



Nigeria / Epidemic (Cholera)

DREF Operation n° MDRNG020
Operational Review Report / August 2015

The DREF operational review was commissioned by the International Federation of Red Cross and Red Crescent Societies – Africa zone disaster management unit. It was carried out from 10 – 15 August 2015 in Abuja Federal Capital Territory, Anambra, Ebonyi and Rivers States.

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Abbreviations/acronyms

BPI	Better Programming Initiative
CFR	Case Fatality Rate
CTC	Cholera Treatment Centre
DM	Disaster Management
DMU	Disaster Management Unit
DREF	Disaster Relief Emergency Fund
ECV	Epidemic Control for Volunteers
EPoA	Emergency Plan of Action
ERC	Emergency Response Centre
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FMWR	Federal Ministry of Water Resources
HAP	Humanitarian Accountability Partnership
HH	Household
IEC	Information, Education and Communication
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organization
KAP	Knowledge, Attitudes, Practices
KII	Key Informant Interview
LGA	Local Government Area
MoH	Federal Ministry of Health

NEMA	National Emergency Management Agency
NFI	Non-Food Items
NHQ	National Headquarters
NRCS	Nigerian Red Cross Society
NS	National Society
ODK	Open Data Kit
ORS	Oral Rehydration Solution
RCRC	Red Cross Red Crescent
RDRT	Regional Disaster Response Team
RWSSA	Rural Water Supply and Sanitation Agency
SOP	Standard Operating Procedures
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

In 2015, 13 of the 36 States in Nigeria reported cholera cases, with Anambra, Kano, Rivers and latterly Ebonyi States being the worst affected. By the end of April 2015, 2,108 cases, with 98 deaths had been reported, and though it compared positively with previous years, the CFR had risen to as high as 12% in some areas. Following the outbreak, the International Federation of Red Cross and Red Crescent Societies (IFRC) released CHF 175,228 from the Disaster Relief Emergency Fund (DREF) to support the Nigerian Red Cross Society (NRCS) respond to the needs of the 15,000 people (3,000 households (HHs) in Anambra, Kano and Rivers States for a period of three months. Kano was later replaced by Ebonyi State.

As part of the IFRC's efforts to improve its operations and the level of accountability to all stakeholders, it was recommended that a review was carried out of the MDRNG020 Nigeria Epidemic (Cholera) to assess its 1) Relevance and appropriateness, 2) Efficiency, 3) Effectiveness, 4) Coverage, 5) Coherence, and 6) Sustainability and connectedness; with the intention of establishing lessons learned and recommendations for future operations. It was carried out from 10 – 15 August 2015 in Abuja Federal Capital Territory, Anambra, Ebonyi and Rivers States, using a standardized tool kit and comprised: review of secondary data, key informant interviews, focus group discussions, household surveys and a lessons learned workshop.

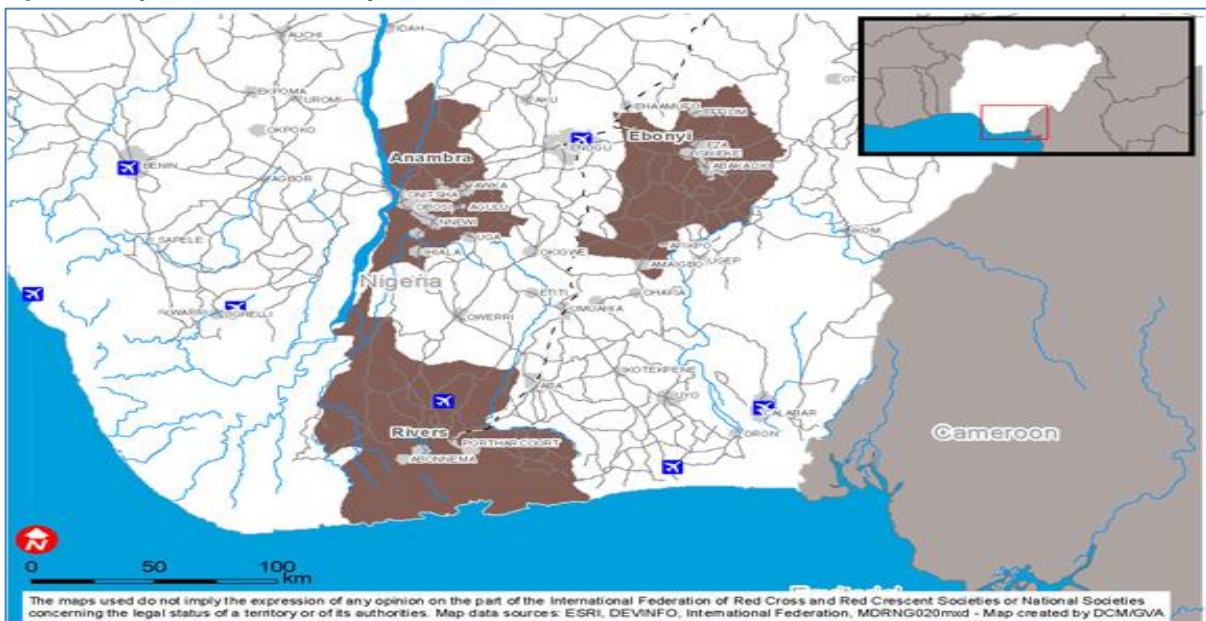
Based on the findings of the review, the DREF operation was able to exceed the targets that were agreed in the EPoA, and to some extent, contribute to a reduction in the number of cholera cases being reported in Anambra, Ebonyi and Rivers States. In total, 31,800 people (6,360 HHs) were reached through the DREF operation, which equates to 212% of the intended target (15,000 people / 3,000 HHs); and the response of the affected/at-risk population to the interventions was positive. In addition, the unprecedented number of cases that were being received compared to previous years, and also the exceptional CFR level also justified the launch of a DREF operation. Based on this, the operation can be seen to have been an effective response. Nonetheless, it should be noted that there were concerns identified in terms of the implementation of the DREF operation (based on the review criteria), which resulted in a rating of 17 / 30 (refer to "Chapter 2 / Key findings" for the rationale for this); and this report provides lessons learned and subsequent recommendations, which should be considered in future operations by the NRCS and the IFRC in Nigeria (and elsewhere as relevant).

Chapter 1: Introduction

1.1 Background

In Nigeria, following the epidemic in 2010, which recorded 41,787 cases and 1,716 deaths attributed to cholera, there have been recurrent outbreaks every year since. In 2014, there were 35,996 cases and 755 deaths (Case Fatality Rate (CFR) of 2.10%) reported. In 2015, 13 of the 36 States in the country reported cases, with Anambra, Kano, Rivers and latterly Ebonyi States being the worst affected. By the end of April 2015, 2,108 cases, 98 deaths had been reported, and though it compared positively with previous years, the CFR had risen to as high as 12% in some areas. According to World Health Organization (WHO) recommendations, with proper case management, the CFR should not exceed 1%, and as such the situation in Nigeria given the outbreaks in previous years, was of extreme concern (based on the technical advice of the Africa zone emergency health unit). On 6 March 2015, the IFRC released CHF 175,228 from the Disaster Relief Emergency Fund (DREF) to support the NRCS respond to the needs of the 15,000 people (3,000 households) in Anambra (South – East), Kano (North – West) and Rivers (South – South) States for a period of three months. Following discussions with the Federal Ministry of Health (MoH), it was agreed that Kano State should be removed from the DREF, and Ebonyi State (South – East) added (explained in “Chapter 2 / Programme sectors / Coverage” section).

Figure 1: Map of Nigeria, including areas of implementation through the MDRNG020 operation, specifically: Anambra, Ebonyi and Rivers



The “Sword and Shield” strategy (hereafter referred to “Sword and Shield”), which was developed initially by the United Nations Children’s Fund (UNICEF) that has since been used by many other international organizations in the responding to cholera, specifically in West African countries, was used to inform the activities planned within the MDRNG020 operation. The “Sword and Shield” comprises response (“Sword”) related interventions aimed at containing or erasing all potential sources of contamination within locations that are affected; and preparedness (“Shield”) related interventions aimed at reducing the potential contamination within locations that are at risk. The DREF operation was expected to be completed by the end of 6 June 2015. On 11 June 2015, an Operations Update was issued to extend the timeframe by two months (New end date: 6 August 2015) and make an additional allocation of CHF 26,566 (total allocation: 200,794); and then again on 22 July 2015, by an additional two weeks (until 20 August 2015).

As part of the IFRC's efforts to improve its operations and the level of accountability to all stakeholders, it was recommended that a review was carried out of the MDRNG020 Nigeria Epidemic (Cholera) operation (hereafter referred to as the "DREF operation") to assess its effectiveness. It was intended that the review would contribute to a meta-analysis of cholera operations (in Kenya, Nigeria and South Sudan) in order to capture lessons learnt, and inform recommendations for future DREF operations (and other relevant RCRC responses), specifically those related to epidemics. In addition, it was anticipated that the review would provide an opportunity to develop a case study/lessons learned document, which could be used to provide quality assurance to stakeholders including supporters of the DREF.

1.2 Objectives

- Review the effectiveness of the DREF operation in meeting the planned objectives; and outputs in the agreed EPoA;
- Provide a means of establishing successes, challenges, lessons learned from the MDRNG020 operation in order to inform recommendations for operations (and other relevant Red Cross responses), specifically those related to epidemics;
- Promote the DREF tool to relevant partners/donors in order to provide quality assurance; as well as improve the profile/visibility of the Red Cross response.

1.3 Methodology

A DREF standardized tool kit, which has been developed by the IFRC Africa zone disaster management unit (DMU) in collaboration with IFRC East Africa and Indian Ocean Islands Planning Monitoring, Evaluation and Reporting (PMER) unit, was used for all the activities carried out within this review (refer to Annex V – DREF Review Tool kit) – and included:

Desk review; and review of secondary data including:

- MDRNG020 Nigeria Epidemic – EPoAⁱ;
- MDRNG020 Nigeria Epidemic – Budget;
- MDRNG020 Nigeria Epidemic – Operations Update no.1ⁱⁱ;
- MDRNG020 Nigeria Epidemic Baseline/Assessments (Anambra, Ebonyi and Rivers);
- MAANG002 Nigeria Development Operation Plan (DOP);
- NRCS Strategic Development Plan 2016 – 2020;
- UNICEF Cholera Toolkitⁱⁱⁱ.

Key informant interviews (KII) with partners, staff and volunteers, including:

- NRCS national headquarter (NHQ) level staff, including: National Health Coordinator, Deputy Health Coordinator, Health Officer, Information and Technology (IT) Officer, and Disaster Management (DM) Officer (logistics focal person);
- NRCS branch level staff, including: Branch Secretaries (BS) (Anambra, Ebonyi and Rivers), as well as those volunteers involved in the DREF operation (Ebonyi and Rivers);
- MoH representatives (Federal, State and LGA level);
- Federal Ministry of Water Resources (FMWR) representative (Federal level);
- National Emergency Management Agency (NEMA) (State level);
- Rural Water Supply and Sanitation Agency (RWSSA) (State level);
- UNICEF representative (State level);
- World Health Organization representative (State level).

In addition, KIs were carried out with 10 selected volunteers (in total, five in Ebonyi, and five in Rivers), with the purpose of testing the knowledge they had acquired by being involved in the DREF operation, specifically related to the prevention, identification and control of cholera.

Household (HH) survey with beneficiaries:

In total 851 surveys were completed, which equates to approximately 30% of the target population (3,000); and 42.55% of the target population in Ebonyi and Rivers - refer to “Table 1: Sampling Plan”. It should be noted that the HH survey was developed in collaboration with the IFRC zone emergency health unit, based on the standards recommended by key sectorial stakeholders (i.e. UNICEF and the WHO), and is being used as part of an Africa wide initiative to enable an analysis of DREF operations related to epidemics (specifically cholera), according to a common methodology. As part of the IFRC Africa zone DMUs intention to promote the use of innovation and technology in disaster response, the HH survey was carried out using the Open Data Kit (ODK) software, which enabled data collection via Android OS mobile devices (cell phones). The Africa zone DMU shared the HH survey with the IFRC Nigeria country representation and NRCS to enable it to be converted for ODK; and then uploaded onto the server/downloaded onto the mobile devices.

Table 1: Sampling Plan

State	Local government area (LGA)	Village(s)	# HHs beneficiaries	# HHs targeted by survey	% HHs targeted by survey
Ebonyi			1,000	519	51.9%
Rivers	Andoni	Unyeada	1,000	333	33.3%
Total			2,000	851	42.55%

At field level (in the Abakaliki LGA, Orizou and Omeazale villages Ebonyi State; and Unyeada village, Andoni LGA in Rivers State), 15 volunteers (one per phone), who were involved in the DREF operation were selected; and then oriented on the use of the ODK software/cell phones (from the NRCS Deputy Health Coordinator and IFRC DREF delegate), as well as the tool. All volunteers were expected to have either participated in the ODK training as part of the DREF operation (please refer to “Annex II – MDRNG020 Nigeria Epidemic (Cholera) – EPoA”), or if not, were able to demonstrate that they could use a cell phone. The volunteers were divided into pairs (to provide peer support), and then over two days (12 – 13 August 2015) went house to house to interview people that had received assistance through the DREF operation. Each interview took on average approximately 25 minutes per household. Respondents were asked questions, which used “Yes/no”, “Select one”, “Select multiple options”, or used “Filter or contingency” logic, as well as provided ratings of “Excellent”, “Good”, “Average” or “Poor”. At the end of this exercise all completed surveys were downloaded onto the server, and then analysed by the IFRC DREF delegate in collaboration with the NRCS IT Officer (please refer to “Chapter 2 – Key findings” for a breakdown of the results).

Focus Group Discussions (FGDs) with:

- Beneficiaries including representatives from women, youth and religious groups within the communities (in the Abakaliki LGA, Orizou and Omeazale village Ebonyi State; and Unyeada village, Andoni LGA in Rivers State)
- NRCS volunteers involved in the DREF operation (in total, 15 from Ebonyi, and 18 from Rivers States)

Lessons learned workshop (one-day), hosted by the NRCS Anambra State Branch in Awka, with participants, including:

- NHQ staff including: National Health Coordinator, Deputy Health Coordinator, Health Officer, and IT Officer.

- NRCS branch level staff, including: Branch Secretaries and DM Coordinators (Anambra, Ebonyi and Rivers);
- NRCS volunteers involved in the DREF operation – two per State (Anambra, Ebonyi and Rivers)
- Beneficiaries (5 from Anambra State) including both men and women.

The DREF review team comprised: the IFRC zone DREF delegate, IFRC zone Emergency Health delegate and IFRC country representation (Health delegate), with support received from NRCS including the: National Health Coordinator, Deputy Health Coordinator, Health Officer, IT Officer, as well as designated IFRC / NRCS drivers. Following briefing at NHQ level the DREF review team was divided (3 per team), and deployed to Ebonyi and Rivers States respectively in order to enable both locations to be covered in the timeframe, before convening in Anambra State for the lessons learned workshop. On completion of the DREF operational review, the report was compiled by the IFRC zone DREF delegate, with inputs from the IFRC zone Emergency Health delegate and IFRC Nigeria Health delegate, prior to dissemination.

