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Emergency appeal operation update

Sierra Leone: Cholera Epidemic

 International Federation
of Red Cross and Red Crescent Societies

Emergency appeal n° MDRSL003
GLIDE n° [EP-2012-000041-SLE](#)
Operation update n°1
24 October 2012

Period covered by this Ops Update: 17 September to 17 October, 2012.

Appeal target (current): CHF 1,358,780 in cash, kind and services.

Appeal coverage (current, does not include DREF): 34% [<click here to go directly to the updated donor response report >](#)

Appeal history:

- This Emergency Appeal was initially launched on a Preliminary basis on 16 August 2012 for CHF 1,151,632 for 6 months to assist 1,440,000 beneficiaries. CHF 150,000 was allocated from the International Federation of Red Cross and Red Crescent (IFRC) Disaster Relief Emergency Fund (DREF) as start up funds. Unearmarked funds to replenish the DREF are encouraged.
- The Emergency Appeal was launched on 17 September 2012 for CHF 1,358,780 for 6 months to assist 1,539,206 direct beneficiaries and 2,000,000 indirect beneficiaries.
- CHF 1,389,250 was provided in kind to support the deployment of three Emergency Response Units (ERUs), consisting of a Basic Health Care Unit from the Finnish and Japanese Red Cross, Community Health Module from the Norwegian and Canadian Red Cross, and a Mass Sanitation Module from the British Red Cross. These bilateral contributions are not included in the current appeal target.
- The current Ops Update informs on progress of the operation to date.

Summary: The operation has reached over 1,131,613 people to date in 5 districts, namely; Western Area, Bombali, Tonkolili, Port Loko and Kambia. They have benefitted from basic health care including daily surveillance, hygiene promotion, and social mobilization as well as provision of Oral Rehydration Solution (ORS) and water and sanitation hardware. A Field Assessment and Coordination Team (FACT) was deployed to obtain detailed assessment information. IFRC assisted with deployment of 3 Emergency Response Units (ERUs) consisting of a Finnish Red Cross Basic Health Care module (BHC ERU) supported by Japanese Red Cross, a Norwegian Red Cross community health module (CHM ERU) supported by Canadian Red Cross, and a British Red Cross mass sanitation module (MSM ERU). The ERUs operated in the districts of Bombali, Tonkolili, Port Loko and Kambia.



Red Cross volunteer supervises well rehabilitation.
Photo/SLRC

To decrease the transmission of cholera, the operation has provided clinical case management, referral, surveillance, and support to the Ministry of Health (MoH) emergency response. The activities have contributed to reducing the risk of waterborne diseases through water, sanitation and hygiene promotion, as well as improving disaster management and the capacity of the SLRC to respond to cholera outbreaks and other emergencies in the future.

The IFRC supported the ERU teams to carry out epidemiological analysis. Additionally, IFRC carried out a Knowledge Attitudes and Practices (KAP) baseline survey in two districts. A follow up survey will be conducted in the same villages at the end of the operation.

The cholera outbreak in Sierra Leone has declined from a high of more than 2,000 cases per week at the peak of the outbreak (in weeks 32 - 34), down to 433 cases per week in week 41. Although this is a significant decline, the number of cholera cases is still significant, requiring ongoing prevention and control efforts to ensure the outbreak does not spread further. Epidemiological surveillance will be continued to the end of the operation.

Since the appeal launch, 355,850 beneficiaries have specifically been reached through targeted community mobilization by 647 volunteers. A mobile cinema supported by the British Red Cross has reached more than 13,000 direct beneficiaries and more than 200,000 indirect beneficiaries with health promotion messages. Through the implementation of water and sanitation activities, 10 wells have been rehabilitated and 6 WASH committees established.

The operation is only partially funded to date. Cash contributions have been gratefully received from British, Japanese, Swedish, and Canadian Red Cross Societies and the British Government. In kind contributions (goods, transport and personnel) have been received from British, New Zealand, Icelandic, and Japanese Red Cross Societies. Additional bilateral contributions through the provision of Emergency Response Units have been received from the British, Finnish, Norwegian, and Canadian Red Cross Societies. Donors are urged to provide further support to this operation so that all planned activities can be completed.

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

The situation

An outbreak of cholera was declared in Sierra Leone in February 2012 in the border district of Kambia. Ongoing cases on the border regions of Guinea and Sierra Leone since February made control difficult. These mobile fishing communities along the coast are regularly affected by cholera due to unsafe water access. The cholera outbreak spread and reached significant levels in Port Loko. As shown on the epidemic curve below, cases gradual declined is attributed to an increase in awareness and preventative measures from a number of partners including the SLRC, MSF, ACCF and the Ministry of Health.

In mid June, initial cases were detected in Freetown, the capital of Sierra Leone situated on the coast in the Western district and a hub for regional travel. Freetown is characterised by high levels of urban poverty, poor sanitation, with intermittent access to a degraded piped water system and overcrowding. On 11 July 2012, the Sierra Leone Ministry of Health and Sanitation laboratory confirmed cholera in the Western District. The cholera cases on a weekly basis from the national level rose quickly to 2,000 cases per week with more than 50 per cent of those coming from the urban area in Freetown. On 16 August, the President of Sierra Leone declared a public health emergency and confirmed a national epidemic with 12 out of 13 districts confirming cholera cases.

Cholera cases have been reported annually in Sierra Leone in recent years; however the country has not seen an outbreak of this size in more than a decade. Cholera outbreaks tend to show a rapid upward trend but a slower declining "tail" after the peak. The Sierra Leone nationwide trend for weeks 35, 36, 37, 38, 39, 40 and 41 seems to follow a similar pattern. The total cumulative from 1 January – 14 October was 21,599 cases, including 290 deaths (case fatality rate (CFR) = 1.35). The case fatality rate was extremely high in some locations with a daily high of 38% CFR at some points at the peak. With consistent intervention, the national average since the beginning of the year is now down to 1.35%, which is still over the accepted limit of 1% for cholera.

Figure 1: National cholera trend 1 Jan – 12 October. (Source: MoH).

