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Emergency Plan of Action Operation Update
Democratic Republic of the Congo: Population movement: 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° 2; December 2018	**Timeframe covered by this update: December 23, 2017, to November 30, 2018**
Operation start date: December 23, 2017	**Operation timeframe: 15 months (until February 22, 2019**
Project manager: Project Manager: Dr André Zamouangana, (Program Coordinator DRC Country Office, / IFRC, overall responsible for planning, implementation, monitoring, reporting and compliances	**National Society contact: Mitanta Makusu Emmanuelle, Secretary General Democratic Republic of the Congo Red Cross (DRC RC)**
- **Overall operation budget CHF 1.2 million** - **Total income (including DREF): CHF 1,178,942**	**DREF amount initially allocated: CHF 200,119**
N° of people being assisted: 4,200,641 people	
Red Cross Red Crescent Movement partners currently actively involved in the operation: British Red Cross, Swedish Red Cross	
Other partner organizations actively involved in the operation: ALIMA; MSF; UNICEF; WHO; MoH; APEDE[1]; ADDRA; MDA[2]	

Summary of major revisions made to emergency plan of action:

The operation update reflects changes the operation has undergone to adapt its plan in order to comply with the latest epidemiological status which has tremendously changed, not only in terms of Cholera prevalence but also as regard affected zones and subsequent funding opportunities which requires an amendment as far as the implementation time and budget is concerned.

Whereas the latest WHO and MoH reports indicate that the Cholera is being far from being eradicated over at least in 3 provinces bordering Lomami, i.e. Kasai central, Sankuru where the epidemics prevails in weeks 46-48 of 2018, the government of DRC through the Ministry of Health (MoH) has urged all partners, especially the Red Cross, to scale up their efforts in order to put an end to Cholera epidemics in the designated provinces. While an increased vigilance will be put on WASH related activities including the finalization of the ongoing construction of public latrines and bore holes which was delayed due to the recruitment of an external consultancy expertise and delayed tender process. Community awareness on Cholera and water purification activities will equally be maintained during the revision period for better efficiency of the response.

While the project has faced several timing constraints namely the two Ebola outbreaks in Equateur and North Kivu which put an overwhelming pressure on available Human Resources and Logistics means to the National Society, difficulties in terms of accessibility of some hard-to-reach areas, poor road infrastructure in the region and the change of a population movement issue into a Cholera outbreak problem amongst the IPDs required a change of strategy both in terms of planning and implementation with a focus on:

[1] *APD: Ami des Personnes en Détresse (local NGO)*
[2] *MDA + Médecins d'Afrique*

1. Increased Surveillance and active case finding
2. Scale up of volunteers' trainings on cholera sensitization
3. Training and distribution of water purification products, aqua tabs and hygiene kits in target households and IDPs
4. Continue the finalization of ongoing construction of WatSan infrastructures public latrines and bore holes

The operation is therefore seeking a 3-month No-Cost extension until 22 February 2019. This extension will allow the IFRC and DRCRC to finalize the currently engaged and not finalized activities and enable the project team to evaluate in a participatory way what has been done so far, and identify strengths, weaknesses of the operation for future similar operations. The 3-month extension will equally be used to finalize already initiated WatSan activities which had been delayed due to long tender processes.

The other reason of extension request is to facilitate multi-sector technical mission consisting of profile in operations coordination, health/cholera response, shelter, disaster law programme and PMER on mid-January 2018 to assess priorities and needs in changing context and inform changes on operational strategies. As the operation was designed to grow in planned phases, eventual scaleup in terms of geographical scope and areas of focus will be considered.

Since the revision done in September 2018, the operation has made further progress to outcomes. Despite operational challenges and changing context, the implementation rate stands at 55%.

A. SITUATION ANALYSIS

Description of the disaster

The Emergency 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 persistent cholera outbreak in Lomami.

