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Emergency appeal final report
Sierra Leone: Cholera outbreak

International Federation of Red Cross and Red Crescent Societies

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Final report

Emergency appeal n° MDRSL003
GLIDE n° EP-2012-000041-SLE
31 July, 2013

Period covered by this Final Report: 16 August 2012 - 30 April 2013

Appeal target (current): CHF 1,061,852

Appeal coverage: 107% ***<click here to go directly to the final financial report or here to view the contact details>***

Mangay Loko Village, Bombali district: 27 years old Red Cross volunteer, Issa. M. Sesay, demonstrates to Sorie I Koroma and his family how to make sugar and salt solution for rehydration of cholera patients. Samura, Sorie's 14 years old daughter became sick with cholera in September. She received oral rehydration solution from Red Cross volunteers and was referred to the public health unit where she was administered intravenous fluid. Photo/SLRCS

Appeal history:

- A **Preliminary Emergency Appeal** was launched 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.
- An **Emergency Appeal** was launched on 17 September 2012 for CHF 1,358,780 to support the Sierra Leone Red Cross Society (SLRCS) to assist 1,539 206 direct and 2,000,000 indirect beneficiaries for six months.
- **Operations update no. 1,** published on 24 October and provided a progress update on the deployment of a Field Assessment and Coordination Team (FACT) and 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.
- **Operations update 2** and the **Revised Emergency Appeal** were published on December 29, 2012, aligning activities with anticipated funding. Budget was revised to CHF 1,061,852.
- **Operations Update 3** was published on February 15, 2013, extending the operation with one month due to late arrival of funds.
- **Operations update 4** was published on March 11, 2013, extending the operation with one additional month to finalize the TERA messaging system implementation.

Summary:
917,000 direct beneficiaries were targeted with emergency health and care, water, sanitation and hygiene promotion. 2,000,000 people were targeted with SMS messaging, and 2,350,000 people with radio health and hygiene messages. The appeal target included also rehabilitation or construction of 120 strategic water points and 40 latrines. The operation targeted 778 volunteers with epidemic control training (ECV), 129 volunteers were targeted with training on case definition and reporting.

23 cholera treatment centres (CTC) were established in hospitals and health unit, treating 7,280 cases of cholera. 380 oral rehydration points were established, benefitting an estimated 380,000 people. Through the operations 1,388,106 people (151% of target) have been reached with hygiene promotion. More than 2,000,000 SMS messages have been sent through the TERA SMS system, and a SLRCS radio show is broadcast countrywide on a weekly basis in addition to local radio programming by several branches estimated to reach more than 2,000,000 million beneficiaries. 101,696 beneficiaries were reached through construction and/or rehabilitation of 111 water points (92% of target) and 29 latrines (72% of target). 1,232 volunteers were trained in ECV (158% of target), and 97 on case reporting (75% of target).

Emergency health and care:

- During the first stages of the Sierra Leone cholera operation three emergency response units were operational in four districts. A BHC ERU supported 23 Primary Health Unit (PHUs) and two district hospitals through the establishment of Cholera Treatment Centres (CTC), treating some 7,289 cases of cholera.
- 130 Red Cross volunteers were trained by the CHM ERU and MSM ERU in case finding, surveillance and referral. These cascaded their knowledge to 647 additional volunteers. These volunteers have participated in case finding and referral at 419 oral rehydration points (ORPs) in 4 districts. From November an additional 455 key volunteers were trained in ECV (epidemic control for volunteers) by the SLRCS in all districts, cascading their knowledge to 9,100 community volunteers. 820 school children and 40 teachers were trained in hygiene promotion in all districts.
- 380 ORPs were established through the operation, benefitting an estimated total of 380,000 people.
- 97 ORP volunteers were trained to report weekly on the number of people with watery diarrhoea treated at all ORPs.

Water, sanitation and hygiene promotion:

- An additional 904,649 beneficiaries benefitted from hygiene promotion activities by SLRCS/IFRC from October until April 2013 (including radio listener clubs, 16,000 people benefitted from hygiene messaging at ORP's, 38,828 people benefitted from hygiene promotion through touring cinema, and 101,696 people benefitted from hygiene promotion related to WatSan hardware installations. This brings the total direct beneficiaries of hygiene promotion to 1,388,106 people.
- The weekly SLRCS Red Cross show established as a part of the cholera operation continues on a permanent basis, reaching an estimated 2,000,000 people with hygiene and health information.
- The SMS TERA system established as a part of the operation targets mobile phone users in all districts with hygiene SMS messages on a permanent basis. More than 2,000,000 SMS messages have been delivered
- A cholera behaviour change communication strategy and set of recommendations for the sustainability of beneficiary communication activities have been developed, based on the results of a mini KAP survey (Knowledge, Attitudes and Practices). This strategy provides recommendations to SLRCS on the key audiences, messages and channels to focus on to reduce the impact of future cholera outbreaks.
- By the end of December the touring mobile cinema had reached 38,018 direct beneficiaries in 5 districts Out of these 18,828 were school pupils. 16,018 people who attended the cinema received soap and 8,500 received leaflets.
- 317,573 direct beneficiaries in the four initially targeted districts were reached through targeted community mobilization supported by the CHM and MSM ERUs (community and school gatherings, house to house visits, community sensitization campaigns). Another 272,301 direct beneficiaries in all districts were reached through the same type of activities as well as branch mobile cinema (implemented by SLRCS, supported by the IFRC operational team in Sierra Leone).
- The operation reached 9,360 direct beneficiaries through the distribution of 468 wind-up radios to an equal number of radio listening groups managed by SLRCS volunteers.
- Through the oral rehydration points (ORP's) 800 health promotion volunteers 7 in 5 districts (Western Area, Kambia, Port Loko, Tonkolili and Bombali) reached 16,000 beneficiaries.
- A KAP survey was completed in September and a follow-up survey using RAMP was conducted during the first week of March.
- A total of 455 key volunteers were trained in epidemic control for volunteers, 820 peer educators in schools and 40 school teachers were trained in hygiene promotion by the SLRCS in the post-emergency phase from November until end of April. (This is in addition to the 647 volunteers trained by the ERUs as mentioned above.)