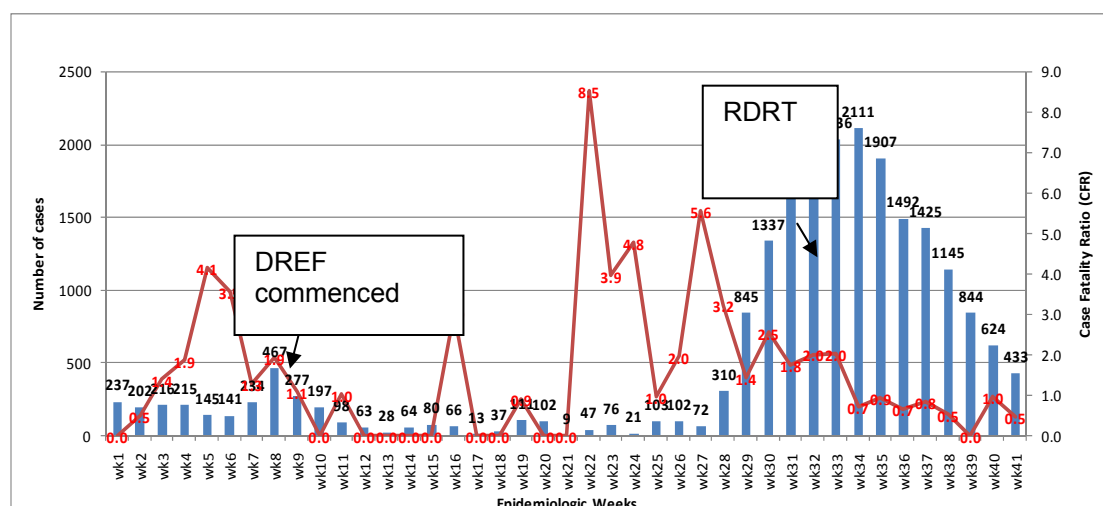


Figure 2: District Cholera CFR between 1 January and 14 October. (Source: MoH)

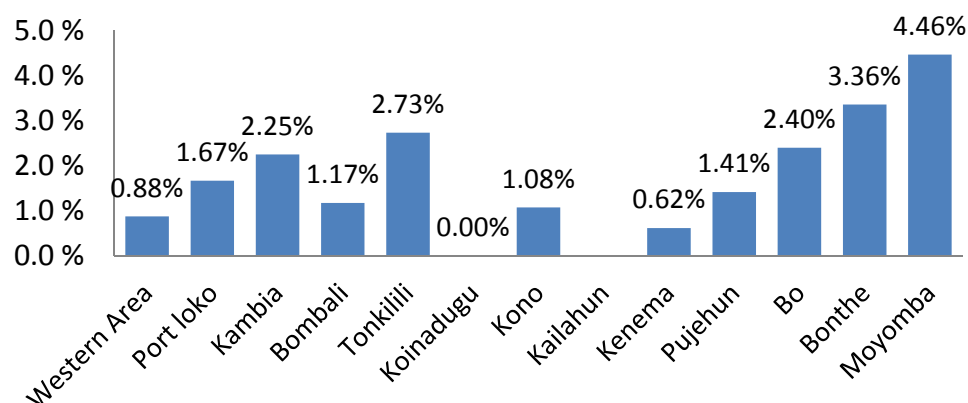


Table 1: National Cumulative Cholera Cases between 1 January and 14 October. (Source: MoH Sierra Leone)

Name of affected district	District Population	Cumulative Number as reported up to 13 October 2012			CFR	Attack Rate	
		Cases		Deaths			
		<5	≥5				Total
Western Area	1,243,804	1,429	9,786	11,215	96	0.9	0.90
Port Loko	529,831	1,740	1,693	3,433	58	1.7	0.65
Kambia	324,769	271	1,190	1,461	32	2.2	0.45
Pujehun	320,686	386	625	1,011	14	1.4	0.32
Bo	624,386	74	535	609	14	2.3	0.10
Bombali	469,064	204	1,081	1,285	15	1.2	0.27
Moyamba	262,725	35	321	356	15	4.2	0.14
Tonkolili	413,276	152	1,034	1,186	32	2.7	0.29
Bonthe	160,114	75	204	279	9	3.2	0.17
Kono	305,952	27	159	186	2	1.1	0.06
Kenema	621,750	56	458	514	3	0.6	0.08
Koinadugu	318,849	6	58	64	0	0.0	0.02
TOTAL	5,595,206	4,455	17,144	21,599	290	1.34	0.39

The overall causal factors for water related diseases and specifically cholera remain extremely high in Sierra Leone in general. The country lacks adequate sanitation facilities, quality and quantity of water sources (water points and public water networks) and has insufficient waste management systems and limited access to health care in some areas.

Coordination and partnerships

IFRC initially responded to the outbreak with the deployment of a FACT team supported by 3 Emergency Response Units (ERUs), consisting of a Basic health Care Unit from the Finnish and Japanese Red Cross, the Community Health Module from the Norwegian and Canadian Red Cross, and a Mass Sanitation Module from the British Red Cross. Through the existing co-ordination structures of the government and in close collaboration with the National Society as lead agency, the FACT team and the ERU teams have ensured efficient use of resources and while avoiding duplications.

The coordination of the national response to Cholera is done by the Ministry of Health technical group assisted by WHO meets daily. The Ministry established a National Cholera Task Force and SLRC is a member. This Task Force has two main sub committees; case management/logistics and the WASH sub-committee. In addition, the government established a Presidential Task Force chaired by the Chief of Staff and functions as an internal Government management and coordination body. Partner Coordination meetings are held by WHO, UNICEF and all other actors on a weekly basis to enhance better coordination between actors.

SLRC is an important strategic partner to the Health authorities and is working with them both at the national and district levels in health promotion activities, such as social mobilization during immunization campaigns and bed net distribution. SLRC is also a member of the disease surveillance committee set up by the Ministry of Health and Sanitation more than two years ago to monitor and report on communicable disease situations across the country. Task Force mechanisms have also been established at the district level. These meetings are attended by the district health officers and other key partners, and NGOs are invited. SLRC has extensive experience both in cooperation and coordination with other humanitarian agencies, particularly UNICEF and ACF. This is used as an entry point to increase district level coordination.

National Society Capacity Building:

The SLRC has extensive experience in community mobilization, hygiene awareness activities, and long term community based health programs in all districts. This has greatly facilitated the capacity building components that are an integral part of all activities in the operations. This includes the training of 778 volunteers in cholera case management and hygiene promotion activities. The increased access to trained long term volunteers as a component of SLRC disaster preparedness structures improves its ability to respond swiftly and effectively to cholera epidemics and other similar disasters. Each branch on the mobile cinema tour also receives their own cinema kit so they can continue activities and use this resource for raising awareness of other health and disaster preparedness topics. The strong volunteer base is one of the factors that further will enhance the key role played by the SLRC in disaster response on a national level. Ongoing and planned hygiene awareness activities will continue to strengthen community resilience.

