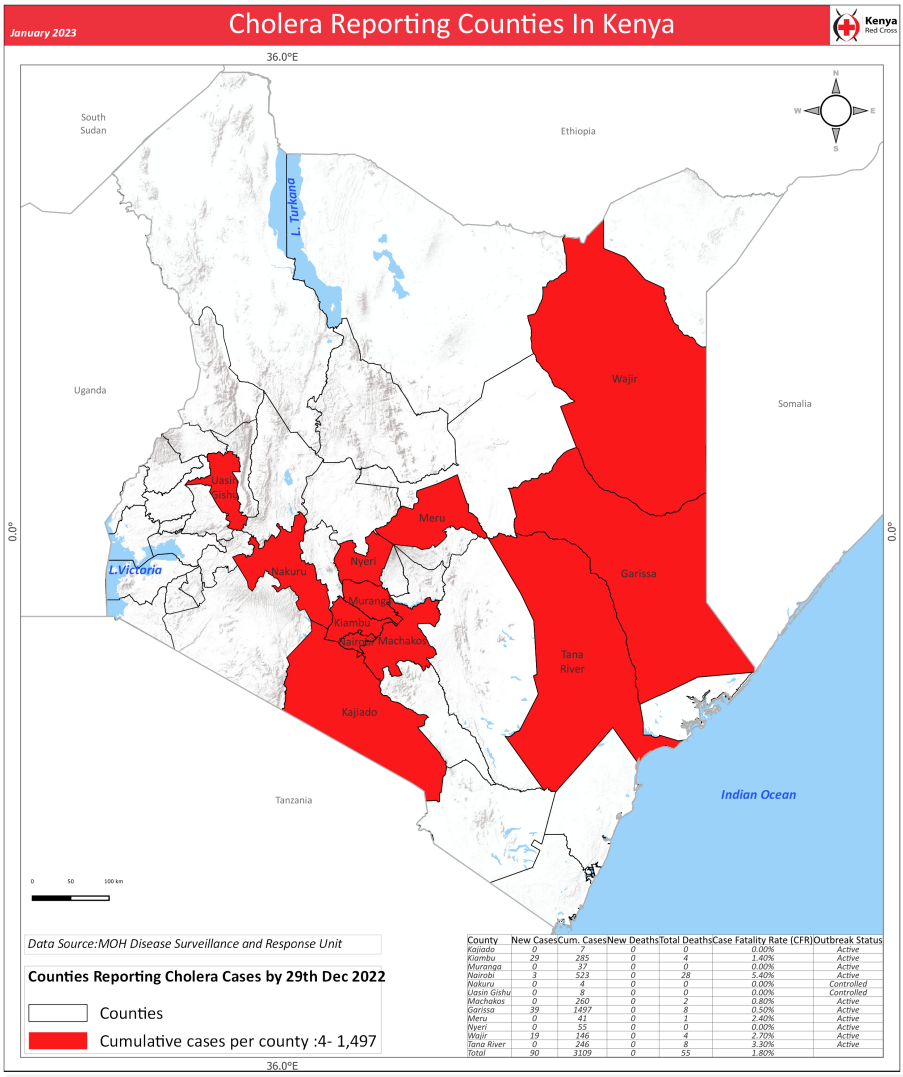
DREF APPLICATION

Kenya: Cholera Outbreak

Assessment of a Cholera treatment center in Wajir county.

Appeal: **MDRKE054**	DREF Allocated: **CHF 498,819**	Crisis Category: **Yellow**	Hazard: **Epidemic**
Glide Number: **EP-2022-000367-KEN**	People Affected: **1,928,800 people**	People Targeted: **1,410,720 people**	
Event Onset: **Slow**	Operation Start Date: **2023-01-07**	Operation End Date: **2023-04-30**	Operation Timeframe: **3 months**
	Targeted Areas:	**Tana River, Garissa, Wajir, Meru, Machakos, Murang'a, Kiambu, Kajiado, Nairobi**	

Description of the Event



County	New Cases	Cum. Cases	New Deaths	Total Deaths	Case Fatality Rate (CFR)	Outbreak Status
Kajiado	0	7	0	0	0.00%	Active
Kiambu	29	285	0	4	1.40%	Active
Muranga	0	37	0	0	0.00%	Active
Nairobi	3	523	0	28	5.40%	Active
Nakuru	0	4	0	0	0.00%	Controlled
Uasin Gishu	0	8	0	0	0.00%	Controlled
Machakos	0	260	0	2	0.80%	Active
Garissa	39	1497	0	8	0.50%	Active
Meru	0	41	0	1	2.40%	Active
Nyeri	0	55	0	0	0.00%	Active
Wajir	19	146	0	4	2.70%	Active
Tana River	0	246	0	8	3.30%	Active
Total	90	3109	0	55	1.80%	

Map showing Cholera Reporting counties.

What happened, where and when?

The current outbreak of cholera started on 19th October with its origin being traced to a wedding festival in Kiambu County which later spread across Kiambu (31), Nairobi (17), Murang'a (1), Kajiado (2), Nakuru (2) and Uasin Gishu (8) counties. The disease has been relatively low in terms of cases and in most of the counties controlled through the county level actions by the health department and with support from partners.

There has however been a concerning increase of cholera cases with worrying trends in death rates due to over stretched capacity of the local governments, KRCS local branches and partners to effectively respond. The increased cases are mainly within Nairobi and in counties that are currently reporting persistent drought, communities utilizing unsafe water sources and limited access to sanitation and hygiene services and corresponding poor WASH practices. In particular, Nairobi, Tana River, Garissa and Wajir counties have recently reported increased caseloads with reported highest mortalities in Nairobi, Garissa, Tana River and Wajir counties.

During the initial phase of the outbreak, Nakuru, Uasin Gishu, Kajiado, Muranga and Kiambu responded effectively with the outbreak contained in Nakuru, Uasin Gishu and Kajiado. Nairobi county government together with KRCS Nairobi branch and other partners sustained interventions but unfortunately the CFR has now risen to a concerning 5%. The gaps identified in Nairobi center on limited community level sensitization and WASH interventions as well as overburdened case management rea the leading causes identified for the high CFR. Currently Nairobi County runs two Cholera treatment Units (CTUs) at Mama Lucy hospital (close to the sub counties that are reporting most of the cholera cases and is situated proximal to most of the informal settlements in Nairobi). The other CTU is

located at Mbagathi hospital hosts fewer admissions. The health care workers at Mama Lucy hospital are currently overstretched.