The National Coordination team for cholera control in DRC has reported that the lack of systematic community-led response hinders and limits the overall control of the cholera outbreaks across the Country. The epidemiological trends and recent history in DRC show that health indicators deteriorate further for Internally Displaced People (IDPs). IDPs staying with host communities, often having suffered before and during displacement from poor hygiene and a weak health condition generally, are more exposed to cholera outbreaks and other communicable diseases.

Even though many families have returned to their homes, the long-term impacts of the violence and mass displacement have left populations extremely vulnerable in the Lomami province. The risk exposure to cholera and other water-borne diseases has been extremely high all due to lack of access to potable water, hygiene infrastructure and adequate medical care. The graph below indicates the trend of Cholera situation throughout the period.

The latest figures provided by the MoH indicate that there has been a continuous decrease of cases from around 1,000 per week at the beginning of the year 2018 to only 209 in week 21 which is the lowest case count since January 2017. Unfortunately, cases have started to increase again on week 23 where 396 cases and 30 deaths are reported in 10 provinces including Lomami.

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)
  - conduct trainings for 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.
- ✓ Through deployment of these volunteers 211,809 were reached 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.
- ✓ 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.
- ✓ Launched tenders and hired a construction company to implement the WatSan facilities (Public latrines and bore holes) in selected most affected villages. Construction progress estimated currently at 45%.
- ✓ 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 National Society 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 first operation update in September 2018 reflecting changes on operation scope and budget.

The country's previous 11 provinces were recently reorganised into 26 provinces by the central government. 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 and is undergoing initial setup to be operational. Given these limitations, IFRC's presence specifically focused on the management of the Emergency Appeal operation 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

IFR has a permanent office in DRC since May 2018. Since end of January 2018, an Operations Manager for the appeal has been based in Kinshasa to coordinate the appeal at the central level with the NS technical directors and with senior management of the NS where additional two RDRTs (health and WATSAN) have been deployed for 3 months to Lomami province to support the operation. This deployment was supported by the support of the British Red Cross and Canadian Red Cross Emergency surge support programs.

There currently no Partner National Societies (pNSs) working in the Lomami province but ICRC has an office there though working on other priorities including detention centres. The DRC RC has established a number of bilateral partnerships with the Spanish RC, Belgium RC, French RC, Iranian RC, Canadian and Swedish RC who have a physical presence in Kinshasa.

The Movement coordination is done via Movement Coordination meetings and, on a more operational level, through meetings between IFRC, pNSs and DRCRC and ICRC. A Movement coordination agreement has been drafted and signed to facilitate the running of the operations in the field, especially in North Kivu and Ituri where EVD operation is going in a highly tense security situation.

Overview of non-RCRC actors in country

The MoH 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 have 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 its 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, a number of local and international actors have responded to the 2017 population movement and cholera crisis epidemic. So far, MSF and ALIMA are working on cholera treatment centres in the province while WHO and UNICEF are supporting the improving of health and hygiene conditions of the affected population both health centres and at the community level. 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

