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Emergency Plan of Action Final Report

Niger: Cholera Epidemic Outbreak

International Federation of Red Cross and Red Crescent Societies

DREF operation	**Operation n° MDRNE022**
Date of Issue: 29 April 2019	**Glide number: EP-2018-000132-NER**
Date of disaster: 4 July 2018	
Operation start date: 11 August 2018	**Operation end date: 11 December 2018**
Host National Society(ies): Niger Red Cross Society	**Operation budget: CHF 352,270**
Number of people affected: 3,824 people (546 households)	**Number of people assisted: 468,139 (66,877 households)**
N° of National Societies involved in the operation: one (Niger Red Cross Society)	
N° of other partner organizations involved in the operation: IFRC, UNICEF, WHO, BEFEM/ALIMA, CISP, MSF FRANCE, MSF SPAIN	

A. SITUATION ANALYSIS

Description of the disaster

Starting on the night of 4 – 5th July 2018, with three patients originating from the JIBIYA health Centre in neighbouring Nigeria to N'Yelwa Health Centre in the Madarounfa Health District of Niger, with acute watery diarrhoea and vomiting, the Niger cholera outbreak rapidly surged, with large numbers of new cases and deaths registered. New districts including Madarounfa, Maradi Commune, Guidan-Roumdji, Dakoro, Aguié and Tessaoua (Maradi region), Gaya (Dosso region), Damagaran-Takaya,Takeita and Mirriah (Zinder region), Birni-N'Konni, Malbaza, Keita and Madaoua were also reported to be affected. According to the Directorate of Surveillance and Epidemics Response of the Niger Ministry of Health (MoH) report presented during the last WASH cluster meeting held on 28 February 2019, the Maradi Cholera epidemic outbreak erupted on week 27 and ended on week 44. The outbreak affected **3,824** people with at least **78** deaths, for a lethality rate of **2%.** Madarounfa Health District in Maradi Region was the most affected with **2,638** cases, **(68.88%)** of the cumulative cases reported. Eighty-three percent of cases were age 5 and above and females constituted **56.2%** of the cases reported (WHO, 1 Oct 2018). The areas of Dan Issa, Gabi, Harounawa, Madeini, Maraka and N'Yelwa were the most affected in terms of Health Centre (each Health Centre covers an area with a specific number of inhabitants). The risk factors for the spread of the disease in the communities were huge. The latest WASH assessment carried out by UNICEF and WHO states that only **37%** of the population in

Red Cross Movement coordination for the response to Maradi cholera outbreak, (NRCS, Belgian Red Cross, IFRC and the Head of Nyelwa Health Centre)

Maradi Region has access to basic sources of potable water -- **75%** of the population are said to practice open defecation, with only **10%** having access to basic sanitation (WHO, 7 Sep 2018). The precarious sanitation conditions in most of the affected health districts and the movement of population across borders with Nigeria, where cholera was reported several months before this operation, were among the major contributors to the outbreak. The heavy rainfall and floods in the affected area affected more than **38,000** people and exacerbated the risk of contamination. (ACAPS, 24 Aug 2018).

The outbreak was initially located in Madarounfa department on week 27 but finally spread to the heavily populated city of Maradi, the capital of the region and over to other regions. All places, likely to exacerbate the risk of contamination of water sources. According the MoH report, the epidemic finally affected four (4) regions including Maradi, Zinder, Dosso and Tahoua. The outbreak ended on week 44 with an overall 3,824 people affected with 78 deaths recorded.

The table below gives the summary on the number of affected cases and deaths per region.

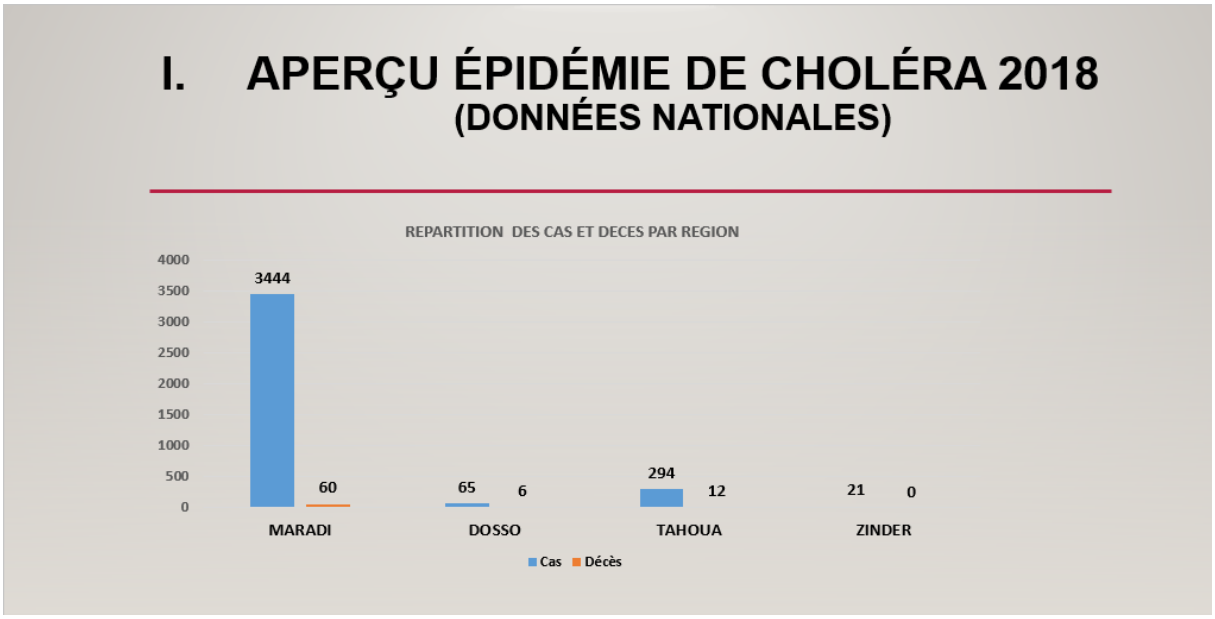

Figure 1: Number of affected cases and deaths per region. *Source: Niger Ministry of Health 28 February 2019*

Overall, the Maradi cholera outbreak finally affected 14 Health Districts including: Madarounfa, Maradi Commune, Guidan-Roumdji, Dakoro, Aguié and Tessaoua (in the region of Maradi), Gaya (in the region of Dosso), Damagaran-Takaya,Takeita and Mirriah (in the region of Zinder), Birni-N'Konni, Malbaza, Keita and Madaoua (in the region of Tahoua) as seen in the map below.

Cholera affected health districts in Niger

Cholera affected states in Niger

Nigeria states at the border level free from cholera

Figure 2: Map indicating the geographical areas affected by cholera at border side between Nigeria and Niger

The MoH's report indicated that the cholera phenomenon started on 2nd July 2018, in Makada village located in the JIBIYA health area in Katsina state in neighbouring Nigeria and the affected people crossed the border to Niger in

search of better treatment. Kindly note that most of the Nigerian states bordering Niger including Katsina, Sokoto, Zamfara, Kano, Yobe and Borno experienced a Cholera epidemic during the same period. Therefore, the Diffa region of the country which is still free from cholera is at high risk due to its proximity with Borno state. According to the MoH' report, out of 3,824 affected cases, **483** (at least **12.63%** originated from Nigeria).

On 6 July 2018, a new case was reported at the same health centre -- the new patient came from Dan-Koussou village, located 4 kms away from the N'Yelwa health centre. On 7 July 2018, three (3) other new cases erupted in the same N'Yelwa Centre. Among them, two (2) people came from Dan-Koussou while one came from Abdallah village, located 4 kms away from JIBIYA health centre in Nigeria.

