

# DREF operation final report



International Federation  
of Red Cross and Red Crescent Societies

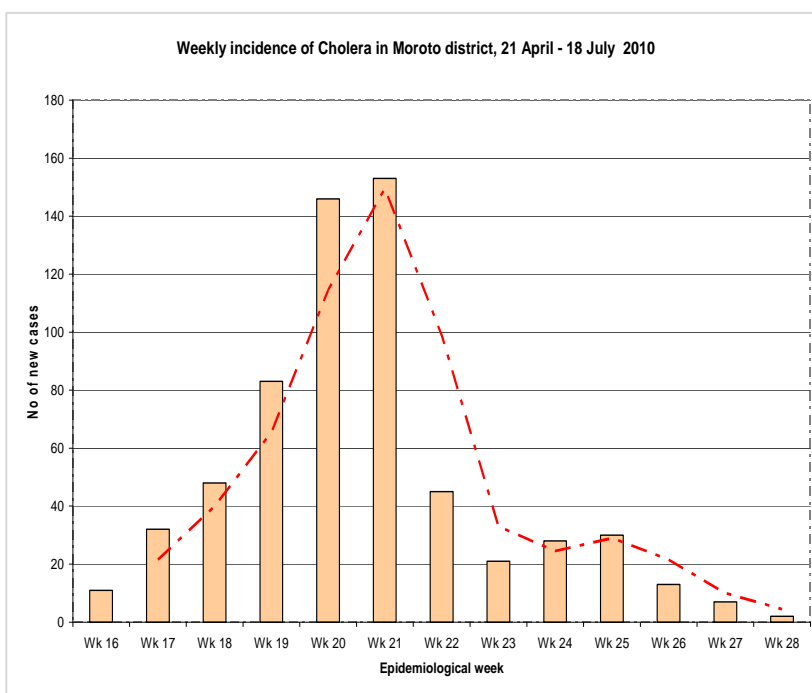
## Uganda: Cholera

DREF operation n° MDRUG016  
GLIDE n° EP-2010-000088-UGA  
12 November, 2010

The International Federation's Disaster Relief Emergency Fund (DREF) is a source of un-earmarked money created by the Federation in 1985 to ensure that immediate financial support is available for Red Cross Red Crescent response to emergencies. The DREF is a vital part of the International Federation's disaster response system and increases the ability of National Societies to respond to disasters.

**CHF178,676 (USD 160,969 or EUR 126,721) was allocated from the International Federation of Red Cross and Red Crescent s Disaster Relief Emergency Fund (DREF) on 10 May, 2010 to support the Uganda Red Cross Society (URCS) in delivering assistance to some 145,000 beneficiaries.**

A serious cholera epidemic broke out in Moroto District in April 2010 and later spread to four other neighbouring districts affecting 664 people causing 11 deaths, with Case Fatality Ratio of 1.6 per cent in Moroto alone. With this DREF support the URCS was able to implement key water and sanitation activities such as intensive household hygiene by use of Participatory Hygiene and Sanitation Transformation in Emergency Response (PHASTER) methodology, distribution of necessary hygiene supplies such as soap, water vessels, latrine digging kits and water purifiers that contributed to provision of safe water chain and improved household hygiene. Besides, intensive social mobilization through the media,



information, education and communication (IEC) materials and community dialogue provided key awareness messages about the disease. This facilitated effective preventive and surveillance mechanisms, in addition to the provision of the required treatment supplies that promoted a sharp decline in the epidemic trend as shown in the descriptive epidemiological graph shown above. After consistently reporting zero cases since 14<sup>th</sup> July 2010 Moroto District was finally declared 'cholera-free' on 12 August 2010 when all 3 Cholera Treatment Centres (CTCs) were closed. Despite this improved situation in Moroto, the conditions in neighbouring districts of Amudat and Kotido still remain fragile with critical gaps in case management, water and sanitation as well as social mobilization. Through the mutual coordination exhibited during the operation, key resource gaps for interventions in the other affected communities were mobilized from partners such as the International Committee of the Red Cross (ICRC) and the United Nation's Office for Coordination of Humanitarian Affairs (OCHA). This is currently helping to replicate the programmes in other newly affected communities in Moroto and Kotido districts respectively.

The URCS is grateful to the Netherlands Red Cross and the European Commission Humanitarian Office (ECHO) for their support during the operation. This operation was expected to be implemented over a two-month period, and was completed by 30<sup>th</sup> June, 2010.

