



Cholera awareness session in East region of Cameroon by CRC

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| Appeal: MDRCM032 | DREF Allocated: CHF 389,282 | Crisis Category: Yellow | Hazard: Epidemic |
| Glide Number: EP-2022-000369-CMR | People Affected: 1,380,379 people | People Targeted: 1,380,379 people | |
| Event Onset: Slow | Operation Start Date: 2022-11-30 | Operation End Date: 2023-04-30 | Operation Timeframe: 5 months |
| | Targeted Areas: | Extrême-Nord, Littoral, Sud-Ouest | |

Description of the Event

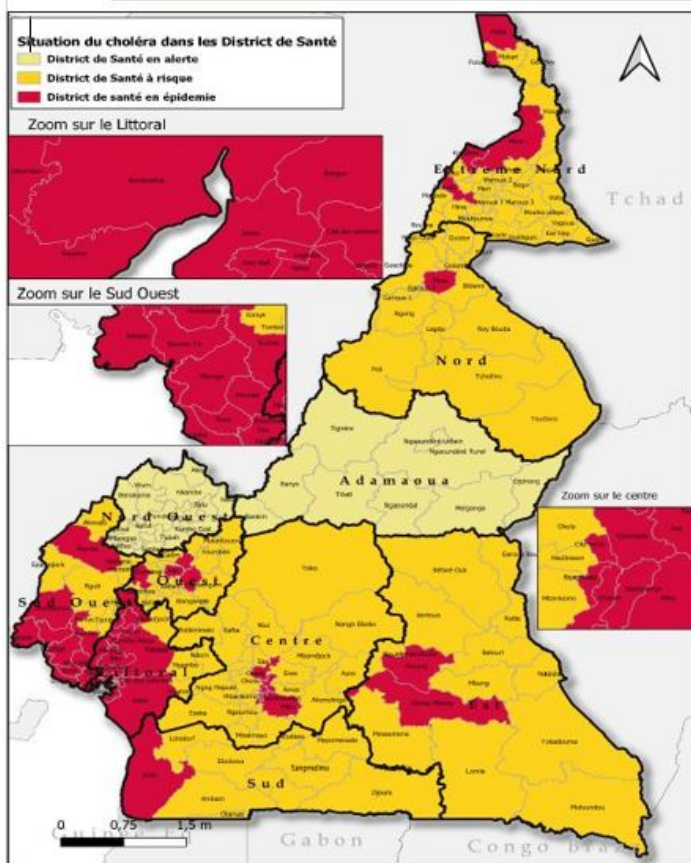
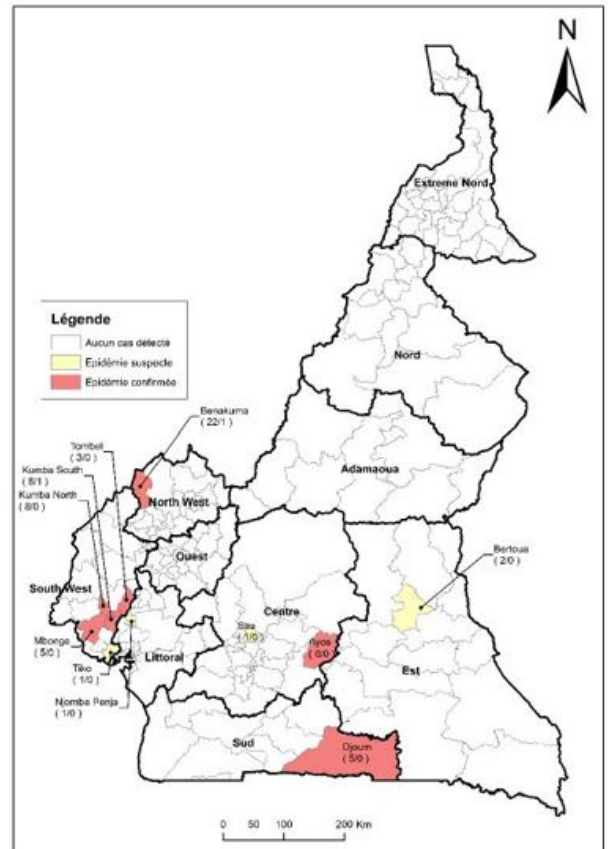


Figure 2: Districts de Santé touchés dans les régions affectées à la 45^e SE, 2022