Prepositioning of stocks such as ORS and water treatment materials at branch and HQ level as a part of the operations also enhances the ability of the National society to respond to a cholera outbreak in the future. Although Sierra Leone has not seen a cholera outbreak of this magnitude for decades, cases of the disease are reported every year, and there is a considerable risk of repeated outbreaks that require a swift response.

Red Cross and Red Crescent action

Overview

Immediate needs continue to be addressed by SLRC staff and volunteers in all regions with support from IFRC staff and emergency response units (ERU) deployed in four of the affected districts. The exit of all ERUs is planned to be completed by the end of October.

Knowledge and awareness of cholera treatment and prevention is being raised through the training of volunteers, with a growing emphasis on hygiene awareness and health promotion as the number of new cholera cases continues to decline, reducing the need for cholera treatment activities. Surveys show that community-based promotion activities have a positive effect on people's knowledge and understanding of cholera and its prevention. A knowledge, attitudes and practices (KAP) survey will be completed in the final stages of the operation to assess

the impact of interventions. A monitoring system is being put in place to ensure the quality of health promotion activities and preparedness.

Data surveillance has been supported in the initial phases of the operation through the deployment of an epidemiologist, who has carried out capacity building in communities on how to effectively monitor the situation in the early phases of the operation. A surveillance system has been put in place to ensure that cholera cases are being reported by volunteers at ORS post level to SLRC branches and to the headquarters which in turn is provided to the government's system, administered by the MoH.

The overall implementation of the operation and its activities is proceeding as planned, with many of the volunteer training goals already accomplished. Due to the steadily declining number of new cholera cases, case management activities are being scaled down. However, a continued emphasis on prevention and reduction of risk factors is necessary. Despite the successful response to date there are still more than 400 cases per week. The capacity building activities that have been completed to date have provided the national society and the ministry of health the expertise needed to continue to implement control and prevention activities. This will need to continue for another 4 to 5 months to ensure cholera is brought completely under control and that further outbreaks are prevented.

Progress towards outcomes

Emergency Health and Care	
A decrease in the case fatality rate (CFR) for cholera is achieved, through the provision of clinical case management and support to the Ministry of Health emergency response	
Outputs (expected results)	Activities planned
<ul style="list-style-type: none"> A mobile BHC is operational and providing clinical case management support starting in four target districts (Port Loko, Kambia, Bombali and Tonkolili) of up to an estimated 8,684 people and/ or as per need based on evolution of the epidemic. 	<ul style="list-style-type: none"> Deploy mobile Basic Health Care (BHC) ERU to areas affected to provide clinical case management in existing facilities and/or establish supplementary Cholera Treatment Centres (CTCs) if the need arises. Provide clinical supervision and on the job training in areas of operation to Primary Healthcare Units (PHUs). Supply district hospitals and PHUs with essential items if required to ensure proper case management and infection control practices are enabled. Support UNICEF and the MoH in supply chain management for essential materials for treatment of cholera by assisting with information management, stock control and case estimation.
Decrease the morbidity (case load) related to cholera through the provision of community-based management, referral and surveillance in five priority districts.	
Outputs (expected results)	Activities planned
<ul style="list-style-type: none"> Improve the knowledge base of 778 volunteers through capacity building, training and on the job supervision so that they are able to identify the signs and symptoms of cholera and dehydration. They will also learn community based case management and referral systems. 	<ul style="list-style-type: none"> Deploy a mobile CHM module to affected areas to provide technical support and supervision in community based management and surveillance. Identify volunteers to be trained in affected chiefdoms. Epidemic Control for Volunteers (ECV) training will be given to 129 key volunteers.(who in turn will train others)
<ul style="list-style-type: none"> The existing community volunteer referral system for patients who show signs of Cholera will be reinforced. 	<ul style="list-style-type: none"> 129 volunteers will participate actively in case finding and referral. The mobile CHM will support the national society in the establishment of ORS corners

	through the provision of training and supplies to volunteers.
<ul style="list-style-type: none"> Households have improved knowledge of prevention, symptoms, early treatment and the correct way to manage cholera. 	<ul style="list-style-type: none"> Key volunteers will cascade the knowledge to 649 volunteers on cholera community level treatment and prevention. 778 volunteers will provide ORS to mildly dehydrated cholera patients at selected points in their communities. More serious cases will be referred to cholera treatment centres. 778 volunteers will provide health promotion messages related to cholera and other water and sanitation related diseases to individuals and households at opportunistic points of contact such as ORS points, clinic waiting areas, markets and schools.
<ul style="list-style-type: none"> In two chiefdoms, volunteers will provide community- based oral zinc to all Children under 5 years affected by cholera. This will be used as a pilot for feasibility. 	<ul style="list-style-type: none"> The volunteers in two chiefdoms, with support from the CHM and the MoH, will pilot the feasibility of community based ORS and zinc distribution to all patients under the age of five who are not seen at a medical facility.
Improved epidemiological surveillance of epidemics is achieved through capacity building of the Sierra Leone Red Cross and its Ministry of Health counterparts.	
Outputs (expected results)	Activities planned
<ul style="list-style-type: none"> A system will be established where volunteers manage 40 key ORS points. They will report on the weekly numbers of cases, which will add to the information collected through the existing system. 	<ul style="list-style-type: none"> Community surveillance will be set-up through 40 selected ORS points. More serious cases will be referred to cholera treatment centres. 129 ORS volunteers will be trained on case definition and reporting.
<ul style="list-style-type: none"> Contribute to improved data management at the national level. 	<ul style="list-style-type: none"> The epidemiologist in the IFRC team will regularly participate in the C4 meetings. Regular analysis and predictions related to the epidemic are made based on data collection, and shared with other implementing partners.

Progress: A mobile basic health care emergency response unit (BHC ERU), a mass sanitation module (MSM ERU) and a community health module (CHM ERU) were deployed to four districts areas between 21 to 23 August and provided support in clinical case management in existing health facilities and set up 196 ORS points in the four target districts. The Finnish Red Cross BHC ERU in collaboration with Japanese Red Cross BHC ERU team established Cholera Treatment Centres (CTC) and provided clinical supervision and on the job training in 23 primary health units and 2 district hospitals. In total, 7,289 cases of cholera were treated in the facilities between the months of August to October.

