

NIGERIA AND NIGER

Cholera outbreak

CRISIS OVERVIEW

Cholera is endemic in Nigeria, and there has been an increase in reported cases since June 2021. Following this rise in infections across the country, the Nigeria Centre for Disease Control (NCDC) activated a comprehensive cholera Emergency Operations Centre on 21 June (NCDC 21/06/2021). As at 24 October, there have been 93,932 suspected cases and 3,293 associated deaths in Nigeria in 2021. These numbers put the case fatality rate at 3.5%, which is higher than the previous annual outbreaks in the past four years. The outbreak has affected 32 of the 36 states of the country, including the capital Abuja. Children aged 5–14 are the most affected group. Northern Nigeria is the most affected region, with 89% of all suspected cholera cases. 57% of the cumulative suspected cases are reported in four states in northern Nigeria: Bauchi (19,452), Kano (12,116), Zamfara (11,100), and Jigawa (10,763) (NCDC 09/11/2021 and 22/10/2021; IFRC 28/09/2021).

In Niger, the Minister of Public Health declared a cholera epidemic on 9 August. As at 12 October, there have been 5,343 confirmed cases and 156 deaths in 2021, for a case fatality rate of 2.9%. The most affected regions are Maradi, with 3,011 cases and 49 deaths; Tahoua, with 1,239 cases and 64 deaths; Zinder, with 566 cases and 20 deaths; Tillabéri, with 307 cases and 10 deaths; and Niamey, with 112 cases and 12 deaths (IFRC 04/09/2021; OCHA 10/11/2021).

The first cholera cases in Niger were reported in Maradi, which is very close to the border with Nigeria. The Niger-Nigeria border is very porous, with a lot of movement happening between the two countries. The initial cholera cases in Maradi were linked to the outbreak in northern Nigeria (UNICEF 20/08/2021).

Poor sanitation (including open defecation practices) and the consumption of contaminated water are some of the key drivers of the current outbreak in Nigeria. The rainy season and subsequent flooding also worsened the situation (NCDC 09/08/2021; OCHA 03/09/2021).

The number of cholera cases has started decreasing in Niger and Nigeria, but the disease is endemic in both countries. This report highlights the impact of the outbreak considering the current conflict environment and other aggravating factors.



KEY FIGURES

NIGERIA

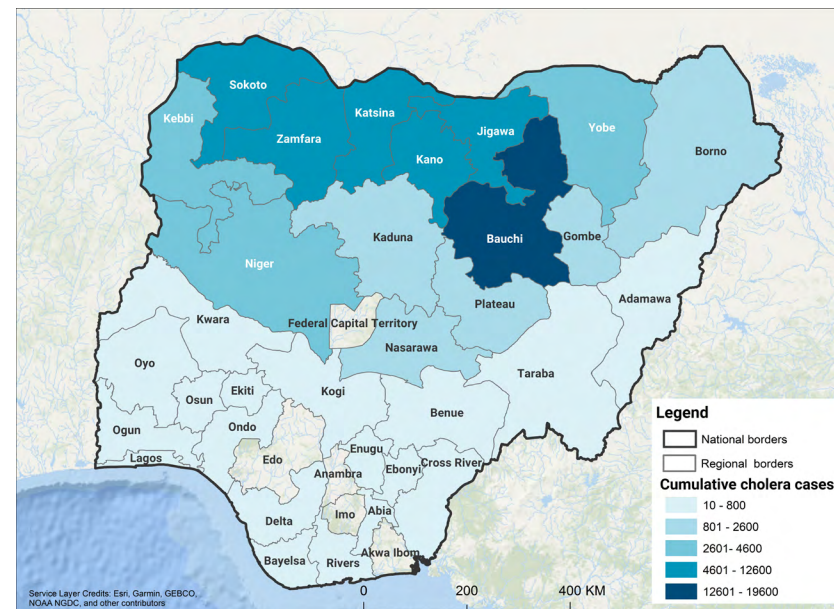
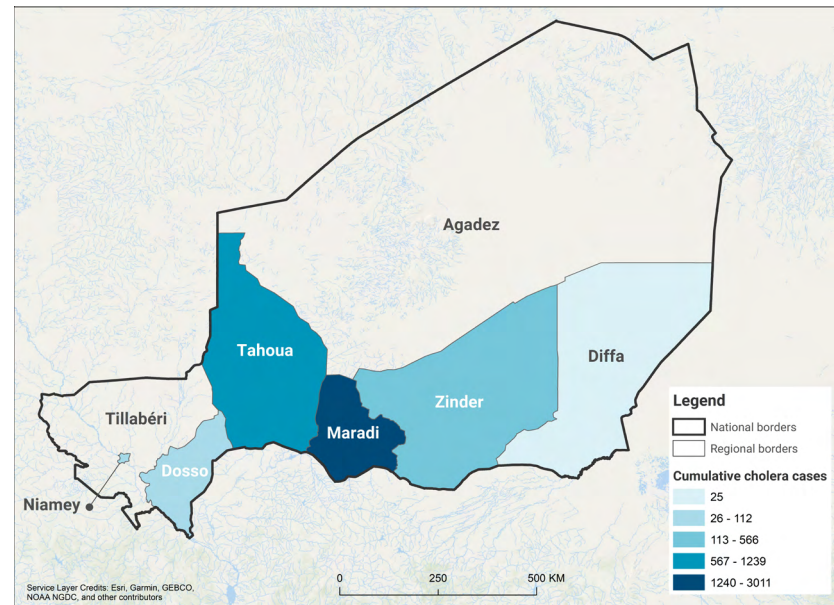
93,932
CHOLERA CASES