CERMES Niger

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Ministère de la Santé Publique

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Niamey, le 12 Juillet 2018

COMPTE RENDU D'EXPERTISE

Le laboratoire de Bactériologie du CERMES a réceptionné trois (3) échantillons de selles en provenance du district sanitaire de Madarounfa région de Maradi pour suspicion de choléra.

Si dessous le résultat bactériologique.

Date prélèvement	Date réception	Nom & Prénom	Age	TDR	Résultats Culture
07/07/2018	11/07/2018		6 ans	Positif	*Vibrio cholerae O1 inaba*
			6 ans		
			12 ans		

Antibiogramme : en cours

Figure 3: Laboratory test analysis sample taken from the affected people

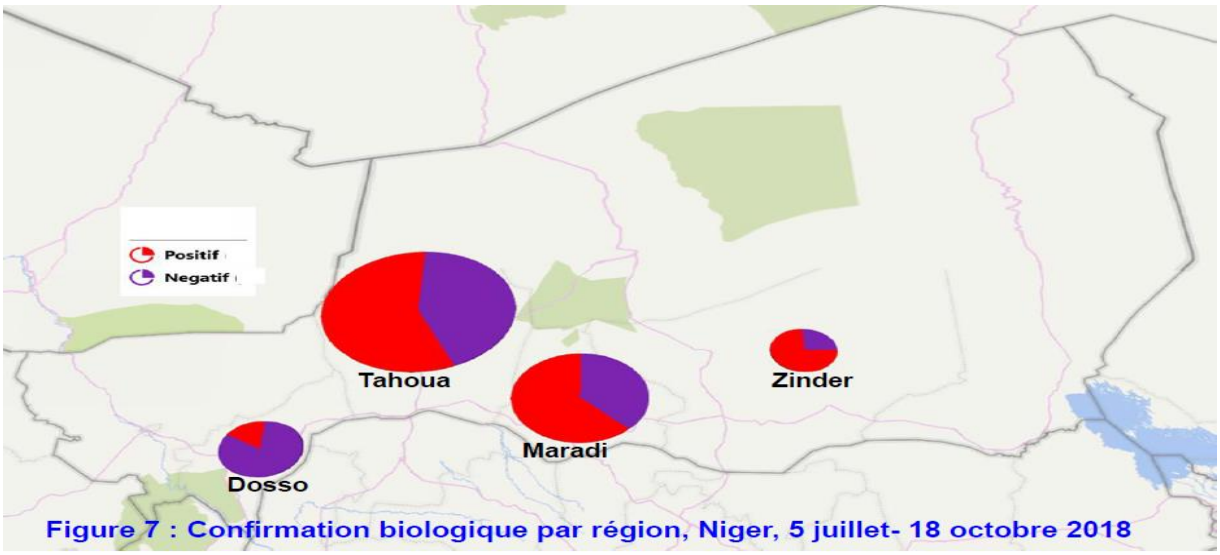

Figure 4: Laboratory test per sample taken from the affected region as of 18 October 2018

Districts	Echantillons	Positifs	Négatifs
Madarounfa	8	6	2
Maradi ville	4	1	3
Guidan Roumdji	1	1	0
Dakoro	1	1	0
Aguié	2	1	1
Gaya	8	3	5
Damagaram Takaya	2	2	0
Mirriah	2	1	1
Malbaza	20	10	10
Birni N'Konni	8	5	3
Kéita	4	4	0
Madaoua	3	1	2
Total	63	36	27

Figure 5: Results of the lab tests from samples taken from the affected areas as of 18 October 2018

To contain the outbreak, the Ministry of Public Health positioned medicines, set up six treatment centres and strengthened epidemiological surveillance. (OCHA, 23 Jul 2018). Further, on 31 July 2018, the Niger Minister of Public Health, through a letter requested the support of the Niger Red Cross Society in the response to this epidemic outbreak. The Minister's request targeted the following activities:

- Provision of calcium hypochlorite, chlorine, Aquatabs and PUR for the purification of water at the treatment centres and within the communities;
- Carrying out community-based surveillance;
- Organization of cross-border meetings between the Health District of Madarounfa (Niger) and the JIBIYA (Nigeria) in collaboration with the Red Cross Societies of the two countries;
- Organization of central support mission to identify community risk behaviour that contribute to the spread of the epidemic in order to develop appropriate messages.
- Training of community actors, Security and Defence Forces (FDS) at border level (Police, Customs, environmental agents, peer educators) on the knowledge of cholera disease, the symptoms, mode of contamination and universal prevention measures;
- Dissemination of awareness messages through community radios in the region;
- Production and elaboration of communication tools.

On 13 August 2018, in order to enable NRCS provide the requested support from MoH, the International Federation of Red Cross and Red Crescent Societies (IFRC) allocated a CHF 352,270 grant from its Disaster Relief Emergency Fund (DREF). The EPoA focussed on the training of volunteers on Epidemic Control for Volunteers (ECV) manual, especially on cholera, community-based awareness sessions using IEC materials, setting up Oral Rehydration Points (ORP) and Handwashing Point with handwashing devices, disinfection of public latrines in schools and health facilities and the distribution of water related non-food items including soaps, jerrycans, buckets with lids and Aquatabs for water purification tablets at households level. The DREF operation targeted 21,000 people (3,000 hh) for a period of three months.

On 15 October 2018, a one month no-cost timeframe extension was granted through publishing of an Operation Update to extend the scope of the operation due to the geographical spreading of the epidemic. Indeed, the MoH requested the deployment of Red Cross volunteers to fight back the outbreak in newly affected areas, including Tahoua region and Dan Issa area of Madarounfa.

