www.ifrc.org
Saving lives, changing minds.

Emergency Plan of Action operation update
Kenya: Mandera Cholera Outbreak

DREF n° MDRKE038	**Glide n°** EP-2015-000013-KEN
Update no. 1 **Date issued:09/08/2016**	**Timeframe covered by this update:** 8th June to 6th August 2016.
Operation start date: 12th April 2016	**Operation timeframe:** 1-month new time frame 3 months. **End date** New time frame 6th September 2016
Overall operation budget: CHF 276,165	**DREF amount initially allocated:** CHF 140,244
N° of people being assisted: 200,000	
Red Cross Red Crescent Movement partners currently actively involved in the operation: Kenya Red Cross Society (KRCS), 87 surge Staff, 4 HQ staff, 14 Field staff and 250 volunteers	
Other partner organizations actively involved in the operation: MoH, Médecins Sans Frontières (MSF), WHO, UNICEF, UNFPA, The African Medical and Research Foundation (AMREF) and The Kenya Medical Research Institute KEMRI	
This Operations Update is requesting an extension to the timeframe of the by 4 weeks (New end date: 06 September 2016) to enable completion of the planned activities in the Mandera. The activities were disrupted due to 4 terror attacks in Elwak, which is on the outskirt of the Mandera County near the Somalia border. This however did not have a direct impact on the operation. However, due to the rumours and threats on planned attacks, 22 staff deployed in the operation had to be evacuated back to Nairobi since they were non-residents and more at risk of being targeted by the Al Shabaab.	

A. Situation analysis

Description of the disaster

Kenya has reported cholera outbreak in 30 of its 47 counties since 26 December 2014, when it was first reported in Nairobi County. The outbreak was later spread to other counties with the recent outbreak reported in Mandera and Tana River counties. At the same time Mandera County had been experiencing an increase of febrile illness presenting with joint pains since the beginning of May 2016. The County has also experienced dengue fever outbreaks in the past and health officials suspected this to be another dengue fever outbreak, although the joint pain presentation showed this wasn't the case. After laboratory tests were conducted in KEMRI, it was confirmed that the disease was Chikungunya fever.

Situation in Mandera

Cholera Outbreak

Mandera County is located in the North Eastern Region of the country. It is the latest county to report cholera outbreak. This is an ongoing transmission which was first reported in December 2014. Cholera outbreaks occurred in several waves in most of the counties. It has also been occurring inform of acute watery diarrhoea in recent past in Mandera, with the last episode being in March 2015, while the other diarrhoea is the leading cause of morbidity especially during the dry season when water is scarce and wet season when water sources are contaminated.

In this current wave of outbreak, Cholera was first reported in Mandera 2016, and up to 894 cases were reported, on 12 April 2016. As at reporting time, 1629 cases had been reported with 18 deaths recorded - Case Fatality Rate (CFR) of 1.1%. KRCS has since closed the Cholera Treatment Center (CTC) and is supporting in the running of the Government CTC (which was handed over by the MSF). During the operation, KRCS reached a total of 391, 941 people through awareness sessions conducted in house to house visits including revisits, demonstration of Handwashing and

Handwashing facilities. This represented over 200% of the target population due to revisits and the huge population affected by the outbreaks. The cases admitted at the CTCs were given a discharge package which included sensitization and distribution of soaps, buckets and water treatment chemicals. The response by the KRCS, MoH and other partners helped contain the outbreak within Mandera East Sub County.

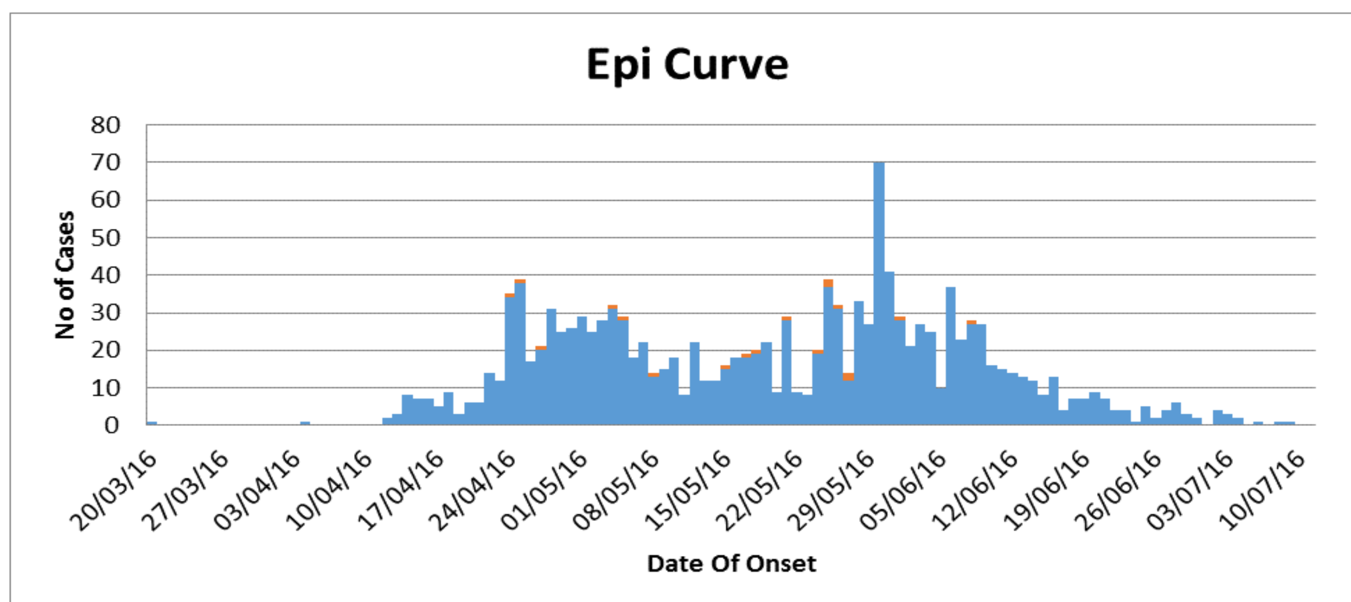

Figure 1: Mandera Cholera Outbreak Epi-curve

Chikungunya outbreak

Chikungunya fever was confirmed in Mandera East sub-county on 20 May 2016. As at reporting time, 1574 cases had been documented with no deaths reported. Cases with severe debilitating joints pains were managed as short stay inpatients for five days. Majority of the cases were however treated as outpatients.