3,293
CHOLERA DEATHS

NIGER

5,343
CHOLERA CASES

156
CHOLERA DEATHS



See full map on pages 5 and 6.

HUMANITARIAN CONSTRAINTS

- The volatile security situation in Nigeria is an access constraint for humanitarian and health workers (OCHA 03/09/2021; Health Cluster 19/10/2021; NCDC 22/10/2021).
- In Maradi, the region most affected by the cholera outbreak in Niger, the activities of armed groups hamper the access of displaced people to health services. Incursions by armed groups also force hundreds of people to relocate each month, moving them away from health services or leading to increased pressure on health facilities already working with limited capacities (UNHCR 29/07/2021).
- Complex administrative procedures in northeast Nigeria (such as the clearance requirement for aid convoys to some locations) delay the delivery of critical medical supplies and treatment kits (OCHA 03/09/2021).
- There is poor network coverage in some affected areas of northeast Nigeria, particularly where the Government has recently gained control from insurgents. This hinders the timely submission of health data (Health Cluster 19/10/2021).

Limitations

- It is highly likely that the number of cholera cases and deaths in Nigeria has been undercounted, since some affected communities are in areas that are difficult to access given high levels of insecurity (OCHA 03/09/2021; IFRC 28/09/2021).
- According to the NCDC, some states in Nigeria inconsistently report data regarding cholera cases and deaths. The NCDC collates all the data on the number of cases and deaths (NCDC 22/10/2021).
- The latest official figures for cholera in Niger date back to 12 October. Even though many outbreaks are extinct, there are no figures showing the trend over the past month (OCHA 12/10/2021).

PRIORITY NEEDS

WASH

Nigeria

There are significant WASH needs in Nigeria, especially in the states most affected by the cholera outbreak. Only 14% of the Nigerian population has access to a supply of safely managed and uncontaminated drinking water. The level of access to basic services throughout northern Nigeria is well below the national average. Access to safe drinking

water is particularly low in the states of Bauchi (1.1%), Jigawa (2.4%), and Zamfara (3%), which are also the most affected by the cholera outbreak. Bauchi state also has a very low level of access to basic hygiene services; only 1.7% of Bauchi residents have handwashing facilities with soap and water on their premises. Open defecation practices in Nigeria also compromise hygiene and sanitation standards (UNICEF 03/11/2020).

Niger

In Niger, open defecation is common in most sites hosting displaced people, including host communities, because of the absence of latrines. There is also insufficient access to water in most localities. In Tahoua, the majority of the population does not have access to sufficient water in 57% of the assessed localities (REACH 30/07/2021). In Maradi, 91% of the assessed households have high WASH needs mainly because of the lack of latrines and the poor quality of drinking water. Poor hygiene and sanitation conditions in flood-prone settlement areas provide fertile ground for the spread of cholera, which is transmitted in particular through the consumption of water and food contaminated by infected people's excreta (REACH 31/01/2021).