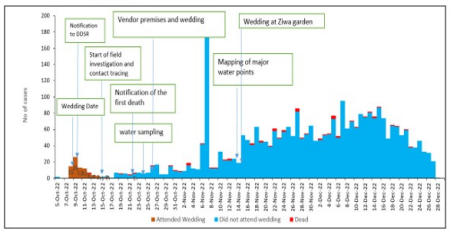
In the recent days cholera has now spread to new counties of Meru, Tana River, Garissa and now Wajir county with Tana River being the most recent to report cholera on the 24th November 2022. The additional counties have a different profile as compared to the initial reporting counties as they are in the drought affected areas of Kenya, have the least access to water, sanitation and hygiene services and health care services. In a recent Kenya Health Demographic Health Survey counties like Wajir and Garissa reported 76.7% and 48.2% of its population defecating in the open as compared to Uasin Gishu's 1.8% and national average of 43%. This among other poor performing WASH indicators in the new reporting counties concern the county governements and KRCS. Based on the previous cholera outbreaks in Kenya, the counties of Nakuru and Uasin Gishu have had a robust response by local governments and report high rates of access to health care and WASH services. The same lessons learnt have shown that cholera in the arid and semi-arid lands cause expansive and sustained cholera transmission and often high case fatality rates

On 22 december 2022, departments of health from the county governments of Kiambu, Nairobi, Meru and Tana River have requested support to Red Cross. While the official requests are from the 4 counties mention above, this DREF will cover the other four counties of Garissa, Kajiado, Muranga and Wajir based on KRCS assessment carried out from 20th to 24th December covering the 8 counties. The report is attached with the findings of a risk factors assessment of the current cholera outbreak and the need for the emergency intervention, thus triggering this operation. The assessment was carried out jointly by the Kenya Red Cross and County Health Departments. Data held in this DREF is based on the County requests, KRCS joint assessments and latest National Cholera Outbreak surveillance reports dated 29 December.

KRCS health Care Worker at Daadab Refugee Camp

S/No.	County	Cases		Deaths		Cumulative Cases	Outbreak Status
		New cases in the last 48hrs	Total Cases as of 29th Dec	New Deaths in the last 48hrs	Total Deaths as of 29th Dec		
1	Kajiado	0	7	0	0	7	Active
2	Kiambu	29	281	0	4	285	Active
3	Murang'a	0	37	0	0	37	Active
4	Nairobi	3	495	0	28	523	Active
5	Nakuru	0	4	0	0	4	Controlled
6	Uasin Gishu	0	8	0	0	8	Controlled
7	Machakos	0	258	0	2	260	Active
8	Garissa	39	1489	0	8	1497	Active
9	Meru	0	40	0	1	41	Active
10	Nyeri	0	55	0	0	55	Active
11	Wajir	19	142	0	4	146	Active
12	Tana River	0	238	0	8	246	Active
		90	3054	0	55	3109	

Figure 1 Cholera Epicurve, 2022



Surveillance Data Summary up to 29 December

Scope and Scale

As of 29 December 2022, the outbreak counts 3,109 cases being registered in 12 counties representing an overall case fatality rate of 1.8% higher than the WHO recommended CFR of less than 1% for cholera cases. 55 deaths. latest available data are from the Surveillance report from MoH dated 29 December 2022.

So far, the most affected counties include Garissa, Wajir, Tana River, Nairobi, Machakos, Muranga, Kiambu, Nyeri, Meru, and Kajiado.

It's also been reported that the cases have started spreading to the host communities in Dadaab and Dagahaley refugee camps which are hosting part of the asylum seekers who have not been registered.

Based on the national MoH Surveillance reports the latest available summary of death per county is as follow:
- Nairobi-28 deaths - CFR 5.4%
- Tana River-8 deaths - CFR 3.3%

• Garissa-8 deaths - CFR 0.5%
• Kiambu-4 deaths - CFR 1.4%
• Wajir-4 deaths - CFR 2.7%
• Machakos-2 deaths - 0.8%
• Meru-1 death - CFR 2.4%

Forty-two (76%) of the deaths are male, age category:
• < 5 years-12
• > 5 years-40
• Missing- 3

The respective county branches in collaboration with county departments of health continue to support surveillance and response mechanisms while leveraging on the support of other KRCS-implemented projects in Tana-River, Dadaab, and Nairobi. The preliminary findings from coordination meetings held and rapid assessments identified some general elements as contributing pressing needs and factors to the outbreak:
- Lack of funds and limited human resources to support CTC and conduct health and hygiene promotion activities in communities.
- Poor logistics and human resources to carry out community awareness and health education.
- Inadequate IEC materials such as posters, flyers, and banners.
- Inadequate supply and logistics to carry out Infection prevention and control in treatment centers,
- Open defecation in affected communities mainly in Dadaab refugee camps where sanitation facilities are stressed due to the influx of asylum seekers.
- Lack of potable drinking water in some rural areas which is exacerbated by the current drought being experienced in the Garissa, Kajiado, Wajir, and Tana River. Urban slums in Nairobi and Kiambu also face the same challenge of insufficient water supply.
- Inadequate health facility infrastructure and cholera supplies and equipment for the management of patients including the need for a standard setup of a CTC.
- Limited number and capacity of human resources for Cholera outbreak detection, investigation, and management,
- Poor and inconsistent reporting from the districts,
- Limited access to drinking water for vulnerable communities has led to poor hygiene and sanitation situation in the affected areas.

So far, the outbreak response has been focused on clinical case management, with very limited focus on behavioral change through risk communication, community awareness creation, and sensitization on the key messages to prevent community transmission of Cholera.

Cholera Treatment Unity (CTUs) have been set by the Ministry of health in the affected counties. However, the established treatment units are not adequate to accommodate the increasing number of cases requiring admission and putting much pressure on human resources. Equally, standards of IPC are not properly constituted at these CTCs posing a risk of infection of caretakers and even staff.

Furthermore, in the Dadaab refugee camp, there is limited health facility capacity due to the influx of asylum seekers in the country which puts pressure on the available resources.