1.4 Limitations

During the review process, the following limitations were experienced in terms of the methodology that was used:

- Federal and/or State level representatives from some stakeholders were not available to participate in KIIIs, which was due to either the availability of contacts during the timeframe of the exercise^{iv}, or in some instances them having no pre-existing relationship with the NS, which made the organization of meetings challenging (explained here within this report in regards to coordination). Following the launch of the DREF operation, there was also a change in Federal and State governments (in May 2015), which meant that in some instances staff in ministries (e.g. FMOH) who were in place at the time of the epidemic had since departed. It should be noted therefore that it was not possible to gain the perspectives of all stakeholders on the DREF operation.
- For the FGDs with beneficiaries, efforts were made to ensure that there was representation from men/women, children, elderly, people living with disability; however due to the timeframe available, the sessions were mixed, which may have impacted on some of the more vulnerable people within these groups being able to give their perspectives on the DREF operation.
- The HH survey tool was prepared in English, and then translated by the volunteers to beneficiaries in the local language, which may have impacted on the consistency of the questions asked and therefore the responses given. Following the completion of this exercise, it was also identified that there was an error on one of the cell phones, which resulted in the loss of 60 surveys (Rivers). In addition, filter or contingency logic should have been applied to some questions, as not all questions received responses, which also impacted on data collection. It should be noted that HHs interviewed were targeted based on their availability on the days of the visit, and as such it was not a random sample, though efforts were made to ensure that it was representative (based on the beneficiary selection criteria). All HHs interviewed were willing to participate in the survey.
- Lessons learned workshop participants were invited from all areas of DREF operation implementation (Anambra, Ebonyi and Rivers); levels (NHQ, branch, and divisional), as well as beneficiaries (from Anambra). It should be noted that these efforts were made to ensure it was representational; however in some instances, there were issues with language (i.e. English was not their first language, particularly for beneficiaries), which may have impacted on these participants being able to give their perspectives on the DREF operation, though interpreters were made available where possible. In addition to the above, it was only possible to carry out activities within the review in Ebonyi and Rivers States (with the exception of the lessons learned workshop, which as noted involved participants from Anambra) during the timeframe available.

Chapter 2: Key findings

2.0 Programme sectors

Relevance and appropriateness: the extent to which the situation necessitated the launch of a DREF operation; the interventions suited the priorities of the affected population, if other interventions would have been more suitable; how they were revised based on the needs assessments carried out.

Rating
3/5

Between January – February 2015, the MoH reported 798 suspected cases attributed to cholera, and 67 deaths across 11 States, with a CFR levels of 8.4%, reaching as high as 12% in some areas exceeding the accepted WHO level of 1% (as noted in “Chapter 1/Background” section)^v. Despite the epidemiological situation comparing positively to previous years (specifically in 2014: 35,996 suspected cases; 755 deaths and a CFR 2.10%), the exceptional CFR level was identified^{vi} as an extreme cause for concern. Refer to “Table 1: Reported cholera cases – 2014/2015”. In addition, the situation was compounded by other issues in the country, including: Presidential elections scheduled on 28 March 2015, and widely expected to lead to civil unrest (and population movement), as well as the approaching rainy season (March – July, anticipated to peak in June) which were also regarded as increasing the risk of the outbreak spreading to other States.

Table 2: Reported cholera cases – 2014/2015^{vii}

Period	Case fatality rate (CFR)	Region surveyed	# of suspected cases	# of deaths
Jan – Dec 2014	2.10%	182 LGAs in 19 States	35,996	755
Jan – Feb 2015	8.40%	20 LGAs in 13 States	798	67

On 26 February 2015, an alert was issued (by the NRCS) to provide notification of the situation via the IFRC Disaster Information Management System (DMIS). On 27 February an Operational Strategy Call was convened with representatives from the IFRC country representation, West Coast regional representation, Africa zone, and Geneva disaster and crisis management unit; and it was agreed that given the circumstances (outlined above) a DREF allocation could be considered to support the NRCS respond to the needs of the affected/at risk population, initially in Anambra, Kano and Rivers States (Ebonyi was added later).

According to the KIIs with MoH representatives from State and LGA level (in Ebonyi and Rivers)) cases of cholera began to be reported in communities (in their respective States) from January 2015, peaking in March 2015, before reducing. At the LGA level, more than 10 referrals were received per day^{viii} (at the peak of the outbreak), which was above levels experienced in previous years and included referrals from many surrounding communities^{ix}. In addition, the MoH also provided verification of the extreme CFR levels that were reported during the outbreak (8.40%)^x; and indicated that industrial action (by MoH personnel) had led to reduced services at all levels, which was perceived as contributing at least in part to these rather unusual level. At Federal level, the FMWR representative corroborated this, indicating that the CFR could be attributed to the quality and timeliness in providing proper case management and treatment at community level, while the cholera outbreak due to poor quality of water across the country, and sanitation practices in rural areas.

The DREF operation was developed in accordance with the “Sword & Shield” strategy (refer to “1.1.1 Background”), with activities planned focused on:

- Conducting an assessment; and knowledge attitudes and practices (KAP) – with the intention of using the results to inform the revision of the activities as/if required;

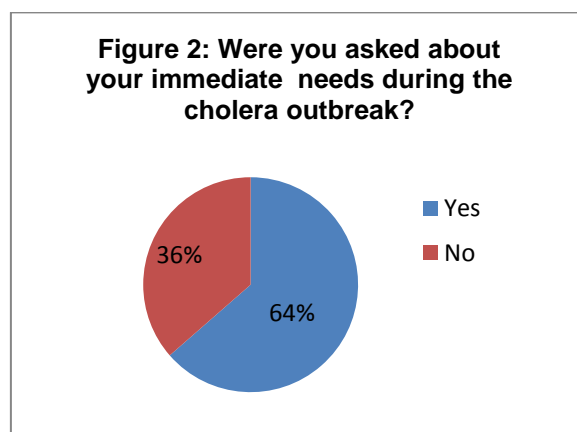
- Strengthening the capacity of volunteers to respond to the epidemic through training on the Epidemic Control of Volunteer (ECV) manual; and ODK approach;
- Community and household level activities to improve the knowledge and practices on the prevention and control of cholera; including the distribution of information, education and communications (IEC) materials;
- Distribution of water purification tablets to promote safe water supply; and hygiene related non-food items (NFIs) for safe water storage;
- Establishing and equipping of community WatSan committees to carry out environmental sanitation activities.

The assessments/KAP were carried out initially in three States of Anambra, Kano and Rivers. After the initial assessment Kano was replaced with Ebonyi State (refer to “Chapter 2 / Programme sectors/Coverage”). In total, six staff members were involved in the assessment and KAPs (two in each State), who carried out interviews with stakeholders at State level including State MoH, State emergency management agencies (SEMA) and UN agencies. An interview guide was developed with the help of the NRCS PMER officer. Each assessment was carried out for an average of three days in each State. In Ebonyi, an assessment was carried out, but a KAP was not as it was added later. Following the completion of these exercises it was identified that the activities planned in the original EPoA remained relevant to the “*immediate humanitarian needs*” (in accordance with the DREF guidelines) of the affected/at risk population, and as such revisions were not seen to be required. According to the assessments, the epidemiological information that had been issued by the MoH (in Anambra and Rivers) was valid, specifically in regards to the number of cases, worst affected areas, and the needs of the affected/at risk population, with recommendations to prioritize the following assistance:

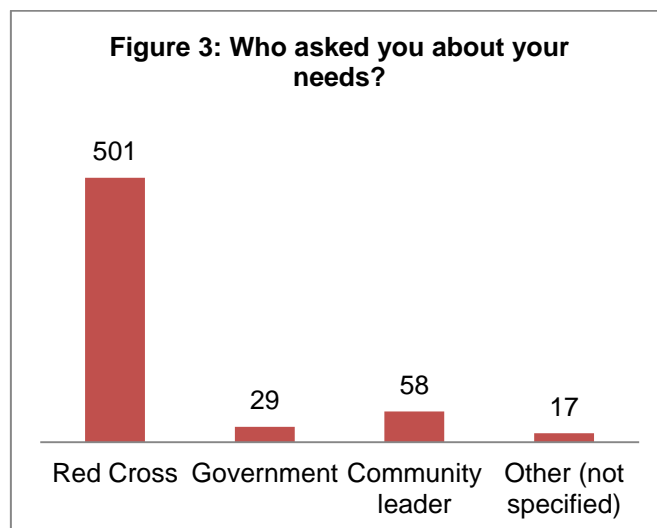
- Building knowledge of the affected/at risk population on the prevention, symptoms and transmission of cholera^{xi}; and
- Provision of access to safe water supply and adequate sanitation, as well as the distribution of hygiene related items (water storage etc.).

It should be noted that the assessments/KAPs also identified medium/longer term priorities (i.e. improving water supply and sanitation infrastructure), which were not considered for inclusion in the DREF operation and these needs were also reinforced by the HH survey^{xii}.

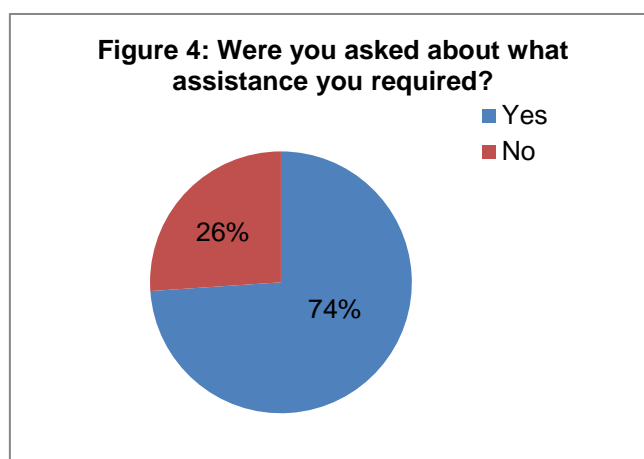
From the HH survey, 64% of respondents (541) indicated that they had been asked about their immediate needs during the cholera outbreak; however 36% of respondents (310) indicated that they had not been asked. Refer to “Figure 2: Were you asked about your immediate needs?”



Of the 541 respondents that indicated they had been asked about their immediate needs, 93% (501) had been asked by the Red Cross (NRCS), 11% (58) asked by a community leader and/or neighbour, 5% (29) asked by Government officials, and 3% (17) asked by others (not specified). Refer to “Figure 3: Who asked you about your needs?”. It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them.

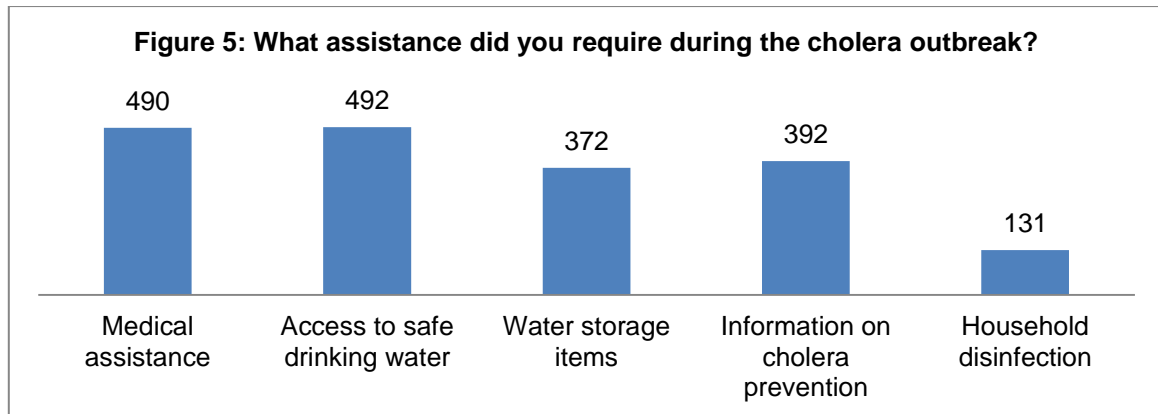


Of the 541 respondents that had been asked about their immediate needs, 74% were asked about what assistance they required (during the outbreak); however 26% were not asked. Refer to “Figure 4: Were you asked about what assistance you required?” As such, of the 851 respondents to the HH survey, only 48% were asked about their immediate needs and what assistance they required during the cholera outbreak.

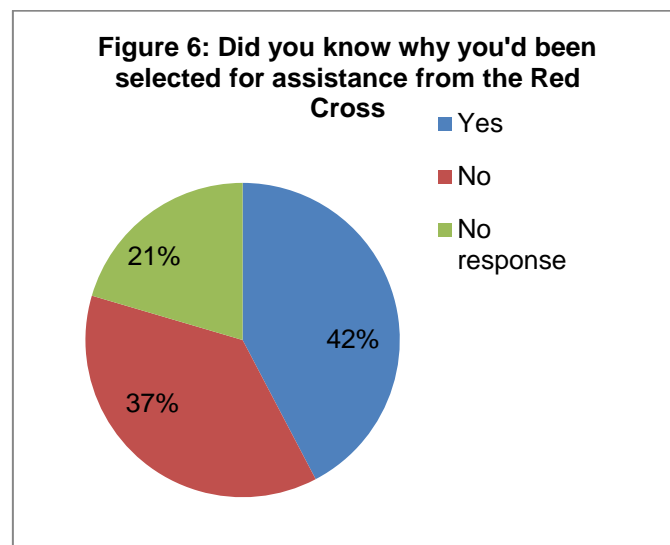


From the HH survey, 57.81% of respondents indicated that they required water treatment chemicals, 57.58% required medical assistance, 46.06% required information on cholera prevention, 43.71% required water storage items (buckets, jerry cans etc.), 15.39% indicated that they required support with household disinfection. Refer to “Figure 5: What assistance did you require during the cholera outbreak”. It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them. During the DREF operation, consultation with beneficiaries was captured (informally) via the volunteers, or from community leader groups (from the KIIs with BSs (Anambra, Ebonyi and Rivers States); FGDs with beneficiaries, and volunteers (Rivers); however no (formal) beneficiary communications mechanism was established. Nonetheless, it was noted (from the FGDs with beneficiaries) that beneficiaries, e.g. the community WatSan committees, participated

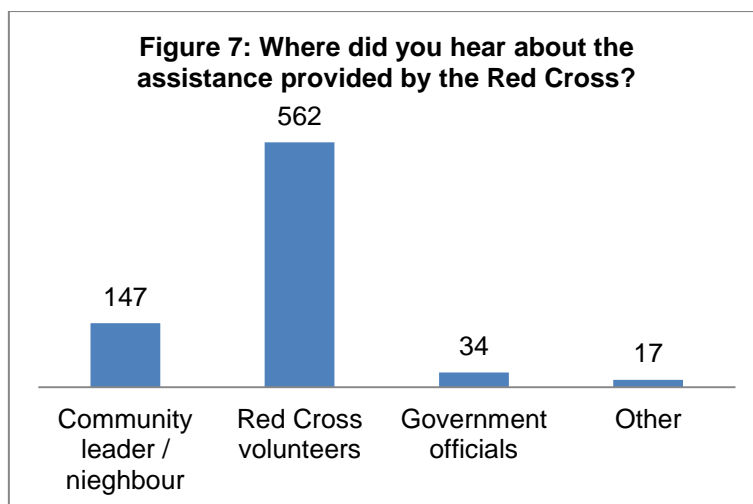
in the activities planned through the DREF operation, including: identification/selection of beneficiaries, selection of volunteers, mobilization of beneficiaries and crowd control during distributions (of NFIs).



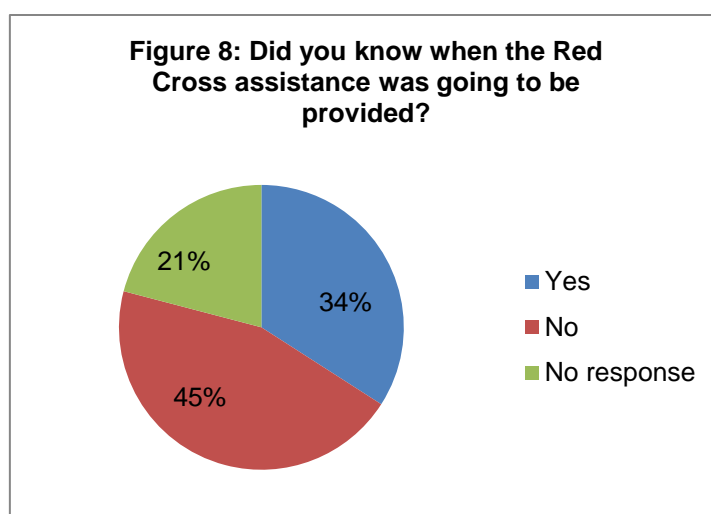
Of the respondents, 42% (360) were aware why they had been selected to receive assistance (from the Red Cross), 37% (317) were not aware, while the remaining 21% (174) did not provide a response. Refer to “Figure 6: Did you know why you'd been selected for assistance from the Red Cross”.