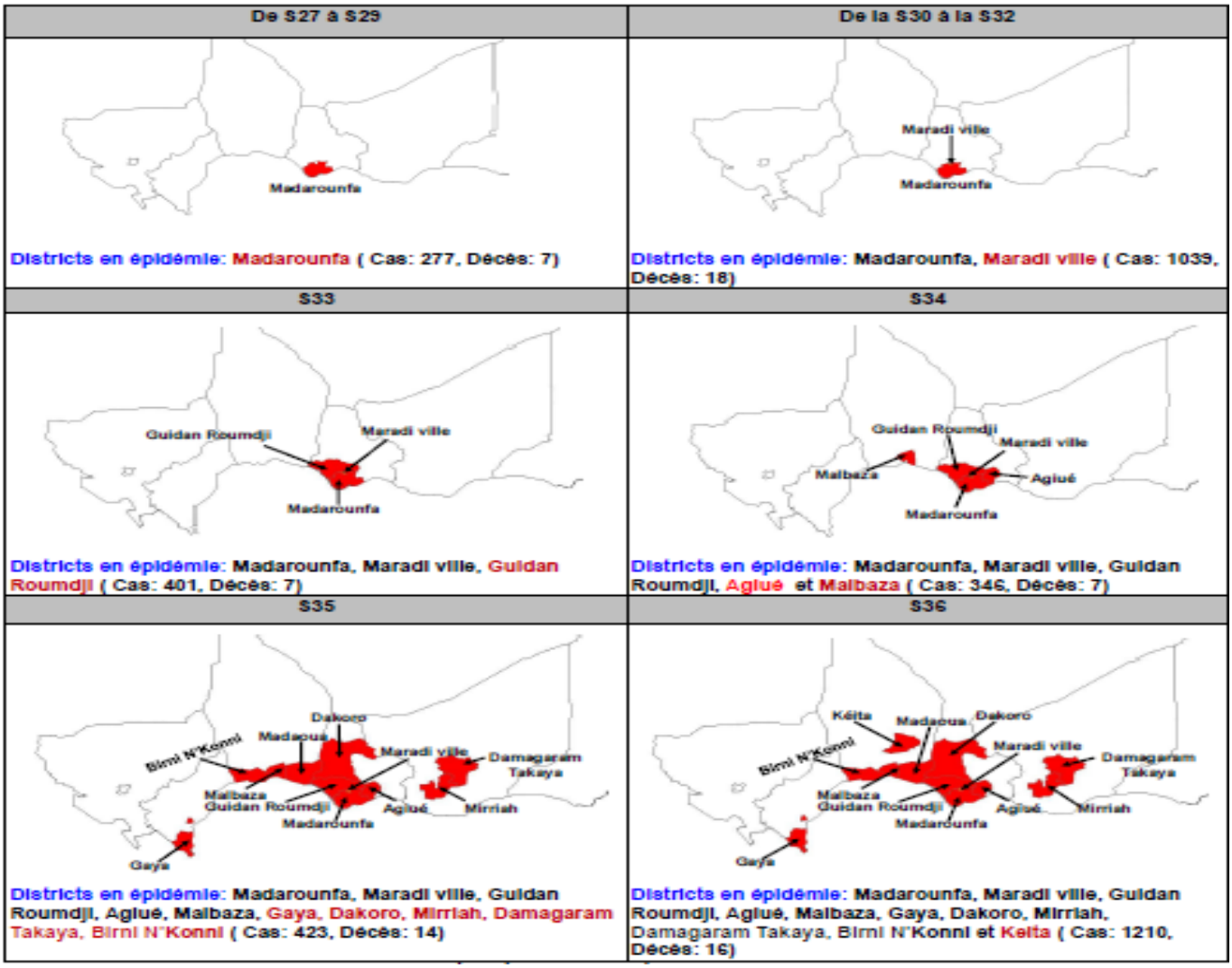

Figure 6, Geographical spreading of the Maradi epidemic outbreak over the time from week 27 to week 36.

The major donors and partners of the Disaster Relief Emergency Fund (DREF) include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, Canada, Denmark, Finland, Ireland, Italy, Japan, Luxembourg, Monaco, the Netherlands, Norway, Spain, Sweden and the USA, as well as DG ECHO, the UK Department for International Development (DFID), AECID, the Medtronic and Zurich Foundations and other corporate and private donors. On behalf of Niger Red Cross Society (NRCS), the IFRC would like to extend its gratitude to all partners for their generous contributions.

Summary of response

Overview of Host National Society

In its role as auxiliary to the authorities, Niger Red Cross Society (NRCS) is fully involved in responding to all epidemic outbreaks in the country.

From 13 July 2018, when news of the Cholera outbreak was shared by the MoH and WHO, the Governor of Maradi Region requested the support of the Red Cross in the response to this epidemic. The NS immediately begun taking part in the crisis meetings chaired by the MoH on the strategic response plan for this outbreak. As part of the initial response, the NS deployed 15 volunteers from its roster of volunteers and conducted awareness sessions around the Cholera Treatment Centres (CTC). Further, the NRCS provided tents for the isolation of patients at the CTC. During the operational call held on 20 July 2018, it was discussed that DREF could be an option for response depending on the information to be collected and the evolving situation of the epidemic.

Once the DREF grant was allocated, the NS deployed 175 volunteers in the affected areas. They were all trained on ECV manual focussing on cholera management and later on implemented activities in the affected areas. NRCS volunteers covered nine (9) health centres in three health districts including Madarounfa, Maradi Commune and Guidan

Roumdji, Tahoua Region and the area of Dan-Issa health Centre in the Madarounfa health District, greatly contributing to curbing the rising trend of the outbreak.

Overview of Red Cross Red Crescent Movement in country

The IFRC provides NRCS support through its Niger Country Office, and Africa Regional Office based in Nairobi. From the onset of the disaster, contacts were established with the Regional Office and regular updates on the situation and activities were shared. An alert was issued on 17 July 2018 using the IFRC Disaster Management Information System (DMIS), and the Operational Strategy Call was held with colleagues at regional level on 21 July 2018. After the operational call, it was recommended that the IFRC Niger team support the NS to develop an EPoA and relating budget for the DREF request, which was granted in August 2018. The IFRC, through this DREF operation, enabled the deployment of an RDRT to support NRCS in implementing planned activities.

IFRC Niger Country Office, in collaboration with the Niger Red Cross Society, continues to attend the crisis meetings chaired by the MoH, where it presents the epidemiological situation of the country and continues working on the strategic issues around Cholera outbreak. Movement partners in Niger include the International Committee of Red Cross (ICRC), the French Red Cross, the Spanish Red Cross, the Luxembourg Red Cross, the Danish Red Cross and the Belgium Red Cross. The Spanish Red Cross is present in the Maradi region and conducts activities dedicated to livelihood resilience. They are not responding to the ongoing Cholera outbreak in the region of Maradi.

It is important to note that Movement Coordination meetings are held on a monthly basis to improve collaboration and seek, where necessary, synergies that will have a positive impact on activities implemented for the affected population.

Overview of non-RCRC actors in country

The Ministry of Public Health with technical support of WHO, UNICEF, BEFEN /ALIMA, CISP, NRCS, MSF (Spain, France and Switzerland) and the Italian Embassy in Niger led the response to the Cholera outbreak in Maradi. Regular crisis meetings were held at the Ministry of Health in Niamey and at the regional level to coordinate the strategic response plan. Further to the official declaration of the outbreak, the Niger Minister of Public Health instructed the following actions:

- To open six (6) operational sites for free of charge treatment,
- To reinforce epidemiological surveillance with daily reports on new cases in all the health centres of the region,
- To pre-position cholera treatment kits in high risk health districts,
- To deploy treatment products in the affected health centres,
- To hold daily meetings of the epidemic management committee put in place by the MoH including Niger Red Cross Society;
- To carry out the distribution of Aquatabs to the population for the treatment of water at household level;
- To increase community-based awareness raising to the population on the symptoms of cholera through the existing communication channels,
- To increase community-based awareness raising to the population on the use of health services;
- To use community relays, Red Cross volunteers and community leaders for community-based awareness sessions,
- To disseminate communication on Cholera outbreak through community radio stations.

Based on the above, the UNICEF provided its support in intravenous infuscate for drip and 22 cartons of Aquatabs of 16,000 tablets each and 30 cartons of soap; however, the needs remained enormous. According to the WASH cluster meeting held on 19 July 2018, the needs were summarized in the following: Medication for the treatment of cases, WASH items especially Calcium hypochlorite (HTH), soap and Aquatabs; awareness raising and dissemination of information on cholera. The Niger Red Cross Society, through this DREF operation provided medication and intravenous (IV) drip packs to all the affected health Centres through the Regional Directorate of Public Health in Maradi. UNFPA also provided support with medicines and IV drip packs.

Needs analysis and scenario planning

Daily updates and monthly summaries provided by the Maradi Regional Public Health Directorate, in collaboration with UNICEF and WHO, highlighted the extent and trends of the outbreak. Health cluster coordination meetings in Niamey and at the regional level as well as cholera crises meetings, held twice per week, helped to outline the gaps that required partners attention and for coordinated response to the outbreak. Key among these gaps identified included:

- Inadequate access to basic Social Services in the areas where the outbreak occurred -- in the district of Madarounfa, most villages do not have neither well nor boreholes.
- Inadequate funding and logistic/supplies for rapid response to the outbreak;
- Inadequate coordination between the Health Cluster and the Ministry of Public Health;
- Inadequate community-based surveillance in place for early waring information to assist investigations and response;
- Insufficient capacity of staff in case management;
- Need to scale up WASH interventions to increase common access to safe water and adequate sanitation.