Healthcare

Nigeria: Nigeria faces a significant disparity in health services across different states and geopolitical regions, with rural areas in northern Nigeria at the biggest disadvantage (WHO 05/2018; IntraHealth accessed 01/11/2021). After the long period of conflict, only 58% of health facilities in northeast Nigeria are fully functioning (Health Cluster 19/10/2021). Some areas in Nigeria have weak healthcare systems and lack skilled medical staff (OCHA 03/09/2021; Health Cluster 19/10/2021).

AGGRAVATING FACTORS

Floods and the rainy season

Nigeria

The rainy season runs from June–September in northern Nigeria and March–October in southern Nigeria (Federal Republic of Nigeria 18/04/2020). Flooding occurs almost annually in Nigeria and is caused by poor drainage systems, inadequate waste management, and poor urban planning (The Conversation 25/10/2021). Flooding compromises sewerage systems, leading to food and water contamination and ultimately raising the risk of spreading

waterborne diseases like cholera (Journal of Flood Risk Management 16/02/2021; OCHA 03/09/2021). Flooding also causes displacement into overcrowded settlement camps, where diseases spread easily (Journal of Flood Risk Management 16/02/2021). In 2021, flooding has affected many states in Nigeria, including Bauchi and Jigawa, as well as some highly populated cities such as Lagos and Abuja (ECHO 16/09/2021; CNN 02/08/2021; FloodList 16/08/2021).

Niger

As at 24 September 2021, the floods following heavy rains recorded in July–August have affected more than 238,000 people and caused 77 deaths in Niger (WFP 26/10/2021). At least 12,475 houses have collapsed as at 6 September. In 2020, flooding occurred at the same period during the rainy season (mid-June to October), affecting 432,613 people and causing the death of 58 people (OCHA 08/09/2021). The 2021 floods have caused the displacement of populations, who have found refuge in schools and with close families, particularly in the regions of Dosso, Maradi, Tahoua, and Zinder. Overcrowding in classrooms exposes those affected to diseases such as cholera as a result of poor hygienic conditions (IFRC 09/08/2021).

Multiple health emergencies

Nigeria

The cholera outbreak was declared in Nigeria when most health resources were directed towards the COVID-19 response. Nigeria is also facing other public health emergencies on a smaller scale, such as Lassa fever, yellow fever, monkeypox, and measles (AP News 14/09/2021; NCDC 30/09/2021; NCDC 24/09/2021; Health Cluster 19/10/2021).

In August 2021, resident doctors in Nigeria went on a strike that lasted two months to protest salary arrears and poor working conditions. Since resident doctors make up 38% of all doctors in Nigeria, the strike left most hospitals understaffed. Many patients in critical condition were either turned away or left unattended in hospitals as a result of the lack of staff capacity to treat them (Al Jazeera 17/09/2021; AP News 04/10/2021). Even at full staff capacity, the ratio of doctors to patients in Nigeria is 1 to 5,000 (The Guardian 04/02/2021). The resident doctors' strike coincided with the rise in cholera cases and worsened the shortage in well-trained health workers (NCDC 15/08/2021).

Niger

Because of the flow of patients from neighbouring Nigeria, health centres in Mardi were already overwhelmed long before the cholera outbreak. In the Dan Issa commune health centre, which is very close to the border with Nigeria, around 70% of patients are Nigerians. As a result of insecurity and the very limited accessibility of health services in northern

Nigeria, refugees rely almost exclusively on Nigerien health services, particularly for prenatal consultations, childbirth, and the management of other pathologies such as malaria and malnutrition-related illnesses (TV5 Monde 06/08/2021; Studio Kalangou 07/09/2021). In Tahoua, the region second-most affected by the epidemic, functional health centres experience difficulties related to the supply of electricity, the availability of drugs, and the insufficient capacity of staff in case management (UNICEF 17/11/2020; IFRC 04/09/2021).

Conflict and insecurity

Nigeria

Nigeria is facing high levels of insecurity as driven by several factors, such as the Boko Haram/Islamic State–West Africa Province insurgency in the northeast, attacks by armed groups in the northwest, farmer-herder conflict in the Middle Belt region, and separatist agitation in the southeast (BBC 19/07/2021). Some violent attacks in Nigeria have been targeted towards health and WASH facilities, with some reports of the theft of medical supplies by armed groups for their own use. Healthcare and humanitarian workers are sometimes targeted in kidnapping incidents (OCHA 03/09/2021; Eons Intelligence 03/08/2021; Reuters 05/07/2021).

