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Emergency Plan of Action Operation Update

Democratic Republic of the Congo: Population movement, phase 1: Community health response

International Federation of Red Cross and Red Crescent Societies

Emergency Appeal n° MDRCD023	**GLIDE n° CE-2017-000116-COD**
EPoA update n° 1; XX. March 2018	**Timeframe covered by this update: December 23, 2017, to March 20, 2018**
Operation start date: December 23, 2017	**Operation timeframe: 9 months (until September 22, 2018**
Project manager: Project Manager: Andrei ENGSTRAND-NEACSU, (Operation coordinator and budget holder), Head of Cluster, Central Africa / IFRC	**National Society contact: MITANTA MAKUSU Emmanuelle, Secretary General Democratic Republic of the Congo Red Cross (DRC RC)**
Overall operation budget: Revised to CHF 1,784,251 ***from the original*** **CHF *1,996,294***	**DREF amount initially allocated: CHF 200,119**
N° of people being assisted: 234,000 people	
Red Cross Red Crescent Movement partners currently actively involved in the operation: Red Cross of the Democratic Republic of the Congo; IFRC	
Other partner organizations actively involved in the operation: none	

Summary of major revisions made to emergency plan of action:

To date, the DRC RC has nearly completed its target of sensitization communities at risk of the cholera infection as describe in the first phase of the appeal that focuses on the essential epidemiological health and WATSAN needs. This start includes fundamental capacity building of newly formed territorial chapters and a volunteer base that is accustomed to basic lifesaving response activities. The successful growing of skills and support set up and knowledge of the evolving situation on the communities will permit the eventual expansion of the response into its second phase to address needs in Helath, nutrition and livelihood and eventual a potential third phase that would see the geographic expansion of the familiar activities.

In the EPoA published on December 22, 2017, the intervention area is broadly defined as the Lomami province, which is divided into 21 health zones with a total population of 2,443,000. After evaluating the epidemiological situation, it was decided that the response will not specifically target displaced, returnees and host families but instead those communities in the cholera affected areas (or at risk of being affected). Using official Ministry of Health epidemiology data and in collaborations with the health authorities in Lomami province, the DRC RC and IFRC proposed that the first phase of the EA to focus on reducing the risk of cholera in five health zones; Kabinda, Kalambayi, Kamiji, Kanda-Kanda and Ngandajika (total population 1,173,055).

At the time, Ngandajika was the only of the 5 zones with confirmed cholera deaths and the highest confirmed cases reported. Having an active presence in the zones has allowed the teams to focus the sensitization where the cases are still emerging, considering the existing government capacity to deliver sensitization as well as avoid duplication with other organisations doing similar work. Their reports will allow the DRC RC to proactively respond to cases with intensified campaigns as well as disinfection work.

The timing of response activities of the first phase is divided into two parts and has had activities revised and added;

First month:

Sensitization for the reduction of risks of contracting cholera, identifying new cases and reference to medical aid through house-by-house visits by 192 trained volunteers and 19 team leaders to reach 244,300 individuals in all 5 priority health zones. Train and supply materials and equipment for safe burials and household disinfection for suspected cases. Ensure the protection of volunteers (orientations, insurance, protection equipment, etc.)

Subsequent 7 months:
In week 6 of 2018 the Ministry of Health warned of an increase in cholera cases, with 79% originating in the Grand Kasai region. This region includes the Lomami province where the Ngandajika health zone reported18 confirmed cases in week six and a total of 9 deaths this year. Given this epidemiological development, not all activities will need to be implemented in all of the five health zones and still require further evaluation to select the areas where. Therefore, the second phase will consist of two blocks of activities:

(i) Focus on disease surveillance in 4 Health Zones with very low caseloads. Minimum community based monitoring in case of a flare, and a gradual exit strategy with capacity building for the territorial branches. Activities will focus on:
- Surveillance and active case search: Training of 150 volunteers in Module 6 of the CBHFA training cycle in all 5 priority health zones. Use the training to highlight gender inclusion in the activities.
- In the 5 health zones, train focal points and supply them with materials and safety equipment to carry out household disinfection of cholera cases and safe and dignified burials. These focal points will be working in close collaboration with the local health authorities.
- Training of WATSAN focal points with the PHAST tool in the 15 territorial branches. This will ensure future capacity to report on needs and initate community based WATSAN activities.
- Liaising with other implementers in the health zones to discuss if RC volunteers could be used as agents in their program implementation (Save the Children is currently conducting an evaluation)
- Discussion with other RC Movement partners to evaluate possibility of bilateral program implementation

(ii) Concentrate risk reduction activities in the most affected Health Areas within the Ngandajika Health Zone. One hundred volunteers and 5 supervisors deliver intensified sensitization to 45,000 persons and WATSAN support to 1,500 households in most affected areas using vulnerability as selection criteria;
- WATSAN baseline and Household vulnerability assessment of 7,500 households
- Establish three chlorination points in the three most affected « health areas »in the health zone of Ngandajika
- Train population of targeted communities on safe water storage/household water treatment and safe use of chlorine tablets (aqua tab).
- Distribute up to 3000 covered containers (jerry cans) for transporting and storing drinking water at the household and soap bars to 1500 vulnerable HH.
- Distribute up to 2,065,500 chlorine tablets (aqua tab) for household water treatment, sufficient for 90 days, to 45,000 people.