Of the respondents, 66% (562) heard about the assistance provided from the Red Cross, 17% (147) from a community leader and/or neighbour, 4% (34) from Government officials, 2% (17) from other sources, while 24% provided no response. Refer to “Figure 7: Where did you hear about the assistance provided by the Red Cross”. It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them.



Of the respondents, 45.01% (383) were not provided with information on (date, time and place of the distributions etc.) the when assistance was going to be provided, 34.08% (290) were provided with information, while 20.92% provided no response. Refer to “Figure 8: Did you know when the Red Cross assistance was going to be provided?”



Efficiency: the extent to which the DREF operation was managed in an organized and competent way; if the allocation was adequate to deliver the expected outputs / activities; if costs could have been reduced or most cost effective approaches taken.

Rating

3/5

The DREF operation (EPoA and Budget) was developed by the NRCS NHQ (the National Health Coordinator and/or Deputy Health Coordinator) with support the IFRC Nigeria country representation; as well as technical input from the IFRC zone disaster management and emergency health units following its submission the Africa zone. If relevant, the lessons learned from previous operations, specifically the MDRNG015 Nigeria Epidemic (Cholera) operation in 2014 carried out in Bauchi State were considered, e.g. the inclusion of water treatment chemicals (Water Guard product) that would be readily available to the affected/at risk population, rather than those that had to be procured internationally (aqua tabs etc.) From the KIIs with NHQ staff, it was noted that though a NS staff member trained on the IFRC “Better Programming Initiative” (BPI) was available, they were not involved in preparing the EPoA; and there was also limited consultation with the BSs at the State level. Following the launch of the DREF operation, the NHQ informed the respective branches in the

States (Anambra, Kano and Rivers; then latterly Ebonyi, after the removal of Kano) of the activities planned in the DREF operation; and information was cascaded to the volunteers at divisional level in the communities.

The DREF allocation was received (at branch level) within 48hrs of being notified by NHQ. From the KIIs with BSs it was identified that the EPoA and Budget for the approved DREF allocation were not shared, nor were there any tools or templates developed to support them with the planning of the DREF operation, or the proper use of the funding, i.e. in accordance with the Budget, or per the IFRC/DREF procedures). It was agreed by the BSs during the KIIs and the lessons learned workshop that the information that was provided by NHQ if insufficient, was useful.

From the KIIs with BSs, it was identified there was limited orientation on humanitarian standards on quality and accountability (e.g. ACAPS, Humanitarian Accountability Partnership (HAP), Sphere etc.), Red Cross approaches ECV that were expected to be used during the DREF operation, nor awareness of the resources available to them via IFRC (e.g. FedNet etc.). Nonetheless, the BSs developed their own tools based on the documentation that they had available (e.g. NRCS manuals, State level response plans etc.) and ensured that volunteers were oriented on the Fundamental Principles, as well as any relevant NRCS policies etc. It was agreed that it would have been helpful to receive more support on quality standards. It should be noted that the respective branches in Anambra, Ebonyi and Rivers had limited or no previous experience of managing DREF operations^{xiii}, and some instances the BS were relatively new to the position^{xiv}. All of the BSs indicated that they were responsible for ensuring the supervision of the volunteers, and implementation of the activities planned in the EPoA. The DREF operation was coordinated at the national level by the National Health Coordinator, with the assistance of the Programme Coordinator. The National Health Coordinator was also assisted by four health staff, that were deployed to monitor and provide support to the branches and volunteers. At the branch level, the BSs coordinated and monitored the implementation of the DREF operation. At community level, volunteer supervisors were appointed in each community to oversee the activities planned. Briefing/debriefing (often by cell phone from the BS to the disaster management coordinator and volunteers at divisional level) was then carried out at the start/end of each day of activities; with divisional to branch reports submitted bi-weekly, which were then submitted (by the BS) onto the NHQ, and IFRC country representation. From the KIIs with staff, and the lessons learned workshop it was identified that there were inconsistencies between what was reported by the NS to the IFRC, and the implementation of the activities planned in the EPoA. According to Operations Update no.1, the intended targets for training on KAP (30 volunteers), training on the use of ODK (30 volunteers) had been reached; however it was identified during the lessons learned workshop that this was inaccurate, i.e. only 20 volunteers (10 per State in Anambra and Rivers) received the training, since this Ebonyi was added later (following the removal of Kano) and as such there was not sufficient time for this to be completed.

During the KIIs with BSs and the lessons learned workshop, it was noted that though NHQ / branch level monitoring^{xv} of the divisional structures was planned (and budgeted for in the DREF allocation), it was not carried out in accordance with the EPoA. At NHQ level, monitoring missions were planned (two per State) but was only carried out once. It should be noted that this was despite an additional CHF 11,944 being allocated through Operations Update no.1 to support this. At branch level, monitoring missions were carried out inconsistently across the States. In Anambra, the BS carried out monthly monitoring visits to the communities; in Ebonyi, the BS carried out weekly visits; while in Rivers, the BS carried out two visits (across the five-month timeframe). It was explained (by the BSs) that the remoteness and distance of the riverine communities, and their accessibility (i.e. by boat) made monitoring challenging (particularly in Anambra). Nonetheless, it raises concerns on both the management of the DREF operation, and the monitoring processes (given the reduced level of supervision) that were put in place given the inconsistencies in the information that was provided by the NS to the IFRC.

Based on the schedule of the DREF operation, the activities planned were expected to be carried out from 6 March 2015 until 6 June 2015; however as has been noted, they were not initiated until May 2015, and then not then completed until July/August 2015. On 11 June 2015, an Operations Update was issued to extend the timeframe of the DREF operation by two months (until 6 August 2015)^{xvi}. As such, the efficiency of the response provided to the affected/at risk population and accordance with the EPoA schedule related to its timeliness, was identified as a concern^{xvii}. It should be noted that there were unforeseen circumstances that contributed to this including: the reorientation of the area of implementation (removal of Kano; and addition of Ebonyi), security conditions as a result of the elections in March and April 2015, which restricted the movement of NRCS staff and volunteers, and the inauguration of a new governance that led to a review of the NSs logistics and supply chain processes and procedures (delaying procurement/delivery of hygiene related non-food items (NFIs)).

During the KIIs with BSs it was indicated that the DREF allocation was not sufficient (i.e. its adequacy to deliver the expected outputs/activities), and as such, the branches had to mobilize funds internally (from NRCS staff) to ensure they were able to complete all of the activities planned in the EPoA. It was not possible to confirm if this was due to under budgeting of the activities planned at the onset of the DREF operation, if there were unexpected expenditures incurred, or the extent of the funding that was transferred from NHQ to the branches (based on the agreed EPoA + Budget). It should be noted that the level of expenditure against the DREF allocation (CHF 200,794) was CHF 200,827, which equates to an overspend of CHF 33 and a rate of > 100%^{xviii}. It was not possible to confirm if costs could have been reduced or most cost effective approaches taken. All of the BSs (during the KIIs) indicated that there was a need to increase the DREF allocation in order to reach more beneficiaries, specifically with sensitization activities and hygiene related NFIs (corroborated from the FGDs with beneficiaries) as the resources provided were not sufficient to meet the needs of all of the affected/at risk population, as well as provide training for additional volunteers in the communities. It was noted that though the DREF allocation contributed to meeting the immediate needs of the most vulnerable among the affected/at risk population, there were remaining needs that could have been addressed if the resources had been made available; and this was also reinforced by beneficiaries (from the HH survey), who indicated improvements that could be made to improve responses to cholera outbreaks in their communities in future (refer to “Chapter 5 / Lessons learned”).

Effectiveness – the extent to which the DREF operation was able to meet its intended objectives and outputs in accordance with recognized international standards	Rating 3/5
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2.1 Health and Care

Outcome 1: Immediate risk of cholera to the health of the population is reduced through prevention and control activities in the Anambra, Ebonyi and Rivers States

Output 1.1: Capacity of Nigeria Red Cross Society to respond to the epidemic in the affected area is strengthened

In total, 90 volunteers (30 in Anambra, 30 in Rivers and 30 in Ebonyi) received training on ECV manual, which equates to 100% of the intended target (90 – 30 per State); and as such the NRCS was able to reach what was agreed on in the EPoA. It was agreed (from the FGDs with volunteers and the lessons learned workshop) that the ECV training covered the areas required for the prevention and control of cholera, and thus contributed to strengthening the volunteers capacity to disseminate the correct messages in the affected/at risk communities. Through the ECV training, the volunteers received knowledge on the prevention, transmission, the symptoms and complications, as well as on how to manage (for example through the preparation of ORS). In addition, they received information on “Safer Access Framework” and RCRC code of conduct. The ECV training was carried

out in March/April 2015. As part of the review process, a selection of volunteers (in Ebonyi and Rivers) were tested on their knowledge.

- All of the selected volunteers were able to give the signs and symptoms of a cholera case, i.e. diarrhoea/stooling, vomiting and stomach cramp, and also the main actions to perform to a cholera patient as a volunteer, i.e. identified rehydration with OR and alerting the health authorities/RC. In addition, volunteers were able to successfully explain how to prepare ORS.
- 40% of volunteers were able to recognize eight complications (of eight main complications, i.e. 100%), 40% were able to recognize five complications, and 20% were able to recognize at least five complications. It should be noted that none recognized the decrease/absence of urine as a complication.
- 40% of volunteers were able to recognize at least five measures (of eight main measures) for preventing cholera and transmission, 40% were able to recognize four measures, and 20% were able to recognize six measures. It should be noted that none recognized hygiene measures during social gatherings as a method for preventing cholera transmission.
- 60% of volunteers were able to recognize at least four critical times (of six critical times) for hand washing, 20% were able to recognize six times, and 20% were able to recognize five times. It should be noted that 0% recognized after handling child faeces.

In addition, 15 volunteers (seven in Anambra, and eight in Rivers) were trained in ODK for data collection which equates to 50% of the intended target (30). It should be noted that it was explained (by the NRCS IT officer) that the limited number of cell phones available (15) to the NS meant that it was challenging to meet the targets, which were agreed in the EPoA, i.e. in Rivers State, they only had access to eight phones, and as such only eight volunteers received training. In Ebonyi State, since it was added later, the training on the use of ODK was not carried out. During the FGDs with volunteers and the lessons learned workshop), it was agreed that that the training on the use ODK improved their knowledge/experience of mobile data collection (and using “smart” phones), as well as speeded up the collection and analysis of the data.

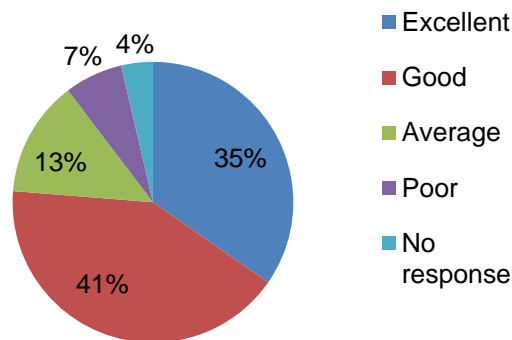
Output 1.2: Target population in the affected areas are provided with sensitization to improve the knowledge and practices on the prevention and control of cholera (Target: 15,000 beneficiaries / 3,000 households)

In total, 31,800 people (6,360 HHs)^{xix} were reported to have been reached with sensitization sessions to improve their knowledge and practices on the prevention and control of cholera, which equates to 212% of the intended target (15,000 people/3,000 HHs) and as such the NRCS was able to far exceed what was agreed on in the EPoA. It was expected (and budgeted) that the sensitization sessions would be completed by volunteers for a period of 28 days (three days per week for 12 weeks plus an additional two days as catch up following the disruption caused by the elections); however it was identified that there were inconsistencies with the extent to which this was complied with across the States. In Anambra State, it was noted that the activities were carried out for three days per week during May 2015 (total of 12 days approx.); in Ebonyi State, were carried out for three days per week during June/July 2015 (24 days approx.); while in Rivers State, were carried out for three days per week during May/June 2015 (24 days approx.) – as such, the volunteers were mobilized for less days than was planned (or budgeted). Nonetheless, it was still possible for the volunteers to exceed the number of people targeted through the DREF operation. During the KIIs with partners, FGDs with volunteers, and the lessons learned workshop, it was indicated that the sensitization activities improved knowledge and practices in the communities, and helped contribute to a reduction in cholera cases, e.g. in Rivers State, the local MoH structure (from the KII) indicated that they had not received a cholera case since mid-June 2015, within 2-3 weeks of them being initiated by the volunteers. In addition, 15,000 leaflets (5,000 per State), 3,000 posters and (1,000 per State) were distributed, which were identified to be appropriate to the needs of the affected/at-risk population

(covered key messages on the prevention and control of cholera), and also sufficient in quantity. It was noted that the IEC distributions were an effective means of providing information to the communities, especially the youth, and impacted on the credibility/visibility of the NS at the community level (e.g. mobile cinema/radio jingles in local languages, sports events and loom bands etc.). During the lessons learned workshop, it was noted that the IECs were not received until May 2015, and not distributed until May/June 2015, which was 2-3 months after the launch of the DREF operation (and peak of the cholera outbreak).

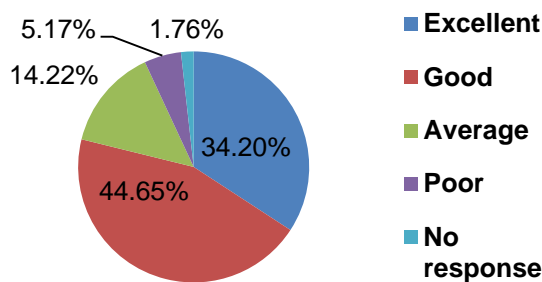
From the HH survey, respondents were asked to rate the assistance that they received through the DREF operation, this included the sensitization activities, and the IECs. Of the respondents, 41.60% indicated the sensitization they received on the prevention and control of cholera from volunteers (i.e. in terms of its usefulness) was “Good”, 34.67% that it was “Excellent”, 13.40% that it was “Average”, 6.70% that it was “Poor”, while 3.65% provided no response. As such, 76% approx. of respondents can be deemed to regard the information they received as useful, i.e. “Excellent” or “Good”, and 20% approx. as not useful, i.e. “Average” or “Poor”. Refer to “Figure 9: Please rate the information received on the prevention and control of cholera”.

Figure 9: Please rate the information on the prevention and control of cholera that you received?



Of the respondents, 44.65% (380) indicated that the number of sensitization sessions received on the prevention and control of cholera (i.e. in terms of its frequency) was “Good”, 34.20% (291) that it was “Excellent”, 14.22% (121) that it was “Average”, 5.17% (44) that it was “Poor”, while 1.76% provided no response. As such, 79% of respondents can be deemed to regard the number of sensitization sessions received as sufficient, i.e. the frequency was “Excellent” or “Good”, and 19% approx. as not sufficient, i.e. the frequency was “Average” or “Poor”. Refer to “Figure 10: Please rate the number of sensitization sessions received on the prevention and control of cholera”.

