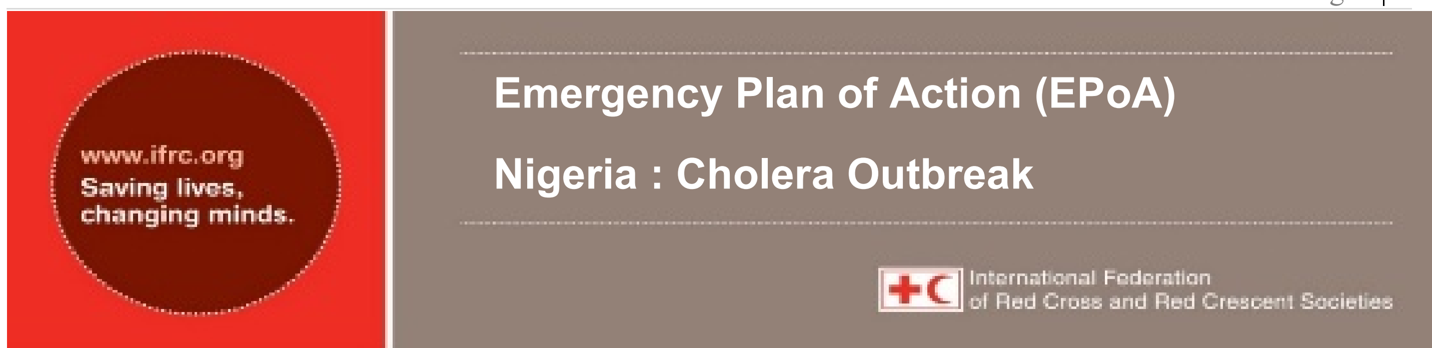


DREF Operation n°	MDRNG033	Glide n°:	EP-2021-000143-NGA
Date of issue:	28 September 2021	Expected timeframe:	4 months
Operation start date:	26 September 2021	Expected end date:	31 January 2022
Category allocated to the disaster or crisis: Orange			
DREF allocated: CHF 303,187			
Total number of people affected:	73,055 suspected cases and 2,407 deaths	Number of people to be assisted:	684,131 people • Direct targets: 13,683 people (2,280 HH) • Indirect targets: 670,448 people
States affected:	Benue, Delta, Zamfara, Gombe, Bayelsa, Kogi, Sokoto, Bauchi, Ekiti, Osun, Kano, Kaduna, Plateau, Kebbi, Cross River, Nasarawa, Ogun, Niger, Jigawa, Yobe, Kwara, Adamawa, Enugu, Katsina, Borno, Taraba, Abia and Abuja (FCT)	States targeted:	Sokoto, Katsina, Kebbi, Gombe and Bayelsa
Host National Society presence (n° of volunteers, staff, branches): 350 Volunteers, 30 Branch staff, 10 branches, 5 NDRTs, 3 NHQ Health Officers, 1 Finance, 1 logistics, 1 Communication officer, 1 ICT, and 1 PMER			
Red Cross Red Crescent Movement partners actively involved in the operation: International federation of Red Cross and Red Crescent Societies (IFRC)			
Other partner organizations actively involved in the operation: Médecins sans Frontières (MSF), Ministry of Health (MoH), Action contre la faim (ACF), UNICEF, WHO, Nigeria Centre for Disease Control (NCDC)			