Other sources reported there was a 55-fold increase in cholera cases and an outbreak of measles in Kenya's refugee camps strain health resources as of December 22, 2022 — At least three refugees have lost their lives, and 504 others treated for acute dehydration following an outbreak of Cholera diseases at Hagadera in Dadaab Refugee Camp in Kenya. Cumulative Cholera cases have increased from 9 cases on November 1, 2022 to 504 cases on 18 December 2022 in an IRC-run health facility in Hagadera, Dadaab refugee camp. (https://reliefweb.int/report/kenya/55-fold-increase-cholera-cases-and-outbreak-measles-kenyas-refugee-camps-strain-health-resources-warns-irc)

Around 20 to 30% of the population in ASALs have minimal to no access to essential health services and are mainly served through biweekly integrated health outreaches. Outpatient attendance in health facilities has reduced by about 42% due to several factors including population movement, poorly supplied health facilities, insecurity, and the inadequate scale of outreaches. For instance, in October 2022, the average stockout rate of essential medicines was about 61% in Garissa, Marsabit, and Wajir Counties 12 tracer drugs for children and women were.

The main reasons for stock-outs included poor fill rates, delayed supply, delayed payments, and some counties' failure to submit 100% orders requested by facilities. (https://reliefweb.int/report/kenya/unicef-kenya-flash-situation-report-no-6-drought-october-2022).

SOS dated 1 Jan 2023, Kenya: Cholera outbreak (Level: Notice): An outbreak of cholera has been confirmed across 12 counties: Garissa, Kajiado, Kiambu, Machakos, Meru, Muranga, Nairobi, Nakuru, Nyeri, Uasin Gishu, Tana River, and Wajir. The origin of the outbreak was linked to a wedding held in Limuru sub-county, Kiambu county in early October 2022. Cases have now been reported in people who did not attend the event, indicating that the outbreak has spread to the community. More than 2,950 cases, including over 280 confirmed, and at least 50 deaths have been reported.

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**Yes**
Did it affect the same population groups?	**Yes**
Did the National Society respond?	**Yes**
Did the National Society request funding from DREF for that event(s)?	**Yes**
If yes, please specify which operations	**MDRKE044**

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent

1. The scale; The 2019 cases were sparsely within the period. In a span of 12 months Kenya had recorded 3,847 cases and a CFR of 0.7 while in the current outbreak within a span of 2 months Kenya has already recoded 2,570 case with CFR of 1.9.
2. Cholera in new geographic areas: There are counties which have not reported cholera in the recent years and or in the past decade but have reported sudden large number of cases. Such counties as Muranga, Kiambu, Meru and Nyeri are new cholera reporting counties.
3. Influx of asylum seekers into Kenya from Somali due to drought and armed conflict has complicated the situation in and around the refugee camp at Dadaab. The counties most affected due to this factor are Garissa, Wajir and Tana River counties.

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

1. Community Based Surveillance critical in early detection and preventing spread of such infectious diseases. The areas where KRCS has been able to deploy CP3 project with a strong CBS component there is heightened surveillance and disease control measures strengthened. This are counties such as Bomet, West Pokot, Narok and Tharaka Nithii. Unfortunately, the counties experience out the current outbreak do not have CP3 interventions.
2. Strong community engagement is critical for sustained behaviour change practices. Initial response by KRCS branch teams have shown reduction of spread of the outbreak in some of the counties.
3. Based on the Cholera response of 2016 and other operations within the North-Eastern region of Kenya, enlisting of local volunteers from affected areas is key in terrorism prone areas, cultural and religious barriers are surmounted by engaging cultural and religious leaders from specific response areas and that due to distances to health facilities that establishing ORPs is life saving.

Current National Society Actions

Coordination	KRCS attends national and all county Cholera response coordination mechanisms.
Assessment	KRCS is currently undertaking assessments in Wajir, Garissa and Tana River counties in collaboration with county health departments and with ICRC in Garissa County only. Based on the requests from county health departments earlier mentioned and on consultations with the county health leadership the following populations have been targeted and county specific activities prioritized: County - Targeted population - Prioritized activities under DREF 1. Kiambu - 72,000 - Case management, RCCE, WASH, Surveillance including contact tracing. 2. Muranga - 11,200 - RCCE 3. Nyeri - 16,960 - NO RESPONSE UNDER DREF 4. Meru - 84,000 - RCCE, WASH and Surveillance including contact tracing 5. Wajir - 107,200 - Case management, RCCE, WASH, Surveillance including contact tracing. 6. Garissa - 589,920 - Oral Cholera vaccination, Case management, RCCE, WASH, Surveillance including contact tracing. 7. Tana River - 153,600 - Case management, RCCE, WASH, Surveillance including contact tracing. 8. Uasin Gishu - 0 - NO RESPONSE UNDER DREF 9. Machakos - 0 - NO RESPONSE UNDER DREF 10. Nairobi - 380,800 - Oral Cholera vaccination, Case management, RCCE, WASH, IPC, Surveillance including contact tracing. 11. Kajiado - 12,000 - RCCE 12. Nakuru - 0 - NO RESPONSE UNDER DREF
Water, Sanitation And Hygiene	In Nairobi, Kajiado, Kiambu, Muranga, and Tana River County branches have supported the various county health departments with the distribution of aqua tabs and sensitization of community health volunteers to conduct hygiene promotion activities and awareness creation activities. In Daadab refugee camp (Garissa County) KRCS has been supporting access to safe through water trucking of 30,000ltrs a day at IFO and Daghaley respectively. Water treatment chemicals procured under the DREF shall be for replenishments and distribution in all the targeted counties (Garissa, Tana River, Wajir,

	Meru, Muranga, Kiambu and Nairobi) while in Kajiado we shall only have risk communication and community engagement activities only.
Health	Through Dadaab Refugee operations at the IFO camp in Garrisa county, a CTU was set up on 23rd October to support the treatment of patients from the refugee and host communities. As of 14th Dec 2022, the IFO 1 CTC updated line list is 233 with 24 patients admitted in the ward. Equally in Tana river county, the society through the branch has supported the ministry of health with 2 tents to set up a 28-bed space cholera treatment unit that as of 20th December had 16 patients admitted. There has also been limited case management interventions in Nairobi, Kiambu, Muranga and Meru where KRCS supported the setting up of CTUs by providing tents and cholera beds.