This DREF operation strongly contributed to addressing some of these gaps so as to effectively respond to the outbreak. The operation targeted about 21,000 people (3,000 households) in the affected and at-risk areas. However, there is a need for provision of potable water points, adequate sanitation and increased awareness for the construction and use of family latrines. The outbreak, which was initially located in small pockets at the beginning, appeared to be higher at the borders between Nigeria and Niger due to the high porosity of the borders and the persistent movement of population at border level. In addition, a Cholera outbreak was reported in Nigeria a few months before Niger, hence the higher risk of infection from shared amenities and services, general unsanitary conditions, coupled with use of unsafe water. The target population for this operation was selected from areas that have no other organization providing the much needed support.

Risk Analysis

Besides the population Movement being the main trigger for the overall increase of cases during the cholera outbreak, there were a number of risks directly associated with the outbreak, including the floods affecting the whole country in general and the Maradi region in particular as well as the weakness of community-based surveillance of disease information and inadequate access to basic social services.

Community perception of water treated with chlorine or Aquatabs equally affected the successful implementation of planned interventions under the DREF operation. Generally, the community had some hesitation in drinking water treated with Aqua tabs, complaining that the natural taste of water is lost. Sustained community sensitization, weighing heavily on the derived benefits of chlorinated water, is helping to change perception to water treated with chlorine or Aqua tabs.

Taxi drivers were all exposed because cholera patients as well as taxi drivers were not well informed on cholera transmission factors. Once a patient is carried on board a taxi, he/she easily vomits on the other clients of the taxi. This put the drivers and the other passengers at high risk of contamination.

B. OPERATIONAL STRATEGY

Overall Operational objective:

The main aim to this DREF operation was to implement lifesaving interventions including improved surveillance for early case detection, timely response, including effective case management, to curb the rising trend of the current outbreak and contribute to preventing further outbreaks of cholera in the target population.

Through a combination of strategies such as improved surveillance, timely alerts and responses, WASH activities, effective case management and sustained social mobilization by Niger Red Cross volunteers, the National Society significantly contributed to control the outbreak and promote healthy living among the target population.

Proposed strategy

The proposed strategy, in accordance with IFRC's response and preparedness strategy for epidemic countries in the region, aimed at supporting NRCS through staff and volunteer mobilization and training, as well as awareness raising of target population, distribution of information, production of education and communication materials, setting up community-based epidemiological surveillance, dead body management, communication of key messages for the preparedness and prevention of Cholera epidemic outbreaks, as well as social mobilisation to reduce the risk and

improve prevention activities, in collaboration with the MoH. To reach the at-risk population, NRCS continued to utilize its network of existing community volunteers to establish community-based Oral Rehydration Points (ORP). Activities carried out included:

- The training of 407 volunteers including 232 in the region of Maradi, 175 in the region of Tahoua, 37 supervisors and 60 community leaders on the Epidemic Control for Volunteers (ECV) manual, specifically linked to the risks related to cholera outbreaks (two-days training). The NRCS volunteers received training on knowledge of the disease, the signs and symptoms, the transmission risk factors, actions to be taken in case of suspected cases, prevention and control measures. The training was carried out by the staffs of the Regional Directorate of Public Health co-facilitated by the Niger Red Cross Society Health Coordinator and the RDRT deployed to support the implementation of the operation under the supervision of the IFRC Operations Coordination Delegate,

- Social mobilization carried out in the affected areas under Red Cross control – especially in the health centres of Madarounfa, N'Yelwa, Dan-Issa and Angoual Mata (in the health district of Madarounfa), "17 Portes", Place du chef, Ali Saibou and Sabongari health centres (in the health district of Maradi Commune); and Tibiri and Gouma Health Centres (in the health District of Guidan Roumdji) in the Maradi region, and at community level in the township of Madaoua, township of Sabon Guida, and township of Galma in the Madaoua Health District, the township of Dogueraoua, township of Malbaza in the health District of Malbaza and Tahoua township 1 & 2 in the health District of Tahoua where an overall 407 NRCS volunteers were mobilized through the whole period of the operation. The overall 407 volunteers were involved in door to door campaigns and mass awareness sessions, using megaphones and distributing information, education and communication (IEC) materials in public places (churches, mosques and schools) as well as community-based disease surveillance.

- Community-based disease surveillance including monitoring/referral by volunteers at community level, as well as participation by the NRCS in information/coordination meetings.

- Community-based management: NRCS set up 100 Oral Rehydration points (ORP for the community-based management of the cholera especially in the affected areas where there are no health facilities, for the distribution of household water treatment (Aquatabs /PUR) and ORS for at least 3,000 affected families and the most at-risk people.

- The nine (9) health centres under the control of the Red Cross in affected areas were provided with calcium hypochlorite (HTH) for the preparation of chlorine solutions for various use (disinfection of surfaces which had received vomit, faeces, urine and other biological fluids), hand washing and disinfection of public latrines. The Red Cross volunteers also carried out the disinfection of the compounds of the affected people as well as the compound in the perimeter of 50 metres surrounding the compound of the affected person.

- Provision of 3,000 family kits to the most vulnerable households (soaps, buckets and jerrycans).

- Reproduction of IEC materials with keys messages on cholera management put in place by the Ministry of Public Health for community-based awareness sessions (17 image boxes for door-to-door and focus groups discussions, 1,400 posters posted in public places such as markets, Mosques, Churches, Health Centres and schools, and 3,500 leaflets for the distribution to family members both in French and Hausa dialect).

- Production of 100 hand washing devices which were positioned at the entrance of all the health centres, schools, market places and moto parks and other public places with chlorinated water for hand disinfection. Volunteers are demonstrated hand washing techniques with soap. At least 1,600 people cross the border every day, so NRCS volunteers also set up handwashing devices and disinfections points at the border side. Volunteers were managed these handwashing and disinfection points. People crossing the border were all invited to wash their hands before continuing their journey. All vehicles, moto bikes, and bicycles were disinfected at the disinfection points before crossing the border.

- Water Purification: Some 540,000 Aquatabs were purchased and distributed to 3,000 most at-risk households (180 tabs/HH), which did not have access to potable water, to be used within 3 months. NRCS volunteers also conducted demonstration sessions for the use of Aquatabs and ensured follow-up of residual chlorine at

residential level. Further, volunteers were posted to conduct chlorination of water at each water point to make sure that the water consumed at household level is clean.

- At least 175 volunteers were provided with protection material including masks, protective clothing, boots, hand disinfectant and gloves for their protection during activities.

- A stock of medication was also purchased and distributed to the Integrated Health Centres of the affected areas through the regional Directorate of Public Health in Maradi.

C. DETAILED OPERATIONAL PLAN

Health
People reached: 468,139
Male: 191,936
Female: 276,203

Outcome 1: **Vulnerable people's health and dignity are improved through increased access to appropriate health services.**		
Indicators:	**Target**	**Actual**
% of affected people that have access to appropriate health services	100%	100%
Number of people reached by the NS with services to reduce health risks	21,000	468,139
Health Output 1.1: **Communities are provided by NS with services to identify and reduce health risks**		
Indicators:	**Target**	**Actual**
Number of assessments conducted	3	3
Number of volunteers trained on the ECV / cholera control	400 volunteers and 40 supervisors	407 volunteers and 40 supervisors
Number of community leaders trained on the ECV / cholera control	60	60
Number of IEC material produced	40 image boxes, 1,000 posters, 3,000 leaflets	17 images boxes, 1,400 posters and 3,500 leaflets
Number of visibility material produced and distributed to volunteers and NS staff	200 caps and 200 t-shirts	200 caps and 200 t-shirts
Number of tents procured and distributed to HCs for isolation of affected cases	16 tents	75 tarpaulins and 75 rolls of 100-meters rope
Number of cholera kits procured and distributed to health centres	8 kits	9 kits
Number of volunteers and supervisors trained on the use of ORP and ORS	400 volunteers and 40 supervisors	407 volunteers and 40 supervisors
Number of monitoring missions conducted	21	45
Number of lessons learnt workshops organised	1	1
Health Output 1.2: **Communities are supported by the NS to effectively detect and respond to infectious diseases outbreak**		
Indicators:	**Target**	**Actual**
Number of suspected cases identified and referred to the treatment centres	300	345
Number of community discussion sessions held	96	104
Number of ORS procured and deployed	1,000	1,000
Number of people reached with ORS	200	345
Number of volunteers deployed to high risk areas	400	407
Number of ORPs set up	100	100