A. Situation Analysis

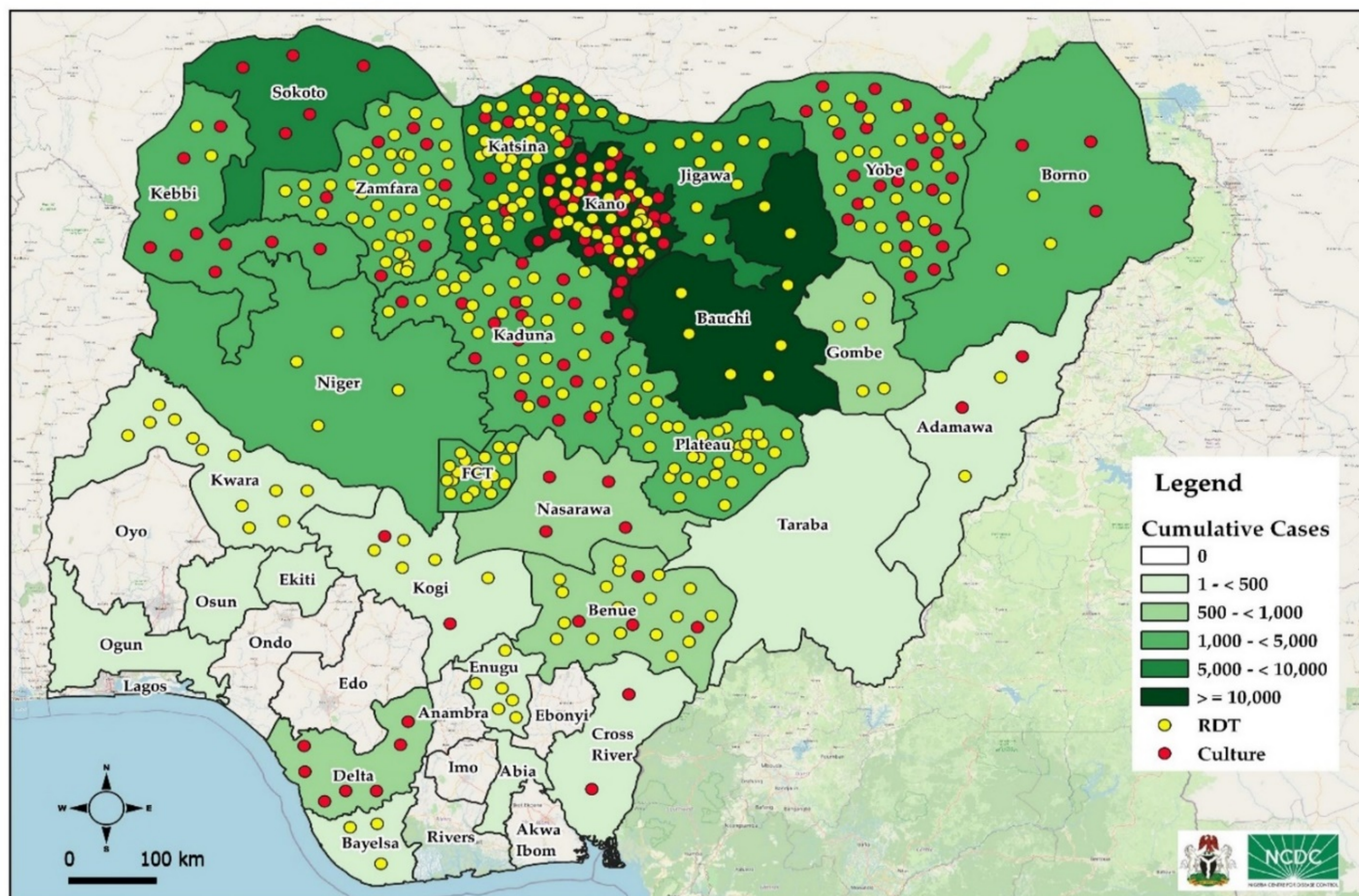
Description of the disaster

Nigeria is experiencing one of its worst cholera outbreaks in years. According to Nigeria Centre for Disease Control (NCDC) Cholera Situation Report No. 38, as of 21st September 2021, a total of 73,055 suspected cases including 2,407 deaths (CFR 3.3%) have been reported from 27 states[1] out of 36 states and in Abuja, the Federal Capital Territory (FCT). According to the NCDC, children between 5 and 14 are the most affected age group and the overall case fatality rate is 3.3%. So far, the affected states are Benue, Delta, Zamfara, Gombe, Bayelsa, Kogi, Sokoto, Bauchi, Ekiti, Osun, Kano, Kaduna, Plateau, Kebbi, Cross River, Nasarawa, Ogun, Niger, Jigawa, Yobe, Kwara, Adamawa, Enugu, Katsina, Borno, Taraba, Abia, and the FCT.

With over 2,407 people dead from suspected cholera this year, there are concerns that there might be an undercount given that many affected communities are in hard-to-reach areas with high security challenges. Indeed, although the overall situation across the country seemed to be improving with significant reduction of cases as of week 32, it has also been highlighted those cases are being reported in additional states and cases increasing again as of week 38 in areas where it had dropped.

[1] https://www.ncdc.gov.ng/diseases/sitreps

Internal



Map of Nigeria, highlighting number of States affected and caseload ©Nigeria Centre for Disease Control (NCDC)

This year's outbreak, which is associated with a higher case fatality rate than the previous four years is also worsened by the COVID-19 pandemic. States with high levels of rainfall are worst hit due to seasonal flooding. Aside from being endemic and seasonal in Nigeria, cholera is also common in environments with high levels of poor sanitation, lack of clean food and water, and areas where open defecation is common practice.

The National Cholera Emergency Operations Centre (EOC) was activated on the 22 June 2021, following an increase in the number of cholera cases at the start of the rainy season. The Emergency Operations Center (EOC) which is hosted at NCDC, is being coordinated in collaboration with the Federal Ministries of Health, Environment and Water Resources, National Primary Health Care Development Agency (NPHCDA), World Health Organization (WHO), IFRC, the Nigerian Red Cross Society (NRCS) and other implementing partners. The national multi-sectoral EOC activated at level 2 continues to coordinate the national response. According to sitrep from the EOC, cholera activity in Nigeria in 2021 has grossly surpassed the total case counts identified in 2020 and 2019, when 1,800 cases and 3,500 cases were reported, respectively.

Cholera is a water-borne disease, and the risk of transmission is higher where there is poor sanitation and disruption of clean water supply. Cholera is transmitted directly through food or water contaminated with faecal material from an infected person due to poor sanitation and hygiene services practiced in the locations. Most infected people develop no symptoms or only mild diarrhoea. However, 1 in 10 infected people develop severe cholera, which causes symptoms including profuse watery diarrhea, vomiting, rapid heart rate, low blood pressure, muscle cramps, restlessness, or and/irritability. Symptoms typically appear 2-3 days after exposure but can develop up to 5 days after exposure. Individuals with severe cholera can develop acute renal failure, severe electrolyte imbalances, and coma. If left untreated, these can lead to shock and rapid death.

The long-term solution for cholera control lies in access to safely managed drinking water, maintenance of proper sanitation and hygiene. Treatment through fluid replacement is the recommended approach, typically through ORS or IV fluids. Zinc is recommended in small children, and it is highly recommended to continue breastfeeding, even when the mother is affected. NRCS has been conducting low scale awareness on prevention and early detection, of cases due to lack of resources. The Government of Nigeria has called on all local and international partners to support in intensifying the response to save lives and curb the spread of this epidemic.

Internal

Summary of the current response

Overview of Operating National Society Response Action
Since the onset of the outbreak, NRCS has promoted disease control measures by creating awareness on health and associated issues. These activities include:

- Sensitization and social mobilization
- Regular household visits by volunteers
- Community meetings
- Radio shows to discuss the outbreak
- Social mobilization for Oral Cholera Vaccination
- Coordination meetings at the EOC
- Infection Prevention and Control support at Cholera Treatment Centres
- Regular training and support to community volunteers
- Linkage (referral) between community and peripheral health facilities.
- Feedback analysis and response through those different activities.

In August 2021, the Nigerian Red Cross Society with support from the International Federation of Red Cross and Red Crescent Societies (IFRC) supported the reactive Oral Cholera Vaccination campaign in Bauchi State, to curb the outbreak through social mobilization, demand creation and referral services to cholera treatment sites. Targeting 3 worst hit LGAs in the state - Bauchi, Toro and Dass. In a campaign that lasted for 4 days, NRCS trained and mobilized 100 volunteers in the 3 targeted LGAs. A total of 63,321 eligible persons (5 years and above) were mobilized for OCV: Male - 32,694, Female - 30, 627 with a total of 2,960 households reached with cholera prevention messages. Despite this support, the recent large scale spread of the disease (weeks 35 – 38) has become concerning to authorities, which have requested an upscale of support from all partners to control the outbreak.

Being the country's largest volunteer-based organization with more than 800,000 volunteers countrywide, NRCS has 37 State branches which are further divided into Divisions at Local Government Area (LGA) level and detachments at community level. Each state branch of NRCS is managed by a Branch Secretary assisted by program coordinators, among them a health coordinator. Most volunteers and health staff have received training on epidemic control for volunteers (ECV), community-based health and first aid (CBHFA) and are equipped to respond to health emergencies at branch level, coordinating activities of members of the Health Action Teams (HAT). The health coordinators and their assistants provide support and active management of the core functions of the society at the divisions/Local Government Areas and the detachment levels, where the Health Action Teams (HATs) and the Mothers Clubs is the strength of the NRCS through their support in implementing the Health and Care programs at community levels.

Overview of Red Cross Red Crescent Movement Actions in country
The IFRC Operations and Health team is providing technical support to the NRCS team. The IFRC Cluster Delegation in Abuja facilitated an initial support to NRCS to support Oral Cholera Vaccination Campaign in Bauchi State. The IFRC Senior Immunization Officer, together with the NRCS Health Officer conducted a joint monitoring visit to support the branch and volunteers during the social mobilization campaign.