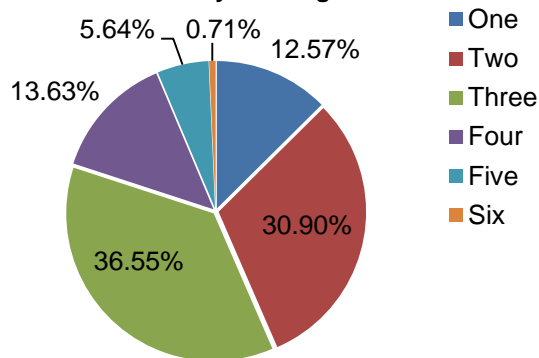
Figure 10: Please rate the number of sensitization sessions received on the prevention and control of cholera



From the HH survey, respondents were also tested on their level of knowledge, this included recognition of symptoms, complications, measures of prevention (including critical hand washing times), and also treatment, as a means of establishing the effectiveness of the sensitization activities

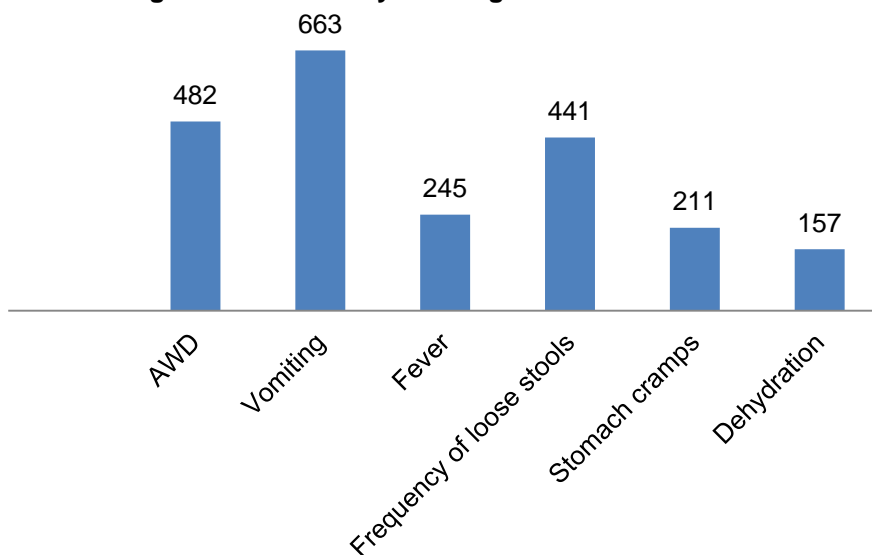
carried out through the DREF operation. It should be noted that since other organisations (refer to “Chapter 2 / Programme sectors/Coherence”) also carried out sensitization activities, it is not possible to accurately establish to what extent the level of knowledge of the population can be attributed to the DREF operation. Of the respondents, 36.55% (311) were able recognize at least three cholera case symptoms, 30.90% (263) were able to recognize two symptoms; 13.63% (116) were able to recognize four symptoms, 12.57% (107) were able to recognize one symptom, 5.64% (48) were able to recognize five symptoms, and 0.71% were able to recognize six symptoms. Refer to “Figure 11: How many cholera case symptoms can you recognize?”

Figure 11: How many cholera case symptoms can you recognize?



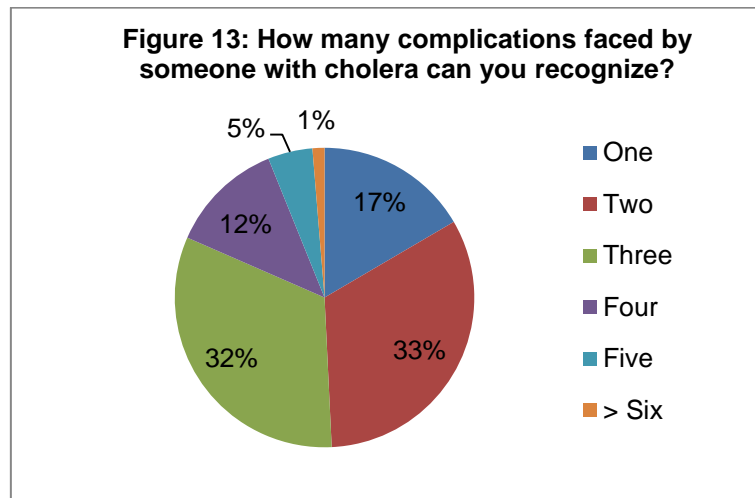
Of the respondents, 77.91% (663) identified vomiting as a symptom of cholera, 56.64% (482) identified acute watery diarrhoea as a symptom, 51.82% (441) identified having more than three stools per day, 28.79% (245) identified fever, 24.79% (211) identified stomach cramps, and 18.45% (157) identified dehydration. It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them. Refer to “Figure 12: How many cholera case symptoms can you recognize?”

Figure 12: How can you recognize a cholera case?

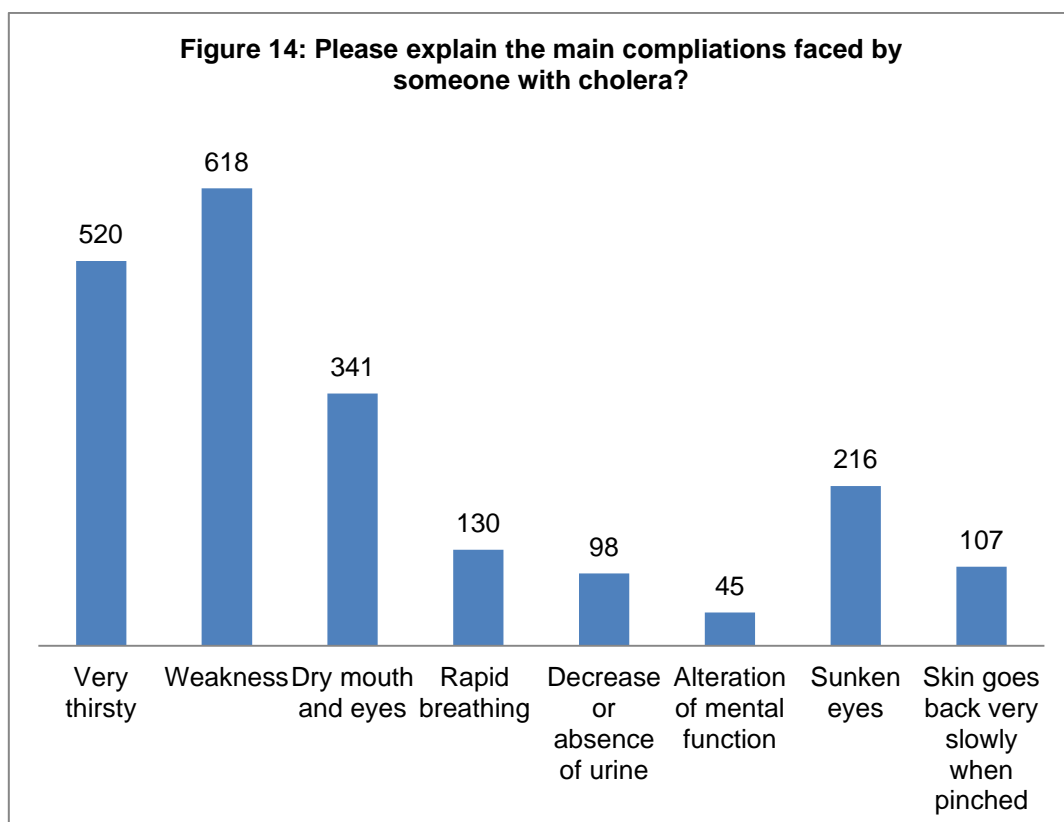


Of the respondents, 32.67% (278) were able to recognize at least two complications faced by someone with cholera, 32.32% (275) were able to recognize three complications, 16.57% (141) were able to recognize one complication, 12.34% (105) were able to recognize four complications, 4.82% (41) were able to recognize five complications. 1.30% (11) were able to recognize more than six

complications. Refer to “Figure 13: How many complications faced by someone with cholera can you recognize?”

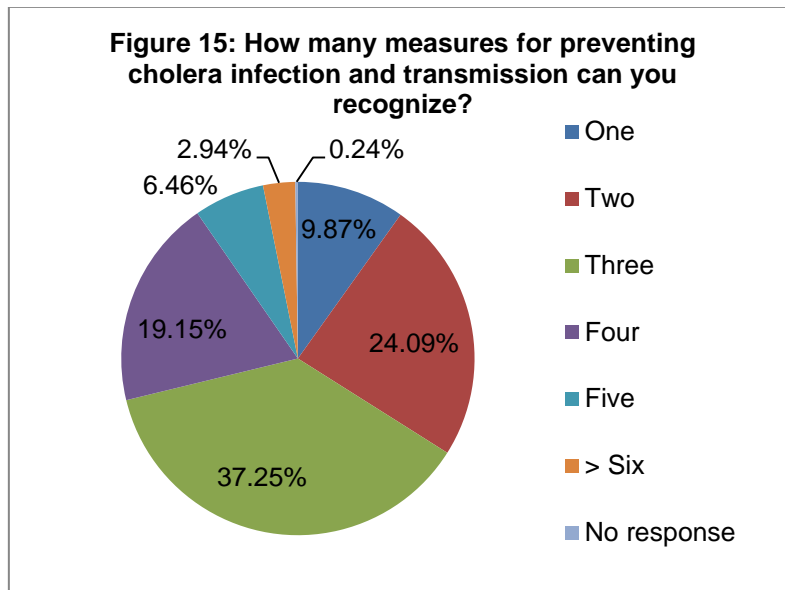


Of the respondents, 72.62% (618) identified weakness as a complication faced by someone with cholera, 61.10% (520) identified being very thirsty, 40.07% (341) identified a dry mouth and eyes, 25.38% (216) identified sunken eyes, 15.28% (130) identified rapid breathing, 12.57% (107) identified skin going back very slowly when pinched, 11.52% (98) identified a decrease / absence of urine, and 5.29% (45) identified an alteration in mental function. It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them. Refer to Figure 14: Please explain the main complications faced by someone with cholera?



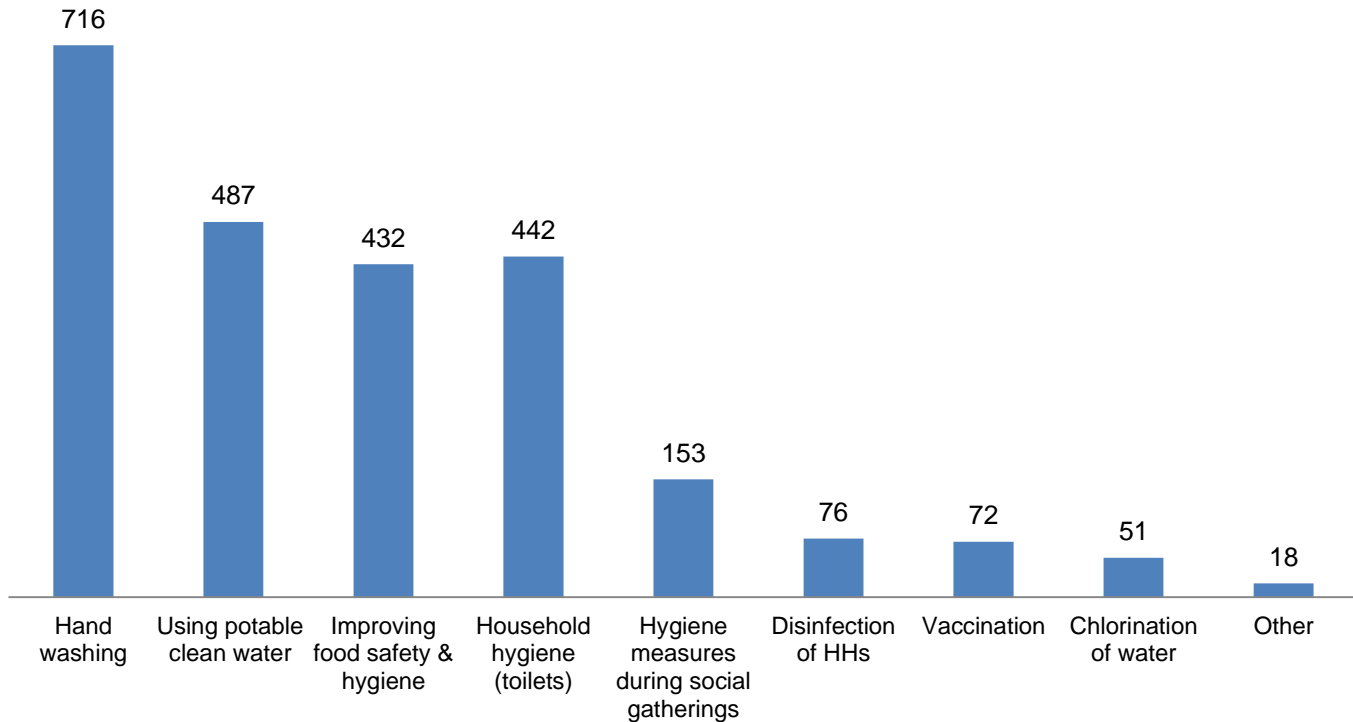
Of the respondents, 37.35% (317) were able to recognize at least three measures for preventing cholera infection and transmission, 24.09% (205) were able to recognize two measures, 19.15% (163) were able to recognize four measures, 9.87% (84) were able to recognize one measure, 6.46% (55) were able to recognize five measures, 2.94% (25) were able to recognize more than six measures,

while 0.24% (2) provided no response. Refer to “Figure 15 - How many preventative measures for avoiding cholera infection and transmission can you recognize?”



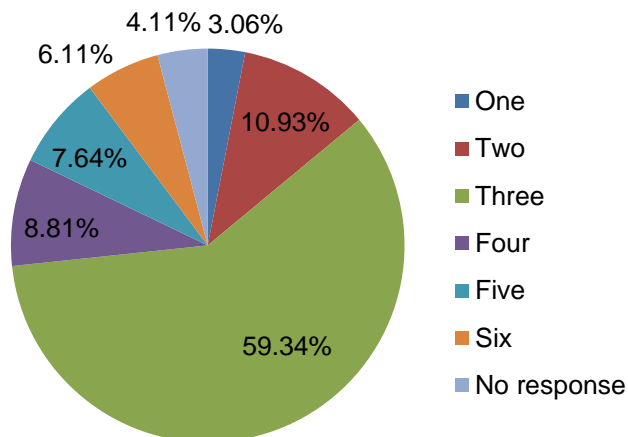
Of the respondents, 84.14% (716) identified hand-washing as a main preventative measures for avoiding cholera infection and transmission, 57.23% (487) identified using potable clean water for HH consumption, 51.94% (442) identified household hygiene (latrines), 50.76% (432) identified improving food safety and hygiene measures, 17.98% (153) identified hygiene measures during social gatherings, 8.93% (76) identified disinfection of HHs (of vomit and faeces of cholera patients), 8.46 (72) identified vaccination, 5.99% (51) identified the chlorination of water sources, while 2.12% (18) provided other measures (not specified). It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them. Refer to “Figure 16: What are the main preventative measures for avoiding cholera infection and transmission”.

Figure 16: What are the main preventative measures for avoiding cholera infection and transmission



Of the respondents, 59.34% (505) were able to recognize three critical times for hand washing, 10.93% (93) were able to recognize two critical times, 8.81% (75) were able to recognize four critical times, 7.64% (65) were able to recognize five critical times, 6.11% (52) were able to recognize six critical times, while 4.11% (35) provided no response. As such, 81.9% (697) of respondents were able to recognize at least three critical (or more) times for hand washing. Refer to “Figure 17: How many critical times for hand washing can you recognize?”.