- NFI household kits (aquatabs, soap, buckets and ORS) were distributed to the 4,000 most vulnerable households in Port Loko, Bombali, Kambia and Tonkolili in November.
- Totally 101,696 direct beneficiaries were reached with WatSan hardware activities through the operation. In the 4 targeted districts, by the end of April, 62,312 people had been reached through construction and rehabilitation of a total of 111 water points, and 21,730 people were reached through the construction and rehabilitation of a total of 29 latrines. An estimated additional 17,654 direct beneficiaries were reached by construction of garbage disposal areas, disinfection pits, incinerators, disinfection spraying, hand and foot washing areas.
- An IFRC Cholera Operational Review was conducted between December 2012 and January 2013.
- SLRCS and IFRC health team held a lessons learnt workshop on the cholera response on 2 February.
- A SLRCS PHAST ToT Refresher course took place between 5 February and 9 February 2013.

Disaster Management and Capacity Building

- A Trilogy Emergency Relief Application (TERA) SMS system was installed at telecommunications company Airtel in Sierra Leone and handed over to SLRCS. During the last week of April the SLRCS sent out over 2 million SMS health promotion messages through the TERA SMS system and reached around 1.4 million people. This system will continue to send out millions of SMS messages per month as a permanent part of SLRCS activities. In addition telecommunications companies Comium and SierraTel who were not able to install the TERA system have signed an agreement to issue messages on behalf of the SLRCS.
- Through the operation 380 ORPs have already been established in the four districts of Kambia, Port Loko, Tonkolili and Bombali. Volunteers have been trained in all districts to operate ORPs, ensuring a quick response by the SLRCS in establishing new ORPs in affected areas in case of another cholera outbreak.
- Before the departure of the CHM and MSM emergency response units (ERU's) 20,000 sachets of ORS were distributed to 14 branches for contingency from Norwegian RC donation. Presently registered cholera contingency stocks at the SLRCS HQ include 500 back packs for volunteers, 150 pairs of disposable gloves, 5,734 sachets of ORS, and one PHAST tool kit.

Finances: This Emergency Appeal received 107% of the requested funding, which allowed a continuation of most activities in the two months extension period. Unfortunately a revised budget was not posted with the timeframe extension operations update, which has caused unauthorized expenditures in the following budget lines: an over expenditure of CHF 16,420 (+12%) on Water, Sanitation and hygiene promotion due to extension of activities, and over expenditure of CHF 16,289 (+50%) on trainings and workshops due to increased activities based on available funding. An unbudgeted expenditure of CHF 39,019 occurred on consultants as the finance delegate was hired through a consultancy contract. A total of CHF 145,763 was transferred to the Norwegian Red Cross as replenishment of ERU deployment expenses funded by ECHO. This includes ERU personnel, travel and ERU running costs. After completion of the operation, a positive balance of CHF 52,289 remains. This will be reallocated to the regional Disaster Management budget to support DM activities in Sierra Leone.

Lessons learned

Overall the response strategy for Sierra Leone was relevant and added value to the overall response to the cholera epidemic. Some actions could have taken place earlier, but the intervention did reduce the impact of the epidemic through the community hygiene sensitisation programme. This was done through the establishment of 380 Oral Rehydration Points (ORP), through the provision of adequate supplies of ORS and Aqua-tabs, through WatSan interventions at the community and district levels and through case management and technical support for district hospitals. The excellent capacity of the Sierra Leone Red Cross Society (SLRCS) and their close relationships with national and local health authorities has proved critical to the success of the programme.

The establishment of ORPs and the large sensitisation programme were major factors in reducing the impact of the epidemic, especially in regard to reducing the case fatality rate (CFR) and reducing the impact on the government health structures which had reached maximum capacity during the height of the epidemic.

The impact of the operation has been documented in an IFRC cholera operational review, a Sierra Leone government cholera operation lessons learned report, an IFRC ERU review (CBHFA analysis), and a KAP survey report.

The operation greatly contributed to the capacity of the national society through staff and volunteer training and lessons learnt from the activities. Through the implementation of cholera response activities SLRCS gained valuable experience and more ability to respond effectively to similar disasters in the future.