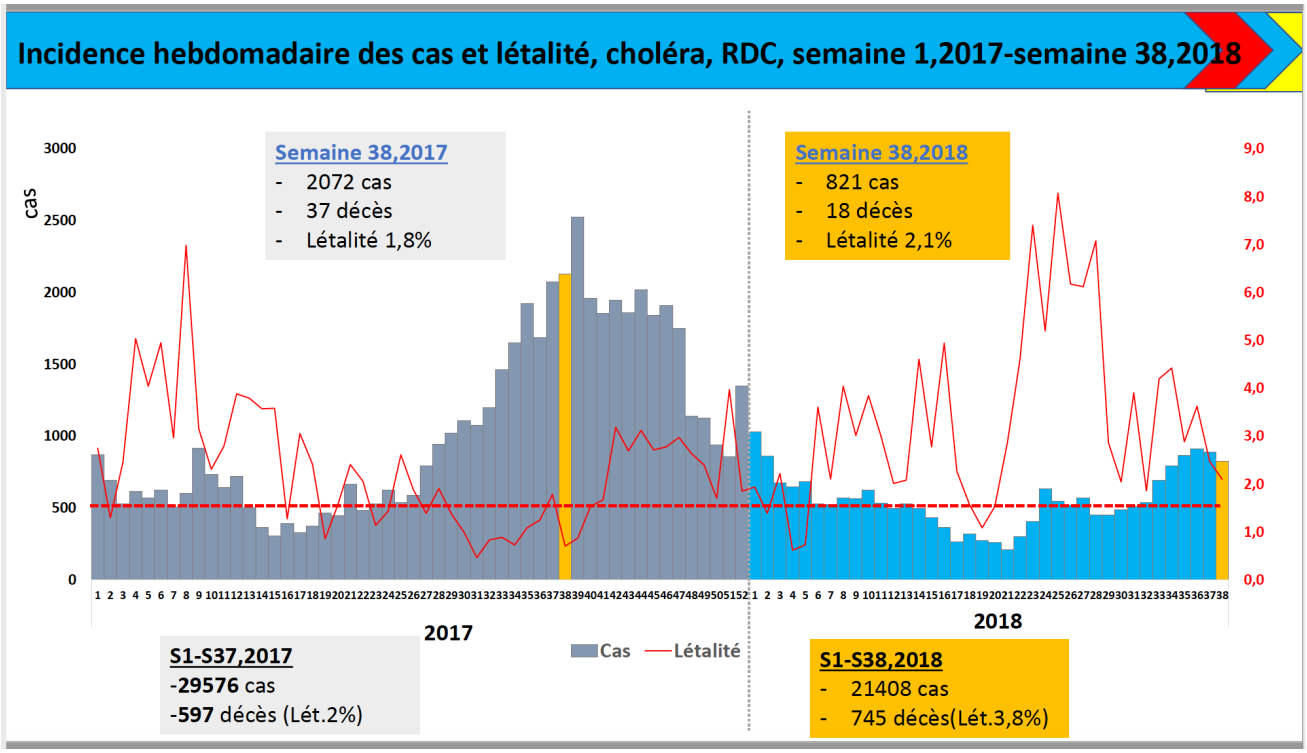
Needs analysis

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 operation 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 MoH, the peak of the epidemic has passed, and caseloads have stabilized at around 600 cases per week countrywide[3]:

[3]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.

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:

The latest figures provided by the MoH indicate that there has been a continuous decrease of cases from around 1,000 per week at the beginning of the year 2018 to only 209 in week 21 which is the lowest case count since January 2017. Unfortunately, cases have started to increase again on week 23 where 396 cases were recorded in 10 provinces, with 30 deaths reported.

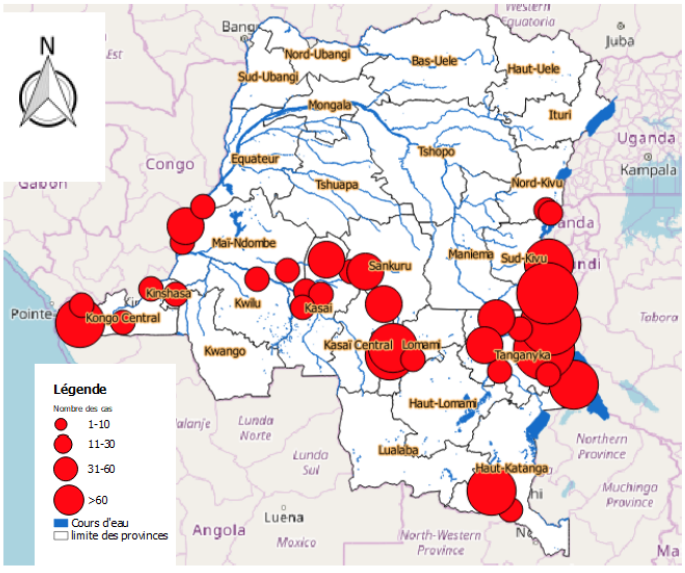


Above: Trend of cholera cases evolution from week 1 of 2017 to week 38 of 2018. (credit: MoH, March 2018)

