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Final Report

Niger: Cholera Outbreak

 International Federation
of Red Cross and Red Crescent Societies

DREF operation	Operation MDRNE025
Date of Issue: 2 September 2022	Glide number: EP-2021-000130-NER
Operation start date: 03 September 2021	Operation end date: 28 February 2022
Host National Society: Niger Red Cross Society	Operation budget: 275,635
Number of people affected: 5,591 people with 166 deaths	Number of people assisted: 254,121 directly and 1,650,000 indirectly
Red Cross Red Crescent Movement partners currently actively involved in the operation: French Red Cross and International Committee of Red Cross (ICRC) and international Federation of Red Cross and Red Crescent Societies (IFRC)	
Other partner organizations actively involved in the operation: UNICEF, WHO, MSF	

The major donors and partners of the Disaster Response Emergency Fund (DREF) include the Red Cross Societies and governments of Belgium, Britain, Canada, Denmark, Germany, Ireland, Italy, Japan, Luxembourg, New Zealand, Norway, Republic of Korea, Spain, Sweden, and Switzerland, as well as DG ECHO and Blizzard Entertainment, Mondelez International Foundation, Fortive Corporation, and other corporate and private donors. The Canadian Government contributed to replenishing the DREF for this operation. On behalf of the Niger Red Cross Society (NRCS), the IFRC would like to extend gratitude to all for their generous contributions.

A. SITUATION ANALYSIS

Description of the disaster

A cholera outbreak was declared in Niger on 9 August 2021 by the Minister of Public Health. This announcement came 22 weeks after the first registered case on 13 March 2021. By 16 August 2021, Niger had recorded 845 confirmed cases with 35 deaths initially located in two regions of the country: Zinder and Maradi. Unfortunately, the epidemic spread rapidly and by 24 August 2021, the number of confirmed cases had increased to 1,904 with 70 deaths (4% lethality rate). From two regions in March 2021, namely Dosso and Tahoua, the cases spread to six regions by 24 August, successively: Tahoua, Dosso, Maradi, Zinder, Tillabery and Niamey. In September, cases were registered in the seventh region of Niger, Diffa. The epi-data per region was increasing over the weeks, spreading geographically a total recorded cases and death in constant evolution, despite some weeks of cases decreasing in Maradi.



Cholera sensitization session in a Maradi Ville market by 2 NRCS volunteers
©NRCS

This [DREF Operation](#) was launched on 03 September for CHF 275,635 to reduce the immediate health risks of the outbreak on the people of Maradi, Tahoua and Niamey. Through [Operation Update 1](#), changes were made to the operational strategy as some budget lines were freed up thanks to participation in cost from Regional Office Surge budget and support provided by UNICEF. These savings helped to ensure that MoH strategy could be supported to curb the spread of the disease. Initially set to last four months, the operation was extended through [Operation Update 2](#) until 28 February 2022, for a total implementation timeframe of 5 months.

The epidemiological data by the end of the outbreak shows a cumulative number of 5,591 cases with 166 deaths distributed as follows:

Number of cases	Zinder	Maradi	Tahoua	Tillabery	Niamey	Dosso	Diffa	Total
Total recovered	580	2,989	1242	298	100	143	73	5,425
Total deaths	20	49	67	11	12	7	0	166
Cumulative cases	600	3,038	1,309	309	112	150	73	5,591

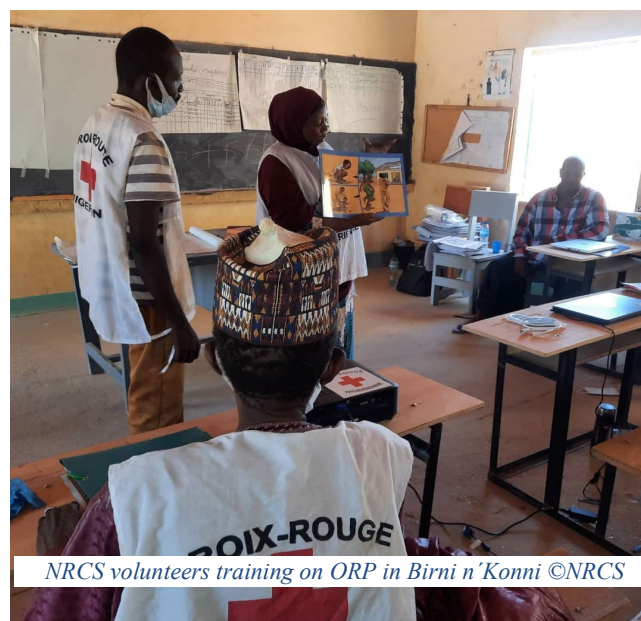
Table 1: Division of cholera cases during the cholera outbreak. Source, 35th Operational Update of 22nd December 2021

Summary of response

Overview of Host National Society

The response plan centred on the set-up and running of Oral Rehydration Points where Red Cross volunteers provided first aid through provision of Oral Hydration Salt, referrals to health centres, and hygiene promotion messaging. Given the high caseload of the outbreak on Maradi Region, it was decided to prioritize activities under this operation to this region, particularly the districts of Tibiri, Madarounfa and Maradi city in Maradi, although the operation covered the regions of Tahoua and Niamey. Based on the field visit to Maradi from 07 to 12 October 2021, the NRCS revised the response plan to include the approach of Branch Transmission Intervention Teams and support for social mobilization for the success of the Oral Cholera Vaccination Campaign.

The Niger Red Cross Society (NRCS) revised the plan on 12 October 2021 to include new activities and align with MoH priority based on the epidemiological evolution. On 13 December 2021, [Operation Update 1](#) was published with the revised approach of intervention, followed by [Operation Update 2](#) on 21st of January 2022, which extended the operation by one month.



NRCS volunteers training on ORP in Birni n'Konni ©NRCS

When cases in Diffa were reported in October 2021 this news was alarming for the MoH as the cases raised concern as the outbreak was spreading to a new area, the seventh Region of Niger. The situation in Diffa was closely monitored and MoH called on the support of the NRCS to increase community-based activities to prevent further spread of cases. The MoH requested the NRCS to support them by setting up an ORP in case the situation would worsen. Fortunately, the situation got under control quickly. In October, cases were reported in Dosso region and again, the MoH asked the NRCS to prepare for a response. The NRCS prepared for this internally, however when the cases registered in Dosso turned out to be isolated cases it was decided not to proceed with the intervention in Dosso region.