KRCs deployed a surge team and backup who were on standby due to the high risk of personnel getting infected with the Chikungunya virus. Measures were however put in place through provision of mosquito repellents to protect the staff from bites by infected mosquitoes. Since the beginning of the response period, 6 of the KRCS personnel deployed in the operation were infected with the virus. This was however, a minimal number and did not affect the overall response plans.
The County and National Government of Mandera held meetings with the neighbouring Somalia which had similar outbreaks of Cholera and Chikungunya, to discuss on means of containing the outbreak. The borders were closed resulting in reduced number of cases.

Summary of current response

Overview of Host National Society

Since the Cholera and Chikungunya outbreak, the County Government of Mandera in collaboration with the National Government initiated the outbreak response mechanisms. A rapid assessment was conducted led by the National and County Government Ministry of Health. The Mandera County Government requested the Kenya Red Cross Society (KRCS) and other partners to support the cholera and Chikungunya outbreaks response. Consequently, on 28 May 2016, KRCS mobilized a team of health and WATSAN technical staff experienced in Advocacy, Communication and Social Mobilization (ACSM), active case finding, hygiene and sanitation and safe water provision. An additional team of medical personnel (Medical Doctors, Nurses, Clinical officers, Public Health Officers and Lab technicians) were then deployed to provide services at the Cholera Treatment Centre (CTC) set up at the Moi stadium, Mandera for case management near the epicentre of the 2 outbreaks in Mandera town. The technical teams worked closely with the County and National Government teams, other partners on the ground and were supported by team of local volunteers. The teams provided clinical care for case management, contact tracing services for all the patients at the CTC, supported the volunteers to undertake active case finding of Cholera and Chikungunya cases, conduct advocacy, communication and social mobilization activities at community level, hygiene and sanitation promotion and integrated

vector management interventions at Household and Community level focusing on Chikungunya virus and the CTC patients identified during active case finding.

The Kenya Red Cross worked as part of the National and County outbreak response coordination mechanisms. The Kenya Red Cross at National level participated in the high level consultation meeting convened by Cabinet Secretary for Health to strategize on the key strategies for the outbreak response and lobby support from other key development partners and actors. Kenya Red Cross also participated in the Kenya Humanitarian Partners (KHPT) meeting which brought together actors from the UN and other development partners that discussed the need and urgency for the UN and other actors to support the Mandera County in the Outbreak response.

During the reporting period, it is estimated that 90% per cent of the activities planned have been completed and progress made in accordance with the agreed EPoA

Overview of Red Cross Red Crescent Movement in country

The International Federation of Red Cross and Red Crescent Societies (IFRC), through its Eastern Africa and Indian Ocean Islands Regional Representation, which is based in the country, supports operations in 12 countries in the region, including KRCS. On 31 May 2016, the IFRC and KRCS came up with an agreed operational strategy in response to the Cholera and Chikungunya Outbreak.

The ICRC works in partnership with KRCS in restoring family links (especially in the provision of phone call services to Dadaab and Kakuma camps), emergency preparedness and response, and promotion of IHL and fundamental principles. Additionally, joint assistance projects are ongoing at the Coast, including distribution of relief items, food and seeds/tools in Lamu and Tana River, as well as support to waterworks project in Kilifi. The ICRC regional delegation is hosted in Nairobi which also serves as a hub for operations in Eastern and Central African countries

The ICRC has so far provided samples of Cholera Information Education and Communication materials translated into Somali for use in the response.

The KRCS hosts a number of Participating National Societies (PNSs), including: Australian, Austrian, British, Canadian, Danish, Finnish, German, Japanese, Netherlands, Norwegian, and Swedish Red Cross Societies.

The operation in Mandera was supported by Chinese Red Cross through provision of tents for the CTC.

Movement Coordination

In Kenya, all the components of the movement exist and these are; the IFRC, ICRC, PNSs and the host National society. The Movement coordination is normally done through sector specific coordination forums or meetings, senior management and governance level meetings and forums.

In this case, Mandera County borders Somalia to the East and Ethiopia to the North. A cross-border meeting was conducted to discuss on the coordination towards the response for the Cholera and Chikungunya outbreaks between the IFRC, the ICRC, the KRCS, the Ethiopian Red Cross Society and the Somalia Red Crescent Society.

On 31 May 2016, the KRCS held a briefing with PNSs, ICRC and IFRC, in which key elements of the cholera and Chikungunya operation were highlighted.

Overview of non-RCRC actors in country

The Ministry of Health (MoH) at the National Government and the Mandera County Government have put in place an outbreak response coordination mechanism at their respective levels. In response to cholera the Ministry of Health issued a cholera alert in January 2015, to all the counties and advised all the health care workers to step up surveillance of diarrheal disease. This led to the detection of cases in Mandera County. The Government then put in place National and County outbreak mechanisms. The Ministry of Health from the National Government deployed a team of disease control experts to Mandera County to provide technical assistance in conducting comprehensive outbreak investigation and response. The County ministry of health team worked with partners including Kenya Red Cross and MSF to actively search for suspected cases in health facilities and within communities. Contacts of individuals who presented with signs and symptoms were being tracked by surveillance teams and provided with pre-emptive treatment. The National government supplied the initial contingent of medical and non-medical supplies were used in the response. UNICEF developed Information, Education and Communication (IEC) materials on mode of infection, signs and symptoms, prevention and appropriate health seeking behaviour.