(iii) Following an evaluation that will consider the impacts the displaced and returning families on their host communities, select areas to assists with structural WATSAN improvements. Concentrate risk reduction activities in the most affected Health Areas within the Ngandajika Health Zone. One hundred
- Provide safe water to the higher risk schools, market places and health centres by constructing 10 boreholes
- Monitor treatment, use and storage of water through household surveys and household water quality tests.
- Construct up to 10 latrines in public spaces such as schools, markets or health centres. Each latrine will consist of 4 blocks of 5 doors.
- Roll out PHAST (Participatory activity) to promote the construction and proper maintenance along with forming a sustainable promotion structure in the community by training of committees. Provision of essential consumables for maintenance and incentives to ensure most vulnerable can build latrines.
- Hygiene promotion activities in public spaces and at household level,
- Proposed BOCAC evaluation to help guide the capacity building of existing and newly established Territorial National Society chapters. Specific trainings to ensure basic capacity for WATSAN and disease surveillance activities across the province with minimum rehabilitation of NS Provincial offices and provision of basic IT equipment to ensure effective support to the activities and timely reporting by the National Society

The funding coverage reached around 40% of the total budget. Efforts are being made to mobilize resources to the Emergency Appeal operation. A partners conference call with partner National Societies (pNSs) was held on 9 March 2018 to update on implementation and request for additional support. Following the partners call, bilateral discussion with partners are taking place exploring windows for new or supplementary contribution.

The EPoA budget was reduced from CHF 1,996,294 to CHF 1,784,251.

A. SITUATION ANALYSIS

Description of the disaster

The appeal responds to the needs resulting from the population movement from the Kasai province into neighbouring Lomami province. While a multisector assessment carried out in October 2017 identified a large number of needs, this appeal focusses on responding specifically to the cholera outbreak in Lomami.

According to the ministry of health[1], during 2017, 54,588 cases were reported countrywide, with 1,145 reported cholera related deaths (lethality 2.1%). In the first six weeks of 2018, 4,421 cases and 81 deaths were reported in 16 of the 21 provinces of the country. 79% of these cholera cases are recorded in the Gran Kasai region, which includes the Lomami province. Within Lomami, the health zone of Ngandajika is the most severely affected, with 18 of 22 confirmed cases in week six, and 100% of all cholera related deaths (9 deaths in week six). The ministry of health specifically warns of the increasing case load in Ngandajika. Latest figures (week 11 of 2018) show 150 confirmed cases in Lomami Province with 17 deaths.

Summary of current response

Overview of Host National Society

The DRC RC is a neutral humanitarian organization and auxiliary to the public authorities. At the national headquarters there is an operational management structure including six technical directorates and professionals trained as part of the national disaster response team (NDRT). The National Society has a provincial disaster response team (PDRT) with 110 trained members, a NDRT with 30 trained members, and 10 National Society staff members trained as regional disaster response team (RDRT) members. Moreover, the DRC RC has a pool of approximately 130,000 registered volunteers, of which 60,000 are active.

The DRC RC has one branch in each of the 26 provinces and has experience in responding to epidemics such as cholera outbreak, yellow fever, measles and Ebola Virus Disease as well as natural disasters such as floods, volcanic eruptions, landslides and population movement. In a 2016 emergency appeal some 3,424 volunteers and 342 supervisors were identified by the National Society and participated in social mobilization activities in 8 provinces, providing preventive vaccination campaigns against Yellow Fever, Measles and Cholera. In addition, 3,329 volunteers and 333 supervisors were trained on social mobilization for the preventive vaccination campaign against Yellow Fever in 6 provinces. The DRC RC deployed people through its network of trained volunteers.

Given the protracted, multi-layer and complex humanitarian context, DRC RC/IFRC had launched two DREF (MDRCD021 and MDRCD022) operations during June-November 2017 to deliver immediate assistance in health, emergency shelter and non-food items, water and sanitation targeting 8,478 refugees from Central Africa Republic (CAR) to North Ubangi and Bas-Uele provinces and 3,060 IDPs in Kwilu, Sankuru and Lomami provinces. As part of the DREF MDRCD022 operation, a multi-sector needs assessment has been carried out to inform operational strategies for the humanitarian response. The assessment report is available in English and French for details.

In December 2017, the emergency appeal MDRCD023 was launched. In order to kick-start the operation, DREF funding of a total of CHF 200,119 was made available, and a corresponding MoU was signed between the National Society and IFRC on January 10th, 2018.

The National Society has so far:

- Deployed their CBHFA focal point to Lomami province in order to
  - Present the cholera response activities to the local authorities (provincial governor, provincial medical inspector, provincial health directorate, authorities related to security, and representatives of various health zones)
  - Trained 192 volunteers over two days in the five health zones on reducing the risk of cholera, hygiene promotion, sanitation, and general sensitization methods. The training was developed by the DRC RC together with UNICEF and the Ministry of Health, and was co-facilitated by a representative of the local health authorities.
- Deployment of these volunteers has reached 211,809 with household level sensitisation in the five priority health zones. Volunteers have been outfitted with visibility materials. Sensitization includes safe water and hygiene messaging.
- Procured and distributed materials and equipment for household disinfection all necessary materials to the DRCRC offices in the 5 health zones.

[1] Ministry of Health : Evolution de la situation épidémiologique du Cholera en RDC, semaine 6 (du 05-11 février 2018)

- Printed cholera prevention posters produced in consultation with government and other NGOs.
- Deployed the WATSAN focal point and the gender/diversity advisor to Lomami province, where together with the two IFRC-deployed RDRTs they prepared for the remaining activities.
- Developed the PMER tools and trained 16 (10 men and 6 women) volunteers in data collection techniques using data sheets and smart phones data collection platforms. These tools are used by team leader to upload the results of the paper surveys used by volunteers. The NS is working of contextual challenges like battery charging and data allowances to ensure the timely reporting. A WATSAN specific survey has also started to check on sensitization impact, guide the 2nd phase activities and help select priority areas
- Prepared the Operation update and the resulting budget revision with the IFRC

The country's previous 11 provinces were recently reorganised into 26 provinces. The DRC RC followed this division by creating new branches to ensure that every administrative province has a branch presence. The Lomami branch is one of these new branches, so there is still a lack of experience regarding management of operations. Given these limitations, IFRC presence specifically focused on the management of the appeal is needed both in Kinshasa as well as in Lomami province.

The National Society has a number of constraints to overcome to successfully implement this response:

- On the *national* level, many partners compete for the National Society's human resources. Partners request participation of key staff on field trips, in trainings or meetings, which reduces availability of this key staff for the appeal.
- On the *provincial* level, the DRC RC Lomami branch's committee is complete and functional, and a network of trained volunteers is available. The branch has an office in a private building, but no functional transportation or communication equipment. Relationships with the authorities are well established.
- Four *territorial* branches cover the area of the five health zones covered by this appeal. There is a complete committee for each territorial branch, but except for the Ngandajika branch, these branches do not have any office space and lack basic office and field equipment.

