

# Emergency appeal final report

## Haiti and Dominican Republic: Cholera outbreak – response and preparedness

### Final report

Emergency appeal n° MDR49007

GLIDE n° [EP-2010-000210-HT](#)

24 August 2012

**Period covered by this Final Report:** 27 October 2010 to 28 February 2012.

**Appeal target:** 13,371,804 Swiss francs (CHF), including the Emergency Response Units cost of CHF 1,885,000 not part of the IFRC budget.

**Appeal coverage:** 96%; [<click here to go directly to the final financial report, or here to view the contact details>](#)

#### Appeal history:

- [Disaster Relief Emergency Fund \(DREF\)](#): CHF 78,853 Swiss francs were allocated on 27 October 2010 for preparedness activities in the Dominican Republic related to the cholera outbreak in Haiti.
- A [Preliminary Appeal](#) was launched on 3 November 2010 for CHF 5,946,897 to support the Haitian Red Cross and the Dominican Red Cross to assist 345,000 beneficiaries.
- An [Emergency Appeal](#) was launched on 23 December 2010 for CHF 13,741,932 - including Emergency Response Units (ERUs) – to assist 500,000 people in Haiti for up to a year and 150,000 people in the Dominican Republic for up to 6 months.
- A [Revised Appeal](#) was issued on 18 July 2011, with a revised budget of CHF 13,371,804 (including ERUs) and extending the operation timeframe until February 2012 to assist 500,000 people in Haiti and 150,000 people in the Dominican Republic.



**A young girl, among other patients, receiving her treatment against cholera (Ringer lactate solution via canulas) in a Cholera Treatment Centre managed by the Red Cross.  
Julien Goldstein /IFRC**

**Summary:** After the devastating earthquake in January 2010, the population of **Haiti** was once more affected at the end of 2010 by a cholera outbreak. The battered medical facilities, sanitary authorities as well as the international community were not prepared to face a second crisis of this size in the aftermath of the earthquake and in a country affected by political turmoil.

The secretariat of the International Federation of Red Cross and Red Crescent Societies (IFRC) —which was already supporting the population affected by the earthquake<sup>1</sup>— rapidly started to respond to the cholera epidemic in support of the Haitian Red Cross (HRC), jointly with 16 Partner National Societies (PNS) and the International Committee of the Red Cross (ICRC). The Federation provided coordination amongst the International Red Cross and Red Crescent Movement components in-country in addition to technical support with activities. Based upon the Haitian Red Cross' Cholera Response Plan of Action, four main areas

<sup>1</sup> This support was ongoing through the Emergency Appeal launched on 13 February 2010 (MDRHT008) and the IFRC team based in Haiti.

of response and objectives were defined in December 2010 focusing on four groups of activities:

- I) water supply;
- II) sanitation;
- III) preventive health and hygiene promotion; and
- IV) curative health facilities.

At the same time in the **Dominican Republic** severe diarrheic outbreaks started to affect the population in the border provinces and in main urban centres. With the aim of supporting the Dominican Red Cross (DRC) response and ensuring a more comprehensive response to cholera within La Hispaniola Island, the IFRC-supported cholera operation encompassed a response in both countries.

Since the beginning of the operation, the Red Cross partners mobilized all the resources available to address the emergency. In order to support the Haitian Red Cross in treating the growing population of affected Haitians. Three Basic Health Care Emergency Response Units —Canadian Red Cross, Japanese Red Cross Society and Norwegian Red Cross— were quickly deployed. The PNS, the ICRC and the IFRC in support to the HRC reached the most affected and vulnerable with water distributions, cholera prevention and control activities: managing cholera treatment centres, cholera treatment units, maintaining oral rehydration points and organizing hygiene promotion activities.

The National Societies supported by the IFRC, but more specifically the Movement, met the targets established —and in many parts exceeded them— as per the planned outcomes set up by the initial and revised appeals.

- In the **Dominican Republic**, water purification plants were prepositioned in key areas of the country and 17,700 families received chlorine for purifying water and sensitization on its use.
- With support of the Appeal and Spanish Red Cross funds, the Dominican Red Cross conducted disinfection spraying in 2,634 places and 125 volunteers were trained as part of the disinfection brigades.
- In the Dominican Republic, 72,247 persons were reached with messages approved by the Ministry of Health in both Spanish and Creole about cholera prevention and hygiene promotion. (See article published on the Federation web site).
- In **Haiti**, curative services were in place and maintained to treat the patients affected by the epidemic. More than 250,000 individuals received oral rehydration solution in the framework of hygiene promotion activities. The Haitian Red Cross volunteers and staff were trained on disinfection, hygiene good behaviours, cholera medical management of patients. A long-term strategy to tackle the epidemics was launched through the training of HRC volunteers and community facilitators on Community-Based Health & First Aid and on Epidemiologic Control to ensure a strong network is in place to cascade the trainings in the communities. The IFRC, PNS and HRC worked together to preposition stocks in the regions to facilitate the deployment of the HRC regional branches in case of new outbreak.
- More than 1,157,423 hygiene promotion activities in houses, schools, medical facilities or internally displaced persons' (IDP) camps were organized throughout Haiti, which was completed by distribution of non-food items to at least 1,830,173 people. Informational posters and flyers were also distributed in public places.
- Volunteers from **both National Societies** were trained on psychosocial support in order to address stigma and fears related to cholera among the population.
- The Dominican and Haitian Red Cross Societies also reached a large section of the population at risk with cholera prevention and hygiene promotion messages through the use of technologies in particular SMS messages via cell phones, sound trucks and the use of social media outlets.
- Both National Societies have included contingency measures, in particular the prepositioning of stock (items most needed in case of an immediate response to cholera), with the aim to have installed capacity to rapidly respond to new outbreaks.

Despite the efforts involved in the cholera response in both countries, the threat of major outbreaks is still present as the rainy season and hurricane season take place between June and November 2012. In Haiti, many PNS have reduced the scale of their cholera response due to reduced resources (same for the IFRC and many other humanitarian actors working in Haiti) and the facilities and capacities of the Ministry of Health are still limited. The IFRC published an advocacy report in June 2012 with the aim to raise public awareness, as well as to bring the attention of the international humanitarian community and above all, the governments, on the potential risks incurred by the population if preventive measures are not taken.

**Lessons learned:** An evaluation of the Cholera operation was carried out in February 2012 and highlighted key recommendations. In addition, the operation teams in both countries have identified some lessons learned for future operations. Below some of the lessons learned identified:

- More clearly defined linkages with other programmatic areas such as health and water & sanitation would have better facilitated the **programmatic integration of activities at community level**.
- An **earlier development of planning tools** (logical frameworks, Plan of Action, contingency plan) would have enabled better monitoring of progress against outputs and outcomes as well as of the impact of the activities implemented.
- The Red Cross actors demonstrated a great motivation to participate in the response against the cholera epidemics and tried its best to alleviate the pain of the population while providing support to the health and sanitary authorities and infrastructures (both at national and decentralized level) to reinforce their capacities. The Movement responded united to the crisis taking into account the urgency to deploy a response to the massive outbreak. Despite the coordination mechanisms put in place, some difficulties arose, which highlighted the **need to improve data collection processes and monitoring** of the activities. Even though, after the revision of the Appeal in July 2011, mechanisms were put in place, it is key to have a common understanding in the data collection approach in order to be able to see the impact of the Red Cross in the crisis. In these sense, the different methodologies used at different stages of the operation and by each partner limited data analysis which led to several approximations in relation to the overall result really achieved by the Movement. The evaluation of the cholera response organized in February 2012 highlighted those gaps while underlining the progress and several achievements.
- In Dominican Republic, the main lesson learned was **the need of flexibility to enable response efforts outside of initially prioritized target areas**. While correct planning allowed the operation to provide support to the population living in most affected areas, the nature of the disease called for a nation-wide strategy as outbreaks happened around the country and control measures required immediate action. In response to local authorities, the rapid action of Dominican Red Cross supported 1,498 people and their families living in areas non-prioritized by the Revised Appeal, thus contributing to reduce the possibility of the disease to further spread.
- The second lesson learned by the DRC is that **permanent coordination with government authorities** enables all humanitarian actors to share the same messages and response strategies. While immediate attention is being provided to vulnerable population, efforts should also be made to increase cooperation with the government and agencies, for the validation of messages and methodologies. Coordination with Movement components can make the difference in delivering a more comprehensive and extended support to the population.
- Furthermore, an **increased coordination between the Dominican and Haitian Red Cross Societies** could lead to extend the impact of actions through utilization of both recourses and technical expertise available in both countries. The problem of epidemic diseases in an island require for the whole island territory to be covered.
- Another lesson learned is linked with the exit strategy, which entails **National Society capacity building**. The IFRC support through the RIT system and the Americas zone emergency health coordinator allowed the revision of the DRC's procedures and favoured the integration of a cross-cutting health approach in the National Society procedures. This and the network of volunteers trained with standards agreed with the Ministry of Health and other humanitarian institutions, built an increased overall capacity in the Dominican Red Cross to deal with future complex emergencies.
- **Prepositioning of preparedness and response stock** and the establishment of a delivery plan, counting with updated inventories, is also important in both countries in order to respond to the needs of the population in a timely way.

**Financial situation:** This Emergency Appeal received a total income of CHF 11,058,680 covering 96 per cent of the appeal target. Overall expenditure at the close of the operation timeframe was CHF 10,184,007 of funds received (92 per cent), with a closing balance of CHF 874,673. The IFRC seeks approval from its donors to allocate 90 per cent of the remaining funds for emergency health activities within the health programme of the Haiti Earthquake operation (MDRHT008) and 10 per cent to support to the disaster risk management programme in the Caribbean (MAA49001). **Partners/Donors who have any questions in regards to this balance are kindly requested to contact the Americas zone office within 30 days of publication of this final report. Past this date the reallocation will be processed as indicated.**

The IFRC on behalf of the Dominican and Haitian Red Cross Societies is thankful to the Partners National Society, governments and institutional donors and entities for their financial support.

[<Click here to view the final financial report or here to view contact details>](#)

## The situation

The earthquake that struck Haiti on 12 January 2010 devastated a third of the country's population. Hundreds of thousands of people lost their homes and took refuge in camps or settlements in very poor living conditions. It is in this precarious context that the country was stricken a second time by a cholera outbreak, which was officially confirmed on 21 October 2010 by the Haitian authorities<sup>2</sup>. The first case was declared in the Artibonite region, located in the centre of the country. Although this area was not directly affected by the 12 January earthquake, it had become home to thousands of vulnerable persons displaced by the earthquake. The epidemic quickly spread to the Centre, Nord, Nord-Ouest, Ouest and Sud departments and then to rest of the country. The speed of transmission was attributed to multiple factors namely an absence of local immunity to the particular strain of the *Vibrio Cholerea*, poor social and economic environments, precarious living conditions, insufficient water supply, poor sanitation and hygiene practices as well as high population density areas in camps which were home to most of the 1.3 million internally displaced persons.

The epidemic placed immense pressure on the already-stretched health system to treat a growing number of cholera patients in addition to the usual caseloads. Within days, hundreds persons had been hospitalized and by 1 November 2010, the Haitian Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population* - MSPP) had reported 4,764 cases and 337 deaths countrywide. On 5 November 2010, in the midst of the cholera outbreak, the Hurricane Tomas brought heavy rains to Haiti's south-western departments. The floods caused by the hurricane aggravated the escalation of the epidemic in the ten departments of Haiti: Artibonite, Centre, Grand Anse, Nord, Nord-Ouest, Ouest, Nord-Est, Nippes, Sud-Est and Sud. The national medical structures were overwhelmed and the cholera epidemic escalated into a disaster.

As shown in the Figure 1 below, a massive wave of cholera, bigger than ever seen before in any country<sup>3</sup>, continued for the first three months of the outbreak. Thus, first three months of the epidemic accounted for 43 per cent of all cholera cases and 60 per cent of all cholera deaths reported during the first year of the epidemic in Haiti. During this period, the case fatality rate (the CFR<sup>4</sup> is shown on the right axis of the figure) was also at his highest point. Over January 2011, the number cases declined from epidemic levels and cholera was termed as endemic by June 2011. When the second rainy season began in May and June, there was a slight increase in the number of cases.

The end of 2011 saw a reduction in the number of new cholera cases as the rainy season was reaching its end. According to OCHA situation report issued on 22 March 2012 (figures up to 1 March 2012), the global lethality rates had decreased or stabilized in the ten departments of the country. The national lethality rate was at its lowest level since the beginning of the epidemics, i.e. 1.3 percent compared to 2.4 percent in November 2010. From November 2010 to 1 March 2012, 530,953 cases of cholera were recorded by the MSPP, bringing the number of deaths related to cholera to 7,040 countrywide. The number of cases reported throughout Haiti during the first 12 months was roughly equal to 4 per cent of the national population. This was the highest cholera incidence ever documented anywhere in the world<sup>5</sup>.

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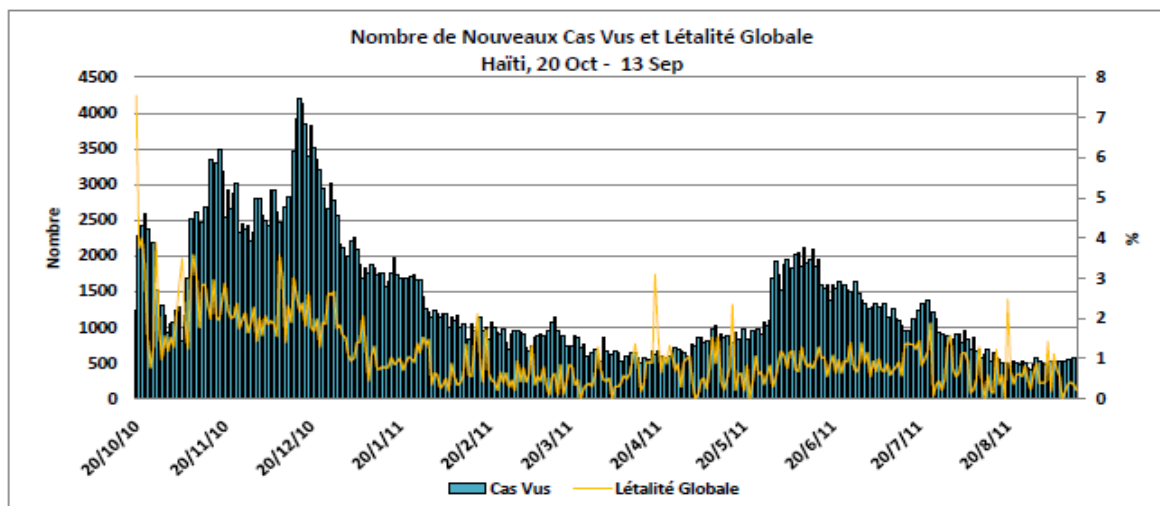
<sup>2</sup> OCHA, Haiti. Cholera. Situation Report #1, 22 October 2010.

<sup>3</sup> To put this wave into perspective, the number of cholera cases reported in Haiti during the first 3 months of the epidemic (206,713), was 160 per cent of the total number of cases reported in Zimbabwe (128,208) during the entire 2 years of the outbreaks in this country.

<sup>4</sup> Case fatality rate (CFR) expresses deaths from cholera as a percentage of all reported cases of cholera. This is the most important indicator of the outcome of cholera treatment efforts. A high CFR indicates either late care seeking or inadequate case management or both.