In response to the Chikungunya fever outbreak, a public health alert and fact sheet on the disease was issued on the 20 May 2016, by the Director of Medical services to all County Health departments and key stakeholders. The National Ministry of Health heightened surveillance in the Mandera East sub-county and surrounding areas. The Ministry issued a standard case definition to all the county health departments and dispatched a team of experts who were guiding and the county health workers in actively searching for suspected cases of Chikungunya in health facilities and communities. The National Ministry of Health deployed a multidisciplinary team comprising of epidemiologists, an entomologist, an environmental health expert and health promotion expert to Mandera County to provide technical assistance in conducting comprehensive Chikungunya outbreak investigation and response.

WHO provided the technical teams with overall outbreak response management and entomologists who supported in entomological survey in response to the Chikungunya outbreak. UNICEF provided WASH supplies, chemicals and general awareness on hygiene and sanitation. UNFPA sent technical teams on the ground to work with the counties to ensure continuity of essential services amidst the outbreak response.

Médecins Sans Frontières (MSF) set up a Cholera Treatment Centre CTC at the Mandera County Referral Hospital to facilitate timely management of cholera cases. The CTC had a 60 bed capacity and was handed over to MoH since the cases were managed.

The African Medical and Research Foundation (AMREF) provided support in the transportation of commodities and supplies. The Kenya Medical Research Institute KEMRI centre for viral Research laboratory has the capacity to confirm viral infections including Chikungunya, dengue and yellow fever. KEMRI continues to provide laboratory support for confirmation of the outbreaks and continued surveillance. The county continues to regularly send random samples to KEMRI laboratory to ascertain disease causing pathogens.

Other actors such as UNOCHA, UNDSS and World Bank have continued to avail support where needed. Trocaire of Somali also supported in cross border control of the epidemic.

Needs analysis and scenario planning

A joint rapid assessment conducted by the MoH in collaboration with Kenya Red Cross and other key actors noted that there existed an outbreak coordination mechanism at the County level for both diseases. The National government had already instituted heightened surveillance for both diseases and deployed technical teams to support the Mandera County in comprehensive outbreak response for both Cholera and Chikungunya fever.

The assessment identified the following gaps both in the Cholera and Chikungunya Outbreak responses which include:

- Lack of outbreak response plan for both cholera and Chikungunya diseases.
- Inadequate number of Health workers since 50% had been affected by Chikungunya fever and had taken medical leave. The county government health care system was functioning at less than 50% capacity and thus not able to contain the outbreaks. There was a need to quickly mobilize a surge team to step in to boost the county capacity to manage the outbreaks.
- Knowledge gap among health workers on management of Cholera and Chikungunya outbreak.
- Water safety and sanitation.
- Low latrine coverage 30%.
- No water treatment at household level.
- No cross border coordination activities for both outbreaks which may likely contribute to increase patient load.
- Advocacy Communication and Social Mobilization. Had no Advocacy, Communication and Social Mobilization (ACSM) plan for community mobilization.
- MoH didn't not have enough IEC materials for both diseases.
- Weak laboratory Capacity at the county.
- Vector Control: Have no fogging machines, no larvicides and no pyrethroids for the dengue response.
- Poor Infection prevention and Control at the CTC in Mandera
- No safe burials.

From the identified gaps, different actors including the National Government Ministry of Health which undertook to work with the County Government and other partners including the Kenya Red Cross developed an outbreak response plan for the 2 diseases to address the identified gaps based on their areas of expertise and areas of focus to address different areas. The National government availed all the training materials and trained health workers on case management of the 2 diseases. This was done through on the job training and short sensitization sessions.

A surge team was deployed by the Kenya Red Cross to increase the capacity to contain the outbreaks as the County Government health care system had been affected with a number of personnel affected by the Chikungunya virus. Kenya Red Cross was the only agency that had the capacity the quickly mobilize a surge team in this type of emergency and thus the request from the county for the Kenya Red Cross to pull in the surge team.

The existing CTC put up by the MSF was overloaded and not able to cope with the caseload of Cholera in the county. KRCS deployed another 60 bed capacity CTC to decongest the one run by MSF.

The Kenya Red Cross working together with the National Government and the County Government developed an advocacy communication and social mobilization plan for the 2 diseases. The awareness messages were broadcast to the public in the local language to get a wider reach. This was through the agreed messages by the National Government and the volunteers from KRCS. Printing of the same messages is to be done at the headquarters level.

The coordination of the cross border activities, was initiated by the County Government of Mandera with an initial meeting being held bringing together teams from the 3 neighbouring countries (Kenya, Somalia and Ethiopia). A meeting was convened at Bula Hawa in Somalia with members from the National and County Government of Mandera,

representatives from Kenya Red Cross, MSF and Trocaire of Somalia. To ensure the containment of the outbreak, there was an agreement to have the Somalia-Kenya border closed.

The National Government conducted Vector Control through fogging by use of Deltamethrim (to be used for) and Temaphos (used for larviciding). Kenya Red Cross provided spraying pumps to supplement the motorized pumps had been supplied by the National Government. KRCS volunteers also worked with the households and communities to implement other vector control measures such as environmental manipulation and self-protection and promoting use of repellents and mosquito nets and clean up exercises.

Protective gears were provided to the team operating in the CTCs to avoid cases of contamination. MoH ensured safe burial of the dead directly supervising 16 burials in the community. Community education was enhanced through awareness sessions and campaigns as well as radio broadcasts through the local radio.

Considering the gaps identified, the role of other actors including the National and County Government, the Kenya Red Cross focused on the following areas:

- Set up an additional CTC at the Moi Stadium Mandera
- Provided health workers surge capacity
- Conducted advocacy communication and Social mobilization
- Integrated Vector Management actions at Household and community level in collaboration with the county government
- Conducted hygiene and sanitation promotion by provision of soap, hand washing facilities and hygiene promotion messages
- Promotion of Household Water treatment options through provision of water treatment chemicals and chlorination of water tanks for domestic use
- Ensuring access to safe water for domestic use through chlorination and treating water sources

Beneficiary selection

KRCS interventions targeted three groups of people in the county for Cholera response and 2 groups of people in the county for Chikungunya Response while fo Cholera the 3 groups were as follows:

- The first group of beneficiaries were those diagnosed with Acute Watery Diarrhoea (AWD) and required rehydration and management, either at community rehydration points or at the CTCs being set up at Moi Stadium Mandera.
- The second group of beneficiaries were those persons who had been in contact with the first group during the period of incubation or during the period that the patient was showing signs of illness (AWD with or without vomiting).
- The third group comprised the general public living in villages where cases of cholera had been confirmed or where there was an upsurge of AWD

For Chikungunya, the two groups were as follows:

- The first group was the general population who were benefitting from the Integrated Vector Management interventions targeting the individuals, the households and the community.
- The second group were those who were presenting with signs and symptoms of the Chikungunya Virus. These were the beneficiaries of active case finding and referrals to health facilities for effective management of the fever.