Weaknesses identified during the recent OCAC process cover the following business areas:

- Resource mobilisation
- Strengthening of branch capacity
- Financial management
- Government relations
- Security management
- External communication

Overview of Red Cross Red Crescent Movement in country

The acting IFRC representative left the country at the end of 2017. Since end of January 2018, an Operations Manager for the appeal has been based in Kinshasa to coordinate the appeal at central level with the NS technical directors and with senior management of the national societies and two RDRTs (health and WATSAN) have been deployed to Lomami province, where they support local RC branches in the implementation of appeal activities. These two RDRT now have confirmed a 3-month deployment through the support of the British Red Cross and Canadian Red Cross Emergency surge support programs.

None of the partner National Societies (pNS) present in DRC, nor the ICRC are operating or currently planning to operate in the Lomami province.

The Movement coordination is done via Movement Coordination meetings and, on a more operational level, through meetings between IFRC, pNSs and DRC RC. A Movement coordination agreement has been drafted but not yet signed.

Overview of non-RCRC actors in country

The "Ministère de Sante Publique" is the agency responsible for epidemic response in country and the key counterpart in all health-related activities for the DRC RC in this appeal. Reporting of cases is based on their structure of hospital and reference centres. Historically, they work closely with the DRC RC for support with complimentary sensitization, household disinfection and safe burials. Their structures of community volunteers, mostly used to promote vaccination campaigns, are trained and deployed to deliver cholera sensitization. But with the high risk (a recent death of a volunteer) and lack of incentives, this initiative falls short of expectations. In fact, some DRC RC volunteers that make up the response team, were originally part of this structure but shifted to work with DRC RC. In an effort to harmonize messages in communities, Health officials has assisted in trainings of volunteers and will continue to be consulted for the different phases and strategic decisions of the response.

The IFRC has supported the DRC RC in drafting a letter to the Minister of Interior and Security, informing about the beginning of implementation of the appeal in Lomami, the permanent presence of two IFRC international staff on the ground, and field visits from international staff in Kinshasa on a needs basis. At provincial level, the project was presented to the Governor of Lomami and other governmental agencies by the DRC RC.

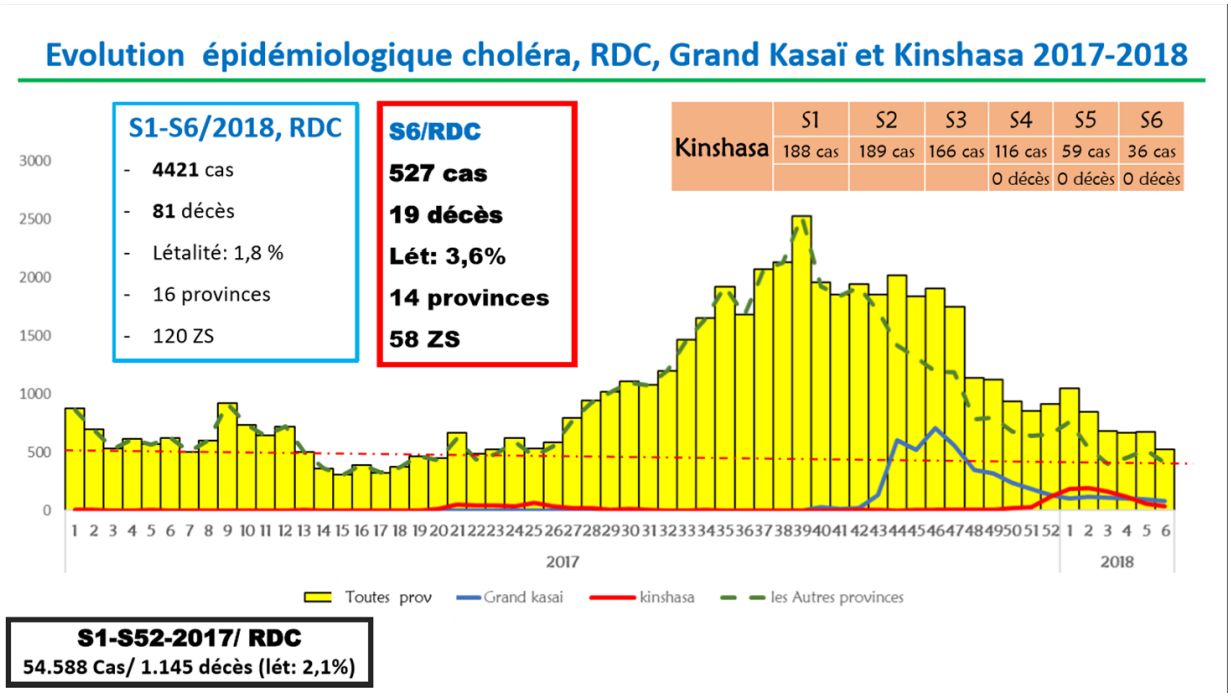
At the point of writing this update, movement partners in country are coordinating RC Movement participation in the main inter-agency meetings at national level in Kinshasa: Cluster meetings (food security, health, logistics, shelter and Non Food Items, nutrition, protection, WATSAN), national coordination meeting on health, Humanitarian Country Team meeting, and the NGO forum meetings.

In the province of Lomami, numerous actors had responded to the 2017 cholera epidemic (WHO, UNDP). As recently as January 2018, both MSF and ALIMA have closed cholera treatment centres in the province. Amis des Personnes en Détresse (APEDE), GIZ, and a number of small NGO supported by USAID are still operating in the area and are consulted to avoid duplication and gaps in coverage. The IFRC/ DRC RC team noted an assessment mission by Save the Children and will follow up with them to see if it will materialize into a project that they would be coordinating and collaborating with. Further, UNICEF supports a local NGO in implementing WATSAN activities in two of the five health zones covered by the appeal and will be considered in selecting the specific areas to assist.

