adverse effects have been reported so far.

**Travel and trade**

Today, no country requires proof of cholera vaccination as a condition for entry. Past experience shows that quarantine measures and embargoes on the movement of people and goods are unnecessary. Import restrictions on food produced using good manufacturing practices, based on the sole fact that cholera is epidemic or endemic in a country, are not justified.

Countries neighbouring cholera-affected areas are encouraged to strengthen disease surveillance and national preparedness to rapidly detect and respond to outbreaks should cholera spread across borders. Further, information should be provided to travellers and the community on the potential risks and symptoms of cholera, together with precautions to avoid cholera, and when and where to report cases.

**WHO response**

Through the WHO Global Task Force on Cholera Control, WHO works to:

* support the design and implementation of global strategies to contribute to capacity development for cholera prevention and control globally;
* provide a forum for technical exchange, coordination, and cooperation on cholera-related activities to strengthen countries’ capacity to prevent and control cholera;
* support countries for the implementation of effective cholera control strategies and monitoring of progress;
* disseminate technical guidelines and operational manuals;
* support the development of a research agenda with emphasis on evaluating innovative approaches to cholera prevention and control in affected countries;
* increase the visibility of cholera as an important global public health problem through the dissemination of information about cholera prevention and control, and conducting advocacy and resource mobilization activities to support cholera prevention and control at national, regional, and global levels.

**Annex 2: Press release 1**

Country X is suffering from the worst cholera outbreak ever known in recent world history. This outbreak is due to a deficiency in the treatment of waste in two villages. The strain of the virus would have spread in the river, which water is used for washing, cooking and drinking in most parts of the country.

The action plan includes steps on the short, medium and long terms divided into three phases; each phase has specific objectives to overcome the current crisis and significantly improve the water system and water treatment in country X to prevent future disasters. Two years later, only 9.5% of the budget has been gathered, and the trainings which were planned have not been conducted. In addition, there are frequent drugs shortages for the treatment of patients.

During the first two years when action was taken against the epidemic of cholera, only 2.5% of the cholera emergency budget, have been managed by the National Directorate of Drinking Water Supply and Sanitation in country X (DINEPA).

Without any adequate funding at the disposal of the Department of Public Health and Population (DPHP) and other agencies, the epidemic of cholera continues to kill the most vulnerable people, especially children under 5 years. As of December 15, 2013, over 695 cases were reported and one death recorded in one of the 2 most affected villages.

The Ministry of Health has appealed to partners to provide assistance to the country. They are asked to:

1. Mobilize the Member States, unusual donors, and other international actors to fully fund the 10 years plan, 3 phases and $ 2,27 billion of the National plan to eradicate cholera
2. Ensure the United Nations implement the guidelines made by the panel of independent experts:
   1. Cholera screening measures applied to the United Nations staff and emergency services teams coming from pandemic zones.
   2. Vaccinations and antibiotics treatment provided to the United Nations staff assigned to emergency services.
   3. Local treatment of all waste in the United Nations facilities in the whole world to neutralize dangerous pathogens such as *vibrio cholerae*.

For more information, please contact the Ministry of Health Communication Officer Phone (220 4455 87 243)

**Annex 3: Press release 2**

# The national public health association fears new outbreaks of cholera

On the eve of the start of the rainy season in country X, the National Public Health Association launches an alarm call: given the poor quality of water and sanitary conditions, we fear that the number of cholera cases increases.

If the number of patients treated in the cholera treatment center of the regional hospital remains stable, the association calls for the improvement of the sanitation services as quickly as possible to avoid a new outbreak.

2 566 patients have been admitted to the regional hospital since July 2015. 39 persons did not survive the disease. Today many water sources are dry. There are not enough structures for the disposal of human waste in the area. Given this situation, the epidemic is very likely to experience a new boost.

« The cholera epidemic which has been affecting the country for more than one year is far from over », Charles D, president of the Association explains. «the number of patients has decreased, but the coming March and April rains will certainly revive the epidemic. If no energetic and immediate measures are taken and if no significant investments are done on the long term, we are very likely to witness an increase in the number of cholera cases in the near future ».

Shortly after the epidemic begins, the partners have deployed emergency teams with local and international staff notably. A campaign promoting health was led alongside the public health department of the local county committee and water purification kits were distributed to 5728 families. In December, when cases multiplied because of rain, the cholera treatment center teams from the regional hospital were strengthened. Since the cholera epidemic has started in the country X, end of 2014, the Ministry of Public Health reported more than 10 000 cases in the country.

**About cholera**

Once the people are infected by water or contaminated food, cholera spread quickly. The spreading is accelerated by poor hygiene and insufficient sanitation. Cholera can be treated in a simple and efficient way by replacing the fluids and salts lost through vomiting and diarrhea as fast as possible. The patients with cholera are always treated with oral rehydration solutions and antibiotics. More severe cases will require to be rehydrated by intravenous.

For more information, please contact: (229) 634 24 56 4

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