Figure 3: Number of patients in the districts of operation between July and October.

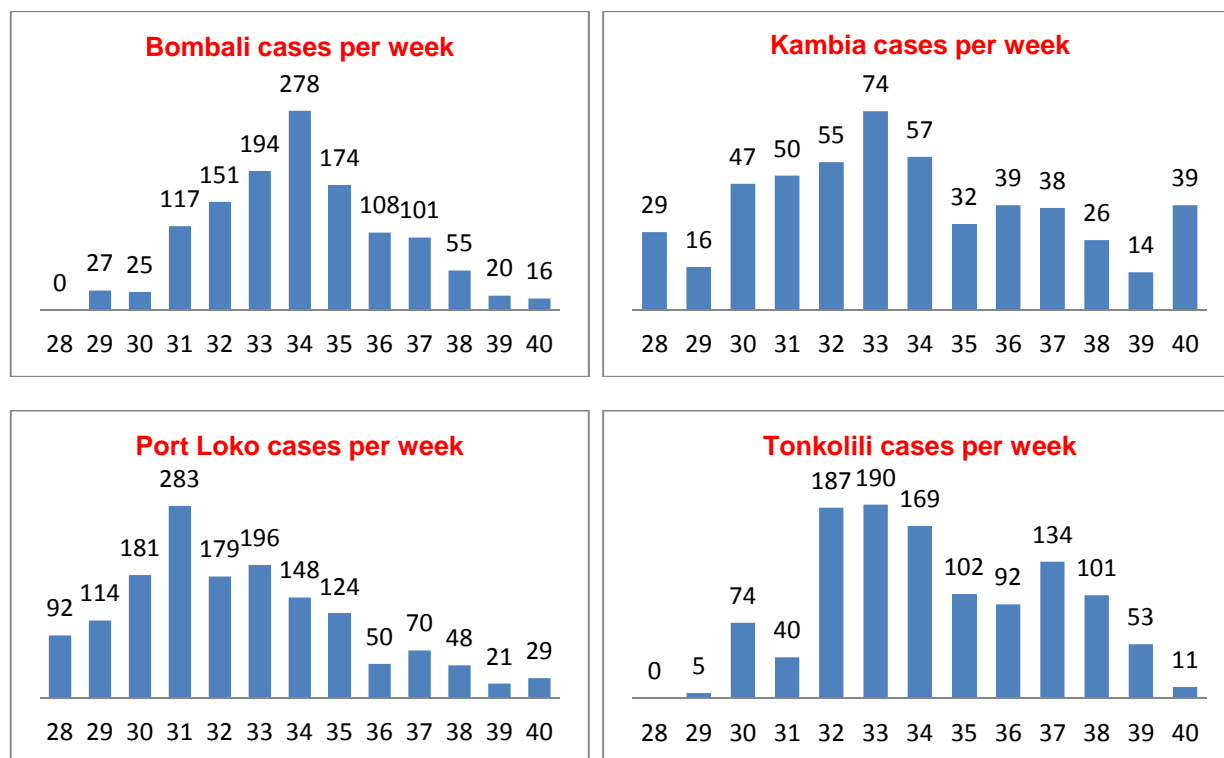


Table 2: District Cumulative Cholera Cases by first week of October

District	Number of cases reported	Number of fatalities
Bomabali	1,277	15
Kambia	1,422	32
Port Loko	3,419	57
Tonkolili	1,171	32
Total	7,289	136

Due to the gradual reduction in the number of cases, the pressure on health facilities is considerably less than before, which has made it possible for the BHC ERU to cease operations earlier than planned. Original deployment plans had allowed for 4 week deployment, with the potential to stay for up to 3 months of operations.

Following the exit of BHC ERU team at the beginning of October, drugs and medical items with all the necessary documentation with safety protocols attached were donated by the SLRC to the Ministry of Health and Sanitation for use as need arises. The WatSan equipment and all other technical materials were handed over to SLRC for use within Sierra Leone or other operations. Other items handed over included IT and electronic hardware, laptop computers, printers, generators, radio equipment, tents, consumable office material and cleaning materials.

Through the support of the MSM and CHM ERUs capacity building and training for SLRC staff and volunteers on cholera transmission was conducted. A total of 778 Red Cross volunteers received training in Epidemic Control for Volunteers (ECV) with 130 Red Cross volunteers of them trained in case finding, surveillance and referral. A part of these volunteers were selected for additional ECV training, emphasizing monitoring and surveillance. A total of 49 volunteers and SLRC staff received this additional training. These trained volunteers are key in cascading knowledge of cholera treatment and prevention at community level reaching 6, 47 additional volunteers. The volunteers have participated in case finding and referral in 419, Oral Rehydration Points (ORPs) in 4 districts as well as disseminating health promotion messages related to cholera and other water borne diseases. In addition, 196 ORS points in 14 chiefdoms were established and continue to provide community surveillance, health promotion and case management with referral of mild cases to health centers. Training and supplies are provided to volunteers providing ORS to mildly dehydrated cholera patients. The ORS points are fully operational under the supervision of key volunteers.

One of the planned operation activities was to pilot the feasibility of community based ORS and zinc distribution to all patients under the age of five not seen at a medical facility with the support of CHM ERU and the MoH. In consultation with the MoH the planned pilot for this activity has been cancelled and all patients under five are referred to the nearest health clinic where zinc distribution will be covered by the MoH.

Table 3: Volunteers trained and reporting at Oral Rehydration Points.

District	Key volunteers	Community volunteers	Total volunteers	Oral Rehydration Points they serve
Bombali	68	340	408	207
Tonkolili	10	44	54	27
Port Loko	12	115	127	127
Kambia	18	40	58	58
Total	108	539	647	419

In Bombali and Tonkolili there are 2 volunteers per Oral Rehydration Point and 1 volunteer per Oral Rehydration Point Port in Loko and Kambia.

Regular analysis and prediction related to the epidemic has been made throughout the operations based on daily updates from the MoH and WHO and shared with other implementing partners. Until October this has been done by an epidemiologist from the Norwegian Red Cross but will be continued by the Federation health delegate until an official announcement on the end of the outbreak has been made. A Community based surveillance system has been set-up with 45 ORS point volunteers selected reporting weekly on the number of people with watery diarrhoea who receive ORS in all of the 419 ORS points and statistics collected and compiled by branch managers. Between week 37 and 40, 751 beneficiaries received ORS or SSS at the ORS points and 34 cases were referred to PHUs or hospitals.