Movement Partners Actions Related To The Current Event

IFRC	IFRC has supported KRCS with technical assistance to strengthen KRCS planning and initial response. The initial response was within KRCS branch and county government's capacity to respond. However, the current situation calls for extra National Societies capacity. IFRC has been approached through this DREF for support.
ICRC	ICRC has supported KRCS in response at Daadab refugee camp, providing WASH commodities. There are indications that ICRC will support surge staff and case management supplies to the Daadab refugee operations response
Participating National Societies	No action at the moment but KRCS will keep sharing information within the movement.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
	The Ministry of Health has advised all counties to maintain heightened surveillance at the community level, and in all public and private health facilities across the country. The following interventions are ongoing: (i) Issuance of Cholera alert. Immediately after the outbreak was confirmed, the Ministry of Health issued an alert to all Health Care workers highlighting the importance of early detection, confirmation, and management of suspected cases of Cholera (ii) Coordination of Response: Response efforts are coordinated through a whole of government and multi-agency approach in accordance with disease outbreak management practices. The outbreak incidence management team (IMT) led by the Ministry's Department of Disease Surveillance and Epidemic Response, and the respective County Departments of Health under the coordination of the National Public Health Emergency Operations Centre are on the ground implementing response activities including, regular coordination meetings, field investigations, enhanced surveillance, laboratory testing, case management, risk communication, community engagement, and

National authorities	environmental sanitation to prevent the further spread of the disease. (iii) Technical assistance to affected Counties: The Ministry of Health through the Division of Disease Surveillance (DDSR), Field Epidemiology and Laboratory Training Program, and National Public Health Laboratory Services have provided technical support through rapid response teams to the affected counties. (iv) Diagnostic Capacity: The National Public Health Microbiology laboratory is actively supporting the county governments in confirming and serotyping samples from suspected cases to inform appropriate management. (v) Isolation Facilities: All affected counties have been directed to set up adequately staffed Cholera Treatment Units as per the laid down cholera infection prevention and control guidelines, for efficient management of the outbreak. (vi) Community Engagement: The Ministry of Health through the Health Promotion Unit and the county governments have engaged the community health volunteers to distribute key messages on cholera prevention and control to the population – involve internal security. V) Cholera response plan: The Division of Disease Surveillance and Response has developed a draft cholera response plan which will be finalized and disseminated to counties and stakeholders. The plan is expected to guide and improve the current response measure in place and ensure mitigation measures are put in place to prevent future outbreaks. vii) Training: The Ministry of Health is currently capacity-building national and county staff on cholera case management, Infection prevention and control supported by the Africa Centre for Disease Control. (vii) Ongoing Response Activities at county level Counties are undertaking measures such as treatment of all bulk water storage containers, distribution of chlorine tablets at household level, disinfection of households of confirmed cases of Cholera, distribution of Commodities (chlorine granules, Chlorine tablets, and other non-pharmaceutical supplies) and enforcement of public Health Laws including inspection of eateries, markets, and water points. (viii) Cholera Vaccine: The Ministry of Health has received the International Coordinating Group (ICG) approval for 2,213,942 doses of oral cholera Vaccine (OCV). Plans are underway to conduct a reactive vaccination campaign targeting people above 1year in the high-risk counties of Nairobi and Garissa (ix) The Ministry is convening a multi-stakeholder meeting with the Ministry of Water, Sanitation, and Irrigation and the Nairobi City County Government to deliberate on interventions required to respond to the outbreak in Nairobi County. 22 Dec: MOH - County Governments and all other stakeholders have also been urged to enhance risk communication and community engagement on COVID-19 and Cholera to effect social behaviour change. The measures include issuance of a cholera alert to all Healthcare workers highlighting the importance of early detection, confirmation and management of suspected cases, while coordinating a whole of government and multi-agency approach. The government has put in place a raft of measures to mitigate against the spread of epidemic prone diseases, as well as reduce the number of Cholera cases and potential fatalities. (https://twitter.com/MOH_Kenya/status/1605845988886708224?s=20&t=JecWb7R4mSLWYinIZ4uimA)
	UNICEF through an integrated Nutrition HPD program supported with sensitization of 30 CHVs and 18 KRCS volunteers in Madogo and Mororo in Tana River County on drought-related disease outbreaks including Cholera on hygiene promotion in emergencies in mid-November. Equally, the organization has also supported Nairobi County with the development of IEC materials on

UN or other actors	cholera prevention and provision of WASH supplies for 1000 households in Dadaab refugee camp and 1000 households in Tana River counties. 27 Dec - Life-saving emergency supplies just landed safely in Kenya on a @UNICEF charter flight. The shipment contains health supplies, protective equipment and essential supplies for cholera treatment and drought response to support @MOH_Kenya (https://twitter.com/UNICEFKenya/status/1607759394862776320?s=20&t=JecWb7R4mSLWYinIZ4uimA) "8 Dec - @MSF supported the @MOH_Kenya in setting up a 22-bed #cholera treatment unit in Mama Lucy Kibaki Hospital. Donated 15 cholera beds, drugs, consumables, water and sanitation supplies and trained the clinical team in case management. (https://twitter.com/MSF_EastAfrica/status/1600756061912190976?s=20&t=JecWb7R4mSLWYinIZ4uimA)"

Are there major coordination mechanisms in place?

In Garrisa county, each of the three camps, as well as the two sub-counties that host them (Dadaab and Fafi), have established their own multi-sectoral response teams, and a meeting between the Ministry of Health and partners, led by the UNHCR, takes place every Thursday. At the county level, there is also a multi-sectoral emergency Response team at the EOC, although coordination between the two teams is still weak.

In Nairobi County, multi-sectoral response teams with the leadership of the Ministry of health hold their meetings every monday.

Needs (Gaps) Identified

Water, Sanitation And Hygiene

Wajir town's main water source is shallow wells. A majority are drying up due to drought thus inadequate water supply to meet the demand for households in Wajir township. The town depends on water trucking and or water vendors who draw water from the congested shallow wells hence the high risk of contamination during drawing, transportation/delivery, or at the household level.
Water storage at the household level is by open super-drums (100ltrs) and drawn using jugs hence the risk of contamination
• Poor water treatment practices
• Low latrine coverage across all the sub-counties and villages reporting cases with observed open defecation being a rampant practice including in Wajir town. Latrine coverage is at 43.6% in the county while Biyamadhow is at 35%.