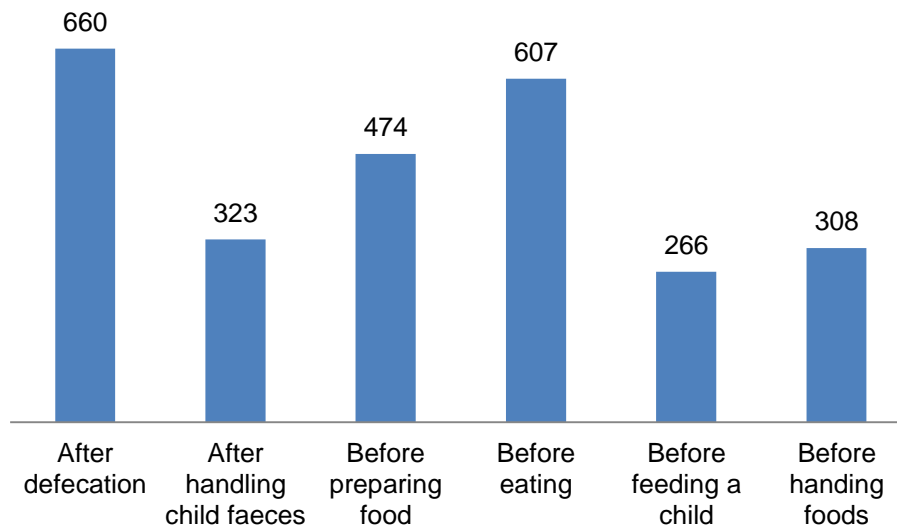
Figure 17: How many critical times for hand washing can you recognize?



Of the respondents (816), 80.88% (660) indicated after defecation as a critical time for hand washing, 74.39% (607) indicated before eating, 58.09% (474) indicated before preparing food, 39.58% (323) indicated handling child faeces, 37.75% (308) indicated before handling food, and 32.60% (266)

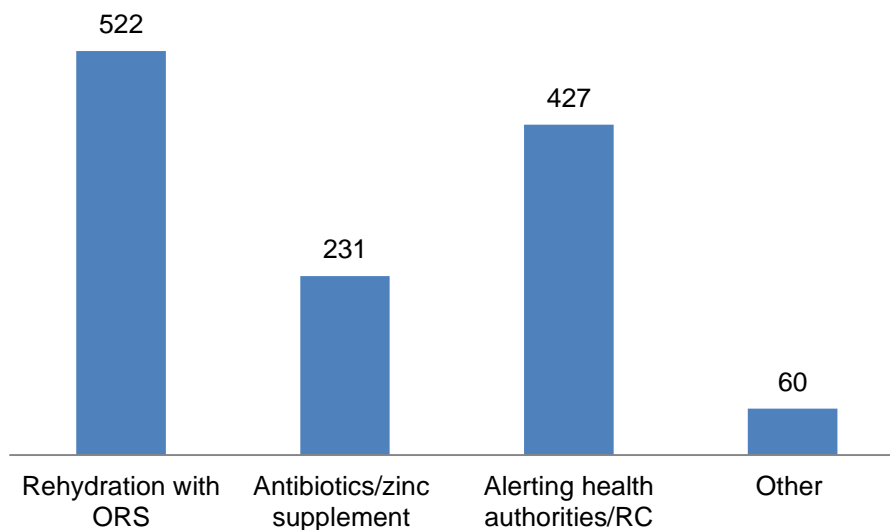
indicated before feeding a child. It should be noted that this was a multiple choice question; and as such respondents could select all that applied to them. Refer to “Figure 18: Please name three critical times for hand washing recognize?”

Figure 18: Please name critical times for handwashing



Of the respondents, 61.34% (522) identified rehydration with ORS as a main action to perform to a cholera patient, 50.18% (427) identified alerting health authorities/RC, 27.14% (231) identified issue of antibiotics/zinc supplements to reduce diarrhoea, while 7.05% (60) identified other actions (not specified) Refer to “Figure 19: What are the main actions to perform to a cholera patient?”.

Figure 19: What are the main actions to perform to a cholera patient?



2.2 Water, sanitation and hygiene promotion:

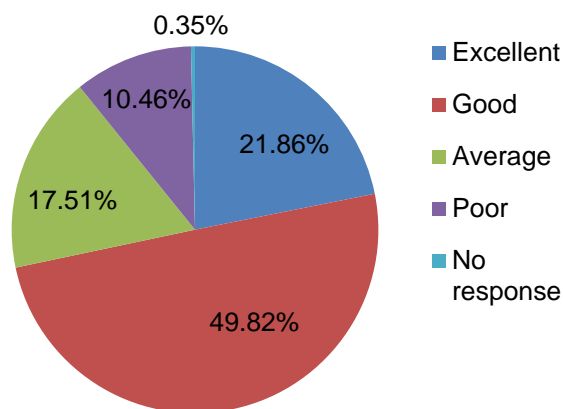
Outcome 1: Immediate risk of cholera is reduced through the provision of safe water supply and hygiene promotion in the Anambra, Ebonyi and Rivers States

Output 1.1: Target population in the affected area is provided with access to safe drinking water supply (Target: 15,000 beneficiaries/3,000 households)

In total, 3,192 HHs (15,960 people) received water treatment chemicals (water guard - two bottles of solution per HH) to promote their access to safe drinking water supply, which equates 106 per cent of the intended target (15,000 people/3,000 HHs) and as such the NRCS was able to exceed what was agreed on in the EPoA. During the distribution of the water treatment chemicals, it was accompanied with a demonstration on their use (e.g. number of litres per water to be treated etc.). It was indicated that the response of the affected/at risk population to the water treatment chemicals was positive (from the FGDS with beneficiaries, and the lessons learned workshop), and helped reduce their reliance on dirty water. It should be noted that, the water treatment chemicals were not received until July 2015, and then not distributed until July/August 2015, which was four - five months after the launch of the DREF operation (and peak of the cholera outbreak).

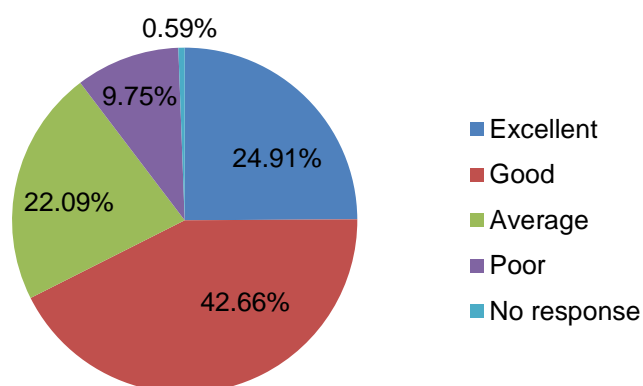
From the HH survey, respondents were asked to rate the quality and quantity of the water treatment chemicals. Of the respondents, 49.82% (424) indicated that the quality of the water treatment chemicals (“Water Guard”) that were received was “Good”, 21.86% (186) that the quality was “Excellent”, 17.51% (149) that the quality was “Average”, 10.46% (89) that the quality was “Poor”, while 0.35% (3) provided no response. As such, more than 70% approx. of respondents can be deemed to regard the quality of the water treatment chemicals as satisfactory, i.e. “Excellent” or “Good”, and 28% approx. as unsatisfactory, i.e. “Average” or “Poor”. It was noted (during FGDS with beneficiaries and volunteers; and the lessons learned workshop), that the expiry date for the use of the of Water Guard, which were distributed to beneficiaries was extremely short, and only provided them with a limited period in which they could have access to safe water supply. It is possible (however was not verified during the review) that the inauguration of the new governance that led to a review of the NSs logistics and supply chain processes and procedures may have contributed to this, i.e. meaning that there was a lapse between the procurement of the items and their distribution to the beneficiaries. Refer to “Figure 20: Please rate the quality of the water treatment chemicals you received”.

Figure 20: Please rate the quality of the water treatment chemicals you received?



Of the respondents, 42.66% (363) indicated that the quantity of water treatment chemicals was “Good”, 24.91% (363) indicated that the quantity was “Excellent”, 22.09% (188) indicated that the quantity was “Average”. 9.75% indicated (83) that the quantity was “Poor”, while 0.59% (5) provided no response. As such, 67% approx. of respondents can be deemed to regard the quantity of the water treatment chemicals to be satisfactory for their immediate needs, i.e. “Excellent or “Good”, and 32% as unsatisfactory, i.e. “Average” or “Poor”. Refer to “Figure 21: Please rate the quantity of the water treatment chemicals you received”.

Figure 21: Please rate the quantity of the water treatment chemicals you received?



Output 1.2: Target population in the affected area is provided with adequate drainage environmental sanitation facilities. (Target: 15,000 beneficiaries / 3,000 households)

Through the DREF operations, two “WatSan” committees had been established (at the time of the review), one in Ebonyi and Rivers States, and one committee was in the process of being established in Anambra State. Each of the committees established had received sanitation related equipment (nose masks, shovels, wheel barrows etc.) to assist them with environmental sanitation activities in their respective communities (under the supervision of the NS divisional structure). It was noted (from the lessons learned workshop) that the committees were not established, equipment not received, and activities initiated in July/August 2015, which was four - five months after the launch of the DREF operation (and peak of the cholera outbreak), and as such the intended target (15,000 people / 3,000) to benefit was not reached.

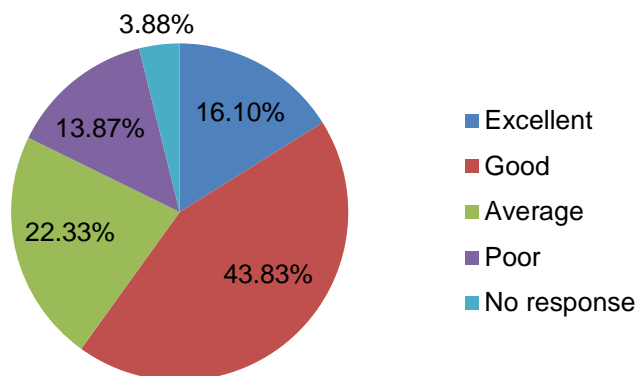
Nonetheless, from the FGDS with beneficiaries, and the lessons learned workshop, it was indicated that the response of the affected/at risk population to the environmental sanitation activities was positive, they appreciated the equipment that had been provided and thought it mostly appropriate - though it was noted that cutlasses would have been useful, as well as first aid kits to attend to minor injuries when carrying out the activities. In addition, the importance of keeping their communities clean was increasingly recognized, and the activities were reported to being sustained (in the States where they been initiated). As such, it was expected that now that the environmental sanitation activities had been initiated the intended target (15,000 people/3,000 HHs) would be reached even after the end of the DREF operation.

Output 1.3: Target population in the affected areas are provided with hygiene-related items (NFIs), which meet SPHERE standards (Target: 10,700 beneficiaries / 2,140 households)

In total, 2,140 HHs (10,700 people) received hygiene related NFIs, which equates to 100% of the intended target (10,700 beneficiaries/2,140 HHs); and as such the NRCS was able to meet what was agreed on in the EPoA. Each HH received a bucket with a lid (one pc), a jerry can (one pc), and soap (60,000 pcs distributed in total). During the distribution of the NFIs, it was accompanied with a demonstration on their use (e.g. using the bucket in conjunction with demonstration on using the water treatment chemicals etc.). It should be noted that, the NFIs were not received until July 2015, and then not distributed until July/August 2015, which was four - five months after the launch of the DREF operation (and peak of the cholera outbreak).

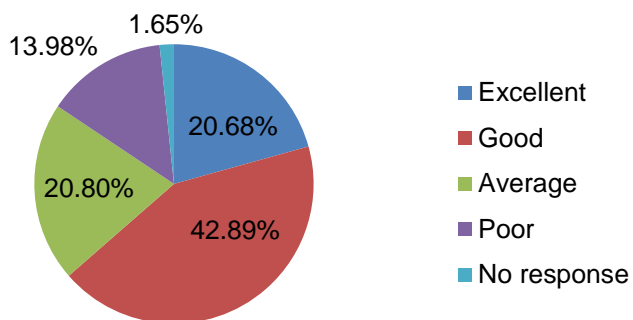
From the HH survey, respondents were asked to rate the quality of the water storage items. Of the respondents, 43.83% (373) indicated that the quality of the water storage items (buckets and jerry cans) was “Good”, 22.33% (190) that the quality was “Average”, 16.10% (137) that the quality was “Excellent”, 13.87% that the quality was “Poor”, while 3.88% (33) provided no response. As such, 60% approx. of respondents can be deemed to regard the quality of the water storage items as satisfactory, i.e. “Excellent” or “Good”, and 36% as unsatisfactory, i.e. “Average” or “Poor”. Refer to “Figure 22: Please rate the quality of the water storage items you received”.

Figure 22: Please rate the quality of the water storage items you received?



Of the respondents, 42.89% (365) indicated that the quantity of the water storage items was “Good”, 20.80% (177) that the quantity was “Average”, 20.68% (176) that the quantity was “Excellent”, 13.98% (119) that the quantity was “Poor”, while 1.65% (14) provided no response. As such, 63% approx. of respondents can be deemed to regard the quantity of the water storage items as satisfactory, i.e. “Excellent” or “Good”, and 35% as unsatisfactory, i.e. “Average” or “Poor”. Refer to “Figure 23: Please rate the quantity of the water storage items you received”.

Figure 23: Please rate the quantity of the water storage items you received?



It was indicated that in some instances, there were challenges experienced with the distribution of the NFIs to beneficiaries, e.g. in Rivers State, there was confusion between registration/selection and the distribution of the items, i.e. more people were registered than those selected for assistance, which resulted in some of those people arriving at the distribution point that had not been selected. In addition, the distance between the distribution point and the communities, resulted in a reluctance of people to come collect the items. As noted, many beneficiaries (45% approx.) did not receive

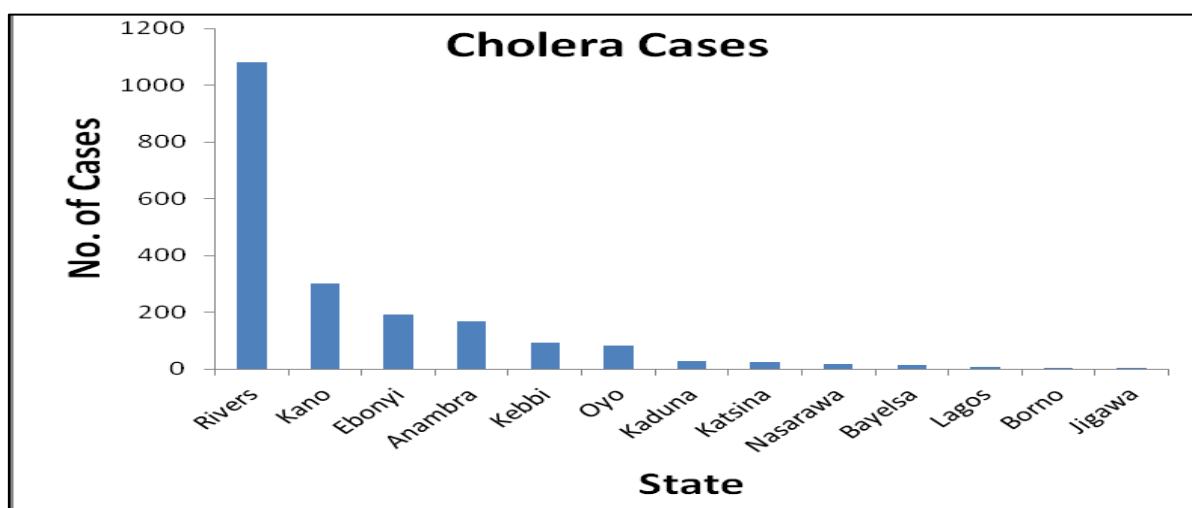
information on the date, time and place of the assistance being provided, which also contributed to issues experienced with the distribution of the NFIs. During the KIIs with BSs, FGDs with beneficiaries and lessons learned workshop, it was identified that in the future, the distribution of NFIs should be carried out much sooner when there are cholera outbreaks; and also to consider providing larger water storage containers to enable treated water to be kept for longer given the lack of access to safe water supply, as well as dignity kits (for personal hygiene). In addition, it was indicated that the NFIs should in future to be distributed to all affected/at risk HHs (i.e. all 3,000 HHs targeted).