Water, Sanitation, and Hygiene Promotion

Risks of waterborne and water related diseases have been reduced through the provision of safe water, sanitation and the promotion of safe hygiene practices for 151,670 households (estimated 910,195 beneficiaries) in the five priority districts.

Outputs (expected results)	Activities planned
<ul style="list-style-type: none"> A behavioural change communication strategy will be developed, which will help the SLRC tackle barriers to good hygiene. 	<ul style="list-style-type: none"> The strategy will be developed based on the results of a mini Knowledge Attitudes and Practices (KAP) survey. Approved key messages aimed at addressing key myths and barriers to good hygiene and health practices will be developed.
<ul style="list-style-type: none"> 10,000 people will benefit from improved hygiene knowledge through interactive community and school events. 	<ul style="list-style-type: none"> A mobile cinema will tour the Western District, Port Loko, Bombali, Tonkolili and Kambia using events in schools and communities to engage people in hygiene promotion and give them an opportunity to ask key questions. Mini-cinema kits will be provided to each branch to continue this work in smaller villages and schools. Support SLRC social mobilisation activities in public places (markets, transport hubs) with local partners.
<ul style="list-style-type: none"> 8,000 households will have improved access information through the distribution of 500 radios. 	<ul style="list-style-type: none"> Wind-up, solar powered radios will be distributed to identify communities through key volunteers to improve access to information for people deprived of electricity and the means to buy batteries.
<ul style="list-style-type: none"> 2,000,000 indirect beneficiaries will have better access to information through mass 	<ul style="list-style-type: none"> A weekly one-hour talk-back radio show will be established allowing the SLRCS to discuss in more detail issues surrounding cholera and provide the population with a chance to ask questions and raise issues. This can be used beyond

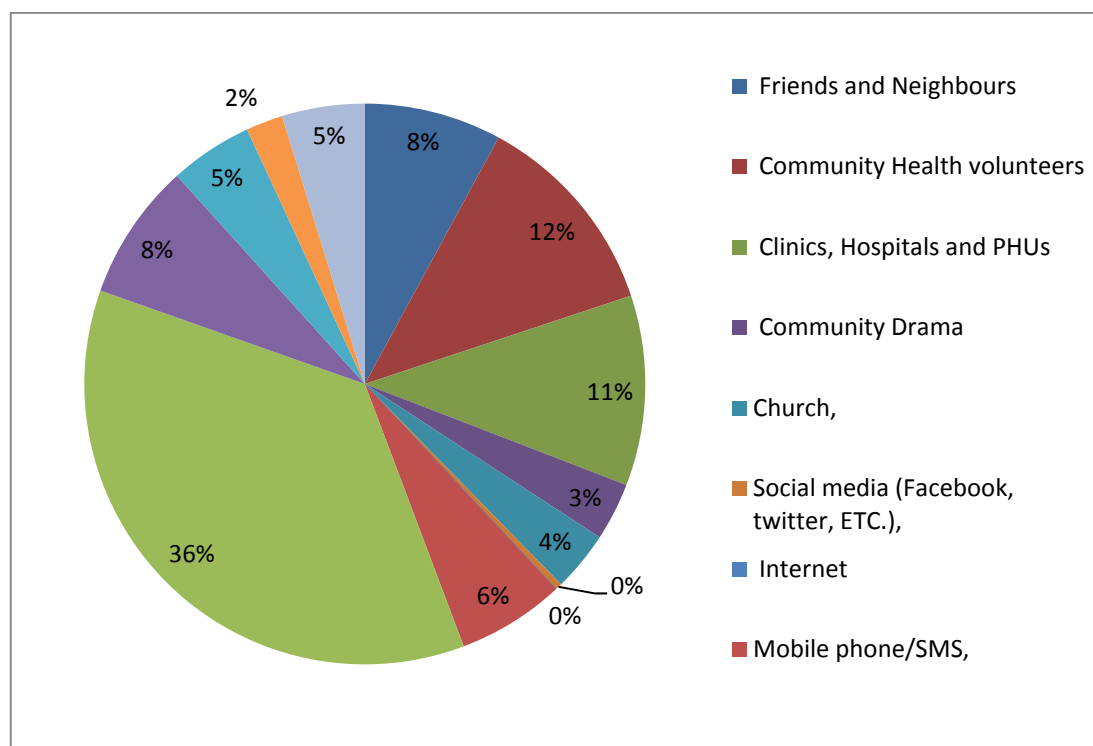
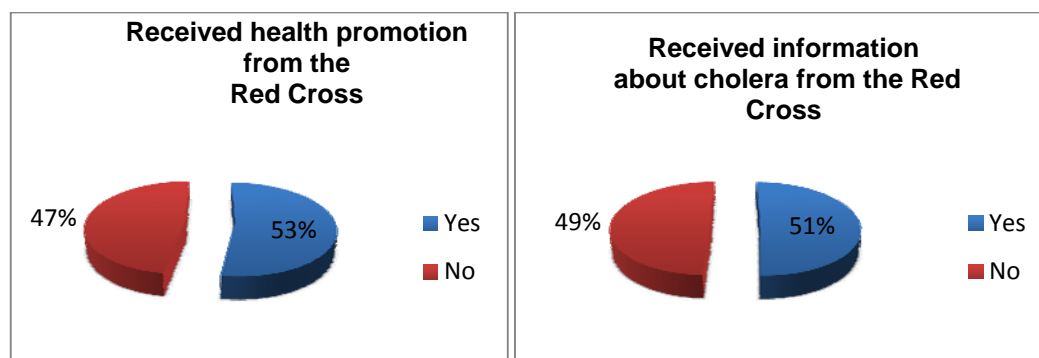
<p>communication tools, such as radio and SMS.</p>	<p>the cholera outbreak to disseminate practical, useful information on other areas of SLRCS programming.</p> <ul style="list-style-type: none"> • In partnership with UNICEF and the national telecommunications regulator, a more targeted SMS system will be established to allow individual communities to be targeted with information relevant to them, such as increases in cholera cases or the location of ORPs. This system would have use to the SLRCS beyond the cholera outbreak as a means of disaster warning and health education.
<ul style="list-style-type: none"> • Households will have improved knowledge related to four key hygiene messages; they will use safe sanitation and hygiene practices, and will also have improved access to safe water. 	<ul style="list-style-type: none"> • With the support of the CHM, the SLRCS will train 129 key community volunteers in five districts. • Community mobilisation activities will be established by the key volunteers, activating community based hygiene promotion volunteers (649). • Conduct KAP survey at the beginning of activities and in three to four months (end line will trial Mobile Monitoring Survey System). • Information, Education, Communication (IEC) materials, such as hygiene promotion discussion flip charts, and cholera awareness leaflets will be produced for use at ORPs and to disseminate to the population. • House to house hygiene promotion and social mobilization activities will be conducted, including information on health seeking behaviours and key prevention messages. • Peer educators and key school staff will be trained on cholera prevention in targeted areas. • The distribution and demonstration of the use of household water treatment products will be conducted at the household level, strategic water points and schools. • Village WASH committees will be reinvigorated to take a key role in prevention messaging and behaviour change.
<ul style="list-style-type: none"> • Targeted households have access to treatment and safe storage of drinking water. 	<ul style="list-style-type: none"> • 4,000 highly vulnerable households will be provided with NFI kits to ensure safe hygiene and sanitation practices.
<ul style="list-style-type: none"> • A maximum of 40 high risk water points are identified and bucket chlorination is implemented for a period of three months as a pilot project. 	<ul style="list-style-type: none"> • Bucket chlorination will occur where appropriate at strategic open water points for a period of three months in urban areas with a high population. • The major potential routes of transmission will be identified and targeted for hygiene promotion, such as food sellers in markets.
<ul style="list-style-type: none"> • The health, hygiene promotion and clinical activities are supported by emergency WASH hardware (infrastructure rehabilitation and construction) activities. 	<ul style="list-style-type: none"> • Minor repairs will be done of 20 water points used for public consumption in affected communities. • 40 institutional latrines will be built or rehabilitated • Institutional latrines will be disinfected over a period of three months, by request or need. • The RDRT will be deployed to provide technical and coordination support to the National Society, both in the field and at the national level. • Rehabilitation of up to 100 strategic water points/pumps