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

## The situation

The index cholera cases were admitted in Moroto Hospital on 21 April 2010 in the 16<sup>th</sup> epidemiological week. Results from four specimens taken to Central Public Health Laboratory (CPHL) in Kampala were positive for Vibrio Cholera 01 bacteria. Up to end of the epidemic in July 2010, all the 11 sub counties in Moroto District reported at least one suspected case. The sub-counties that reported cases included North Division, South Division, Nadunget, Katikekile, Lopei, Lokopo, Matany, Lotome, Irriiri and Rupa. The cumulative number of cases recorded in Moroto District alone was 664 with 11 deaths (CFR = 1.6%). However, since 14 July 2010, the district consistently reported zero cases, which led to it being declared cholera-free on 12 August 2010. Subsequently, all treatment centres in Moroto Hospital, Matany and Kidepo health centres were closed.

**Table 1: Cholera Cases in Moroto District by Sub County**

Sub-county	New cases	Cumulative cases	New death	Cumulative deaths
Nadunget	0	294	0	5
North division	0	44	0	0
Rupa	0	189	0	1
South Division	0	89	0	2
Matany	0	17	0	0
Lokopo	0	8	0	0
Lotome	0	1	0	0
Lopei	0	10	0	2
Lorengechora	0	1	0	0
Irriiri	0	1	0	0
Katikekile	0	8	0	1
Others (visitors)	0	2	0	0
<b>Total</b>	<b>0</b>	<b>664</b>	<b>0</b>	<b>11</b>

As seen from the table 1 above, all affected sub-counties have recorded remarkable and sustainable decline in case incidence and fatality. This is attributed to intensified public health responses by the National Society and other partners to contain the spread of the epidemic.

This significant achievement was due to concerted efforts that took root with consistent public health responses mounted by the 'Cholera Response Team' and the task force. These were operational until the epidemic was finally contained and Moroto District declared cholera-free on 12 August 2010. However, the environment still remains delicate with continued rains in the district. All humanitarian agencies and the government therefore need to work out follow-up programmes in way of long-term interventions taking in account of, and building on, the current cholera response to reduce the vulnerability of the communities to future outbreaks. There is need to pay attention to household latrines, hygiene promotion, and creating systems for monitoring safe water supply in the communities.

In Kotido District, the cumulative number of cases of cholera registered since the beginning of the outbreak on 12 May 2010 is 503 including 11 deaths (CFR 2.18 per cent). Sub-counties registering cases include Nakapelemoru, Panyangara, Kotido rural and Regen. Out of these cases, 87.6 per cent are registered from Nakapelemoru and Panyangara sub-counties. Since the epidemic outbreak in Kotido District still has the potential to escalate, the URCS secured USD 50,020 from OCHA to support community hygiene promotion and social mobilization activities that will ensure control of the epidemic in two parishes in the most affected Nakapelemoru and Panyangara sub-counties.

## Red Cross and Red Crescent action

When the cholera outbreak was first reported, the URCS together with the Ministry of Health (MoH) and the World Health Organization (WHO) conducted a detailed assessment that brought out the key humanitarian needs on the ground and guided the appropriate disease control strategies. Through this, the 'National Cholera Task Force' was established. The Ministry of Health launched a cholera control and resource mobilization campaign that focussed on key needs in surveillance and case management, water and sanitation as well as social mobilization where partners such as the United Nations Children's Fund (UNICEF), WHO and OCHA committed to contribute to the resource mobilization effort. However, there were still gaps in key areas such as medical supplies and community led hygiene promotion activities. The URCS therefore came in to meet these critical gaps identified through this DREF support.

During the two months period of implementation key progress was made in areas such as training of 40 PHASTER trainers, who subsequently trained 200 community hygiene promoters. The latter were composed of Village Health Teams (VHTs) and were trained in PHASTER methodologies. They were also trained, in collaboration with local leaders and other stakeholders, in intensive social mobilization activities which were done through six radio talk shows, 240 radio spots, house-to-house hygiene promotion sessions and the distribution of the required supplies to the target beneficiaries. This has promoted community awareness about the dangers of cholera disease and key preventive measures such as adopting construction and use of pit latrines, hand washing at critical moments and household water treatment. Appropriate response mechanisms for suspected cholera cases in the communities have been initiated by household members with support from the trained community based hygiene promoters who acted as role models and effective community change agents. Cholera kits procured filled the critical medical supplies gaps that promoted effective treatment of cases at Moroto CTC that eventually ensured that the case fatality ratio remained within WHO's acceptable limits (as low as 1.6 per cent).

