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Emergency Plan of Action Operation Update
Democratic Republic of the Congo (DRC)
Population Movement

International Federation of Red Cross and Red Crescent Societies

Emergency Appeal n° MDRCD023	**GLIDE n° CE-2017-000116-COD**
EPoA update n° 3; February 2019	**Timeframe covered by this update**: December 23, 2017, to February 22, 2018
Operation start date: December 23, 2017	Operation timeframe: 18 months (until 22 May 2019)
Project Manager: Dr André Zamouangana, (Program Coordinator DRC Country Office, / IFRC, overall responsible for planning, implementation, monitoring, evaluation, reporting and compliances	**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 - Total income (including DREF): CHF 1,178942	**DREF amount initially allocated**: CHF 200,119
N° of people being assisted: 244,300 people; **N° of people affected:** 361,326 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 current operations update for the Emergency Appeal operation is to adapt the operational plan in order to respond to the latest epidemiological developments which has significantly changed in Lomami and the surrounding provinces. The update will equally focus on the progress made since the last operation update published early December 2018 on one hand, and highlight the changes in implementation strategies for the next phase of the operation on the other hand.

According to the latest WHO and Ministry of Health (MoH) reports in DRC, the current trend of Cholera in the country has taken a new turn, with 2 new provinces upgraded to the epidemic status with 24 provinces in total. On week 4, 2019 (i-e 14 – 21 Jan. 2019) the Haut Katanga and Sud Kivu have reflected the highest records of the disease with 14 and 10 cases respectively, with a total of 18 deaths in the four epidemic provinces: Haut Katanga: Haut Lomami, Sud Kivu and Tanganyika

Whereas significant efforts to eradicate Cholera in the province of Lomami have been deployed since late 2017, it would be essential for the DRC RC to scale up the current intervention in order to accomplish the work started and make sure Lomami and neighboring provinces reach zero cases in a reasonable timeframe. The MoH and other local stakeholders including the Congolese government are already highly thankful as regard the results achieved in the implementation zones assigned to the Red Cross. This is reflected in the epidemiological status reports where zero cases were reported by end of November 2018. Cholera prevalence

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

in Lomami has ever since slightly changed by end of week 49, 2018 with an exceptional increase of cases in 3 Health Zones of Mulumba, Ngandanjika and Kalambanyi.

The current Cholera trend in DRC (the 2nd country in Africa with largest caseload in Cholera according to 2017 WHO report) has pushed the government and partners to strengthen their response mechanisms throughout the recently issued ”Cholera Response Plan'': which is a national countrywide Strategy being piloted by the DRC government since December 2018. Thanks to this new strategy, the government aims at combining a strengthened community response approach with an adequate clinical case management, the government of DRC through the MoH has urged all partners, especially the Red Cross, to continue support the government's efforts to put an end to Cholera outbreaks in the 4 endemic and 7 epidemic provinces. While an increased vigilance will be put on WASH related activities including the finalization of the ongoing construction of public latrines and boreholes which was delayed due to the recruitment of an external consultancy expertise and procurement 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 led to the delay in initial project timeframe, pushing IFRC to extend the response for an additional 3 month period, i-e December 2018 to February 2018. This period was mainly dedicated to the completion of WASH infrastructures, namely 9 latrines and 9 boreholes with a global of achievement of 75% and 87% respectively. The overall implementation progress of the operation reached to 92% while the budget implementation is has reached 77,47% (see attached report for details)[3].

Therefore, the operation seeks 3-month time extension till 22 May 2019 to cover delay in implementation and provide an ample time to plan for needs assessment to inform operational strategies. During the first month of the extended period, the operation will complete the 9th borehole and 9th public latrines Kalula and Salanga localities. Whereas the delay for some boreholes was due to the fact that the water table was beyond the expected depth, requiring to seek for another search of appropriate site and approval of the land owner, that sometimes took weeks or so. For schools, delays were mainly attributed to the impracticability of roads, which seriously complicated the transport of building material to the construction sites.