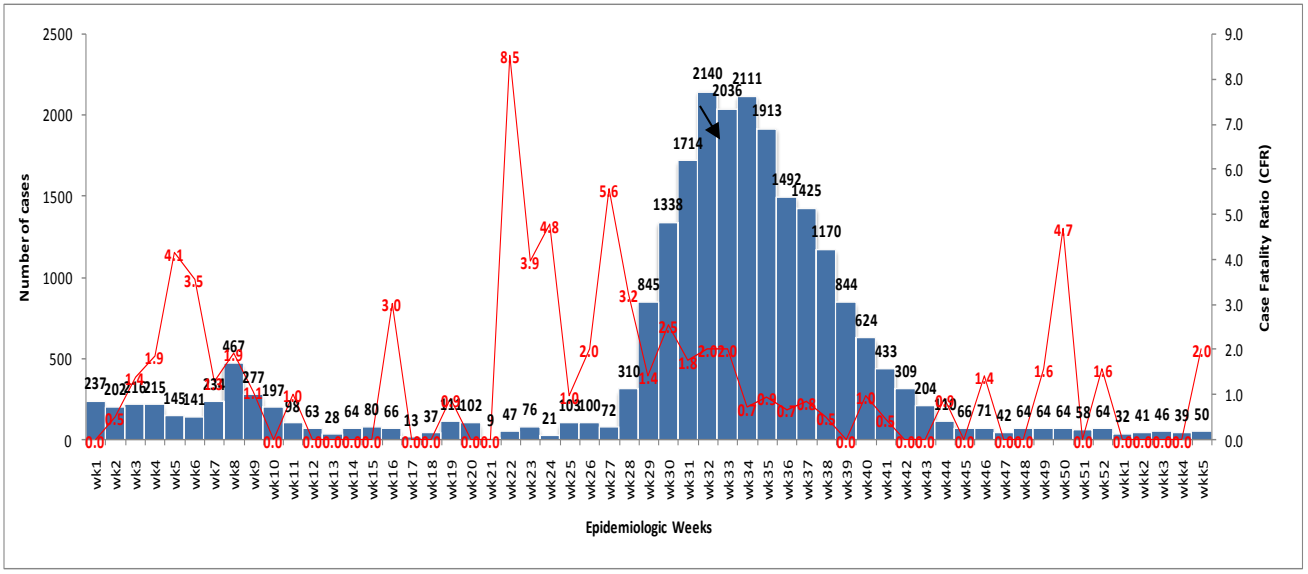
Throughout the operation the IFRC worked within the coordination framework established by cholera task force headed by the SL ministry of health. IFRC and SLRCS met regularly with other implementing agencies and organizations to ensure effective coordination of activities.

In all activities an effort was made to ensure participation of all age groups, men and women, and gender ratio among beneficiaries is well documented in operational reports, showing a healthy gender balance in most activities where it was possible.

The situation

An outbreak of cholera was declared in February, 2012. On 11 July 2012, the Sierra Leone Ministry of Health and Sanitation lab confirmed cholera in the Western District. A significant and rapid rise in cases of cholera can be seen in the graph below. The 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 reporting cholera cases. Only four districts reported cholera cases during the 1 week of 2013 Kenema (6), Tonkolili (2), Bombali (2) and Kambia (6).

Figure 1, national trend of cholera cases 2nd Jan 2012 to 11th Feb 2013 (Source: MoH).



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. The total cumulative from 1 January 2012 – 11 February 2013 was 23220 cases, including 300 deaths (case fatality rate (CFR) = 1.29). The cholera case fatality ratio by district between 1 January 2012 and 11 February 2013 is shown in the table below as well as a table of cumulative CFR by district. The majority of new cases in week six were in Kambia and Kenema.

National Cumulative summary of Cholera Cases 1 January 2012-11 February 2013

Name of affected district	District Population	Cumulative Number as reported between 1 January 2012 and 11 February 2013				CFR	Attack Rate
		Cases			Deaths		
		<5	≥5	Total			
Western Area	1,243,804	1400	10405	11805	97	0.8	0.95
Port Loko	529,831	1740	1720	3460	58	1.7	0.65
Kambia	324,769	282	1378	1660	32	1.9	0.51
Pujehun	320,686	391	645	1036	14	1.4	0.32
Bo	624,386	80	589	669	17	2.5	0.11
Bombali	469,064	204	1128	1332	16	1.2	0.28
Moyamba	262,725	37	356	393	15	3.8	0.15
Tonkolili	413,276	154	1128	1282	35	2.7	0.31
Bonthe	160,114	75	260	335	10	3.0	0.21
Kono	305,952	27	166	193	2	1.0	0.06
Kenema	621,750	77	883	960	4	0.4	0.15
Koinadugu	318,849	6	89	95	0	0.0	0.03
TOTAL	**5,595,206**	**4,473**	**18,747**	**23,220**	**300**	**1.29**	**0.41**

The overall risk factors for water related diseases, and cholera specifically remain extremely high in Sierra Leone in general. Throughout the country there is a lack of sanitation facilities, inadequate quality and quantity of water sources (water points and public water networks) and insufficient waste management and access to health care can be limited in some areas.

The outbreak stabilized late 2012 and due to the considerably lower case load, the remaining activities focused primarily on WatSan hardware, hygiene promotion and expanding the network of SLRCS volunteers capable of managing ORPs, reporting on cases, and hygiene promotion. Given the fact that cholera outbreaks occur every year in Sierra Leone, repeated outbreaks are likely to occur in the coming years. The activities in the revised appeal have been crucial with regards to reducing the risk of cholera epidemics, as well as lowering the number of cases and the case fatality rate in future outbreaks.

Red Cross and Red Crescent action

Achievements against 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**
A mobile BHC is operational and providing clinical case management support starting in four target districts (Port Loko, Kambia, Bombali and Tonkolili) and/ or as per need based on evolution of the epidemic.	• 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
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.	• 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.
The existing community volunteer referral system for patients who show signs of cholera will be reinforced.	• 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.
Households have improved knowledge of prevention, symptoms, early treatment and the correct way to manage cholera.	• 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. • 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.
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.	• 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**
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.	• Community surveillance will be set-up through 40 selected ORS points. • 129 ORS volunteers will be trained on case definition and reporting.
Contribute to improved data management at the national level.	• 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.