In addition to the above, severe prolonged drought led to reduced water sources (drying of wells). Kenya facing a Drought alarm stage in Wajir, Kitui, Kajiado, Garissa, and Tana River following the NDMA report Monthly Drought update - December 2022.

Health

Risk communication and community engagement and Community based surveillance:
Villages/households reporting cases are in unhygienic conditions with rampant open defecation being practiced.
Affected communities unaware of the current cholera outbreak especially in Wajir Town.
Inadequate water for Hand washing and no presence of hand washing equipment/tipi-taps including soap at household level.
No Promotional/IEC materials available/visible
Poor Food supply and Unhygienic selling of Food products especially wet foods and those eaten raw.

Case management:
Inadequate space and or defective CTC units; There is need for renovation of existing structures and additional structures/rooms to enable separation of gender and other provisions right from triage to recovery and morgue/body holding area.
Lack of adequate water storage due to borken water tank at Biyamadhow - need replacement
Weak IPC systems at the CTCs in Wajir and Biyamadhow – lack of hand washing stations at critical steps (records, nurse station, observation area, stores, Kitchen area)
Inadequate staffs at CTC -lack an MO in Biamadhow, RCOs, nurses and PHOs
Lack of extra cholera treatment center facility · Inadequate furniture – tables and chairs and shelves.

Surveillance, contact tracing, and reporting:
The use of the standard case definition for case identification has not been cascaded to the lower levels (to CHAs and CHVs). Current infection is in all ages including those below 2yrs hence need to contextualize the case definition
PHOs, CHAs, and CHVs have not been trained in community-based surveillance
Lack of logistics for contact tracing and supervision of CBS activities including ORS corners.

Supplies:
There is a shortage of Personal Protective Equipment (PPEs) for Cholera response, especially at the CTCs.
There is also a shortage of Aqua tabs for household water treatment reported in Wajir central; there is low knowledge of aqua tab use in Wajir South and West hence potential hesitance in the use. This is due to their main water sources being boreholes as compared to Wajir East which majorly depends on shallow wells.

Inadequate Essential drugs and non-pharms for case management.
Inadequate NFIs.

Staff capacity:
Under-staffing – burnout was reported by the responsible staff due to long working hours and minimal rotations.
Most rural health facilities are manned by one staff hence no leave is taken in the year: building up to burnout.
Knowledge gap among the refugee Health Care workers on Cholera outbreak response
Some of the villages reporting cases do not have CHVs/CUs hence no structure to undertake outbreak RCCE/CBS.

Coordination:
No regular stakeholder meetings – meetings done on a need basis
Sub-county RRTs have not been activated and hence most of the response actions are done by the county rapid response team (CRRT).

Operational Strategy

Overall objective of the operation

This DREF allocation aims at supporting 1,410,720 people in need of affected by the cholera outbreak by providing water sanitation and hygiene, risk communication and community engagement, psychological first aid, community-based surveillance, and disease control services in Wajir, Garissa, Tana River, Nairobi, Machakos, Meru, Kiambu, and Kajiado, counties for a period of 3 months.

Operation strategy rationale

Specific Objectives.
a) To prevent and control the spread of Cholera outbreaks at the community and facility levels in the affected counties by breaking the chain of transmission.
b) To facilitate improved case management of cholera outbreaks at facility and community levels in the affected counties.

To address the needs of the target population, KRCS based on the previous experiences, will focus its response on controlling the transmission and improve case management of Cholera at community and facility levels in the affected counties.

In order to control the transmission, the response will facilitate capacity building and deployment of Red Cross action team and community health volunteers, support monitoring of the outbreak evolution through active case finding, strengthen community capacity to identify and refer cholera cases through Epidemic Control for Volunteers (ECV), facilitate Risk Communication & Community Engagement (RCCE) at community level and mass media, support the MoH planned Oral Cholera Vaccination campaign in Nairobi and Garissa through social mobilization activities, and promoting hygiene and sanitation for prevention and control of Cholera.

Considering that this is re occurrence of cholera response in the targeted areas, Epidemic prevention in communities (EPIC) training component will be undertaken for 3 days sessions each to ensure relevant capacity building on Epidemic control for volunteers, RCCE and Oral rehydration points is delivered to the teams of Volunteers to be engaged.

The operation will also improve case management both at facility and community levels through the provision of oral rehydration therapy and support with the setup of Oral rehydration points whose determination will be based on the scale of the outbreak in the affected counties. This allocation will also support the setup of 3 CTUs in Wajir, and Tana River counties and Garissa town; the purchase of infection prevention control equipment's for the CTUs and provision of Personal Equipment (PPEs); deployment of surge teams in CTUs to support healthcare workers to

deal with the influx of patients; promote the continuation of breastfeeding for mothers suffering from Cholera; and hygiene promotion.

Targeting Strategy

Who will be targeted through this operation?
This DREF operation will target community members in villages that have reported cholera cases and the neighboring communities.

In Refugee camps, more focus will be put on the host communities and refugees leaving in the camp settlements due to their high vulnerability.
Families who have lost their loved ones due to cholera will be targeted for PFA sessions by volunteers.
Through community engagement, vulnerable groups will be targeted and given specific attention while delivering Cholera prevention services to the community.
These include the elderly, pregnant and lactating mothers, and children under 5 years.

Direct target will focus on groups of people living in families and communities with reported cases and will be prioritized for Direct target for door-to-door activities and sanitation. The direct target will cover a minimum of 70,000 people (5%).

Explain the selection criteria for the targeted population
The eight targeted counties are those with worsening situations, that KRCS branch and county governments are getting overwhelmed, and that do not have adequate partner support for the response.

These are Garissa, Wajir, Tana River, Nairobi, Muranga, Kiambu, Kajiado and Meru counties.

Garissa county which has one of the highest numbers of cases is partially by ICRC within the refugee camp.