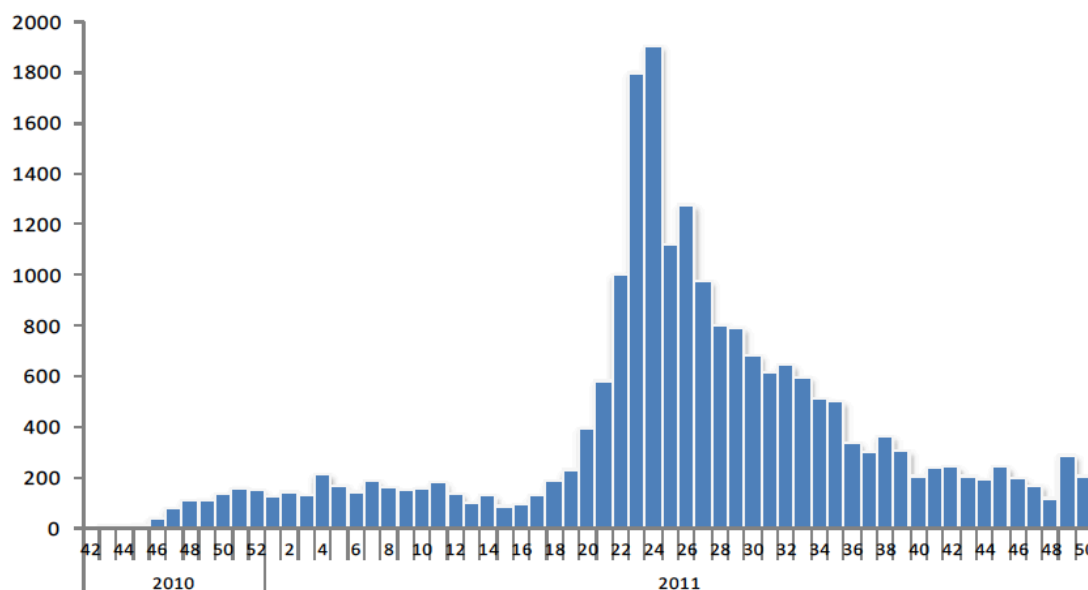
<sup>5</sup> Again, to put this into perspective, the incidence in Haiti during the first 12 months was 8 times the annual incidence seen during the cholera outbreaks of Zimbabwe in 2008 and 2009. "Final evaluation of the IFRC emergency cholera response in la Hispanola Island", Bob Pond & Yannick Brand, February 2012.

Figure 1. Number of new cases and global lethality from October 2010 to August 2011 in Haiti



In the Dominican Republic, the development of the disease and fatality rate was steady with a sharp increase in the number of suspected cases around the epidemiological week 24 coinciding with the hurricane and rainy seasons in the country.

Figure 2. Number of suspected cholera cases for epidemiological week from October 2010 to December 2011 in the Dominican Republic



Sensitization actions carried out in border areas seem to have contributed to preventing the spread of the disease as the reported number of cases in the border remained low. Dominican Red Cross also carried out activities in the most populated areas as it was expected for them to develop the bigger number of cases. In addition to this, the Dominican Red Cross response efforts provided support to non-previously prioritized areas as outbreaks of the disease developed in December 2011, when the Ministry of Health declared an outbreak of 351 cases and one death person.

Figures provided by health authorities for the epidemiological week no. 8 for 2012 showed 22,231 reported cases and a death toll of 384 deaths, out of which 162 are confirmed deaths due to cholera. After the early emergency in 2010, the most affected areas are the Elias Piña border province and the heavily populated areas, being the province of Santo Domingo the most affected. As the overall basic water and sanitation conditions remain the same in the country, is expected that the disease will present similar behaviour during

2012<sup>6</sup>.

## Coordination and partnerships

From the onset of the outbreak, the International Red Cross and Red Crescent Movement mobilized all available resources to address the emergency. The IFRC and the Red Cross Societies present in **Haiti** worked in close collaboration with the Haitian Red Cross as well as with the Ministry of Public Health and Population to support response efforts. The Haitian Red Cross jointly with the IFRC, ICRC and PNS in the country centred their efforts towards the most affected and vulnerable people.

The IFRC focused its intervention in coordinating the activities of the different Movement components involved and providing them with support in terms of water & sanitation, health, logistics and communications and technical advice and guidance. The cholera response demanded a Movement-wide approach which at its height involved 16 PNS<sup>7</sup>, the ICRC and the IFRC alongside the Haitian Red Cross. Given the scale of the response, an IFRC cholera coordination team was established in November 2010 to facilitate the coordination of Movement components. The team comprised delegates with expertise in health, water, sanitation & hygiene promotion, programme management, logistics, finance and reporting. To improve and maintain a regular communication and coordination amongst all these actors, bi-weekly cholera operation meetings were held at the base camp of the Haitian Red Cross.

In addition to the joint Movement meetings, the IFRC actively participated in relevant Clusters and government coordination meetings (i.e. water, sanitation and hygiene cluster, health cluster, logistics cluster) as well as sub-clusters and inter-clusters forum on a weekly basis. In addition, the IFRC and the Red Cross National Societies present in Haiti worked in close collaboration with the MSPP, the Directorate of Civil Protection (DPC) and the World Health Organization (WHO). The IFRC is also part of the Humanitarian Country Team led by the United Nations which enabled it to be part of the humanitarian decision-making mechanism of the country.

**Dominican Republic:** the Dominican Red Cross coordinated with the national disaster management system, promoting the Information, Education and Communication (IEC) strategy and messages agreed with the ministries of Health and Education at the local and national level. It also coordinated activities with the Humanitarian Working Group in the country which includes the United Nations Children's Fund (UNICEF), the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the United National Development Programme (UNDP), the Spanish Agency for International Development Cooperation (AECID) and the European Commission' Office for Humanitarian Aid and Civil Protection (DG ECHO). In addition to the support provided through this operation, the Dominican Red Cross also received technical and financial assistance from Partner National Societies in-country to conduct awareness-raising, training and prevention activities as well as to increase the capacities of the National Society.

## Red Cross and Red Crescent action

### Achievements against outcomes

To understand the extent of the Red Cross cholera response in Haiti, it is important to underline that, the IFRC both responded to the epidemics by mobilizing its resources for direct implementation of activities on the ground, by coordinating PNS in their cholera response activities and by supporting the response of the Haitian Red Cross. As such, it is necessary to view the progress made in achieving outputs also in lights of the PNS activities as the vast majority received logistical and technical support from the IFRC.

In response to the cholera outbreak that was confirmed in October 2010, IFRC launched an Emergency Appeal to respond to the crisis. Based upon and bolstering the actions of the Haitian Red Cross' Cholera Response Plan of Action, this Appeal was dedicated to support the affected and vulnerable population through a comprehensive strategy of four key group activities: I) water supply; II) sanitation; III) preventive health and hygiene promotion; and IV) curative health facilities.

In Haiti, as IFRC technical teams in the field already involved with the earthquake operation (MDRHT008) and cholera response operation (MDR49007) were running in parallel with technical departments supporting both

<sup>6</sup> [http://salud.gob.do/download/docs/Boletin/Boletin\\_Semanal\\_50-2011.pdf](http://salud.gob.do/download/docs/Boletin/Boletin_Semanal_50-2011.pdf) The picture shows number of suspected cholera cases for epidemiological week from October 2010 to December 2011.

<sup>7</sup> See in **Annex 1** of this report the map localizing the PNS presence in Haiti since the beginning of the outbreak.

operations. Together these Appeals worked to support the essential needs of the Haitian population that has endured two disasters in 2010. The Appeals also sought to deliver material, logistical and technical support to the Haitian Red Cross in furtherance of its auxiliary role to the Haitian government.

As the majority of the initial planned outputs were achieved over the [six-month period](#) for Haiti, new objectives for the remainder of the programme were identified in Haiti focusing on responding to the outbreaks and needs of the patients while strengthening the capacities of the Ministry of Health and the Haitian Red Cross. While, in the Dominican Republic additional time was needed to carry out preventive health and hygiene promotion activities, addressing the needs of vulnerable families due to the deterioration of sanitary conditions during the rainy season. Furthermore, it was decided to also include the repositioning of stocks dedicated to facilitate the response of the Movement to future major outbreaks. Thus a [Revised Appeal](#) was issued in July 2011 featuring also a revised budget and a timeframe extension until the end of February 2012.

The main lines of action continued to focus on the areas of health (curative and preventive), water & sanitation and communications, with logistical support interlinked throughout. However, in Haiti the water and sanitation activities were no longer included in the Cholera appeal although they were still implemented by the IFRC water & sanitation team under the Earthquake operation. Water & sanitation activities in the Dominican Republic continued to be reported under the cholera appeal as the Dominican Red Cross National Society was only running one operation. An additional outcome for contingency planning while responding to cholera alerts was added.

Distribution of cholera prevention items was initially planned for 20,000 families across the earthquake-affected zone and three non-earthquake affected areas in Haiti. This output was modified from 20,000 families to 250,000 beneficiaries after six-months – for the reasons mentioned above – in response to programme focus on hygiene promotion and cholera prevention through distribution of items such as aqua tablets and hygiene sensitization campaigns.

Planned outputs for Haiti are highlighted in **blue** and planned outputs for the Dominican Republic are highlighted in **green**.

<b>Water supply</b>	
<b>Outcome: The risk of cholera is reduced through the provision of safe water.</b>	
<b>Output 1:</b> Communities in the five provinces on the Dominican Republic border have access to safe water.	<b>Activities</b> Pre-position water supply equipment at the border of the Dominican Republic.
<b>Output 2:</b> Safe water needs of at least 10,000 vulnerable families and cholera treatment facilities are addressed.	Carry out at least two one-month water supply operations for at least 600 families in the border region and in the south central Region (water operations include distribution of water, chlorine and buckets along with training (in line with Preventive health and hygiene promotion - Output 4)  Distribute chlorine to households for water purification to 10,000 families (in line with Preventive health and hygiene promotion - Output 4)  Provide safe water with 0.7 mg/l residual chlorine in distribution points  Support health facilities' water services in coordination with the national authorities (as required).

**Note:** Water supply activities in Haiti are reported under the operations updates of the Earthquake operation (MDRHT008)

**Achievements:** The outcome of water supply in the Dominican Republic aimed at ensuring the equipment necessary for delivering water to population is in place at request of local authorities, and also at enabling 10,000 families to purify water to start early treatment at home should a severe case of diarrhetic disease appears at home.

From November 2010 to August 2011, the Dominican Red Cross prepositioned 4 water plants in the border provinces and then increased the number of prepositioned plants to thirteen. This increases the speed for delivering water to population. The plants are ready to work in case of emergencies.

The operation supported 17,700 families with chlorine for purifying water and sensitization, exceeding the original target of 10,000 families.

Output 1 aimed at ensuring response capacity for supporting population if required and in coordination with authorities. The Dominican Red Cross prepositioned 13 water plants in the border provinces of Dajabón (1 water plant), Elías Piña (2), Independencia (4), Montecristi (1) and Pedernales (1). Other two were prepositioned in Santiago and 13 more in the branches of Santo Domingo province and Headquarters. The Dominican Red Cross has 28 water plants, of which 24 (with a capacity of 720,000 litres per day) are ready for deployment to affected areas in less than ten hours.

During the months of October, November and December 2010, the DRC provided 6,300 people with 94,500 litres of water in the province of Independencia at request of local authorities. Supported by IFRC, the DRC addressed the needs of 870 families.

Between 10 July 2011 and 31 January 2012, the DRC water and sanitation team produced and distributed 4,129,699.14 litres of water (1,092,513,00 gallons) for 360 families (1,800 people) living in the following communities in the Elías Piña province: La Rosa, Junquito, Angostura, Sabana Larga, Palo de la Cruz, Los Córvanos, Batey and Hato Viejo. Coordination has been carried out for the local authorities to continue providing services to families as the operation out of the Dominican Red Cross concluded.

The Dominican Red Cross also supported families living in Villa Magante (Espaillat) distributing 560,952 litres of water (148,400 gallons) between December 2011 and January 2012.

The level of chlorination offered by the DRC is 1.0-1.5 mg/l. In coordination with local and national authorities, water tanks and water pumps were installed. DRC volunteers cleaned and taught communities how to clean their wells and use pool testers. All this is important for ensuring sustainability. In addition to this, 17,000 heads of families received chlorine flasks and training on how to use chlorine for purifying water.

**Challenges:** While, the DRC has the capacity to assist the population during emergencies, further advocacy with the government is required for ensuring water supply to the population.

Sanitation	
<b>Outcome: The risk of cholera is reduced through the improvement of sanitation conditions.</b>	
<b>Output 1:</b> Disinfection of households of cholera patients and health facilities is ensured to prevent further spread of the disease in Elías Piña, San Santo Domingo, Santiago, Monte Plata and San Pedro de Macorís	<b>Activities planned</b> Train and equip five disinfection brigades (ten members per brigade).  Spray houses where cholera cases have been confirmed with chlorine-solution and households in the disinfection of clothes and kitchen utensils.  Disinfect health facilities through spraying and cleaning.

**Note:** Sanitation activities in Haiti are reported under the operations updates of the Earthquake operation (MDRHT008)

**Achievements:** With support of the Appeal and Spanish Red Cross funds, the Dominican Red Cross carried out disinfection spraying in 2,634 places, of which 94 per cent were done in the Revised Appeal target area.

Between October 2010 and January 2011 the Spanish Red Cross supported sanitation training for 17 disinfection brigades around the country. These brigades were equipped with sprayers and cleaning tools to carry out disinfection. In coordination with local health authorities, the brigades disinfected 145 locations between February and March 2011.

As the health authorities consider spraying to be an adequate control measure, DRC supported by the IFRC have carried out this activity. During the operation, 125 volunteers of DRC received training and were integrated into the National Disinfection Brigades. These volunteers were also trained on How to Work at Community level, thus becoming an important part of DRC Human Recourse asset.

From July 2011 to February 2012, 5,200 rooms in 2,489 houses of affected people and health facilities were disinfected in Santo Domingo, Elías Piña, Dajabón and Espaillat as required by communities, where there appeared some suspected cases. Hygiene and health promotion sensitization was carried out along with disinfection. In addition to these training, the Dominican Red Cross has carried out assessments and

disinfection in three prison facilities in the provinces of Elias Piña, Santo Domingo and El Seibo with assistance of the Ministry of Health, the ICRC and the IFRC.

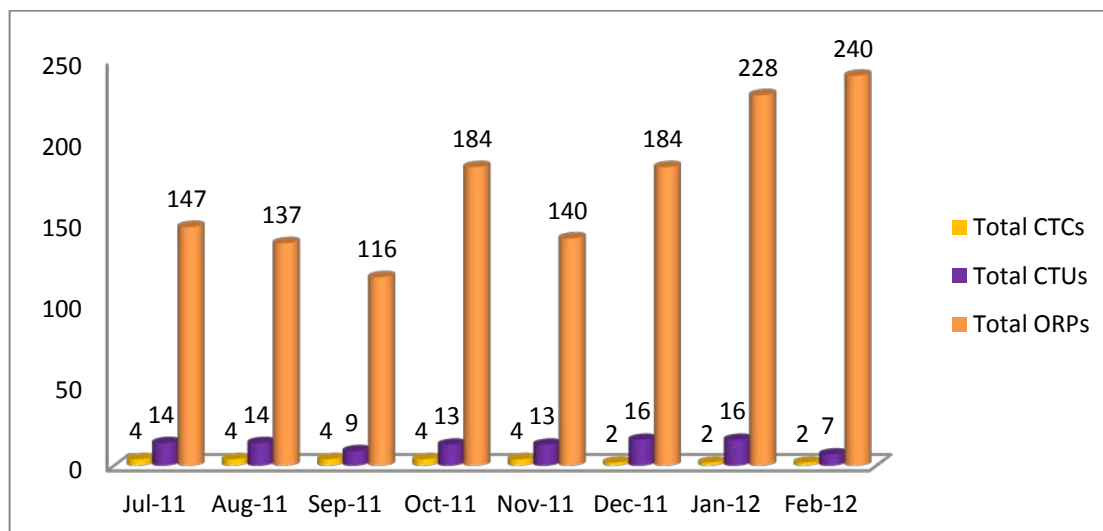
<b>Health</b>	
<b>Outcome: Cholera-related morbidity and mortality is reduced through a comprehensive health approach including surveillance, oral rehydration solution (ORS) distribution and case management/treatment.</b>	
<b>Output 1:</b> Low and moderate cases of dehydration are addressed (Level 1) in both earthquake-affected areas and the other departments.	<b>Activities planned</b> 50 ORS points maintained by PNS and HRC  At least 200,000 beneficiaries reached through ORS distributions.
<b>Output 2:</b> The health sector is supported to meet the increased needs relating to cholera treatment services (Levels 2 and 3) in both the earthquake-affected area and the other departments.	Additional Cholera Treatment Centres are implemented in affected areas in the event of an outbreak.  5 Mobile Teams are supporting health facilities and respond to hot spots alerts  90 per cent of the medical supply needs of PNS in running Red Cross Cholera Treatment Centres and Units are supported by IFRC till the end of operation
<b>Output 3:</b> Management of cholera patients is enhanced.	15 MSPP affiliated health facilities are supported by the Red Cross Red Crescent  70 per cent of medical staff of those 15 health facilities are trained on cholera prevention  4 ambulances given to HRC continue to service cholera patient transportation (part of wider implementation support to HRC Cholera Plan of Action)  IFRC Cholera, Health and Logistics departments provide medical supplies and equipment to support PNS and HRC running the Red Cross Cholera Treatment Centres and Units (including that logistics activities are implemented, supervised, and monitored by continual assessment of control activities).
<b>Output 4:</b> Local health authorities are supported to meet the needs relating to cholera treatment services in Elías Piña, San Santo Domingo, Santiago, Monte Plata and San Pedro de Macorís, including distribution of ORS and psychosocial support.	Distribute 2,500 cholera supply kits (containing jars, mugs and chlorine, ORS) to cholera patients.  Distribute ORS for starting early treatment of cholera at home to 10,000 families (complementing preventive health and hygiene promotion talks).  Conduct psychosocial support activities in health centres and communities in order to enhance the awareness campaign and address stigma and fears surrounding cholera  Support health authorities with supplies including stretchers, ORS and tents for cholera treatment facilities as required

The Red Cross and Red Crescent Movement actively took steps to respond to the cholera epidemics in treating patients presenting a low, moderate or severe infection to cholera.