BHC ERU (clinical case management)

The mobile BHC ERU completed its activities during the first half of October and handed over all materials to the MoH and the SLRCS. The Finnish Red Cross BHC ERU supported by the Japanese Red Cross supported 23 Primary Health Unit (PHUs) and two district hospitals through the establishment of Cholera Treatment Centres (CTC). These clinics treated some 7,289 cases of cholera during the weeks 32 - 40. The teams provided capacity building and training for staff and volunteers on cholera transmission. Following the exit of the Finnish Red Cross ERU at the beginning of October, all drugs and medical items were donated to the Ministry of Health and Sanitation.

ECV (Epidemic Control for Volunteers) ToT training and cascading

The CHM ERU completed all its activities during the first half of October. As was previously reported (MDRSL003 Operations Update no. 1), in October 130 Red Cross volunteers in Bombali, Tonkolili, Port Loko and Kambia were trained by the CHM ERU team in case finding, surveillance and referral (Epidemic Control for Volunteers (ECV). Out of these 108 volunteers served as 'key' volunteers in cascading knowledge of cholera treatment and prevention at community level to 647 additional volunteers, bringing the total number of trained volunteers to 778, in line with original plans. These volunteers have participated in case finding and referral in 419 oral rehydration points (ORPs) in 4 districts. Detailed accounts of completed activities are available in **operations update no 1.**

	Total volunteers trained through ERU operations who were reporting in October 2012			
District/ Branch	Key volunteers	Community volunteers	Total volunteers	Total number of ORP
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**

These numbers are provided directly by branch health officers on 22 October. In Bombali and Tonkolili there were two volunteers per ORP, but in Port Loko and Kambia there is one volunteer per ORP.

Supported by the IFRC, ECV training was completed in all districts at the beginning of March 2013. The first six training sessions had earlier been postponed due late arrival of funds. All ECV training had previously been planned to be completed by the end of February. 35 key volunteers in each district received ECV training in each of the 14 districts of the country. Each of the key volunteers cascaded their ECV knowledge to an additional 20 community volunteers, or a total of 700 community volunteers in each district. Additionally 63 school children and 3 link teachers in each of the 14 districts received hygiene promotion training.

Volunteers trained trained by SLRCS in all districts as a part of the IFRC cholera operation in the post-emergency phase after the departure of the ERU's	
No of key volunteers trained in ECV	455
No of community volunteers receiving ECV messages from key volunteers	9,100
No of school children trained in Hygiene promotion	820
No of link teachers trained in HP	40

Establishment of ORS points

Through the operation 380 ORPs were established in Kambia, Port Loko, Bombali and Tonkolili during the emergency phase of the operation (a total of 419 ORPs were confirmed to exist in the four areas on 22 October 2012). 380,000 people (an estimated 1,000 people per ORP) benefitted from the ORPs that were established through the operation. Due to the persistently low cholera attack rates that have been experienced for more than three months any plans to extend the network of active ORP´s during the present operation have been cancelled. Instead there has been a strong emphasis on contingency planning and prepositioning of stocks. For details please refer to **operations update no1.**

Community based cholera case surveillance system (Case definition and reporting) (training of 129 volunteers)

During the emergency phase of the operation a community based cholera case surveillance system was established in Kambia, Port Loko, Bombali and Tonkolili.[1] 97 ORP volunteers (The total of surveillance volunteers trained by NRC ERU team and reporting on 22 October 2012) reported weekly on the number of people with watery diarrhoea treated at ORPs. Data has been collected from key volunteers in the districts. In addition community deaths were reported. Case monitoring activities and sensitization continue in the four targeted districts.

[1] Information on the establishment of the case surveillance system has been detailed in MDRSL **situation report no 16**,

Provision of zinc
The operation as outlined in the appeal originally included the possibility of zinc distribution to all patients under the age of five administered by ORP volunteers. In consultation with the MoH the planned feasibility study for this activity has been cancelled. All patients under five were referred to the nearest health clinic where zinc distribution was covered by the MoH.

Epidemiological surveillance
The epidemiologist in the IFRC team regularly participated in coordination meetings until end of mission in October. Epidemiological surveillance and analysis of MoH data was continued by IFRC health delegate until end of mission on the 17th of March. Regular analysis and predictions related to the epidemic based on data collection, was shared with other implementing partners.

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**
A behavioural change communication strategy will developed, which will help the SLRCS tackle barriers to good hygiene.	• 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.
Ten thousand people will benefit from improved hygiene knowledge through interactive community and school events.	• 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 SLRCS social mobilisation activities in public places (markets, transport hubs) with local partners.
Eight thousand households will have improved access information through the distribution of 400 radios.	• Wind-up, solar powered radios will be distributed to identified communities through key volunteers to improve access to information for people deprived of electricity and the means to buy batteries.
Two million indirect beneficiaries will have better access to information through mass communication tools, such as radio and SMS.	• 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 the cholera outbreak to disseminate practical, useful information on other areas of SLRCS programming. • 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.
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.	• 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.
Targeted households have access to treatment and safe storage of drinking water.	• Four-thousand highly vulnerable households will be provided with NFI kits to ensure safe hygiene and sanitation practices.
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.	• 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.
The health, hygiene promotion and clinical activities are supported by emergency WASH hardware (infrastructure rehabilitation and construction) activities.	• Minor repairs will be done of 20 water points used for public consumption in affected communities. • Forty 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