Total Targeted Population

Women:	**717,674**	Rural %	Urban %
Girls (under 18):	**287,069**	**68.90 %**	**31.10 %**
Men:	**692,726**	People with disabilities (estimated %)	
Boys (under 18):	**277,090**	**2.20 %**	
Total targeted population:	**1,410,720**		

Risk and security considerations

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

Risk	Mitigation action
Rainfall for 2023 January, February March is projected to be poor hence putting more people at-risk counties specifically Tana River, Wajir and Garrisa of water shortage.	Continuous supply of water treatment materials. Support drought-affected communities with water trucking services.
Terror attacks along the Kenya-Somalia Border and proximity areas from Al-Shabaab militants	KRCS has increased levels of acceptance from the community members due to a wide network of local staff and volunteers who can enhance situational awareness

	of the possible security risks in these areas. KRCS is not a target of the militants except for collateral impacts. This is mitigated by avoiding close proximity to security forces convoys who are a primary target of attack militants in these areas. The field teams mitigate these risks through increased visibility of the fleet while traveling in these areas. KRCS Security Unit conducts continuous monitoring of the local security situation and advises the response teams on mitigation measures in case of a heightened security situation.

Please indicate any security and safety concerns for this operation

Terror attacks along the Kenya-Somalia Border and proximity areas from Al-Shabaab militants will possibly affect project implementation. Non the less, KRCS has increased levels of acceptance from the community members due to a wide network of local staff and volunteers who can enhance situational awareness of the possible security risks in these areas. Equally, KRCS is not a target of the militants except for collateral impacts. This is mitigated by avoiding close proximity to security forces convoys who are a primary target of attack militants in these areas.

The field teams mitigate these risks through increased visibility of the fleet while traveling in these areas.

KRCS Security Unit conducts continuous monitoring of the local security situation and advises the response teams on mitigation measures in case of a heightened security situation.

Planned Intervention

	Health	**Budget**	CHF 254,222
		Targeted Persons	1410720
Indicators		**Target**	
Number of ORP sites set up		4	
Number of CTCs set up		3	
Number of people reached during OCV mobilization in Nairobi and Garissa		50000	
Number of Oral Cholera vaccine trainings done for RCVs/CHVs		2	
Number of Group information sessions conducted by volunteers to disseminate cholera prevention messages (1 session per week)		72	
Number of key stakeholders sensitized on cholera prevention. (20 stakeholders per county)		160	
Number of radio talk shows and presenter mentions on Cholera prevention co produced and disseminated (2 mentions per week for 8 counties for 3 weeks		62	
Number of PAS/mobile cinemas sessions conducted to enhance RCCE (1 session per week for the 8 targeted counties for 3 months)		48	
Number of households visits conducted with cholera prevention		282144	
Number of RCVs/CHVs to be trained on ECV/RCCE/ORP		600	
		A total of 600 volunteers comprising of Red Cross volunteers and community health volunteers will be engaged and trained and they will be coordinated to shift between community health system strengthening in the context of the cholera outbreak and support to the CTUs and health facilities. They will be trained on ECV, RCCE, ORP, and surveillance including contact tracing to support early active case finding and hygiene and sanitation activities in the community.	

The following activities will be implemented under structured response:
1. Control of community transmission. This operation will support the:
• Delivery of training as a full EPiC package with each session taking 3 days (Training sessions for ECV, RCCE and ORS/ORP, CBS and PFA during outbreaks)
• Deployment of volunteers to support with active case finding as a contribution to the community-based surveillance, promote Epidemic Control for Volunteers (ECV). All teams to be supported by necessary material.
• Facilitate Risk Communication & Community Engagement (RCCE) at community level and through mass media, mobile cinemas, household visits and group information sessions
• Support the implementation of Oral Cholera Vaccination campaign in Nairobi and Garrisa counties and promoting hygiene and sanitation for prevention and control of Cholera.

Details of specific activities below:
1.1. Train Volunteers in the affected area in Epidemic Control for Volunteers (ECV) in Cholera prevention and Control: 600 volunteers will be trained for 3 days. The training will focus on equipping volunteers with knowledge and skills in conducting house to house visit in the communities in order to sensitize the communities on the early signs of Cholera disease and the importance of reporting the risk to relevant health authorities.

1.2. Provide ECV volunteers with tools, pocket guides for Cholera and visibility materials to support disseminating Cholera prevention and control messages including signs and symptoms, risk factors and prevention measures. Cholera IEC Materials to be used.

1.3. Train staff, volunteers, and stakeholders on Community Based Surveillance (to include contact tracing). The training will cover 600 volunteers. The training will be facilitated using IFRC CBS training manual and guidelines with the support from CP3 team supporting implementation in Narok, Tharaka-Nithi, Bomet and West Pokot counties.

1.4 Support deployment of volunteers to undertake door-to-door visits to deliver targeted information on cholera: 600 volunteers will be deployed to support house-to-house visits to sensitize communities on the early signs of cholera to enable early detection, educating household members in Cholera prevention, case management and roles they will play in engaging households on availability and use of sanitary facilities, handling of safe drinking water and hygiene practices. Volunteers will be deployed for 3 days per week for 1 month and will be supported with volunteer allowance and logistical support where possible. These volunteers will target to reach 282,144 households (1,410,720 people).

1.5. Support 600 volunteers 3 days per week for 3 months by providing volunteer allowance and logistical support to conduct active case finding as a contribution to the MoH CBS in place in collaboration with community health assistants and community health volunteers. The trained volunteers will support primary