Districts de santé en épidémie de Monkeypox au Cameroun, Novembre 2022

Mapping of both outbreaks extract from SITREP 45 MOH CAMEROON

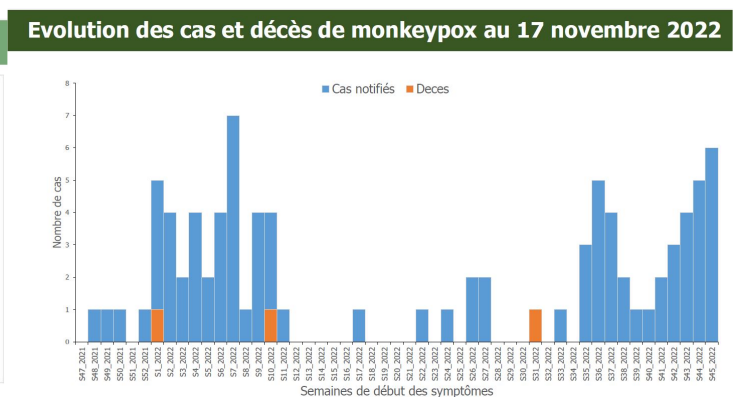
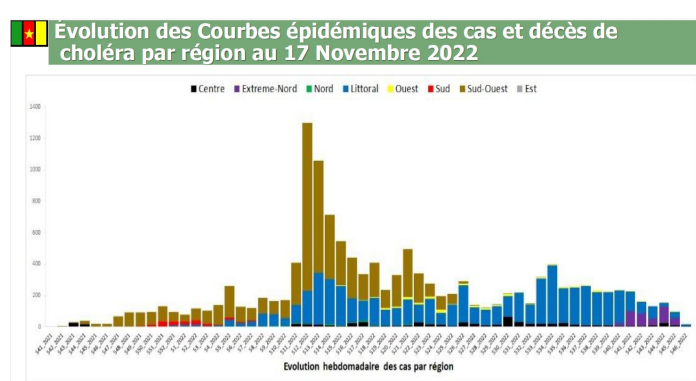
What happened, where and when?

For several months now, Cameroon is in the grip of multiple epidemics. This is associated with and exacerbated by the heavy rains with repeated floods observed since August 2022, as well as conflicts and large population movements in many regions of the country. These various elements create a conducive environment for the development of epidemics and put pressure on the Government's response capacity. Cholera and monkeypox epidemics are particularly alarming with major concern in the Far North, South-West, and North-West, and Littoral regions. On 17 October 2022, the Ministry of Health called on Cameroon Red Cross to increase support for the ongoing response to these epidemics.□

Cholera has been rife in the regions for several months and has spread this year to all regions of the country with as of 17 November 2022: 20 active districts in 04 regions with active cases. According to data from the Ministry of Health consolidated in the epidemiological SITREP for week 45, a total of 13,730 cases were reported, with 295 deaths recorded.

Since October 2022, the Far North region of Cameroon is hard hit by the cholera outbreak, precisely in the Mayo Sava and Mayo Tsanaga Divisions with more than 305 cases recorded, including 45 in Fotokol and 94 in Mora (Mayo Sava), 118 in Mokolo (Mayo Tsanaga) where the Minawao refugee camp is highly affected with 86 cases and 3 deaths. The situation of flooding and continuous population movements during these periods, especially in the Far North, South-West, and Littoral regions, greatly exposed to the risk of cholera.□

Concerning the Monkeypox outbreak, it was declared in several regions of the country by the health authorities. On 10 October 2022, the South-West Regional Delegate confirmed cases of Monkeypox. Despite the rapid setting up of the surveillance system, the epidemic spread rapidly to 6 regions, 5 of which are active with a total of 10 active health districts. Overall 92 cases of monkeypox were reported, 18 of which were confirmed out of 76 samples. The epidemic has caused three deaths with an average case fatality rate of 3.2% for the whole country. According to the Sitrep curve, there was a drastic increase in new cases between week 40 and week 45. That is 16 confirmed cases and 2 deaths distributed as follows: 9 cases confirmed in the South-West for 1 death, 2 in the North-West for 1 death, 4 in the Centre, and 1 case respectively in the South, the Littoral and the Far North, i.e. a case fatality rate of 2.7%. This situation clearly shows a progression of the epidemic and the need for a rapid containment to avoid a broader spread. It should be noted that in 2022, the number of monkeypox cases reported to WHO exceeded the total number of cases reported in the last 60 years combined (since 1958). Monkeypox is feared by the population because the disease is not well known by the general public.



epidemic curve of cholera cases from January 2022 to N epidemic curve of Monkeypox cases from January 2022 to November 2022

Scope and Scale

Monkeypox

On 23 July 2022, the Director-General of the World Health Organisation (WHO) declared the escalating monkeypox epidemic a public health emergency of international concern due to the unusually high number of cases and the wide geographic spread of the virus. (Source <https://news.un.org>). The disease is mainly present in Central and West Africa, and Cameroon is an endemic country that has witnessed several epizootic outbreaks with 2 human cases between 2019 and 2020, and 6 in 2021. The current epidemic is higher than the monkeypox epidemics observed over the last 60 years. For reference, over the last 10 years Cameroon has reported the following cases: In 2016: 300 Chimpanzees exposed, of which 8 were sick, 3 confirmed and 3 died. This took place at the Mefou Park in the Centre Region, Mefou and Afamba Division, Mfou Subdivision. In 2018: 15 suspected human cases, including 1 confirmed in the Njikwa Health District, North-West Region. In 2019: 01 human case confirmed in the South-West Region. In 2020: 01 human case confirmed in Tomba I Health Area, Ayos Health District, Central Region, with notion of human-to-human transmission and 01 human case in the Doumé HD/Bertoua HD, East Region. In 2021, there were 02 human cases confirmed in the Bertoua Health District, East Region, 01 case confirmed in the Ndikinimeki Health District from Ndom in the Littoral Region, 02 suspected cases and 01 case confirmed in the Ayos Health District.