The ICRC has a country delegation in Abuja with three sub-delegations in Port Harcourt, Jos and Maiduguri and an office in Kano in support of areas affected by conflict and other situations of violence. Relating to the overall response to the outbreak, the ICRC is currently providing bilateral support to Adamawa, Borno, Plateau and Yobe states to raise awareness in response to the cholera outbreak.

For better coordination, NRCS plans to commence by fourth week of September, Movement coordination meetings involving the movement partners to discuss areas of interest, support, and reporting. Multiple engagements have taken place so far between IFRC, NS and ICRC in different areas for coordination.

Overview of other actors actions in country
The National multi sectoral Emergency Operation Centre activated at level 02[2], coordinated by NCDC has continued to work closely with all states, relevant stakeholders, and partners, to provide the necessary support for cholera control in Nigeria.

NCDC is supporting states through deployment of rapid response teams, development and dissemination of National Acute Watery Diarrhoea Guidelines, deployment of cholera rapid diagnostic kits, to eleven states - Benue, Kano, Kaduna, Zamfara, Bauchi, Plateau, Jigawa, Katsina, Niger and the FCT. Unfortunately, due to ongoing COVID-19 pandemic, resources have become lean for adequate response to the unforeseen scale of the cholera outbreak. The NCDC communication team with support from UNICEF is coordinating the airing of Cholera jingles, being aired in English and local languages.

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[2]During an emergency, NCDC Emergency Operations Centre is activated at three levels depending on the scale of events. Level 3 is the lowest and Level 1 the highest.

Internal

In March 2021, Reactive OCV campaigns were conducted at Agatu LGA, Benue State and in August at Bauchi LGA, Bauchi State, under the lead of the National Primary Health Care Development Agency (NPHCDA), which with support from NCDC, is monitoring the epidemiological trends which have guided a request tabled to the International Coordinating Group (ICG) on Provision of Vaccines. Indeed, MoH through relevant agencies, is planning to launch mass vaccination campaigns in several states with high caseload, but the dates are yet to be communicated. The NCDC communication team with support from UNICEF is coordinating the airing of Cholera jingles, being aired in English and local languages.

Médecins sans frontières (MSF) is also supporting efforts to address the current cholera outbreak by supplying cholera kits, investigating outbreaks, establishing cholera treatment facilities, community education, improving access to water and sanitation and vaccinations, among other efforts. Cholera kits include “rehydration salts, antibiotics and IVs, along with buckets, boots, chlorine and plastic sheeting. Despite this support, there are still gaps as the cases keep rising.

The Global Task Force for Cholera Control (GTFCC), through its Country Control Platform, has also highlighted in recent meetings, the need to for further engagement from partners to respond and prevent further spread of the disease. Contact will be made with the CSP Officer in Nigeria to ensure they are aware of the work being done and to ensure alignment with the GTFCC Global Roadmap 2030 and to identify opportunities to work with other GTFCC partners.

Needs analysis, targeting, scenario planning and risk assessment

Needs analysis

So far, the outbreak response has been focused on Clinical Case management, with very limited focus on behavioural change through risk communication, community awareness creation and sensitization on the key messages to prevent the continuous spread of the disease and avoid future outbreaks.

As the coordinating agency for disease outbreaks and emergency response, the NCDC has identified the following challenges and gaps in the national response to the outbreak:

- Difficulty in accessing some communities due to security concerns
- Lack of funds and inadequate manpower to carryout active case search
- Poor logistics and manpower to carry out community awareness and health education
- Inadequate SBCC materials such as posters, fliers and banners
- Inadequate supply and logistics to carry out Infection prevention and control in treatment centers
- Open defecation in affected communities
- Lack of potable drinking water in some rural areas and urban slums
- Inadequate vaccines to cover all LGAs, wards and settlements with cholera outbreaks
- Inadequate health facility infrastructure and cholera commodities for management of patients (Ringer’s lactate and ORS)
- Inadequate trained manpower for Cholera outbreak, detection, investigation, and management
- Poor and inconsistent reporting from states.

In addition to above, Nigeria is naturally endowed with an uneven spread of abundant surface and groundwater resources, but they are poorly managed and harnessed, leading to water scarcity especially in Northern region. On the other hand, climate change aids an increase in coastal floods and saline water intrusion in the south or tropical rainforest zone. Indeed, seasonal floods which affect the country yearly, contribute to limiting access to drinking water for vulnerable communities and worsens their hygiene and sanitation situation, especially in the northern regions also affected by drought.

Practices such as the improper disposal of refuse and open defecation endanger the safety of water used for drinking and personal use. Without proper water, sanitation and hygiene (WASH), Nigeria remains at risk of cholera cases and deaths. With factors such as poor sanitation, open drainage conditions, and contaminated water sources, the cholera outbreak has worsened in recent months with more states reporting cases, adding pressure to an already stretched health sector heavily impacted by the COVID-19 pandemic. The health care system is currently experiencing a strike by resident doctors which started 2 August 2021.

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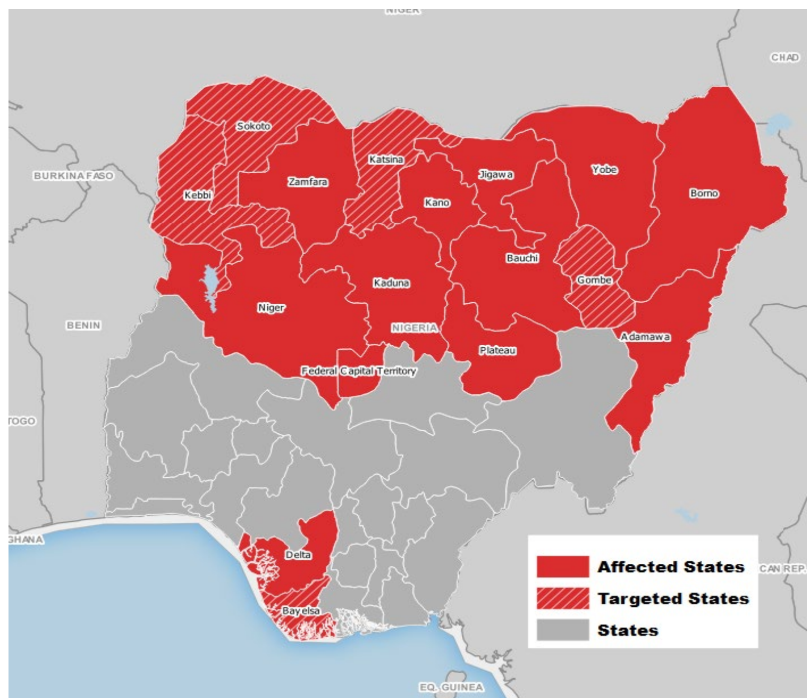
Targeting

After consultations with NCDC, NRCS geographical target will focus on Sokoto, Katsina, Kebbi, Gombe and Bayelsa States. This selection is to ensure priority is given to the affected states which are not currently targeted through other interventions and funding. In terms of population, the National Society will have two target groups as detailed below:

- Indirect targets: 684,131 people (3%) of overall population in target states
- Direct states: 13,683 people (2,280 HH)

NRCS's work will focus on specific local government areas (LGAs) which have a high caseload, per guidance from NCDC but have received little to no support outside of clinical case management. The selection criteria for direct targets will include families of affected persons, women and child-headed households, the elderly and breastfeeding women.