Priority Actions:	information on basic community case definition and identification while working hand in hand with healthcare workers who will take samples for further investigation by health authorities on reports of cases meeting the community case definition. Under this strategy, KRCS will deploy volunteers to support communities in identifying and alert on potential further transmission of the outbreak through both paper base and use of USSD codes. 1.6. Conduct community engagement meetings with community leaders, village elders, local administrators, and religious leaders including the development of local community contingency plans to facilitate community responsibility in supporting response initiatives: The activity will target influential local leaders and community organizations structures in affected areas and their surroundings to discuss with them on the current risks of the cholera outbreak. The purpose is to bring to the attention of the local leaders to lead in sensitizing their subjects and enforce by-laws where they exist and formulate where they don't exist. 1.7. 200 volunteers in Nairobi and Garissa for 10 days will be supported in activities of social mobilization ahead of the planned MoH OCV campaign. 1.8. Conduct mass media awareness creation on cholera prevention and control by: • Support Co-production and airing of jingles: The project will support the development of jingles tailor-made to local languages. The process of the development will engage community radio stations in the targeted districts in collaboration with the ministry of health at all levels. The project will then support the airing of jingles in different community radios in the hot spot areas for a period of 3 months. Furthermore, talk shows and phone-in programs will also be supported where the health professionals will engage the communities through radio to address cholera myths and misconceptions. • Conduct 2 sessions per month of public address/Mobile cinemas in 8 of the affected counties for 3 months • Production of banners and IEC materials with Cholera Specific messages. • production of visibility materials for volunteers (T shirts, Caps etc.) 1.9 Monitoring of rumors and collection of feedback on the response: • Train volunteers in feedback mechanism • Volunteers collecting feedback data using paper-based form • Support Feedback data entry, analysis, and reporting meetings in collaboration with MOH health promotion departments. • The information collected will be used to adjust the mass media messages/ RCCE approach and to monitor community perception of the response. 2. Improving case management both at facility and community levels: 2.1. Training of 600 Volunteers for three days in Oral Rehydration Therapy (ORT). The training will equip the staff, volunteers, and stakeholders with the necessary knowledge and skill they require

	to help to assess dehydration and provide necessary treatment through the provision of ORS and Zinc. The same volunteers will be trained on the safe continuation of breastfeeding in the context of a cholera outbreak to help addresses cases of malnutrition. ORS training will be integrated as the same package as ECV training. 2.2. Support Volunteers to provide Oral Rehydration Therapy. The response will support the setup and operation of 4 Oral Rehydration Points. This will require a combination of volunteer support, training in the above 2.1 activities, ensuring procurement of necessary supplies In section 2.4, and ensuring sharing of information through the MoH system in place to branches, and partners. 2.3. Support setting up of CTUs (tents, demarcation of isolation areas/traffic barriers, temporary WASH facilities at CTC, etc.) to provide isolation space to Cholera patients. The action will be done as a response to the request by the Ministry of Health as there is inadequate treatment space in most health facilities especially those registering high cases on daily basis like Tana River, Wajir, and Garrisa counties. This will be aligned with MoH's strategy for clinical case management. 2.4. Procurement of materials to support IPC and Case Management (ORS, Chlorine, gloves, gumboots, and facemasks).

	Secretariat Services	**Budget**	CHF 6,339
		Targeted Persons	3
Indicators		**Target**	
Number of county multistakeholder coordination meetings held in the 8 cholera active counties. (weekly meetings)		48	
Number of field monitoring missions by National and county MOH/KRCS/IFRC (1 mission per county per month. KRCS can plan for monitoring visits at county level with support from regional teams)).		3	
Regular technical coordination meetings		12	
Priority Actions:		To continuously support monitoring of outbreak response, KRCS will support and participate in national and county level coordination meetings to provide technical support. 2 Volunteers will be supported per day to compile daily reports. This will ensure regular review of cholera response in the various counties and provide technical guidance to the response teams. Periodic supportive supervision will be provided by county and National teams both from KRCS and MOH to filed teams. This will strengthen coordination aspect of the response. Coordination and technical support	

	• Health and WASH coordination support from the regional emergency health and cholera coordinators • PMER coordination support. • Field monitoring missions.

	National Society Strengthening	**Budget**	CHF 147,735
		Targeted Persons	800

Indicators	**Target**
# of after action review sessions held with RCATs and surge teams	2
# of volunteers and Surge team insured	674
# of coordination meetings conducted with HQ/IFRC teams conducted online on weekly basis.	12
Number of lessons learnt workshop	1
Number of field monitoring missions by National and county MOH/KRCS/IFRC (1 mission per county per month. KRCS can plan for monitoring visits at county level with support from regional teams)).	30
% of counties submitting daily Sitreps and monthly reports	100
Number of monthly progress reports submitted to IFRC	3
Number of National coordination meetings held	3
	KRCS will strengthen and participate in sub county, county and national cholera coordination mechanisms. The coordination platforms are geared at enhancing synergy of efforts, enhance coverage, to efficiently utilize available resources and most importantly bring to a holt the outbreak in the shortest time. Jointly with the national, county governments and other stakeholders: •KRCS will support inception meetings in the 8 supported counties to inform the counties of the planned support towards cholera response in counties. All actors will be present to ensure that no duplication of activities is being done. • KRCS will support and participate in coordination meetings in collaboration with MOH and other key stakeholders to periodically monitor response status of the operation. • All counties except Garrisa will be supported to conduct initial rapid assessment and develop cholera response plans to be used for effective response. • At the end of the operation, KRCS will conduct a lesson learnt

Priority Actions:	workshop together with regional health leads and key personnel from Ministry of health. •Two after action review sessions will be supported targeting RCAT leaders with surge team to enable them reflect back and provide for a support system that will enable them to improve their mental health after the operation. This will also be done to the national team at headquarters and National MOH. • To ensure that volunteers and surge team staff are well protected, a group insurance will be issued to them. Operations support: • Volunteers insurance • Volunteer's and staff PPE • Vehicles and fuel • Communications and IT • Communications • Admin, logs and finance support•

Community Engagement And Accountability

Budget	CHF 27,750
Targeted Persons	1410720

Indicators	**Target**
Number of meetings held to verify and address romuors by RCATs	24
Number of complains and feedbacks from community actioned on 10 complains per county.	100
Number of Volunteers trained on CEA	600
	• The CEA activities and the majority of the corresponding budget allocation are integrated within the Health and WASH sectors. • The KRCS will ensure that the already developed CEA tools, tailored to the Kenyan context, are adopted, and used to collect data relevant for planning CEA approaches and activities during implementation, gather community feedback and make sure of the feedback to generate ownership within the community during Cholera operation. • Prior to implementation of this DREF, KRCS will conduct consultative meetings with communities and representatives of communities aimed at discussing preferences on feedback channels and the type of questions that they would like to have answers on. Meetings will be done with community feedback sessions. The community will initially be accessed and informed through the community leaders, before planning with them on how to engage the wider community including all components including vulnerable groups. A feedback mechanism will be put in place to get the necessary feedback from community members on issues related to the overall Cholera response. This feedback will be shared at different platforms at community, county and national including the technical and sub technical working groups that have been

Priority Actions:	established under the cholera response. • The community members in the target areas will be involved as fully as possible in the planning stages and throughout the response to increase their ownership of the response sharing clear information about response activities, selection criteria and distribution processes with communities through community meetings and door to door activities. • Feedback and complaints on Cholera interventions will also be collected through community health volunteers, community meetings, radios, focus group discussions and CEA boxes and responses provided through community meetings and on a case-by-case basis where it is a sensitive issue, or a concern shared by one person provided directly to the individual. • Frequently Asked Questions (FAQ's) will be developed in collaboration with ministry of health and shared with volunteers so they can address frequent questions, concerns and beliefs that are seen from the feedback data. • As specified in the CEA section, the feedback mechanisms and tools for KRCS are in place or already developed and used. They will need to be further adapted in the areas of the operations. Also, CEA will be incorporated to CBS and EPIC trainings. • Through CEA, most of PGI desired impacts will be felt since all volunteers will have been sensitized to ensure PGI programming.