Risk Analysis

While KRCS continued to have adequate humanitarian access to Mandera County, the unpredictable nature of attacks from Somalia presented a challenge in operational areas. During the operation period, there had been 4 different terror attacks in a span of 1 month. This was along the road near Elwak town. The attacks led to the killing of 2 police officers and 3 civilians. The town is approximately 250 km from Mandera town which is the operation base and did not therefore have a direct impact on the operation. In a bid to maintain the security level, KPR and Prison wardens were deployed to man the areas surrounding the CTCs. There was also a restriction of movement of the personnel deployed with personnel expected to settle within their accommodation after 1800 hours. The movement of the vehicles was also limited to within the areas in proximity to the operation base unless there were cases of emergency. There was need to evacuate 22 members of the surge team who had been deployed from Nairobi due to safety concerns.

The rapid spread of Chikungunya also posed a risk to the staff with 3 staff and 3 HCWs getting infected by the virus. This number was however minimal and did not cause a strain on the response.

Strategy: **Contribute to the Cholera and Chikungunya outbreak containment and control (management of cases and prevention) in Mandera County targeting 200,000 people (affected and at risk) in support of the MoH.**

KRCS reached a population of 391, 941 people through advocacy in public meetings and house to house visits. To assist in creating community awareness and serve in the CTCs, 350 KRCS volunteers were trained on simple ways of assessing dehydration levels and issuing of ORS, hygiene promotion, simple ways of managing cholera cases and prevention of contamination. A population 2,666 households received NFIs including soaps and jerry cans with a total of 7998 sachets of aqua tabs were distributed to the general population in the affected areas of Mandera East. KRCS also conducted disinfection of latrines to 36,637 households and chlorinated 31,924 water storage tanks. The religious leaders were sensitized through two sessions on the prevention and control of the outbreak. Similar sessions were conducted among the chiefs, sub chiefs and village headmen, bringing on board opinion leaders and other villagers. These were done through four sessions. The KRCS team also conducted demonstrations on hand washing reaching a direct population of 50,141.

B. Operational strategy and plan

Proposed Strategy

Through the DREF operation, the following strategies were prioritized;

Strategy 1: Outbreak Confirmation and Continuous Joint Assessments

- KRCS continued to work closely with the MoH (national) and the Mandera County government in establishing the extent of the cholera outbreak, by ensuring the maintenance of line-listing, as well as establishing factors enhancing the sustained transmission of vibrio cholera. Kenya Red Cross has also continued to work with the MoH at National and County level to monitor the extent of the Chikungunya fever. The Kenya Red Cross support to surveillance is to inform on active case finding using the MoH approved case definition for both the diseases and referrals of these cases for management at Facility level.

KRCS, MSF together with the County and County Government of Mandera and Trocaire (of Somalia) conducted a cross border meeting to discuss on the coordination of cross border control of Cholera and the Chikungunya virus.

Strategy 2: Case Management

- KRCS deployed a surge team to support with case management at the CTCs and other key facilities. The team comprised of 7 Medical Officers, 22 Nursing Officers, 10 Clinical Officers, 14 public health officers, 2 laboratory technicians and 1 nutrition officer. A total of 350 staff and volunteers were deployed and were taken through on -the-job-training on infection prevention, case identification and management of dehydration. The surge team was drawn from the KRCS emergency data base.
- A surge capacity was also put on standby should there be a need to boost staffing levels based on caseload in the CTCs. The supplies in use included 15 tents, consumables (including Ringers Lactate, Normal Saline, 5% Dextrose and infusion sets), 50 cholera Beds, infection control supplies (90kg Chlorine, which was also be used for chlorination of wells by Hygiene Promotion Teams). Others are lab supplies, including specimen collection kits, Cary Blair Transport Media, cold boxes, etc.

Strategy 3: Hygiene Promotion and Advocacy, Communication and Social Mobilization of Communities

- A team of public health officers (14 PHOs) working with 200 volunteers at the community level worked on sensitizing the community regarding the outbreak and the need to participate in efforts to contain the outbreak. The team also carried out health and hygiene promotion, including promotion of safe faecal matter disposal, promotion of hand-washing, take part in promoting hygienic food handling, chlorination of water storage tanks (as well as distribution of point of use water treatment chemicals), community level integrated Vector control actions and delivered key messages on outbreak prevention and control to individuals and families. The initiative, being a mandate of the Government was being led by the Government.
- Community sensitization was conducted through public meetings, with the participation of religious leaders and local administrators. The team, equipped with cholera kits and hygiene promotional materials, also carried out frequent disinfection of compounds within and around CTCs and carrying out vector control in and around CTCs. Environmental cleaning has also been on-going.
- The community was sensitized and made aware on Chikungunya prevention measures at household and community level through the public health team and volunteers.

- The use of public service announcements (PSAs), the local media and the production of cultural-sensitive information, education and communication (IEC) materials was enhanced to increase levels of awareness.
- As a key lesson learnt from the previous responses, this response incorporated a strong addition of Advocacy with the County government authorities with an aim of ensuring smooth phase out of the operation and strengthened health systems that were crucial in mitigating the impact of the outbreak.