Coverage – the extent to which the DREF operation was able to reach the populations/areas most affected by the epidemic; how the criteria for this was identified/implemented.

Rating
3/5

Between January – February 2015 cases of cholera began to be reported in 20 LGAs across 13 States in Nigeria, (refer to “Table 2: Reported cholera cases – 2014/2015”), with the worst affected States being: Anambra, Kano and Rivers, which constituted more than 70% of all cases, and were as such targeted through the DREF operation. Refer to “Figure 24: Geographical distribution of cholera cases (by State)”.

Figure 24: Geographical distribution of cholera cases (by State)^{xx}



Following the launch of the DREF and completion of the assessments/KAP, it was identified, based on consultation with the MoH, that the situation in Kano State had stabilized and the activities planned were no longer required. As such, Kano State was removed, and Ebonyi State, which was also amongst the worst affected by the cholera outbreak, added, and was authorised (by IFRC) through the issue of Operations Update no.1. As such, the selection of the geographical areas targeted through the DREF operation was informed by the information reported by the MoH, which was then validated by the assessments carried out by the NS, and revised as required, to ensure the worst affected/at risk areas were reached.

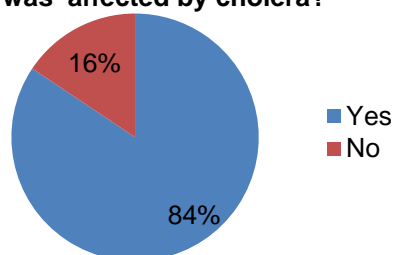
During KIIs with MoH and NEMA representatives, it was noted that the LGAs targeted through the DREF operation, e.g. Andoni LGA in Rivers State, contained the communities, which were worst affected in their respective States (based on their own assessment information), and as such their selection was validated. Nonetheless, it was also indicated that there were other communities that were amongst those worst affected/at risk (particularly in remote riverine areas of Anambra and Rivers States), from where the referral of suspected cases was often received too late for the proper case management and treatment, and as such would have benefitted from assistance through the DREF operation, e.g. sensitization sessions on the prevention and control of cholera, community

based management (e.g. through the application of ORS), as well as increased surveillance, referral and transportation mechanisms between the NRCS and MoH structures.

According to the EPoA, the criteria for the selection of beneficiaries was to be established following the completion of the needs assessment that was included, however it was identified that the process was inconsistently applied across the States involved in the DREF operation; and in some instances seemed limited understanding of it by volunteers (based on KIIs with BSs, and FGDs with volunteers). In one of the States (Anambra), the selection beneficiaries was based on those HHs that reported a confirmed case of cholera; and their level of vulnerability (based on a standard criteria developed by the BS); while in others (Rivers) it was based on those HHs that had been affected by cholera (either had reported a confirmed case, and/or someone had died), those neighbouring HHs that had been affected (and therefore at risk), with prioritization of those HHs that were female headed, and with no access to safe water supply. During FGDs, the volunteers were mostly unable to explain the criteria for the selection of beneficiaries.

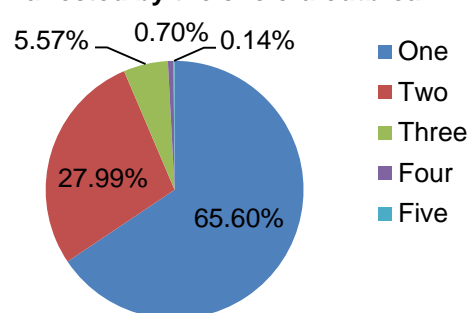
From the HH survey, 99% of respondents (842) indicated at least one additional vulnerability in their HH, which suggests that the beneficiaries were amongst the “most vulnerable” in their communities. It included HHs that reported: 1) persons above 60 years old living alone, 2) persons living with a disability; 3) persons with very young children (0-5 years), 4) self-supporting parents; 4) orphaned or child-head family; 5) and Other (though not specified). In addition, 84% of respondents (718) indicated that someone in their HH had been affected by cholera, and the remaining 16% indicated that no-one in their HH has been affected. Refer to “Figure 25: Was someone in your HH was affected by cholera”.

Figure 25: Was someone in your HH was affected by cholera?

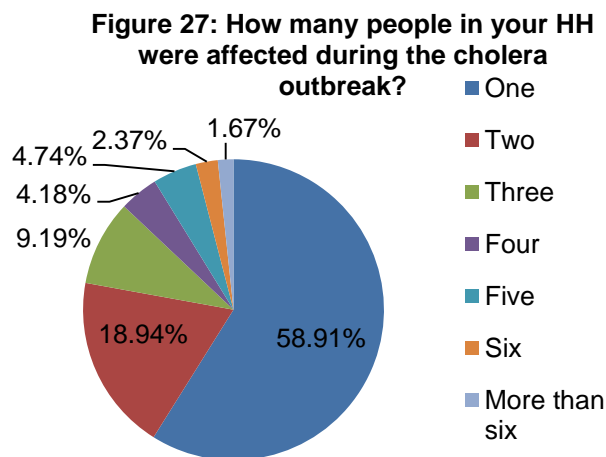


Of the 718 respondents that indicated someone in their HH has been affected, 65% (471) indicated that they had been affected in one way, 28% (201) in two ways, 6% (40) in three ways, and less than 1% in four or five ways – which included being affected themselves, family member being affected, not being able to work, not being able to raise money etc. Refer to “Figure 26: How many ways were you affected by the cholera outbreak”.

Figure 26: How many ways were you affected by the cholera outbreak?



Of the 718 respondents that indicated someone in their HH has been affected during the cholera outbreak, 59% (423) indicated that one person had been affected, 19% (136) indicated two people, 9% (66) indicated three, 5% (34) indicated five, 4% (30) indicated four people, 2% (17) indicated six people, and less than 2% (12) indicated more than six. On average, 1.6 people were affected by HH. Refer to “Figure 27: How many people in your HH were affected during the cholera outbreak”.



During the DREF operation, there were efforts made (from the KIIs with BSs, as well as FGDs with beneficiaries and volunteers) to ensure that the activities planned in the EPoA were adapted to ensure they were sensitive to the immediate needs of the most vulnerable, and therefore inclusive. Before initiating the sensitization activities, the volunteers consulted with community leadership committees to ensure they were culturally appropriate; IEC materials were provided in local languages and used pictures so that they could be understood by all, irrespective of their level of literacy. NFIs were delivered directly to beneficiaries if they were unable to collect them themselves from the distribution point, e.g. if they were elderly or living with a disability. In addition, the volunteers were recruited from the affected/at risk population, and their selection supported by the community committees to ensure that they were representative, i.e. in terms of gender, age etc. and included people who might otherwise have been marginalised. Nonetheless, as noted, there was limited consultation with the affected/at risk population, and not with them on the identification of their priority items in terms of NFIs (in accordance with recommended Sphere Standards). During the KII with the BS in Anambra, it was noted that there was a need to ensure that activities planned were contextualised to the communities that are being targeted, rather than using pre-determined approaches.

Coherence – the extent to which the DREF operation was in accordance with the EPoA, the policies and strategies agreed by key stakeholders for the response; and how it was complimentary to the interventions of other actors.

**Rating
2/5**

As noted, the “Sword and Shield” was used to inform the activities planned; however during the KIIs with BSs and lessons learned workshop it was identified that there were inconsistencies with the extent to which this was respected. In accordance with the “Sword and Shield”, it is expected that there should be a continuous analysis of the outbreak, including collection of/analysis of data regarding the context of transmission, as well as of the worst affected/at risk populations and geographic areas, to inform the revision of activities planned as/if required. Following the assessments / KAP that were carried out, there was revision to the geographical areas targeted (removal of Kano; and addition of Ebonyi), but no revisions to the activities planned since they validated what had already been planned. As per the “Sword and Shield” there was to an extent, some level of analysis and adaptation of the activities planned, while, both affected and at risk HHs were targeted; however

it was identified that during implementation of the DREF operation, there was limited if any consideration of this, and if so it was incidental. Despite data collection being carried out (including reporting of suspected cases of cholera), the results of this was not used to inform any adaptations to the activities planned, e.g. the revision of the sensitization messages based on the identified context of transmission etc. nor was it consistently shared with other actors (Government authorities, MoH etc.). In addition, the inclusion of training of volunteers was expected to enable the NS to perform mapping by using the phones to establish the “hotspot” areas ” where there was reporting of suspected cases, to thus enable the reorientation of the activities planned into these areas, however this was not carried out. It should be noted that it was explained (by the NRCS IT Officer) that the limited number of cell phones available (15) to the NS, meant that they had to be retained at NHQ, and not issued to the volunteers, which meant that it was challenging to continue to perform the mapping exercises. Nonetheless, the proposed strategy of the DREF operation remained mostly unchanged rather than adopting the more proactive/dynamic approach that is characterized within the “Sword and Shield” and as such its coherence with the proposed strategy (“Sword and Shield”) was extremely limited.

Following the declaration of the cholera outbreak (made at individual State; rather than Federal level), there were numerous other agencies involved in the response during the cholera outbreak, this included: FMWR (at Federal level^{xxi}), MoH (at State and LGA level), NEMA (State level), Rural water and sanitation agency (RWSSA), UN Agencies (UNICEF and the WHO at Federal, State and LGA level), as well as corporate organizations wealthy individuals, e.g. Shell (at LGA level), which provided donations (bottled water etc.); however it was identified (from the KILs, FGDs with volunteers, and the lessons learned) that coordination and collaboration with these agencies was extremely limited, if not non-existent. During the cholera outbreak, the response was coordinated by the MoH, which activated its Emergency Response Centres (ERC) and stakeholders committees, which meet when there are disease outbreaks, and includes other agencies (e.g. International Non-Governmental Organizations (INGOs) and UN agencies), and also established Cholera Treatment Centres (CTCs). Joint assessments (NEMA, MoH and UNICEF) were carried out, which provided statistics on the situation and were shared with the NS. It was explained (by the IFRC Nigeria Health delegate) that this informed the initial design of the DREF operation; however the NS did not participate in the assessments, and there was no follow up. It was indicated (repeatedly during the KILs with partners) that there was limited awareness of the DREF operation; while during the FGDs with beneficiaries at community level, it was noted that the assistance provided by the NS and other organizations (MoH and UNICEF etc.) was not coordinated. As the NEMA representative (in Rivers State) indicated “***we but did not know about the response. Unless we specifically ask for information, they do not provide it***”; and this was even reinforced by representatives from local health structures based in the in the same communities as the DREF operation; nor did they report having received any referrals (of cholera cases) from the volunteers. In addition, WASH cluster meetings (led by UNICEF) were convened at Federal and State level. It was not possible to verify the participation of the NS at these at State level, but at Federal level it was at most occasional (on attending during the review, UNICEF asked the whereabouts of an IFRC delegate that had left the country more than two years previous). The FMWR representative (at Federal / Abuja level) indicated: “***the Nigerian Red Cross Society is isolated, they work alone. Other agencies report on what they are doing, but the information we receive from them is limited, and they do not attend the coordination meetings***”. At LGA level, the MoH ensured that local health structures were equipped with the medicines required, and installed water supply infrastructures (boreholes) in strategic locations in affected communities (in collaboration with the RWSSA , which also installed latrines). In addition, UN agencies (UNICEF and WHO) were already active and coordinated with the MoH, e.g. participated in assessments, provided medicines/equipment to local health structure, as well as carried out sensitization activities, and distributed water treatment chemicals (aqua tabs). It should be noted however, that the scale and scope of response by external agencies differed; and there was not necessarily the same level of assistance provided or coordination across all of the States. In Anambra State, it was indicated (from

the KII with the BS) that external partners (MoH, UNICEF and WHO, as well as local health structures) were visited prior to the implementation of the DREF operation. In addition, there was consultation with the Director of Public Health (at MoH), and the BS where possible coordination meetings were attended throughout. It should be noted that it was not possible to verify this, as it was not possible to carry out KIIs with external partners in Anambra State. At LGA level, it was noted (from the KIIs with BSs, the FGDs with beneficiaries and volunteers) that there was close cooperation with the community and advocacy to the community, religious and traditional leaders.

Sustainability & connectedness – the extent to which the outcomes of the operation will be sustained (where relevant); particularly in relation to capacity and learning gained through the interventions; and how they can be integrated within contingency planning activities being carried out by the NRCS in preparation for epidemics in the future.

**Rating
3/5**

Prior to the cholera outbreak, it was noted (from the KIIs with the BSs) that the branches had not been involved in any emergency response, in some instances for many years. The DREF operation demonstrated the lack of capacity in the States. In Anambra, it was indicated that the last IFRC supported response the branch had been involved was in 2012/13 through the MDRNG014 Nigeria Floods Emergency Appeal, and they had not had any experience of DREF since 2005, though provided ad hoc assistance to UNICEF as requested. In Rivers, it was indicated that the last IFRC supported response was through the MDRNG019 Civil Unrest operation (through DREF), that was launched in late 2014 to prepare the NS for the elections (on 28 March 2015); however this was intended at strengthening capacity at branch level, and given the elections went largely peacefully there was no need for any widespread response. In addition, at LGA / community level, though there were existing NRCS divisional structures in place, they were not involved in any on-going activities, and were for the most part “dormant”. During the KIIs with BSs, NHQ staff and from the FGDs with volunteers, it was widely agreed that the launch of the DREF operation was able to contribute (as its primary objective) to the prevention and control of the cholera outbreak, as well as to NS capacity building, e.g. training for volunteers on the ECV manual, KAP survey/assessment process, and new approaches (ODK software), the experience of completing the activities planned etc. As the BS from Anambra indicated: **“the DREF operation has boosted the branch, and empowered the volunteers who are no longer in their shell”**. In addition, it was noted that the “added value” of having existing divisional structures in place (even if dormant) was also demonstrated, as the NS was able to quickly mobilize these for the response. Since the volunteers involved were members of the communities targeted through the DREF operation, they were aware of the context, and already had the acceptance of the affected/at-risk populations. It was also identified that the DREF operation had contributed to increasing the credibility/visibility of the NS, particularly at the community level.

It should be noted that the purpose of the DREF is to: “support to National Red Cross and Red Crescent Societies to support them in meeting the immediate humanitarian needs”, and as such should not be expected to address all of the needs in the communities, e.g. medium/longer term needs. Nonetheless, at the community level, there were indications reported that the outcomes of the DREF operation would continue to be sustained, particularly in relation to personal hygiene practices, e.g. hand washing at appropriate times, and environmental sanitation. As was indicated by community leader Mrs Eguuiung Paul, (Ungeada in Rivers): **“I was affected by cholera myself, and am now evangelical about hand-washing. I continue to tell my family and neighbours to ensure they do this as can see how important it is”**. It also was reinforced by the volunteers, who due to the knowledge they had gained, indicated that they would continue to apply the learning they had gained through the DREF operation, e.g. continue to practice both hand washing themselves and avoid open defecation, as well as provide (informal) sensitization to HHs on the importance in their respective communities. It was also reported that some HHs (from the FGDs with beneficiaries) had begun building their own latrines, after learning of the importance of avoiding open defecation. In addition,

the WatSan committees (in Ebonyi and Rivers) were expected to sustain the environmental sanitation activities, even after the end of the DREF operation for there to be a continuation of the relationship between the communities and the NRCS (since the equipment was to be used under the supervision of the NS divisional structures). Nonetheless, it was noted (from the FGDs with volunteers and the lessons learned workshop) that though there were behavioural changes reported in the communities targeted there was a need to extend the interventions beyond the timeframe of the DREF operation in order to ensure that it was reinforced. It was also indicated that the volunteers were only active during cholera outbreaks, but there was a need for them to provide sensitization as a regular preparedness measure to avoid them recurring.