Most importantly the extension will allow to give room to second multi-sector needs assessment of the humanitarian situation in Lomami and neighbouring provinces as a whole to have more updated picture of the situation for a better informed operational strategies in terms of transiting into next phases of intervention or into longer-term planning strategies. It is worth mentioning that the assessment's purpose will be mainly to inform the scope and funding needs and possibilities.

A needs assessment team consisting of multi-sectors profile of needs assessment, cholera response, shelter, disaster law, information management and PMER is being mobilized through IFRC Regional Office for deployment. The estimated time of the assessment is 1 and half month starting second week of February 2019.

[3] This percentage will significantly increase once the PSSR is passed and booking of all expenditures completed

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, the operation 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 shows 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 50% of returnees[4] are believed to have been returned in their respective homes in the whole of Kasai region including Lomami, 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
Refer to OU published in December 2018
http://adore.ifrc.org/Download.aspx?FileId=222019

Overview of Red Cross Red Crescent Movement in country
Refer to OU published in December 2018
http://adore.ifrc.org/Download.aspx?FileId=222019

Overview of non-RCRC actors in country

Refer to OU published in December 2018
http://adore.ifrc.org/Download.aspx?FileId=222019

B. The operational strategy

1. **Needs assessment and beneficiary selection**

DRC is known to present one of the most challenging humanitarian situation in Africa. Health issues such as Cholera, polio and Ebola outbreaks to armed conflicts and population movement affecting millions of vulnerable persons across the country are very common.

[4] According to UNOCHA's report (Oct.2017), out of 1.4 million displaced persons in 2016, 760.000 persons (roughly 50%) have returned to their homes.

The country is also prone to infection diseases and has faced recurring communicable disease outbreaks of cholera, measles, polio, yellow fever and malaria, among others. Increased violence and political turmoil have resulted in 8,000 people being displaced per day on average. According to the United Nations (UN), the total number of internally displaced people in the (DRC) is estimated to 3.8 million which turns to be one of the highest in Africa. The recent double Ebola crisis has further contributed to the weakening of the health system and a surge in cholera-related morbidity and mortality.

Tension and violence in the Kasaï Central province that took place in August 2016 onwards led to the forced displacement of around 1.4 million people and contributed to further worsening of the overall humanitarian situation throughout the Greater Kasai and the neighbor provinces. In 2017, the violence expanded to Kasai, Kasai Oriental and Lomami provinces. In October 2017, the UN classified DRC crisis as an IASC Level 3 Emergency partly because of the situation in the Greater Kasai.

The Emergency Appeal aims therefore at responding to the humanitarian needs resulting from the population movements from the Kasai province into the neighboring Lomami province. While a multisector assessment carried out in October 2017 identified a large number of needs, this appeal focused on responding specifically to the cholera outbreak in Lomami. Even though many families how now 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 is extremely high and even though the number of cases has decreased over the past few months, new cases are still reported on a weekly basis in the health zone and the local health system remains on alert.

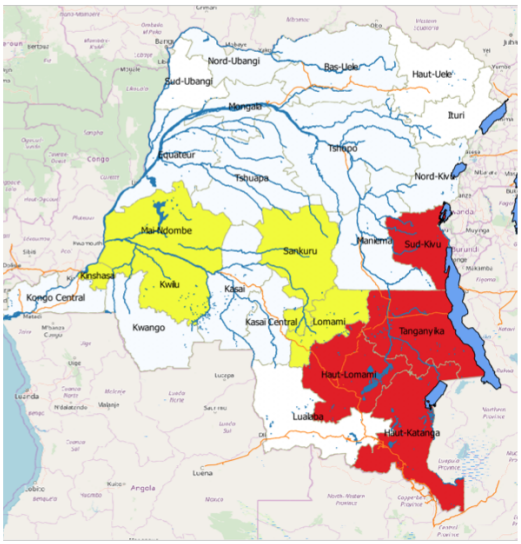
On 28 November 2018, the latest WHO sitreps indicate that Cholera is present in 21 provinces out of the 26 of the country and 4 of them have reached an epidemic level: Kasai oriental, Sud Kivu, Haut Katanga and Lomami. A total number of 60 Health zones are currently affected by Cholera with 13 of them reaching the epidemics level. At the end of week 46, 640 cases and 13 deaths were reported in the above-mentioned provinces with 1,9 as the average lethality rate.