#### **Output 1:**

The Red Cross and Red Crescent partners established Oral Rehydration Points – ORPs – in Artibonite, Grande-Anse, Ouest, Sud and Sud-Est departments to treat the low and moderate cases of dehydration, a major consequence of the infection caused by the virus of cholera. The Red Cross and Red Crescent partners reacted in a timely manner and adjusted their activities to the fluctuation in the numbers of cholera cases (shown in Figure 1 in the Situation section above). Indeed a clear correlation between the outbreaks and the settlement of new ORPs can be seen when comparing the Figure 1 and the presentation of the trend of the epidemics in Haiti (Situation section above) and the Figure 3 below. The Haitian Red Cross volunteers and/or medical staff in charge of ORPs were trained to administer treatment, promote of good hygiene behaviours or disinfection techniques as some of the ORPs were staffed with people in charge of disinfecting the houses of cholera affected patients. The Oral Rehydration Points were also places of distribution of items such as soap, flyers conveying prevention and/or treatment messages but also aqua tablets to disinfect water or Oral Rehydration Serum.

**Figure 3. Red Cross cholera treatment facilities<sup>8</sup>.**



**Note:** CTC: cholera treatment centres, CTUs: cholera treatment units; ORPs: oral rehydration points.

The patients presenting the first symptoms of the disease (dehydration, weakened state due to diarrhoea or vomiting) or moderately affected by cholera who were received at Oral Rehydration Points were given Oral Rehydration Serum (also called Oral Rehydration Sachet because of the packaging of the treatment). In addition to the low or moderate cases treated with Oral Rehydration Serum, ORS sachets were distributed to beneficiaries during hygiene promotion activities in the communities or in the camps during sensitization campaigns as preliminary treatment measure for people showing the first signs of the epidemics. In total, 1,300,253<sup>9</sup> were distributed by the PNS in six departments of the country (as listed in the *Table H4*) surpassing the target of 200,000 beneficiaries set in the revised Appeal. The Haitian Red Cross regional and local branches also participated in the effort of treating low or moderate cases by distributing ORS in the framework of hygiene promotion and sensitization campaigns.

#### **Output 2:**

The Movement supported the Ministry of Public Health and Population (Ministère de la Santé Publique et de la Population - MSPP) and the Haitian Red Cross in bolstering the curative response to the epidemics. The Partner National Societies and the ICRC supported and operated Cholera Treatment Centres – CTCs – and Cholera Treatment Units – CTUs – to treat the patients moderately and severely affected by the epidemics. Many CTCs then transitioned to CTUs when the number of cases of cholera were decreasing. The Red Cross treated 34,119 patients in the treatment facilities operated from November 2010 to February 2012. The Figure 3 above shows the evolution of the treatment facilities operated by the Haitian Red Cross and PNS in Haiti during the second phase of the operation (related to the revised appeal: July 2011 to February 2012).

The International Committee of the Red Cross was also involved in the treatment of cholera affected prisoners. The ICRC supported the places of detention in the installation and operation of cholera treatment units in the premises of the places of detentions, by transporting the affected patients in the closest treatment facilities while maintaining the safety of the detainees or by supplying the health-care facilities already in place in the prisons. The ICRC also provided support to emergency centres and hospitals treating detainees (outside of the prisons). Until October 2011, the ICRC supported the treatment of 916 detainees affected by cholera on around 7,000 detainees (71 of the cases were fatal).

To complement the curative activities implemented in CTCs or CTUs, the Psychosocial Support (PS) teams of the IFRC and the Haitian Red Cross worked to address the psychosocial needs of the patients. Also mobilized to cope with the cholera epidemic, the IFRC and HRC PS teams were particularly active, developing specific and innovative forms of intervention. The teams carried out a context study on community beliefs and perceptions linked to the cholera epidemic. This study, which was taken up by the majority of humanitarian agencies (World Health Organization, Centre for Disease Control, United Nations Office for Humanitarian

<sup>8</sup> The figures above do not include the treatment facilities operated or supported by the ICRC. Only the structures operated or supported by PNS and the HRC are counted.

<sup>9</sup> This figure does not include the ORS distributed by the HRC nor IFRC.

Coordination) and published in March 2011, helped shed light on cultural and social factors that were hindering the cholera prevention campaign. On the basis of the conclusions and recommendations of this study, the PSP volunteers participated in the prevention campaign by organizing discussion groups aimed at lessening fears, beliefs and prejudices linked to the epidemic, thereby promoting behavioural change in the community. No fewer than 4,426 awareness-building actions were carried out in 2011, reaching a total of 118,582 beneficiaries. These efforts, which specifically tackled the psychosocial aspects of the epidemic, were broadened to include key actors, in particular the voodoo community (130 voodoo priests and priestesses reached) and 70 journalists. For the first time in connection with the Movement's response to a cholera epidemic, volunteers were also mobilized directly in five cholera treatment centres to provide psychological first aid to particularly isolated and stigmatized victims. More than 16,312 children, adults and the elderly undergoing treatment in five CTCs were assisted by specially trained volunteers.

To facilitate immediate response to cholera outbreaks, the Haitian Red Cross supported by Partner National Societies, the IFRC and the international Committee of the Red Cross established and deployed mobile teams composed of trained staff and volunteers. The PNS deployed 854 times their mobile teams to respond to outbreaks of cholera in their respective zones of intervention. The IFRC also deployed mobile teams, especially in areas not covered by the PNS or in remote areas difficult to access with the objective of supporting the branches of the Haitian Red Cross to respond to outbreaks or assess suspected diarrheal cases in communities. The ICRC deployed a mobile team composed of medical and water & sanitation delegates circulating between places of detention, ready to respond to alerts and supporting hygiene promotions sensitizations in places of detentions and police stations.

The IFRC cholera coordination and logistics teams provided support to the PNS to supply them with medical and prevention equipments for their activities (as shown by the Figure 4 below which is an example of the support provided by the IFRC) in treatment centres and prevention and education sessions. A great quantity of materials and equipment was procured by the IFRC for the Red Cross and Red Crescent partners in Haiti. The IFRC also facilitated procurement services for materials to NGOs, partners, health centres or authorities when requested. Refer also to the Output 1 of the *Contingency Planning* section below for further details.

**Figure 4. Example of material support provided by the IFRC to the PNS and external partners\***

Recipient	Number of aqua tablets	Ringer Lactate packs of 1 litre	Total nb of boxes** of Canula provided
<i>Aide Médicale Internationale - AMI</i>	0	100	0
<i>American Red Cross</i>	3,136,000	0	0
<i>British Red Cross</i>	6,912,000	1,200	29
<i>Finish Red Cross mobile clinic</i>	0	1,200	0
<i>French Red Cross</i>	0	0	40
<i>German Red Cross</i>	5,578,000	400	5
<i>Haitian Red Cross</i>	0	7,104	26
<i>Japanese Red Cross Society</i>	192,000	4,143	0
<i>Netherlands Red Cross</i>	7,488,000	100	0
<i>Norwegian Red Cross</i>	960,000	1'000	0
<i>Spanish Red Cross</i>	7,200,000	0	130
<i>Swedish Red Cross</i>	384,000	0	
<i>Swiss Red Cross</i>	251,130	0	8
<i>Government: Civil Protection Directorate</i>	5,000	0	
<i>Government: Ministry of Foreign and Cultural Affairs</i>	2,500	0	0
<i>Merlin</i>	8'900	0	0
<i>Port-à-Piment Health Centre</i>		3,000	
<b>Total</b>	<b>8,900</b>	<b>18,247</b>	<b>238</b>

\*The listed materials above were provided thanks to the contributions of the Korean Red Cross (aqua tablets) and the Australian Red Cross (canulas and ringer lactate solution).  
 \*\*Each box contains 50 canulas.

### Output 3:

The cholera outbreak generated a medical response to tackle the epidemics which was clearly exceeding the capacities of the Ministry of Health facilities. Seriously affected by the earthquake, many health-care facilities had been destroyed by the earthquake or had lost qualified staff. Participant National Societies and the ICRC provided support to the MSPP affiliated health facilities in supplying them with material and equipments, in providing staff, in training staff or simply in lightening the burden generated by the cholera epidemics in installing cholera treatment facilities in the health premises. The French Red Cross, for example, provided support to Health Centres and to the Health Direction of West department in training medical staff or paying the salaries of medical staff. The Luxembourg Red Cross supported the MSPP in establishing a Community Health Centre in Gressier. This facility was completed by a Cholera Treatment Unit to manage cholera cases. In January 2012, the CTU was transferred into the premises of the hospital and its activities were expended to treat diarrheal infections in the newly named *Severe Diarrhoea Treatment Unit*. At least 2,000 medical staff were formed or benefited from training on the management of cholera cases during the operation.

The management of cholera patients was also enhanced through the support provided to the Ambulance services of the Haitian Red Cross. The IFRC Cholera department set up an Ambulance Centre in December 2010 and equipped it with a radio room, VHF radios and six phones were also provided to the drivers to facilitate the communication and efficiency of the service. Extensive maintenance was realized on 12 ambulances. The strengthening of the Ambulance services was a necessity to transport sick people to hospitals or treating facilities in Port-au-Prince but also to improve the referral system and ensure more patients would be treated and saved by being transferred to CTCs or CTUs. In total, from October 2010 to February 2012, the Ambulance services of the Haitian Red Cross managed 6,258 people suspected to be affected by cholera, representing 51 per cent of the activity of the services over the 17 months that lasted the response supported by the IFRC.

Figure 5. Haitian Red Cross Ambulance services activities in support to the cholera operation.

Month	Number of victims managed	Number of cholera patients	Percentage of cholera cases managed among the total of patients managed by the Haitian Red Cross ambulance service.
Oct-2010	131	4	3%
Nov-2010	263	159	60%
Dec-2010	1'138	986	87%
Jan-2011	1'203	914	76%
Feb-2011	1'062	688	65%
Mar-2011	999	645	65%
Apr-2011	745	404	54%
May-2011	848	499	59%
Jun-2011	1'006	659	66%
Jul-2011	520	122	23%
Aug-2011	652	174	27%
Sep-2011	692	296	43%
Oct-2011	831	301	36%
Nov-2011	708	211	30%

<b>Dec-2011</b>	561	101	18%
<b>Jan-2012</b>	465	57	12%
<b>Feb-2012</b>	534	38	7%
<b>TOTAL</b>	<b>12,358</b>	<b>6,258</b>	<b>51%</b>

In addition to the Ambulance services of the Haitian Red Cross, the French Red Cross and the British Red Cross established an ambulance and transportation system of cholera affected patients to treatment facilities through their bilateral operations. The French Red Cross requisitioned 5 tap-tap (Haitian taxis) they transformed into ambulances in addition to 2 other ambulances. In total, the 7 vehicles deployed transported 1,139 patients in the Ouest department to support the Health Office of the West department (Direction Sanitaire de l'Ouest - DSO). The vehicles of the French Red Cross were also used for the transport of dead bodies to appropriate burial places. The British Red Cross established a similar transportation system of patients in Port-à-Piment, in the Sud department. In total, more than 1,115 patients were transferred and transported to the Cholera Treatment Unit until end of October 2011 (the CTU was handed over to the Haitian Red Cross but the not the ambulance/transportation system).

Regarding the support provided by the IFRC to PNS and Haitian Red Cross running Red Cross Cholera Treatment Centres and Units supplying them with medical supplies and equipment, please refer to the Output 2.3 above and the Output 1 of the Contingency Planning section below.



**A team of the French Red Cross transporting a cholera-affected patient to one of the French Red Cross cholera treatment units in Petit-Goâve. FRC/ April 2011**

**Output 4:**

During the operation, the Dominican Red Cross (DRC) increased its coordination with the Ministry of Health through its community health department, with the result of shared methodologies and messages. The integration of the DRC community health coordination into the DRC Emergency Coordination Room allowed the National Society to integrate a cross-cutting health approach into procedures and monitoring.

Synergy between the local health authorities and the Dominican Red Cross enabled prompt action to support the vulnerable population affected by diarrheic disease outbreaks. As local health authorities requested support —confirming DRC assessments in the Espaillat, Monseñor Nouel and Independencia provinces— the DRC operation extended the area of the intervention to cover the emergency needs of provinces with a sudden increase of cases.

1,000 cholera supply kits (containing jars, mugs and chlorine, ORS) for diarrheic disease patients were delivered in Sabana del Puerto (Monseñor Nouel); another 468 in Villa Magante (Gaspar Hernández, Espaillat) and 100 families in Jimaní (Independencia). Other 932 cholera treatment kits have been prepositioned in target branches to respond to future crisis.

More than 17,700 ORS sachets were distributed to representatives of vulnerable families along sensitization and training talks of preventive health and hygiene promotion from July 2011 to February 2012 in the provinces of Dajabón, Elias Piña, Espaillat, Monseñor Nouel, Monte Plata, Peravia, Puerto Plata, San Cristobal, San Pedro de Macorís, Santiago, Santo Domingo (See below Output 4).

Furthermore, 150 DRC volunteers received training in psychosocial support. They provided psychosocial support to diarrheic disease patients in order to address stigmatization and fears, and contributed with DRC Youth section in delivering sensitization for children in 10 communities in urban areas. Methodologies were adequate for younger audience and used games, puppets, performances, and a rap song that teaches about cholera prevention and good hygiene practices.

The Dominican Red Cross has made available two dispensary tents and 40 cholera beds and buckets to support health authorities for the treatment of patients as it was requested for supplementing existing capacity in case of dire need. By the close of the operation, the Ministry had not requested this additional support as

number of cases had not exceeded the bed capacity of treatment centres for long.

**Challenges:**

In Haiti, there is a clear need to standardize counting and data collection methodologies between Red Cross actors in relation to cholera patients treated, in order to have a common understanding and distinguish between several categories for improved monitoring (i.e. distinction between the patients received and those hospitalized). The issue was also present under the hygiene promotion activities or items distribution. This is particularly important in the context where many partners were actively involved in treatment activities. Although some monitoring and reporting tools and indicators were developed later in the operation, a clear data collection methodology should be put in place at the beginning of an operation to be agreed between partners working under a common strategy.

In the Dominican Republic, due to high mobility of at-risk population and overall limited access to water and sanitation, the way the disease progressed showed that programmes need some degree of flexibility to attend the surge of outbreaks in any province in the country. While the operation in the Dominican Republic aimed to build up resilience and response capacity in most vulnerable provinces (close to the Haitian border), efficiency in the use of resources allowed the programme to reach population in vulnerable areas outside these target areas.

<b>Preventive health and hygiene promotion</b>	
<b>Outcome: Cholera-related morbidity and mortality is reduced through a comprehensive approach to preventive health and hygiene promotion while strengthening the National Societies' capacity in preparedness and response to cholera outbreaks</b>	
<b>Output 1:</b> Haitian Red Cross volunteers and community volunteers are trained and mobilized to deliver hygiene promotion, with emphasis on cholera prevention messages, in all Haiti departments, in support of implementing the Haitian Red Cross Cholera Plan of Action.	<b>Activities planned</b> Total 500 HRC and community volunteers trained in hygiene promotion by 28 February 2012. At least 20 hygiene promotion activities (including disinfections) delivered by each of the HRC regional branches by 28 February 2012.
<b>Output 2:</b> Cholera prevention non-food items (NFIs) are distributed to 250,000 beneficiaries across the earthquake zone and 3 non-earthquake affected areas in Haiti.	At least 90 per cent of 250,000 beneficiaries have received NFIs by 28 February 2012. 200,000 cholera prevention flyers and posters have been distributed through regional branches of HRC, PNS and CTCs by 28 February 2012.
<b>Output 3:</b> Provide support as required to HRC/IFRC Health programme to enable development of preventive and epidemic control activities.	Total 1,000 of HRC volunteers trained in epidemic control (ECV). 15 trainers of trainers are trained at the national level by 28 February 2012 in Community Based Health and First Aid (CBHFA). 2 trainers of volunteers in each of the 108 local committees (216 trainers of volunteers in total) are trained by 28 February 2012 CBHFA.
<b>Output 4:</b> In the Dominican Republic, increased awareness and prevention of cholera is ensured through a campaign in branches on the Dominican-Haitian border and the most populated urban areas	Carry out preventive health and hygiene promotion talks in five border provinces and in the most populated urban areas. Conduct epidemic control (ECV) and PHAST trainings for communities and volunteers Increase bio-security measures and trainings in at least 20 DRC branches, reducing the possibility of cholera infection within the premises. Print and distribute information, education and communication awareness materials such as brochures and posters.