## Achievements against objectives

### Water, sanitation, and hygiene promotion

**Objective: To reduce the spread and/or transmission of cholera epidemic in Moroto District by ensuring access to safe water, sanitation and hygiene supplies and raised community awareness leading to improved hygiene behaviour for 145,000 people.**

#### Activities planned

- To support water quality analysis of 15 water sources in the 20 cholera affected villages in Moroto municipality and Nadunget sub-counties in Moroto district.
- Procure and distribute 50,000 pieces of water purification chemicals (Aqua Safe tablets) to support purification at source and household levels
- Provision of 5,000 pieces of clean water containers to maintain safe water chain.
- Promote hand washing with soap (HWWS) at critical moments by procurement and distribution of 7,500 bars of soap (200g).
- Mobilize and train 40 volunteers in Moroto District on integrated Participatory Hygiene and Sanitation Transformation in Emergency Response (PHASTER), and Epidemic Control, and Household Water Treatment (HHWT).
- Conduct health education targeting 145,000 individuals in the affected district. These include at-risk communities neighbouring the affected villages who will indirectly benefit from the social mobilization and health education activities.
- Provide 50 sanitation kits to support construction of at least 200 household latrine stances in the affected villages. These kits will be provided for a group of household members who will use them in turn to complete digging and construction of household pit latrines before transferring to another group.
- Procure and distribute 20,000 cholera posters, 30,000 brochures, 500 T-shirts with hygiene messages translated in the local "Nakarimojong" language for promotion of community awareness about the risk factors, case identification, and actions to be taken to handle cases and preventive measures against the spread of the disease.
- Conduct media campaigns (16 radio talk shows and 240 radio spots) for promoting community awareness and mobilization of communities in hard to reach areas for hygiene improvement in their areas.
- Procure five PHAST tool kits for facilitating community based hygiene promotion by the volunteers and Village Health Team (VHT) members.

- Procure and distribute 2,500 jerry cans (3-litre capacity) and nylon ropes for promotion of cost effective – appropriate hand washing technology (tippy taps) in the affected communities.
- Carry out hygiene promotion and household inspection using the community based structures (volunteers and/or VHTs, local leaders, and health inspectorate units). This will be preceded by promoting exemplary leadership amongst the local leaders in line with the Kampala declaration and role model-ship amongst the volunteers.

### **Achievements**

A total of 40 ToTs in Moroto District underwent five-day training at St. Phillip's Community Centre. The training aimed at creating a multiplier effect on integrated PHASTER and epidemic control. The ToTs were trained to be coaches and supervisors of 200 VHTs, who were selected from the affected and high risk communities of Nadunget, North Division, South Division and Rupa sub-counties respectively, to strengthen community hygiene promotion activities through sustained house-to-house visits. According to the original plan, only trainees from three sub-counties had been selected. However, Rupa Sub County was included as it was also prone to many risks. It neighbours Nadunget, and had the second highest reported cases at the cholera testing clinic. Due to the mobile nature of the community, it was important to identify community-based volunteers who were trained to help conduct health education as an effective way of fighting the epidemic from spreading further.

Some of the topics covered during the training included basic facts about cholera with key messages to be disseminated, community based case surveillance and First Aid for cholera patients, PHASTER concepts, community mapping, investigating community practices using pocket chart voting, transmission and prevention of diarrhoeal diseases by use of the F-diagram, preventing transmission, purification of water, behaviour change communication, community mobilization and home visiting skills, action planning for activities such as community mobilization for actions such as clean-up campaigns, latrine construction, among other topics.

A total of 30,000 brochures and 20,000 posters that were originally developed by Ministry of Health and WHO were procured and distributed to the communities through the existing community structures as well as by the community hygiene promoters. The clearly illustrated graphics and key messages translated in the local *Ikarimojong* language helped to sensitize the people on dangers of the disease and possible control measures. The cholera operation also facilitated the development and dissemination of repeated, coherent and simple hygiene promotion messages. This was achieved through a mixture of channels such as radio spots, radio talk shows, community dialogue, and IEC materials that reached the target audience with a great impact at minimal costs hence the adoption of new hygiene behaviour. Six radio talk shows were conducted on a weekly basis on two FM stations (Nenah FM and Radio Karamoja FM) to promote public awareness about cholera epidemic. This reached an estimated number of 900,000 listeners in six districts of Moroto, Nakapiripirit, Amudat, Abim, Kotido, and Kaabong within Karamoja sub region. However, this was less than the planned target of 16 radio talk shows due to increased price/charges that more than doubled the budget allocation for the activity. These charges are uniquely high because of the remoteness of the region with poor infrastructure (such as electricity) that makes it costly to run the only two radio stations in the whole of Karamoja sub-region.