Map of Nigeria highlighting affected and target areas ©IFRC

Overall people targeted									
S/No	States	Case load	Supported by ICRC	Supported by NCDC/other partners	# of volunteers for RCCE, ECV,WASH	State population	# of people targeted with RCCE and awareness (3% of state pop)	# of people targeted with WASH items (2% of awareness targets)	# of HH targeted with WASH items
1	Sokoto	6,835	No	No	30	4,998,090	149,943	2,999	500
2	Katsina	6,330	No	Inadequate	30	7,831,319	234,940	4,699	783
3	Kebbi	3,646	No	No	20	4,440,050	133,202	2,664	444
4	Gombe	688	No	No	50	3,256,962	97,709	1,954	326
5	Bayelsa	658	No	No	30	2,277,961	68,339	1,367	228
Total		**32,335**			**160**	**22,804,382**	**684,131**	**13,683**	**2,280**
NB: Number of volunteers based on geographical spread of cases across LGAs.									

NRCS will also complement the Government effort in targeting worst affected states where there are still identified gaps and needs and work closely with the National EOC to harmonize plans and avoid duplication of efforts and activities.

Scenario planning

Scenario	Humanitarian consequences	Potential response
In the best case: The incidence rate subsides and the recoveries increase. The ongoing rains quell down within four weeks.	- Decrease in the case fatality rate - No further spread of the disease to other States - The disease contained within 3 months. - The health system is able to manage the outbreak.	NRCS will continue with the DREF Operation, however, long-term and sustainability measures will be planned through KAP surveys/lessons learnt workshop and integrated in annual planning for the National Society.
Most likely scenario: The epidemic spreads to more States but the incidence remains lower than the target of this operation. The health system is overwhelmed as	- Increased morbidity and mortality with a higher CFR. - More people are admitted into health facilities and treatment centres become overstretched while resources are minimal to contain the spread.	The DREF EPOA will be revised and extended to accommodate other plans and states where immediate and intensive response is required.

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cases increase and struggles to control the epidemic within the next three months.	- Local disruption of health systems capacity and service continuity.	
Scenario 3: The situation escalates and spreads beyond National capacity to respond with increased number of deaths reported in all 36 states and FCT.	- Other related health issues like malnutrition and other epidemic outbreaks deteriorate because healthcare system is overstretched - Death toll rises - High risk of contamination of primary health care centres with greater disruption of health services continuity	NRCS will launch an emergency appeal through the IFRC and request for international surge capacity

Operation Risk Assessment

As a result of the ongoing Hunger Crisis Emergency Appeal and national level Flood response, several NRCS operational staff are currently on the field, and some are engaged in other tasks in support to the ongoing interventions in the states. To close the gap in coordination and monitoring, and ensure efficient service delivery in supported branches, NRCS will deploy members from her team of trained National Disaster Response Teams (NDRTs) to the branches to work closely with the Health Action Teams, under the overall supervision of the Assistant Coordinator, Health & Care Department.

Aside from the flood emergency which is a major contributing factor to the current cholera outbreak, there are also issues of insecurity, and escalated situations of violence in the targeted states. Therefore, the safety of staff and volunteers has become a big operational challenge which needs to be closely monitored. NRCS will leverage on the security assessment report and continuously rely on the regular security reports and briefings from the NRCS/IFRC security teams to identify and avoid potential risks. Volunteers and staff will also be trained and retrained on Safer Access framework and security tips to stay safe.
NRCS teams will also work in line with the security rules governing the targeted states. For instance, in the Southeastern States, where the opposition groups have called for a sit-at-home rule one day per week, volunteers will be exempted from going to the field on these days, while activities will continue the days that movement is allowed, and safety is ensured.

With the emergence of the COVID-19 Delta variant in Nigeria, the safety of volunteers has also become a challenge. To mitigate the risk of infection, volunteers will be advised to strictly adhere to COVID-19 protocols and take the COVID-19 vaccines to reduce to chances of getting seriously ill. NRCS will also provide the volunteers with face masks, hand sanitizers and other disinfectants to minimize chances of infection.

B. Operational strategy

Overall Operational Objective

Contribute to controlling cholera outbreak for at least 684,131 people representing 3% of population in Sokoto, Katsina, Kebbi, Gombe and Bayelsa States of Nigeria; as well as reducing its impact on the affected and at-risk communities through risk communication, epidemic control activities, surveillance, referrals and hygiene promotion. Operational timeframe will last four months with end date on 31 January 2022.

Lessons learnt from previous disease outbreaks

- The current overall response since the beginning of this outbreak has been focused on clinical case management whereas, to reduce the spread of the disease, there is need to integrate RCCE/ECV approaches that allows health education and disease prevention through community-based volunteers, while collecting and addressing disease information within the communities.
- There is need to deploy community-based volunteers in affected communities, to raise awareness and mobilize communities during OCV campaigns on the importance of getting vaccinated against cholera as behavioral changes are observed over time
- Integrate community-based health and first aid (CBHFA) that enables active case search, community surveillance and referrals of cases.

Specific Objectives

1. Support early detection and referral of cases to designated treatment centres;
2. Support social mobilisation ahead of oral cholera vaccination (OCV) campaigns in targeted states;
3. Contribute to improving treatment capacity through provision of oral rehydration points (ORPs);

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4. Contribute to reducing the risk of cholera transmission through RCCE and behavioural change activities focusing on safe water, sanitation, and the promotion of safe hygiene practices for communities at risk;
5. Strengthen NRCS partnership with National and local stakeholders, by establishing linkages, referrals, and IPC support to Cholera Treatment Centres (CTCs);
6. Support the families affected by cholera and other most vulnerable families with hygiene related household items;
7. Increase NRCS capacities on cholera prevention and response activities.