**Output 1:**

Haitian Red Cross volunteers and community volunteers were trained and mobilized to deliver hygiene promotion, with emphasis on cholera prevention messages. Jointly, the IFRC and the HRC trained 530 volunteers on cholera prevention in the 13 regional branches, and 150 volunteers were trained to disinfect the homes of persons who contracted the disease while 123 volunteers from the 13 regional branches were

trained to care for cholera victims in the CTCs and to treat water. The IFRC cholera coordination and water & sanitation teams also established 260 community facilitators dedicated to focus on the epidemiological situation in the camps of the capital city and 14 in the communities of Port-au-Prince (or a total of 425 community facilitators in Port-au-Prince). The PNS reported the training of 44'371<sup>10</sup> HRC and community volunteers during the operation.

The IFRC water & sanitation and health teams, in support to the IFRC cholera coordination team and the Haitian Red Cross health department were involved in hygiene promotion activities implemented by volunteers across the camps and the communities. The volunteers conducted outreach campaigns on methods to prevent cholera contamination, carrying out demonstrations on hand-washing, safe food storage, treatment of water, safe disposal of excreta, conducting disinfections and distributing prevention and treatment messages. 8 Participant National Societies, the Haitian Red Cross and the IFRC cholera coordination team conducted hygiene promotion activities. The activities took place daily or at least once a week via door-to-door sensitization, households visits in the camps, hand-washing demonstration, sensitization on public places such as schools, churches and markets or community talks. In total, more than 1,157,423<sup>11</sup> hygiene promotion activities (among them, 7,193 disinfection activities in houses, schools, medical facilities or IDP camps were reported) were organized throughout the country.

The Red Cross and Red Crescent members also participated in special national events such as Patrons Festivals<sup>12</sup>, organizing water points and taking advantage of these events to widely sensitize people. For example, during the Hand Washing day organized in October 2011, the IFRC mobilized 42 HRC volunteers to implement hygiene promotion activities in the camps and 40 HRC volunteers were deployed in the Ouest department, sensitizing more than 10'448 adults and 2'033 children only during this specific event. The American Red Cross organized schools visits on the Hand Washing day, sensitizing 2'940 students and 160 teachers. The HRC Health department also participated in the "Hand Washing day" by supervising sanitation activities, installing water points at various key sites in certain neighbourhoods and by distributing soap and brochures. In addition, at the various Patron festivals, more than 30 public places for washing hands were set up in nine localities. The IFRC, HRC and American Red Cross were not the only ones to organize hygiene promotion activities for the Hand Washing day, almost all the PNS involved in medical, water and sanitation or cholera response activities organized specific activities: sensitization on public places, distribution of soaps or other items, dissemination of messages, installation of water points, etc.

The International Committee of the Red Cross also organized hygiene promotion activities. The ICRC provided support to the penitentiary administration and the National Haitian Police in their fight against cholera in 16 places of detention and 4 police stations (covering around 7'000 prisoners). In all permanent places of detention, the ICRC was involved in hygiene promotion and disinfection activities of cells and latrines. As per its mandate, the ICRC actively advocated an improvement of the living conditions of the detainees while supporting the authorities in their response to the epidemics in the places of detention.

## **Output 2:**

To bolster the impact of hygiene promotion and sensitization activities against cholera, distributions of non-food items (NFI) were organized. The target of distributing NFIs to at least 90 per cent of 250'000 beneficiaries was reached and surpassed as at least 1,830,173 people (*Please see in Table H3 below the repartition of beneficiaries reached by PNS per departments*) received NFIs during door-to-door or mass distributions and at strategic points such as treatment facilities (CTUs, CTUs, or ORPS). The Haitian Red Cross health department, the regional and local branches also distributed non-food items during sensitization campaigns or special events (such as the Hand Washing day mentioned above, the Carnival or the Patrons Festivals). The common effort of the Red Cross and Red Crescent Movement led to the distribution of more than 253'392 posters and flyers promoting prevention and treatment messages on cholera both in the communities and in the IDP camps. The intensified cholera response efforts from the Emergency Health team of the HRC also took the form of the distribution of 1'000 Cholera albums designed to encourage beneficiaries to adopt the

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<sup>10</sup> It is not possible to clearly distinguish the HRC volunteers and the community facilitators (formerly called community volunteers) in the activity reports provided by the RCRC partners. The original designation of community volunteers vs. HRC volunteers was not initially clarified among partners. Eventually, this led to the clarification of the status of volunteers of the Red Cross. However, the distinction was not made before the end of the Cholera operation, leading to a cumulating of HRC volunteers and community volunteers.

<sup>11</sup> This figure does not include the number of hygiene promotion activities organised by IFRC Water and Sanitation departments nor by ICRC in places of detention. Moreover, hygiene promotion activities organised by the regional and local branches of the Haitian Red Cross were not always counted nor reported to the IFRC Cholera department. Thus, the figure indicated is based on the figures provided but may be higher than reported herein.

<sup>12</sup> Patrons Festivals are religious festivities consisting in celebrating the Patron of the city or the province. On 15 August, Les Cayes celebrate Notre Dame or the Virgin Mary. These festivities are mostly related to the Catholic religion.

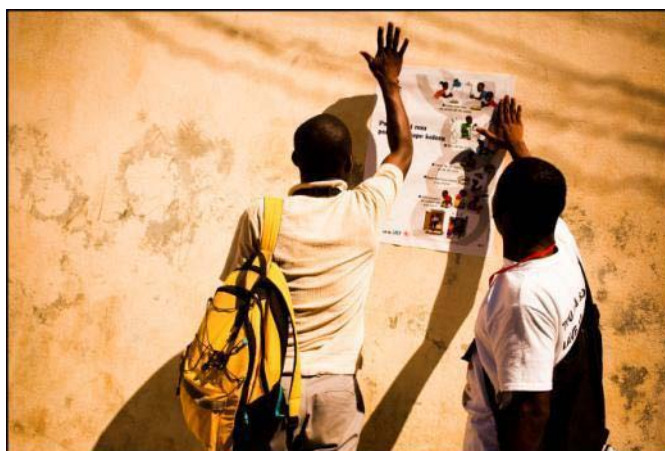
right behaviours.

**Table 1. Total of beneficiaries reached by non-food items distributions organized by Participants National Societies.**

Beneficiaries of Red cross and Red Crescent non-food items.*		
Movement member	Nb of beneficiaries	Locations
American Red Cross	718'828	Nord; Nord-Est; Ouest
British Red Cross	307'095	Sud; Ouest
Canadian Red Cross	148'411	Nippes; Sud-Est; Ouest
French Red Cross	291'780	Artibonite; Ouest
German Red Cross	111'224	Ouest
Netherlands Red Cross	124'485	Sud-Est
Norwegian Red Cross	56'569	Ouest
Spanish Red Cross**	70'357	Ouest
Swiss Red Cross	1'424	Ouest
<b>Total</b>	<b>1,830,173</b>	

\* Please note figures are based on the data provided by PNS to the IFRC during the operation. At the time the report was edited, certain figures were under reported. Consequently, total figures may be higher than indicated herein.

\*\*Data only covering July and August 2011.



**Red Cross volunteers distributing cholera prevention messages in the district of Rivière Froide in Port-au-Prince. Julien Goldstein /IFRC**

**Table 2. Items distributed by Red Cross members as means of prevention against cholera.**

Non-food item distributions to beneficiaries*									
Movement Member	Nb of beneficiaries	Aqua tablets	Bars of soap	Jerry cans	Buckets	Sprayers	HTH Chlorine (kg)	Prevention & Treatment flyers and posters	Oral Rehydration sachet
American Red Cross	718'828	12'511'721	3'135'153	83'419	534	0	0	0	462'913
British Red Cross	307'095	4'534'046	139'969	0	64'470	63	566	12'150	81'301
Canadian Red Cross	148'411	3'338'420	29'876	29'251	2'372	0	8	3'231	17'823
French Red Cross	291'780	101'392	164	150	222	22	518	45'000	6'300
German Red Cross	111'224	177'157	151'372	0	55	36	155	49'816	498'647
Netherlands Red Cross	124'485	3'427'799	52'706	23'333	276	86	971	112'339	42'802
Norwegian Red Cross	56'569	91'795	49'000	721	105	109	480	24'801	51'100
Spanish Red Cross**	70'357	5'000	887	0	6	0	3	4'723	28'800
Swiss Red Cross	1'424	153'500	1'053	408	8	0	0	1'332	1'467
ICRC	-	3'290'000	0	0	0	0	3'120	0	109'100
<b>Total</b>	<b>1'830'173</b>	<b>27'630'830</b>	<b>3'560'180</b>	<b>137'282</b>	<b>68'048</b>	<b>316</b>	<b>5'821</b>	<b>253'392</b>	<b>1'300'253</b>

\* Please note figures are based on the data provided by Red Cross and Red Crescent partners to the IFRC during the operation. At the time the report was published, certain figures were under reported. Consequently, total figures may be higher than indicated herein.

\*\*Data only covering July and August 2011.

### **Output 3:**

During the cholera operation, the IFRC worked with HRC health department to establish a long-term strategy focused on prevention to continue tackling cholera epidemics. The cholera coordination team provided technical and financial support to the community-based health and emergency health units of the National Society for the training of trainers and of Haitian Red Cross volunteers in two key methodologies: Epidemic Control for Volunteers (ECV) and Community-Based Health and First Aid (CBHFA) *in Action*.

In order to improve the response to epidemics, in particular cholera outbreaks, the Haitian Red Cross emergency health unit introduced with the support of the IFRC health team an epidemics control programme in all 13 regional branches of the Haitian Red Cross. The purpose was to set up community epidemic control teams (to combat cholera and other epidemics linked to water contamination) in all 13 regional branches via the training of 1,000 volunteers by the end of July 2012. Since July 2011, a series of training courses on Epidemics Control for Volunteers (ECV) were carried out. In July and August 2011, 80 senior trainers - five per region - were trained in the HRC's 13 branches in the ECV methodology. From September 2011 to February 2012, 8 ECV trainings for HRC volunteers were organized, 5 of the trainings receiving support from the IFRC-s cholera operation and trained 395 volunteers on epidemic control (72 HRC volunteers from La Gonâve, 88 from le Sud, 65 from Haut Artibonite, 85 from Bas Artibonite and 82 from Les Nippes).

The purpose of the Community-Based Health and First Aid (CBHFA) approach is focused on training communities and community facilitators to identify health priorities, thereby developing a long-term response to any epidemics (including cholera) that break out in the country. This training method, based on the skills and capacities of the communities themselves, is aimed at preventing disease, minimizing the impact of disasters and epidemics, and promoting healthy behaviour. Haitian Red Cross CBHFA activities started in February 2011 and were implemented in seven localities divided up among three regional branches. Between February and December 2011, a total of 30 senior trainers and 32 facilitators were trained in CBHFA methodology in the localities of Arcahaie, La Piste, Gressier, Léogâne, Petit Goâve (in the Ouest regional branch), Jacmel (in the Sud-Est regional branch), and Saut d'Eau (in the Bas- Plateau Central regional branch). In all, 164 volunteers were trained as supervisors, broken down as follows: 47 in Arcahaie with the support of the German Red Cross, 36 in Léogâne with the support of the IFRC, 2 in La Piste IDP camp with the support of the British Red Cross, 24 in Saut d'Eau with the support of the Finnish Red Cross, and 26 health promoters, 24 from the water & sanitation department and two from the ICRC. Fifty members of Community Health Committees were trained in the CBHFA approach in Sud-Est (24 in La Vallée and 26 in Jacmel). In addition, 24 supervisors from all different sites were trained in CBHFA monitoring and evaluation tools, and 1,041 community volunteers were trained in the CBHFA approach (662 in Arcahaie, 164 in Léogâne and 215 in La Piste).

In 2011, 1,317 persons were trained in CBHFA techniques, and more than 28,791 households benefited from community health activities (6,518 in Léogâne, 13,673 in Arcahaie and 8,600 in La Piste).

### **Output 4:**

The preventive health and hygiene promotion component of the operation in Dominican Republic directly reached 72,247 people with messages approved by the Ministry of Health in both Spanish and Creole, increasing their awareness about cholera and preventive measures. For this it was necessary to strengthen the capacities of the National Society branches, so that volunteers received training of trainers in ECV and PHAST methodologies for starting cascade training to branches around the country both addressing community and partner institution leaders and households. A total of 1,329 volunteers received training in PHAST and ECV focusing on cholera for conducting sensitization and training in communities around the country. While it was crucial to ensure population awareness in the border provinces and the most populated areas, country wide action was required. The island of La Hispaniola is a confined geographical territory with a high level of internal migration. Families travel to different places seeking job opportunities both in the agriculture and tourism sectors. This migrant population and a general lack of sanitation and water solutions for vulnerable population around the island leave population with little knowledge most prone to disease.

The Red Cross coordinated support built up the Dominican Red Cross' capacity training 1,329 volunteers in different areas related to epidemic control and hygiene promotion. From October 2010 to July 2011, 653 Dominican Red Cross volunteers, including 25 trainers, attended ECV and PHAST trainings. From July 2011 to February 2012, other 551 volunteers were trained in community health methodologies. From them, 94

received ECV training and 150 attended Psychosocial support training. Further, the National Disinfection Brigade trained and added 125 new members. The operation has also benefited from synergy with previous PHAST training and other programmes activities as Health NIT and Health Rapid Assessment.

This increased capacity allowed the DRC to implement different strategies for reaching vulnerable population, according to DRC branches, capacities, and characteristics of target families. Strategies employed included: sound-trucks, house visits and mass training in schools, health facilities, markets and public places.

While the first phase of the DRC strategy prioritized children in schools as multiplier agents and also carried out mass sensitization in public places, the DRC strategy for the Revised Appeal included training of organizations such as clubs, enterprises and local associations. This way training also aimed to 1) reinforce DRC and organization partnerships and 2) train leaders of organizations thus multiplying the effect of training. From July 2011 to February 2012, 335 out of 869 talks were carried out for organizations. The Operation printed brochures, banners, booklets and equipped the trained volunteers and partner organization leaders with training kits for carrying out sensitization.

The final figures for the countrywide operation carried out by DRC with through the Appeal, bilateral support of Spanish Red Cross and own recourses are the following as per 29 February 2012.

**Table 3. Community trainings in the Dominican Republic**

<b>People trained at the community level by the Dominican Red Cross</b>				
<b>Province</b>	<b>Total</b>	<b>Adult Male</b>	<b>Adult Female</b>	<b>Children</b>
Azua	2,666	384	852	1,430
Bahoruco	879	325	408	146
Barahona	2,562	147	233	2,182
Dajabón	2,088	885	841	362
Duarte	647	167	111	369
Elias Piña	10,599	4,003	4,120	2,476
Espailat	460	123	224	113
Hato Mayor	242	63	98	81
Hermanos Mirabal	170	18	31	121
Independencia	4,987	1,205	1,728	2,054
La Altagracia	174	56	69	49
La Romana	178	36	93	49
Monseñor Nouel	510	153	352	5
Montecristi	1,803	433	547	823
Monte Plata	2,342	782	1,272	288
Pedernales	13,539	2,702	2,790	8,047
Peravia	7,962	859	1,260	5,843
Puerto Plata	704	344	274	86
Samana	1,550	638	752	160
San Cristobal	2,151	749	796	606
San Juan	432	214	175	43
San Pedro de Macorí	1,375	456	573	346
Santiago	3,170	1,031	1,155	984
Santo Domingo	11,057	3,074	4,283	3,700
<b>Total</b>	<b>72,247</b>	<b>18,847</b>	<b>23,037</b>	<b>30,363</b>

From October 2010 to July 2011, the operation reached 54,453 people. 28,936 of them live in the five border provinces of Dajabón, Elías Piña, Independencia, Montecristi and Pedernales. 47 per cent of these people were children and 28 per cent adult female.