Water, sanitation and hygiene promotion: Divided by activity	**Number of direct beneficiaries***
MSM/CHM Hygiene promotion	317,573
SLRCS/IFRC Hygiene promotion	904,649
Radio listener clubs	9,360
Hygiene messaging at ORPs	16,000
Touring cinema	38,828
WatSan hardware with hygiene promotion	101,696
Total:	**1,388,106**

***Numbers exclude figures for training volunteers. Also, particularly in the four districts of Kambia, Port Loko, Bombali and Tonkolili in some cases the same beneficiaries may have been counted in more than one of the listed activities.**

Behavioural change communication strategy and development of key messages

As previously outlined in **operations update 2**, a cholera behaviour change communication strategy and set of recommendations for the sustainability of beneficiary communication activities were developed based on the results of a mini KAP survey (Knowledge, Attitudes and Practices). This strategy provided recommendations to SLRCS on the key audiences, messages and channels to focus on to reduce the impact of future cholera outbreaks.

Mobile cinema tour, branch cinema kits, community and school events (excluding health promotion activities that were part of WatSan activities)

By the end of December the touring mobile cinema had reached 38,018 direct beneficiaries in 5 districts Out of these 18,828 were school pupils. 16,018 people who attended the cinema received soap and 8,500 received leaflets.

Separately mobile cinema activities continue on branch level as a permanent component of their activities after the end of the cholera operation, focusing on schools, market places and communities. School and peer education clubs have been trained to run the mobile cinema activity in their schools. The branch cinemas are not a part of the touring cinema, and beneficiaries are counted separately. All SLRCS branches have been equipped with their own cinema equipment and this activity will continue under the direction of the branch health officers and SLRCS CBHP department.

Through the support of the IFRC ERUs during the emergency phase of the operation a total of 317,573 direct beneficiaries were specifically reached through targeted community mobilization (community and school gatherings, house to house visits, community sensitization campaigns and branch mobile cinema) by 647 volunteers in 5 districts Western Area, Kambia, Port Loko, Tonkolili and Bombali during the emergency phase of the operation. These activities were all supported by the CHM and MSM ERU's that exited the country at the beginning of October 2012.

Another 904,649 direct beneficiaries in the whole country, (of these 485,569 were in the five districts of Kambia, Port Loko, Bombali and Tonkolili), were reached through the same type of activities (implemented by SLRCS, supported by the IFRC operational team in Sierra Leone), from October 2012 until end of April 2013. In the whole of Sierra Leone, 309,583 school children were reached with hygiene promotion/sensitization in schools,176,652 direct beneficiaries received hygiene/health messages through household visits, 39,555 direct beneficiaries were reached through community meetings, 317,491 through community sensitization, and 52,393 through branch mobile cinema.[2]

Radio Listening Groups (wind-up solar radios)
178 SLRCS radio listening groups were established through the operation in the five districts of Western Area, Kambia, Port Loko, Bombali and Tonkolili as part of the operation following the distribution of 468 wind up radios to hygiene promotion volunteers that have been trained through ECHO supported activities of the operation. (The Radio hardware was donated by the NZRC). The hygiene promoters disseminate health/hygiene related information to the group, who also listens to the weekly SLRCS radio show and receives other related hygiene messages. This activity includes an estimated 9,360 direct beneficiaries (average of 36 groups per branch, 20 members per group).

Through the oral rehydration points (ORP's) 800 health promotion volunteers in 5 districts (Western Area, Kambia, Port Loko, Tonkolili and Bombali) were estimated to have reached 20 direct beneficiaries each through health and hygiene messages. An estimated 16,000 beneficiaries were reached through this activity.

SLRCS Radio Show
The SLRCS Red Cross show established as a part of the cholera operation continues on a weekly basis, and the radios that have been distributed continue to be used by SLRCS listener groups on a permanent basis. The weekly Red Cross nar Salone radio show dedicates one full show to cholera every six weeks, focusing on less well known topics such as food and water safety. The SLRCS radio show reaches an estimated 2,000,000 people with hygiene and health information on a regular basis.

Follow-up KAP Survey using RAMP system
A Knowledge Attitudes and Practices **(**KAP) baseline survey was conducted among 405 respondents between 17 and 18 September and an end-line survey using a rapid mobile phone-based survey system (RAMP) 6-9 February 2013[3] [4] with a sample size of 406 households. 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. Results and analysis of the first survey have already been completed and a summary was presented in operations update no 1.

Training of Peer Educators and School Staff on Cholera Prevention

[2] Data on beneficiary numbers was updated by the SLRCS Health department in May 2013. Beneficiary data covers the period October 2012 until April 2013.
[3] International Federation of Red Cross and Red Crescent Societies, End-line KAP survey with 2-day introduction course for RAMP, RAPID MOBILE PHONE-BASED SURVEY, Progress Report, Freetown, 4th -9th March 2013
[4] Detailed information in MDRSL003 situation report no 14.

It was reported in operations update no 1 that during the emergency phase of the operation community mobilisation activities were established by the key volunteers, activating community based hygiene promotion volunteers. These activities were supervised by the MSM and CHM ERU's operating in Kambia, Port Loko, Bombali and Tonkolili. Totally 108 key volunteers and 503 community volunteers
were trained through the ERU operations and reporting in November 2012. A total of 455 key volunteers,9100 community volunteers, 820 school children and 40 link teachers were trained in hygiene promotion by the SLRCS in all 14 districts of the country in the post-emergency phase of the operation following the departure of the ERU in October.