Number of ORP management sessions held	1,000	345
Number of people served at ORPs	21,000	15,752
Number of radio broadcasts	180	3,840
Number of awareness sessions conducted	288	312
Health Output 1.3: **Community-based disease prevention and health promotion is provided to the target population**		
Indicators:	**Target**	**Actual**
Number of people reached with community-based awareness sessions	21,000	468,139
Number of information and coordination meetings held	36	136
Number of community monitoring committees set up/enhanced for cholera surveillance	8	89
Percentage of volunteers actively reporting surveillance cases	100%	100%
Case fatality rate (CFR) change	2.4%	2%
Number of suspected cases referred	250	345
Percentage of new cases reported	100%	100%

Narrative description of achievements

Activities implemented had a positive impact in the areas covered by the NRCS. The number of affected cases decreased rapidly in Maradi, Madarounfa and Guidan-Roumdji health districts soon after the Red Cross volunteers started activities in the communities. Despite the efforts, the cholera epidemic rapidly spread in the country reaching other regions such as Tahoua, Zinder and Dosso. According the MoH report of the 1st October 2018, a number of cases were declared in Dan-Issa village in the district of Madarounfa, Madaoua in the Region of Tahoua. The Regional Directorate of Public Health requested Red Cross volunteers to deploy to the above-named areas to carry out community based activities, as these were not being covered by any other humanitarian actor.

1.1.1.: Three (3) assessments were carried out to determine the evolving situation and the spread of cholera in the country. At the end of the operation timeframe, 3,824 affected cases were registered by the MoH with 78 deaths for a lethality rate of 2%. The epidemic has spread from the Madarounfa Health District in the Region of Maradi to 13 others health districts reaching four regions including Maradi, Dosso, Tahoua and Zinder.

1.1.2.: A total of 407 RC volunteers and 40 supervisors were trained on the Epidemic Control for Volunteers Manual focusing on cholera management. In the initial Plan, the NRCS was to train 175 volunteers and 20 supervisors, but after the cholera spread to other regions, the NS organized another batch of training for 175 volunteers and 20 supervisors in the region of Tahoua. An additional 57 volunteers were also trained in the health Centre of Dan Issa. These trained volunteers actively carried out community-based activities including awareness sessions using image boxes, posters and leaflets, handwashing demonstration, disinfection of public latrines in the schools and health facilities, as well as disinfection of the affected people's households properties, distribution of and demonstration of the use of Aquatabs, distribution of WASH related non-food items including soaps, buckets and jerrycans, setting up and management of ORP in the villages situated far away from Health Centres.

1.1.3: A total of 60 community leaders including the traditional healers, religious leaders, traditional rulers and Mayors of the affected areas were identified and trained on the knowledge of the disease, the transmission factors, the prevention measures. They were requested to assist volunteers' activities in delivering awareness messages in the working places (Mosques, churches and within the communities).

1.1.4.: The Niger Red Cross Society was able to produce 17 images boxes, 1,400 posters and 3,500 leaflets to support volunteer activities at community level. The Number of image boxes dropped from 40 to 17 due to the unit price of the production being higher than planned while the unit price to produce posters and leaflets was less than planned, increasing the initial numbers from 1,000 to 1,400 for posters and from 3,000 to 3,500 for leaflets.

1.1.5.: A total of 200 T-shirts and 200 caps were produced with the logo of Niger Red Cross Society and IFRC for volunteer visibility during the implementation of activities.

1.1.6.: A total of 75 tarpaulins and 75 rolls of 100 meters rope were purchased and distributed to the 9 affected Integrated Health Centres (IHC) for the construction of cholera treatment Centres. The change from tents to tarpaulins and ropes was the choice of the Head of the targeted Integrated Health Centres for easy storage at the end of the operation.

1.1.7.: Medical items were purchased from two sources: a small quantity from Europe via Geneva and from ICRC Niger Delegation and handed over to the Regional Directorate of Public Health of Maradi for the distribution to the 9 targets Integrated Health Centres. The list and quantity of the medical items provided is found in annex to this report. When the operation started, the Regional Directorate of Public Health in Maradi assigned the Red Cross to work on 8 Health Centre areas, and the cholera kits were planned for these 08. Later on, the Gouma Health Centre was assigned to the Red Cross as well as some health Centres of Tahoua region and Dan Issa increasing the number of Health Centers to support by the RC. During the distribution, the kits were divided into two parts and shared with the two regional Directorate of Public Health (Tahoua and Maradi) to be distributed to Health Centres where the Niger Red Cross Works.

1.1.8.: At least 175 volunteers and 20 supervisors were trained on ORP management and 100 ORP set up in the villages found far from IHC, this includes: 15 ORP in Tibiti, 10 ORP in Gouma, 35 ORP in Madarounfa, 25 ORP in Angoual Mata and 15 ORP in N'yelwa.

1.1.9.: The RDRT deployed to the field, Niger Red Cross Health Coordinator and the Maradi regional branch conducted monitoring of activities on a daily basis. Given the situation (epidemic outbreak), the NS health Coordinator and the RDRT were obliged to visit volunteer's activity every day to ensure that the message delivered was appropriate. Further, the IFRC Operations Coordinator Delegate visited the operation four (4) times. The IFRC Niger HoCO and the Head of Delegation of Belgian Red Cross in Niger also visited implementation sites. Furthermore, ECHO staff in Niger carried out a monitoring visit to the Red Cross area of intervention. In total, at least 45 monitoring visits were carried out for this operation.

1.1.10.: The lesson learnt workshop was carried out in Maradi at the end of the implementation period. It brought together a sample of volunteers, supervisors, beneficiaries and the implementing partners including Ministry of Health, UNICEF, CISP, BEFEM/ALIMA and MSF (Spain and France). The main outcomes of this workshop are highlighted in the indicated section below.

1.2.1.: Volunteers were trained to recognise and understand cholera symptoms, contamination factors, modes of contamination and universal control measures. The volunteers were later deployed in their respective communities for community-based activities, including community-based surveillance and community-based awareness sessions. Thanks to their capacities being strengthened in this area, volunteers were able to identify 345 suspected cases, which were referred to the nearest Health Centres for confirmation as cholera-related. Volunteers dedicated to this activity played the role of community-based surveillance teams.

1.2.2.: Red Cross volunteers organised focus group discussions on cholera prevention using megaphones and posters at community level. This activity was carried out with women, men and youth groups separately in neighbourhoods of the affected villages and in the main town of Maradi. At the end of the project, 104 discussion sessions had been carried out, which is above the 96 sessions planned.

1.2.3: A total of 1,000 ORS were purchased and deployed to the community to be used in the 100 ORPs set up within the community.

1.2.4.: At the end of the project time frame, a total of 345 ORP management sessions were carried out at the ORPs for volunteers to master the preparation of ORS. They were given to Cholera patients before being referred to the nearest Integrated Health Centres.

1.2.5.: The affected areas allocated by MoH for Red Cross activities were the most at-risk areas. These are the areas from where the epidemic erupted in Niger. Therefore, all the 407 volunteers and 37 supervisors were deployed in the areas most at risk to carry out community-based activities for cholera prevention.