Of the 18 cases confirmed according to the SITREP for week 45, 05 cases are of clade I and 13 cases of clade II.

It should be noted that the prevalence rate of HIV in Cameroon is 2.2% and no case has been detected as an HIV carrier.

Cameroon is the only country where both virus clades were identified (WHO, 2022). From 1979 to 2022, there have been.

11 monkeypox epidemics in humans and 2 epidemics in the animal population, with a continuous decrease in the interval of occurrence of these epidemics, especially in human populations. Between January and October 2022, 09 confirmed cases of human monkeypox were reported, of which 05 are of clade 1 type (more virulent, more contagious, and more lethal). The monkeypox risk analysis in Cameroon in May 2021 reveals that the occurrence probability is high in human and animal populations living near forest areas, due to one or more close contacts with wild animals and failure to observe sanitary measures.

In Cameroon, monkeypox is classified as a priority zoonosis (NZERP, 2020) and poses challenges for public health officials and health care personnel in terms of surveillance and laboratory capacity, disease management and treatment. The response to the monkeypox epidemic finds its importance in the context of the public health system already being overburdened by the COVID-19 pandemic and many other ongoing epidemics (cholera, measles, yellow fever etc.).

Health workers lack knowledge and experience in detecting and managing monkeypox cases. Communities are not aware of the disease and how to prevent it. Multi-sectoral coordination of interventions between the human and animal health sectors is needed, including systematic information sharing. Given the human and animal health, socio-cultural, environmental and economic consequences of monkeypox, it is important to support the national preparedness and response to the monkeypox epidemic in Cameroon

Cholera

For many years now Cameroon is witnessing an upsurge of cholera cases which, in addition to the North and Far North Regions has spread to others such as the South West, Centre and Littoral. Between 2019 and 2021, vulnerability to this epidemic has greatly increased across the national territory. During the same period, more than 4,500 cases of cholera were detected, with approximately 250 deaths.

However, after a good period of latency (October and November 2021) we are witnessing a resurgence of the epidemic. It resurfaced exactly on 16 November 2021 with a total of 61 cases recorded. The disease appeared this time in the Centre, Littoral, South, South-West, North and Far North Regions. However, there is an exponential increase in the number of cases of infection per week. Some major events led to numerous movements of people between regions, and even with neighbouring countries. We can cite as an example, the organisation by Cameroon of the African Cup of Nations from 9 January to 6 February 2022. All these things led to the comings and goings of populations between the South-West and Littoral regions or even towards the Centre which hosted many groups. These movements and the resulting promiscuity could provide evidence that the preventive measures put in place witnessed some slackening. In fact, the Littoral and South-West Regions cumulate more than 94% of new cases since November 2021. The South-West alone has nearly 1,600 cumulative cases. Followed by the Littoral with nearly 500 cases; the South region comes next with its 200 cases and the Centre with about 80 cases. According to the latest SITREP data, a new upsurge of cholera cases was recorded between 11 and 20 March 2022. But for this period in the various Regions mentioned above the statistics are as follows: over 1,587 cases reported in the South-West with 40 deaths and a case fatality rate of 2.5% for an estimated population of 1,951,677 inhabitants i.e. 43 cases and 20 deaths in Kumba; 111 cases and 02 deaths in Buea, 553 cases and 13 deaths in Limbe ; 68 cases and 05 deaths in Tiko, 345 cases and 12 deaths in Bakassi, 312 cases and 07 deaths in Ekondo Titti, 16 cases in Muyuka, 09 cases in Mbonge; in Yaounde in the Central Region, 16 cases and 02 deaths were also recorded with a case fatality rate of 3.8% for an estimated population of 5,188,860 inhabitants. The current outbreak started on 29 October 2021 with the Confirmation of the first 2 cases of cholera in the Ekondo Titi Health District (HD), South West Region and others in the South Region ;03 January 2022 : Activation of the Incident Management System in response to the Cholera outbreak;06 Regions affected: Centre, Far North, Littoral, South, South-West and North; 29/03/22: 05 Active Regions, 29 Health Districts affected, 22 Active Health Districts, 3,407 cases reported, 83 deaths recorded for a Case fatality rate of 2.4 %.

After a slight lull in the epidemic, an upsurge was observed in the Far North region (SITREP No. 3 CHOLERA). More than 150 cases were reported from week 41 to 45 in the districts of Mora and Mokolo

We can rightly say that in addition to contaminating communities and entire families in the regions, these cholera and monkeypox epidemics could become a gateway for contamination to other parts of the country due to migration flows, the epidemic nature of these diseases, and the current response capacities of the various stakeholders.