Distribution of Household Water Treatment Products/ Non Food Items
As was previously outlined in MDRSL situation report no 15, distributions of NFI household kits to the 4,000 most vulnerable households (estimated 24,000[5] beneficiaries) in Port Loko, Bombali, Kambia and Tonkolili was completed by the end of November and was monitored by the IFRC health delegate The criteria used for the selection was that the village had not already received comparable assistance from other actors, and that there were SLRCS volunteers in the village. Each household received kits consisting of 15 strips of aquatabs (10 tabs of 76mg per strip), 6 bars of soap, 1 20L bucket and 2 sachets. Before the distribution, Red Cross volunteers gave instructions on hand washing and water chlorination.

District	Number of chiefdoms	Number of villages
Port Loko	7	33
Kambia	3	10
Bombali	5	23
Tonkolili	4	11

Bucket Chlorination
It was previously reported in operations update no 1 that as a pilot project to test the feasibility of using a liquid chlorine dosing system, bucket chlorination was conducted at selected open water points in urban areas with a high population. The pilot project was implemented as a part of community based hygiene promotion in Bombali, Makeni market and transport park.

WatSan hardware rehabilitation, construction and RDRT Deployment
In the early stages of the operation two WatSan RDRT worked within the four initially targeted districts: Port Loko, Bombali, Kambia and Tonkolili. The WatSan RDRT left Sierra Leone on 14 November. A WatSan delegate supported the operation from the arrival of the FACT team in August, until the 20th of January. Two local SLRCS WatSan officers continued the implementation of WatSan activities in the field until the end of April. The regional IFRC WatSan delegate based in Abidjan was in Sierra Leone between 1st and 12th February 2013 and provided support to SLRCS WatSan officers and PHAST training.

WatSan activities, as part of the cholera operation continued until end of April. The total targeted number of projects included the rehabilitation and construction of 120 water points and 40 latrines. The construction or rehabilitation of 79% of targeted water points and 90% of targeted latrines was completed.

At the end of April 2013 rehabilitation or construction of an additional 95 water points and 36 latrines were completed in Kambia, Port Loko, Bombali and Tonkolili but the exact figures have not yet been confirmed. An estimated 117,216 people benefited from latrines and wells completed at the end of April 2013 as a part of the cholera operation. WatSan committees were established or re-established in these areas ensuring that the beneficiaries of hardware (water treatment units, aqua tabs etc.) were also direct beneficiaries of hygiene promotion aiming at bringing on behavioural change in household storage, usage and management of safe water.

[5] Beneficiary number is calculated by estimating household size at an average of 6 people

	4 districts	Total all districts	Total all districts
Activity	Number of projects	Beneficiary numbers	Projects as % of Appeal
water points	95	73,862	79%
latrines	36	29,700	90%
0ther**	9	13,654	n/a
	140	**117216***	

***Beneficiary numbers are calculated from the average number of beneficiaries of confirmed projects in the districts of Port Loko, Kambia, Bombali and Tonkolili at the end of April 2013.**
**** Garbage disposal, disinfectant pits/area, incinerator, disinfectant spraying, Hand/foot wash Hospital**

Locations of hardware installations were selected by identifying communities that were severely affected by the cholera epidemic, and were also underserved with respect to access to water and hygiene facilities. Cholera epidemics traditionally originate in the area of Kambia, spreading into Port Loko, Bombali and Tonkolili, and by improving water access and hygiene in key infection routes it is hoped that the severity of future outbreaks may be controlled to some extent. A number of randomly selected project sites were visited for monitoring purposes.

IFRC Sierra Leone Cholera Operational Review (Global ERU review)
All ERUs had exited their operational areas by the middle of October. An IFRC Cholera Operational Review (global ERU review) was conducted between December 2012 and January 2013. Its findings were published in a report in January 2013.[6] Findings underlined the importance of training volunteers and the establishment of ORP´s as appropriate responses to the epidemic. The SLRCS ORP's were found to have significantly reduced the burden on the health system in the 16 chiefdoms where they were operational. It was furthermore concluded that the impact of the ORP's would have been even greater in a worst case epidemic scenario.

Lessons Learnt Cholera Response Workshop
SLRCS and IFRC health team held a lessons learnt workshop on the cholera response on 2 February. A detailed progress report on the lessons learnt workshop on Red Cross cholera response 2012 was compiled in February 2013[7]. This workshop confirmed the importance of continuing the effective use of beneficiary communication tools, such as radio, SMS, cinema for awareness raising campaign. The report highly recommended that community sensitization and hygiene promotion also continue through the dry season.

PHAST ToT refresher course and modification of IEC materials
In collaboration with the Regional IFRC WatSan delegate, the SLRCS PHAST ToT Refresher course took place between 5 February and 9 February 2013. 31 participants were trained as trainers in the PHAST methodology. Most participants were involved directly or indirectly in hygiene promotion activities under the CBHP or Cholera response project. The main purpose of this PHAST ToT refresher course was to re-build on participant's skill and knowledge of PHAST methods through case studies and mutual information sharing and to equip them to pass on this information to other trainers.