Throughout the cholera outbreak, NRCS deployed 150 volunteers and 15 supervisors to the affected areas in Maradi, Tahoua and Niamey. Those volunteers were trained on the following areas of intervention: sensitization through the Branch Transmission and Intervention Team (BTIT) approach, Risk Communication and Community Engagement (RCCE) and demonstrations of adequate hygiene practices. NRCS received technical support through IFRC's deployment of Health Surge personnel and the IFRC's Country Support Platform (CSP) project with the Global Taskforce on Cholera Control (GTFCC).

Overview of Red Cross Red Crescent Movement in country

The IFRC provided support through its Niamey Country Cluster Delegation and Africa Regional Office. From the onset of the disaster, contacts were established with the Disaster, Climate and Crises Preparedness Response and Recovery (DCPRR) and Health units of Africa Regional Office and regular updates on the situation and activities were shared.

For the Cholera response operation, IFRC deployed a Public Health Delegate on mission, while an ORP trainer and Community Engagement and Accountability (CEA) coordinator were also deployed through the Rapid response system. The ORP trainer and CEA coordinator were funded through Regional Surge unit and supported the response for a period of three months each. To improve coordination, weekly meetings were organized to discuss implementation of the operation. A WhatsApp group was set-up to improve communication.

Technical support was provided to the operation through frequent contact with IFRC regional office. Updates were shared and virtual meetings were organized with regional staff to improve coordination. IFRC regional office hosted an online training for the staff involved in DREF operation on the new Branch Transmission Intervention Team training (BTIT), with focus on modules four and five.

Movement partners in Niger include the French, Spanish, Luxembourg, Danish Red Cross, Finnish, Italian, Belgium Red Cross Societies, and the International Committee of the Red Cross (ICRC).

Several Movement coordination meetings were organized throughout the outbreak, some general coordination meetings and others specific on the response to the cholera outbreak. Details of RCRC Movement actors support during this operation, especially the Spanish RC and ICRC, can be found on page 5 of [Operation Update 1](#).

Overview of other actors' actions in country

The response to the cholera outbreak was led by the Ministry of Health and although most of the partners responded relatively late to this outbreak, a good level of mobilisation was observed with WHO, UNICEF and MSF which have a long-term presence in Niger and supported the response. With regards to coordination, bi-lateral meetings were organised with all local actors led by the MoH. At country level, IFRC and NRCS took part in the following technical cluster coordination bodies: WASH cluster; Health cluster and One Health meetings at the MoH. Details of non-Red Cross partners support can be found on page 5 of [Operation Update 2](#).

Needs analysis and scenario planning

The Ministry of Health defined the following gaps in the response during the cluster meeting held on 5 August 2021:

- Inadequate access to basic Social Services in the areas where the outbreak occurred.
- Inadequate funding and logistic/supplies for rapid response to the outbreak.
- Inadequate community-based surveillance in place for early detection of cases and sharing information to assist investigations and responses.
- Insufficient capacity of staff in case management.
- Need to scale up WASH interventions to increase common access to safe water.

Following the launch of this operation, an initial assessment was conducted at national level from 4 to 8 October 2021, and through analysis of secondary data and meetings with key stakeholder. This national assessment was followed by assessments in the three geographical areas of intervention. During the operation, the evolution of the outbreak was closely monitored to adapt the response if needed.

The areas of declared cases were the focus of this operation and the National Society (NS) closely followed-up the evolution of the outbreak as detailed in the table below:

Tableau 1 : Dynamique de l'épidémie du choléra, Niger, 13 Mars-21 décembre 2021

Region	Districts	Cas	Décès	Létalité	Début de l'épidémie	Date dernier cas	Evolution	# Jours sans cas
Diffa	Diffa	73	0	0%	24/09/2021	28/11/2021	Foyer éteint	23
	Boboye	1	0	0%	23/09/2021	23/09/2021	Foyer éteint	89
Dosso	Dioundiou	1	0	0%	30/03/2021	30/03/2021	Foyer éteint	266
	Dosso	47	6	13%	20/10/2021	22/11/2021	Foyer éteint	29
	Doutchi	1	0	0%	01/08/2021	01/08/2021	Foyer éteint	142
	Gaya	86	1	1%	01/08/2021	30/10/2021	Foyer éteint	52
	Logo	2	0	0%	19/09/2021	21/09/2021	Foyer éteint	91
	Tibiri	12	0	0%	28/08/2021	30/08/2021	Foyer éteint	113
Maradi	Aguie	10	0	0%	04/09/2021	22/09/2021	Foyer éteint	90
	GUIDAN ROUMDI	370	5	1%	30/07/2021	27/09/2021	Foyer éteint	85
	MADAROUNFA	1763	8	0%	04/04/2021	23/10/2021	Foyer éteint	59
	MARADI VILLE	880	36	4%	28/07/2021	23/09/2021	Foyer éteint	89
Niamey	TESSAOUA	15	0	0%	03/08/2021	20/08/2021	Foyer éteint	123
	NIAMEY 1	38	7	18%	17/08/2021	09/09/2021	Foyer éteint	103
	NIAMEY 2	41	3	7%	12/08/2021	05/09/2021	Foyer éteint	107
	NIAMEY 3	21	1	5%	09/08/2021	21/09/2021	Foyer éteint	91
	NIAMEY 4	8	0	0%	16/08/2021	08/09/2021	Foyer éteint	104
	NIAMEY 5	4	1	25%	16/08/2021	19/09/2021	Foyer éteint	93
Tahoua	Abalak	4	1	25%	06/09/2021	18/09/2021	Foyer éteint	94
	Birni N'Konni	428	35	8%	13/03/2021	18/10/2021	Foyer éteint	64
	BOUZA	164	9	5%	21/08/2021	24/11/2021	Foyer éteint	27
	ILLELA	8	0	0%	18/08/2021	07/09/2021	Foyer éteint	105
	KEITA	37	3	8%	10/08/2021	01/10/2021	Foyer éteint	81
	Madaoua	141	6	4%	10/08/2021	05/10/2021	Foyer éteint	77
	Malbaza	526	13	2%	16/08/2021	12/10/2021	Foyer éteint	70
Tahoua Dépt	1	0	0%	23/09/2021	23/09/2021	Foyer éteint	89	
Tillabéri	Gotheye	30	1	3%	25/08/2021	12/09/2021	Foyer éteint	100
	Kollo	165	4	2%	30/08/2021	17/10/2021	Foyer éteint	65
	Say	6	0	0%	13/09/2021	04/12/2021	Foyer éteint	17
	Tillabéri	108	6	6%	10/08/2021	22/09/2021	Foyer éteint	90
TANOUT	DTK	7	2	29%	16/07/2021	21/07/2021	Foyer éteint	153
	DUNGASS	6	0	0%	28/07/2021	02/10/2021	Foyer éteint	80
	Tanout	20	3	15%	28/07/2021	23/08/2021	Foyer éteint	120
Pays	5 591	166	3%	13/03/2021	04/12/2021		17	