The most affected province of Kasai oriental, is neighbouring the Lomami province and is potentially at risk of recurrence since many people are transiting between the two provinces. In fact, according to data from the Provincial Ministry of Health,9 new cases have been reported over the past 3 weeks in the two health areas of Mulumba and Kalambayi. This pattern has been repeating itself for weeks now reflecting the heightened risk factors in these areas.

Provinces on epidemic status

Province	Cases W4	Deaths W4
Sankuru	19	0
Kinshasa	6	0
Kasai-Oriental	4	0
Kwilu	3	0
Mai-Ndombe	2	0
Equateur	1	0
Kasai	1	0

- **7 provinces**
- **36 cases, 5,5% cases**
- **0 deaths**



Provinces on endemic status

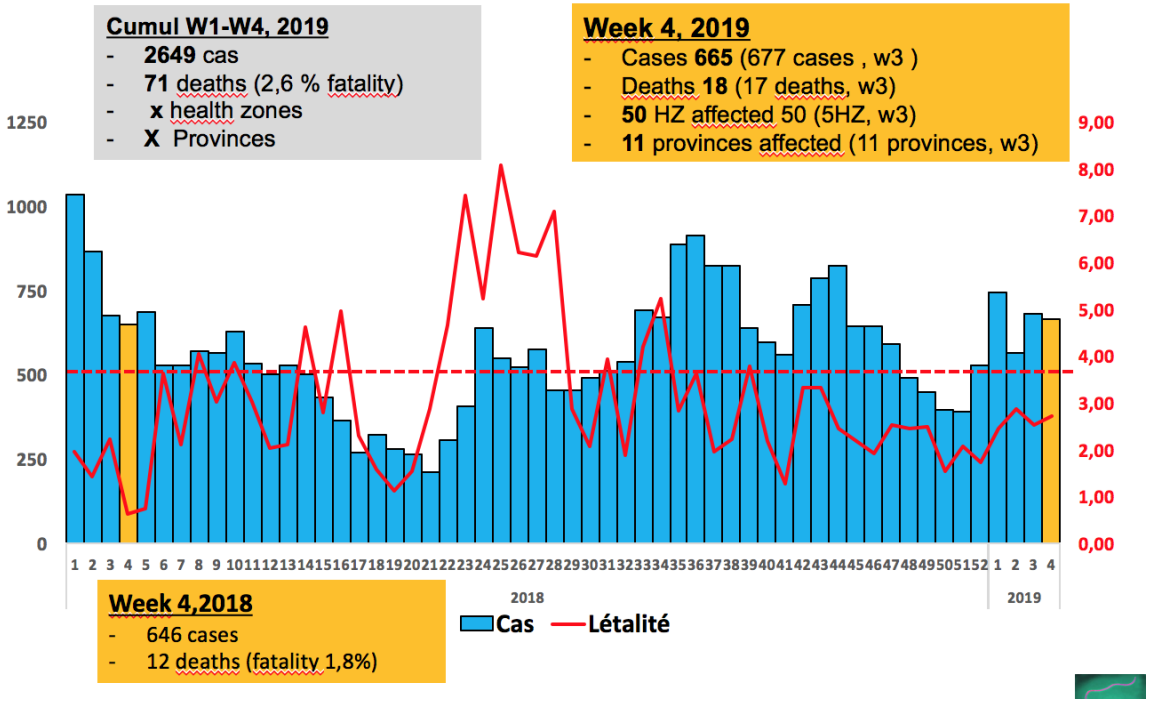
Province	Cases W4	Deaths W4
Haut-Katanga	274	9
Haut-lomami	150	8
Sud-kivu	135	0
Tanganyika	70	1

- **4 provinces**
- **629 cases, i-e, 94,5%**
- **18 deaths, i-e, 100 % deaths**

Above: The epidemiological trend of cholera during week 4, 2019 with 4 provinces upgraded to the endemic level and 7 classified on epidemic level (source: WHO)

The original needs analysis was based on a multisector assessment conducted in October 2017 that looked at the needs of displaced populations and their host communities. Based upon this analysis it was decided that the appeal should focus on reducing the impact of the cholera outbreak on host communities and contain the spread to other vulnerable populations.