Previous Operations

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| Has a similar event affected the same area(s) in the last 3 years? | Yes |
| Did it affect the same population groups? | No |
| Did the National Society respond? | Yes |
| Did the National Society request funding from DREF for that event(s)? | Yes |
| If yes, please specify which operations | Cholera emergency appeal in 2004, MDRCM027 and MDRCM030 Population movement include some health prevention awareness. |

Specify how the lessons learnt from these previous operations are being used to mitigate similar challenges in the current operation

The recent DREF operations are not related to a similar outbreak but are mainly linked to the same implementation regions with similar coordination, administrative and implementation challenges to anticipate. Below are some ways the previous operations will inform and reinforce the proposed intervention.

- For the activation of Regional and International Support on the MDRCM026 operation, it was challenging for the NS to hire a Surge who was unable to speak the local language for speedy work with branches and HQ NS and for community acceptance, RCCE, and CEA. Considering the fact that one of the target areas is English speaking and the others French-speaking, it will be very important to ensure all staff involved especially RDRT and staff are bilingual.
- During the intervention under MDRCM028, a lack of awareness by some committee leaders on the principles guiding humanitarian action and the content of the assistance compromised the beginning of the operation and blocked NS access to the communities, thus delaying the response. The governance of the local committees, all branches, and the central level, as well as MoH during this operation, should be briefed on the DREF Procedures, assistance, RCRC mandate, and principles before the launch of activities.
- Lessons learnt in terms of Coordination with Authorities, communities, and all stakeholders should be improved to ensure better implementation, a swift sharing of information, and timely implementation. NS should also coordinate with the local authorities and leaders for the identification of the best logistic arrangements for safer access.□
- It is equally important to contact partners as early as possible and involve them in the planification of the operation, in order to motivate them to participate. Moreover, it is also encouraging for the partners that NS respects the set deadlines. Therefore, the NS should strive to stick to its schedule as much as possible.□
- MDRCM028 operations highlighted the necessity for each operation to provide for the training of a greater number of volunteers, given that these localities are difficult to access and, above all, that they face recurrent floods, epidemics, and other humanitarian needs. Each DREF operation would contribute that way to NSD with capacity staff and volunteers.□
- Systematic delay in the implementation, especially for inking procurement and distribution should be anticipated with a strong monitoring system.
- Delays in financial reporting should be avoided by a monthly review of expenditures as well as formative monitoring of expenditures at the field level.

Current National Society Actions

CRC and IFRC take part in coordination meetings at national level with MoH, WHO, ONE HEALTH and other actors involved in the response. Thus, they are part of the Cholera Incidence Management System in Cameroon and have

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| Coordination | contributed to the development of the National Monkeypox Response Plan. Under the lead of the One Health programme, together with the various partners, CRC participated in the preparation of strategic documents for the fight against cholera and monkeypox. Thus they are involved at the strategic level in the various actions of the government. As soon as the outbreaks occurred, CRC mobilised its vast network of volunteers to carry out sensitisation and support the government's response. |
| Water, Sanitation And Hygiene | Disinfection campaigns were carried out in the health districts, particularly in Mayo Sava and Mayo Tsanaga, on water-borne diseases. These included community sensitisations to help people control and prevent water-borne diseases such as amoebic dysentery, watery diarrhoea, and cholera. In the South-West region, CRC took advantage of its response activities to COVID-19 to support government activities in risk communication and community engagement, infection control, prevention, and community WASH. |
| Health | <p>In the Mayo Sava and Mayo Tsanaga Divisions, volunteers are involved in community surveillance and cholera awareness. Through its CP3 programme, CRC has already carried out surveillance activities in two regions of the country and has the capacity to rapidly install its community-based surveillance system in other regions. In collaboration with the One Health programme, audio spots and posters have been prepared and are awaiting support for production and dissemination.</p> <p>25 volunteers were mobilised for sensitisation on monkeypox in the South-West region. For cholera, all volunteers in the various programmes received a briefing and are supporting sensitisation during their activities. This represents over 300 volunteers in the country. However, they lack materials to support their discussions with communities.</p> |
| Resource Mobilization | The National Society has called on its partners to respond to these outbreaks. However, it has leveraged existing programmes to support the WASH, PCI and RCCE sector in the West, South-West, North and Far North regions. |
| National Society Readiness | <p>The Cameroon Red Cross has a large network of volunteers across the country who were trained in health, hygiene, risk communication, and community engagement in previous operations, including the response to COVID-19.</p> <p>All relevant branches are on alert. Numerous projects and programmes are being carried out in different regions such as the CP3 programme in the North and East regions, the Japanese programme in the West region and the COVID-19 project financed by USAID and SLL in all the 10 regions of the country</p> |

Movement Partners Actions Related To The Current Event

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| IFRC | The Yaoundé office is working alongside CRC to prepare an appropriate response to the situation. It takes part with CRC in coordination meetings at national level with MoH, WHO, ONE HEALTH and other actors involved in the response. IFRC helps CRC in mobilizing funds and provides technical and financial support for implemented activities. In addition, it donated 4 ORP kits to support the response to cholera. |
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| ICRC | ICRC donated 305 NFI kits to CRC, which were distributed to targeted households in the locality of Maltam in the Logone and Chari Division. |
| Participating National Societies | The French Red Cross (FRC) is the only PNS present in Cameroon. In response to the cholera outbreak, FRC carried out several activities in Kousseri, including sensitizations on cholera prevention, broadcasting of radio spots, and distribution of hygiene kits, as well as management of cholera cases. In Maroua, FRC carried out sensitizations in the Mada district, and hygiene kits were also distributed. |