From July 2011 to February, the operation reached 17,794 people with sensitization and training in order for them to be multiplying agents among their families and communities. The targeted people included schoolboys and girls, householders, relatives of people affected by diarrheic disease, local partner organization leaders and community leaders.

National Society development activities allowed the operation to improve reporting capacity through standardization of procedures and accountability. The total male/female ratio of reached population was 0.74. For children, the male/female ratio was 0.86. Adult females represent 42 per cent of reached group and children 28 per cent of the total reached population. Around 5 per cent of the talks were carried out in Creole.

In addition to direct training, the families of the 17,794 trained people received ORS sachets and chlorine flasks following Outputs described under **Water supply** and **Health** headings above.

ORS and Chlorine Distribution	
Province	Families
Dajabón	1,083
Elias Piña	2,997
Espailat	460
Monseñor Nouel	510
Monte Plata	2,113
Peravia	20
Puerto Plata	146
San Cristobal	362
San Pedro de Macorís	1,375
Santiago	2,139
Santo Domingo	6,589
<b>Total</b>	<b>17,794</b>

From these families, 1,498 were aimed after health and water & sanitation assessments were carried out in Sabana del Puerto (Monseñor Nouel province), Montellano (Puerto Plata province), Baní (Peravia province), Gaspar Hernández (Espailat ) and Pedro Brand.

Since the beginning of the operation the DRC has increased its cooperation with Ministry of Public Health and the Pan American Health Organization (PAHO) and other organizations such as the Humanitarian Group (Including United Nations agencies, ECHO, AECID, and NGOs) in the country and the Ministry of Education, sharing information, standards and printed material designed for the emergency. DRC assessments were carried out after consideration of data provided by Government and Local Health authorities.

The operation ensured provision of minimum bio-security measures and trainings in 30 DRC branches, supplying chlorine and soap for disinfection, thus reducing the possibility of cholera infection within the premises.

#### **Challenges:**

In Haiti, the challenges faced in the implementation of preventive health and hygiene promotion activities were similar as the ones developed in the Health section above.

In the Dominican Republic, continuous monitoring of the situation and flexibility is essential to attend the needs of population, as sources of infection are mobile. The operation has addressed both its original target area and extended area as needs arise. The addressed number of families living in the extended area is 8 per cent of the total. Further, 22.9 per cent of population reached by the revised appeal live in the Haiti Border area and 49 per cent live in the most populated areas.

Part of the vulnerable population is Haitian citizens living in the Dominican Republic. The Dominican Red Cross in close coordination with authorities facilitated the translation of the official messages from Ministry of Health and validated them. A small Creole speaking team carried out talks for Haitian families living in Dominican Republic.

## Contingency Planning

<b>Outcome: Cholera incidence, morbidity and mortality is reduced by increasing basic prevention and response capacity in preparation of any possible increase in cholera cases.</b>	
<b>Output 1:</b> Minimum cholera-related stocks (i.e. HTH, aqua tablets, soap, ORS), including IEC materials, are maintained in targeted locations.	<p>Minimum emergency stocks are available.</p> <p>5 PNS warehouses receive stock from IFRC to be pre-positioned.</p> <p>7 branches of the HRC where cholera hotspots are high also receive stock from IFRC for pre-positioning.</p>
<b>Output 2:</b> The IFRC Emergency health team is reinforced to ensure staff and volunteers are ready to respond to any future epidemic outbreaks.	An additional emergency health delegate positioned with the IFRC Health team (28 February 2012).
<b>Output 3:</b> Updated Cholera Contingency Plan incorporated within the Haitian Red Cross National Contingency Plan to enable the Movement to provide emergency health services, water and sanitation as needed.	Contingency plan updated and implemented.
<b>Output 4:</b> A cholera programme reporting system is designed and implemented across the HRC and its branches.	<p>A database for reporting on the implementation of the cholera programme response is designed and distributed within the HRC and its branches.</p> <p>An HRC Reporting Focal Point and an HRC Finance Focal Point are identified and have received training on programme information collection including database maintenance.</p> <p>The HRC Reporting Focal Point and the HRC Finance Focal Point become trained in training branches in financial and narrative programme reporting.</p>

### **Output 1:**

Since the beginning of the cholera response operation, the IFRC cholera coordination team and logistics team adapted their organization (staff-wise and equipments/warehouse-wise) to face and respond quickly and appropriately to the increasing needs of the Haitian Red Cross and PNS. As summarized in the 6-month report a warehouse was established to increase supply effectiveness. Some logistics staff working under the framework of the Earthquake operation were relocated to the Cholera operation and a separate database and a scanning process of requisitions was established independently for the Cholera operation.

The IFRC regularly and continuously supported the Movement's cholera operation. Supplies were offered to PNS free of charge allowing them to do more with their own resources and scale-up their programmes. With an average of 60 requisitions every two months from May to August 2011, the requisitions submitted by the PNS and ICRC slowly decreased in late 2011 in line with a reduced number of cholera cases. After logistic mechanisms for the cholera response were established in the first part of the Cholera operation, the revised appeal of the operation introduced a focus on the prepositioning of stocks in the HRC branches and the PNS warehouses. In the last three months of the operations, IFRC cholera coordination team launched a large procurement process in order to supply the PNS needing materials and to fill-in warehouses of the regional HRC branches around the country to ensure every actor would be in a position to immediately respond in case of new cholera spikes. The process was to create buffer stocks the Movement could use rapidly before ordering additional materials and equipments. The Canadian Red Cross, the American Red Cross, the French Red Cross and the Netherlands Red Cross requested equipments in November 2011 (*as shown in the table H5 below*), to fill-in their warehouse and complete their pre-positioned stocks. In addition to the Cholera-related items prepositioned by the IFRC in July and August 2011 (*details in the table H6 below*), the stocks of the HRC regional branches were refilled and completed with the same objective of ensuring the branches would be capable to respond to cholera spikes.

**Table 4. List of materials and equipments requested by PNS by November 2011**

	Unit	Total
<i>Aquatabs(Bte 3200 units)</i>	Box	120
<i>Bed for cholera</i>	Piece	160
<i>Body bag</i>	Piece	110
<i>Boots</i>	Pair	200
<i>Bucket with tap</i>	Piece	200
<i>Chirurgical cloth</i>	Piece	200
<i>Chlorine</i>	Piece	98
<i>Cholera Treatment Posters</i>	Piece	1'250
<i>Disposable Latex Gloves Medium</i>	Piece	7,200
<i>Disposable Latex Gloves Large</i>	Piece	5,076
<i>Face masks</i>	Piece	2,000
<i>Flyers prevention</i>	Piece	182,174
<i>Flyers treatment</i>	Piece	1,000
<i>Infusion set</i>	Piece	200
<i>Intracath 18G</i>	Piece	2,450
<i>Intracath 20G</i>	Piece	2,300
<i>Intracath 22G</i>	Piece	2,950
<i>Intracath 24G</i>	Piece	2,401
<i>Jerry can (10-litres capacity) with tap</i>	Piece	303
<i>Oral Rehydration Salt</i>	Piece	270,896
<i>Plastic sheeting grey</i>	Piece	30
<i>Plastic bucket (14 L) with clip cover</i>	Piece	68,346
<i>Pool test</i>	Piece	8
<i>Raincoat</i>	Piece	200
<i>Ringer lactate</i>	Litres	11,000
<i>Safety glasses</i>	Piece	50
<i>Soap</i>	Bar	1,006,350
<i>Soap Banda(Cs 45 units)</i>	Piece	400
<i>Soap GIV (Cs 72 units)</i>	Piece	400
<i>Soap Genna (Cs 72 units)</i>	Piece	400
<i>Soap Oleda (Cs 72 units)</i>	Piece	400
<i>Sprayer</i>	Piece	136
<i>Stretcher</i>	Piece	100
<i>Trash bag</i>	Piece	1,700
<i>Water purification agent</i>	Litres	26,600
<i>Water tank (of 2500 gallons)</i>	Piece	40
<i>Yellow glove Medium</i>	Box	62

**Table 5. Composition of the cholera kits prepositioned in the HRC regional branches in July and August 2011 by IFRC and HRC.**

Article	Breakdown per Branch												TOTAL
	Nord	Sud	Ouest	Nord-Est	Nord-Ouest	Grande-Anse	Sud-Est	Nippes	Bas Artibonite	Haut Artibonite	Bas Plateau Central	Haut Plateau Central	
ORS (box of 800 ORS)	11	11	11	11	11	11	11	11	6	6	6	6	112
Gloves (box of 100 gloves)	9	9	9	9	9	9	9	9	5	5	5	5	92
Soap (box of 70 bars)	500	500	500	500	500	500	500	500	250	250	250	250	5'000
Aquatabs (box o 10'000 aqua tablets)	10	10	10	10	10	10	10	10	6	6	6	6	104
Prevention posters (pack of 1'000 posters)	3	3	3	3	3	3	3	3	2	2	2	2	32
Treatment posters (pack of 1'000 posters)	3	3	3	3	3	3	3	3	2	2	2	2	32
Prevention flyers (pack of 1'000 flyers)	3	3	3	3	3	3	3	3	2	2	2	2	32
Treatment flyers (pack of 1'000 flyers)	3	3	3	3	3	3	3	3	2	2	2	2	32
14L Plastic buckets (batch of 20 buckets)	100	100	100	100	100	100	100	100	50	50	50	50	1'000
10L Jerry can (batch of 150 jerry cans)	15	15	15	15	15	15	15	15	7	7	7	7	148
Shroud (box of 25 shrouds)	4	4	4	4	4	4	4	4	2	2	2	2	40
Chlorine (HTH) (45kg drum)	2	2	2	2	2	2	2	2	2	2	2	2	24

### **Output 2:**

An Emergency health delegate was in place in Haiti across all the critical time of the rainy and hurricane season to bring additional support to the Cholera team. The delegate ended her contract in November 2011, at the end of the hurricane season. Till the end of the Cholera operation in February 2012, the IFRC Cholera team was composed of a Cholera operation coordinator, a water & sanitation delegate, a finance delegate, a reporting delegate, one national medical coordinator and a national logistics officer. The Cholera operation team worked closely with the IFRC and HRC health departments to ensure complementarity of the response and health activities. While the team initially focused on coordinating the IFRC cholera response and support to the Haitian Red Cross, through the last phase of the operation the team focused on boosting the capacities of the Haitian Red Cross' health department to integrate cholera as an emergency health component within their ongoing work.

### **Output 3:**

The Haitian Red Cross Contingency Plan was revised with the support of the IFRC cholera team at the end of the Cholera operation to ensure all the lessons-learned and best practices would be integrated in the document. Thus a new Contingency plan of the Haitian Red Cross covering the period of April 2012 to April 2013 was developed and details the strategy of the Haitian Red Cross in responding the cholera epidemics. The Haitian Red Cross has decided to focus its activities on the prevention modes to tackle the transmission of cholera and no more in the treatment of affected patients. The activities will be focusing, among others, on increasing the number of HRC Health volunteers trained in Epidemic Control and Community-Based Health and First Aid and promoting Water, Sanitation and Hygiene good behaviours to multiply the sensitizations and

trainings of community members through the entire country are increased. (Please see more details on ECV and CBHFA in the Preventive Health and hygiene promotions section above and on HRC activities for 2012-2013 in the Looking Ahead section below).

**Output 4:**

The Haitian Red Cross medical response to the cholera epidemics increased through 2011 as gradually more Participating National Societies hander over the activities and cholera treatment structures they were managing to the Haitian Red Cross. As the HRC undertook additional programme activities in the operation, it was determined essential to increase the monitoring and reporting capacities of the HRC health department staff focusing on the cholera response. As such, the IFRC cholera coordination team developed an internal reporting system facilitating the regular collection of programmatic information. By June 2011, two focal points within the HRC health team were identified and trained on the implementation of the system. Moreover, two additional focal points attended a one-day training on how to train the regional and departmental branches in information management using the system. The IFRC Cholera department then funded the Reporting Focal Point to implement the training across 5 branches.

**Challenges:**

Although two HRC Health staff were trained in gathering and compiling data on cholera activities implemented by the Haitian Red Cross, it proved difficult for them to regularly get the data from the treatment facilities and from the regions implementing cholera response activities. As such, the data were submitted lately or partially which did not facilitate an accurate reporting process. In addition, one of the Reporting Officer resigned before the end of the operation bringing additional difficulties in gathering data. However, the people involved in the operation have been able to use the monitoring and reporting templates and tools developed for the operation, it should then be easier, in case of a future response, to ensure that the templates are in place and used since the beginning of the activities to collect more accurate data.

Communications	
<b>Outcome: Improve community awareness of, and resilience against cholera through communications.</b>	
<b>Output 1:</b> In Haiti, in the event of cholera outbreaks or identification of cholera-vulnerable areas, communications modalities will be employed to increase community awareness of cholera prevention and treatment.	<p><b>Activities Planned</b></p> <p>80 per cent of all identified cholera outbreaks are targeted by cholera-related messages delivered via SMS to vulnerable communities by 28 February 2012.</p> <p>At least 5 Radyo Kwa Wouj programmes dedicated to cholera information and awareness will be broadcast nationwide by 28 February 2012.</p> <p>A sound truck is available to be deployed to vulnerable areas in Port-au-Prince by 28 February 2012.</p>
<b>Output 2:</b> In the Dominican Republic, increased awareness and prevention of cholera is ensured through a web-based and SMS campaign.	<p>Carry out an SMS awareness-raising campaign targeting 1.5 million people</p> <p>Carry out a web-based campaign to increase the Dominican Red Cross visibility</p>

**Output 1:**

A key requirement to tackling the cholera epidemics is fast treatment and public information on prevention methods. In Haiti, as explained in the Beneficiary Communications Evaluation (*please see the report published on the IFRC website*) word of mouth and radio are the preferred methods of communications in Haiti. In addition, mobile phones are increasingly important for sharing information, so it appeared important for the Red Cross to brand its messages clearly so they are easily recognized and the population can take the advices provided into account. In the Cholera operation, Beneficiary Communications played a major role sharing life saving messages with the population using SMS, radio and sound trucks.

From October 2010 to February 2012, 15.4 million SMS were sent around the country. Thanks to a partnership with Trilogy International Partners (parent of Voila, Haiti's 2<sup>nd</sup> largest mobile network), messages were sent to the people living in camps and in communities on a regular basis and when outbreaks of cholera would develop. The efficiency of the SMS system was not only relying on the increasing use of mobile phone among the population but also on the possibility to reach identified zones affected by cholera in selecting the antennas of the network which cover the affected area to disseminate the messages. This system ensured that all the consumers having a Voila phone would receive the prevention or treatment related messages. Messages were focusing on providing information on cholera: the symptoms of cholera, the good behaviours

to avoid being affected or to adopt in case a member of the family presents symptoms, the methods to wash food and store water.



**The sound truck disseminating cholera prevention and treatment messages in La Piste IDP camp, Port-au-Prince. IFRC**

In addition to the SMS system, shows were broadcasting on the radio. According to a survey realized for the Beneficiary Communication department, the radio is the most popular source of information in Haiti. The Cholera operation used the extensive impact of this communication tool to inform and communicate with the population on cholera. From the November 2010 to February 2012, 18 *Radyo Kwa Wouj* show (Red Cross radio show in Creole) related to cholera were broadcasted on Radio Caraïbes and on Radio One. The *Radyo Kwa Wouj* show was (and still is) broadcasted twice a week, one hour on each radio.

The sound truck was also used as an informative tool for the population. It was deployed since the beginning of the operation to alert and inform the population at risk. The sound truck made 360 visits in the camps and

communities of and around Port-au-Prince, playing cholera prevention and treatment messages.

**Output 2:** The Dominican Red Cross improved the delivery of cholera prevention and awareness through the use of information technologies.

The Operation delivered more than 1.9 million SMS messages for more than 1.5 million cell phone users with awareness-raising content.

The DRC extended the awareness promotion campaign using social networks and information technologies while increasing its visibility. The DRC has an active blog ([blogoficialcruzrojadominicana.blogspot.com](http://blogoficialcruzrojadominicana.blogspot.com)), a Twitter account (@crdominicana) and a Facebook site, where information on programmes and operations is updated.