Table 2: Dynamics of the Cholera outbreak in Niger, 13 March to 21 December 2021

When cholera cases started increasing in the regions of Diffa and Dosso, discussions were held between IFRC, ICRC and other humanitarian partners on how to coordinate with the DREF Operation and plan the scale-up in a Movement approach. ICRC provided support to the NRCS to scale-up the response in Diffa region and it was decided that the DREF operation would continue in Niamey, Maradi and Tahoua. When cases in Dosso suddenly increased the response was discussed in the cluster meetings led by Ministry of Health and with participation of the humanitarian organizations. The NRCS with support of IFRC presented flexibility to intervene in Dosso, though fortunately the situation got quickly under control and no further response was required.

Regarding the gaps identified by the Ministry of Health, the assessments carried out by the NRCS showed similar results. The inadequate community-based surveillance was further explored in the assessments and the resistance of community members to go to health centres in cases of Acute Watery Diarrhoea was identified. Based on the assessments, it was decided to adapt the strategy from Oral Rehydration Points to deploy Branch Transmission Intervention Teams, which aligns better to the gaps of information and need for immediate action at household level.

Risk Analysis

During the implantation period, the security situation in Niger continued to deteriorate resulting in increasing number of attacks with lethal outcomes as well as population movements. However, the main areas affected by violence are Tillabery and Diffa regions, which were not covered by this DREF Operation. Indeed, the ICRC responded to the outbreak in these locations with the NS. The security situation hindered IFRC colleagues to do supervision and monitoring in the rural areas as movements are limited to the larger cities and road travel is only allowed in specific cases. The CEA and ORP surge were permitted to conduct one mission to Birni n’Konni in Tahoua and the different delegates conducted missions in Maradi village. Hence, the technical support of IFRC was limited to support at Headquarters level and in the larger cities.

The other security risks described in the [EPoA](#) were an increase in COVID-19 cases, malaria, malnutrition and their impact due to the floods. COVID19 cases increased mainly in December 2021 and January 2022 with the Delta variant, however, the Health system was not largely impacted by this development. The rumours about COVID19 vaccines did influence the Oral Cholera Vaccination campaign, as people lost faith in efficacy and safety of vaccines in general.

During the response, the food insecurity situation in Niger was aggravated due to the failed agricultural season in 2021 caused by floods and ongoing desertification. The Cadre Harmonisé reported that between 2.5 and 3.3 million were food insecure by the end of February (Phase 3 to 5 as per the Integrated Food Security Phase Classification – IPC). Moreover, almost 43.5 percent of children under five were suffering from chronic malnutrition and 12.5% from acute malnutrition.

B. OPERATIONAL STRATEGY

Proposed strategy

The overall strategy of this DREF operation was to reduce immediate risk of the cholera outbreak to the health of the affected population with interventions including improved surveillance for early case detection, timely response, including effective case management to curb the outbreak and contribute to preventing further outbreaks of cholera in the areas of Maradi (3,000 HH), Tahoua (focusing on Birni Konni: 800 HH) and Niamey (1,200 HH) for a total of 5,000 HH (35,000 people).

During the operation, continuous needs assessments and analysis were carried out to adapt the response to the most vulnerable people in need of support. Although the cholera outbreak evolved quickly, the team monitored the epidemiological situation to ensure efficacy of the response. The NRCS cooperated closely with MoH on different levels to respond to the priorities defined and to strengthen the health system.

Following the initial assessments, the implementation strategy was adapted to the epidemiological situation and in line with the request of the Ministry of Health (MoH). Three response approaches were included in the NRCS intervention, all aligned with MoH plan. They focused on (i) ORP kits installation/distributions, (ii) Branch Transmission Intervention Teams (BTIT), and (iii) Oral Vaccination Campaign Support (OCV).

1. ORP kits installation/distributions

Due to a decrease in officially registered cases, the Ministry of Health of Madarounfa and Tibiri expressed a preference for sensitization activities at community level through household visits. A concern was expressed that ORP's in the communities could result in cases not being forwarded to the Cholera Treatment Centres. It was proposed to have the ORP's next to CTC's which could be beneficial in situations where there the capacity of CTC was overwhelmed. As this situation did not arise, IFRC and NRCS did not consider this a suitable option.

The Oral Rehydration Points and Oral Rehydration Treatment (ORP/ORT) were no longer considered the most adequate response to the cholera outbreak. NRCS and IFRC discussed the ways forward with MoH as ORPs was not longer the first main approach for this cholera response. As such, in consultation with IFRC Regional Office, it was decided to finalize the planned trainings on ORP/ORT as prevention for future outbreaks and these trained volunteers could be deployed.



ORP simulation in Maradi ©NRCS

2. Branch Transmission Intervention Teams (BTIT)

As described in [Operational Update 1](#), the ORP approach was replaced by the newly developed Branch Transmission Intervention Team Approach. This approach integrated activities in which the NRCS has experience. The newest development of the approach was the household risk assessment conducted by the volunteers. Below are the main points of what was implemented using this approach:

- The volunteers conducted household visits and used a rapid risk assessment tool to evaluate the risks of transmission. They assessed the quality and storage of drinking water, availability and quality of latrines, cleanliness of house and particularly the kitchen. Volunteers assessed the cholera transmission as well risks at markets, schools, health centres and other public spaces. Based on the risks encountered they provide adequate response to improve the hygiene situation and reduce the risks of transmission of cholera. An example cholera risks faced in households was stagnant and polluted water in the space around the house, lack of adequate sanitation, inappropriate storage of water by not covering the water reservoirs.
- Household hygiene kits were distributed to the most vulnerable 2,650 households in Maradi region, more specifically in the districts of Madarounfa and Tibiri.
- Volunteers conducted household visits and used a rapid risk assessment tool to assess the risks of transmission following the BTIT approach.

3. Oral Vaccination Campaign Support (OCV)

✚ Trainings of volunteers and community leaders:

In September, the training of volunteers belonging to the most affected health districts begun, and refreshment training for the volunteers trained in 2018. In total, 150 volunteers and 10 supervisors were trained on ORT/ORTP in the regions of Maradi, Tahoua and Niamey during a three-day session in October 2021. Areas of intervention proposed in the operation were discussed by NRCS with its Movement partners, humanitarian partners and MoH. The evolution of the outbreak and capacity of other humanitarian partners were the chosen criteria for this assessment.