Other Actors Actions Related To The Current Event

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| Government has requested international assistance | Yes |
| National authorities | Through the health facilities across the country, the Ministry of Health (MoH) is in charge of case management and epidemiological surveillance. Coordination meetings are held at the Ministry of Health with partners including CRC and IFRC. On 17 November 2022, MoH requested assistance from CRC to support the ongoing response. |
| UN or other actors | <p>For both outbreaks</p> <ul style="list-style-type: none"> •WHO supported the coordination meeting under the leadership of SGI for Cholera and One health program for Monkeypox •WHO supported the development of the national plan of response to Monkeypox •MSF deployed its CATI strategy in the North-West and South-West regions •All partners were involved in the three OCV campaigns for three regions (South, Littoral, and South-West) •BREAKTHROUGH ACTION, with funds from USAID, produced audio and video spots on cholera and monkeypox in local languages, French and English. |

Are there major coordination mechanisms in place?

The major coordination mechanisms in place are: For cholera the SGI (incident management system) is in place since March 2022; the one health program is having the lead.
In general, MoH has the lead to both Cholera and Monkey Pox response.

Needs (Gaps) Identified



Water, Sanitation And Hygiene

The vulnerability of communities to epidemics such as cholera and monkeypox is often increased by problems of access to safe water and hygiene practices. This problem occurs in all seasons and relates to both outbreaks as an essential pillar of the response.

In the rainy season, water points are sometimes contaminated because of the non-respect of construction standards for water points, latrines, and the layout of garbage collection points. This season is also the period of the profusion of fruits that are consumed without respect for basic hygiene rules.

In the dry season, water shortages and the drying up of certain collection points often lead to the multiplication of vectors (flies, rats, and other birds and domestic animals).□

Sensitisation activities are needed in the communities to inform the population about the current epidemic and to promote community health. The South-West, Littoral, and Far North Regions, which are the most exposed and do have an approximate response, should be particularly covered by a harmonised response.

From this analysis, it appears that.

- A need for community sensitisation to hygiene conditions appropriate to the epidemiological context of cholera and to raise awareness about the disease. This is the case in all localities of the Regions
- In the Far North Region, it is a question of multiplying appropriate mass communications to appeal to the communities

The following challenges were identified.

- Lack of information at the community level on cholera and Monkeypox.
- Continuation of customs such as the practice of traditional autopsies and funeral rites.
- Need for potable water and sanitation in the community. There is a need for community hand-washing facilities and maintenance of water supply points
- Rapid access to community-based interventions such as the establishment of suspected case management centers.



Community Engagement And Accountability

-The circulation of false rumours (monkeypox cases are attributed to witchcraft) which increases risk behaviours such as the unsafe handling of cholera suspected corpses.

-In view of these observations, there is a need for greater commitment from the various leaders (religious, traditional, and community leaders). Traditional healers should be involved in the identification of suspected cases.□

- Sensitive management of information is to be considered and will need to be applied especially for Monkeypox in alignment with Government position and considerations to avoid any reluctance.

Operational Strategy

Overall objective of the operation

This DREF's overall objective will be to contribute to risk communication, community engagement, early detection, and response to Cholera and Monkeypox outbreaks in the 3 most affected regions of the country: South-West, Littoral, and Far North

Operation strategy rationale

For an understanding of the cluster approach of Monkeypox and Cholera in this DREF operation, it is crucial to justify the strategy through an approach on the points of similarity and concordance of the Cholera and Monkeypox response taken into account. See below.

- The spread of epidemics is most often exacerbated by lack of information, which is the case with these 2 epidemics. Although different, awareness messages will go through the same mass and proximity channels with the same objective of informing, providing health education, etc
- Improved access to water, promotion of household hygiene management, secretion management and care in processing food for consumption will also be cross-cutting for both epidemics considering some of the transmission factors that are common to both.

The CRC's strategy to prevent these diseases will be mainly based on risk communication, community engagement and community-based surveillance through the following axes:

Health

- Risk communication and community engagement through the production and dissemination of communication tools on cholera and monkeypox, the training of volunteers and the deployment of these volunteers for mass sensitisation, door-to-door, mobile cinema. All these activities will be carried out in collaboration with religious leaders and key community actors for a better adhesion of the community.
- Setting up of a CBS system through the NYSS platform to ensure rapid detection of cholera and monkeypox cases.

WASH

The WASH pillar will contribute to improving the hygiene conditions of the population, CRC will also carry out the following activities:

- Distribution of Aquatabs for water purification, maintenance of community water points, community clean-ups, installation and maintenance of hand-washing points in sensitive areas (especially food sales points),
- Hygiene promotion and deployment of ORP kits.
- For early detection, CRC will carry out community-based surveillance activities.

CEA

- Risk communication via various channels and with messages already prepared by MoH to avoid panic and misinformation
- Community engagement because communication and sensitisation activities require community involvement and buy-in.
- Setting up of a feedback system and management of rumours and misinformation.