Progress: A Knowledge Attitudes and Practices (KAP) baseline survey was conducted among 405 respondents between 17 and 18 September and a follow up survey is planned to be conducted by the end of the operations. The main findings of the survey relate to cholera infection rates, means of treatment, defecation practices, hand washing, breastfeeding by sick mothers, and the ratio of households who have received information about cholera from the Red Cross.

During the KAP survey reporting period one household reported a death from cholera. 26% of HH reported at least one case of diarrhoea in the last three weeks. 40 persons reported a case of cholera within the house in the last

3 weeks. This is almost 10% of those surveyed which is higher than the current attack rates being reported. 79% of households reported using storage container with a lid, and 81% were confident that their water was safe. 55% of households reported treating their water while 87% of people reported defecating in a latrine and 10% access to a communal latrine. However the observed data reports 60% of HH surveyed had visible evidence of open defecation. Almost all houses were able to give at least one key time of the day for hand washing, but few knew all the key times. The majority of houses had a good understanding of ORS and SSS. 96% of HH knew what ORS was and 86% knew what SSS was. Most HH could name at least two correct reasons to use ORS. Just over 50% of households had received information about cholera from a Red Cross volunteer already, with approximately the same number reporting receiving health promotion.

Figure 4: Medium through which households received cholera messages



MSM ERU worked with FACT and SLRC in the roll out of the IFRC Cholera Operation KAP survey in Bombali and Tonkolili, identifying and training 11 enumerators from local universities and link teachers to undertake the work. ERU assisted in planning the logistics, pre testing and surveying approach. Survey work was undertaken over 4 days in September.

A mobile cinema has toured the districts, using events in schools and communities (public places such as markets, transport hubs) to engage people in hygiene promotion and give them an opportunity to ask key questions. During the reporting period, the cinema visited 12 schools and 24 communities, and more than 13,000 people have attended across five districts. Soap and cholera awareness leaflets were also distributed to participants at the events. The mobile cinema is scheduled to continue for the next two months reaching an additional 8,000 to 16,000 direct beneficiaries.

Mini cinema kits have been provided to branches in these districts to continue this work in smaller villages and schools. In addition, 500 wind-up, solar powered radios have been received in the SLRCS warehouse and will be distributed to identified communities through key volunteers to improve access to information for people without electricity or the means to buy batteries. By the end of October volunteers will be trained to set up listener groups around the radios.

A weekly one-hour talk-back radio show has been established allowing the SLRCS to discuss in more detail cholera related issues. This can be used beyond the cholera outbreak to disseminate practical, useful information on other areas of SLRCS programming. The first broadcast took place on 17 October 2012.

The establishment of a targeted, SMS system is being prepared through ongoing negotiations with telecommunication companies to allow individual communities to be targeted with selected information, such as increases in cholera cases or the location of ORPs. This system will have use to the SLRCS beyond the cholera outbreak as a means of disaster warning and health education.

Community mobilisation activities have been established by the key volunteers, activating community based hygiene promotion volunteer. WASH committees have been founded in 6 villages and the work of existing committees continue to be reinvigorated in the areas of operations. Bucket chlorination will be conducted at selected open water points in urban areas; with a high population. This activity is a pilot project to test the feasibility of using a liquid chlorine dosing system. Bucket chlorination has been implemented as a part of community based hygiene promotion in Bombali, Makeni market and transport park.

Two RDRT WatSan delegates are providing technical and coordination support to the National Society, both in the field and at the national level. Minor repairs of 20 water points used for public consumption in affected communities is on-going as well as the construction or rehabilitation of 40 institutional latrines. Disinfection of institutional latrines is also ongoing as the need arises, as well as the rehabilitation of up to 100 strategic water points/pumps. The RDRT delegates also provide for two SLRCS WatSan staff who will continue the activities of the program.

Table 4: Volunteers reached through different events

District	Community events	School events	Radio show	Total events	Direct beneficiaries	Indirect beneficiaries ¹	Total indirect and indirect beneficiaries
Western	7	0	0	7	1,430	-	1,430
Bombali	5	1	1	7	2,796	50,000	52,796
Tonkolili	5	3	1	9	3,660	50,000	53,660
Port Loko	5	3	1	9	2,505	50,000	52,505
Kambia	3	5	1	9	2,795	50,000	52,795
Total	25	12	4	41	13,186	200,000	213,186

¹ Radio show listeners are estimated at 50,000 per show. Number of indirect beneficiaries likely to be higher given that people will tell others in their community about what they have seen and heard.