In December, the same 150 volunteers and 15 supervisors involved in the response were trained on BTIT and CEA. Modules one to three of the BTIT training contain information which is already covered in the ORP/ORT training. Therefore, it was decided to focus on module 4 on household interventions and module 5 on community interventions. Moreover, during the supervision visits, it was noticed that volunteers had challenges on two-way communication and enhancing behaviour changes. Community Engagement and Accountability (CEA) being new within the Niger Red Cross, it was proposed to take advantage of this operation to institutionalize CEA within the NS. No system for rumour and feedback collection existed, so it was decided to set this up. It was thus decided to train all volunteers during one day on CEA and RCCE on top of the information provided on these topics in the ORP/ORT training.

✚ Volunteer mobilization and sensitization:

From the DREF allocation, the CRN has been carrying out a broad variety of sensitization activities to reduce the risks of cholera transmission. Household visits is considered as one of the most effective activities as it provides room to answer questions from beneficiaries and have in-depth conversations.

It was decided to prioritize activities under DREF to the region of Maradi as this was the hardest hit region, in particular the districts of Tibiri, Madarounfa and Maradi city. In Maradi, ninety-five (95) volunteers and even supervisors were trained and two additional ORP's were transported to the region. Due to a decrease in officially registered cases the Ministry of Health of Madarounfa and Tibiri expressed a preference of sensibilization activities on community level through household visits. A concern was expressed that ORP's in the communities could result in cases not being forwarded to the Cholera Treatment Centers. It was proposed to have the ORP's next to CTC's which could be beneficial in situations where there the capacity of CTC is overwhelmed, as this is not the case now IFRC and NRCS do not consider this a suitable option. In December and January volunteers visited 11,870 households reaching 96,644 persons of which 42,724 men and 53,920 women.

In Tahoua region, awareness activities on all barrier measures to fight against the cholera outbreak were launched in the district of Konni on Monday 18 October 2021. The Red Cross sub-committee has urgently put in place ten (10) teams composed of four volunteers in each, amounting to forty (40) volunteers in total. Nine of these teams are working on sensitization and are going door-to-door and a total number of 1862 houses were visited, meeting the community members, visiting schools and do mass sensitization whenever they are in front of a bigger audience – either at baptism or wedding ceremonies (a total of 33,041 people were sensitized, there in 11,056 men, 9,480 women and 13,293 children). The 10th team are composed of four trained hygiene volunteers which oversee disinfecting the affected households and sites at risk (in total 12 houses and 9 sites were disinfected). In addition, the volunteers referred four people with suspected cases of cholera to the closest health centres. All activities in the region are supervised by two supervisors. In addition to the activities carried out by the volunteers, the NRCS launched a dissemination of key messages on barrier measures to fight against the cholera epidemic every day on the two community radios. All the surrounding villages at 15 km are listening to this message.

Supporting Vaccination campaign:

In early October, the MoH informed the Movement that they would launch a cholera vaccination campaign in the hardest hit regions. The NRCS was engaged as part of this DREF response and has implemented the activities below:

- In Birni N'Konni district in Tahoua, the volunteers took part in sensitization activities during the first dose of the Oral Cholera Vaccination from 09th – 13th of January. Information on the cholera vaccination campaign was provided to volunteers to include in the regular sensitization activities. A total of 3,972,343 Oral Cholera Vaccines (OCV) were distributed to Maradi region, targeting 1,986,172 people. CEA and RCCE activities were kept ongoing considering the campaign.
- Community meetings were organized in Maradi region to discuss the cholera vaccines. MoH initially set the first vaccine dose for 22nd of November 2021, then second from 22nd of December 2021 and onwards in Maradi. In the period leading towards the second dose, the volunteers continued to spread messages as it is important to receive the second dose to be immune for a period of two years. The cholera vaccine is an important aspect in preparation for future outbreaks.


Community Engagement and Accountability (CEA) / Risk Communication and Community Engagement (RCCE):

- CEA/RCCE was a stood central part of this response, and the opportunity was used to start institutionalizing CEA within the NRCS as this approach is still new to them. As volunteers were trained on CEA/RCCE, the quality of community sensitization activities improved and hence, accelerated the process of behaviour change. Thanks to these training sessions, volunteers improved communication styles to best adapt to different beneficiaries and ensure two-way communication. Through continuous on-the-job training, the volunteers improved their capacities in capturing rumours and feedback and were able to share this information through feedback mechanisms. The feedback collected at community level enabled the NRCS to constantly adapt to the needs and questions of the population. An example is that in the group discussion with communities, some participants expressed fear for Cholera vaccines because of the rumours around COVID-19 vaccines. Based on the feedback collected, key messages were adapted to explain the difference between both vaccines.
- In this response, the most vulnerable people were targeted as they were already weakened persons and the disease was more likely to be fatal for them. During the trainings, volunteers were taught to identify the most vulnerable people in their communities: children under five and pregnant women. In light of the deteriorating security situation in country, it was discussed how to best reach migrant populations. Emphasis was given on the importance of gender as this is incredibly important considering Islam being the dominant religion and having 96,2% of the population strictly following their religion. There are strict norms and values on contact between male and female and therefore it is important to aim at a fifty-fifty balance in the gender distribution of volunteers. Female households did not accept male volunteers talking to them and they could not enter the households to assess the cholera risks with them.
- To enhance transparency and accountability, several field visits were organized by IFRC together with the National Health Coordinator of the NRCS to the regions. During these visits, meetings were organized with

MoH, the regional branch, volunteers, supervisors, and humanitarian partners to discuss the implementation. Supervision of activities took place daily by the district supervisors to assure quality of implementation.

A lessons learnt workshop was organized on 15 February 2022. During this event, the three cholera RCRC approaches were presented and NRCS response assessed, with key learnings captured for future actions. The following groups of stakeholders took part in the lessons learned workshop: Staff from NRCS from HQ and field; MoH, RCRC Movement partners (ICRC, Belgium, Italian, British, Belgium, Luxembourg, Spanish Red Cross Societies); namely WHO, MSF, UNICEF; Staff from IFRC from IFRC Niamey Cluster; IFRC Regional Office; Representation of Nigerian Red Cross.