## Looking ahead

The Haitian Red Cross, as auxiliary to the government, is important health actor and with the added-value of its presence all over the country, is meant to be a major actor of the response to cholera. Although the Haitian Red Cross was involved in a treatment response until February 2012, the National Society developed a strategy to tackle cholera based on prevention rather than treatment. The response to cholera outbreak will be managed by the HRC emergency health team with the support of IFRC team in the field. Both the IFRC and the HRC emergency health teams have fully been in charge of responding to cholera since the IFRC cholera coordination team closed at the end of February 2012. The emergency health teams work in close coordination to take over the responsibility implementing cholera response activities in line with the HRC strategy. The Haitian Red Cross will increase its activities in CBHFA and Epidemic Control to strengthen the capacities. In the same manner, volunteer training will continue at the branch level, ensuring an efficient dissemination of prevention methods and knowledge against diseases such as cholera, dengue and malaria.

Among the Red Cross and Red Crescent Movement members who intervened and supported the Haitian Red Cross in the cholera response between 2010–2012, a number shared with the IFRC and the HRC their plans regarding cholera for 2012.

- **The American Red Cross** was implementing cholera response activities in the North, North-East and West departments. In the North and North-East, the American Red Cross confirmed the continuation of prevention activities at community level, hygiene promotion and water and sanitation activities in rural areas until mid-2012. As per the activities implemented in the West department, the intervention of American Red Cross in the IDP camps phased out in early 2012 to transition into development activities. The American Red Cross is joining the IFRC and other PNS in the Integrated Neighbourhood Approach (*please see additional information in the Operation updates reports related to the Earthquake operation appeal MDRHT008*) activities in Health. In this objective, any cholera response will be provided by the Health and Water and Sanitation teams and no longer by a dedicated team.
- **The British Red Cross** phased down its Water and Sanitation activities and Cholera response activities in end of 2011, handing over the CTC in La Piste IDP camp to the Haitian Red Cross as well as the CBHFA

(Community-Based Health & First Aid) volunteers trained in the camp. The HRC volunteers, thanks to the training and systems put in place would be able to alert the HRC in case of cholera cases.

- **The Canadian Red Cross** will maintain Oral Rehydration Points in Léogâne, Jacmel and Les Nippes until end of August 2012. The Canadian Red Cross plans on continuing to training volunteers in CBHFA in Jacmel. A strategy to respond to cholera would be developed to decide what strategy to adopt regarding sensitive issues (whether or not using vaccines in the response).
- **The Finnish Red Cross** will continue the implementation of CBHFA activities and prevention and hygiene promotion activities in Sodo (Centre department) in close collaboration with the Haitian Red Cross.
- **The French Red Cross** will continue to support the Health Office of the West Department (*Direction Départementale de l'Ouest – DSO*) until July 2012 (4 nurses supporting DSO activities and communal offices) and continue to provide support to 5 Severe Diarrhoea Treatment Units integrated in 5 MSPP Health Centres (2 Health Centres in Port-au-Prince and 3 in Petit-Goâve) and provide 9 Health agents to Health Centres (3 in Petit-Goâve and 6 in Port-au-Prince) to do sensitisation and education activities.
- **The German Red Cross** phased down its cholera response activities in Arcahaie (Ouest Department) to focus on CBHFA activities and hygiene promotion activities. In case of major outbreak in 2012, the German Red Cross would be ready to re-open the CTU in Arcahaie using the prepositioned stocks and tents.
- **The Luxembourg Red Cross** will continue its health project in Gressier (Ouest Department) consisting of supporting the MSPP and the Haitian Red Cross in implementing a Health Centre. The CTU managed by the Luxembourg Red Cross was transformed into a Severe Diarrhoea Treatment Unit which will remain within the Health Centre to treat, among diarrhoeal affected patients, cholera affected patients as developed by the MSPP guidance and strategy on cholera.
- **The Spanish Red Cross** Water and Sanitation teams in Léogâne and Jacmel will remained active hygiene promotion and support to water facilities. The Spanish Red Cross will continue its prevention and disinfection activities. In Jacmel and Port-au-Prince, cholera response stocks were prepositioned and can be used to respond to any major outbreak though the capacities of the Spanish Red Cross are more oriented towards prevention and disinfection than treatment.
- **The Swiss Red Cross** will continue supporting the Health Centre by distributing items (such as aqua tablets, bars of soap, informational flyers or ORS) to patients visiting the centre. A long term Water, Sanitation and Hygiene project has started in Palmiste-à-Vin (Ouest department) and will mainly focus on reducing the incidence of water borne diseases and cholera.
- **The International Committee of the Red Cross** will continue to regularly visit the detention places and the Prison Civile of Port-au-Prince, Cap-Haitien and Les Cayes. The mobile team for hygiene promotion will continue providing support as urgencies appear and will continue supplying places of detention with cleaning and disinfection material and medical supplies when needed. The ICRC will also continue advocating for a comprehensive health-promotion plan for detainees drawn-up and implemented by the relevant authorities.

The International Federation will continue providing support to the Haitian Red Cross. The cholera coordination team close at the culmination of this Appeal and the water & sanitation delegate was integrated into the IFRC health team to continue implementing hygiene promotion activities and monitoring cholera outbreaks. As detailed in the *Strategic Direction for Federation-Wide Cholera Preparedness and Response 2012*<sup>13</sup>, the IFRC health team will continue its hygiene promotion activities and sensitizations in locations of long-term activities, areas surroundings the Integrated Neighbourhood Approach areas and in particular vulnerable in addition to 21 camps. This approach, ensuring IFRC is providing (as part of the logic of the Integrated Neighbourhood Approach) an entire range of services in its current and/or previous areas of intervention is meant to provide as much safety as possible to the communities living in the targeted areas. In addition, with the conclusion of most of the activities in the camps (due to governmental decisions to focus on the rehabilitations of neighbourhoods), the population still living in precarious conditions in the spontaneous settlements is more vulnerable than before to cholera outbreaks. Hygiene promotion activities, coupled with CBHFA and epidemic control trainings for volunteers and community members will facilitate the dissemination of prevention and treatment information and good behaviours to adopt to prevent contamination.

The IFRC supported the Haitian Red Cross in developing a Multi-risks Contingency Plan for the Red Cross and Red Crescent Movement which was completed during the first part of 2012. This contingency plan details the mechanisms and capacities of the Movement to respond to cholera outbreaks (as well as hurricanes and floods), developing several scenarios of response based on the importance of the potential outbreaks. This draft document has been shared with the members of the Movement components present in Haiti for feedback and comments received are being integrated to finalize the process as soon as possible. Based on this Multi-

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<sup>13</sup> Please see attached in **Annex 2** the *Strategic Direction for Federation-Wide cholera Preparedness and Response 2012*.

risks Contingency Plan for the Movement, the HRC health department of has drew up a cholera contingency plan still under draft.

It is important to mention that as a result of the operation, the Dominican Red Cross, cholera has been integrated into the community health programmes of the National Society in particularly the emergency health programmes. After the close of the operation, the National Society will continue its strategy and activities for cholera prevention, mainly focused on epidemiological surveillance, psychosocial support, water and sanitation. This will be carried out in coordination with governmental authorities and key actions. Furthermore, cholera and diarrheic diseases have been integrated into the Contingency Plan of the National Society and Partner National Societies present in the country will continue supporting the Dominican Red Cross in its efforts to tackle future outbreaks.

As a response to an increase of the cases of cholera the first months of 2012, the close of the Cholera operation, the risks posed by the rainy season and the threat of new cholera outbreaks the IFRC Communications unit supported the Health department in the development and dissemination of an [Advocacy Report](#) titled "*The Looming Threat*" dedicated to raise awareness of partners and the international community. In the same manner, a web story from the Dominican Red Cross was published. The attention of the international community, institutional donors but also governments, has drastically reduced as other disasters were appearing on the international scene and as the economical crisis was reducing the funds available for the external aid. However, the situation in Haiti regarding cholera remains a huge concern for the actors still present and especially for the Haitian Red Cross as the means to respond to a massive outbreak similar to October 2010 will be more difficult to mobilize.

## Annexes

Annexes related to the cholera response in Haiti and Dominican Republic.

- **Annex 1:** Map localizing the PNS intervention zones in Haiti since the beginning of the outbreak in October 2010.
- **Annex 2:** Strategic Direction for Federation-Wide Cholera Preparedness and Response 2012.

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## Contact information

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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 (NGOs) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster 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.

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**Saving lives, changing minds.**



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.
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**I. Funding**

Selected Parameters	
Reporting Timeframe	2010/1-2012/7
Budget Timeframe	2010/1-2012/7
Appeal	MDR49007
Budget	APPROVED

All figures are in Swiss Francs (CHF)

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	Deferred Income
<b>A. Budget</b>	<b>11,486,811</b>					<b>11,486,811</b>	
<b>B. Opening Balance</b>	<b>0</b>					<b>0</b>	
<b>Income</b>							
<b>Cash contributions</b>							
American Red Cross	2,201,678					2,201,678	
Andorran Red Cross	14,035					14,035	
Australian Red Cross	337,995					337,995	
Brazilian Government	9,369					9,369	
British Red Cross	78,000					78,000	
Danish Red Cross	281,225					281,225	
European Commission - DG ECHO	223,187					223,187	7,048
Finnish Red Cross	478,194					478,194	
Italian Government Bilateral Emergency Fund	137,684					137,684	
Japanese Government	3,542,085					3,542,085	47
Japanese Red Cross Society	211,679					211,679	
Norwegian Red Cross	320,928					320,928	
Other	0					0	
Senegalese Red Cross Society	1,127					1,127	
Swedish Red Cross	285,431					285,431	
Swiss Red Cross	23,550					23,550	
Taiwan Red Cross Organisation	142,626					142,626	
The Canadian Red Cross Society	433,994					433,994	
The Netherlands Red Cross	391,370					391,370	
The Republic of Korea National Red Cross	972,925					972,925	
<b>C1. Cash contributions</b>	<b>10,087,081</b>					<b>10,087,081</b>	<b>7,095</b>
<b>Inkind Goods &amp; Transport</b>							
American Red Cross	275,677					275,677	
Finnish Red Cross	303,251					303,251	
The Netherlands Red Cross	215,250					215,250	
<b>C2. Inkind Goods &amp; Transport</b>	<b>794,177</b>					<b>794,177</b>	
<b>Inkind Personnel</b>							
Finnish Red Cross	50,353					50,353	
The Canadian Red Cross Society	73,103					73,103	
<b>C3. Inkind Personnel</b>	<b>123,456</b>					<b>123,456</b>	
<b>Other Income</b>							
Programme & Services Support Recover	53,965					53,965	
<b>C4. Other Income</b>	<b>53,965</b>					<b>53,965</b>	
<b>C. Total Income = SUM(C1..C4)</b>	<b>11,058,680</b>					<b>11,058,680</b>	<b>7,095</b>
<b>D. Total Funding = B + C</b>	<b>11,058,680</b>					<b>11,058,680</b>	<b>7,095</b>
<b>Coverage = D/A</b>	<b>96%</b>					<b>96%</b>	

**II. Movement of Funds**

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	Deferred Income
<b>B. Opening Balance</b>	<b>0</b>					<b>0</b>	
<b>C. Income</b>	<b>11,058,680</b>					<b>11,058,680</b>	<b>7,095</b>
<b>E. Expenditure</b>	<b>-10,184,007</b>					<b>-10,184,007</b>	
<b>F. Closing Balance = (B + C + E)</b>	<b>874,673</b>					<b>874,673</b>	<b>7,095</b>

Selected Parameters	
Reporting Timeframe	2010/1-2012/7
Budget Timeframe	2010/1-2012/7
Appeal	MDR49007
Budget	APPROVED

All figures are in Swiss Francs (CHF)

### III. Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination		
A							B	A - B
<b>BUDGET (C)</b>		<b>11,486,811</b>					<b>11,486,811</b>	
<b>Relief items, Construction, Supplies</b>								
Shelter - Relief	120,000	212,062				212,062	-92,062	
Construction - Facilities	13,500	279				279	13,222	
Construction Materials	27,000	1,778				1,778	25,222	
Clothing & Textiles	2,025						2,025	
Water, Sanitation & Hygiene	2,386,797	2,273,413				2,273,413	113,384	
Medical & First Aid	1,139,014	1,006,322				1,006,322	132,692	
Teaching Materials	100,000	66,803				66,803	33,197	
Utensils & Tools	900,000	763,857				763,857	136,143	
Other Supplies & Services	10,636	7,400				7,400	3,236	
<b>Total Relief items, Construction, Suj</b>	<b>4,698,972</b>	<b>4,331,913</b>				<b>4,331,913</b>	<b>367,059</b>	
<b>Land, vehicles &amp; equipment</b>								
Vehicles	30,000	29,997				29,997	3	
Computers & Telecom	25,000	16,421				16,421	8,579	
Office & Household Equipment	45,000	7,768				7,768	37,232	
Others Machinery & Equipment	1,000						1,000	
<b>Total Land, vehicles &amp; equipment</b>	<b>101,000</b>	<b>54,186</b>				<b>54,186</b>	<b>46,814</b>	
<b>Logistics, Transport &amp; Storage</b>								
Storage	180,000	167,533				167,533	12,467	
Distribution & Monitoring	791,882	643,971				643,971	147,911	
Transport & Vehicles Costs	239,737	197,134				197,134	42,603	
Logistics Services	232,776	142,109				142,109	90,667	
<b>Total Logistics, Transport &amp; Storage</b>	<b>1,444,395</b>	<b>1,150,748</b>				<b>1,150,748</b>	<b>293,647</b>	
<b>Personnel</b>								
International Staff	943,127	808,433				808,433	134,695	
National Staff	233,193	234,106				234,106	-913	
National Society Staff	709,584	770,589				770,589	-61,005	
Volunteers	100,000	196,820				196,820	-96,820	
<b>Total Personnel</b>	<b>1,985,904</b>	<b>2,009,948</b>				<b>2,009,948</b>	<b>-24,044</b>	
<b>Consultants &amp; Professional Fees</b>								
Consultants	21,701	59,853				59,853	-38,152	
Professional Fees	22,500	35,541				35,541	-13,041	
<b>Total Consultants &amp; Professional Fe</b>	<b>44,201</b>	<b>95,394</b>				<b>95,394</b>	<b>-51,193</b>	
<b>Workshops &amp; Training</b>								
Workshops & Training	471,476	366,649				366,649	104,827	
<b>Total Workshops &amp; Training</b>	<b>471,476</b>	<b>366,649</b>				<b>366,649</b>	<b>104,827</b>	
<b>General Expenditure</b>								
Travel	114,250	70,134				70,134	44,117	
Information & Public Relations	522,614	145,468				145,468	377,146	
Office Costs	57,435	55,996				55,996	1,440	
Communications	15,506	10,442				10,442	5,064	
Financial Charges	97,304	33,837				33,837	63,467	
Other General Expenses	69,680	34,869				34,869	34,811	
Shared Office and Services Costs	1,000,000	734,445				734,445	265,555	
<b>Total General Expenditure</b>	<b>1,876,790</b>	<b>1,085,190</b>				<b>1,085,190</b>	<b>791,599</b>	
<b>Depreciation</b>								
Depreciation and impairment	0	4,348				4,348	-4,348	
<b>Total Depreciation</b>	<b>0</b>	<b>4,348</b>				<b>4,348</b>	<b>-4,348</b>	
<b>Contributions &amp; Transfers</b>								

Selected Parameters	
Reporting Timeframe	2010/1-2012/7
Budget Timeframe	2010/1-2012/7
Appeal	MDR49007
Budget	APPROVED

All figures are in Swiss Francs (CHF)

### III. Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination		
A							B	A - B
<b>BUDGET (C)</b>		<b>11,486,811</b>					<b>11,486,811</b>	
Cash Transfers National Societies	163,000	400,099				400,099	-237,099	
<b>Total Contributions &amp; Transfers</b>	<b>163,000</b>	<b>400,099</b>				<b>400,099</b>	<b>-237,099</b>	
<b>Operational Provisions</b>								
Operational Provisions	0						0	
<b>Total Operational Provisions</b>	<b>0</b>						<b>0</b>	
<b>Indirect Costs</b>								
Programme & Services Support Recov	701,073	604,624				604,624	96,449	
<b>Total Indirect Costs</b>	<b>701,073</b>	<b>604,624</b>				<b>604,624</b>	<b>96,449</b>	
<b>Pledge Specific Costs</b>								
Pledge Earmarking Fee		76,308				76,308	-76,308	
Pledge Reporting Fees	0	4,600				4,600	-4,600	
<b>Total Pledge Specific Costs</b>	<b>0</b>	<b>80,908</b>				<b>80,908</b>	<b>-80,907</b>	
<b>TOTAL EXPENDITURE (D)</b>	<b>11,486,811</b>	<b>10,184,007</b>				<b>10,184,007</b>	<b>1,302,804</b>	
<b>VARIANCE (C - D)</b>		<b>1,302,804</b>				<b>1,302,804</b>		





**Strategic direction for federation-wide cholera  
preparedness and response  
HAITI 2012**

## **Strategic Direction for Federation-Wide Cholera Preparedness and Response 2012**

### **Introduction**

The Movement strategic direction in respect of our resources and capacities to prepare for and deal with a cholera outbreak is at a crossroads. The IFRC Cholera Appeal ended in late February 2012 with the Cholera Unit now merged within the HRC / IFRC Health Programme within the Emergency Health thematic area. Other partners have also seen restructuring of their cholera preparedness and response capacities with a corresponding reduction in resources. Evidence suggests that as we face the onset of the rainy season national capacity to adequately deal with the almost inevitable cholera outbreaks has been severely diminished with MSPP and other government structures struggling to find resources and with many NGOs having withdrawn from the country. This will mean that RC partners will, in all likelihood, be expected to play a greater role and assume more responsibilities to respond to the epidemic. With this scenario in mind Haitian Red Cross and IFRC Senior Management have tasked the health and water & sanitation departments with developing a coherent strategic plan to be implemented in the coming months (ideally for the next 12 months) to ensure credibility and long-term response to our partners – MSPP among others- to mitigate against and respond to a cholera epidemic. As a Movement, we recognize that it is vital that all the actors agree on one single strategy of interventions to ensure it is efficient, there is no duplication and/or overlap between the actors' activities and to keep in mind that our activities always support the capacity of the Ministry of Health (MSPP) and other state structures and entities including DINEPA to plan for and respond to the epidemic.