Needs analysis and scenario planning

Needs analysis

The original needs analysis was based on a multisectoral assessment in October 2017 that looked at the needs of displaced populations and their hosts. Later, it was decided that the appeal should focus on a higher priory response to the to the cholera outbreak in these same communities and the potential spread to other vulnerable populations. According to data provided by the ministry of health, the peak of the epidemic has passed, and caseloads have stabilized at around 600 cases per week countrywide[2]:



Within Lomami, the Ngandajika health zone has the highest case load (33 cases in the first six weeks of 2018), and has been identified as a zone at risk due to a rising number of cholera cases:

[2]Thanks to the newly instituted monitoring system of the DRCRC at community level, and direct collaboration with Health Centre staff, a quicker response can be initiated instead of waiting for weekly results.

Evolution par Zone de Santé, Cas, Choléra, Grand Kasaï, S6, 2018

Province	ZS	Cas S2	Cas S3	Cas S4	Cas S5	Cas S6	Décès S6	Létalité S5
KASAI	Dekese	98	94	95	75	55	0	0,0
	Bulape	0	0	3	5	2	0	0,0
	Musheng e	9	2	0	0	0	0	0,0
	Mikope	1	0	0	0	0	0	0,0
	Ilebo	0	0	0	0	0	0	0,0
	Total	108	96	98	80	57	0	0,0
LOMA MI	Kalambay i	4	5	2	5	4	0	0,0
	Kandakan da	0	0	0	0	0		0,0
	Mulumba	4	1	1	0	0		0,0
	Ngandaji ka	2	1	2	8	18	9	50,0
	Total	10	7	5	13	22	9	40,9
SANKU RU	Bena dibele	3	4	0	0	0	0	0,0
	kole	0	4	0	0	0	0	0,0
	Total	3	8	0	1	0	0	0,0
Total Grand Kasai		121	111	103	94	79	9	11,3

Persistance des cas dans la zone de santé de Dekese

Attention : Ngandajika: ça continue à remonter

Based on this data, the health zone of Ngandajika in the Lomami province was selected as the target zone of the operation. A detailed evaluation and needs assessment at household level of the 7,500 households targeted in Ngandajika, specifically related to cholera/ hygiene related issues, is in progress. From the field work of the past three weeks, a few general needs are already known:

- Knowledge on key aspects of cholera needs to be transmitted to the population, especially as this is the first recorded cholera outbreak in that health zone and thus considerable knowledge gaps exist which need to be addressed through sensitization and health promotion campaigns.
- The local health authorities lack surveillance capacities, as well as capacities for disinfection and contained burials with safe conditions for workers. The DRC RC will therefore support the health authorities in these tasks.
- Ngandajika is a transit zone with a large market, limited public access to sanitation facilities and safe water presenting a very high risk of transmission.
- Given the lack of a sufficient amount of safe water sources in Ngandajika (only 3 out of 21 water sources are covered, and many people use surface water and the river as their main source of water), there is a need to ensure access to safe water to household.

Operation Risk Assessment

A security assessment was conducted in November of 2017 by the security delegate of the Abuja CCST. The assessment, including recommendations for mitigation measures, focuses on the overall security situation. A security assessment specifically for the operational areas in Lomami will be carried shortly by a contracted security specialist recommended by the Nairobi Regional Office.

B. OPERATIONAL STRATEGY

Proposed strategy

Considering the evolving epidemiological situation in the Lomami Province, the response has shifted towards a health-focused epidemic response operation, activities will not specifically target displaced, returnees and host families but instead those communities in areas affected (or at risk of being affected) by cholera. The response has preserved the original target of 244,300 persons which represents 20% of the overall population of the 5 prioritized health zones (total population 1,173,055);

- Kabinda[3] pop. 337,551
- Kalambayi pop. 211,020
- Kamiji pop. 53,966

[3] Pop : population

- Kanda-Kanda pop. 245,598
- Ngandajika pop. 325,331

Out of these five health zones, in week 11 of 2018, Ngandajika has had 56 cases with 11 deaths making it the priority zone to concentrate efforts in the coming months. Kalambayi is being monitored closely to see if sensitization work there needs to be intensified.

CHOLERA	0 – 5 ans		Plus de 5 ans		TOTAL	
	CAS	DECES	CAS	DECES	CAS	DECES
Total	**10**	**0**	**140**	**17**	**150**	**17**
KABINDA	0	0	1	1	1	1
KALAMBAYI	5	0	68	3	73	3
KAMIJI	0	0	0	0	0	0
KANDA KANDA	0	0	1	0	1	0
NGANDAJIKA	3	0	53	11	56	11

Sensitization activities will be intensified in the priority areas while the volunteers in other areas will shift to more passive surveillance activities to ensure cases are reported and transmition is avoided. Additional volunteers have been proposed for better geographic coverage to reduce challenges with moving to the communities. These will be selected from women's groups to ensure a better connection to the groups that are responsible for the cleaning, food preparation, water collection and health care for children. They will receive CBHFA Module 6 "Epidemic control" training as well as some gender inclusion guidance. They will report observations and identify gaps in hygiene knowledge and practices that can be addressed in participatory community driven interventions like focus groups and community meetings. Ongoing monitoring of officially reported cholera cases is done by the DRC RC using weekly reports from inter-agency coordination meetings in Kinshasa, as well as through health meetings between local branches of the DRCRC and the health authorities in Kabinda, the capital of Lomami. The DRCRC regularly responds to cholera outbreaks and is accustom to these essential coordination measures.

A WATSAN focused household level baseline survey has begun in Ngandajika health zone. The survey was developed by the National Society PMER focal point with support from the IFRC PMER focal person in Yaoundé, and with input from the RDRTs and the National Society WATSAN and health technical departments. This survey will also be used to identify vulnerable households for the distribution of chemical water treatment (7,500 households will receive 3 tabs a day for 90 days), while 1,500 households will receive soap (for 90 days) and water storage devices (jerry cans and buckets). The same survey will be used on a sample basis in other communities to determine the effectiveness of initial sensitization efforts and help design further health messaging, for example; food storage hygiene at public markets. Amongst other criteria, vulnerability will be measured through displacement status (displaced, returnee, host family), age, gender, and socio-economic status.