Table 5: Summary of WatSan hardware activities in Kambia, Bombali, Port Loco and Tonkolili to date

	Finished	Ongoing	Pending
Rehabilitation of wells	4		1
Borehole pumps	1		
Sub-mer pump			2
Solar pump		1	
Hand pumps	14	7	2
New latrines at cholera treatment centres	5		
Rehabilitation of latrines	1	1	2
Garbage disposal	2		
Disinfection of pits and surrounding area	2		
Incinerator	2	1	
Disinfection spraying	2		
Hand and foot wash system in hospitals	3		
ORS water points at hospitals	3		
WASH committees	6	2	
Hand washing stands (not including CTCs)	4		
Temporary cholera ward at PHU	1		

Disaster Management and Capacity Building

The skills and resources of the SLRCS Headquarters and branches are available for rapid and efficient response to cholera and other water borne diseases as well as other emergencies

Outputs (expected results)	Activities planned
<ul style="list-style-type: none"> The Sierra Leone Red Cross branches will have both human and material resources in order to be able to respond quickly and effectively to future epidemics. 	<ul style="list-style-type: none"> District health management teams will be engaged and provided with support. Key equipment for future outbreak will be prepositioned. Two people from each of the ten branches will be trained on ECV. The development and revision of branch and community response plans will be supported. A Red Cross radio show will be created, as well as an SMS system that will allow the national society to respond quickly to future threats. Targeted branches will be provided with a mini cinema kit and a full PA system will be available at national office for community events and cinema for beneficiary communication activities. Conduct national disaster response team training (NDRT)
<ul style="list-style-type: none"> IFRC standard operational procedures will be implemented to support the ongoing operation (supplies, warehouse and fleet management). 	<ul style="list-style-type: none"> SLRCS staff will be given on the job training and capacity building on the receiving of relief goods and equipment, warehouse management, fleet management, procurement and reporting. An exit strategy will be developed on the mobilised fleet and central warehouse

	<ul style="list-style-type: none"> A logistic workshop will be organized.
<ul style="list-style-type: none"> A well coordinated response with shared plan resources, and reports leading to effective epidemic control. 	<ul style="list-style-type: none"> The progress of the program will continue to be reported on regularly. Coordination meetings will be regularly attended by team members, in all districts.

Progress: To ensure that skills and resources of the SLRCS HQ and branches are available for rapid and efficient response to future outbreaks of cholera and other water borne diseases, district health management teams have received support as a part of the operation. All oral rehydration points (ORPs) have been equipped with the necessary equipment and supplies to continue their work and the remaining equipment and supplies left behind by the ERU teams has been handed over to SLRCS HQ for prepositioning.

Two SLRCS staff from 14 branches received special 2 days epidemic control training from the SMS and the CHM teams to be able to conduct ECV training locally in the branches. Originally this training program aimed at covering 10 branches but it was possible to expand this activity to include all SLRCS branches in the country. The continuing training of volunteers and the established ORS points as well as hygiene/health activities support the revision and development of community response plans on branch level.

The establishment of a SLRCS radio show (one hour per week on national radio) is in its final stages. The show will initially address hygiene related concerns as part of the cholera response, but it is planned to become a permanent SLRCS activity that will allow the national society to respond quickly to other threats in the future. The targeted listener group is an estimated 250,000 people.

There are also on-going negotiations to establish a countrywide SMS system that will give the SLRCS the ability to reach an estimated 2.86 million beneficiaries with health messages (this number is based on 50% of the population having access to mobile phones).

The travelling cinema has already met the initial target of reaching 10,000 beneficiaries in all five districts in the north. Following a one week break it will run for another four weeks from the 15 October. It will reach a further 8000 beneficiaries, including schools and communities. Each branch is estimated to be able to reach 200 people per week for a minimum of two months starting from Monday, reaching an additional 14,400 beneficiaries. In total cinema activities are estimated to reach 22,400 beneficiaries in the period from 15 October until the 8 December.

Table 6: Water and sanitation, hygiene promotion and beneficiary communication beneficiaries

District	Activity area	Beneficiaries per activity area	Total beneficiaries
Western area	Water/sanitation hardware	0	1,430
	Hygiene promotion	0	
	Beneficiary communications	1,430	
Bombali	Hygiene promotion	234,860	287,656
	Beneficiary communications	52,796	
Tonkolili	Hygiene promotion	29,750	83,410
	Beneficiary communications	53,660	
Port Loko	Water/sanitation hardware	529,831	669,007
	Hygiene promotion	86,671	
	Beneficiary communications	52,505	
Kambia	Water/sanitation hardware	5,012	90,110
	Hygiene promotion	32,303	
	Beneficiary communications	52,795	
TOTAL			1,131,613

The National Society staff continue to benefit from on the job training with regard to management of relief goods and equipment, warehouse management, fleet management, procurement and reporting. A logistic workshop is planned before the end of October. An exit strategy will be developed on the mobilised fleet during later stages of the operation. The central warehouse will be exited at the end of 2012.

Taskforce meetings and C4 meetings continue to be attended by IFRC and SLRCS staff in Freetown. All ERUs have now exited the field but regional taskforce meetings continue to be attended by SLRCS branch staff. Regular reporting on the progress of the program will continue until the end of activities.

Logistics

Outcome: Provide logistics support to the CTC, water sanitation and hygiene activities	
Outputs (expected results)	Activities planned
<ul style="list-style-type: none"> That the operation is logistically well supported in their emergency activities. The warehouse containing ERU materials and other items purchased for the ongoing response is well managed Capacities of logistics staff within SLRC is strengthened. Well managed and inventoried handover process of ERU's. 	<ul style="list-style-type: none"> Purchase construction and NFI materials in a fair and transparent manner Set up and manage the warehouse facility in Freetown. Build capacity within SLRC staff with regards to good practice in warehouse management. Order items from IFRC Las Palmas if need be Further assess the needs in the field to inform programming Actively collaborate with all parties in executing ERU handover process.

Progress: Through the appropriate use of IFRC procurement procedures, construction and NFI materials have been purchased. The capacity of warehouse staff is being built through on the job training through the daily warehouse operations. Support for local procurement, fleet management, reception, clearing and forwarding of international shipments is being provided to the national society. Branch warehouses in Port Loko, Kambia, Bombali and Tonkolili have been assessed with regard to prepositioning of NFI kits. Assessment of branch warehouses in Kenema and Bo with regard to prepositioning of materials from ERU teams is planned.