C. DETAILED OPERATIONAL PLAN

	Health People reached: 254,121 Male: 152,472 Female: 101,649	
Outcome 1: The immediate risks to the health of affected populations are reduced		
Output 1.1: The health situation and immediate risks are assessed using agreed Guidelines		
Indicators:	Target	Actual
# of assessments carried out	2	2
Outcome 4: Transmission of diseases of epidemic potential is reduced		
Output 4.1: Community-based disease control and health promotion is provided to the target population		
Indicators:	Target	Actual
% reduction of waterborne diseases in the affected areas	100%	100%
# of volunteers trained on ORT/ORP	160	160
# of community leaders trained	90	270
# of CEA activities carried out to promote disease control at community level and health promotion (theatre, community meeting)	50	36,303
Output: 4.2: Transmission is limited through early identification and referral of suspected cases using community-based surveillance, active case finding, and/or contact tracing		
Indicators:	Target	Actual
% of targeted communities with active volunteers conducting early case detection and referrals	160	160
# of capacity assessments for early case detection and referral	1	1
# of alerts investigated/ reacted to in under 24 hours	50	4
# of community leaders trained at the RCCE	90	270
# of community case definitions identified	1	1
Output 4.6: Improved knowledge about public health issues among 35,000 people in in 3 regions of the country including Maradi, Tahoua and Niamey.		
Indicators:	Target	Actual
# of poster produced on cholera prevention	3,000	3,000
# of posters with A3 format produced on hand washing	3,000	3,000
# of languages the cholera prevention spots are broadcast in, on the national and private TV channels	3 languages including French, Hausa, and Zarma	3 languages including French, Hausa, and Zarma
# of people reached through the dissemination of cholera prevention messages on community radios	At least 35,000 persons	1,650,000
# of people reached with the RCCE activities	At least 35,000 persons	254,121
# of documentary film on the realization of these operations	1 film	1 film

Outcome 5: Less severe cases of acute watery diarrhoea are treated in the community, with referral pathways for severe cases established

Output 5.1: Cholera cases are managed in the community, with referral established for severe cases

Indicators:	Target	Actual
# of Oral Rehydration Points set up at community level	10 kits	0
# of people trained on the management of ORP	160	160
# of volunteers trained in simple methods of assessing dehydration levels	160	160
# of ORP purchased	6	6
# of cases detected and referred to the nearest oral rehydration points and CTCs	N/A	0

Narrative description of achievements

After approval of the operation, an assessment on the situation was carried out through analysing primary and secondary data. NRCS supported by IFRC health meetings with the Movement partners including the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO), UNICEF, MoH, WHO, MSF and OCHA. Both participated in regional, national, and global coordination meetings of Health and WASH Clusters. Based on this assessment, the areas of intervention were further specified. This assessment was completed with a visit of NRCS and IFRC to Maradi in the last week of September 2021.

When the operation was launched on 3rd September 2021, there were about 120 new cases of cholera per day. The cholera outbreak was officially declared over at the end of January 2022 and hence it can be concluded that there has been a 100% reduction in cases.

A total of 160 volunteers participated in 3-day ORP/ORT training. As part of the ORP/ORT training, the volunteers were taught basic knowledge on CEA/RCCE in module 5 on community mobilization and module 6 on stigmatization. In these modules, volunteers learnt on the importance of community mobilization, risk perception, six pillars of a well-prepared community, different methods for social mobilization, danger of rumours, management of rumours. On the last day of the training, the volunteers practiced household visits in simulation using the IEC material donated by UNICEF. In addition, community case was defined based on directives of the Ministry of Health and the existing ORP training materials as: "any person with an episode of three or more watery stools in a single day, accompanied by dehydration (persistent skinfold test or sunken eyes)." This information was shared with all volunteers during the 3-day ORP/ORT training so that they can recognize suspected cholera cases in their activities and do referral.

To note, four (4) ORP kits were prepositioned in Niger in 2020, two in Maradi and two in Niamey. The kits in Niamey were transported to Maradi for deployment. To complement the four kits already available in Niger before the cholera outbreak, six ORP kits were shipped from Nairobi to Niger. As the strategy has shifted from a response through ORP's to the Branch Transmission Intervention Teams zero ORP's were set-up. All kits are now prepositioned and ready to be use in future outbreaks. The division of ORP kits per NRCS warehouse is as follows: 4 in Maradi, two if Diffa, one in Tahoua and three in Niamey. The MoH and humanitarian partners at various levels have expressed interest in deployment of ORP kits in future outbreaks, at an earlier stage.

A total of 160 volunteers and supervisors were trained as well on module 4 and 5 of the Branch Transmission Intervention Team (BTIT), Oral Cholera Vaccination (OCV) and Community Engagement (CEA). As this training was not mentioned in the first publication of the DREF and added in the first operational update, no target was mentioned. The volunteers implemented the Branch Transmission Intervention activities at household level and at community shared spaces such as market and schools. The Risk Assessment tool was also used during household visits. All trained 160 volunteers, supported by the 10 supervisors, conducted early case detection and referrals integrated in all sensitization activities. Indeed, once volunteers came across persons with symptoms matching the community case definition of cholera, they referred this person to the Cholera Treatment Centre (CTC) or Health Centre. In all districts, the volunteers had daily contact with the district MoH to plan the activities and to refer cases.

A total of 270 community leaders were trained on CEA in December 2021 (150 in Maradi, 100 in Tahoua and 20 in Niamey). The number of community leaders trained surpassed the initial target as both the NRCS, MoH and communities showed great interest in this activity. Community leaders have a significant impact on accelerating behaviour change as they are respected by the community. NRCS has taken the opportunity of this operation to initiate institutionalization of CEA in the NS. No system for rumours and feedback collection has been in place and it was decided to set this up. Therefore, it was decided to train all volunteers during a one-day on CEA and RCCE on top of the information provided on these topics in the ORP/ORT training. A meeting was organized with all coordinators of the NS and the CEA Surge coordinator presented CEA/RCCE. A roadmap was then designed for implementation of CEA within NRCS, which shall continue after the DREF operation.

In total, in the three regions, 36,303 households were visited, with 254,121 people reached, including 152,472 men and 101,649 women. In addition, 2,479 people were reached by the mobile caravans and 1,078 by the community meetings and dialogues.

Challenges

The main challenge in this response was the delay in official declaration of the cholera outbreak by the Ministry of Health. First cholera cases were confirmed in March 2021 and the outbreak was only declared five months later in August 2021. When the response started, the epidemiological curve of officially reported cases was already showing a downward trend. However, at community level, suspected cases continued to be identified.