Strategy 4: Active Case Finding and Enhanced Surveillance

- The KRCS team collected information relating to patients admitted at the CTCs (one run by MSF and second one run by KRCS), as well as in community rehydration points, with tracing of cases being conducted up to their villages and households together with local administrators and volunteers. This was aimed at ensuring the spread of disease is minimized as much as possible.
- People who had been in contact with patients were monitored for development of symptoms, and where possible, and in consultation with the county department of health, targeted prophylaxis was provided to the case contacts to minimize the risk of becoming cases in line with the MoH guidelines for targeted prophylaxis. This team also carried out community surveillance and mortality surveillance. All mortalities were audited by the team to identify the immediate cause of death. The results of community and mortality surveillance were then fed into the County Health Information System.
- KRCS also participating in continuous coordination efforts at the County and National level.

Strategy 5: Integrated Vector Management

- Kenya Red Cross working with the County public health teams undertook Integrated Vector management actions which included sensitization of the community on individual, household and community actions on vector control. The teams conducted fogging and larviciding at the community level to help in reducing the density of both adult and larvae of the mosquitoes to cut the transmission of the Chikungunya virus.

Operational support services

Human resources (HR)

The DREF operation deployed the following personnel:

- Surge team to support case management at the CTCs and other key facilities: 7 Medical Officers, 22 Nursing Officers, 10 Clinical Officers, 14 public health officers, 2 laboratory technicians and 1 nutrition officer. The surge team was drawn from the KRCS emergency data base.
- For purpose of water and sanitation hygiene, 1 WASH officer was also deployed in the operation.
- To ensure good documentation, reporting and visibility, one audio-visual officer and 1 communications officer were also deployed as part of the operation.
- Three hundred and fifty (350) volunteers were deployed to support the operation in different capacities. The volunteers were given on-the-job training on infection prevention and case identification and management of dehydration, with a total of 45 staff and volunteers.
- Of the 350, 200 volunteers were involved in conducting community awareness creation, hygiene promotion and health education. The other 150 remained on standby to back the response teams due to the high risk of disease infection even to the response teams.
- Contact tracing was also carried out by the volunteers through the coordination by 10 public health officers to cover three zoned areas reporting highest number of cases. The officers also carried out community level surveillance and mortality surveillance and referring cases traced at village levels to the CTCs.
- The KRCS Mandera branch supported the operation through volunteers and storage of supplies as well as other logistics.
- All the staff and volunteers in the field were supported through allowances for the duration of the deployment.

Information Communication Technology

Field and Headquarter based ICT equipment was used in supporting the cholera response. Mandera presents challenges in communication as mobile networks, internet connectivity and power supply are not stable. Vehicles deployed to the operation were fitted with radios to enhance coordination within teams. Cell phone airtime for staff assigned to the operation was budgeted. The headquarters provided technical and back up support.

Logistics and supply chain

Logistics support to the DREF operation includes delivering a range of relief items in line with operational priorities and activities. These include:

- Through the procurement guideline, KRCS has procured and prepositioned delivered medical consumables, cholera beds. Tents and PPEs to be used in CTCs.
- Through the supply chain department, KRCS has provided transportation for prepositioning of cholera response water treatment chemicals, hygiene promotion materials and IEC materials in line with MoH, IFRC and KRCS guidelines.
- Reception and storage of items before delivery to distribution sites will be managed according to KRCS supply chain management rules and regulations, as well as coordination of the transport of all relief items at the headquarters and regional level.

Communications

Through the DREF operation, the KRCS worked closely with the National and County level ACSM committees to design media messaging. The messaging targeted various groups, including key stakeholders, opinion leaders and affected communities. KRCS took advantage of the local volunteers to carry out public sensitization in the local language through the use of public address systems. Further communication was done through three sessions in the local radio. The aim was to build trust and raise awareness among the communities on the cholera and Chikungunya responses. KRCS through the Mandera County Branch ensured appropriate information on the unfolding humanitarian situation was delivered to the branch and other relevant partners for information, awareness and response planning. The KRCS PR team also carrying out media monitoring to ensure high publicity and reach as well as to gauge impact of the messaging and stations communication materials.

Security

Since the start of the operation, KRCS worked to ensure high security was enforced through deployment of a security officer who was conducting security assessments, liaising with security contacts and gathering intelligence information in the field. The information collected was triangulated with information from other sources by the security manager to inform decisions relating to security risks. Movement was also restricted among the team deployed under the operation to ensure everyone is within one area. Security was also maintained around the CTC through deployment of KPR and Prison officers.

Towards the middle of the operation period, there were 4 terrorist attacks in Elwak which, is on the outskirt of the County near the Somalia border. This however did not have a direct impact on the operation. However, due to the rumours and threats on planned attacks, 22 staff deployed in the operation had to be evacuated back to Nairobi since they were not residents of the area and therefore were more at risk of being targeted by the Al Shabaab.

Planning, Monitoring, Evaluation & Reporting (PMER)

The National Society Headquarters (through the Monitoring, evaluation and learning department, Health and Social Services and operations team) supported the implementing teams to ensure effective, timely and efficient delivery of operation. Monitoring visits were conducted to assess levels of adherence to minimum standards in humanitarian service delivery, compliance to humanitarian principles guiding the Movement's humanitarian operations, timeliness in delivery of supplies and services to beneficiaries, management of supplies during storage, accuracy, and timeliness of reporting among others. Field monitoring and technical support visits were also conducted where necessary. The KRCS worked closely with the IFRC East Africa and Indian Ocean Islands regional representation to strengthen the implementation of the operation. Joint monitoring visits (IFRC and KRCS) were to be conducted subject to security clearance by the security unit at KRCS and IFRC and were budgeted for. At the end of the intervention, operational review/lessons learned workshop will be organized.

Administration and Finance

The KRCS has a permanent administrative and financial department, which is ensuring the proper use of financial resources in accordance with conditions discussed in the Memorandum of Understanding between KRCS and IFRC. The management of financial resources is according to the procedures of the KRCS and guidelines specific to DREF.

All the activities were done in close cooperation with the community and through advocacy to the community, religious and traditional leaders as well as other actors.