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:

ZS ayant notifiées plus de 30 cas

Province	Zone de santé	Semaine 38
TANGANYIKA	KALEMIE	90
SUD KIVU	FIZI	73
TANGANYIKA	NYEMBA	60
KASAI ORIENTAL	TSHILENGE	57
KASAI ORIENTAL	KASANSA	56
HAUT KATANGA	KAPOLOWE	51
SUD KIVU	UVIRA	39
KONGO CENTRAL	LUKULA	38
TANGANYIKA	MOBA	37
5 Provinces	**9 ZS**	**501**



9 ZS avec plus de 30 cas, 501 cas , soit 61%

Above: The epidemiological trend of cholera during week 38 of 2018 (source: WHO – DRC country office)

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 are weak in surveillance and don't have capacity 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. Although there is currently no immediate security threat to the Red Cross activity, Lomami is part of the greater Kasai region where armed groups remain active and therefore an extensive security assessment would still be necessary.

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);

HEALTH ZONE	TARGET POPULATION
Kabinda[4]	337,551
Kalambayi	211,020
Kamiji	53,966
Kanda-Kanda	245,598
Ngandajika	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.

Sensitization activities against cholera outbreak have been intensified in the priority areas while the volunteers in other areas have been also conducting passive surveillance activities to ensure cases are timely reported and responded to and further contamination is avoided. Additional volunteers have been proposed for better geographical 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.

[4] Pop : population

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). These items are stored at Kabinda and will be distributed after training. 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 has been measured through displacement status (displaced, returnee, host family), age, gender, and socio-economic status among other things.

A two-week WATSAN assessment has been conducted in the field in July 2018 in order to identify the exact location where the WASH infrastructures need to be constructed and a total of 20 boreholes and public latrines were identified as a key priority in specific target areas. The team complemented the study with an analysis of secondary data from other sources to determine where their program of community training and infrastructure construction are most required. The criteria for selection have returned to the original intention of the Emergency Appeal that recognises the added risk that displaced and returning population face and bring to communities.

Table1: Number of volunteers mobilized and trained on cholera prevention techniques

Indicator description		**Number of volunteers per target Zone**					
		NGANDAJIKA	KANDA-KANDA	KABINDA	KALAMBAYI	KAMIJI	TOTAL
Volunteers trained to conduct health activities	*Women*	10	6	16	9	6	47
	Men	35	24	39	36	11	145
	Total	**45**	**30**	**55**	**45**	**17**	**192**

The training of territorial WATSAN focal points were conducted and focused on 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 households. 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.

Table2: Number of HH sensitized on cholera risks prevention

Health zones/area zone	Target Populations	Target HH	Total HH sensitized	Number of people reached
ZONE DE SANTE DE NGANDAJIKA	335,091	55,848	**10,507**	46,893
ZONE DE SANTE DE KABINDA	347,884	57,981	**13,950**	77,487
ZONE DE SANTE DE KANDA-KANDA	250,735	41,789	**7,678**	50,740
ZONE DE SANTE DE KAMIJI	107,513	17,919	**2,745**	28,104
ZONNE DE SANTE DE KALAMBAYI	217,353	36,225	**1,631**	20,919
Total	**1,258,576**	**209,763**	**38,801**	**224,143**

At field level, two deployed RDRTs (health and WATSAN) have followed 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. The MoH has told the DRC RC that they will cover this if required. Volunteers are informed that OR is available through the MoH.
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 MoH. At the national level, government collaboration is limited to provision of cholera data through the inter-agency coordination mechanisms which happen on a weekly basis. The issued data and health statistics are therefore used as input for the development of the programme strategy and adjustment of the response strategy in the field.