Proposed strategy

Based on above lessons collected from previous responses to health outbreaks implemented in Nigeria and in line with the Global Task Force for Cholera Control (GTFCC) Roadmap 2030 and the IFRC approach to cholera, NRCS will ensure its response aligns with IFRC's Africa Region preparedness approach to cholera, to provide the following responses. Contact will be made with the CSP Officer in Nigeria to ensure they are aware of the work being done and to ensure alignment with the GTFCC Global Roadmap 2030 and to identify opportunities to work with other GTFCC partners. The action is aimed at reducing the suffering of the affected, their families, and the communities at large through four main strategies:

1. Risk Communication, Community Engagement, and OCV Campaign
2. Case Management through ORPs
3. Support Infection prevention and Control (IPC) with disinfection of identified CTCs across the targeted states.
4. Breaking of cholera transmission routes through WASH based interventions in households and communities using trained volunteers as part of a Branch Transmission Intervention Team (BTIT)

1. Health (Target: 684,131 people)

a) Risk Communication and Community Engagement (RCCE) and Health Education

All response activities will involve the religious/ traditional leaders, women groups, schools, youth groups, community healthcare workers, trade and transport workers etc., to work in close cooperation with the community and advocacy to the community. These are also important partners when it comes to identifying the most vulnerable groups. The communities at large shall benefit from the operation through Red Cross volunteers from the local branches and community level because of their knowledge of the culture and tradition of the community people. In terms of activities, below will be implemented:

- Conduct one national level refresher session on ECV modules including community case definition of cholera and referrals, RCCE ,WASH, and social mobilization for OCV Campaigns for 15 branch people (one branch secretary, health focal point and PMER officer per state) to support cascading trainings of volunteers across the five targeted states.

- Mobilise and train 160 Health Action Teams (HAT) and Mothers' Club (MC) members on ECV, RCCE, social mobilization for OCV campaigns, and specific cholera related WASH activities. These people will serve as volunteers throughout the operation and will receive the training from above mentioned focal persons in each branch.

- Deploy 160 HAT and MC members across targeted states to share useful tips and information to households on cholera prevention awareness and hygiene promotion through STOP Cholera mass awareness campaigns and also support with social mobilization during OCV campaigns organized by the government. In the Northern communities where, male volunteers are not allowed in the households due to cultural and traditional restrictions, Mother's clubs will be used to provide access to the compounds. They will be deployed for four months. To note NRCS provides incentives for volunteers on operations at a monthly rate for cost efficiency.

- Conduct monthly community meetings to engage stakeholders across 5 targeted states. Key stakeholder groups and opinion leaders (taxi drivers, health workers, religious leaders, traditional birth attendants, community leaders and teachers) will be targeted as change agents for RCCE and health promotional activities.

- Conduct radio shows to dispel rumours, reduce fear, raise awareness on the transmission roots and prevention methods. Red Cross volunteers will respond to questions and document feedbacks during engagements with the public/community.Through the various identified and trusted communication channels by the NCDC, radio jingles and house-to-house approach were both found to be more effective in the response to cholera outbreaks, therefore, the operational team will ensure that timely, accurate and appropriate information is passed to targeted beneficiaries and that community participation is promoted and ensured in all activities. A guest speaker from the NCDC or Ministry of Health will be invited to the show to provide technical guidance

and responses to listeners. Feedback received through the feedback communication channels and radio shows will also contribute to topics to present on the live call-in radio sessions. NRCS Health and Communication/CEA teams will coordinate and anchor the radio shows in the states.

- Conduct mobile messaging (*baba ijebu)* twice a month across five targeted states for 4 months, to support awareness and dispelling rumours.

- NRCS will build on the existing feedback mechanisms (community meetings and NRCS toll-free lines) to document community beliefs, fears, questions, and suggestions in each state. Feedbacks collected will be actioned on a real-time and weekly basis, while a monthly report will be shared with the Health Department for onward transmission to the Movement partners, NCDC and other stakeholders to inform decision making and address concerns and misconceptions. In the communities, the feedback collected will be shared with community members to refine the health information and activities to better address the needs and concerns in the community. In addition, it will enable conversation with communities this will help volunteers and the NS to provide relevant and tailored messages in the community. Actions taken to address the concerns and needs of the community will be communicated back to the community members, to promote accountability and build trust.

- Produce Information, Education and Communication (IEC) materials and disseminate during the awareness exercises, with consideration for people with identified impairments or disabilities.

b) Case Management and Infection, prevention and Control (IPC)

Based on cholera hotspot mapping carried out by UNICEF, IFRC has procured 4 ORP kits through GTFCC project to be stationed in selected communities across targeted states, with priority given to areas with highest caseload. The ORPs will serve as stabilization points for community case management of cholera especially in the affected areas located far from the health facilities to reduce the chances of death resulting from cholera. This operation will support replacing the consumables used from these ORPs. The ORPs will be deployed such that they are linked with cholera treatment centres.

- A virtual training of trainers (ToT) for the NHQ staff will be carried out with support of the IFRC Africa Cholera Coordinator and Country Support Platform (CSP) hosted by the IFRC West Coast office delegation. Curriculums will be developed by IFRC Africa Regional Office.
- Stepdown training of volunteers would be conducted at the State level on ORP management and IPC. Ten volunteers will be trained to support work in each of the four ORPs deployed, making it a total of 40 volunteers with health background to be trained.
- These volunteers will be deployed to manage ORP points and support disinfection of the existing Cholera Treatment Centres (CTCs) in the targeted LGAs. To note, these volunteers are separate from the 160 indicated under targeting section. Adequate PPEs (Protective Personal Equipment) will also be made available to all volunteers with additional context-specific PPEs for the volunteers working at the ORPs and CTCs.

2. Water, Sanitation and Hygiene – WASH (Target: 13,683 people or 2,280 HH)

The 160 HAT and Mothers' Club volunteers will be trained using the Branch Transmission Intervention Team methodology. Breaking of cholera transmission routes will be conducted through WASH based interventions in households and communities. This training is already integrated in the health strategy above.
NRCS will distribute water purification tablets, water storage containers and soaps to most vulnerable families in need of this assistance as detailed below. These items would be distributed in areas where there are local outbreaks to protect the population. It will target households that are most prone to cholera based on epidemiology.

- Procure and distribute Aqua tabs for water purification, sufficient for 30 days. Based on Sphere standards, each person should have access to 5L of water per day. So, for a full month, each household will need 5L X 6 persons x 30 days, which sums up to 750 litres of water per month. Each tablet of Aquatabs is meant to purify 20litres of pure water, as it is not good for turbid water. Thus, each household needs 45 tablets of Aquatabs. Based on above, a total of 45,000 tablets of Aquatabs will be procured and distributed to 1,000 households to serve for one month.
- Procure and distribute WASH related items for 2,280 households (jerricans, buckets, soap and family hygiene kits). Beneficiary selection and registration will be carried out in a way that puts the community at the centre of the activity, promoting community integration and participation.
- Provide households with support through household disinfectants to limit the spread of the disease (1 bottle of 1 L per HH)

- Trained NRCS volunteers will conduct community awareness and sensitization on cholera prevention and treatment, water purification and storage, safe excreta disposal, food hygiene and storage, hand washing with soap through house-to-house visits, community group discussions, sensitization at markets and other meeting

points using a mobile cinema (to project the cholera story) and distribution of IEC materials with key messages on Cholera prevention and control.
- Support Community-led total sanitation (CLTS) through the engagement of key stakeholders and the definition of plans to prevent the spread of cholera, and build community resilience to both cholera and vector borne diseases, especially in contexts of floods / surface water stagnation. To achieve this, sanitation material will be provided to the 5 state branches to organize sanitation as appropriate within most affected LGAs.
- A community satisfaction survey will be organised after distribution to monitor the use of the distributed NFIs and also receive feedback from the beneficiaries on their perception and impact of the NRCS activities.