Among the talk show panellists were the Resident District Commissioner (RDC), District Health Officer (DHO), District Health Educator (DHE), Principal Health Inspector of Moroto Municipality, District Water Officer (DWO), health inspectors from water and sanitation department, and those from Matheniko health sub-district, a World health representative and the URCS Branch Coordinator. These participants are all members of the district cholera task force representing case management, surveillance, water and sanitation and social mobilisation working groups.

These live talk shows were very participatory and allowed the public to phone-in asking pertinent questions that were ably clarified. They also gave their views on how to improve community hygiene to solve the cholera problem in the region. These interactions created more awareness among the public as evidenced from the increased number of suspected cases referred to health facilities and also inquiry calls made to the task force members.

A total of 240 radio spot messages, for promoting community awareness and mobilization of the communities in hard to reach areas, aimed at improving hygiene and sanitation were run in Nenah FM one of the local radio stations in Moroto. These messages were run in both English and Ngakarimojong languages. The messages contained basics such as how cholera is spread, preventive measures, and symptoms and care of cholera patients. The messages also highlighted the areas already affected, those at risk, and a call for people to be on alert and always refer the suspected cases to the nearest health unit.



**Beneficiaries receiving hygiene supplies (jerry cans, soap and water purifiers) at Nadunget sub-county headquarters  
Photo, URCS**

In the course of media campaigns a high listenership was noted with reference to talk shows. For example the station had callers as far as from Karamoja Districts of Kaabong, Kotido, Abim, Nakapiripirit,

Napak all the sub-counties of Moroto, and neighbouring districts of Katakwi and Pader. These areas had an estimated listener-ship population of over a million people. The majority of callers in appreciation commended URCS and the District Health Department for the good work done in a bid to save lives (recordings of the media campaign messages are available on CDs).

The URCS supported Moroto district water office with fuel for collecting water samples, and funds for procuring the required reagents. The latter made it possible to set up two laboratories that screened samples from 21 boreholes in 19 villages within 3 sub-counties. Out of the 21 samples analyzed 9 were found to be contaminated with e-coli (average of 1.05) thus unfit for human consumption. Communities in these villages were the main target beneficiaries of the water purification chemicals that were distributed. Results were shared with partners for possible disinfection of deep wells.

Through this activity it was also discovered that out of 435 boreholes available in the affected communities 45 were broken down and non-functional. This left the communities to fetch water from alternative sources such as rivers, surface dams, and ponds that were highly contaminated. After sharing these needs the ICRC committed CHF 25,000 to support the URCS rehabilitate eight of these broken down boreholes to enable communities have reliable access to safe water supplies as a sustainable solution to the epidemic.

A total of 4,900 pieces of 20-litre capacity jerry cans were procured and distributed to target communities between 7 June and 16 July 2010, benefiting 5,000 households in the affected sub counties of Nadunget, North and south Division of Moroto Municipality. The supply served the purpose planned as the beneficiary communities changed from using unclean containers like pots that were highly responsible for household water contamination in the process of drawing it. These positive behaviour changes were noted by community hygiene promoters when carrying out household visits and sensitization campaigns. In addition, 40,000 water purification tablets were procured and distributed to 8,000 households in affected communities in the three sub-counties. This helped to improve on the water quality hence mitigating the spread of the disease as a result of drinking dirty water from contaminated sources (especially from the river beds).

In a bid to promote hand washing at critical moments 7,500 bars of soap and 2,500 3-litre jerry cans were distributed to the affected communities to reduce more contamination with the cholera germs. These items were meant for the promotion of cost effective hand-washing technology. A total of 2,500 households from 32 villages received the bars of soap. The distribution greatly enhanced the eradication of disease because the communities began using the 'tippy-taps' with soap after using the latrine, and before preparing and after serving food. Due to high demand and vulnerability 15 additional villages in the affected areas were reached by a mechanism designed to enable two households to share the soap.



Sanitation kits distribution in Nadunget Sub-county and Moroto Municipality. Photo, URCS

A PHASTER training was conducted, reaching 200 community hygiene promoters in the affected as well as in neighbouring communities at risk. Five PHAST tool kits were procured to help in the training of the selected volunteers. The kits aided the sensitization process in that the communities were able to identify bad and good hygiene practices. The “F” diagram, which shows the transmission mode of diarrheal diseases, was the most preferred method for the trainees. As it enabled them to easily identify good and bad practices such as open defecation, and drinking un-safe water etc that exposes them to disease.