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 were developed jointly by the DRC RC, the MoH, 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 National Society capacity, some basic Community Engagement and Accountability (CEA) 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: 211, 809
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	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	20
# of cholera coordination meetings attended by DRC RC (added in this Update)	24	12

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	5

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	10
# of women trained by DRC RC who take part in cholera surveillance activities	25	11
# of volunteers trained in CBHFA module 6 for epidemic surveillance and Gender and diversity	125	25

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, 122,445 men, 131,196 women and 107,688 children between the ages of 6 and 14 (unfortunately the gender of the children is not recorded).

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 plan because government is not planning it and the National Society 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	361,329

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%[5]	6 %
# of households receiving water supply services[6] in line with agreed standards[7]	7,500	1,300

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	5000
% of latrines constructed that are maintained by the target population	100%	60%

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	7000

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

Indicators:	Target	Actual
# of volunteers involved hygiene promotion activities	300	321
# of people reached by hygiene promotion	244,300	361,329

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 321 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.

Since April 2018, 129 additional volunteers were trained. So, the number of trained people reached to 321. The themes of trainings include WASH, gender and diversity. PHAST method was applied to the training.

[5] 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. Update on number of boreholes built

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

[7] 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.

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.

e 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	6
# of DRC RC local branches strengthened	5	5

Progress towards outcomes

In collaboration with the MoH and the DRC RC health representatives deployed to the intervention area and trained 321 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 MoH 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 National Society. 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	1
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. During the first phase of the operation, 3 RDRTs were deployed in WASH and health areas.		
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	1
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%	100 %
# and % of financial reports submitted in time	100%	100%
Progress towards outcomes		

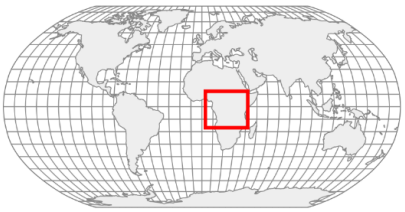
As of the writing of the report, the IFRC Country Cluster Finance Assistant is in country to support the preparation of the first finance report. The visit of the Regional Communication Officer has permitted the preparation of the first video that presents the situation in Lomami and the work of the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

About communication, another video activity is planned for first quarter of 2019.