### **Cholera: The Risks**

The epidemic of cholera in Haiti began around 14 October 2010 with a cluster of cases of acute watery diarrhoea reported in Artibonite led to the number of cases reported throughout Haiti during the first 12 months being roughly equal to 4% of the national population. This is the highest cholera incidence ever documented anywhere in the world.<sup>1</sup>

Since early December, 2011, the reported incidence of cholera in Haiti has dropped to less than 500 cases per day nationwide. This number, while exceptionally high for most countries, is relatively low and manageable by comparison with the earlier waves. If cholera in Haiti begins to behave as it has in other countries where the disease has become endemic, the annual incidence should eventually fall to 1% or less of the levels seen during Haiti's first year. Or will the next wave be as large as during May to July 2011 or as large as during October 2001? To date, the epidemiologists of PAHO, CDC and other public health agencies have yet to publish any predictions of the size of future outbreaks.<sup>2</sup>

What is clear is that cholera, now endemic, poses a significant public health threat and one that we cannot say we are unaware of. As we approach the May – June rainy season there is a pressing need to put in place clear planning documents including Strategic Plans and Contingency Plans and to focus developing and articulating a clear movement strategic direction as regards to cholera.

This paper has been written in response to requests to begin a process leading to the development of these and other tools, strategies and guidelines and comes from a number of discussions and deliberations involving HRC and IFRC management and technical staff. It is hoped it will be the first step towards the development of a coherent Movement position on cholera.

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<sup>1</sup> Final Evaluation of Emergency Cholera Response on Hispaniola Island. Pond and Brand February 2012. Not yet finalized.

<sup>2</sup> Ibid

## Recommended Geographical Focus:

After evaluating the geographical areas most at risk of a sudden and sustained cholera outbreak and bearing in mind our own current and potential capacities we as a movement will focus on the following geographical areas whilst retaining the capacity through trained volunteers to assist in the response to localized outbreaks elsewhere in the country:

### 1. IDP Camps

As of February 2012, an estimated 120,791 IDP households or 490,545 individuals remain in 660 sites across the earthquake affected area. Most IDP sites that remain open today were established immediately after the earthquake. Most IDP sites continue to be made up mostly of tents and makeshift shelters. As of February 2012, 606 sites (92%) have shelters made up of tents and makeshift structures. 43 sites (7%) have a mix of tents, makeshift shelters and transitional shelters (T-shelters). 11 additional sites (2%) are composed mostly of T-shelters.<sup>3</sup>

As a Movement we believe that the overcrowded and precarious living conditions in the camps pose a significant threat of an outbreak or cholera. Evidence points to there being a deterioration in water and sanitation and hygienic practices in the camps. These findings are backed up by reports from other agencies: as far back as May 2011 the CCCM were stating that *basically camps are no longer "safe" and could be at proportionally higher risk for cholera transmission.*<sup>4</sup> They attributed the change in risk to a number of factors including:

- Reduced camp management agencies
- Vastly reduced presence of WASH actors/services
- Cessation of free water trucking in most camps
- Cessation of latrine maintenance
- Reduced latrine desludging
- Reduced presence of health partners in camps
- Frequent flooding due to onset of rains à increased risk of contamination

Haitian Red Cross / IFRC are currently working in seventeen (17) IDP camps mainly on hygiene promotion activities. We are also involved in La Piste JMV, La Piste T-shelter, Automeca and Annexe la Mairie with a combined total population **62,274**. For a full list of camps see Annex 1. Other movement partners such as the French Red Cross and American Red Cross are working in other IDP camps which increases our reach and relevance.

### 2. Integrated Neighbourhood Approach (INA) locations

Building on our commitment to bring a package of services (including health) to INA targeted areas we propose scaling up cholera prevention activities as part of an integrated health programme in the following (and potentially further) areas:

- Commune: Port-au-Prince. Quartier: Carrefour Feuilles. # of households (catchment area): 200. Est. # of beneficiaries: **1,000**
- Commune: Delmas Quartier: Delmas 30. •# of households: 400. •Est. # of beneficiaries: **2,000**
- Commune: Delmas. Quartier: Delmas 33 – Bethanie and Place Cazeu. # of households 1,354. Est. # of beneficiaries: **6,770**

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<sup>3</sup> Displacement Tracking Matrix V2.0 Update IACS Haiti E-Shelter / CCM Cluster 20 February 2012

<sup>4</sup> Cholera in Camps - update for rainy season: CCCM Cluster. May 2011

- Commune: Leogane. # of households 4,408. Estimated # of beneficiaries: **22,040**. (With Spanish RC)

**Note:** Locations to be confirmed with other areas being supported by other movement partners - will be included in the final list.

### 3. Localities surrounding our designated INA areas

We recommend working on cholera prevention and other activities in areas surrounding our INA locations to ensure INA communities and communities surrounding our INA sites get a more equitable provision of services. These sites have yet to be decided upon. An assessment of 39 camps in the perimeter of INA sites has been made by the IFRC water & Sanitation Programme and the results of the assessment will be made available at the end of next week.

### 4. Locations where we have long-term health activities

HRC, IFRC and PNS are running multi-year community health projects in a number of locations focusing on the Community-Based Health & First Aid (CBHFA) approach in:

- Leogane: HRC, IFRC & with Spanish RC. 6,425 household's inc. 4,408 in INA.
- Petit Goave: HRC and Norwegian RC. 4,000 households
- Jacmel: HRC and Canadian RC. 10,748 households
- Saut d'Eau: HRC and Finnish RC. 9,000 households
- Arcahaie: HRC and German RC. 20,000 households
- Gressier: HRC and Italian RC (just beginning)

We recommend that we pay special attention to cholera prevention activities in these locations as part of the overall CBHFA package and that we strengthen links with local health and municipal authorities to be better able to coordinate response capacity in the event of outbreaks.

### 5. Areas with particular vulnerabilities

We advocate paying special attention to areas where particular vulnerabilities exist and where RC has a means to react and assist.

Locations include but may not be limited to remote areas and islands where public authorities may have limited presence or access. With the imminent purchase of boats for the expanded HRC ambulance service we particularly recommend focusing on the islands of Isle La Vache and La Gonave and other areas pending further analysis. See **Appendix Two: Cholera Risk and Vulnerability Analysis**.

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## Recommended Interventions

In proposing a list of recommended activities we have been guided by research that has been carried out by others, by our own collective experiences since October 2010 and by the recommendations from the (draft) cholera evaluation by Bob Pond and Yannick Brand which has not, as yet, being published but whose recommendations we include in **Appendix Three**. "*Five complementary interventions to slow cholera: Haiti*" of Ivers, Farmer, Almazor and Leandre<sup>5</sup> details recommended activities and strategies that should be taken into account – many are applicable to our RC activities.

- (1) Identify and treat all those with symptomatic cholera.

Community health workers can play a critical role as first responders in the epidemic. To refer patients, networks of community health workers need to be able to do more than note the onset of diarrhoea: they must be able to start oral rehydration therapy and transport the sick even where roads are poor or get flooded. Ambulances are in critically short supply – more are needed to move the afflicted to proper care.

- (2) A concerted effort should be made to make oral vaccines available in Haiti and elsewhere

Trials being carried out in Artibonite by MSPP and Partners in Health with financial support from American RC.

- (3) Remedy Haiti's Water Insecurity and Improve Sanitation

All effort should be focused on improving access to clean drinking water through public works projects, point of use water purification systems and other proven means. Public health messages about hand wash or water treatment with chlorine tablets should not be limited to what is called social marketing but should instead be linked to a massive effort to make sure soap, treated water and safe latrines are available to those receiving the messages.

- (4) All vertical health projects must be dedicated at least in part to strengthening Haiti's Health system

We need to ensure that cholera is integrated into all our health (and other programme) activities and to make sure we are strengthening the existing MSPP health structures.

- (5) Cholera demands not merely a harmonization of global health policy but also raising the bar on our goals.

Cholera along with other pathogens such as AIDS, and dengue will continue to affect Haiti so we need to look at the bigger picture, have more ambitious goals and look at how cholera, for instance, is being addressed in other settings – the authors mention Florida and the Dominican Republic.

Haitian Red Cross developed a Cholera Plan of Action which was presented twice to the membership in 2011. In keeping with recommendations from the recent Cholera Evaluation we recommend that our collective efforts try as much as possible to follow the direction of this Plan of Action with some additional activities as recommended in the Cholera Evaluation and during our HRC / IFRC Cholera Meeting of 6<sup>th</sup> March 2012.

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<sup>5</sup> "Five complementary interventions to slow cholera: Haiti". Ivers, Farmer, Almazor and Leandre. The Lancet, Volume 376, Issue 9758. 18 December 2010

The activities can be roughly divided into three areas:

- ongoing activities focusing on prevention including water & sanitation and advocacy
  - scaled up assessment and response capacity in event of outbreaks
  - scaled up treatment capacity in the event of outbreaks through re-activation CTC's, reinforcement of MSPP facilities and, in the case of a massive outbreak, the deployment or other mechanisms such as FACT and ERU's.
- **Prevention**

HRC will continue to contribute to the reduction of cholera related mortality and morbidity in Haiti by:

- Reinforcing prevention and hygiene promotion activities by working with community groups in targeted areas.
- Ensure a permanent and active surveillance system in target areas.
- Ensuring people in targeted areas have access to safe water and adequate sanitation.

We have a strong group of trained volunteers using standardized tools and approaches (ECV, CBHFA, PHAST), ORS at community level, methods to do proper water treatment

- **Water, Sanitation and Hygiene Promotion**

The main concern since end of 2011 and the beginning of 2012 is the end of WatSan intervention in camps. Water distributions in camps have stopped: many camps are no longer supplied with treated water. The same situation is happening with latrines: latrines are no longer desludged in camps [some are dislodged with Bayakou (manual dislodging) but this is less efficient]. In addition, the reduction of hygiene promotion activities in camps is leading to a reduction in the knowledge on good hygiene practices. The situation is creating risks of contamination in the camps whereas so far the camps had been quite protected thanks to the intervention of WASH actors. Hygiene promotion activities have been done however, there is a need to continue and focus on household's level. There is a need to change the treatment system established in camps as the water committees are no longer treating the water though they are now in charge to do it. The use of chlorine seems to be complicated meaning there is a need to simplify the process. Commercially available Clorox is being recommended to be used in the as it is readily available, more easily acceptable and will be easier to use.

- **Advocacy**

There is a need to advocate at MSPP level to ensure the water provided by private vendors is safe and treated. There is a need to advocate at governmental level to "put pressure" on the state structures to reinforce the legislation on the quality of water sold by private vendors. The observatory of DINEPA is receiving information but there are not sufficient tools/guidance/notes explaining how the information was captured/collected. There is a need for the Movement to develop a tool that can cross-checked the information received at DINPEA level to ensure about the accuracy of the information. There is a need to bring the MSPP and DINEPA at the same table to ensure all the governmental authorities involved in cholera response are working together as it will make the response more comprehensive and global, so more efficient. The Ministry of Trade is also an entity that has to be involved in the advocacy process as it is also concerned by the issue with the private vendors selling water of bad quality.

## - **Assessment and Response**

HRC and IFRC will strengthen training and capacity of our Emergency Response Team composed of hygiene promoters, DRM volunteers and trained health volunteers to ensure national coverage and response capacity.

## - **Transportation**

In regards to transportation of patients, in common with other activities, there is a need to clearly agree on and define what the Movement can and cannot do the conditions of the intervention and the limits of the intervention. In the case of an outbreak we need to be flexible to provide support and response. It is also important to have a clear policy the issue of the transportation of affected patients. People know that RC Movement have capacities in this area and there will be an expectation from partners and the public that we assist. For reasons of infection control we recommend that where possible existing ambulances are not used but that old Land Cruisers or other vehicles be modified and made available should there be requests to transport cholera affected patients. Some PNS have also used modified Tap Taps given that they have a separation between the driver and the patient making the system safer and are easy to clean / disinfect. This transportation issue needs to be further investigated as a matter of urgency.

## - **Treatment**

Following a MSPP request for support HRC took responsibility for the running of two Cholera Treatment Centers: a CTC in Carrefour-Feuille and a CTU in Port-à-Piment managed with the support of IFRC and Canadian Red Cross. In December 2012 British Red Cross handed over the CTC in La Piste (JMV) to HRC / IFRC. Carrefour-Feuille and Port-à-Piment closed at the end of February 2012 due to the decrease of cholera cases and patients they were receiving and also due to financial considerations with La Piste (JMV) due to close at the end of March. Since their opening the CTC in Carrefour-Feuille has treated 1,428 cases with one death and the CTU in Port-à-Piment has treated 2,724 cases with 35 deaths. The CTC in La Piste received 150 patients in February.

The main risk faced with the closure of the structures is in not being able to respond on time to a potential outbreak. It has been noticed that more than 60% of the deaths occurred within the 3 first weeks of the cholera epidemic. As the structures are closed our response will take more time. Port-à-Piment is a particular case given that no other structure exists for some distance around it.

Given our constraints and the fact that we consider our comparative advantage being predominantly in prevention and surveillance it is important that the Movement ensures the capacities of the MSPP are really reinforced otherwise the action developed will not be sustainable. The problem of the NGOs response in 2010-2011 was to treat patients, to respond to the emergency but there has been a lack of involvement and reinforcement of the capacities of the state structures. We can't duplicate these existing mechanisms but rather need to work with MSPP and others to reinforce their services.

We have supplies in our central warehouse and have pre-positioned material (soap, ORS, aqua tabs, protective material and IEC material) at the thirteen branches. In the pipeline we have additional supplies which should arrive in the next month or so. Materials from the closed CTC's will be cleaned and assessed and medical supplies checked so we have a clear vision of the physical resources available. As assessment of the stock coming for the first cholera operation and remaining in Barbancourt has been done. The stock left will not be sufficient to respond to major outbreaks. A detailed assessment of material available, in the pipeline and required will be carried out and shared with all partners.

## **Next Steps**

This is a discussion document for our 9<sup>th</sup> March Movement-Wide Cholera Meeting where we will (hopefully) reach a consensus on the way forward. We recommend that once geographical focus and activities are agreed a small group representing HRC, IFRC and PNS work together to develop a more detailed document taking into account this paper and the detailed recommendations of the cholera evaluation.