Cross-cutting issues

Protection, gender and Inclusion (PGI): PGI will be mainstreamed throughout the intervention to ensure communities dignity, access, participation and safety. As part of the needs assessment and analysis, a gender and diversity analysis will be included in sector responses including health and WASH. All sectors will seek to meet the IFRC Minimum Standards on Protection, Gender and Inclusion in Emergencies

Acknowledging that women, girls, men and boys with diverse ages, disabilities and backgrounds have very different needs, risk and coping strategies, the operation will pay particular attention to protection and inclusion of vulnerable groups and on gender and diversity analysis.

Community Engagement and Accountability (CEA): NRCS will work closely with the community leaders and representations of different groups (women, youth, transport unions, healthcare workers, traditional healers, etc.) to select households that are most prone to cholera, which includes but not limited to pregnant/lactating mothers, elderly, People with Disability (PWD), people displaced by flood, Child headed family, Orphans and Vulnerable Children (OVC), families with recorded case(s) of Cholera.

Operational support services

Human resources
Due to the busy schedule of key program staff at the NHQ, who are currently involved in several ongoing interventions in the states, the NRCS will require support from 3 NDRTs during the implementation of the operation. These NDRTs will be deployed to support the states, reporting directly to the Assistant Coordinator, Health & Care, who in turn reports to the Head of Health department of the National Society. The cost for these local surge members (NDRTs) will be covered by the operation.

The Branch Health Coordinator will oversee the activities of this operation in the branches under the supervision of the Branch Secretary in each state. The cost for these 10 persons will be included to the operation for overall timeframe.

A total of 200 volunteers (including Divisional secretaries) will be deployed to support implementation of activities. The cost for their incentives will be covered at a monthly rate, throughout the intervention. Divisional Secretaries at the LGA level will coordinate all volunteer activities and provide immediate technical and operational support to the volunteers. All necessary protective equipment will be provided to them as necessary.

Logistics and supply chain
A finance and logistics officer will be required to support the operation. Further support might be required from Movement partners when appropriate. All the items required for the operation will be procured locally by the NRCS, in accordance with the agreed IFRC logistics standards. IFRC Local Logistic Officer will support the NS in the procurement process in respect of IFRC policy. The IFRC Regional Officer will be responsible for procurement and deployment of the ORPs to the country.

Communications
With technical support from IFRC, NRCS will share information on the operation with the media, government, and partners. The Secretary General will be responsible for communication to the external stakeholders. At the operational level, NRCS Communications Department will organize a press briefing to provide information on the DREF and NRCS support to Government effort.

The health department will work closely with communications team to promote NRCS activities on social media using the NRCS official social media handles. A documentary on the NS contribution to overall cholera containment will be produced to support visibility of the National Society. As such, two NS communication officers will be deployed across 5 states to support on recording necessary content for this production.

Internal

Security
The main security concerns in the target areas of the operation include intercommunal and religious clashes, militancy, banditry, and kidnapping carried out by criminal gangs with purely financial motives.

It should also be noted that the government recently ordered telecom operators to suspend all telecommunications networks in Zamfara State, and at least 13 local government areas of Katsina State to check banditry of which could possibly extended to Sokoto State.

The NRCS and IFRC Security team continues to provide regular security briefings and updates to program departments. The NRCS/IFRC security teams recently conducted a security risk assessment in all the Northern and some southern states; the operation teams will rely on the report of the assessment and security clearance to visit the states during the period of operation. In the Northeast, where there is a strong ICRC presence, ICRC will support the NRCS on security issues by sharing regular updates on security situation in the operational area.

The IFRC security plans will apply to all IFRC personnel throughout. Area specific Security Risk Assessment will be conducted for any operational area should any IFRC personnel deploy there; risk mitigation measures will be identified and implemented. All IFRC must, and RC/RC staff and volunteers should complete IFRC Stay Safe e-learning courses, i.e., Stay Safe Personal Security, Stay Safe Security Management and Stay Safe Volunteer Security online training.

Senior Security Officer for the Cluster will continue to monitor the security situation, provide security support, and maintain close coordination with the host National Society security structures. Field security assessment missions have been conducted and cleared by the joint Teams setting the pre-conditions for access and running operations in the articulated states and localities. Additionally, one surge security from the regional office has been deployed to support the Cluster.

Planning, monitoring, evaluation, & reporting (PMER)
Supervision of the project will be done at all levels and at the three stages of implementation: Training, sensitization and public awareness and distribution. The project will be coordinated at the National level by the Assistant Coordinator, Health, under the supervision of the National Health Coordinator.

At the branch level, the Branch Secretary will coordinate and monitor the implementation of the project, overseeing the activities of the HATs/Mothers' club, assisted by the Branch Health coordinator, who will support the activities at both community and divisional level, reporting to the Branch Secretary who in turn reports to the Project Manager. At community level, a volunteer supervisor will be appointed in each project community to oversee the project activities in the community. The volunteer supervisors shall be responsible for volunteer identification, mobilization and deployment, community mobilization and registration, linkages with community/traditional leaders and health facilities.

Reporting will involve daily record keeping of all activities carried out by the Community-Based Volunteers (CBVs) and the submission of the reports to the Branch Health Officers who will in turn collate and forward to the NHQ through the Branch Secretary. The Branch Secretary and team will conduct weekly monitoring visits to the volunteers who are working at community level. The NDRTs will work closely with the Branch Secretary to ensure that the operation is effective and efficient.

At HQ level, monthly visits will be made by the operational teams to provide on the spot check to the team on the ground. Five monitoring visits will be conducted by NRCS NHQ staff including Head of health unit, deputy head of heath unit, PMER officer, finance officer, and Logistics officer. The health staff will each conduct one mission to ensure smooth implementation and redirect operation as necessary. The finance and logistics staff will ensure that procedures are respected in their various fields and support procurement process. The PMER will ensure data is collected to facilitate reporting as necessary. operation as necessary. The finance and logistics staff will ensure that procedures are respected in their various fields and support procurement process. The PMER will ensure data is collected to facilitate reporting as necessary.