D. BUDGET

Interim financial report annexed

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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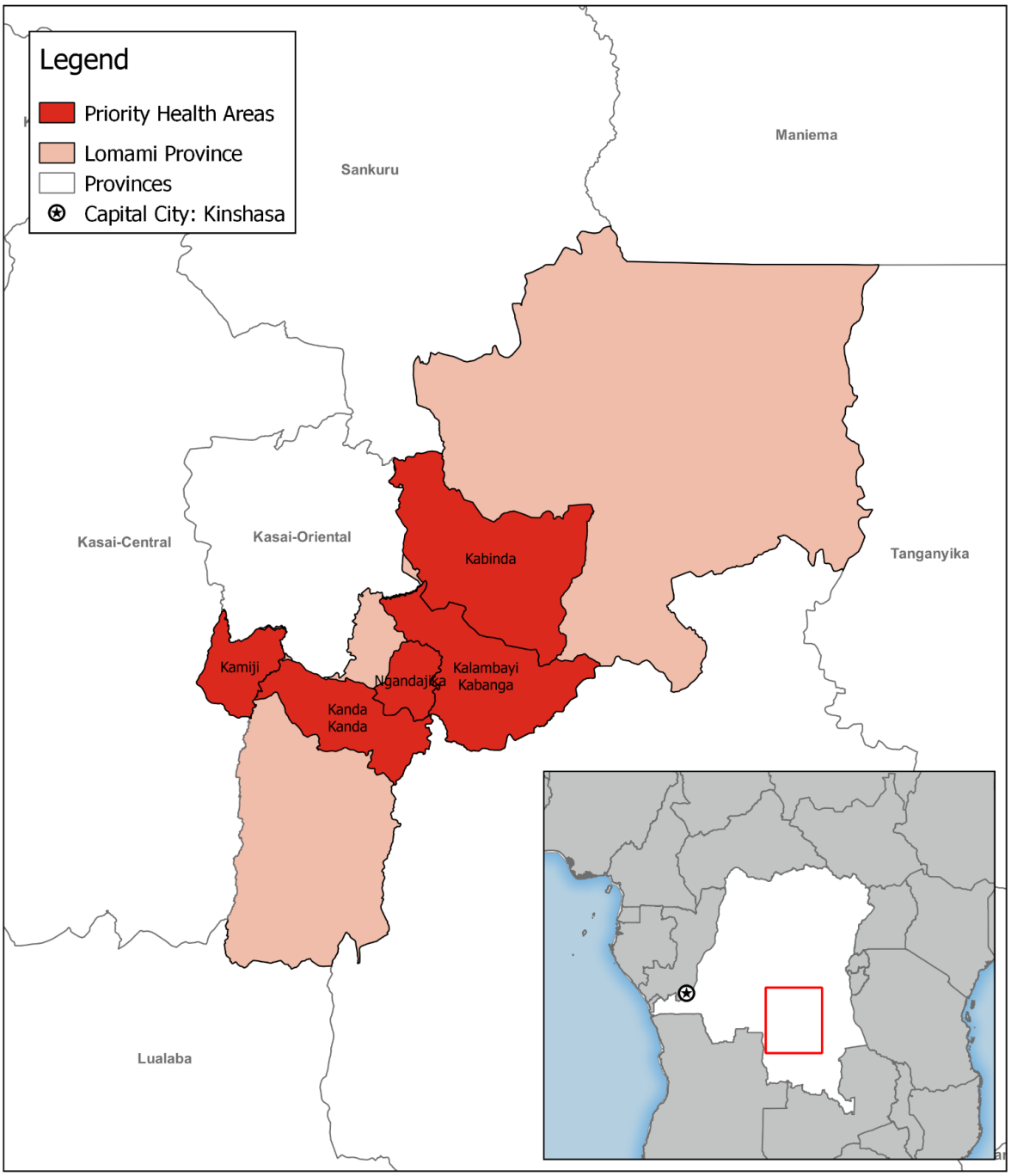

The maps used do not imply the expression of any opinion on the part of the International Federation of the Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.
Map data sources: IFRC, OCHA, GADM. Map produced by: IFRC Africa Regional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

0 30 60 90 120 km

N

Reference documents ↘

Click here for:

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

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For In-Kind donations and Mobilization table support:

- IFRC Africa Regional Office for Logistics Unit: RISHI Ramrakha, Head of Africa Regional Logistics Unit, email: rishi.ramrakha@ifrc.org; phone: +254 733 888 022

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

- **IFRC Africa Regional Office:** Fiona GATERE, PMER Coordinator, email. fiona.gatere@ifrc.org, phone: +254 780 771 139

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.

Disaster Response Financial Report

MDRCD023 - DR Congo - Population Movement

Timeframe: 28 Dec 17 to 22 Dec 18

Appeal Launch Date: 28 Dec 17

Interim Report

Selected Parameters			
Reporting Timeframe	2017/11-2018/10	Programme	MDRCD023
Budget Timeframe	2017/12-2018/12	Budget	APPROVED
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget			**695,497**			**695,497**	
B. Opening Balance							
Income							
Cash contributions							
American Red Cross			*74,005*			*74,005*	
British Red Cross			*97,625*			*97,625*	
China Red Cross, Hong Kong branch			*48,703*			*48,703*	
Japanese Red Cross Society			*65,900*			*65,900*	
Red Cross of Monaco			*17,638*			*17,638*	
Swedish Red Cross			*230,056*			*230,056*	
The Netherlands Red Cross			*283,326*			*283,326*	
The Netherlands Red Cross (from Netherlands Government)*			*161,569*			*161,569*	
C1. Cash contributions			***978,823***			***978,823***	
Other Income							
DREF Allocations			*200,119*			*200,119*	
C4. Other Income			***200,119***			***200,119***	
C. Total Income = SUM(C1..C4)			**1,178,942**			**1,178,942**	
D. Total Funding = B +C			**1,178,942**			**1,178,942**	