C. Detailed Operational Plan

Programming / Areas Common to all Sectors

Areas common to all sectors				
Outcome 1: Continuous joint assessments and analysis is used to inform the design and implementation of the operation	**Outputs**			**% of achievement**
	Output 1.1 Monitoring of service provision in the areas of intervention			85%
	Output 1.2 The findings of evaluations lead to adjustments in on-going plans and future planning as appropriate			0%
Activities		**Is implementation on time?**		**% progress (estimate)**
		Yes (x)	**No (x)**	
1.1.1. KRCS county teams carry out joint visits with MoH to verify information and confirm outbreak. Information to be used locally and shared with national team to inform decisions and to enhance coordination for effective management and prevention of the disease.		X		100%
1.1.2. KRCS at Headquarters level to liaise with Disease Surveillance and Response Unit to continue implementing a common approach based on national guidelines for cholera outbreak control		X		100%
1.2.1. Operational review/lessons learned		X		50%
1.2.2. Conduct media monitoring to establish visibility and impact of response		X		70%
Progress towards outcomes				

1.1.1. Initial assessments were completed in the county which corroborated the projections made by MoH on the caseload, scale and coverage in the affected areas. KRCS has also carried out joint visits with the MoH to verify information and confirm outbreak. The information gathered is shared with the national team to inform on decisions and enhance coordination
1.1.2. The KRCS headquarters has been working closely with the disease surveillance and response unit to continue implementing a common approach based on national guidelines for cholera control and ensuring that the current situation is documented at every level.
1.2.1. An operational review/lessons exercise will be carried out at the end of the operation led by the organizational M&E department and the Terms of Reference for this are currently being prepared.
1.2.2. A team of 2 media personnel were deployed for documentation and provide visibility of the operation through videos and case studies.

Health & Care

Needs analysis: The Mandera County government officially requested KRCS to support the response towards the outbreaks. The support requested include setting up and running a CTC at Moi stadium, provision of health workers to fill in the gap of health workers that had been taken ill and therefore could not provide essential health services and case management of the ongoing outbreaks, ACSM for prevention and other measures necessary for the control of the cholera and Chikungunya outbreaks and Integrated Vector Management actions for control of Chikungunya. KRCS also supported counties where active transmission is ongoing, to scale up hygiene promotion and social mobilization.

Population to be assisted: In total, 200,000 beneficiaries in Mandera East Sub-county.

Health & care		
Outcome 2: Cholera Treatment Centres are set up and operational for up to 2 months in Mandera East	**Outputs**	**% of achievement**
	Output 2.1: Mandera County are supported to control the outbreak by training volunteers on CTC function and deploying staff.	100%
Outcome 3: Immediate risk of cholera and Chikungunya transmission in communities is reduced and the outbreak contained in Mandera county within 6 weeks.	3.3.1. Output 3.1. Capacity of KRCS to respond to the epidemic in the affected area is strengthened	100%
	3.3.2. Output 3.2: Target population in the affected areas are provided with information to improve knowledge and practices on the prevention and control of cholera	100%
	3.3.3. Output 3.3: Community based cholera management	100%
	3.3.4. Output 3.4: Conduct advocacy and coordination in the affected areas	80%

Activities	**Is implementation on time?**		**% progress (estimate)**
	Yes (x)	**No (x)**	
2.2.1 Deliver materials and supplies required for set up which include: 15 tents, consumables (including Ringers Lactate, Normal 15 tents, consumables (including Ringers Lactate, Normal Saline,5% Dextrose and infusion sets), 50 cholera Beds, patients' infection control supplies (90kg Chlorine), lab supplies, including specimen collection kits, Cary Blair Transport Media and cold boxes	X		100%
2.2.2 Putting up of tents, demarcation of isolation areas, construction of temporary sanitation facilities at CTC	X		100%
2.2.3 Deploy technical staff	X		100%
2.2.4 Hold consultative discussions with county health departments	X		100%
2.2.5 Identify and train volunteers to provide support in the CTCs. Initial one-day sensitization followed by on-job training	X		100%
2.2.6 Manage cholera patients based on MoH protocols and guidelines	X		100%
2.2.7 Replenish medical consumables in CTCs	X		100%
3.1.1 Train volunteers on Cholera and Chikungunya prevention and control	X		100%
3.1.2 Source and distribute protection (boots, gloves, sanitizers and disinfectants) and hygiene promotional materials 80 volunteers	X		100%

3.1.3 Source and deliver Epidemic Control Manuals for volunteers and sensitize the volunteers based on these manuals	X		100%
3.1.4 Involve the volunteers in translating key messages into local languages to standardize messaging in collaboration with MoH	X		100%
3.1.5 Sensitize local administrators (chiefs and assistants, village elders etc.) on outbreaks prevention and control measures	X		90%
3.1.6 Sensitize religious leaders in Mandera East as well as other opinion leaders in all target counties on outbreak prevention and control	X		90%
3.2.1 Conduct awareness sessions on cholera and Chikungunya through community meetings and religious gatherings	X		90%
3.2.2. Conduct house to house visits for cholera and Chikungunya prevention messaging, and to conduct community level surveillance	X		80%
3.2.3. Production and distribution of IEC materials, including posters, banners, flyers, factsheets	X		100%
3.2.4. Production and distribution of short videos on the response	X		50%
3.2.5. Production and airing of short awareness PSAs on radio	X		100%
3.3.1. Establish oral rehydration points in affected villages and train volunteers to prepare and administer ORS (with pre-delivered ORS sachets) (Target: One oral rehydration point per cluster of villages)	X		70%
3.3.2. Train volunteers on simple ways to assess levels of dehydration and appropriately refer patients	X		80%
3.3.3. Source and distribute water filters to community Oral Rehydration Points to improve safety of water in use with the support of MoH		X	0%
3.3.4 Conduct case detection and referral of cases to nearest Rehydration points and to nearest CTCs	X		100%
3.3.5. Provide back up support and supervision to volunteers manning Oral Rehydration Points	X		100%
3.3.6. Hygiene promotional messages are delivered to households and communities. Mortality surveillance is done and decent burials are supervised	X		50%
3.3.7. Carry out active case finding and contact tracing of all cases at household and Community level	X		92%
3.3.8. Carry out daily briefings and weekly reviews with all volunteers involved. Weekly reviews to continue during entire period of sensitization and hygiene promotion	X		100%
3.4.1. Provide a platform for meetings with the government at all levels: County, Sub-county and ward level on quarterly basis in line with the lessons learnt recommendation on exit plan	X		70%
Progress towards outcomes			