Targeting Strategy

Who will be targeted through this operation?

As part of this operation, CRC is targeting 1,380,379 people in 3 regions: Littoral, Far North and South-West. The main intervention towns will be:

- Douala in the Littoral with a district population of 450,647 inhabitants.
- Mora with a district population of 319,068 inhabitants.
- Mokolo with a district population of 323,283 inhabitants in the Far North
- Buea with a district population of 287,381 inhabitants in the South-West.

These figures represent the total population of these health zones according to MoH statistics that have had the most cumulative smallpox and cholera cases.

Explain the selection criteria for the targeted population

Since these epidemics affect all layers of the population, regardless of age or gender, this operation targets the entire population of the affected areas. However, priority will be given to the most economically vulnerable people when distributing the Aquatabs

The selection criteria were based on epidemiological data, security access and the response capacity of the NS and partners already on the ground.

For Cholera, response will focus mainly on peri-urban and rural areas and places with low sanitation access and water point availability, also flooded and prone flooding areas and camps for displaced will be targeted as priority for field visit by volunteers awareness's. most vulnerable group will include: children under 10, lactation and pregnant women, elderly.□

For Monkeypox actions will be covering both urban and rural areas depending on the transmission factors given that actually it has been identified that the two types of Monkeypox. Following the communication strategy of the Government, awareness will be focused more on peri-urban and rural communities with dietary habits which include games/bush meat; communities living near forests, adults above 15 years, women heads, and cooking spaces.

Total Targeted Population

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| Women: | 753,963 | Rural % | Urban % |
| Girls (under 18): | - | % | % |
| Men: | 626,416 | People with disabilities (estimated %) | |
| Boys (under 18): | - | % | |
| Total targeted population: | 1,380,379 | | |

Risk and security considerations

Please indicate about potential operational risk for this operations and mitigation actions

| Risk | Mitigation action |
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| Contamination of volunteers and field staff. It is not uncommon for humanitarian staff to be contaminated in the course of their work, either by accident or negligence. As volunteers will be in close contact with suspected cholera and monkeypox cases, they may be exposed to these diseases. | All volunteers will be briefed on the dangers of their activity and how to limit the risks. They will also be provided with masks and hydro-alcoholic gels for their protection. |


Please indicate any security and safety concerns for this operation

Part of the operation will be carried out in areas close to conflict areas in Cameroon that have been subject to attacks in the past.

To limit the risk, volunteers will be informed of security instructions and will be required to respect the fixed security hours. In addition, ICRC will be kept abreast of all field visits, with a call on the radio room every hour.□

For this operation, the targeted areas are not high-risk areas and the volunteers are people from this community. These volunteers are already deployed on a voluntary basis and have the confidence of the communities. Safe access will still be promoted and a briefing on security will be conducted. NS will ensure all engaged staff has appropriate visibility to prevent any case. Coordination on security will be ensured through regular updates with ICRC, IFRC, and local partners.

Planned Intervention

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|  | National Society Strengthening | Budget | CHF 120,597 |
| | | Targeted Persons | 104 |
| Indicators | | Target | |
| Percentage of volunteer insured | | 100 | |
| Percentage of volunteers with PPE | | 100 | |
| Number of volunteers with visibility equipment | | 104 | |
| Priority Actions: | | <p>The following actions will be carried out:</p> <ul style="list-style-type: none"> -The volunteers involved in the operation will be insured, a total of 104 people -The headquarters will monitor the interventions in the various branches, while the delegation will provide technical supervision. -Workers will be informed about the risks related to the interventions and will be provided with protective equipment related to COVID measures, as well as visibility equipment. -Coordination with IFRC throughout the operation. | |

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|  | Community Engagement And Accountability | Budget | CHF 120,180 |
| | | Targeted Persons | 600000 |
| Indicators | | Target | |
| Number of feedback system | | 1 | |
| Number of feedback collected | | 300 | |
| Percentage of feedback treated | | 100 | |
| Priority Actions: | | <p>It is always crucial that communities are at the centre of operations. To ensure their involvement, CRC will carry out the following actions.</p> <ul style="list-style-type: none"> -Questions to identifier the best communication according to the targeted communities and their preferred channels of sensitisation will be inserted in the initial KAP survey questionnaire. -Training on CEA/RCCE will be integrated into the EPIC training to build the capacity of the 100 volunteers and 4 supervisors involved in the operation. -A feedback management system will be created with the help of volunteers as part of the sensitisation activities. It will record com- | |

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| | <p>community rumours, questions, beliefs, observations and suggestions about cholera and smallpox.</p> <p>cholera and monkeypox. The system will record complaints and claims from the community.</p> <p>- The communication and awareness tools will all be translated into local languages, printed and distributed to volunteers.</p> |
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|  | Health | Budget | CHF 86,394 |
| | | Targeted Persons | 512744 |

| Indicators | Target |
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| Number of people reached by sensitisations in schools | 96800 |
| Number of volunteers and supervisors trained | 104 |
| Number of people reached by mass sensitisations | 116480 |
| Number of people reached by door-to-door sensitisations | 299360 |
| Number of opinion evaluation conducted | 1 |