* Funding source data based on information provided by the donor

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance							
C. Income			1,178,942			**1,178,942**	
E. Expenditure			-650,536			**-650,536**	
F. Closing Balance = (B + C + E)			528,406			**528,406**	

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Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)				**695,497**			**695,497**	
Relief items, Construction, Supplies								
Water, Sanitation & Hygiene	270,022			1,027			**1,027**	**268,995**
Medical & First Aid	1,808							**1,808**
Teaching Materials	4,258			2,154			**2,154**	**2,104**
Utensils & Tools	0							**0**
Total Relief items, Construction, Sup	276,088			3,181			**3,181**	**272,907**
Land, vehicles & equipment								
Land & Buildings	0							**0**
Computers & Telecom	0							**0**
Office & Household Equipment	1,306			2,012			**2,012**	**-706**
Total Land, vehicles & equipment	1,306			2,012			**2,012**	**-706**
Logistics, Transport & Storage								
Storage	1,740			850			**850**	**890**
Distribution & Monitoring	4,916			18,121			**18,121**	**-13,205**
Transport & Vehicles Costs	6,501			24,488			**24,488**	**-17,988**
Logistics Services	0			3,710			**3,710**	**-3,710**
Total Logistics, Transport & Storage	13,157			47,169			**47,169**	**-34,013**
Personnel								
International Staff	180,718			256,884			**256,884**	**-76,166**
National Staff	12,766			17,369			**17,369**	**-4,603**
National Society Staff	952			7,558			**7,558**	**-6,606**
Volunteers	27,041			56,527			**56,527**	**-29,486**
Total Personnel	221,477			338,338			**338,338**	**-116,861**
Consultants & Professional Fees								
Consultants	0							**0**
Professional Fees	0			4,847			**4,847**	**-4,847**
Total Consultants & Professional Fe	0			4,847			**4,847**	**-4,847**
Workshops & Training								
Workshops & Training	42,007			49,319			**49,319**	**-7,312**
Total Workshops & Training	42,007			49,319			**49,319**	**-7,312**
General Expenditure								
Travel	38,150			69,742			**69,742**	**-31,592**
Information & Public Relations	6,181			8,293			**8,293**	**-2,112**
Office Costs	19,558			19,642			**19,642**	**-84**
Communications	15,637			6,686			**6,686**	**8,952**
Financial Charges	6,351			12,749			**12,749**	**-6,398**
Other General Expenses	14,064			363			**363**	**13,701**
Shared Office and Services Costs	0			28,204			**28,204**	**-28,204**
Total General Expenditure	99,941			145,678			**145,678**	**-45,738**
Operational Provisions								
Operational Provisions				17,630			**17,630**	**-17,630**
Total Operational Provisions				17,630			**17,630**	**-17,630**
Indirect Costs								
Programme & Services Support Recove	41,522			39,531			**39,531**	**1,991**
Total Indirect Costs	41,522			39,531			**39,531**	**1,991**
Pledge Specific Costs								

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III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)				**695,497**			**695,497**	
Pledge Earmarking Fee	0			2,131			**2,131**	**-2,131**
Pledge Reporting Fees	0			700			**700**	**-700**
Total Pledge Specific Costs	0			2,831			**2,831**	**-2,831**
TOTAL EXPENDITURE (D)	**695,497**			**650,536**			**650,536**	**44,961**
VARIANCE (C - D)				**44,961**			**44,961**	