The WATSAN team will analyse these findings along with secondary data from other sources to determine where their program of community training and infrastructure construction are most required. The criteria for selection will return to the original intention of the appeal that recognises the added risk that displaced and returning population face and bring to communities.

At national level, an appeal management team has been established, consisting of the heads of departments of health, disaster management, communication, and gender/ diversity, as well as the focal points for WATSAN and CBHFA. From IFRC, the operations manager and the logistics delegate are members of the management team. Over the past month, this team has worked closely together on an ad-hoc basis to update the appeal strategy and the EPoA, as presented in this operations update. As appeal implementation moves ahead, the ad-hoc coordination will be replaced by bi-weekly appeal management meetings.

The training of territorial WATSAN focal points will focus on the use of the participatory PHAST and CHAST tools as well as technical latrine construction using locally available materials. They will deliver the modules in the highest risk communities, growing awareness, and concluding with the construction of Household. Using locally available skills and materials like bamboo, the community will receive training through the construction of model latrine for a vulnerable family. Over the 6 months of this operation, a 30% increase can be expected in the number of latrines that currently stands at 10% in the targeted community. The trained focal points from other territories will have the option to propose similar activities in their communities but outside of this emergency response.

At field level, two RDRTs (health and WATSAN) follow a joint plan of action and prepare joint weekly reports. Together with the local teams of the National Society, they developed one common plan for volunteer deployment. Their deployment has been extended to the full three months with the support of the British RC and Canadian RC. Together, the team has agreed to remove the following activities from the EPoA;

Activities	Reason for deletion
Conduct vaccination or immunization campaigns through social mobilization; Support National Society involvement in mass vaccination campaign through 1,125 volunteers through social mobilization and/or independent monitoring in coordination with MoPH/WHO/UNICEF	No cholera vaccination campaign is planned by the government. Moreover, from a health perspective, the NS believes that mass cholera vaccinations are not the right response at this moment
Establish community case management (establishing of oral rehydration points) - 2 per health areas (3 health areas in Lomami)	Due to the relatively low case load and the geographical spread of cases, ORPs are not considered necessary in the response. MoPH has told the DRC RC that they will cover this if required. Volunteers are informed that OR is available through MoPH.
Procure and distribute 5,818 long lasting insecticide treated mosquito nets (LLIN) (2 per household).	The distribution of mosquito nets is not considered a priority during a response to a cholera outbreak

The Emergency Appeal was officially presented through an introductory letter to the Minister of Interior and Security, as well as to the Secretary of the Ministry of Health. At this national level, government collaboration is limited to provision of cholera data through the inter-agency coordination mechanisms, data which was then used as input for the development of the programme strategy and plan of action.

The DRC RC has a close relationship with the government authorities both at provincial and territorial levels, and the local authorities were involved in key decisions of the programme, such as the selection of the health zones in which the appeal should be implemented. Authorities will continue to be involved in specific activities of the appeal where relevant, such as surveillance – the RC volunteers will not operate parallel to the authorities, but their activities shall be coordinated with the (very limited) surveillance and response capacity of the authorities.

Furthermore, the health and water/sanitation training curriculum and material was developed jointly by the DRC RC, the Ministry of Health, and UNICEF, and the provincial health directorate that co-facilitates training of volunteers.

Community participation is an essential element to ensure ownership and the long-term sustainability to the results of this response. In this sense, establishing of water and sanitation committees or the utilization of community peer educators are elements of community participation. As part of growing NS capacity, some basic Community Engagement and Accountability principles can be introduced to the staff and volunteers. It will help to better understand the needs of affected populations and ensure a more active role in their recovery. The DRC RC communication Officer is actively working to support the operation in this effort. The team will begin with structured presentations and consultation with potential beneficiaries and will document findings of the household visits.

The appeal consists of both **emergency and recovery** elements. Activities related to the direct response to the outbreak are surveillance, support to referral, disinfection, chlorination and dignified burial, while most of the other activities are focused on a medium-term improvement or increasing of resilience to a cholera epidemic. IFRC together with the National Society will develop an extended appeal beyond the current period of 9 months, which will likely be focused on recovery and longer-term development aspects.

Local knowledge is important to understanding the practices around water and hygiene in the communities, location of the water sources, how water is transported and stored and sanitation. This information then feeds into the respective activities in health and WATSAN. During implementation of activities, local knowledge and capacities are used whenever this would add value to the quality of the intervention. For instance, local work force will be contracted for the improvement of water sources and the construction of latrines, and water and sanitation committees will be supported in defining their own mode of operation.

Both **SPHERE and WHO standards and guidelines** were taken into account in planning and budgeting of activities. For example, the calculation of the number of aqua tabs needed is based upon the SPHERE standards of litres of water per person per day. In constructing boreholes and latrines, SPHERE standards will be also taken into account.

A **community satisfaction survey** and an **end of operation evaluation** are planned and budgeted for.

Due to the absence of any other implementing agencies in our areas of operation (though this might change, as described above), the only partners are the government authorities. With the government, **sharing of data and information** is a two-way process: While the government shares with RC available data on the development of the

epidemiological situation, RC feeds into this information system through providing data collected during surveillance activities. Data analysis and identification of shortcomings are jointly done during coordination meetings.

C. DETAILED OPERATIONAL PLAN

The following standard reporting tables show the indicators and targets on outcome and output level. These are well defined for the technical areas of health and WATSAN but need to still be further developed on the other areas. The next operations update will include the complete PMER framework and report progress against indicators.