According to the data provided by the MoH, there has been a continuous reduction of cases from around 1,000 per week at the beginning of the year to 209 in week 21, the lowest case count since January 2017. However, according to the latest data available from the Ministry of Heath, cases have started to increase again. On week 23, 396 cases were recorded in 10 provinces, with 30 deaths reported.



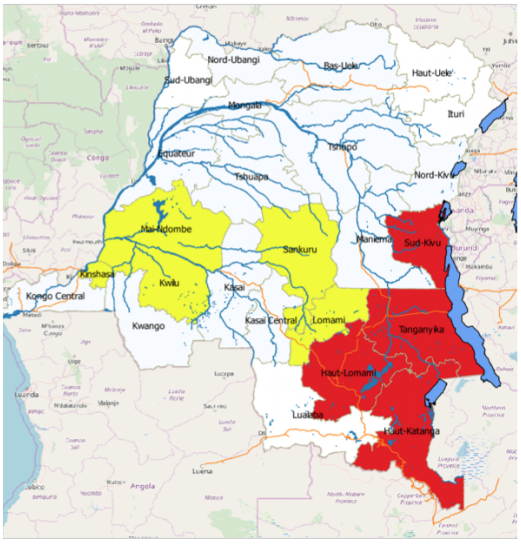
Above: Trend of cholera cases by end of week 4, 2019. (credit: WHO, DRC office))

In the Lomami neighbor provinces, Cholera cases have started to increase again as the rainy season has just began requiring therefore a close monitoring of caseloads in affected provinces. In addition, in the neighboring province of Kasai oriental, the number of cases has been steadily increasing over the past few weeks, threatening a further spread of the epidemics beyond the currently affected zones.

Provinces on epidemic status

Province	Cases W4	Deaths W4
Sankuru	19	0
Kinshasa	6	0
Kasai-Oriental	4	0
Kwilu	3	0
Mai-Ndombe	2	0
Equateur	1	0
Kasai	1	0

- **7 provinces**
- **36 cases, 5,5% cases**
- **0 deaths**



Provinces on endemic status

Province	Cases W4	Deaths W4
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Haut-lomami	150	8
Sud-kivu	135	0
Tanganyika	70	1

- **4 provinces**
- **629 cases, i-e, 94,5%**
- **18 deaths, i-e, 100 % deaths**

By the end of the week 4, the Cholera trend in Lomami shows a significant decrease in caseloads with zero cases in Mulumba and Ndangajika Health Zones, and only 2 new cases in Kalambanyi. On the other hand, the Kasai area and Lomami in particular faces currently another serious health challenge that requires a close monitoring: 110 cases of small pox have been notified in Tshileu (82 cases) and Ngabwe (6 cases). During the same period, 21 cases of polio have been reported in Tshileu and Mande-interieure areas.

B. OPERATIONAL STRATEGY

Proposed strategy

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**

At national level, emergency 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 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 household latrines. 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 HHs sensitized	Number of persons reached
De Ngandajika	335,091	55,848	**10,507**	46,893
Kabinda	347,884	57,981	**13,950**	77,487
Kanda-Kanda	250,735	41,789	**7,678**	50,740
Kamiji	107,513	17,919	**2,745**	28,104
Kalambayi	217,353	36,225	**1,631**	20,919
Total	**1,258, 576**	**209,763**	**38801**	**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 during the initial campaign but vaccination was implemented in some selected areas later although the Red Cross was not involved
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 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 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 Emergency 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.