This led to ORPs not being relevant for the response when it finally started. Delays in funds transfer also slowed the start of the response. Indeed, when the ORP/ORT trainings started the number of cholera cases had reduced and the Ministry of Health no longer considered the ORP approach as the best response at this stage of the outbreak. Therefore, MoH asked the NS to adapt its proposed response towards community-based prevention at household level, as a response the NS proposed the BTIT approach.

Another challenge was the process of shipment of the additional six ORPs from Nairobi to Niamey. As the response was adapted, these kits were pre-positioned for future responses. However, if the kits would have been needed, they should have arrived earlier. These ORP kits were not funded through this response but through another funding source.

As the number of officially reported cases reduced, so did the frequency of coordination meetings, which further delayed the response. WASH cluster meetings were organized on a weekly basis, whereas the health cluster meetings were held only once a month.

The challenge regarding assessments was that no multi-sectoral assessment was carried out. The various humanitarian organizations conducted their own assessments and shared the results.

ORP/ORT training material is not available in the local languages. The BTIT training material was available in English and the team translated it to French and adapted it to the local context.

Though the volunteers were trained on recognition and response to cholera cases, as the number of cholera cases was already reducing it was difficult to report cases, investigate and react on. Therefore, only four cases were reported by the trained volunteers and reacted on. The volunteers provided ORS and referred the persons to the CTCs and district health centres, depending on the availability. After referrals they disinfected the houses of the persons following IPC practices and informing the households on preventive measures. In addition, the number of referred cases was not properly reported due to inadequate expertise from NS PMER and Health colleagues.

CEA/RCCE was implemented relatively late in the response as it was a new approach for the NS and there were delays in appointment of a National CEA focal point. This led to a challenge in the development of the design for the posters and the production for IEC.

Lessons learned

During implementation and in the lessons learned workshop, there were discussions on how improve response to suspected or confirmed cholera cases. Red Cross volunteers could play an important role in the early detection and response of cases with an appropriate community-based surveillance system in place. The NS has shown interest to implement this system and discussions have been initiated with the Ministry of Health. Moreover, there were discussions on how the NS could be strengthened to provide a faster response. Refresher trainings of volunteers before the start of the rainy season could be effective to ensure a quick mobilisation.

In addition, a funding for quick mobilization of volunteers when suspected cases are detected or cases confirmed is needed.

Didactic material for the trainings was in French, which the volunteers understand. However, for a next response it would be better to translate all material in local languages. Available material for radio messages and posters, in local languages, would also serve immediately during an outbreak.

During this response, the CEA/RCCE was integrated in the response. However, there is a need for further institutionalisation of CEA/RCCE within the NS. Therefore, a permanent focal point needs to be appointed to the lead in the elaboration of a National Strategy, training of staff and set-up of feedback systems. In future responses, CEA/RCCE activities should be integrated from the beginning of the response and at each of the steps in the project planning process. The training of community leaders should be done as early as possible in the response, even before an outbreak if possible.

Reporting of the number of cases referred needs to be improved and a meeting was planned with PMER and Health colleagues of NRCS to address this. It has been identified that the form which volunteers use to report their activities requires improvement to register cases referred.

The most important lesson learned regarding the ORP response is to continue to increase advocacy of the main Red Cross and Red Crescent approaches towards the Niger Ministry of Health and its humanitarian partners. It is important that all are aware of the following three RCRC cholera response strategies: (1) Oral Rehydration Treatment, (2) Branch Transmission Support Teams (3) Oral Vaccination Campaign support. Through the response and the lessons learned workshop, this advocacy was done, and this was appreciated by the partners. To have an effective response, it is important that MoH and partners know the capacities and the possible responses of Niger Red Cross.

It is important to integrate the three main RCRC approaches in the Health and Care section of the four-year strategy of the NS and in the roadmap for cholera eradication by 2030 of the Ministry of Health.



Water, sanitation, and hygiene

People reached: 36,862

Male: 18,247

Female: 18,615

Outcome 1: Immediate reduction in risk of waterborne and water related diseases in targeted communities.

Output 1.1: Continuous assessment of water, sanitation, and hygiene situation is carried out in targeted communities

Indicators:	Target	Actual
% reduction in cases of water borne and water related diseases	At least 50%	100%
# of assessment of water, sanitation and hygiene situation in targeted communities are carried out	2	2
# of participations in meetings with WASH colleagues from partner organizations	As necessary	6

Output 1.3: Adequate sanitation which meets Sphere standards in terms of quantity and quality is provided to target population

Indicators:	Indicators:	Indicators:
# of hygiene promotion sessions conducted	24	1,242
# of volunteers engaged in hygiene promotion	160	160
# of sanitation kits provided to targeted communities	10	20
# of IPC activities conducted with disinfection of public latrines and households (twice a week for 3 months)	24	46
# of IPC points installed	20	21

Output 1.5: Hygiene-related goods (NFIs) which meet Sphere standards and training on how to use those goods is provided to the target population

Indicators:	Indicators:	Indicators:
# of 20 litres bucket purchased	3,000	2,650
# of jerrycans purchased	3,000	2,650
# of pieces of soaps purchased	21,000	21,000
# of households reached with the distribution of buckets and pieces of soap	3,000 HH or 21,000 people	2,650 HH or 18,550 people
# of pieces of soap purchased for handwashing demonstration	300	0
# of people trained in the use of the hygiene kits distributed	3,000	0
# of hygiene kits distributed (<i>new indicator</i>)	3,000 HH or 21,000 people	5,266 HH or 36,862 people

Narrative description of achievements

During the health assessment carried out after the launch of the operation, specific attention was given to assessing the water, hygiene, and sanitation situation. These needs were discussed with Ministry of Health, WHO, UNICEF and MSF. In each of the meetings, it was asked where they consider the largest gaps in response and the majority mentioned community sensitization and WASH. The MoH in Maradi Region and Madarounfa district requested the

reconstruction of latrines which went beyond the scope of this operation. Moreover, by the end of the operation, cases of waterborne diseases had decreased by 100%. Lastly, NRCS and IFRC participated in the WASH cluster meetings which were first organized on a weekly basis and later bi-weekly.

In the Health and WASH assessment, substantial risk of acute watery diarrheic transmission was defined, and it was decided with MoH and ECHO to set up Infection Prevention and Control Points (IPC). In total, 21 IPC points were set up (13 at Health centres in Maradi, 1 at a market and 7 at border points with Nigeria such as the borders of Souloulou, N'yelwa and Dan Issa).

Based on the assessed needs in hygiene and sanitation, it was decided to increase the target of sanitation kits from ten to twenty with 16 kits for Maradi region and 04 kits for Tahoua, all procured and distributed. The kits contain brooms, wheelbarrows, rakes, pickaxes, shovels and were be donated to communities to clean their areas. The distribution of these kits was combined with sensitization on the importance of a clean environment in the prevention of cholera spread. The volunteers guided the process and ensured the materials are used accordingly.