The IFRC Senior Immunization Officer, together with 2 Health Officers and CEA focal point would provide technical support to the National Society at all stages of the operation. The cost of three health and CEA monitoring visits will be covered by the operation.

A lesson learnt workshop will be held before the end of the operation to discuss good practices, challenges, and other experiences.

Administration and Finance
The NRCS has an Administration and Finance department that ensures proper management and use of resources. The administrative and financial procedures are in line with the NRCS' quality control procedures, and they will support all actions included in the National Society's humanitarian mission, ensuring transparency and adequate accountability. The Finance department will be closely involved in supporting the operation with a mission planned as described under

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PMER section. Furthermore, the IFRC's in-country office will also support the administrative and financial management processes and provide support to ensure compliance with established quality standards. Prior to the implementation, the NRCS will sign a Memorandum of Understanding (MoU) with the IFRC, specifying the outcomes, timeline, budget, reporting requirements, and compliances). Per diems to volunteers will be made through bank transfers to minimize handling of cash.

C. Detailed Operational Plan

Health

People targeted: 684,131
Male: 273,652
Female: 410,479
Requirements (CHF): 96,448

Needs analysis: With the escalating spread of the disease, prevention of cholera in the affected states has become critical. Risk communication and health education is required in the targeted areas. In addition, gaps have been identified in identification and management of cases, leading to spread of the disease. Thus, there is need to provide ORPs which will be linked to CTCs to support case management. Volunteers will distribute IEC materials in local languages and will also show videos on cholera prevention and control.

Population to be assisted: 684,131 people, representing 3% of overall population in Sokoto, Katsina, Kebbi, Gombe and Bayelsa States.

Programme standards/benchmarks: The operation will seek to meet SPHERE and WHO standards. *To ensure equal access to all targeted persons to the support, the operation will also see to meet* Minimum standards for protection, gender and inclusion in emergencies

<table>
<tr><td rowspan="3">P&B Output Code</td><td colspan="2">Health Outcome 4: Transmission of diseases of epidemic potential is reduced</td><td colspan="12">% targeted population reached with community-based disease control actions (Target: 100%)</td></tr>
<tr><td colspan="5">Health Output 4.1: Community-based disease control and health promotion is provided to the target population</td><td colspan="12">• # of volunteers trained on RCCE and ECV (Target: 160 volunteers)
• # of people reached with awareness messages on Cholera (Target 684,131 people)
• # community of stakeholder meetings held (Target: 20 meetings – 4 per state)
• # of interactive radio shows broadcast (Target: 10 radio shows)
• # of volunteers supporting oral vaccination campaign (Target: 160 volunteers)
• # of mobile messaging sessions conducted (Target: 40)</td></tr>
<tr><td>Activities planned
Week</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr>
<tr><td>AP021</td><td>National level refresher on ECV/RCCE/WASH for branch level secretaries and health focal points (accommodation, perdiem, travel, training venue, facilitation, etc. for 3 days)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>AP021</td><td>Mobilize and train 160 HAT and MC members on ECV, RCCE, WASH in 5 targeted states (venue, perdiem, facilitation, etc. for 3 days)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>AP021</td><td>Deploy 160 HAT and MC for 4 months to conduct cholera prevention awareness and hygiene promotion (incentives)</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>AP084</td><td>Conduct one community stakeholder meeting per state per month across 4 months</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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AP084	Conduct 10 interactive radio shows on at least 1 local radio station per state across 5 states for 4 months																
AP084	Conduct mobile messaging (Baba Ijebu) twice a month across 5 states for 4 months																
AP021	Reproducing IEC materials for awareness (posters and leaflets)																
P&B Output Code	**Health Output 4.4: Transmission is limited through early identification and referral of suspected cases using community-based surveillance, active case finding, and/or contact tracing**				• ***# of volunteers engaged in ORP management and CTC disinfection (Target: 40 volunteers)*** • ***# of ORPs setup and linked with CTCs (Target: 4)*** • ***# of targeted volunteers conducting active case detection and referrals (Target: 100 %)*** • ***# of ORPs supported with consumables (Target: 4)*** • ***% rate of CTC disinfection once case detected (Target: 100%)*** •											
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP021	Training of 40 volunteers on ORP management and IPC for CTCs (4 locations)																
AP021	Deployment 40 volunteers focusing on ORP management and IPC for CTCs for 12 weeks																
AP021	Replenish used consumables from utilized from ORPs as necessary																
AP021	Conduct case detection and referral of cases to nearest Oral Rehydration points and to Nearest CTCs																
AP084	Support disinfection of CTCs as necessary (Chlorine solution, sprayers, etc.)																
AP021	Supervision and data collection/monitoring																

Water, sanitation and hygiene

People targeted: 13,684
Male: 5,474
Female: 8,210
Requirements (CHF): 131,380

Needs analysis: The rising cholera cases being reported in Nigeria is aggravated by lack of safe drinking water and adequate sanitation facilities. To improve access to water, sanitation, and safe hygiene practices, the NRCS will provide basic NFIs such as Jerry cans, bucket with lids, water purification tablets and soap and hygiene kits to the most vulnerable groups in the targeted states. With the increasing rainfall, leading to an elevated risk of exposure to unsafe water, the NRCS will conduct community-level campaigns and sensitization on water sanitation and hygiene practices. Under this sector, response will focus on community hygiene promotion to households, strengthening WASH knowledge and best practices. Specific hygiene related activities to support the wider health and hygiene promotion will be carried out in communities identified to be most at risk. This includes distribution of NFIs to 5,000 most vulnerable households.

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Population to be assisted: 13,684 people, representing 2% of overall targeted population in Sokoto, Katsina, Kebbi, Gombe and Bayelsa States.

Programme standards/benchmarks: The operation will seek to meet SPHERE and cluster standards. Community hygiene promotion will be done using the PHAST (Participatory Hygiene and Sanitation Training) approach in the communities in the target states. Operation will also seek to meet the Minimum standards for protection, gender and inclusion in emergencies.