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 persons
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	20
# of cholera coordination meetings attended by DRC RC (added in this Update)	24 meetings	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 groups (1 per health zone targeted)	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 volunteers	10
# of women trained by DRC RC who take part in cholera surveillance activities	25 people	11
# of volunteers trained in CBHFA module 6 for epidemic surveillance and Gender and diversity	125 volunteers	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, 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 MoH/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.

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 people provided with safe water services that meet agreed standards	244,300	361,326

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]	92%[6]
# of households receiving water supply services[7] in line with agreed standards[8]	7,500	6,200

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	5,000
% of latrines constructed that are maintained by the target population	100%	85%

[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.

[6] One borehole out of nine is still under construction

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

[8] 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.

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	7,000
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	361,326

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. Whereas one of the main reason this appeal was extended for an additional 3 months was due to the delayed WatSan infrastructures in Lomami, field reports and onsite visits confirm that 8 boreholes and 8 blocks of latrines were completed by two selected construction companies that were hired through the regular federation tender process. These infrastructures can be visited in the localities of Nsalanga, Mukala, Ilunga, Kabala, Abena, Mpaiana and Bana Tshibangu.

Outcome 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 (1 in each health zone targeted)	5
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 c6mmunity 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	2
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	2
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	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		
The DRC country office has as urge PMER delegate deployed in the country, and he is currently providing an adequate support to the Population movement operation in Lomami as well as other programs. IN joint collaboration with the finance unit at the country level, all donor reports and information updates are regularly submitted in a timely manner.		

D. BUDGET

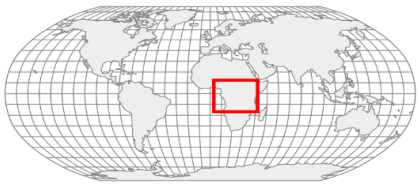
While the programme implementation is estimated to around 92%, the budget consumption is as of 11 February is 77,47% as detailed below[9]:

- Income : 1,178,942
- Expenditure : 913,364 (0r 77,47%)
- Balance : 2,66,578

The expenditure percentage is expected to significantly increase and reach about 94% once all expenses will have been booked and the PSS run. Some of the key payments remaining to be done include the last instalment for two construction companies that were hired to build 9 blocks of latrines and 9 boreholes. Further important payments namely trainings for the setting up of water management committees are equally expected to take place next week.