The toolkits increased public awareness about hygiene issues. They helped promote community participation in the learning process as it was practical and the majority of the household members are illiterate. This encouraged ownership of the programme as evidenced from the adaptation of the good hygiene practices such as building household latrines, purifying household water for drinking and washing hands after latrine use etc.

A total of 50 sanitation kits were procured and distributed to targeted households. One kit consisted of a wheel-barrow, fork, hoe, spade, pick-axe, panga, metallic bucket and rope, hand-saw, sickle and hammer. A total of 45 villages got one kit each. The selection of beneficiaries was done according to the size and population of the village as well as whether some communities had received the same kits from other agencies such as UNICEF. As result of the kits provided, a total of 447 new household latrines were constructed in the course of the operation.

**Table 2: Latrines constructed in the three target sub-counties**

Sub-County	Number of Private Household Latrines	Number of Public Latrines	Setting
Nadunget	140	13	Rural
South Division	144	04	Urban
North Division	163	07	Urban
<b>Totals</b>	<b>447</b>	<b>24</b>	

The figures above do not give a complete picture of what is expected in terms of latrine coverage hence the need for serious follow up on sanitation is recommended in a bid to mitigate the same occurrence in future.

The increase in the latrines constructed is attributed to the pressure mounted by the cholera outbreak onto the communities, and with the assistance from different stakeholders. This assistance ranged from the by-laws put in place by the cholera task force, outright discrediting of open defecation, closure of eating places without sanitary facilities, taking non-compliant landlords without latrines to courts of law, and material assistance to the communities in terms of latrine digging kits from URCS and UNICEF.

The sanitation kits are also assisting in support to other areas including 'food-security' as some of the tools such as hoes, pangas etc, are being used to prepare gardens for cultivation and also promote proper water drainage to control floods during the heavy rains.

**Challenges:**

Due to the remoteness of Moroto District, some of the bulky items such as health and hygiene supplies (plastic jerry cans, latrine digging kits etc) required a lot of space for only small quantities. This made the trucks to travel several trips in order to transport the amounts needed and yet the available mileage provided in the budget was limited. This was solved through the relocation of additional resources from the non-essential functions.

Some households experienced difficulty in completing the latrines superstructure after sinking the pits. This was due to lack of local construction materials as the environment is semi-arid with little vegetation/forest cover. Such affected households were advised to make use of packaging (plastic sheets and sisal bags) from other distributions (such as food etc) to cover the latrines and provide privacy for users.

The newly introduced ECV training toolkit was embraced by the National Society as effective disease prevention and response approach to improve conditions to the frequent occurrence of disease out-breaks in the country. However, the National Society is highly constrained by lack of additional funds to roll out the approach down to community based volunteers. The National Society is engaging partners to support the adoption of this methodology but needs financial support. It believes that, in turn, it will help reduce the cost of responses to disease outbreaks in the future.

**Emergency health**

<b>Objective: Decrease cholera epidemic mortality by ensuring early case detection, adequate care though appropriate community case management of suspected cholera patients and reinforcing the health care systems in the three affected sub-counties in Moroto District.</b>
<b>Activities planned</b>
<ul style="list-style-type: none"> <li>• Procure two cholera kits for treatment of 400 patients and pre-positioning for future outbreaks.</li> <li>• Conduct training of 32 Branch Coordinators from epidemics-prone districts in Uganda who will in turn support training of other community volunteers in their respective areas in Epidemic Control for Volunteers (ECV) skills.</li> <li>• Conduct active case search by community based volunteers and village Health Teams (VHTs) to enable early case detection, reporting and referral of suspected cholera patients.</li> <li>• Conduct community sensitization and health education.</li> </ul>

**Achievements**

Two cholera kits were procured, where one was delivered to Moroto Hospital CTC that supported treatment of over 427 patients admitted. The kits helped to fill the critical gaps of medical supplies needed for effective case management hence it ensured that the CFR remained as low as 1.6%. Other partners who supported case management were WHO, the Uganda Peoples Defense Forces (UPDF), Doctors with Africa (CUAMM), the World Food Program (WFP) and Medecins sans frontiers (MSF) who provided various support in terms of personnel deployment, medical supplies and equipment, training of medical staff on infection control, and surveillance and feeding of patients in the CTCs.