1.2.6.: A total of 100 ORPs were set up in the villages and the neighbourhoods of large towns to provide ORS to the affected people before their referral to the nearest Health Centre.

1.2.7.: A total of 345 ORP management sessions were carried out with community volunteers. The trained volunteers continued to serve the cholera patients and also the people of high-risk areas. To note, there was a mistake in setting in the target for the number of management sessions during planning (1,000 sessions), whereas activity indicated 200 sessions.

1.2.8.: Several people visited the ORPs to enquire about what was happening at these points. The volunteers used this opportunity to brief the population on cholera, its mode of contamination and the contamination factors as well as the universal prevention measures. At the end of the project time frame a total 15,752 people have visited the ORPs.

1.2.9.: Three (3) humanitarian actors responding to the outbreak in Maradi provided funds to support the dissemination of cholera prevention messages through community radios. The Regional Directorate of Public Health therefore decided that all the cholera response actors must disseminate the same and unique message to avoid varied interpretations. Hence, community radios were assigned to the humanitarian organisations to facilitate the dissemination of the message. The Red Cross hired the services of several community radio to disseminate cholera messages in Tahoua, three in Maradi and two in Tessaoua (still in the Maradi region, including three (3) community radio stations of which **RJM radio**, **radio Saraounia** and **radio AMA**. Each radio station broadcast the cholera prevention messages four times a day in four dialects (French, Hausa, Fulani and Tuareg dialect). Further, the Red Cross also hired the services of two community radio stations in Tessaoua including "**Radio TARMMOMOI** and **radio KARKOI** for cholera messages dissemination in the area for one month. The radio broadcast in Tahoua was free of charge while in Maradi and Tessaoua, the Red Cross paid a small amount thanks to the involvement of the Governor of Maradi region. As such the Red Cross only reported the number of radio broadcast in Maradi and Tessaoua which is as follow: the message was broadcasted in 3 community radios, in 4 dialects 4 time a day for 2 months in Maradi: and one month in Tessaoua: 3 x 4 x 4 x 30 x 2 = 2,880 and 2 x 4 x 4 x 30 = 960. General total: 2,880 + 960 =3,840. At the end of the project timeframe, the message was disseminated at least 3,840 times through five community radio stations with the support of the Red Cross.

1.2.10.: A total of 312 awareness sessions were carried out at the end of the project timeframe. The Red Cross volunteers continued to carry out awareness sessions through door-to door and mass media approaches. Cholera prevention messages were also disseminated in religious premises (churches and Mosques). The calculation is as follows: 3 sessions per week x 4weeks x 3 months x 9 IHC =216 This is for the region of Maradi. Further, 3 sessions per week x 4weeks x 2 months x 4 IHC =96. 216 added to 96 gives a total of 312 sessions.

1.3.1.: At least 468,139 people including 276,203 males and 191,936 females were reached by the awareness sessions on cholera prevention in the target areas – this is above the planned 21,000 people. The awareness sessions are conducted through home visits and mass media. This activity covered the two regions including Maradi and Tahoua. Initially, the project area of intervention was just 9 Health Centres of the region of Maradi, and the target population was 21,000 people. However, as the epidemic was gradually spreading to other areas, the MoH of Public Health requested the support of the Red Cross to deploy its volunteers in the areas where there were no humanitarian actors. The Niger RC therefore has deployed volunteers in 3 Health district of Tahoua and in the Health Centre of Dan Issa. The achievement in these health Centres has really increased the number of people reached for awareness sessions.

1.3.2.: The project team attended 136 coordination meetings at national and regional level. At the capital level, two meetings of the Epidemics Management Committee were held every Tuesdays and Thursdays, WASH cluster meetings held twice per month and Health cluster meetings held twice per month. At the regional level, there was an Epidemics Management Committee meeting held on a weekly basis. Furthermore, there was a weekly meeting held at the Madarounfa district hospital. The Red Cross ensured it attended all these meetings. At the Red Cross Movement level, Movement coordination meetings and the Movement Programmes Managers meetings are held once per month and cholera-related issues were also discussed at these meetings.

1.3.3: Initially it was planned to establish 8 community-based cholera surveillance teams in the affected area. However, after the determination of the geographical intervention area of the Red Cross, the field team found that the area covered 89 villages. It was therefore essential to recruit volunteers from the 89 villages. After the training of 407 and 37 supervisors they were deployed to their respective villages (89) to operate as cholera community-based surveillance agents. They were all presented to the nearest Health Centres where they have expected to refer suspect cases. These volunteers worked in good collaboration with the Head of Health Centres. In total, 89 cholera community-based surveillance teams were set up.

1.3.4.: All trained volunteers dedicated to surveillance activities regularly reported any suspected case, thus a total of 345 affected cases were reported by volunteers at the ORPs and referred to the nearest Heath Centres.

1.3.5.: At the beginning of the epidemic, the case fatality rate was 2.4%. According to the MoH's report at the end of the project time frame (11 December 2018), taking into consideration all the affected people and the number of death, the case fatality rate for this cholera epidemic outbreak remained 2%. To date as there is no more cholera affected case in the area, the case fatality rate is zero.

1.3.6.: A total 345 suspect cases were identified by the volunteers and referred to the nearest health Centres.

1.3.7: All the new cases identified were automatically referred to the nearest Integrated Health Centres.

Challenges

1- The first cases of cholera affected people in Maradi were identified on 5 July 2018, the DREF was approved on 13 August and response activities started in September. Unfortunately, this gave time for the outbreak to spread over a large geographical area. It was a real challenge to contain the epidemic in Maradi region. The delays in starting up the response activities was due to the cash disbursement procedures (Preparing the eContract, waiting for all validation processes to complete, before introducing a cash request). This process took quite some time to start up the operation. It is also important to note that when the epidemic erupted in Madarounfa health district, there was an operational call with the DCPRR team in Nairobi, it was therefore agreed to monitor the situation first, since some partners were already providing support to the MoH in addressing the situation. Finally, the EPoA was submitted after the situation escalated.
2- The DREF operation is a short-term operation and the IFRC eContract approval process delayed the start of implementation of activities.
3- During implementation of this DREF operation, it was a major challenge to purchase medical items from abroad because of the short timeframe. This was solved with the assistance of ICRC from which we were able to purchase medical items.

Lessons Learned

1. When community-based disease surveillance works well, cholera and other epidemic diseases are identified at an early stage and the disease is easily controlled. It is thus important to strengthen the capacity of community-based disease surveillance agents especially at border level;
2. In the case of cholera epidemic, it is important to carry out response activities as early as the first case is identified as this enables the community to adopt better hygiene practices in order to limit the spread of the disease.
3. Hand washing is a key activity to avoid contamination from cholera as well as several other diseases.
4. Since IFRC procedures recommend that for Medical items, the procurement is only done by Geneva, it is important to start the process earlier, right at the launching of the DREF operation in order to be able to receive the items in a reasonable time.

Water, sanitation and hygiene
People reached: 25,610
Male: 10,500
Female: 15,110

WASH Outcome 1: **Vulnerable people have increased access to appropriate and sustainable water, sanitation and hygiene services**

Indicators:	Target	Actual
Percentage of reduction of cholera cases in the target areas	100%	100%
Output 1.1: **Communities are provided by NS with improved access to safe water**		
Indicators:	**Target**	**Actual**
Number of people who have access to potable water	21,000	31,500
Number of people reached with water purification tablets	21,000	31,500
Number of people reached with chlorine solutions	21,000	25,610
Number of latrines treated/disinfected	24	52
Number of key hands washing moments demonstration sessions conducted	3,000	25,610
Number of safe water treatment use demonstration sessions held	3,000	4,500
Number of handwashing devices setup	100	100
Quantity of WASH related NFIs procured and distributed (Target: Soap: 15,100, bucket with lids: 3,000, Jerrycan: 6,000, Backpack sprayer: 40)	Soap: 15,100 Bucket with lids: 3,000 Jerrycans: 6,000 Backpack sprayers: 40	Soap: 21,460 Bucket with lids: 4,060 Jerrycans: 2,600 Backpack sprayers:40
Number of people reached with the distribution of WASH related NFIs (soaps, buckets with lids, jerrycan)	21,000	18,998

Narrative description of achievements

1.1.1: After the distribution and demonstration of the use of Aquatabs, at least 31,500 people received water purification tablets and they have access to potable water.