Niger

In Niger, the activity of armed bandits and armed groups in Maradi and Tahoua, the regions most affected by the cholera outbreak, has caused a sharp increase in the number of IDPs. Threats from organised crime in Nigerien villages bordering the states of Katsina, Sokoto, and Zamfara in northwestern Nigeria have forced 26,000 people to flee to Maradi (UNHCR 28/09/2021; UNHCR 31/08/2021). In Maradi, the regional authorities have suspended registration, relocation, and general food distribution activities for refugees and host communities in the host villages because of the spread of the outbreak. This suspension has resulted in the deterioration of the socioeconomic situation for all population groups. Refugees and host communities already struggling to meet their daily expenses have become more vulnerable (UNHCR 28/09/2021; FEWS NET 30/10/2021).

Shelter

Nigeria

53% of the urban population in Nigeria lives in informal settlements (UN HABITAT 31/08/2021). Residents of informal settlements typically face various challenges, such as limited access to clean water, good drainage, adequate garbage disposal, and healthcare facilities (South

East Asia Journal of Public Health 18/01/2014). These conditions are public health hazards that increase the risk of contracting illnesses like cholera (NCDC 09/2017; Wathi 06/07/2020; Annals of Global Health 22/09/2020).

Nearly 2.9 million people in northern Nigeria are internally displaced as a result of conflict. There are also around 74,000 refugees and asylum seekers in Nigeria from neighbouring countries (UNHCR 30/09/2021). Congestion is a challenge in many camps, reception centres, and communities hosting IDPs and refugees (Shelter Cluster and CCCM Cluster 03/09/2021 and 15/07/2021; OCHA 03/09/2021). In the northeastern states of Adamawa, Borno, and Yobe, 73 camps hosting almost 424,500 people face high congestion levels (Shelter Cluster 06/08/2020). A high population density is associated with significant health risks, including cholera and acute watery diarrhoea (UNHCR accessed 01/11/2021; OCHA 03/09/2021).

Niger

More than 280,000 IDPs and around 186,000 Nigerian refugees were reported in Niger as at 30 September 2021 (UNHCR accessed 30/09/2021). These populations are left homeless by the attacks of armed groups and climatic events such as floods, fires, and drought. Some of these populations build makeshift shelters on flood-prone or disputed land, sometimes resulting in conflicts with owners, reduction in the means of production of the host populations, and the risk of secondary displacement. Newly occupied spontaneous displacement sites often lack WASH infrastructure, as well as health and education facilities (Shelter Cluster 21/04/2021).

CONTEXTUAL INFORMATION

Past cholera outbreaks

Nigeria

In Nigeria, cholera is an endemic disease that occurs annually, especially during the rainy season. Nigeria has experienced recurrent cholera outbreaks since 1970. The last serious cholera outbreak occurred in 2018, with 42,466 suspected cases and 830 deaths – a case fatality rate of 1.95% (NCDC 15/04/2019). Between 2010–2017, there were 122,239 suspected cases and 3,713 deaths – a case fatality rate of 3% (Solidarités International 2020). The number of suspected cases and deaths reported in 2021 has raised concerns that it may be one of the worst cholera outbreaks in Nigeria in recent history (Water Aid 06/10/2021; GAAC 06/10/2021).

Niger

In Niger, cholera outbreaks have been recorded since 1990. The most recent outbreak, in 2018, started with patients originating from the Jibiya health centre in neighbouring Nigeria. This outbreak affected 3,824 people with at least 78 deaths – a case fatality rate of 2%. The Madarounfa health district in Maradi region was the most affected, with 2,638 cases or 68.88% of all reported cases (IFRC 29/04/2019).

LESSONS LEARNT

While cholera is treatable if medical intervention is done in a timely manner, cholera outbreaks will continue to occur if the underlying causes are not addressed (NCDC 09/08/2021).