URCS volunteers conducting home visits and health education/hygiene promotion campaigns in Manyattas in Nadunget sub-county. Photo, URCS

With technical support from the Emergency Health Delegate based at the IFRC's Regional Representation office in Dakar Senegal, 32 URCS staff comprising of branch coordinators, regional and national officers were trained as trainers. They then helped roll out Epidemic Control for Volunteers (ECV) amongst community based volunteers in their respective branches that are consistently experiencing disease outbreaks ranging from Cholera, Hepatitis E, Dysentery, Plague, Ebola Haemorrhagic Fever, Marburg fever, Influenza pandemics, and Meningitis. This new IFRC disease control training toolkit provided an opportunity for URCS to adopt use of evidence-based actions and approaches to prevent the spread of communicable diseases in the target communities. This made it easier to provide appropriate care for the sick during outbreaks and reduce the number of deaths arising from such epidemics. It is expected that the knowledge and skills acquired will enable URCS branches to act quickly and effectively in the event of an epidemic, and also that the skills will be transferrable and useful to help them in dealing with other emergencies.

After the ECV trainers' course, a few branches have already initiated the roll-out with support from other programme funds and external partners. For example, Pallisa Branch (through the disaster management funding) plans to integrate ECV training into the disaster risk reduction training activities for the communities that commonly experience cholera outbreaks in the district. In addition, Busia Branch (through support from World Vision) trained 143 (43 females and 100 males) members of the district disaster management committee (DDMC) and sub-county officials from Busia Town Council and Nankoma sub-county in Bugiri District. They were trained in disaster management skills where epidemic control topics were integrated. It is hopeful that this new training approach will roll-out among the volunteers in the epidemic hotspot communities so as to promote community awareness and resilience towards the diseases, hence heavily reduce on the cost of emergency interventions in future.

The trained volunteers provided a good network of community owned resource persons who remained active not only conducting health promotion, but also disseminating simple signs and symptoms of cholera, and teaching household members on what to do in case one shows those signs. Through this, most households who experienced acute attacks in the night have been reporting to the community based volunteers to receive oral rehydration therapy, followed by immediate referral to the treatment centres using bicycles. By doing this, the volunteers acted as the initial link in the continuum of care and supporting community based disease surveillance mechanism for effective interruption of the disease spread.

After the training of both PHASTER trainers and community hygiene promoters, the village health teams (VHTs) were charged with the responsibility of conducting health education in the affected areas and those at high risk. The modes of health education varied from house to house visits, communal meetings, awareness raising sessions within the affected areas, distribution of IEC materials, and sharing of testimonies by the cholera survivors. Being an emergency response, the ToTs worked for 30 days. The VHTs worked for 20 days with an aim of re-enforcing the efforts of the ToTs in their respective villages of the affected communities.

The health education and promotion reached a total of 195,000 people in 78 villages from four sub-counties. In the North Division the following villages were reached: Bazaar hospital quarters, RTC, Moroto High School junior quarters, Police barracks, Moroto Municipal Primary School and senior quarters. In the South Division the team reached Nakapelimen, Regina Mundi, Campswahili Juu, Kambisi, Labour line, Campswahili Chini, Kitale quarters, and Kakolye villages. In Nadunget sub-county the following villages were visited: Katanga, Nachele, Awoimuju, Kaloi, Kanakomol, Nangorit, Nabokat, Nachora, Namijimij, Lopur, Loengetela, Natari, Nachuka, Namatwae, Nangorikipi, Kotaruk, Lokeriaut, Lokilaa, Lokoriot, Loletekia, Loputiput, Nkamistae, Nakapelime, Arechek, Komaret, Longoleki, Loodoi, Lorikokwa, Looi, Apetawoi, Worobu, Kamera, Lokwakwa, Nachogorom, Nadiket, Nasinyonoit, Nataparkochuch, Arengekeju, Atedewoi, Kaipetar, Kopooi, and Simon). In Rupa sub-county, the team conducted hygiene promotion and health education in Acholi inn, Lamario, Lokomerkapel, Mogoth, Kaloi, Musupo, Pupu, Natopojo, Akwapuwa, Kidepo, Namogorat, Kisop, Nongoroko, Kwamong, Nakadeli, Lokoreto and Lorukumo villages.