Protection, Gender And Inclusion

Budget	CHF 0
Targeted Persons	1410720

Indicators	**Target**
Number of refugees receiving cholera management and prevention services	233736
Number of people with disability reached with Cholera prevention messages	31036
Priority Actions:	• The PGI activities and corresponding budget allocation are integrated within the Health and WASH sectors. • The operation will ensure the promotion and participation of men and women including persons with disabilities of different age groups in Cholera awareness activities. • A continuous dialogue among the different stakeholders will be fostered to ensure all programmes/sectors mainstream PGI approach ensuring the Minimum Standards on Protection, Gender and Inclusion in emergencies are met based on the identified needs and priorities of humanitarian imperatives on the ground. This operation will ensure all staff and volunteers are briefed on the Code of Conduct and on prevention and response to sexual exploitation and abuse and child safeguarding as they implement Cholera interventions. It will ensure all NS, IFRC, PNS staff and volunteers involved have signed the Code of Conduct. PGI mainstreaming will be done per Minimum PGI standards in Cholera interventions while ensuring that all the data that is collected is disaggregated using SADDD. • Operations in refugee camps will also foster involvement of asy-

	lum seekers and host communities while planning for response activities. • Debriefing meetings will be done by volunteers and sector team leads to allow sensitization on PGI.•

	**Water, Sanitation And Hygiene**	**Budget**	CHF 62,973
		Targeted Persons	1410720

Indicators	**Target**
Number of WASH assessments conducted	8
Number of households reached with WASH related information	282144
Number of food handlers PHOs/RCAT Team leads trained of food hygiene	50
Number of PUR/Aqua Tabs procured	150000
Priority Actions:	• Support WASH assessment and planning for actions with the community using IFRC assessment tools (including KAP surveys, sanitary surveys, and Water points: The WASH assessments shall include KAP Surveys, and Waterpoint surveys to establish the WASH gaps both in knowledge and infrastructure and inform on the number of water points requiring rehabilitation. The assessments will also establish the extent of damage of the Water points. The MEAL will lead in the KAP surveys while for the water points assessment the Water engineers from the Ministry of Water and Sanitation with the KRCS WASH specialist shall lead the assessments. • Conduct food safety and hygiene educations for all food handlers PHOs/RCAT Team leads • Training of KRCS RCAT on household decontamination. • Distribute Chlorine for water treatment: The action will ensure that Chlorine for Pot-to-Pot chlorination is available in the affected Counties to ensure that households using unsafe water for drinking are treating the water at the point of use. • The project will also support Volunteers who are distributing the PUR and Aqua tabs stock solution to the targeted households (through direct distribution or through clustered distribution as per MoH guidelines). The action shall also ensure that CHVs and RCATS are providing hygiene promotion messages and following up on the usage of chlorine. • Provide spray pumps and PPEs for decontamination use at the community level.

About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.
A total of 600 volunteers from the 8 counties will be engaged and supported by this DREF in this operation. The operation will also engage a surge team comprising of 14 clinical officers, 32 nursing officers, 5 pharm techs, 45 support staff, 18 PHOs, 1 water technician and 15 drivers who will be distributed across the most affected counties.

The operation will also engage a surge team comprising, 14 clinical officers, 32 nursing officers, 5 pharm techs, 45 CTU support staff, 18 PHOs, 1 water technician and 15 drivers who will be distributed across the most affected counties. Their main role will be to provide essential services in cholera treatment centers and provide technical support to volunteers conducting hygiene promotion activities.

If there is procurement, will it be done by National Society or IFRC?
Local procurement will be carried out in accordance with the KRCS standard procurement procedures.
Current procurement plans will include procurement of health and WASH items for ORP, material for CTU etc. A procurement plan is to be developed to ensure timely support to the operation. KRCS has functional procurement and regional/branches warehouses capacity if needed.

How will this operation be monitored?
With the support of the IFRC PMER, the KRCS Monitoring, evaluation, learning, and accountability department will support the DREF operation for Cholera by providing technical inputs and support to the public health in emergencies department on planning, continuous monitoring, assessment results, and information management. They will also support the development and implementation of assessments in this operation. Monitoring reports shall be used to make proper adjustments to the plans and inform ongoing actions.

IFRC will undertake three technical support visits to the National Society. At the end of the DREF, the MEAL team will lead a joint lesson learning workshop with all stakeholders to document lessons that can be incorporated in future such operations. The lessons learned session will be built on the previous lessons drawn from other Cholera responses and will include a two-day debrief of volunteers and MOH staff involved during the operation.

Please briefly explain the National Societies communication strategy for this operation.
KRCS public relations and communication department will ensure the media coverage and visibility of the operation through press article during the implementation, photos, and video documentaries. Information related to the operation will also be disseminated through KRCS social media pages, mainstream media and the organisation Website.

Budget Overview

DREF OPERATION

MDRKE053 - Kenya Red Cross Society
Cholera Outbreak

Operating Budget

Planned Operations	**344,746**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	254,222
Water, Sanitation & Hygiene	62,973
Protection, Gender and Inclusion	0
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	27,550
Environmental Sustainability	0
Enabling Approaches	**154,074**
Coordination and Partnerships	0
Secretariat Services	6,339
National Society Strengthening	147,735
TOTAL BUDGET	**498,819**

all amounts in Swiss Francs (CHF)

Contact Information

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

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