Health

People reached: 0
Male: 0
Female: 0

Outcome 1: The immediate risks to the health of affected populations are reduced

Indicators:	Target	Actual
# of people reached by the DRC RC with services to reduce relevant health risk factors	243,000 people	211, 809

Output 1.1: The health situation and immediate risks are assessed using agreed guidelines

Indicators:	Target	Actual
# of situation reports developed and submitted to the cholera coordination body by DRC RC (added in this Update)	24 national Sit-rep	0
# of cholera coordination meetings attended by DRC RC (added in this Update)	24 meetings	0

Output 1.3: Community-based disease prevention and health promotion is provided to the target population

Indicators:	Target	Actual
# of women's groups participating in the implementation of community-based health activities	5 groups (1 per health zone targeted)	0

Output 1.4: Epidemic prevention and control measures are carried out

Indicators:	Target	Actual
# of volunteers trained and equipped to provide safe household disinfection and dignified burials	50 volunteers	10
# of women trained by DRC RC who take part in cholera surveillance activities	25 people	0
# of volunteers trained in CBHFA module 6 for epidemic surveillance and Gender and diversity	125 volunteers	0

Progress towards outcomes

The sensitization activities were launched quickly to respond to the urgent need to alert households and improve hygiene practices. The essential work of an integrated risk reduction sensitization and hygiene promotion training as well as equipping the volunteers with IEC and visibility material was completed. In the first month of sensitization, 64,635 men, 66,006 women and 82,688 children between the ages of 6 and 14 (unfortunately the gender of the children is not recorded).

Health Zone	Areas in Health Zone	Areas targeted	Health Areas Reached	People reached per week				Total population reached
				1	2	3	4	
Kabinda	26	6	6	17,003	21,131	19,185	20,168	**77,487**
Ngandajika et Bakuamulumba	18	9	9	10,242	9,154	8,398	8,285	**36,079**
Kanda-Kanda	18	18	18	3,888	4,925	0,280	21,647	**50,740**

Kamiji	12	12	12	7,630	5,838	7,534	7,102	**28,104**
Kalambayi	16	5	3	2,676	3,130	6,705	8,408	**20,919**
Total				**41,439**	**44,178**	**62,102**	**65,610**	**213,329**

Coordination with MoPH/Government and other actors in the area are ongoing and these links are providing caseload results that guide the selection of priority areas where the RDC RC will carry out activities.

A cholera vaccination campaign is removed from the EPoA because government is not planning it and the NS believes that mass cholera vaccinations is not the right response at this moment. As the epidemic seems to be under control, developing a referral mechanism (support patient transport) is also not a high priority. Instead, volunteers will provide vital information on the nearest health facility and on safety measures for transportation. Due to the relatively low case load and the geographical spread of cases, ORPs are not considered necessary in the response

Water, sanitation and hygiene

People reached: 213,329 persons
Male: not available
Female: not available

Outcome 1: Immediate reduction in risk of waterborne and water related diseases in targeted communities

Indicators:	Target	Actual
# of households provided with safe water services that meet agreed standards	244,300 households	213,329

WATSAN Output 1.2: Daily access to safe water which meets Sphere and WHO standards in terms of quantity and quality is provided to target population

Indicators:	Target	Actual
% of the target population with access to an improved water source	11%[4]	0 %
# of households receiving water supply services[5] in line with agreed standards[6]	7,500	0

WATSAN Output 1.3: Adequate sanitation which meets Sphere standards in terms of quantity and quality is provided to target population

Indicators:	Target	Actual
# of people with access to hygienic latrines	9,000	0
% of latrines constructed that are maintained by the target population	100%	0%

WATSAN Output 1.4: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population

Indicators:	Target	Actual
# of people reached with orientations on the use of hygiene items	9,000	0

WATSAN Output 1.5: Hygiene promotion activities are provided to the entire affected population

Indicators:	Target	Actual

[4] it is planned to build 10 boreholes for 5,000 people, 1 borehole for 500 people. On the basis of 6 people per household, 5,000 people = 833 households, or 11% of the 7,500 households targeted by this appeal. Thus, the denominator for this indicator will be the 7,500 households planned for the operation, and the numerator will be the actual number of households with access to an improved water source.

[5] Services here refer to water storage items, water treatment tablets and advice received from the DRC RC during the operation.

[6] Agreed standards; each household will receive a 20-liter jerry can, 3 Aqua Tab per day x 3 months where the quality of the water is questionable. For those households with access to potable water sources, the objective is to ensure that they receive at least 10 liters of water per person per day.

# of volunteers involved hygiene promotion activities	300	192
# of people reached by hygiene promotion	244,300	213,329

Progress towards outcomes

In conjunction with the cholera risk reduction sensitisation, the households received orientations on hand washing, water treatment and storage and other basic WATSAN messaging from volunteers during the health and WATSAN integrated house to house visits.

All 192 volunteers that participated in initial integrated 3-day training also learned how to disinfect the suspected cholera affected household and preparing and burring the victims' bodies as well and basic water treatment through chlorination. To date, the essential equipment of the 10 disinfection kits has been positioned in the territorial DRC RC offices. DRC RC will select interested individuals to refresh the learning and practice the work as well as expand the contents of the kits to ensure the protection of the users.

Combined with ongoing intensified sensitization visits, volunteers are carrying out a WATSAN focused survey to gather baseline data in the community and vulnerability indicators of the families. This survey is done on all households of health areas where cholera cases persist in noticeable numbers and on a sample basis for other prioritized health areas of the 5 health zones. A practical Rapid Mobile Phone-based survey application has been set up to enter the paper surveys used by volunteers. RAMP monitoring system is being set up to record the WATSAN survey results and will likely be expanded to future data collection efforts. To ensure the phones are recharged, solar chargers are being purchased. This survey will also collect data on the HH to determine vulnerability and will allow the selection of households to receive materials that will help them practice better hygiene and access and store safe water.

The vulnerability indicators will be used to select the 7,500 households that will receive 3 months' supply of aqua tabs and the 1,500 most vulnerable households to receive a jerry can, a bucket and soap for 3 in the most affected health areas. Delivery of the items will come with orientations on their use and a program of follow up visits to ensure proper practices. This activity could be expanded later if the WATSAN survey reveal the need.