2.1.1	KRCS delivered the following materials for the CTC: 53 cholera beds, 15 tents, Normal Saline, 90kg of Chlorine, lab supplies
2.1.2	KRCS set up 15 tents and a CTC with a bed capacity of 60. Isolation areas were demarcated with temporary sanitation facilities set up to serve the population in the CTCs. 9 pit latrines were constructed during the operation.
2.1.3	KRCS deployed a surge team drawn from the organizational data base to increase the capacity of HCWs in order to manage the patients at the CTCs and referral centers and manage the control of spread of the disease. The teams include: 7 MOs, 22 Nursing Officers, 10 COs, 14 public health officers, 2 laboratory technicians and 1 nutrition officer.
2.1.4	A total of 50 consultative meetings were held with the county health departments to ensure coordination in the management of cases.
2.1.5	A total of 350 volunteers were deployed to serve in various capacities including case management and community sensitization within the operation so as to increase the capacity care givers to manage cases. The volunteers were divided into different groups and were sensitized on vector control, ORS care treatment, and hygiene promotion.
2.1.6	The cholera patients admitted to the CTCs were given health care based on the MoH protocols and guidelines to reduce risk of further infections.
2.1.7	Medical consumables {Intravenous fluid R/L 500MLS (72bottles), Intravenous Paracetamol 100mls (20 vials), Capsules Doxycycline 100mg (10tins)} at the CTC were replenished through procurement at the local level (using the KRCS procurement guidelines) to support the management of patients.
3.1.1	A training of volunteers was conducted with a total of 350 volunteers trained on Chikungunya and cholera control. This was increase the capacity of the response team to enable the disease control within the shortest time possible.
3.1.2	In order to reduce risk of infection among the team managing the patients, the caregivers were provided with personal protective equipment aimed at retaining a high number of care givers is maintained to work on the control of the epidemic. These include 20 gum boots, 100 nose masks, 30 leather gloves, 20 safety goggles and mosquito repellent to prevent bites from mosquitoes carrying Chikungunya virus.
3.1.3	Epidemic control manuals were distributed to the 11 team leads volunteers to sensitize them on the control and management of cholera and Chikungunya so as to increase their knowledge skills and capacity to help control the disease.
3.1.4	So as to increase the numbers reached with the Cholera and Chikungunya sensitization messages, the KRCS volunteers together with the MoH collaborated in the translation of the messages to local language.
3.1.5	The local leaders including chiefs, village elders and assistant chiefs who are in direct contact with the community were sensitized on the outbreak, prevention and control of the disease through 4 sessions. The leaders are expected to disseminate/ guide the rest of community in the control and prevention of the disease.
3.1.6	In order to create a wider reach and influence the acceptance among the community, opinion leaders in Mandera East including religious leaders were sensitized on outbreak, control and prevention of the epidemic since these are key leaders in the communities. 8 Islamic preachers (Imams) were reached during the exercise.
3.2.1	KRCS conducted 30 days of awareness in the centres affected by the outbreak using a public address system to ensure as many people as possible are reached with the information
3.2.2	A total of 49,877 households were reached through house to house visits to disseminate messages on prevention and control of the Cholera and Chikungunya outbreak
3.2.3	Distribution of 60,802 posters was done around the areas affected by the outbreak to increase level of awareness. Among the areas covered include Bulla Mpya, Bulla Jamhuria, Shafeshafey, Bulla Central, Bulla power, Bulla Barwako, township, Bulla Nguvu, Bulla Kamor and Tawakal.
3.2.4	A video documentation on the response is being prepared to help improve future response and educate the public on the prevention and control of cholera.
3.2.5	KRCS conducted 3 radio sessions to create awareness of the control and prevention of cholera. This was aired in the local radio to target the affected population.
3.3.1	Oral rehydration points were not established due to the long distances between areas affected. However, the volunteers trained on simple ways of supervision distributed ORS to the affected persons and referred extreme cases to the nearest CTCs.
3.3.2	A total of 350 volunteers were trained on simple ways of assessing dehydration such the signs and symptoms of dehydration which include sunken eyes, generally weak condition of the patient, excess thirst. A referral mechanism was set where the volunteers would contact their supervisor who would in turn call the ambulance for quick evacuation of cases to the CTC.
3.3.3	Source water filters were not distributed. Instead, the community were supplied with water treatment chemicals and water tanks chlorinated for domestic water use.
3.3.4	The volunteers deployed conducted case detection and referred cases to the nearest CTCs. A total of 803 cases were detected and referred to the CTC.
3.3.5	The volunteers were divided into 11 teams with others serving as backup for the response teams who were also at a high risk of being affected by Chikungunya virus.

3.3.6 The MoH has ensured supervision of 16 decent burials to avoid cases of contamination among the community members living within the burial sites.
3.3.7 Contact tracing were conducted in which a total of 443 cases were successfully traced and sensitized.
3.3.8 Daily briefs were conducted among the staff and volunteers working under the response since the start of the operation for purposes of reviews and plans. Weekly briefs were also conducted during the entire period. The reviews focused mainly on achievements, challenges and areas needing improvement in the operation.
3.4.1 The KRCS team under the operation has been carrying out meetings with the government both direct and through the County Steering Group. KRCS also took part in cross border meetings with the National and County Government of Mandera, MSF and Trocare (of Somali) to discuss on cross border control of the epidemic to minimize cross border infection. As part of the exit plan, KRCS has scaled down on the number of staff and volunteers deployed under the operation and closed down the CTC. Plans are underway to deliver the medical consumables to the MoH.