It was not possible to confirm if the capacity and/or learning gained from the DREF operation had been (at the time of the review) been integrated within contingency planning activities being carried out by the NS – but would be expected to be an outcome of the review process.

2.2 Programme support services

Human Resources

In total, 90 volunteers were mobilized (30 in Anambra, 30 in Ebonyi and 30 in Rivers) for the DREF operation. During KIIs with BSs, it was noted that the DREF operation enabled the reactivation of existing volunteers (refer to “Chapter 2/Programme sectors/Sustainability and connectedness section). RCRC visibility materials (boots, caps and t-shirts), as well as per diem (provided on the same day), were issued to the volunteers, which were identified as a source of motivation. Nonetheless, it was identified that in some instances not all volunteers received this, e.g. in Ebonyi State, volunteers did not receive boots; while there was also a request (given it was the rainy season) to also issue rainwear, e.g. jackets and umbrellas, and other items such as stockings, hand sanitizer etc. as well refreshments (snacks and water), and allowance for transportation. As noted, the volunteers received training on the ECV manual and (in some cases) the ODK for data collection, which was also integrated with orientation on the “Safer Access Framework^{xxii}” and RCRC code of conduct – from the FGDs with volunteers, and the lessons learned workshop, it was agreed that this had assisted them with the implementation of activities planned in the DREF operation. Nonetheless, it was indicated that though the response to the training was positive, they should (in future) be carried out over a longer timeframe to reinforce the knowledge and skills that were gained. In addition, the “added value” of the volunteers was high since they were aware of the context (and terrain) they were able to cover large areas across Anambra, Ebonyi and Rivers States, which contributed to them being able to exceed the intended targets in the EPOA (e.g. the number of people reached with sensitization sessions etc.).

A Regional Disaster Response Team (RDRT) team member was deployed, and this was regarded as timely, and supported the effective implementation of the ECV training. During the KIIs with staff, and the lessons learned workshop, it was indicated that the RDRT was of a suitable profile, and knowledgeable/skilled on the subjects covered during the ECV training, which contributed to a positive response from the volunteers. Nonetheless, it was identified that the deployment of the RDRT coincided with the election period, and their mobility to support the implementation of the activities planned (at community level) was limited.

Logistics and supply chain

The National Health Coordinator in collaboration with the BSs, and advice from the IFRC Health Delegate, managed the procurement of the items required for the DREF operation (NFIs, sanitation equipment etc.), but with limited involvement of the NHQ logistics focal point; with all items then stored at branch level prior to being distributed. It was noted (from the KIIs with staff) that the number of volunteers involved in the distributions were sufficient, and vehicles were rented (at branch level) to

support the process. Nonetheless, the NFIs were not received until July 2015, and then not distributed until July/August 2015. During the KIIs with the NHQ logistics focal point, it is indicated that their limited involvement in the process, as well as the inauguration of the new governance that led to a review of the NSs logistics and supply chain processes and procedures contributed to this. In addition, it was identified that the transportation (by vehicle) to the communities targeted was challenging (e.g. in Ataba and Oyorokoto communities in Rivers State), and in some instances the vehicles that were rented were not suitable for the riverine conditions, e.g. due to the road conditions and river crossings. It was agreed that the planning of distributions (in future) needed to consider the terrain. In addition, the mobility of volunteers to these areas was also challenging, e.g. in some instance the communities could only be reached by boat), as well as impacted on by the weather conditions (i.e. heavy rains).

Communications

As noted, the DREF operation impacted on the credibility/visibility of the NS at community level, i.e. through the implementation of the activities planned, and RCRC visibility materials issued to the staff and volunteers (i.e. caps and t-shirts); however efforts to promote the RCRC response at Federal or branch level was limited if not existent. Despite resources being allocated (in the EPoA and Budget) for the participation of representatives from the NHQ communications unit in monitoring visits^{xxiii}, this was not carried out, and as such no documentation (case studies, photos, press releases etc.) were produced at this level. It should be noted that (admirably), the BS in Anambra State, did ensure that documentation (a professionally produced case study) was done, and this was shared with external partners to promote the DREF operation. It was identified (from the KIIs with partners) that was due to lack of understanding on the role of the RCRC or its mandate at both Federal and State level, e.g. in some instances it was perceived to be a health/first aid organisation working in hospitals, while in others only as a disaster response organisation. In addition, an external partner (from a Federal Ministry) remarked that a member of the DREF review team was only permitted in the country due to their nationality, and that their working for the RCRC and its role or mandate was inconsequential. At community level, there were also instances where populations in the affected/at risk communities requested payment to participate in the activities planned, e.g. the sensitization sessions and the environmental sanitation activities, as such, there is also a need to ensure beneficiaries also receive orientation on the role and mandate of the RCRC.

Resource Mobilization

No additional resources were mobilized to complement the DREF operation, though there was no indication that any efforts were made to do so, which is despite the BSs noting that the size of the DREF allocation was not sufficient. It should be noted that both of the State capitals in Anambra (Awka) and Rivers (Port Harcourt) are commercial and economic centres, which host a number of international corporate organizations, e.g. Chevron, ExxonMobil, Shell etc. that could be expected to provide opportunities for partnership/resource mobilization – indeed during KIIs with partners, it was identified that Shell contributed goods in-kind to the communities in Andoni LGA (Rivers State) – however there were no efforts made to maximise these.

Information technology

As noted, the number of cell phones was not sufficient to complete all the activities planned, e.g. training on the use of OPK, or mapping using the phones to establish the “hotspot” areas” – it was agreed that (in future) this needs to be considered and provision made in the DREF allocation). In some instances paper based surveys were used due to a lack of adequate phones.

Security

The DREF operation, coincided with the elections, which disrupted community level activities, e.g. resulted in volunteers being stood down from carrying out the activities planned due to security concerns, and limited access to the communities targeted by NHQ and branch level staff. Nonetheless, during the KIIs with staff and lessons learned workshop, it was indicated that no security protocols was officially established during this period, nor were staff or volunteers given any proper safety and security induction prior to initiating the activities planned (with the exception of on the “Safer Access Framework”. In addition, based on the FGDs with volunteers and the lessons learned workshop, no volunteers seemed to have received information on their insurance coverage (which was budgeted for in the DREF allocation).

PMER

Refer to “Chapter 2 / Programme sectors / Efficiency”.

Administration and finance

During the lessons learned workshop, and from direct observation, it was noted that there were inconsistencies in the rate of per diem that was issued across the States, e.g. from ₦1,500 to ₦3,000 per day depending on the State. In addition, it was identified (from the KIIs with staff) that the cash transfers from NHQ were made to personal bank accounts.

Chapter 3: Case Studies

Changing behaviours to curb cholera in Nigeria

Ekwe, 27, is a Red Cross volunteer from Anambra State. His community of Inoma was one of the hardest hit by the outbreak. Due to a lack of access to latrines, community members practice *open defecation*, contaminating their only means of drinking water, the Oshimile River, and contributing to the outbreak. “In my community, people didn't understand that open defecation contaminates the water supply,” says Ekwe. When he saw people suffering he wanted to do something to help bring the outbreak to an end and joined the Red Cross. Coming from the community, he was already well accepted by his neighbours, leaving him and other volunteers better placed to help change people's behaviours.



Ekwe received training on the means of preventing and controlling cholera, which he then shared with members of his community. “I appreciated the training,” says Ekwe. “It enabled me to pass on the correct information to people with confidence. We responded at the right time, and it was effective, as once we started working, the number of cholera cases began to reduce almost immediately. We also taught people who had diarrhoea how to treat it with a simple sugar-salt solution.” The State's Ministry of Health provided local health clinics with oral rehydration solutions and intravenous therapy, but it was the Red Cross which worked directly in the communities, reaching 31,800 people.

The work, however, was not without its challenges. “Initially some people didn't believe that they needed to treat the water from the river, but I explained how important it was, and gave them water purification chemicals so they could have access to safe water in their homes,” explains Ekwe. The Nigerian Red Cross Society also distributed buckets and jerry cans to ensure families would store drinking water safely.

Ekwe believes that to stop cholera outbreaks happening in Inoma in the future, there is a need to continue the sensitization of the community to reinforce positive behaviours such as hand washing, boiling and treating water, sinking boreholes, and constructing latrines.

Working in rural Nigerian communities to stop cholera

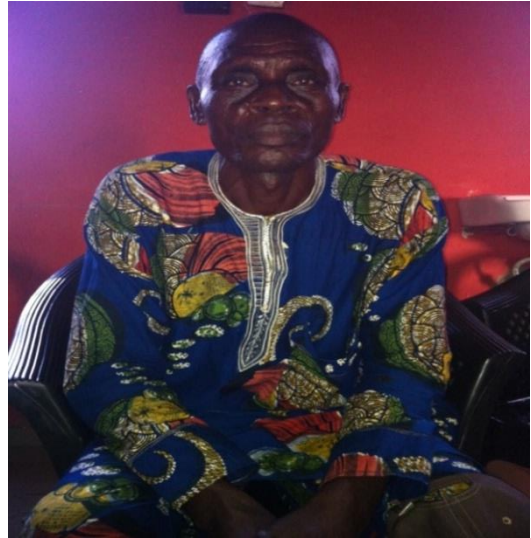
Egwu is 63 years old, a father of eight, and lives in Anambra West, 200 kilometres from the State capital Awka. In early 2015, cases of cholera began to be reported in his Nigerian village, leading to the death of four people, including his five-year-old daughter. In Egwu's village, the only available water source is the Oshimile River which is used by people and animals. Limited access to adequate sanitation also means that open defecation is common. It is believed that these combined issues contributed to the cholera outbreak.

In Anambra West, Red Cross activities were appreciated by community members. “After the volunteers arrived, the number of new cases reduced significantly,” says Egwu. “They distributed chemicals to make water safe to drink, as well as buckets and jerry cans for us to store it in,” says

Egwu. “They also gave us soap, and told us how it was important to wash our hands. If people were sick, the volunteers told them to go to the local health clinic for treatment.”

Red Cross volunteers fanned out across three of the worst affected States of Anambra, Ebonyi, and Rivers, working directly in communities, reaching 31,800 people with messaging on how to keep themselves protected from cholera. “Thanks to the Red Cross, we have established a committee that is now responsible for keeping the village clean. They gave us rakes, shovels and wheelbarrows to help the committee with these activities,” adds Egwu.

Despite the efforts made by the volunteers, Egwu recognizes that there is still work to do to avoid another outbreak. “In the future, we will need to dig boreholes, build toilets and practice proper hygiene if we are to avoid it happening again.”



Chapter 4: Conclusions

Rating
17/30

Based on the findings of the review, the DREF operation was able to exceed that targets that were agreed in the EPoA, and to some extent, contribute to a reduction in the number of cholera cases being reported in Anambra, Ebonyi and Rivers States. In total, 31,800 people (6,360 HHs) were reached through the DREF operation, which equates to 212% of the intended target (15,000 people / 3,000 HHs).

The DREF operation had an overall rating of 17 out of 30 Please refer below for conclusions in terms of 1) Relevance and appropriateness, 2) Efficiency, 3) Effectiveness, 4) Coverage, 5) Coherence, and 6) Sustainability and connectedness.

Relevance and appropriateness

The DREF operation in terms of its rationale (relevance and appropriateness) can be validated, given: the timeliness of the launch^{xxiv} (on 6 March 2015, at the peak of the outbreak), compliance with the IFRC Africa Region DMU Standard Operating Procedures (SOPs), as well as the unprecedented number of cases that were being received (and verified) by the MoH at LGA level in the areas of implementation compared to previous years, and also the exceptional CFR level that was reported. In addition, the activities planned in the EPoA were relevant and appropriate given the number of cases, and the needs of the affected/at risk population; however (explained herein this report – refer to “Chapter 2/Programme sectors/Efficiency” section), it should be noted that they were not initiated at community and household level until May 2015, and not then completed until July/August 2015 i.e. 2-3 months after the peak of the outbreak. As such, though the activities planned seem to have been relevant and appropriate to the priorities of the affected/at risk population at the time of the assessment (March/April 2015), since implementation was not initiated until May – August 2015, it is uncertain if the results of the assessments remained valid. During the DREF operation, there also seemed to have been extremely limited consultation with the affected/at-risk population on their immediate needs, the assistance required, what the Red Cross was providing (and to whom); while mechanisms were not established to provide/receive information from beneficiaries, which also raises concerns if the activities planned were necessarily relevant or appropriate to their priorities (or suitable to the context). It was identified (from the assessments, and during FGDs with volunteers) that beneficiaries indicated they were medium/longer term needs in their communities, which they perceived as more of a “priority”, e.g. installation of water supply and sanitation infrastructure, and contributing to the outbreak than improving their knowledge of how to prevent and control cholera. It was also noted (repeatedly during FGDs with both beneficiaries and volunteers) that such risks were not addressed through the DREF operation, and therefore communities will continue to be vulnerable to outbreaks (of cholera) in the future. Nonetheless it should be noted (from the FGDs, and the lessons learned workshop) that the beneficiaries were for the most part extremely positive about the assistance that they received, and continuously expressed their gratitude (to the Red Cross) for supporting them following the cholera outbreak. In addition, the installation of water supply and sanitation infrastructure (at household level) is not regarded as an immediate “emergency” intervention to address cholera outbreaks, and would not therefore have been eligible to be supported through the DREF.

Efficiency

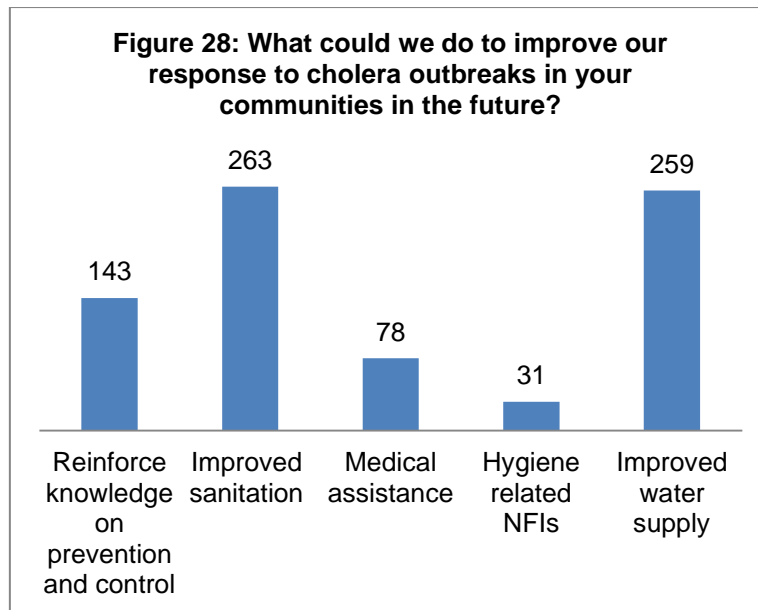
The DREF operation was for the most part managed in an organized and competent way (e.g. incorporation of lessons learned from previous DREF operations, understanding of the roles and responsibilities and lines of communication between the staff and volunteers and lines of involved etc.) Nonetheless, improvements could be made in future, in terms of the application of the appropriate procedures/standards (e.g. DREF, Sphere etc.), as well as the level of support that was

provided by NHQ to the BSs and divisional structures (e.g. improved supervision, monitoring tools/templates etc.), which was not adequate given their previous experience of DREF. In addition, the response to the cholera outbreak, which peaked in February/March 2015 was delayed, and did not start until May/June 2015 (2-3 months later), which though to an extent was unavoidable, raises concerns on the timeliness of the DREF operation (and therefore the relevance and appropriateness). As such, it is strongly recommended that in future the response is carried out as soon as possible following an outbreak. As noted, the size of the DREF allocation was not regarded as sufficient to meet all of the needs that were identified within the affected/at risk population, but it was not possible to confirm if this was due to under budgeting of the activities planned at the onset of the DREF operation, or if there were unexpected expenditures incurred. In addition, it should be recognized that the DREF cannot be expected to meet ALL of the needs of the affected/at risk population but only those that are proportionate to the actions of other agencies and based on an assessment of the most vulnerable (i.e. should not be expected to provide blanket support).