[9] See attached report

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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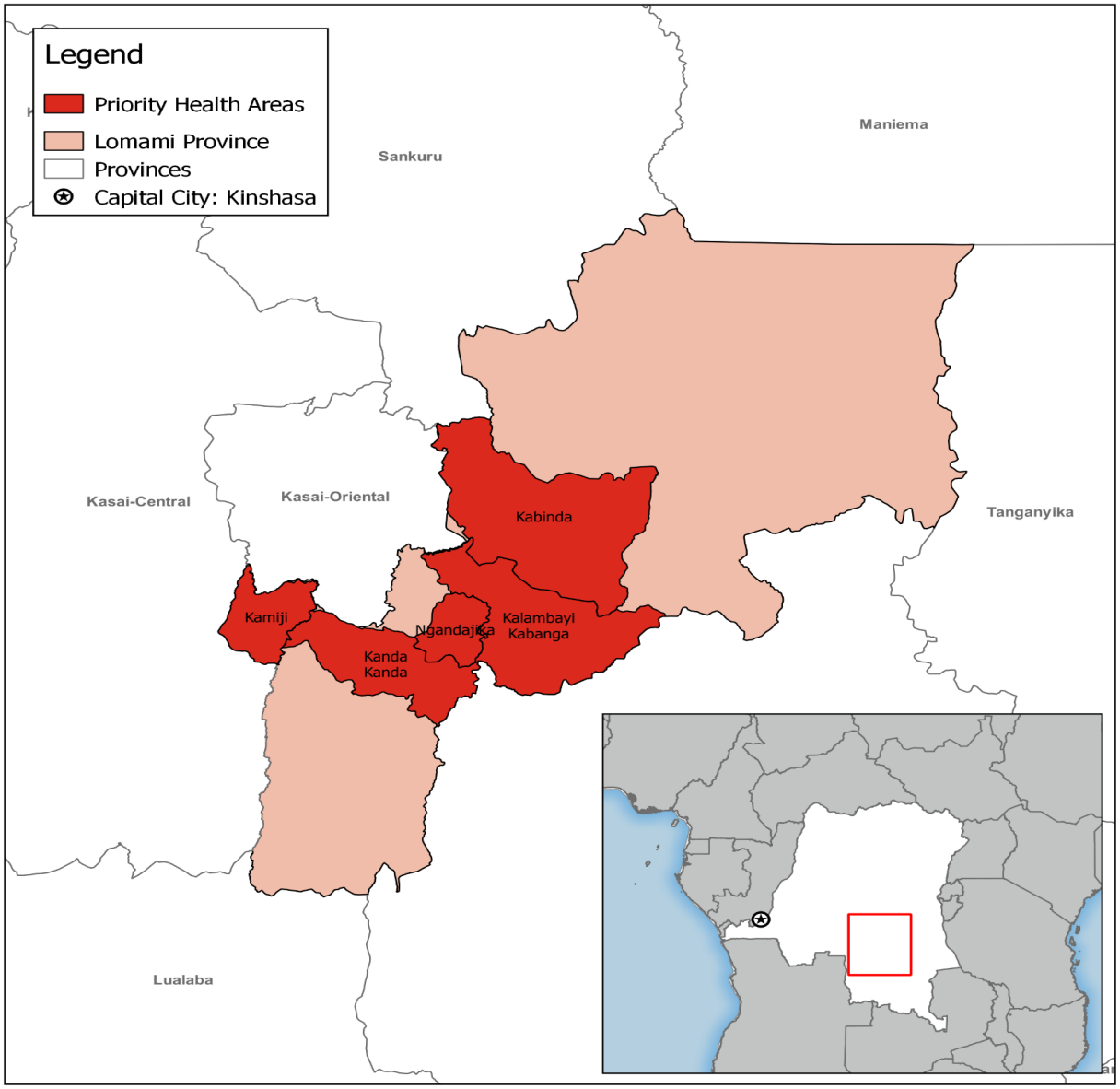

The maps used do not imply the expression of any opinion on the part of the International Federation of the Red Cross and Red Crescent Societies or National Societies concerning the legal status of a territory or of its authorities.
Map data sources: IFRC, OCHA, GADM. Map produced by: IFRC Africa Regional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

0 30 60 90 120 km

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Reference documents Click here for: 1. Previous Appeals and updates	**For further information, specifically related to this operation please contact:** **In the DRC RC** Mitanta Makusu Emmanuelle, Secretary General DRC RC; email: sgcrrdc@croixrouge-rdc.org Dr Balelia Wema Jean Faustin, DRC Red Cross National Director for Health and Social Action; email: j.balelia@croix-rouge-rdc.org; Phone: +243 8989155544, +243 822 951 182 **IFRC Country Office, Kinshasa:** Momodou Lamin Fye, Head of DRC Country Office; email: momodoulamin.fye@ifrc.org **IFRC Office for Africa Region:** Adesh TRIPATHEE, Head of Disaster Crisis Prevention, Response and Recovery Department, Nairobi, Kenya; phone +254 731067489; email: adesh.tripathee@ifrc.org, Khaled Masud Ahmed, Regional Disaster Management Delegate, phone: +254 20 283 5270, Mob +254 (0) 731 067 286; email: khaled.masud@ifrc.org **In IFRC Geneva :** Antoine Belair, Operations Coordinator (Americas and Africa Regions), phone: +41 22 730 4281, Mob. +41 79 708 3149; email antoine.belair@ifrc.org **For IFRC Resource Mobilization and Pledges support:** IFRC Africa Regional Office for resource Mobilization and Pledge: Kentaro NAGAZUMI, Head of Partnership and Resource Development, Nairobi, email: kentaro.nagazumi@ifrc.org; phone: +254 202 835 155 **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.