Water, sanitation, and hygiene promotion

Outcome	Outputs	% of achievement
Outcome 4: Risk of cholera transmission is reduced through the provision of safe water and hygiene promotion for up to 2 months	**Output 4.1** ***Immediate*** risk of cholera reduced through the provision of safe water supply and hygiene promotion in Mandera County over a period of 2 months	90%
	Output 4.2: Target population in the affected areas are provided with hygiene promotion activities, which meet Sphere standards	90%

Activities	Is implementation on time? Yes (x)	No (x)	% progress (estimate)
4.1.1. Distribution of Point of Use Water Treatment Chemicals to affected households. Supplies to include those donated by other partners	X		90%
4.1.2. Distribution of jerry cans to improve safe water storage to affected households. Supplies to include those donated by UNICEF	X		100%
4.1.3. Distribution of chlorine to carry out disinfection of water supply source (shallow wells as applicable).	X		84%
4.1.4. Chlorination of water supply sources (MoH lead)	X		50%
4.2.1. Distribution of soap to affected households (UNICEF and MoH)	X		100%
4.2.2. Promotion of hand-washing in communities	X		80%
4.2.3. Conduct hygiene promotion campaign targeting hand-washing at key times promoted through demonstration at market, schools (once they reopen) and other public places	X		60%
4.2.4. Conduct environmental clean ups, larviciding and fogging for destruction of the Chikungunya vector	X		100%
4.2.5. Installation of hand washing kits in schools (UNICEF and MoH)	X		70%
4.2.6. Promotion of use of other HHWT methodologies e.g. Filtration and SODIS, especially to affected and risk communities	X		100%

Progress towards outcomes
4.1.1. A total of 1,216,334 point of water use chemicals were distributed to affected households 4.1.2. To improve safe water storage, 5332 water jerry cans were distributed to 2666 households that were considered most vulnerable. Each household received 2 jerry cans, 2 buckets, 2 bars of soap and aqua tabs. 4.1.3. Chlorination of water tanks was done to provide safe water for domestic use with a total of 31924 water tanks chlorinated 4.1.4. Chlorination of water supply sources was done two water points that pump water from the river. Water treatment was also done in water storage tanks at community level. 4.2.1. A total of 214 cartons of soap were distributed to the affected population with each household receiving 2 bars of soap. 5,136 households were reached in the exercise. 4.2.2. Promotion of hand washing was done through distribution of soaps, demonstrations and installation of hand washing facilities. 4.2.3. To promote hand washing, demonstrations were done reaching a total population of 54,483 people. 4.2.4. KRCS conducted a number of environmental clean ups to eliminate parasites and larviciding through spraying. 4.2.5. A total of 12,487 hand washing facilities were installed 4.2.6. Promotion of use of other household water treatment methodologies such as the use of water treatment chemicals were done

Budget

Refer to the attached budget.

Contact Information

For further information, specifically related to this operation please contact:

- Kenya Red Cross Society: Abbas Gullet, Secretary General; phone: +25420603593: +25420608681/12; fax: +25420603589; email: gullet.abbas@kenyaredcross.org

- IFRC East Africa Country Cluster: Getachew Taa; Head of Country Cluster Office Eastern Africa and Indian Ocean Islands; Nairobi; email: getachew.taa@ifrc.org

- IFRC Geneva: Tiffany Loh, Senior Officer DREF; phone: +41227304529; email: tiffany.loh@ifrc.org

IFRC Africa Region:

- Farid Abdulkadir, Coordinator: Disaster Crisis Prevention Response and Recovery phone: 254-731-067-489; email: farid.aiywar@ifrc.org

- Logistics Unit (RLU): Rishi Ramrakha, Head of Regional Logistics Unit; phone: +254-733-888-022; Fax: +254202712777 ; email : rishi.ramrakha@ifrc.org

For Resource Mobilization and Pledges:

- Fidelis Kangethe, Partnerships and Resource Development Coordinator; Nairobi; phone: +254731984117; email: fidelis.kangethe@ifrc.org

For Performance and Accountability (planning, monitoring, evaluation and reporting)

- Robert Ondrusek, PMER Coordinator; Nairobi; phone: +254731067277; email: robert.ondrusek@ifrc.org

---

How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

Save lives, protect livelihoods, and strengthen recovery from disaster and crises.

Enable healthy and safe living.

Promote social inclusion and a culture of non-violence and peace.

DREF OPERATION

03/06/2016

MDRKE038 Kenya - Cholera

Budget Group	DREF grant budget	Expenditure CHF
Shelter - Relief	0	0
Shelter - Transitional	0	0
Construction - Housing	0	0
Construction - Facilities	0	0
Construction - Materials	0	0
Clothing & Textiles	0	0
Food	0	0
Seeds & Plants	0	0
Water, Sanitation & Hygiene	2,716	2,716
Medical & First Aid	41,732	41,732
Teaching Materials	0	0
Utensils & Tools	0	0
Other Supplies & Services	0	0
Emergency Response Units	0	0
Cash Disbursements	0	0
Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**44,447**	**44,447**
Land & Buildings	0	0
Vehicles Purchase	0	0
Computer & Telecom Equipment	0	0
Office/Household Furniture & Equipment	0	0
Medical Equipment	0	0
Other Machinery & Equipment	0	0
Total LAND, VEHICLES AND EQUIPMENT	**0**	**0**
Storage, Warehousing	0	0
Distribution & Monitoring	0	0
Transport & Vehicle Costs	25,842	25,842
Logistics Services	6,779	6,779
Total LOGISTICS, TRANSPORT AND STORAGE	**32,621**	**32,621**
International Staff	0	0
National Staff	0	0
National Society Staff	88,579	88,579
Volunteers	59,870	59,870
Total PERSONNEL	**148,449**	**148,449**
Consultants	0	0
Professional Fees	0	0
Total CONSULTANTS & PROFESSIONAL FEES	**0**	**0**
Workshops & Training	11,798	11,798
Total WORKSHOP & TRAINING	**11,798**	**11,798**
Travel	750	750
Information & Public Relations	17,211	17,211
Office Costs	1,221	1,221
Communications	2,313	2,313
Financial Charges	500	500
Other General Expenses	0	0
Shared Support Services	0	0
Total GENERAL EXPENDITURES	**21,995**	**21,995**
Programme and Supplementary Services Recovery	16,855	16,855
Total INDIRECT COSTS	**16,855**	**16,855**
TOTAL BUDGET	**276,165**	**276,165**