### Coordination; Monitoring and support supervision

<b>Objective: To strengthen coordination and local response by supporting long term disaster risk reduction actions and participating in the coordination and monitoring mechanisms</b>
<b>Activities planned</b>
<ul style="list-style-type: none"> <li>• Conduct four field monitoring and technical support supervisory visits in the affected district.</li> <li>• Participate in 6 bi-weekly coordination meetings at sub-county, district and national levels</li> <li>• Conduct follow-up of discharged patients at home to promote improvement in environmental and personal hygiene of affected households.</li> <li>• Conduct continuous monitoring on proper utilization and maintenance of community sanitation enabling facilities constructed.</li> </ul>

### Achievements

At national level, the URCS maintained presence and participated in four national coordination meetings at MoH together with other partners which included WHO, OCHA, UNICEF, and Action against Hunger (ACF). Cholera response strategies were reviewed and adapted to meet the changing environment. This forum also acted as a resource mobilization platform for financing proposed cholera intervention to control the epidemic that was fast spreading across all the districts within the Karamoja region. Through this, the URCS was able to secure USD 50,020 from OCHA to help facilitate cholera response activities in Kotido District over a 2 month period.

At field level, the URCS Branch Coordinator and the Regional Programme Officer participated and represented the Red Cross and red Crescent Movement in the weekly district task force meetings chaired by the Resident District Commissioner (RDC), with members from Moroto District local government departments of health, water, community development, and others from WHO, UNICEF, CUAMM and UPDF.

Within the National Society, internal 'operations' meetings were held on bi-weekly basis among the line departments of disaster management, health, accounts and finance, and logistics to share progress on implementation and review strategies. The URCS shared field and progress reports with the ICRC that resulted into securing CHF 25,000 (UGX 54,282,900). This is being used to support the rehabilitation of 8 boreholes that are currently broken down in Moroto District in order to provide long-term water needs for the cholera affected communities of Nadunget sub-county. The URCS maintained constant contact with the Federation Regional Office through DREF updates and telephone calls that ensured that activities progressed well in line with set objectives.

The operation was maintained on the right course of action through two field monitoring and technical support supervision visits conducted by the regional and national programme officers. These visits also ensured that the district leadership and partners in Moroto were kept abreast of DREF operation procedures. High expectations beyond the capacity of the DREF were clarified as well as providing opportunities to give moral support and effective motivation to the community based volunteers engaged in the operation which kept their spirits high.

### Challenges

The district task force expected the URCS to fill many gaps including the payment of health workers in the CTCs, water trucking, rehabilitation of broken down water facilities, and many other activities after hearing that DREF funds were secured for cholera response. This was however solved through thorough dissemination about DREF requirements and limits. Establishing a coordination mechanism at sub-district level was not possible as local leaders' expectations to be facilitated in order to convene for the meetings deterred such a forum to be organized.

As the cholera control efforts in Moroto were yielding results, the disease continued to spread to other neighbouring districts including Amudat and Kotido. This was largely due to continuous population movements and social interactions that made limited resource envelopes of partners to be split in order to cover a wider target area hence limiting the impact of the operation.

Some of the partners in Karamoja Region continued to implement cholera response activities in a 'slow development mode' without considering the fast changing emergency situation. Hence, the disease persisted in some communities longer than it should have done due to the slow response.

## How we work

**All International Federation 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 is committed to the [Humanitarian Charter and Minimum Standards in Disaster Response \(Sphere\)](#) in delivering assistance to the most vulnerable.**

The International Federation's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

The IFRC's work is guided by [Strategy 2020](#) which puts forward three strategic aims:

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

## Contact information

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

- **In Uganda:** Uganda Red Cross Society; Michael Nataka, Secretary General, Phone: +256.41.258.701/2; Fax: +256.41.258.184; Email: [natakam@redcrossug.org](mailto:natakam@redcrossug.org)
- **In East Africa Region:** Eastern Africa Regional Representation Office: Alexander Matheou; Regional Representative, Phone: +254.20.283.5124; fax: 254.20.271.27.77; Email: [alexander.matheou@ifrc.org](mailto:alexander.matheou@ifrc.org)
- **In IFRC Africa Zone:** Dr Asha Mohammed, Head of Operations, Johannesburg; Phone: +27.11.303.9700; Fax: +27.11.884.3809; +27.11.884.0230  
Email: [asha.mohammed@ifrc.org](mailto:asha.mohammed@ifrc.org)
- **In Geneva:** Pablo Medina, Operations Coordinator for Eastern and Southern Africa; Phone: +41.22.730.43.81; Fax: +41 22 733 0395; Email: [pablo.medina@ifrc.org](mailto:pablo.medina@ifrc.org)