Volunteers were trained on IPC during the ORP training and have been conducting IPC activities based on needs. Thirty sprayers and thirty handwashing stations were procured for Maradi Region. Niger RC received a large donation of aqua tabs and from UNICEF. IPC activities were carried out at households of confirmed cases, health centres, markets, and schools. No activities took place at CTCs and ORPs.

Some 2,650 household hygiene kits were distributed in Maradi region in the districts of Maradounfa and Guidam Roudji. An additional 2,616 hygiene kits were procured and distributed: 1050 for Maradi, 1050 for Tahoua and 516 for Niamey. These hygiene kits consisted of the following items: kettle, pieces of soap, bleach. In total, 5,266 hygiene kits were distributed during this response, reaching about 36,862 people.

UNICEF donated 17,520 pieces of soap, thus the funds from this operation destined for this activity were redirected to procure 200 backpacks with Niger RC logo for volunteers, 30 handwashing stations, 30 sprayers and 30 megaphones.

Challenges

As mentioned above, no multi-sectoral assessments were carried out and the humanitarian partners involved conducted their own assessments and shared outcomes.

Interest in trans-border cooperation was shown by the National Societies and Ministry of Health of Niger and Nigeria. There are many advantages in this cooperation as the historical epidemiological data show that cholera cases are often being transported from Nigeria to Niger and vice-versa due to the fragile border control and intense population movements due to the conflicts in both countries. Although the official languages of both countries differ, French for Niger and English for Nigeria, the local language in the border areas is Hausa. Hence, there are possibilities to develop IEC and training material which can be used in both countries. Unfortunately, due to the immense workload for both National Societies in the cholera responses, it was not possible to implement the transborder cooperation.

The main challenges regarding the activity of distribution of household hygiene kits were the delays in procurement. The prices in the local markets were higher than budgeted and therefore only 2,650 kits could be procured and distributed to families.

Lessons learned

There is a need for ongoing multi-sectoral assessments to continuously adapt to the needs in the community. IPC points at border with Nigeria were effective and appreciated by Ministry of Health. Transborder-cooperation should be further explored.

The Infection Prevention and Control activities and CTC's, health centres, and households were positively evaluated by the Ministry of Health and the population. The new BTIT approach integrated immediate actions based on the risks assessed at household level. This approach was appreciated as well.

Household hygiene disinfection kits should be prepositioned before an outbreak. During the period of implementation of the cholera response, household hygiene disinfection kits and volunteer kits were prepositioned for future outbreaks with support of German Red Cross. As part of its Health & Wash strategy, the NS aims to increase the number of kits prepositioned.

Strategies for implementation

S 1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical, and financial foundations, systems, and structures, competences, and capacities to plan and perform

Output S1.1.4: National Societies have effective and motivated volunteers who are protected

Indicators:	Target	Actual
# of volunteers insured	160	160
# of volunteers who know their roles and responsibility	160	160
# of volunteers properly trained	160	160

Output S2.1.3: Improved compliance by National Societies with the Principles and Rules of humanitarian assistance

Indicators:	Indicators:	Indicators:
# of WhatsApp groups set-up for community engagement	10 i.e., 4 in Maradi, 3 in Tahoua and 3 in Niamey	4
# of feedback received and acted on	At least 50%	1,573
# of lessons learnt workshops conducted	3 workshops (1 per region)	1
# of community engagement activities conducted to help promote healthy and safe behaviour and to ensure that people are kept informed of operational plans and progress <i>(new indicator)</i>	15,000	36,303
# of community feedback systems established <i>(new indicator)</i>	1	4

Output S2.1.4: Supply chain and fleet services meet recognized quality and accountability standards

Indicators:	Indicators:	Indicators:
# of people who understand warehousing procedures	1	1

Narrative description of achievements

A total of 160 volunteers, including the 10 supervisors, were trained in the three-day ORT/ORP training. Approximately 60% of the volunteers selected had already been a volunteer and hence, it was assumed that they knew the basics of the RCRC Movement and their roles and responsibilities as volunteers. At the beginning of each training, a test was done to assess the level of knowledge of volunteers on the RCRC Movement. Volunteers were asked to explain the seven Fundamental Principles, the Movement partners, its history, the function of the Red Cross emblem and the roles and responsibilities of volunteers. Based on the level of knowledge of the volunteers, additional explanation was provided. All 160 volunteers were duly insured.

The volunteers were trained on ORP/ORT on the following dates:

- Maradi: 1+2 were on 7-9 October, & 11-13 October
- Maradi: 3+4: 18-21 & 22-24 October
- Tahoua: 15-17 October
- Niamey: 15-17 October

And on BTIT and CEA on the following dates:

- Niamey: 03-05 December
- Tahoua: 10-12 December
- Maradi: 13- 15 and 16-18 December (two groups at the same time)

The budget was revised by the NRCS with IFRC support, to adapt to the operational changes described in this report. The following changes were made:

Reductions in the budget: There is a reduction of transport of ORP kits in the country. Of the six kits received, it was proposed by the NRCS to send two to Diffa and one to Tahoua. The other three remain in the city of Niamey as the warehouse capacity is better, and the transportation route to Tillabery and Dosso, where they are envisioned to be sent, is shorter. The estimated costs of 17,000 CHF in the original budget were over-estimated. A large donation of IEC material, soap, HH water treatment solution and Aqua tab was generously donated by UNICEF, the costs of soap are therefore reduced in the budget. The Surge costs were also be reduced as this was largely covered by the Regional Office.

Increases in the budget: A second 3-days training for 150 volunteers and 10 supervisors was included in the project. The training consists of 1 day of BTIT module 4 training, 1 day of BTIT module 5 training and 1 day of CEA training. Moreover, the procurement of backpacks and cotton masks for volunteers were added to the budget, and so was the procurement of handwashing stations, megaphones, and sprayers – 30 items of each have already been procured. The handwashing stations are used as IPC points at borders with Nigeria based on the request by ECHO as this was a successful implementation in the 2018 response. Finally, the cost for lessons learned workshop was increased to allow participation of all key stakeholders.

One national WhatsApp group was created with the IFRC support delegates and the RCSN HQ and regional staff. One local WhatsApp group was created for the response in Maradi region.

The NCRS has a logistics coordinator with knowledge on warehouse procedures. IFRC is currently without a logistics manager and a new one is being recruited. An IFRC surge is temporarily supporting the logistics and this person is providing support to the logistics coordinator of the NCRS.