NFI kits for distribution to 4,000 most vulnerable households are in the process of being procured. Soap and buckets have been purchased and are already in the SLRCS warehouse. Aqua tabs and oral rehydration solution will be prepositioned by mid October and distributed to beneficiaries.

Table 7: Non-food items to be prepositioned.

Items	Unit	Port Loko	Kambia	Makeni	Magburaka	Total
Bucket,	pieces	1,000	1,000	1,000	1,000	4,000
Soap(80gms)	pieces	6,000	6,000	6,000	6,000	24,000
ORS sachets	Boxes	20	20	20	20	80
Aqua tabs	Boxes	9.5	9.5	9.5	9.5	38
Aqua granules	Tubes	6	6	6	6	24

Communications – Advocacy and Public information

SLRC continues to maintain a steady flow of timely and accurate information between the field and other major stakeholders for fundraising, advocacy and maintaining the profile of emergency operation. This is an essential mechanism for effective disaster response and the cornerstone to promote greater quality, accountability and transparency. The communications activities planned will support the National Society to improve its communications capacities and develop appropriate communications tools and products to support effective operations.

Capacity of the National Society

The SLRCS has extensive experience in community mobilization and hygiene awareness activities. The National Society has been involved in the implementation of a long-term community-based health program in all districts in the country and active volunteers are already in place. During this operation through the support of the ERUs, the National Society has trained and mobilized 778 Red Cross volunteers from within the affected communities to assist in social mobilization activities. The SLRCS has a branch in each of the 14 districts in the country, with a total number of 3,776 active volunteers. A new SLRCS Act was passed on 22 August 2012 and enhances the status of the National Society while reinforcing auxiliary role of SLRC to the Government.

Capacity of the IFRC

The IFRC is supporting operations in Sierra Leone from its Regional Representation in Abidjan, Ivory Coast and does not have a permanent representation in the country. A multi-sectoral FACT is in country and reporting directly to the Regional Representative for Africa West Coast. Two RDRTs have also been sent to provide support to the ongoing implementation of this response. The Regional Representative for Africa West Coast will provide direct support to the IFRC and the SLRCS personnel involved in the operation to ensure the activities are being implemented efficiently, according to movement principles and following international SPHERE standards. A second line technical support will be provided by the West Africa support hub (Sahel Regional Representation) and the IFRC Africa Zone office in Nairobi.

Contact information

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

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

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How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

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

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Saving lives, changing minds.



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

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
 2. Enable healthy and safe living.
 3. Promote social inclusion and a culture of non-violence and peace.
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MDRSL003 - Sierra Leone - Cholera Epidemic

Appeal Launch Date: 13 aug 12

Appeal Timeframe: 13 aug 12 to 28 feb 13

Interim Report

Selected Parameters	
Reporting Timeframe	2012/8-2012/9
Budget Timeframe	2012/8-2013/2
Appeal	MDRSL003
Budget	APPROVED

All figures are in Swiss Francs (CHF)

I. Funding

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	Deferred Income
A. Budget	1,358,780					1,358,780	
B. Opening Balance	0					0	
Income							
<u>Cash contributions</u>							
<i>British Red Cross</i>	30,314					30,314	
<i>Japanese Red Cross Society</i>	38,000					38,000	
<i>Swedish Red Cross</i>	211,089					211,089	
<i>The Canadian Red Cross Society</i>	5,940					5,940	
C1. Cash contributions	285,342					285,342	
<u>Inkind Personnel</u>							
<i>Other</i>	2,670					2,670	
C3. Inkind Personnel	2,670					2,670	
C. Total Income = SUM(C1..C4)	288,012					288,012	
D. Total Funding = B +C	288,012					288,012	
Coverage = D/A	21%					21%	

II. Movement of Funds

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	Deferred Income
B. Opening Balance	0					0	
C. Income	288,012					288,012	
E. Expenditure	-115,448					-115,448	
F. Closing Balance = (B + C + E)	172,564					172,564	

Selected Parameters	
Reporting Timeframe	2012/8-2012/9
Budget Timeframe	2012/8-2013/2
Appeal	MDRSL003
Budget	APPROVED

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination		
A							B	A - B
BUDGET (C)		1,358,780					1,358,780	
Relief items, Construction, Supplies								
Shelter - Relief	1,000						1,000	
Construction Materials	13,340						13,340	
Water, Sanitation & Hygiene	389,590						389,590	
Medical & First Aid	14,960						14,960	
Teaching Materials	9,300						9,300	
Utensils & Tools	20,000						20,000	
Other Supplies & Services	44,000						44,000	
Total Relief items, Construction, Su	492,190						492,190	
Land, vehicles & equipment								
Computers & Telecom	8,420	3,194				3,194	5,226	
Office & Household Equipment	2,550	561				561	1,989	
Medical Equipment	50,000						50,000	
Total Land, vehicles & equipment	60,970	3,754				3,754	57,216	
Logistics, Transport & Storage								
Storage	15,000						15,000	
Distribution & Monitoring	2,000						2,000	
Transport & Vehicles Costs	44,084	2,360				2,360	41,723	
Total Logistics, Transport & Storage	61,084	2,360				2,360	58,723	
Personnel								
International Staff	229,000	5,136				5,136	223,864	
National Society Staff	25,575						25,575	
Volunteers	27,532						27,532	
Total Personnel	282,107	5,136				5,136	276,971	
Consultants & Professional Fees								
Consultants	15,000						15,000	
Total Consultants & Professional Fe	15,000						15,000	
Workshops & Training								
Workshops & Training	105,000						105,000	
Total Workshops & Training	105,000						105,000	
General Expenditure								
Travel	115,429	12,532				12,532	102,897	
Information & Public Relations	30,120						30,120	
Office Costs	5,050						5,050	
Communications	27,900	480				480	27,420	
Financial Charges	5,000	2,744				2,744	2,256	
Other General Expenses	76,000						76,000	
Total General Expenditure	259,499	15,756				15,756	243,743	
Operational Provisions								
Operational Provisions		81,558				81,558	-81,558	
Total Operational Provisions		81,558				81,558	-81,558	
Indirect Costs								
Programme & Services Support Recov	82,930	6,883				6,883	76,047	
Total Indirect Costs	82,930	6,883				6,883	76,047	
TOTAL EXPENDITURE (D)	1,358,780	115,448				115,448	1,243,332	
VARIANCE (C - D)		1,243,332				1,243,332		