The distribution of mosquito has been removed considering the highest priority is to monitor for and prevent a potential cholera outbreak.

S2.1: Strategies for Implementation (SFI)

Output S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that the National Society has the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform

Indicators:	Target	Actual
# of DRC RC volunteers insured	300	220

Output S1.1.4: National Societies have effective and motivated volunteers who are protected

Indicators:	Target	Actual
# of DRC RC volunteers trained in sensitization in response to cholera	300	192

Output S1.1.6: The National Society has the necessary corporate infrastructure and systems in place

Indicators:	Target	Actual
# of DRC RC directorates supported	6	0
# of DRC RC local branches strengthened	5 (1 in each health zone targeted)	0

Progress towards outcomes

In collaboration with the Ministry of Public Health (MoPH) and the DRC RC health representatives deployed to the intervention area and trained 192 volunteers in sensitization to reduce risk of cholera infection, case load detection and dissemination of referral to medical services in the 5 prioritized health zones. Amongst these, are some standing MoPH community volunteers that will collaborate with the DRC RC teams. An operation hub has been established in Mwene-Ditu that will serve as the operations office for the NS. Basic equipment, including a

generator is provided to support the administrative functions and meetings, as well as potential accommodations for traveling staff and volunteers.

Outcome S2.1: Effective and coordinated international disaster response is ensured

Indicators:	Target	Actual
# of AoF supported by surge staff (Health and WATSAN)	2	2

Output S2.1.1: Effective response preparedness and NS surge capacity mechanism is maintained

Indicators:	Target	Actual
# of RDRTs deployed for the operation, one WATSAN and the other Health	2	2

Progress towards outcomes

The deployment of two RDRT has enhanced the content of initial activities. These has contributed by assisting in training the staff and volunteers, supported the revision and developing of activity details and provided an important link for the field teams to Kinshasa as well as the country cluster. Their full-time integration into the DRC RC team has helped implement the activities with minimal delay. The IFRC Country Cluster has also made a Regional Communication Officer to help capture the progress of the response.

Outcome S2.2: The complementarity and strengths of the Movement are enhanced

Indicators:	Target	Actual
# of Movement partners present in DRC supporting the operation	6	2

Output S2.2.1: In the context of large scale emergencies, the IFRC, ICRC and NS enhance their operational reach and effectiveness through new means of coordination.

Indicators:	Target	Actual
# of service agreements signed with the Partner National Societies (PNSs) present in DRC	6	0

Output **S2.2.5**: Shared services in areas such as IT, logistics and information management are provided

Indicators:	Target	Actual
# of shared services provided (disaggregated by type of service)	3	0

Progress towards outcomes

By showing a positive start to the response in this first quarter, the IFRC hopes to attract the support of pNSs in supporting the Emergency Appeal. Both the British and Canadian RCs have pledged to support the extension of the RDRT deployment and conversations are ongoing with other partners for similar technical capacity support. With the planned opening of a country office in DRC, the IFRC is also looking at the overall needs such as security that could be offered to pNSs in country.

Outcome S3.1: The IFRC secretariat, together with National Societies uses their unique position to influence decisions at local, national and international levels that affect the most vulnerable.

Indicators:	Target	Actual
# of stories on the operation published	3	0

Output S3.1.1: IFRC and the NS are visible, trusted and effective advocates on humanitarian issues

Indicators:	Target	Actual
# of short videos on the operation published	3	1

Output **S3.1.2**: IFRC produces high-quality research and evaluation that informs advocacy, resource mobilization and programming.

Indicators:	Target	Actual
# and % of donor reports (narrative) submitted in time	100%	0
# and % of financial reports submitted in time	100%	0

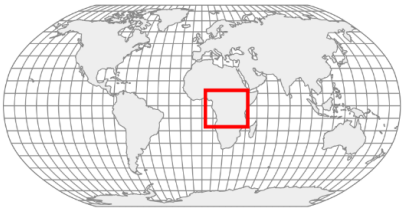
Progress towards outcomes

As of the writing of the report, the IFRC Country Cluster Finance Assistant is in country to support the preparation of the first finance report. The visit of the Regional Communication Officer has permitted the preparation of the first video that presents the situation in Lomami and the work of the RDCRC to date.

D. BUDGET

The appeal budget has been revised downwards from 1,996,294 to CHF 1,784,251. For details, see Excel file annexed to this Operations Update.

International Federation of Red Cross and Red Crescent Societies
Fédération internationale des Sociétés de la Croix-Rouge et du Croissant-Rouge
Federación Internacional de Sociedades de la Cruz Roja y de la Media Luna Roja
الاتحاد الدولي لجمعيات الصليب الأحمر والهلال الأحمر