WASH

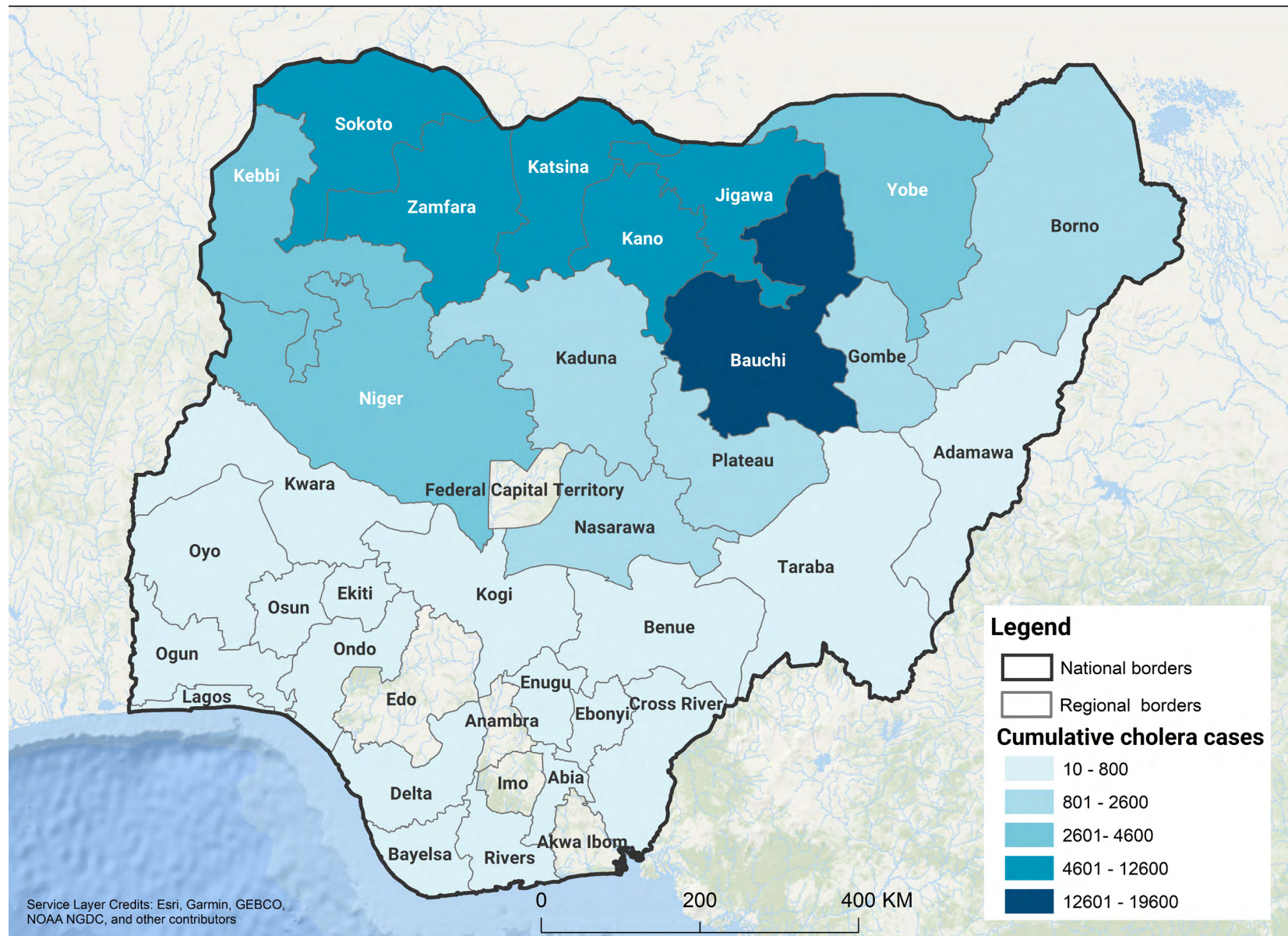
Cholera continues to be endemic in Nigeria because the majority of the population does not have access to safe drinking water and endures poor hygiene and sanitation standards. In other regions of the world where cholera used to be endemic, such as Europe and North America, the illness was eradicated by ensuring equitable access to safe drinking water and improving sanitation systems (WHO 04/10/2017; NCDC 09/08/2021).

In 2018, during the previous cholera outbreak, only around 37% of the population of Maradi had access to a source of clean water, and 75% practised open defecation. The persistence of this situation largely explains the spread of cholera in the country. The lack of WASH infrastructure both in IDP sites and in host communities appears to be a key reason for the cyclical episodes of cholera in Niger (WHO 15/09/2018).

Community engagement

Low health literacy is a challenge in Nigeria. Higher health literacy has had a positive impact on the incidence of malaria and maternal health outcomes in Nigeria (Annals of Global Health 22/09/2020). Community sensitisation programmes, which raise awareness on the importance of maintaining proper hygiene, have been touted as the best approach in cholera prevention (NCDC 09/08/2021).