1.1.2.: At least 540,000 Aquatabs for water purification were purchased and distributed to the most vulnerable people in the affected region. The distribution of the water purification tablets reached 31,500 people almost 4,500 households for two months. The distribution rate is 120 Aquatabs per households, advised by the Niger WASH cluster. UNICEF distributed Aquatabs to compensate the gap (1 month).

1.1.3.: The calcium hypochlorite (HTH) tins were distributed to the 9 Integrated Health Centre and the 4 tins were used by the Red Cross volunteers for chlorinated water in the handwashing devices and for disinfection of public strategic latrines, motorbikes and vehicles at the border level. The hand washing demonstration reached 25,610 people while the motorbike and vehicle disinfection reached 3,445 people at the border level.

1.1.4.: As of the 11 December 2018 (end of the operation), a total of 52 publics latrines had been disinfected in the implementation area. The 52 latrines are found in the schools and health facilities of the following villages: Madarounfa :18 latrines, N'yelwa: 20 latrines, Anguoual Mata: 8 latrines and Tibiri: 6 latrines for a total of 52. However, the Red Cross volunteers also disinfected the compound and belongings of the affected people as well as the households surrounding them within a perimeter of 50 metres. A total of 345 compounds were disinfected during this operation.

1.1.5.: Niger Red Cross volunteers recorded at least 25,610 handwashing demonstration sessions carried out by the target population. The achievement for this activity is exceptionally high due to NS setting up 100 hand washing devices at strategic places including motor parks, at the entrance of schools, Health Centers, at the markets places and at the border between Nigeria and Niger. There were two hand washing devices installed at the border, where at least 800 people cross the border daily. At the end of the operation, a total of 25,610 people was received at these hand washing stations.

1.1.6: At least 540,000 water purification tablets were purchased and distributed to 4,500 most vulnerable households (31,500 people).

1.1.7.: At least 100 handwashing devices were produced and installed in the strategic popular places such as the schools, the entrance of Integrated Health Centres, at the motor park and at the border side between Niger and Nigeria.

1.1.8.: At least 21,460 pieces of soap, 4,060 buckets with lids, 2,600 Jerrycans were purchased and distributed to the most vulnerable and the affected households. The 40 backpack sprayers purchased were used by volunteers for latrines and household disinfection. At the end of the operation, the sprayers were returned to NRCS warehouse for future use. The NS was able to purchase more pieces of soap and bucket because the unit price was well negotiated. It was low compare to the planned amount in the budget. However, the unit price for the jerrycan was higher that the planned amount. The NS used the jerrycan remaining from the last Niger flood DREF operation to compensate the gap.

1.1.9.: Some 21,460 pieces of soap were purchased and 18,998 pieces were distributed to 2,714 households. 152 pieces of soap were used for handwashing demonstration sessions before the RC started using HTH. Some 2,310 pieces of soap are now stored in the NS warehouse. Note that each household received 7 pieces of soap because the number of people per household in Niger is 7 as Niger is the country with the highest fertility rate in the world.

Challenges

1. The rural people have difficulty in consuming water with Aquatabs because of the taste. Thanks to the Niger Red Cross volunteers, after conducting sensitization sessions, the rural communities have understood the importance of using Aquatabs and they are now requesting more-- The RC donation covered two months consumption and UNICEF donation covered the gap for a month.

2. During implementation of activities, the RC volunteers have realised that most the rural population consume river water and stagnant water. Further, open air defaecation is a common practice for most of the population. The population in this area of the country ignore the risk related to the consumption of unclean water.

Lessons Learned

1. The consumption of poor-quality water and the practice of open-air defecation leads to the spread of several disease such as cholera, Hepatitis E and other diarrheal diseases. In order to get rid of the risk of having cholera in the region,

there is a need to continue sensitization of the community on the risks related to the consumption of non-potable water as well as the usage of inadequate sanitation. Furthermore, the Government and its partners need to invest more in construction of public water points to improve access to potable water. Furthermore, educate the population for the construction of family and public latrines to reduce open air defecations.

2. After having visited several households in the region of Maradi, the Red Cross volunteers noticed that the population were living with animals including small ruminants (goats, sheep) and poultry in the same compound, which may pose sanitary risks. The Niger Red Cross has therefore organised a competition of environmental cleaning which provide prizes to the neighbourhoods where all the compounds are well cleaned. This activity was appreciated by the council, the administrative authorities and the population. Its helps to live in a good environment.

D. THE BUDGET

The overall budget for this operation was CHF 350,270, of which CHF 332,004 (94.24%) were spent. The balance of CHF 20,266 will be returned to the DREF pot.

Explanation of variances on the budget expenditures:

1. **Transport and vehicles costs: CHF -1,265**
   This budget line was allocated for hiring of vehicle on leasing and for the transportation of non-foods items. As the project was extended for one month, the amount allocated for was not enough to cover the extra month. Further, as most of the non-food items distributed in this operation was purchased in neighbouring Nigeria, the transportation costs of the NFI was higher than the amount planned in the approved budget. This is the reason for the deficit on this budget line.

2. **Logistic services: CHF -1,000**
   This budget line was not indicated in the approved budget, however, with regard of the medical items purchased in the Netherlands and shipped by air, the Niger country office has to paid for the logistic services. This explains the deficit of CHF – 1,000.

3. **National staff: CHF -2,254**
   The negative variance on under this budget line is due to the wrong usage of the nominal account. Account for National staff has been used for Volunteers Incentives instead.

4. **Workshops & Training: CHF – 12,103**
   This expenditure increased because it was initially planned to train 175 volunteers. After the epidemic spread to other regions of the country, the Red Cross organised a second batch of training for 232 new volunteers to deploy in the newly affected areas. This caused the deficit on the budget line allocated for training.

5. **Travel: CHF -7,375**
   This budget line was provided for the transportation of the RDRT from his home country to Niger and back home. At the beginning of this operation, an RDRT was selected from Guinea Red Cross to support the Niger Red Cross in the implementation of the DREF activities. His flight ticket was purchased and send to him by the HR of the Sahel CCST in Dakar. The day of the journey, he didn't show up at the airport and the ticket was considered as used for no show penalties. Later in the day, he sent an email informing that he denied the deployment because of family issues. The HR had to select another RDRT and purchased a new flight ticket. Further, some of the RDRT accommodation costs were wrongly loaded under travel. This justify the deficit.

6. **Information & public relations: CHF-6,338**
   This budget line increased because the NS produced more data collection tools and the training material for the two batches of volunteers trained was loaded to cover the needs in the new affected areas. Also, this budget line supported the expenses to produce IEC materials which were of high importance for awareness sessions in cholera affected areas.

7. **Other general expenses: CHF-6,502**
   This budget line was not provided in the approved budget. However, during the operation implementation, it appears that there were several expenses that were not indicated in the budget. They were all loaded in the line creating a deficit.