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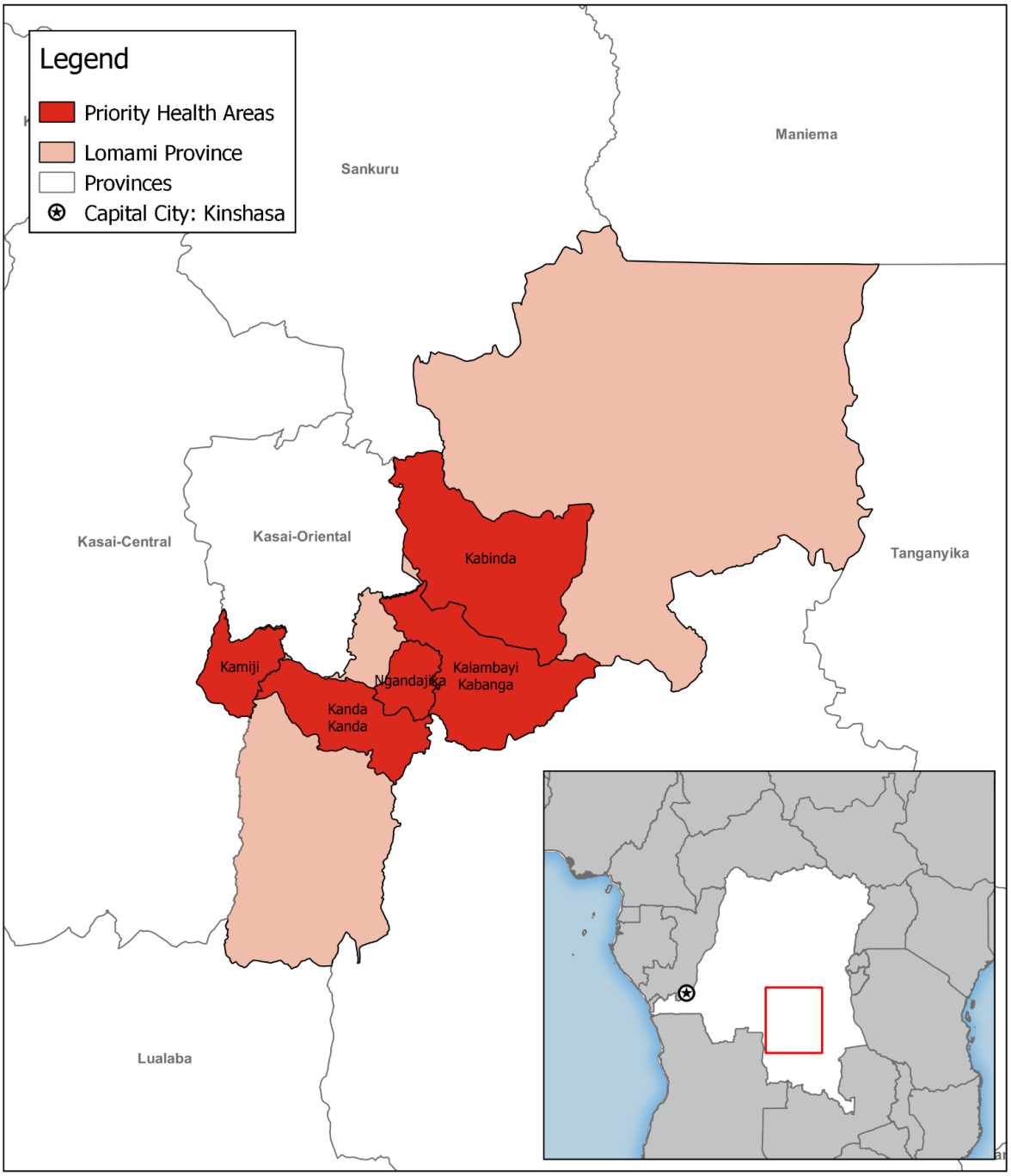

The maps used do not imply the expression of any opinion on the part of the International Federation of the Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.
Map data sources: IFRC, OCHA, GADM. Map produced by: IFRC Africa Regional Office, Nairobi.

0 30 60 90 120 km

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EMERGENCY APPEAL

Appeal name

Appeal code

	Budget Group	Multilateral Response	Inter-Agency Shelter Coord.	Bilateral Response	Appeal Budget CHF
500	Shelter - Relief	0			0
501	Shelter - Transitional	0			0
502	Construction - Housing	0			0
503	Construction - Facilities	0			0
505	Construction - Materials	0			0
510	Clothing & Textiles	0			0
520	Food	0			0
523	Seeds & Plants	0			0
530	Water, Sanitation & Hygiene	419,386			419,386
540	Medical & First Aid	13,800			13,800
550	Teaching Materials	95,197			95,197
560	Ustensils & Tools	0			0
570	Other Supplies & Services	0			0
571	Emergency Response Units	0			0
578	Cash Disbursments	0			0
	Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**528,383**	**0**	**0**	**528,383**
580	Land & Buildings	10,000			10,000
581	Vehicles	0			0
582	Computer & Telecom Equipment	74,167			74,167
584	Office/Household Furniture & Equipment	11,749			11,749
587	Medical Equipment	0			0
589	Other Machiney & Equipment	0			0
	Total LAND, VEHICLES AND EQUIPMENT	**95,917**	**0**	**0**	**95,917**
590	Storage, Warehousing	5,186			5,186
592	Dsitribution & Monitoring	32,500			32,500
593	Transport & Vehicle Costs	97,794			97,794
594	Logistics Services	0			0
	Total LOGISTICS, TRANSPORT AND STORAGE	**135,480**	**0**	**0**	**135,480**
600	International Staff	327,706			327,706
661	National Staff	18,949			18,949
662	National Society Staff	73,968			73,968
667	Volunteers	184,224			184,224
669	Other Staff Benefits	0			0
	Total PERSONNEL	**604,847**	**0**	**0**	**604,847**
670	Consultants	25,000			25,000
750	Professional Fees	0			0
	Total CONSULTANTS & PROFESSIONAL FEES	**25,000**	**0**	**0**	**25,000**
680	Workshops & Training	117,500			117,500
	Total WORKSHOP & TRAINING	**117,500**	**0**	**0**	**117,500**

700	Travel	65,900			65,900
710	Information & Public Relations	9,000			9,000
730	Office Costs	50,683			50,683
740	Communications	22,229			22,229
760	Financial Charges	6,351			6,351
790	Other General Expenses	14,064			14,064
799	Shared Office and Services Costs	0			0
	Total GENERAL EXPENDITURES	**168,226**	**0**	**0**	**168,226**
		0			0
830	Partner National Societies	0			0
831	Other Partners (NGOs, UN, other)	0			0
	Total TRANSFER TO PARTNERS		**0**	**0**	**0**
599	Programme and Services Support Recovery	108,898	0	0	108,898
	Total INDIRECT COSTS	**108,898**	**0**	**0**	**108,898**
	TOTAL BUDGET	**1,784,251**	**0**	**0**	**1,784,251**
	Available Resources				
	Multilateral Contributions				0
	Bilateral Contributions				0
	TOTAL AVAILABLE RESOURCES	**0**	**0**	**0**	**0**
	NET EMERGENCY APPEAL NEEDS	**1,784,251**	**0**	**0**	**1,784,251**

Reference documents ↘

Click here for:

- Previous Appeals and updates
- Emergency Plan of Action (EPoA)

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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.