## Appendix One

### Camps Where HRC and IFRC are Operational March 2012

No	IFRC code	Area	Quartier	Site name	SSID	POP	Estimated Nbre of Household	Institution
1	IFRC 004	Delmas	Delmas 33	Henfrasa	112_01_063	3335	667	IFRC
2	IFRC 10	Delmas	Delmas 31	Ancien Ministere des femmes	112_01_549	75	15	IOM/IFRC
3	IFRC 18	Delmas	Delmas 31	Parc Maguana	112_01_084	750	150	IFRC
4	IFRC 24	Delmas	Delmas 89	Lindor 2	112_01_002	4315	863	IFRC/WV/CRS/UNOPS
5	IFRC 26	Delmas	Delmas 19	Quartier Renoncule	112_01_070	250	50	IOM/IFRC
6	IFRC 34	Delmas	Village OPHSP	Montre Ville	112_01_058	530	106	IFRC
7	IFRC 34 A	Delmas	Village OPHSP	Catalpah		350	70	CRS/IFRC
8	IFRC 68	Delmas	Delmas 33	Rue Charbonniere prolongée	112_01_320	15000	3000	IFRC/AMCROSS
9	IFRC 71	Port au Prince	Belair	Ecole Discrete Aumone	112_01_029	235	47	IFRC
10	IFRC 73	Port au Prince		Avenue Pouplard	111_01_470	260	52	IFRC
11	IFRC 76 B	Delmas	Village OPHSP	Bas Puits- Blain	112_01_498	1000	200	OSHAM/IFRC
12	IFRC 79	Delmas	Delmas 33	Parc Saint Clair	112_01_099	1070	214	IFRC
13	IFRC 96 A	Delmas	Mais Gaté	Linz Harry 3		145	29	IOM/IFRC
14	IFRC	Delmas	Mais Gaté	Mais Gaté 12		1500	300	IFRC/IOM
15	IFRC	Delmas	Delmas 28	Delmas 28 B		675	135	IFRC/UNOPS/BRC
16	IFRC 106	Delmas	Delmas 33	Rue des mines		805	161	IFRC
17	IFRC	Port au Prince	Belair	Republique Argentine		3600	729	IFRC/IOM
18		Delmas	Delmas 2	La piste T shelter		1322	377	INA
19	IFRC 002	delmas 19	Delmas 19	Automeca	112_01_063	4052	1013	BRC?
20		Cite Soleil	Satre	Annexe la Mairie		1756	321	INA
21	IFRC 108	delmas 19	la Piste	La piste JMV	112_01_348	21250	4250	BRC?
<b>Total</b>						<b>62'275</b>	<b>12'749</b>	

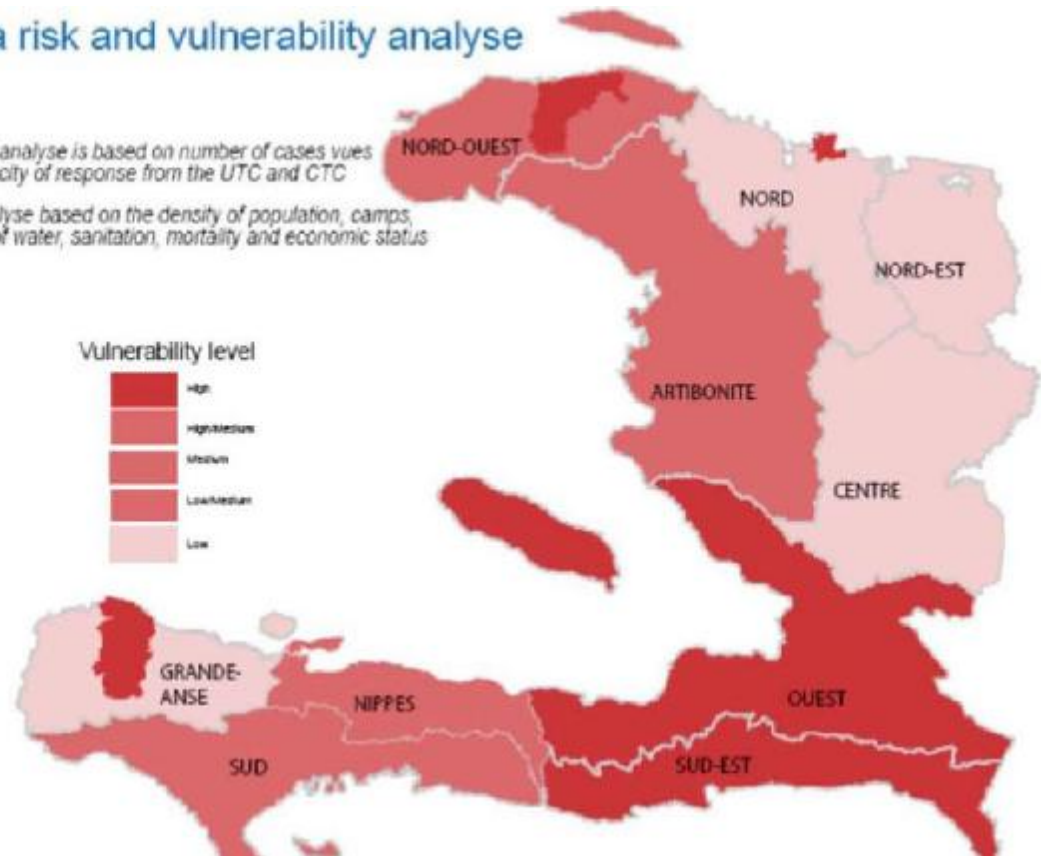
## Appendix Two

### Cholera Risk and Vulnerability Analysis

#### Cholera risk and vulnerability analyse

-Vulnerability analyse is based on number of cases vues and the capacity of response from the UTC and CTC

- the risk analyse based on the density of population, camps, access to prof water, sanitation, mortality and economic status



## Appendix Three

### Recommendations from (Draft) Cholera Evaluation

#### Preparedness

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##### **Reinforce global guidelines and tools for epidemic response**

IFRC should develop guidelines and a model template for structuring rapid assessment during an epidemic emergency. These should guide the assessment of the epidemic as well as the assessment (inventory, mapping) of the available resources (skilled HR, supplies, equipment, guidelines, etc...) and plans (strategies, procurement plans, HR plans, officially designated treatment sites, etc..) for epidemic response;

IFRC should complete the development of the ECV materials in line with the recommendations of the June 2011 evaluation. IFRC should then support rigorous monitoring and evaluation to document the skills that volunteers acquire as a result of the training, the resulting actions that participants carry out and the effectiveness of the approach in supporting epidemic response. To complement the training materials, guidance should be provided on how to coordinate the efforts of ECV volunteers with those of other local health and WASH actors.

Given that a well established delegation may be reluctant to deploy an autonomous FACT team, **IFRC should develop and promote the use of a modified emergency response tool for deployment of additional specialized resources for assessment and coordination.** As with a FACT or a RIT, the SOPs of such a deployment should be well defined so as to assure that it provides sufficient, qualified staff while remaining consistent with the decision making authority of a local delegation.

##### **Develop a model contingency plan for epidemic response**

IFRC should develop a model contingency plan that addresses the possibility of an epidemic emergency. To support the country-level adaptation of such a model contingency plan, especially in countries that are judged to be epidemic prone, IFRC should assure that Zonal offices have the resources to support countries and to regularly update their contingency plans.

##### **Support use of existing guidelines**

IFRC should develop and strengthen mechanisms (i.e. initial training, IMPACT training) to better orient delegates to existing guidelines and other resources (e.g. DMIS) available on its website.

##### **Assessment of an Epidemic Emergency**

If it's really an emergency, then there is no substitute for having sufficient, qualified staff for assessment, planning and coordination. IFRC needs better guidance on how to determine the additional capacities required to assess and respond to a fresh emergency in instances where the Federation and the RC Movement already have a large delegation in country and

they have already begun to implement a challenging work plan (e.g. earthquake response and recovery). Ideally, as discussed under recommendation 3, there should be a global or regional emergency response “tool” that meets the needs of a local delegation. There need to **clearly defined criteria for judging the adequacy of existing capacity and triggering the deployment of a team with well defined SOPs**. These criteria could be specified in the assessment guidelines proposed as recommendation 1.

Epidemics should be assessed in a different way than time-limited, focalized disasters. The response needs to be different so different methods are needed for rapid assessments. Ideally, as discussed under recommendation 1, IFRC would provide global guidelines and a model template for such assessments. In instances where such specialized guidelines do not exist, they must be rapidly developed by qualified staff.

There must be sufficient, trained staff available (perhaps with PNSs) to conduct such guided assessments wherever the epidemic emergency is suspected to have spread.

Written reports of assessments are essential. These written reports should meet the information needs of national and regional clusters. Assessments in multiple regions should be compiled into a summary assessment report that becomes the basis for the overall RC Movement plan for epidemic response

Following the initial assessment, further in-depth assessment is typically required to support implementation and management of response activities. Once again, qualified technical staff of the Movement need to prioritise development of an instrument for in-depth assessment of the epidemic and assessment of early epidemic response. The RC Movement should adopt a harmonized approach to such in-depth assessment. An example of such an in-depth assessment tool is provided on the *One Response* web site<sup>6</sup>

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### Coordination of the response

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For an operation as complex as the cholera response, **a technical movement coordinator is essential** for RC Movement coordination and for external representation/coordination. As was learned from the Earthquake Response, effective Movement coordination is likely to depend upon separation of coordination responsibilities from those of IFRC operations. That is, the capacity for this coordination should have resided **in the TMC Department**. As discussed under recommendation 30, the evaluators recommend that the position of Technical Movement Coordinator for Health be added to support future Movement coordination of health activities including future cholera response.

Coordination is a core function of IFRC and thus requires an HR plan, financial plan and indicators for monitoring. The human resources devoted to coordination should be proportionate to the size of the Movement’s response.

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[http://onerresponse.info/resources/NeedsAssessment/publicdocuments/WHO%20IRA\\_Form\\_and\\_Guidance\\_Notes.pdf](http://onerresponse.info/resources/NeedsAssessment/publicdocuments/WHO%20IRA_Form_and_Guidance_Notes.pdf) or <http://www.un.org.np/resources/mira>

When an emergency becomes widespread, effective Movement coordination requires **delegation of responsibility to locally active PNS and HNS representatives** with mutually agreed Terms of Reference for those tasked with coordination functions.

The role of the **HNS** in **sharing the coordination** needs to be emphasized and clearly defined. This will be discussed further in the recommendations addressing the role of the HNS.

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### **Planning the Emergency Response**

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Even at the outset of an emergency, **a written Movement-wide strategic plan is possible and should be a priority** for IFRC to develop.

Any emergency appeal should be accompanied by a written **IFRC work plan** that includes a **logical framework** and specifies indicators, targets, a Gantt chart, a recruitment plan and a procurement plan. An emergency Appeal is unlikely to constitute an adequate planning document. If necessary, the work plan can be for internal use only.

If such a plans (a Movement strategic plan; an IFRC a work plan/logical framework) cannot be developed at the time an Appeal is launched, then it is a priority to complete them as soon as possible.

When an emergency Appeal is launched by IFRC to supplement an existing emergency operation, **the Appeal and the accompanying plans should clearly distinguish new activities** from on-going operations and clearly **distinguish tasks to be performed by IFRC from tasks to be undertaken by PNSs** and other outside organizations.

To assure that **work plans and logical frameworks** are finalized on time and put into use, **senior leadership/management should place greater priority on these processes.**

As in the classic planning cycle, the implementation of a plan needs to be monitored and evaluated to inform a process of **re-planning**. IFRC's work plan should include provision for re-planning and the means (time allocation, clear findings from monitoring & evaluation) required to complete it.

As is the standard practice with most evaluations of programs of the RC Movement, the present evaluation calls attention to the importance, from the outset of activities, of exit planning and of preparing the HNS for handover of responsibilities. This requires both involvement of the HNS in the planning process and it requires planning HNS OD efforts.

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## Response to Cholera

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Deployment of **autonomous or semi-autonomous ERUs**, particularly in sites that are distant from the IFRC HQ is an appropriate response **during the critical first three months of a massive epidemic**;

**Thereafter**, when epidemic response is added to the responsibilities of an established IFRC emergency response program, it is best to **integrate epidemic response capacity into the strategy and the capacity of existing Health and WatSan departments**. This will require some **re-orientation of the overall work plans and strategies (including exit strategy) of these departments**, at least for the period of the epidemic. This also implies a revision of the logical frameworks, indicators, targets, budgets and HR of these departments before responsibility for epidemic response (e.g. handover from an autonomous ERU to a Health or WatSan department) can be transferred. The initial work plan for the epidemic response should specify indicators to gauge the readiness of the Health and WatSan departments to assume these new responsibilities.

For at least the last year, IFRC Health Department and the HRC Health Department have been functionally linked. Under these circumstances, **a modification of the strategy of the IFRC Health Department** (e.g. to incorporate responsibility for coordination of RC treatment activities) **would have been difficult without some modification of the health strategy of HRC**. The evaluators are of the opinion that this would have been a desirable outcome that would have promoted greater ownership of the cholera response by the HRC and enabled a smoother transition to future cholera activities.

In instances where multiple departments of IFRC are engaged in direct implementation of response activities, sufficient authority is essential for effective coordination of the efforts of these departments. If the Head of Operations cannot take on this responsibility then an additional delegate (a “Deputy Head of Operations for Epidemic Response”) may be required.

**IFRC management processes** (planning, monitoring, knowledge management) **need to be made more systematic and rigorous** for the organization to better achieve and document results achieved. IFRC should sustain and reinforce the improved monitoring practices introduced for IFRC and Movement cholera activities since mid 2011.

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## Transition Strategy

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There is an **urgent need to develop a suitable contingency** plan for the significant possibility of another set of massive cholera outbreaks in Haiti in the next 4 to 6 months. Participants at a workshop on the future of RC cholera response in Haiti generally endorsed a set of **3 strategic objectives** derived from core principles of the Red Cross Movement:

Strategic objective number 1: Function effectively as a Movement in order to **bring relief by all available means** to all persons at risk of death from cholera;

Strategic objective number 2: Create **partnership** and efficient coordination mechanisms as an **auxiliary to government**;

Strategic objective number 3: **Build a strong HNS** to develop **self reliance and sustainability** for cholera response.

With the end of IFRC and PNS support for cholera treatment and WatSan activities in Haiti, **partnership and communication with external agencies (MSPP/DSO, DINEPA/OREPAs, donor agencies, NGOs) are of great importance** – for information, for joint contingency planning and for joint response.

As proposed by recommendation 11, a delegate should be assigned to the position of **Technical Movement Coordinator for Health** with the IFRC delegation in Haiti **to assume these responsibilities** (i.e. external partnership and Movement coordination of future cholera activities) as well to coordinate and represent overall Movement health activities.

**ECV** can play a key role in reporting suspected outbreaks, dissemination of key messages, distribution of water disinfectants and soap, disinfection of sites, referral of patients and initial treatment. However, for effective first response to an outbreak of cholera, volunteer action **needs to be better supervised and it needs to be better coordinated with the efforts of other local actors** – health and WatSan authorities and locally active NGOs. For ECV volunteers to fulfill these roles, the Health Department needs to strengthen its capacities for supportive supervision, monitoring and coordination of ECV activities.

The effectiveness of RC cholera response in Haiti would be greatly enhanced by development of a **cholera rapid response team** that could be rapidly deployed from central level. Remaining members of the cholera team should be assigned to this team which would include:

- *Supervisors* to confirm rumors, liaise with local authorities (including RC branch officials), mobilize previously trained volunteers and direct community-based actions (see the list included with recommendation 30);
- *Clinical staff* to join in the initial *assessment* and *coordination* of cholera response including the treatment response.

IFRC/Haiti should develop and implement SOPs for this rapid response team and provide specific training. In similar fashion, the DM delegate could take responsibility to train and refresh emergency focal points in each section of INA.

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### **The Role of the Haitian Red Cross in Responding to Cholera**

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IFRC should join HRC and PNSs in agreeing on a **common strategy for the future RC Movement cholera response in Haiti**;

The focus of the **HRC/IFRC Emergency Health strategy should be expanded to encompass some aspects of emergency health beyond community-based action**. This would better define the role of the HRC as an auxiliary in the delivery of emergency medical services;

In the advent of future health emergencies, IFRC should “**ensure that the HNRCS is at the core of the planning, coordination and implementation** of the Movement operation.”

If it is necessary to achieve this result (i.e. to be at the core of the Movement’s emergency response) **HRC should make some (at least short-term) adjustments to its strategy and its capacity** to fulfill this role.

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