Challenges

During the training on ORP/ORT it became clear that the knowledge of volunteers has insufficient knowledge on the Red Cross Movement, its seven Fundamental Principles, the emblems and their roles and responsibilities. Therefore, it was decided to include a briefing on the RCRC Movement.

The CEA coordinator has faced challenges in establishing a community feedback system and institutionalization of CEA and RCCE within the NCRS. This is because of delays in appointment of an CEA/RCCE focal point at the NS level. The challenges were overcome, and four feedback systems were set up. One National system and one for each region of intervention, namely Maradi, Tahoua and Niamey.

In all the CEA trainings, the volunteers were trained on the importance of feedback and rumour collection and on how the system to collect these worked, the supervisors were trained on the feedback and rumour collection form and filled this form on a weekly basis and send it to the headquarters. Four WhatsApp groups were created to share rumours quickly, one per region and one for the health staff with NRCS National Health coordinator.

Instead of three workshops, the NS organised one with all the planned participants: volunteers from all the regions.

The warehousing at regional level was disorganized and during the visits a plan was made with the regional branches to improve this.

Lessons learned

To assure that volunteers understand the Red Cross and Red Crescent movement it is recommend starting all training's with a refreshment training on Red Cross Red Crescent, principles, emblems and roles and responsibilities. The volunteers should have refreshments on this as well. Moreover, the volunteer database should be improved to guarantee that information of volunteers is adequately stored and hence the same persons can be deployed in future responses.

It is important to have a permanent CEA/RCCE focal point within the NS who takes the lead in development and implementation of CEA/RCCE strategy and training's. Secondly, there is a need for improvement of feedback collection system that matches the reality on the ground and needs of volunteers and branches.

Continue to support the National Society to improve its capacity building both on procurement processes and warehouse procedures. In the trainings with volunteer's emphasis was given to storage of ORP kits to re-use of materials.

D. Financial Report

The amount allocated for implementation of this operation was CHF 275,635 of which CHF 270,477 (98%) were expensed. The balance of CHF 5,157 will be returned to the DREF pot.

The general explanation from the final variances is the overspent under international personnel costs and general expenses that have been split in the different activities which require more budget. Mainly training sessions and perdiems, IFRC and NRCS monitoring.

Description	Budget	Expenditure	Variance		Variations explanation
Distribution & Monitoring	20,771	18,385	2,386	11%	Distribution cost higher than budgeted as some Distribution and monitoring costs were reported under the various related procurements, transport and travel missions to monitor those distribution.
International Staff	8,629	1,169	7,461	86%	ORP trainer and CEA surge were finally funded by IFRC regional surge unit. The cost allowed for their deployment was thus used to extend NRCS support to MoH strategy to curb the spread of the disease during the period of the second extension. Until 28 February 2022.
National Staff		1,293	-1,293	-100%	Costs related to per diem of volunteers and volunteers' supervisors during all the activities include for some trainings on which the planned budget was finally not sufficient
National Society Staff	3,912	6,800	-2,888	-74%	
Travel		2,474	2,474	-100%	This are costs for monitoring visits from IFRC side following operational need.
Office Costs	6,769	4,656	2,113	31%	all budget was not spent to ensure absorption of travel cost for IFRC monitoring.
Financial Charges	978	3,625	-2,647	-271%	Difference mainly results from financial currency loss between local currency and IFRC system currency in CHF.

Contact information

Reference documents



Click [here](#) for:

- [Operation Update 2](#)
- [Operation Update 1](#)
- [Emergency Plan of Action](#)

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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.

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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

DREF Operation

Selected Parameters			
Reporting Timeframe	2021/9-2022/6	Operation	MDRNE025
Budget Timeframe	2021-2022	Budget	APPROVED

FINAL FINANCIAL REPORT

Prepared on 18/Jul/2022

All figures are in Swiss Francs (CHF)

MDRNE025 - Niger - Cholera Outbreak

Operating Timeframe: 03 Sep 2021 to 28 Feb 2022

I. Summary

Opening Balance	0
Funds & Other Income	275,635
DREF Allocations	275,635
Expenditure	-270,477
Closing Balance	5,158

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			0
PO02 - Livelihoods			0
PO03 - Multi-purpose Cash			0
PO04 - Health	118,884	107,164	11,720
PO05 - Water, Sanitation & Hygiene	64,925	93,232	-28,308
PO06 - Protection, Gender and Inclusion	15,703	6,915	8,787
PO07 - Education			0
PO08 - Migration			0
PO09 - Risk Reduction, Climate Adaptation and Recovery		2,092	-2,092
PO10 - Community Engagement and Accountability	18,462	28,548	-10,086
PO11 - Environmental Sustainability			0
Planned Operations Total	217,973	237,952	-19,979
EA01 - Coordination and Partnerships		9	-9
EA02 - Secretariat Services	23,686	11,589	12,097
EA03 - National Society Strengthening	33,976	20,927	13,048
Enabling Approaches Total	57,661	32,525	25,136
Grand Total	275,635	270,477	5,157

DREF Operation

Selected Parameters			
Reporting Timeframe	2021/9-2022/6	Operation	MDRNE025
Budget Timeframe	2021-2022	Budget	APPROVED

FINAL FINANCIAL REPORT

Prepared on 18/Jul/2022

All figures are in Swiss Francs (CHF)

MDRNE025 - Niger - Cholera Outbreak

Operating Timeframe: 03 Sep 2021 to 28 Feb 2022

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
Relief items, Construction, Supplies	69,927	69,644	283
Water, Sanitation & Hygiene	69,927	69,644	283
Logistics, Transport & Storage	32,116	30,309	1,807
Distribution & Monitoring	20,771	18,385	2,386
Transport & Vehicles Costs	11,345	11,924	-580
Personnel	52,496	49,271	3,225
International Staff	8,629	1,169	7,461
National Staff		1,293	-1,293
National Society Staff	3,912	6,800	-2,888
Volunteers	39,954	40,010	-55
Workshops & Training	55,882	55,416	466
Workshops & Training	55,882	55,416	466
General Expenditure	48,391	49,329	-938
Travel		2,474	-2,474
Information & Public Relations	37,710	35,586	2,125
Office Costs	6,769	4,656	2,113
Communications	2,934	2,988	-54
Financial Charges	978	3,625	-2,647
Indirect Costs	16,823	16,508	315
Programme & Services Support Recover	16,823	16,508	315
Grand Total	275,635	270,477	5,157