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| | <p>1. Initial rapid KAP: The first activity of this operation will be an initial KAP rapid survey on monkeypox and cholera to take stock of the situation and determine priorities for intervention. Prior to data collection, the CRC PMER will work with the IFRC PMER on the methodology of the survey and the development of the questionnaire. Volunteers from the 4 zones concerned will then be briefed on data collection for one day, during which they will have the opportunity to test the questionnaire. They will then go to the field for 2 days for data collection.□</p> <p>2. Mobilisation and training of teams: 100 volunteers and 4 supervisors will be trained for 4 days in their respective areas on the VCE with modules mainly focused on the current response. Modules will include introduction to community first aid and EPiC with risk mapping; risk communication and community engagement (RCCE), psychological first aid (PFA); community-based surveillance (CBS). The focus will be on cholera and monkeypox and on prevention of water-borne and vector-borne diseases, knowledge of disease, symptoms, individual preventive measures, household and community prevention. This training will be organised with the support of IFRC.□</p> <p>3. Sensitisations and health education: Since the risk of cholera and monkeypox in the community depends largely on knowledge of the diseases and individual and collective preventive measures, CRC will increase the number of</p> |
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Priority Actions:

channels through which key messages can be disseminated. Activities will include community sensitisation on the risks posed by these diseases. Red Cross volunteers will prepare key messages on sensitisation and social mobilization. These messages will focus on individual and household protection measures.

The messages will also focus on detecting signs and symptoms at the community level and referring suspected cases. Volunteers will reach out to affected communities in the target areas through door-to-door visits and the use of megaphones to disseminate key messages, including description of symptoms, protection measures. They will also organise focus group discussions and mass sensitisations. They will target crowd-pulling places, such as places of worship, schools, and markets, to display posters and distribute brochures. These activities will be carried out over 4 months and at regular intervals to ensure ownership and change in practices.

Activities will include:

- Sensitisations by volunteers through door-to-door visits. Volunteers and supervisors will have three field trips per week.□
- Dissemination of IEC materials prepared and shared in communities, gathering places, health centres, markets and other strategic areas during the volunteers' field trips. Teams will receive 7,500 IEC materials and 40 loudspeakers to move around the neighbourhoods.□
- To reach a wider population, mass communication campaigns will be used, including the broadcasting of messages on local radio stations. In fact, local radios will also be used with the activation of 5 radios over 3 months. Visual aids on prevention practices and key messages prepared with government and WHO support will be displayed in health centres, places of worship and schools.
- Community dialogue to increase community and institutional participation and mobilization through parallel social mobilisation and engagement activities for sustainable vector control. These activities will include
 - Sensitisation of students in schools by volunteers and teachers informed of the disease and preventive measures
 - Organisation of focus group discussions to involve communities through religious, cultural, and social leaders, including mothers' clubs, elderly associations, traditional rulers and teachers, hunters and bushmeat traders to relay the measures during community gatherings. A minimum of three FGDs per district per month will be organised and facilitated by volunteers and supervisors. Relevant groups will be confirmed depending on the structure of the communities. The focus will be on prevention and sustainable control messages. The selection of groups to be prioritised will depend on the trend of indicators.

4.Support the surveillance system of the Ministry of Public Health by conducting passive surveillance of suspected cholera and monkeypox cases during sensitisation campaigns.


- Volunteers will be trained in community definition of suspected cases and identification of risk within communities.
- Based on the government-approved system, they will report suspected cases in the communities to health officials (health centres) through paper reports prepared during the volunteers' field trips. This is passive surveillance conducted during sensitisation activities by volunteers and supervisors. Active surveillance is the responsibility of the Ministry of Public Health with support from WHO. To m

Make sure that information reaches all actors at the strategic level, supervisors should also prepare a cumulative report and share it with the Ministry of Public Health at the national level.

| | | | |
|---|--------------------------------------|---|------------|
|  | Water, Sanitation And Hygiene | Budget | CHF 62,111 |
| | | Targeted Persons | 260000 |
| Indicators | | Target | |
| Number of volunteers and supervisors trained | | 104 | |
| Number of community water points maintained | | 192 | |
| Number of hand washing points installed | | 40 | |
| Number of houses and places disinfected | | 800 | |
| Number of people with access to safe water | | 120000 | |
| Number of people benefiting from information on hygiene and sanitation | | 60000 | |
| Number of PDM | | 1 | |
| Priority Actions: | | <p>WASH activities will aim to prevent the spread of the epidemic through the management and improvement of hygiene practices. To this end, the following activities will be carried out.</p> <ol style="list-style-type: none"> 1. Training of 104 volunteers in hygiene-related topics, including home water treatment, sanitation, risk mapping. 2. Improvement of water quality by maintaining community water points and training households in water treatment through. <ul style="list-style-type: none"> - Assessment and mapping of existing water sources (availability, types, access, quantity of water, risk of contamination, etc.) in the cholera zones of Mora, Mokolo, Buea and Douala. - Treatment of existing water sources in the above-mentioned cholera Zones, using the most appropriate technical solution based on an analysis of water parameters (at source or point of use). - Distribution of Aquatabs for water treatment in 2,000 households. 3. Improvement of hygiene conditions in the targeted areas through: <ul style="list-style-type: none"> - Disinfection of homes of suspected and/or confirmed cases of monkeypox and cholera - Community clean-ups once a month in each community - Installation and maintenance of 40 hand-washing points in sen- | |

sitive areas (especially food sales points). These points will be supplied with water every morning by volunteers in the area