[6] Peter Rees-Gildea IFRC Consultant, Sierra Leone Cholera Operational Review, Jan 2013
[7] IFRC/SLRCS Lessons Learnt Workshop on Red Cross Cholera Response 2012 Progress Report, February 2013

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**
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.	• 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)
IFRC standard operational procedures will be implemented to support the on-going operation (supplies, warehouse and fleet management).	• 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 • A logistic workshop will be organized.
A well-coordinated response with shared plans, resources, and reports leading to effective epidemic control.	• The progress of the program will continue to be reported on regularly. • Coordination meetings will be regularly attended by team members, in all districts.

TERA SMS system

The installation of the TERA SMS system at telecommunications company Airtel was successfully implemented and the establishment of detailed working procedures and training of key staff within the SLRCS is expected to ensure efficient and effective long term operation of the system. The system was officially launched in April 2013, and more than 2,000,000 million messages had already been sent to subscribers at the end of April.

Airtel is the largest mobile provider in the country with more than a million registered subscribers and 80% coverage, which gives the TERA SMS system access to most households in the country. The telecommunications companies Sierratel and Comium have signed agreements to send out SMS messages on behalf of the SLRCS, but without the installation of TERA.

Through the operation a bank of SMS messages for disasters, outbreaks and health promotion has been established by the SLRCS with a pre-planned schedule covering the next 12 months, or until March 2014. This schedule will remain flexible to respond to arising needs and vulnerabilities, but the main focus is on the serious health related problems in the country such as cholera, malaria, STD's, Lassa, typhoid and tuberculosis.

Oral Rehydration Points (ORPs) and contingency planning for establishment of ORPs

The SLRCS, supported by the IFRC health delegate continued monitoring and follow up of the ORS points and volunteers affiliated to these in the larger centres. Please refer to operations update no 1 and previous situation

reports for details. Through the operation 380 ORPs were established in the four districts of Kambia, Port Loko, Tonkolili and Bombali. Volunteers have been trained in all districts to operate ORPs, ensuring a quick response by the SLRCS in establishing new ORPs in affected areas in case of another cholera outbreak.

Contingency stocks
Before the departure of the CHM and MSM emergency response units (ERU's) 20,000 sachets of ORS were distributed to 14 branches for contingency from Norwegian RC donation. Presently registered cholera contingency stocks at the SLRCS HQ include 500 back packs for volunteers, 150 pairs of disposable gloves, 5,734 sachets of ORS, and one PHAST tool kit.

Logistics

Outcome: Provide logistics support to the CTC, water sanitation and hygiene activities	
Outputs (expected results)	**Activities planned**
• That the operation is logistically well supported in their emergency activities. • Manage the warehouse containing ERU materials and other items purchased for the on-going response • Build capacity of logistics staff within SLRC. • Well managed and inventoried handover process of ERU's.	• 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

Stocks and warehousing:
The warehouse contract expired at the end of February and a water treatment unit from the Finnish RC BHC ERU, (previously donated to SLRCS by FRC), was donated to the MoH. All other items have been either transported to Western Area SLRCS branch warehouse in Waterloo, except for WatSan related items that were transported to Makeni and Port Loko to be used in WatSan activities that were part of the cholera operation.

All items remaining from the three ERU's that were operational in the country during the most serious phase of the cholera epidemic were donated to the SLRCS in October 2012.

Communications – Advocacy and Public information

SLRC maintained 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 was an effective mechanism for disaster response and the cornerstone to promote greater quality, accountability and transparency. The communications activities planned supported 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 Sierra Leone Red Cross Society has been involved in the implementation of a long-term community-based health program in all districts in the country and active volunteers were already in place. During this operation through the support of the ERUs, the National Society trained and mobilized 778 Red Cross volunteers from within the affected communities to assist in social mobilization activities. The SLRCS had a branch in each of the 14 districts in the country, with a total number of 3,776 active volunteers (2011 data). The New SLRCS Act, replacing the previous legislation dating from 1962, was passed on 22 August 2012, enhanced the status of the NS and reinforced the SLRCS auxiliary role 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 was in-country and reported directly to the Regional Representative for Africa West Coast. Two RDRTs were also sent to provide support to the on-going implementation of this response. The Regional Representative for Africa West Coast provided direct support to the IFRC and the SLRCS personnel involved in the operation to ensure the activities were implemented efficiently, according to movement principles and following international SPHERE standards. A second line technical support was 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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- **IFRC Geneva:** Christine South, Operations Quality Assurance Senior Officer; phone: +41.22.730.45 29; email: christine.south@ifrc.org
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For Resource Mobilization and Pledges:

- **IFRC West and Central Africa hub:** Elisabeth Seck, Resource Mobilization Officer, Dakar; phone:+221 33 869 36 60; mobile: +221 77 450 59 49; email: elisabeth.seck@ifrc.org

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

- **IFRC Zone:** Robert Ondrusek, PMER/QA Delegate, Africa phone: +254 731 067277; email:robert.ondrusek@ifrc.org

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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.

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.