Effectiveness

The DREF operation was able to meet the intended outputs and objectives, which were agreed in the EPoA (refer to “Chapter 2 / Programme sectors / Effectiveness” section) – reaching 31,800 (6,360 HHs)^{xxv}, which equates to 212% of the intended target (15,000 people / 6,380 HHs); and helped contribute (anecdotally) to a reduction in the number of cases that were being reported. The DREF operation (based on the FGDs with beneficiaries and volunteers) increased knowledge of the communities targeted, and there was (from the volunteers) examples of improved hygiene practices and sanitation behaviours (e.g. hand washing), satisfaction with the quality/quantity of the assistance provided, which all contributed to a reported reduction in cholera cases. Based on this, it can be seen to have been an effective response, however some concerns were identified.

- Approximately 58% were able to recognize at least three cholera case symptoms; though it should be noted that many respondents put emphasis on vomiting (78%) over other symptoms, followed by acute watery diarrhoea (57%) and frequent stools (52%) – whereas the main symptom is acute watery diarrhoea. In addition, 29% indicated fever to be a symptom, however this is not usually considered as a main symptom.
- Approximately 50% were able to recognize at least three complications faced by someone with cholera at least three cholera complications; though it should be noted that many respondents put an emphasis on weakness (73%) over other symptoms – whereas the agreed main complication is dehydration (weakness is not specific to a cholera case).
- 66% were able to recognize at least three measures for preventing cholera infection and transmission can you recognize; and 84% put emphasis on hand washing, which is the main means. In addition 86% were able to recognize at least three critical times for hand washing.
- 61% identified rehydration with ORS as a main action to perform to a cholera patient, and 50% the referral of the case to the health authorities.
- More than 60% were satisfied (i.e. rated the assistance either “Excellent” or “Good”) with the quality and quantity of the water purification chemicals and hygiene related items that were provided; however it remains that about 40% was not.
- Examples given as to how the RCRC could improve their response to cholera outbreaks in the future (e.g. installation of water supply and sanitation infrastructures, and reinforcing knowledge on the prevention and control of cholera etc.). Refer to “Figure 28: What could we do to improve our response to cholera outbreaks in your communities in the future?”.



Coverage

The DREF operation was able for the most part reach the worst affected/at risk populations by the cholera outbreak in the areas of implementation – despite inconsistencies identified in the application of beneficiary selection criteria. From the HH survey, the beneficiaries, which received assistance were appropriate given: they had mostly been affected directly, or a member of their HH had been affected by the cholera outbreak; and were also amongst the most vulnerable in their respective communities. In accordance with the “Sword and Shield”, HHs that are affected and “at risk” should both be targeted, and as such the assistance provided for 16% (133) of HHs that were not directly affected, was also appropriate, i.e. given both their proximity to those that were affected, as well as being amongst the most vulnerable in their communities (and therefore “at risk”). In addition, the DREF operation was able for the most part to reach the geographical areas that were worst affected/at risk by the cholera outbreak, and justified (based on the information available) though there should be consideration in future as to how assistance can be extended to even more remote communities, which are long distances from local MoH structures.

Coherence

The DREF operation was for the most part carried out in coherence with the agreed EPoA and budget, and irrespective of some exceptions (e.g. training on the use of ODK) it was still able to meet its intended objectives and outputs. Nonetheless, the level of coordination and collaboration with other agencies was identified to have been extremely limited (and therefore coherence with the overall response to the outbreak); and it was noted (repeatedly from the KIIs with partners) that the NS should participate more in the coordination mechanisms to ensure that their role is properly defined, to avoid responses that are duplicated, as well as share more information on their activities (e.g. the EPoA, assessment reports etc.). In addition, since the DREF operation was carried out in the same LGAs / communities as the responses by other agencies, and there was an overlap with the activities by the other agencies, (e.g. sensitization, and distribution of water treatment chemicals), it raises concerns that there was duplication in terms of the assistance that was provided.

Sustainability and connectedness

The DREF operation has contributed extensively to NS capacity building, particularly at branch and divisional level, while there are also indications that the outcomes at community level will continue to

be sustained. Nonetheless, there remains a need to ensure that the capacity and learning from the DREF operation at NS level are institutionalised so that they are better positioned to respond to cholera outbreaks in these States in the future, e.g. through integration within NS and branch level contingency plans; as well as ensure the outcomes that have been achieved at community level are also sustained, and not allowed to dissipate.

Chapter 5: Lessons learned

5.1 Programme sectors

Health and Care

- Community and household level sensitization activities (and the messaging/tools used) can provide a relevant, appropriate and effective means of improving the knowledge of affected/at risk populations, and help contribute to a reduction in the number of cholera cases^{xxvi}; however they should be carried out as soon as possible following an outbreak (not 2-3 months after the peak), and extended beyond the timeframe of the DREF operation to ensure that change (e.g. knowledge and practices) can be reinforced/sustained.
- Promotion of more innovative sensitization strategies (e.g. mobile cinema, radio, use of loom bands etc.) rather than more traditional relying on approaches used in the past (e.g. HH visits) could help reach increased numbers of people, and better engage with different groups (e.g. youth).
- Proper case management (e.g. through ORPs) and surveillance at community level; as well as referral mechanism established with local MoH structures could have helped ensure that suspected cholera cases received quality and timely treatment, especially in the remote/riverine communities where access was challenging.
- Training can help strengthen volunteers knowledge and understanding on how to prevent, control and manage cholera cases (e.g. through the preparation of ORS), as well as on mobile data collection (ODK); however could be intensified (either through a refresher or carried out over longer period) to reinforce the learning gained.

Water, sanitation and hygiene promotion

- Distribution of water treatment chemicals and water storage containers, as well as demonstration on their use can help contribute to a reduction in the number cholera cases^{xxvii}; however they should be carried out as soon as possible following an outbreak (not 2-3 months after the peak), as well as efforts made to ensure that the lifespan (e.g. expiry date); and size of the containers (e.g. jerry cans) are such that HHs can treat and store safe water supply for a longer period.
- Communication of the registration/selection process (including the selection criteria, date, time and place of distributions), as well as the issue of proper registration/distribution cards could have helped address challenges experienced during the distribution of NFIs, and helped ensure that expectations of the RCRC are not raised beyond what can be delivered (e.g. that all of the affected/at risk population expect to receive this assistance).
- Establishing and equipping of community WatSan committees can be an effective means of sustaining environmental sanitation beyond the timeframe of the DREF operation; however should be carried out as soon as possible following an outbreak, and additional items provided (cutlasses to help with vector control, and first aid kits to treat minor injuries).

5.2 Programme support services (as relevant)

Human Resources

- Community based volunteers can provide a comparative advantage for the RCRC, especially in the remote/riverine communities where access is challenging, as can be mobilized immediately to provide community level case management and surveillance following an outbreak, and since they have increased acceptance of the affected/at-risk populations are also better placed to carry out sensitization activities.
- Provision of protective equipment can visibility materials to volunteers can help support them with the activities planned, as well as incentivise; however should be standardized (e.g. provision of

the same items for all volunteers), and consider the conditions in which they are working (e.g. provision of jackets and umbrellas during the rainy season).

- Deployment of RDRT members provide an effective means of supporting the implementation of the DREF operations; however they are better placed at branch level where they can directly assist the NS with the activities planned (e.g. quality assurance).

Logistics and supply chain

- Pre-positioning of stocks (water treatment chemicals and hygiene related items) could help ensure that distributions can be carried out as soon as possible following an outbreak (not 2-3 months after the peak; or delayed due to internal issues).
- Rental of smaller vehicles/motorbikes could have enabled better access (via river crossings for the transfer of NFIs for distributions), and improved the mobility of volunteers to remote/riverine communities.
- Use of the ODK/Mega V systems could have enabled more efficient and effective distribution of hygiene related items (e.g. use of proper bar code registration and distribution cards to recipients).

Communications

- Promotion of the RCRC role and mandate could be incorporated within the activities planned (e.g. sensitization activities; and preparation of external communications) to help address misconceptions at community level and with stakeholders at national and State level.

Resource Mobilization

- Responses through DREF operations can provide an entry point for engaging with donors to mobilize/advocate for additional resources to support the immediate response, as well as meet medium/longer term needs (e.g. water supply and sanitation infrastructure that would not be eligible under DREF).

Information technology

- Use of mobile data collection (e.g. ODK) can help speed up data collection and analysis; however adequate equipment (cell phones) should be made to ensure that there is a consistent approach (e.g. to assessments/KAP methodologies).

Security

- Safety and security of staff and volunteers involved in the DREF operation could be improved by ensuring that relevant protocols are established; and staff/volunteers orientated on them, as well as awareness raised on the insurance coverage provided (by IFRC).

PMER

- Orientation of staff and volunteers on the proposed strategy (e.g. in the EPoA and Budget) could have helped ensure compliance with this (e.g. "Sword and Shield) as well as the relevant standards on quality and accountability (e.g. HAP, RCRC, Sphere" etc.) within humanitarian response.
- Development of an monitoring and evaluation matrix, as well as reporting tools/templates to be used at branch/divisional level could have helped ensure inconsistencies between implementation and reporting were reduced.
- Detailed assessment followed by KAP can help inform decision making (e.g. geographical locations, and the activities planned); and thus contribute to ensuring that interventions are relevant and appropriate to the needs of the affected population.

RCRC / Agency Coordination

- Participation in all coordination mechanisms and at both NHQ and State level can help reduce the risk of duplication where there was an overlap of the activities planned by other with other agencies (e.g. sensitization, distribution of water treatment chemicals).

Chapter 6: Recommendations

Key recommendations include:

- Ensure orientation is provided to all staff involved in the implementation of operations (e.g. through a project inception meeting), including: the sharing of the project plans (e.g. the EPoA + Budget); and briefing on the procedures/standards that need be followed. (e.g. DREF, Sphere, Sword & Shield etc.), as well as any relevant resources (e.g. NS policies, IFRC manuals etc.).
- Ensure orientation is provided to all volunteers involved in the implementation of the operation on the relevant NS volunteer policies, including: on per diem allowance, insurance; security/safety protocols, and ensure consistent application.
- Establish a planning, monitoring, evaluation and reporting framework, including: agreement on the key indicators/targets to be monitored (based on the EPoA); the data that should be collected; and the mechanisms (e.g. tools/templates) for collection and analysis – in order to enable efficient decision making throughout the operation, as well as effective (evidence based) reporting on implementation.
- Pilot the inclusion of beneficiary communications mechanisms throughout the implementation of future operations (e.g. for mechanism for complaints/response), as well as improve the involvement/consultation with the affected population at all points (e.g. in the registration/selection of beneficiaries, and in distributions).
- Establish links with the relevant coordination mechanisms at both NHQ and branch level (including information sharing) to promote collaboration during cholera outbreaks (e.g. surveillance and referral, and involvement in the State ERCs) as well as explore potential opportunities for partnership (e.g. for medium/longer term needs).
- Develop national and state level contingency plans for cholera outbreaks using the best practices/lessons learned from the DREF operation, and identify/advocate to partners to support their implementation.
- Develop plans to address medium/longer term needs in the areas of implementation (e.g. safe water supply and sanitation infrastructure, as well as continuation of sensitization activities); and identify/advocate to partners to support their implementation.

Annexes (available on request)

Annex I: Terms of Reference

Annex II: MDRNG020 Nigeria Epidemic (Cholera) – EPoA

Annex III: MDRNG020 Nigeria Epidemic (Cholera) - Budget

Annex IV: MDRNG020 Nigeria Epidemic (Cholera) – Op Update no.1

Annex V: DREF Review – Tool Kit

ⁱ <http://adore.ifrc.org/Download.aspx?FileId=72356>

ⁱⁱ <http://adore.ifrc.org/Download.aspx?FileId=86725>

ⁱⁱⁱ http://www.unicef.org/cholera_toolkit

^{iv} Note: UNICEF representatives (Federal level) were not available to be interviewed as were all involved in the preparation of the 2016 Humanitarian Needs Overview, during the timeframe of the exercise.

^v Note: 2,108 cases, with 98 deaths (By the end of April 2015).

^{vi} Source: IFRC Geneva/Africa zone emergency health unit.

^{vii} Source: MDRNG020 Nigeria Epidemic (Cholera) EPoA.

^{viii} Source: MoH Primary health care centre (Unyeada / Andoni LGA) KII reported that February/March 2015, the clinic received more than 10 cases per day (on average).

^{ix} Source: MoH Primary health care centre (Unyeada / Andoni LGA) KII reported that referrals were received from surrounding communities (up to one hour walk) from the clinic.

^x Source: MoH Rivers State / Port Harcourt KII: confirmed level of CFR above that recommended by the WHO (1%).

^{xi} Note: For example: in Anambra, 60% of respondents indicated that they had no idea of how cholera was transmitted, only 16% indicated that they were aware that diarrhoea was a symptom of cholera, and 55% indicated that they were not aware that it could be prevented through improved basic hygiene (proper hand washing, handling of food, use of clean water etc.).

^{xii} Note: Of the respondents to the HH survey, 63% (489 of the 771 that made a response to this question) had to walk more than 50m to the nearest latrine; while 44% (367 of 842) had to walk more than 500m to the nearest water source, both of which exceed the maximum distances in accordance with Sphere standards.

^{xiii} Note: Based on KIIs with BS (Anambra): reported that the last DREF operation managed by the branch was in 2005.

^{xiv} Note: Based on KIIs with BSs (Rivers)" reported only in position for six months.

^{xv} Note: Refer to Quality programming / Areas common to all sectors / Activity 1.3.1" in Annex II: MDRNG020 Nigeria Epidemic (Cholera) – EPoA.

^{xvi} Note: IFRC GVA level authorisation was provided prior to expected end date of the DREF operation (6 June 2015); however the Operations Update was not issued until 11 June 2015.

^{xvii} Source: Based on review of secondary data (EPoA – Operational Framework)

^{xviii} Note: Overspend of CHF 33 was covered by the IFRC Nigeria country representation.

^{xix} Source: Lessons learned workshop (NRCS - DREF operation presentation)

^{xx} Source: MDRNG020 Nigeria Epidemic (Cholera) EPoA

^{xxi} Note: The FMWR tasked other agencies (UNICEF and WHO) with response in Anambra, Ebonyi and Rivers; and not operational.

^{xxii} Source: <https://www.icrc.org/en/what-we-do/cooperating-national-societies/safer-access-all-national-societies>

^{xxiii} Refer to Quality programming / Areas common to all sectors / Activity 1.3.1" in Annex II: MDRNG020 Nigeria Epidemic (Cholera) – EPoA.

^{xxiv} Note: As per the DREF guidelines, which indicates request should be submitted/launched within 24-48 hours.

^{xxv} Source: Lessons learned workshop (NRCS - DREF operation presentation)

^{xxvi} Note: since other organisations also carried out sensitization activities is not possible to accurately establish to what extent the level of knowledge of the population can be attributed to the DREF operation – however based on the testimonials of community members and volunteers.,

^{xxvii} Note: since other organisations also carried out sensitization activities is not possible to accurately establish to what extent the level of knowledge of the population can be attributed to the DREF operation – however based on the testimonials of community members and volunteers.,