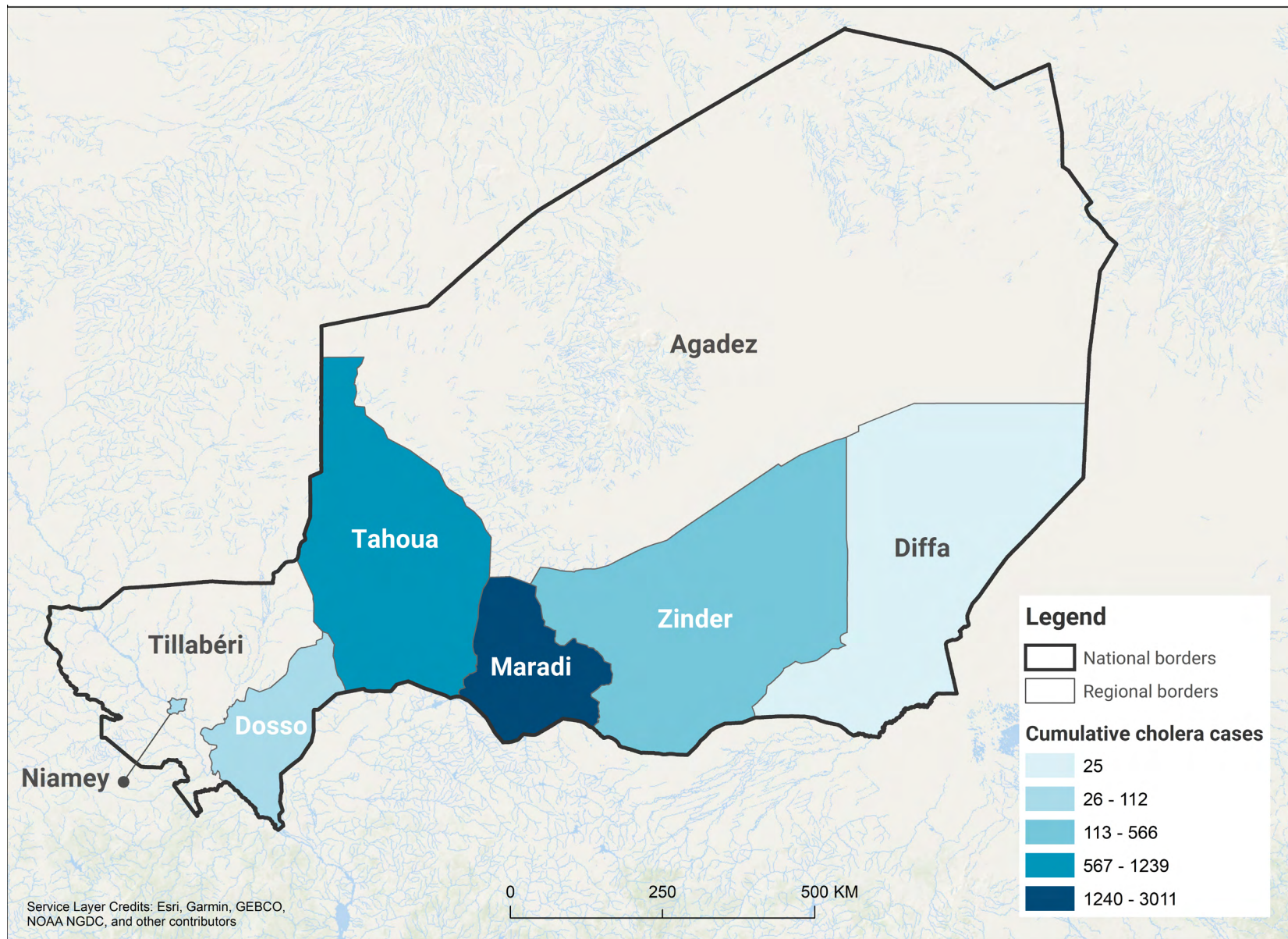
States in Nigeria affected by the cholera outbreak as at 24 October



Map produced by ACAPS

Data source: NCDC 09/11/2021

Regions in Niger affected by the cholera outbreak as at 12 October



Map produced by ACAPS

Source: OCHA 10/11/2021