P&B Output Code	WASH Outcome1: Immediate reduction in risk of waterborne and water related diseases in targeted communities					*% households reached with key messages to promote personal and community hygiene (Target: 100%)*											
	WASH Output 1.1: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population					*• # of volunteers trained on WASH and BTIT (Target: 160) • # of households assisted with water purification tablets (Target: 1,000) • # of households reached with WASH related household items (soap, hygiene kits, buckets and jerricans) (Target: 2,280 HH) • # of hygiene promotion sessions conducted (Target: 24 sessions) • # of volunteers engaged in hygiene promotion (Target: 160 volunteers) • # of Red Cross branches having received sanitation equipment (Target: 5 RC branches) • # of PDMs conducted (Target: 5 – 1 per state)*											
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP084	Develop a hygiene communication plan. Train volunteers to implement activities from communication plan.																
AP084	Design and print IEC materials with hygiene promotional messages																
AP026	Procure and distribute water purification tablets to 1,000 targeted families for one month																
AP026	Procure and distribute hygiene-related household items (buckets, jerricans, hygiene kits, etc.) to 2,280 targeted families for one month																
AP026	Train population of targeted communities on safe use of water treatment products, and proper use of the distributed WASH materials																
AP030	Carry out awareness sessions on hygiene promotion, specifically on the use of latrines																
AP030	Carry out disinfection at households of the affected people																
AP030	Conduct satisfaction survey (PDM) for items distributed																

Strategies for Implementation

Requirements (CHF): 75,360

P&B Output Code	S1.1: Improved NRCS capacity to ensure that necessary ethical and financial systems and structures, and required skills to implement efficiently and effectively					*# of volunteers provided with PPE (Target: 200)*											
	Output S1.1.1: Volunteer's protection and compliance to RCRC principles and SOPs is ensured																
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

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		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP040	Ensure that all 200 volunteers are insured																
AP040	Regular volunteers' briefings on security, access, and potential risks																
AP040	Provide adequate PPEs for volunteers and staff																
AP040	Ensure volunteers are fully engaged in planning and execution of activities through WhatsApp groups and regular meetings																
P&B Output Code	**Output S1.1.6: National Societies have the necessary corporate infrastructure and systems in place**	***# of NDRTs deployed (Target: 3)*** ***# of branch staff supporting the operation (Target: 10 branch staff)*** ***# press briefings conducted (Target: 1)*** ***# of documentaries produced (Target: 1)*** ***# of NS monitoring missions conducted (Target: 5)***															
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP042	Deployment of NDRTs to supervise operations throughout implementation																
AP042	NHQ monitoring costs for 5 persons (head of health, deputy head of health, Logistics, PMER and finance)																
AP042	Deployment of Branch Secretaries and Branch health coordinators in each targeted state for 4 months (2 per state in 5 states)																
AP049	Organize Press briefing on the Operation																
AP042	Produce a communication work (documentary)																
AP042	Deployment of 2 NS comms officers to support production of documentary																
P&B Output Code	**Outcome S2.1: Effective and coordinated international disaster response is ensured**	***% target population reporting acknowledging usefulness of the intervention (Target: at least 60%)***															
	Output S2.1.1: Effective and respected surge capacity mechanism is maintained.	***# of IFRC missions conducted (Target: 3)*** ***# of two-ways feedback system setup (Target: at least 1)*** ***# of lessons learned workshop conducted (Target; 01)***															
	Activities planned Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
AP049	IFRC monitoring missions (Immunization officer, CEA officer and health officer)																
AP084	Manage two-way feedback system																
AP042	Conduct lessons learnt workshop																

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Funding Requirements

The overall funding allocated for this operation is CHF 303,187 as detailed in below budget.

all amounts in Swiss Francs (CHF)

International Federation of Red Cross and Red Crescent Societies

DREF OPERATION

MDRNG033 - NIGERIA - CHOLERA OUTBREAK

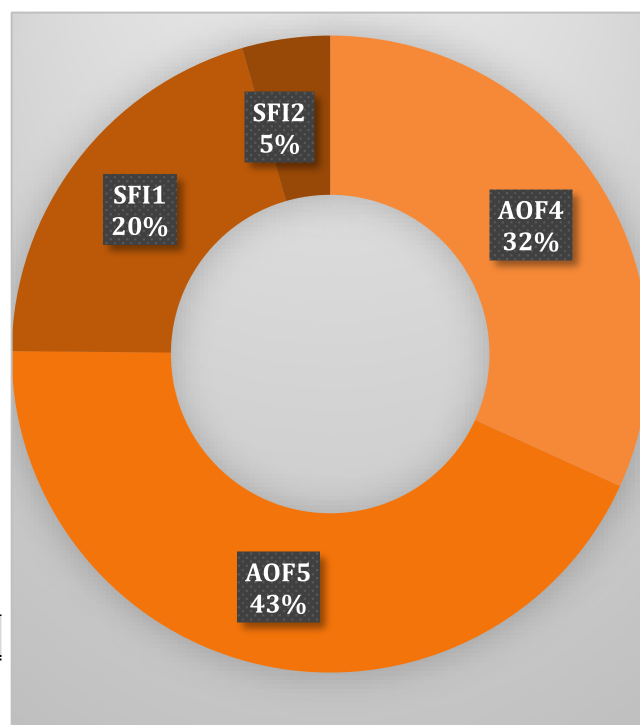
24/09/2021

Budget by Resource

Budget Group	Budget
Water, Sanitation & Hygiene	121,718
Medical & First Aid	19,365
Relief items, Construction, Supplies	**141,083**
Distribution & Monitoring	8,703
Logistics, Transport & Storage	**8,703**
National Society Staff	3,603
Volunteers	51,677
Personnel	**55,279**
Workshops & Training	31,071
Workshops & Training	**31,071**
Travel	4,222
Information & Public Relations	23,846
General Expenditure	**48,547**
DIRECT COSTS	284,683
INDIRECT COSTS	18,504
TOTAL BUDGET	**303,187**

Budget by Area of Intervention

AOF4	Health	96,448
AOF5	Water, Sanitation and Hygiene	131,380
SFI1	Strengthen National Societies	61,847
SFI2	Effective International Disaster Management	13,513
	TOTAL	**303,187**



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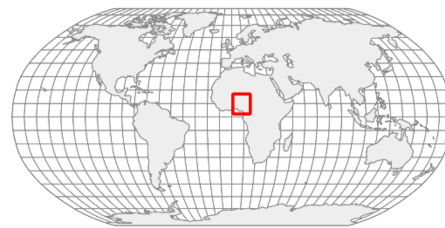
Nigeria : Cholera Outbreak

23 September 2021 ● EP-2021-000143-NGA



73,055 Suspected cases
As of 21 September

2,407 Deaths

13,683 PP Targeted

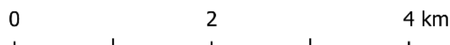
2,280 HH Targeted

NIGER
CHAD
BURKINA FASO
BENIN
TOGO
GHANA
NIGERIA
EQ. GUINEA
GABON
ICAN REP.

Sokoto
Katsina
Zamfara
Kebbi
Kano
Jigawa
Yobe
Borno
Bauchi
Gombe
Kaduna
Niger
Adamawa
Plateau
Federal Capital Territory
Delta
Bayelsa

Affected States
Targeted States
States

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



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Reference documents

Click here for:

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

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How we work

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

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

Save lives, protect livelihoods, and strengthen recovery from disaster and crises.

Enable healthy and safe living.

Promote social inclusion and a culture of non-violence and peace.

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