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2018/08-2019/03	Operation	MDRNE022
Budget Timeframe	2018/08-2018/12	Budget	APPROVED

Prepared on 25/Apr/2019

All figures are in Swiss Francs (CHF)

MDRNE022 - Niger - Cholera Outbreak

Operating Timeframe: 11 Aug 2018 to 11 Dec 2018

I. Summary

Opening Balance	**0**
Funds & Other Income	**352,270**
DREF Allocations	352,270
Expenditure	**-332,004**
Closing Balance	**20,266**

II. Expenditure by area of focus / strategies for implementation

Description	Budget	Expenditure	Variance
AOF1 - Disaster risk reduction			**0**
AOF2 - Shelter			**0**
AOF3 - Livelihoods and basic needs			**0**
AOF4 - Health	157,200	104,340	**52,860**
AOF5 - Water, sanitation and hygiene	135,377	5,079	**130,298**
AOF6 - Protection, Gender & Inclusion			**0**
AOF7 - Migration			**0**
Area of focus Total	**292,577**	**109,418**	**183,159**
SFI1 - Strenghten National Societies	25,294	52,096	**-26,802**
SFI2 - Effective international disaster management	34,400	170,490	**-136,090**
SFI3 - Influence others as leading strategic partners			**0**
SFI4 - Ensure a strong IFRC			**0**
Strategy for implementation Total	**59,693**	**222,586**	**-162,892**
Grand Total	**352,270**	**332,004**	**20,266**

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2018/08-2019/03	Operation	MDRNE022
Budget Timeframe	2018/08-2018/12	Budget	APPROVED

Prepared on 25/Apr/2019

All figures are in Swiss Francs (CHF)

MDRNE022 - Niger - Cholera Outbreak

Operating Timeframe: 11 Aug 2018 to 11 Dec 2018

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	**110,398**	**72,779**	**37,618**
Shelter - Transitional	4,960	4,888	72
Water, Sanitation & Hygiene	63,265	56,359	6,906
Medical & First Aid	25,833	11,533	14,301
Teaching Materials	14,673		14,673
Other Supplies & Services	1,667		1,667
Logistics, Transport & Storage	**26,300**	**25,443**	**857**
Distribution & Monitoring	19,300	16,178	3,122
Transport & Vehicles Costs	7,000	8,265	-1,265
Logistics Services		1,000	-1,000
Personnel	**153,021**	**144,230**	**8,791**
International Staff	12,000	10,787	1,213
National Staff		2,254	-2,254
National Society Staff	6,000	3,827	2,173
Volunteers	135,021	127,363	7,658
Workshops & Training	**18,131**	**30,234**	**-12,103**
Workshops & Training	18,131	30,234	-12,103
General Expenditure	**22,920**	**39,054**	**-16,133**
Travel	3,000	10,375	-7,375
Information & Public Relations	6,020	12,358	-6,338
Office Costs	4,150	4,110	40
Communications	7,000	6,949	51
Financial Charges	2,750	-1,240	3,990
Other General Expenses		6,502	-6,502
Indirect Costs	**21,500**	**20,263**	**1,237**
Programme & Services Support Recover	21,500	20,263	1,237
Grand Total	**352,270**	**332,004**	**20,266**

Contact information

Reference documents

Click here for:

- Emergency Plan of Action (EPoA)
- Operation Update

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How we work

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

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

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of non-violence and peace

Annex 1:

MESSAGES CLEFS CHOLERA
(Validés le 22 septembre 2018 lors de la réunion des partenaires à la DRSP de Maradi)

Une épidémie de choléra est dans la région de Maradi depuis quelques mois. Nous sommes tous à risque de contracter cette maladie qui peut être mortelle.

Le choléra est une maladie qui s'attrape à travers l'eau contaminée, les aliments contaminés, les selles et les vomissements des malades, les mains sales, les dépouilles des malades décédés et tous les objets autour du malade comme nattes, bouilloires, gobelet, tasses, pots, habits et bien d'autres objets.

Une personne qui a le cholera fait la diarrhée et les vomissements ;

Pour se protéger contre le choléra, nous devons prendre les précautions suivantes :

1. Se laver correctement les mains à l'eau et au savon :
   - Avant de préparer les aliments,
   - Avant de manger,
   - Avant de donner à manger aux enfants,
   - Et après avoir été aux toilettes ;
   - Après tout contact contaminant (salutations, manipulation des objets et malades du choléra)

2. Couper régulièrement les ongles ;

3. Utiliser les sources d'eau propre telle que les robinets ou les puits protégés ;

4. Ne pas utiliser l'eau du lac, des mares, et des rivières ou toute eau stagnante après la pluie ;

5. Utiliser les produits chlorés, (PURE ou de l'Aquatab) pour désinfecter l'eau de boisson et d'usage domestique ;

6. Bien cuire les aliments ou les réchauffer, et les consommer pendant qu'ils sont encore chauds ;

7. Réduire au maximum de se serrer les mains pendant les salutations ;

8. Laver soigneusement à l'eau propre les aliments crus (fruits, tubercules, légumes etc.), avant de les consommer ;

9. Les selles et les vomissures des malades atteints du choléra sont les principales sources de contamination. Pour celà:

   - Eviter la défécation à l'air libre ;
   - Utiliser des latrines à domicile ou en voyage ;
   - Protéger les aliments contre les mouches.

10. En cas de diarrhée abondante et vomissements, informer rapidement le centre de santé le plus proche car plus le malade est vu tôt plus ses chances de survie sont grandes.

11. Le choléra n'est pas une malédiction ou une fatalité, c'est une maladie dont on peut éviter, on peut guérir, ne rejeter pas les malades, ne les cachez pas, amener les plutôt dans un centre de traitement.

12. Des équipes de désinfection passeront dans les concessions pour traiter tous les objets ayant été en contact avec les malades, accueillez-les pour leur faciliter le travail dans l'intérêt de la famille et de la communauté ;

13. Les personnes décédées du choléra demeurent encore très contagieuses, Ne manipulez pas les dépouilles. Informez plutôt les centres de santé.

14. Tout malade guéri du choléra n'est plus dangereux et ne transmet pas le choléra.

Ceci est un message de la Direction Régionale de la Santé Publique de Maradi avec l'appui de ses partenaires.

ANNEX II

ICRC

DISTRIBUTION PACKING LIST

Date	Warehouse	Shipper	Ctry	Site	Year	PackNo.
17/12/18	NIA	CICR Niamey	NE	1NIA400	2018	32738

Destination :

Fédération International, Bureau Niamey
Bureau FICR |655, Rue NB45 | Quarti
Niamey-Bas Terminus | Commune II
11386 Niamey
Niger

Accounting Data

COST CENTER :
OBJ. CODE :
AoE number :

Date and Signature of Receiver :

Date°: Signature°:

Item	Description / Storage Temperature	UoM	Qty	Unit Price	Batch/Serial No	Expiry Date	PO Number / Manufacturer	Country of Origin
			Order n° : 18089954					
DASDCHLC5S1	CHLORHEXIDINE DIGLUCONATE 5%, solution, 1L, btl. . *0 Storage +15 to +25 C	EA	200		18013B012 201808221510	31/05/21	SIR00IN/GVA18/006989	IN
			Order n° : 18089954					
DORACIPR5T	CIPROFLOXACINE HYDROCHLORIDE,500 mg, tab. . *0 Storage +15 to +25 C	EA	4000		75038 201811280530	31/12/22	REM00CY/GVA17/017181 REMEDICA	CY
			Order n° : 18089954					
DORADOXY1T	DOXYCYCLINE, 100 mg, tab. . *0 Storage +15 to +25 C	EA	1000		75491 201811280537	28/02/23	REM00CY/GVA18/002952 REMEDICA	CY
			Order n° : 18089954					
DORADOXY1T	DOXYCYCLINE, 100 mg, tab. . *0 Storage +15 to +25 C	EA	9000		75491 201811280538	28/02/23	REM00CY/GVA18/004627 REMEDICA	CY
			Order n° : 18089954					