- Deployment of ORP kits in the 4 districts. CRC already has the kits which can be pre-positioned in the various districts
- Sensitisation campaign via door-to-door, mobile caravans, community radios, mass sensitisation as well as in schools on the response against cholera and also on the treatment of water at home (at the point of use, at the tap or in transport or storage containers), such as boiling, disinfection, chlorination and filtration. Ensuring safe transport and storage of treated water to avoid contamination; these sensitisations will be done in conjunction with the health sensitisations of this operation.

| | | | |
|---|---|--|-------|
|  | Protection, Gender And Inclusion | Budget | CHF 0 |
| | | Targeted Persons | 104 |
| Indicators | | Target | |
| Number of volunteers briefed on PGI | | 104 | |
| Number of people reached with protection messages | | 276075 | |
| Priority Actions: | | <p>To safeguard the dignity of affected populations, gender and inclusion will be included in all volunteer trainings and interventions to ensure that all segments of the community are considered at every stage of the response. The NS will ensure that priority is given to persons with disabilities and the elderly.</p> <ul style="list-style-type: none"> -Registration documents will include specific fields for disabled people, age, and gender to make sure that these categories are identified and prioritised. -Sensitisation on gender-based sexual violence will be added to existing outreach platforms through health interventions. -Relevant groups will be informed of referral pathways for all cases in order to improve access to care. Relevant groups will be informed of referral pathways for all cases, to improve access to services as quickly as possible. | |

About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.

100 volunteers and 4 supervisors will be deployed through this operation, trained in the various themes selected, and then deployed to the field to carry out the activities listed above. For each targeted region, for this DREF, there will be one (01) supervisor per region and 25 volunteers.

The NS will appoint a focal point to coordinate the operation. The latter will be accompanied by CRC's experienced staff, including the health, monitoring and evaluation, logistics and finance managers.

The Yaoundé office teams will provide the necessary support to CRC in the implementation of this operation. A project manager has already been appointed and will benefit from the collaboration of the entire IFRC staff.

Will surge personnel be deployed? Please provide the role profile needed.

Health coordinator surge profile will be deployed for 4 months.

If there is procurement, will it be done by National Society or IFRC?

Some procurement will be done by IFRC and some by CRC based on the WWPP fund transfer agreement.

-CRC

Purchase of 104 visibility kits (bibs, bags and volunteer booklets) Purchase of 50 megaphones for mass deployment

Purchase of 5 kits (disinfection equipment (5 sprayers and 25 packages of personal protective equipment) per intervention zone)

Purchase and prepositioning of 40 hand-washing points Purchase of ORP material (Aquatabs, bleach, etc.)

-IFRC

Purchase of 80,000 sensitization materials (posters and leaflets) Purchase of 4 mobile cinema kits.

How will this operation be monitored?

A surge will be deployed and field supervisions will be done.. IFRC and NS staffs will have a closely monitoring meeting monthly. Field mission will done in addition and financial review will be regularly (monthly basis)

Please briefly explain the National Societies communication strategy for this operation.

A communication strategy on the visibility of the operation and Red Cross in this framework will be developed. Several means and methods of communication will be used. Firstly, at the time of approval of the DREF, an information session will be held for the partners and other stakeholders. A presentation of the objectives and activities will be made during coordination meetings of the ONE HEALTH platform and SGI. The results of the KAP survey will be shared with all the actors along with the priority needs identified by the communities and the health actors. Weekly social media strategies will be shared on social media, a monthly newsletter will be produced and disseminated and at each workshop other stakeholders will be involved.

Budget Overview



DREF OPERATION

MDRCM032 - Cameroon Red Cross Cholera and Monkeypox outbreak

Operating Budget

| | |
|---|----------------|
| Planned Operations | 268,685 |
| Shelter and Basic Household Items | 0 |
| Livelihoods | 0 |
| Multi-purpose Cash | 0 |
| Health | 86,394 |
| Water, Sanitation & Hygiene | 62,111 |
| Protection, Gender and Inclusion | 0 |
| Education | 0 |
| Migration | 0 |
| Risk Reduction, Climate Adaptation and Recovery | 0 |
| Community Engagement and Accountability | 120,180 |
| Environmental Sustainability | 0 |
| Enabling Approaches | 120,597 |
| Coordination and Partnerships | 54,443 |
| Secretariat Services | 0 |
| National Society Strengthening | 66,154 |
| TOTAL BUDGET | 389,282 |

all amounts in Swiss Francs (CHF)

Contact Information

For further information, specifically related to this operation please contact:

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[Click here for the reference](#)