*For Performance and Accountability (planning, monitoring, evaluation and reporting (enquiries):*

- **In IFRC Africa Zone:** Terrie Takavarasha; Performance and Accountability Manager, Johannesburg; Email: [terrie.takavarasha@ifrc.org](mailto:terrie.takavarasha@ifrc.org); Phone: Tel: +27.11.303.9700; Fax: +27.11.884.3809; +27.11.884.0230

**[<Final financial report below; click here to return to the title page>](#)**

MDRUG016 - Uganda - Cholera

Appeal Launch Date: 08 may 10

Appeal Timeframe: 08 may 10 to 08 jul 10

Final Financial Report

Selected Parameters	
Reporting Timeframe	2010/5-2010/10
Budget Timeframe	2010/5-2010/7
Appeal	MDRUG016
Budget	APPEAL

All figures are in Swiss Francs (CHF)

## I. Consolidated Funding

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL
<b>A. Budget</b>	178,676					178,676
<b>B. Opening Balance</b>	0					0
<b>Income</b>						
<b>Other Income</b>						
<i>Voluntary Income</i>	171,839					171,839
<b>C6. Other Income</b>	171,839					171,839
<b>C. Total Income = SUM(C1..C6)</b>	171,839					171,839
<b>D. Total Funding = B + C</b>	171,839					171,839
<b>Appeal Coverage</b>	96%					96%

## II. Movement of Funds

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL
<b>B. Opening Balance</b>	0					0
<b>C. Income</b>	171,839					171,839
<b>E. Expenditure</b>	-171,839					-171,839
<b>F. Closing Balance = (B + C + E)</b>	0					0

International Federation of Red Cross and Red Crescent Societies

MDRUG016 - Uganda - Cholera

Appeal Launch Date: 08 may 10

Appeal Timeframe: 08 may 10 to 08 jul 10

Final Financial Report

Selected Parameters	
Reporting Timeframe	2010/5-2010/10
Budget Timeframe	2010/5-2010/7
Appeal	MDRUG016
Budget	APPEAL

All figures are in Swiss Francs (CHF)

### III. Consolidated Expenditure vs. Budget

Account Groups	Budget	Expenditure					TOTAL	Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination		
A		B					A - B	
<b>BUDGET (C)</b>		<b>178,676</b>					<b>178,676</b>	
<b>Supplies</b>								
Water & Sanitation	45,819							45,819
Medical & First Aid	16,043	13,417				13,417		2,626
Teaching Materials	32,888							32,888
<b>Total Supplies</b>	<b>94,750</b>	<b>13,417</b>				<b>13,417</b>		<b>81,333</b>
<b>Transport &amp; Storage</b>								
Storage		380				380		-380
Distribution & Monitoring	3,542	4,302				4,302		-760
Transport & Vehicle Costs	19,572							19,572
<b>Total Transport &amp; Storage</b>	<b>23,114</b>	<b>4,682</b>				<b>4,682</b>		<b>18,432</b>
<b>Personnel</b>								
International Staff	3,953							3,953
National Society Staff	20,321							20,321
<b>Total Personnel</b>	<b>24,274</b>							<b>24,274</b>
<b>Workshops &amp; Training</b>								
Workshops & Training	16,271	1,792				1,792		14,479
<b>Total Workshops &amp; Training</b>	<b>16,271</b>	<b>1,792</b>				<b>1,792</b>		<b>14,479</b>
<b>General Expenditure</b>								
Travel		493				493		-493
Communications	7,701							7,701
Other General Expenses	952							952
<b>Total General Expenditure</b>	<b>8,653</b>	<b>493</b>				<b>493</b>		<b>8,160</b>
<b>Contributions &amp; Transfers</b>								
Cash Transfers National Societies		140,199				140,199		-140,199
<b>Total Contributions &amp; Transfers</b>		<b>140,199</b>				<b>140,199</b>		<b>-140,199</b>
<b>Programme Support</b>								
Program Support	11,614	10,488				10,488		1,126
<b>Total Programme Support</b>	<b>11,614</b>	<b>10,488</b>				<b>10,488</b>		<b>1,126</b>
<b>Services</b>								
Services & Recoveries		767				767		-767
<b>Total Services</b>		<b>767</b>				<b>767</b>		<b>-767</b>
<b>TOTAL EXPENDITURE (D)</b>	<b>178,676</b>	<b>171,839</b>				<b>171,839</b>		<b>6,837</b>
<b>VARIANCE (C - D)</b>		<b>6,837</b>				<b>6,837</b>		