International Federation of Red Cross and Red Crescent Societies

MDRSL003 - Sierra Leone - Cholera Epidemic

Appeal Launch Date: 13 aug 12

Appeal Timeframe: 13 aug 12 to 30 apr 13

Final

Selected Parameters	
Reporting Timeframe	2012/8-2013/4
Budget Timeframe	2012/8-2013/4
Appeal	MDRSL003
Budget	APPROVED

All figures are in Swiss Francs (CHF)

I. Funding

	Pledge	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL
A. Budget		**1,061,853**					**1,061,853**
B. Opening Balance		**0**					**0**
Income							
Cash contributions							
British Red Cross	*M1210003*	*30,314*					*30,314*
British Red Cross	*M1301086*	*22,500*					*22,500*
European Commission - DG ECHO	*M1301073*	*494,356*					*494,356*
Icelandic Red Cross	*M1211032*	*19,770*					*19,770*
Icelandic Red Cross	*M1301101*	*98,400*					*98,400*
Japanese Red Cross Society	*M1209005*	*38,000*					*38,000*
Japanese Red Cross Society	*M1210074*	*39,969*					*39,969*
Japanese Red Cross Society	*M1210078*	*6,800*					*6,800*
Red Cross of Monaco	*M1211069*	*6,021*					*6,021*
Swedish Red Cross	*M1209004*	*211,089*					*211,089*
The Canadian Red Cross Society	*M1209078*	*5,802*					*5,802*
C1. Cash contributions		***973,021***					***973,021***
Inkind Goods & Transport							
British Red Cross		*10,824*					*10,824*
New Zealand Red Cross		*8,787*					*8,787*
C2. Inkind Goods & Transport		***19,611***					***19,611***
Inkind Personnel							
Icelandic Red Cross		*80,354*					*80,354*
Japanese Red Cross Society		*54,883*					*54,883*
C3. Inkind Personnel		***135,237***					***135,237***
Other Income							
Programme & Services Support Recover		*1,275*					*1,275*
Sundry Income		*4,354*					*4,354*
C4. Other Income		***5,629***					***5,629***
C. Total Income = SUM(C1..C4)		**1,133,498**					**1,133,498**
D. Total Funding = B +C		**1,133,498**					**1,133,498**
Coverage = D/A		**107%**					**107%**

II. Movement of Funds

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL
B. Opening Balance	0					**0**
C. Income	1,133,498					**1,133,498**
E. Expenditure	-1,081,209					**-1,081,209**
F. Closing Balance = (B + C + E)	52,289					**52,289**

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III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	
	A						B	A - B
BUDGET (C)		**1,061,853**					**1,061,853**	
Relief items, Construction, Supplies								
Food		1,778					**1,778**	**-1,778**
Water, Sanitation & Hygiene	117,000	133,420					**133,420**	**-16,420**
Medical & First Aid	840	2,836					**2,836**	**-1,996**
Teaching Materials	10,800	11,196					**11,196**	**-396**
Utensils & Tools	20,000	19,166					**19,166**	**834**
Other Supplies & Services	29,640	3,442					**3,442**	**26,198**
Total Relief items, Construction, Sup	**178,280**	**171,837**					**171,837**	**6,443**
Land, vehicles & equipment								
Computers & Telecom	92,911	60,046					**60,046**	**32,865**
Office & Household Equipment	2,550	1,744					**1,744**	**806**
Total Land, vehicles & equipment	**95,461**	**61,790**					**61,790**	**33,671**
Logistics, Transport & Storage								
Storage	15,000	15,018					**15,018**	**-18**
Distribution & Monitoring	2,000	3,914					**3,914**	**-1,914**
Transport & Vehicles Costs	44,084	54,269					**54,269**	**-10,185**
Total Logistics, Transport & Storage	**61,084**	**73,201**					**73,201**	**-12,117**
Personnel								
International Staff	318,000	269,239					**269,239**	**48,761**
National Staff		92					**92**	**-92**
National Society Staff	25,575	19,683					**19,683**	**5,892**
Volunteers	27,532	24,225					**24,225**	**3,307**
Total Personnel	**371,107**	**313,239**					**313,239**	**57,868**
Consultants & Professional Fees								
Consultants		38,519					**38,519**	**-38,519**
Professional Fees		500					**500**	**-500**
Total Consultants & Professional Fe		**39,019**					**39,019**	**-39,019**
Workshops & Training								
Workshops & Training	30,265	46,554					**46,554**	**-16,289**
Total Workshops & Training	**30,265**	**46,554**					**46,554**	**-16,289**
General Expenditure								
Travel	94,429	59,919					**59,919**	**34,510**
Information & Public Relations	71,979	45,907					**45,907**	**26,072**
Office Costs	5,050	19,381					**19,381**	**-14,331**
Communications	28,390	15,228					**15,228**	**13,162**
Financial Charges	5,000	12,359					**12,359**	**-7,359**
Other General Expenses	56,000	12,585					**12,585**	**43,415**
Shared Office and Services Costs		3,173					**3,173**	**-3,173**
Total General Expenditure	**260,848**	**168,553**					**168,553**	**92,295**
Contributions & Transfers								
Cash Transfers National Societies		145,763					**145,763**	**-145,763**
Total Contributions & Transfers		**145,763**					**145,763**	**-145,763**
Indirect Costs								
Programme & Services Support Recov	64,808	57,507					**57,507**	**7,301**
Total Indirect Costs	**64,808**	**57,507**					**57,507**	**7,301**
Pledge Specific Costs								
Pledge Earmarking Fee		1,544					**1,544**	**-1,544**
Pledge Reporting Fees		2,200					**2,200**	**-2,200**

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III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL	
	A						B	A - B
BUDGET (C)		1,061,853					1,061,853	
Total Pledge Specific Costs		3,744					3,744	-3,744
TOTAL EXPENDITURE (D)	1,061,853	1,081,209					1,081,209	-19,356
VARIANCE (C - D)		-19,356					-19,356	