DREF Operation-Final Report

Tanzania| Cholera Outbreak

DREF operation	**Operation n°** MDRTZ031
Date of Issue: 03 February 2023	**Glide number:** EP-2022-000211-TZA
Operation start date: 18 May 2022	**Operation end date:** 31 July 2022
Host National Society(ies): Tanzania Red Cross Society	**Operation budget: 78,545 CHF**
Number of people affected: 56,883	**Number of people assisted:** 38,468 people (Approx. 7,693 households)
Red Cross Red Crescent Movement partners currently actively involved in the operation: International Federation of Red Cross and Red Crescent Societies (IFRC)	
Other partner organizations actively involved in the operation: Ministry of Health (MoH) - Coordinating operation, secretariat, UNICEF chairing the WASH pillar, Regional and Local Government Authorities. Rural Water Supply and Sanitation Agency (RUWASA), MSF, AMREF, Muhimbili University	

The major donors and partners of the Disaster Relief Emergency Fund (DREF) include the Red Cross Societies and governments of Belgium, Britain, Canada, Denmark, Germany, Ireland, Italy, Japan, Luxembourg, New Zealand, Norway, Republic of Korea, Spain, Sweden, and Switzerland, as well as DG ECHO and Blizzard Entertainment, Mondelez International Foundation, Fortive Corporation, and other corporate and private donors. DG ECHO contributed to replenishing the DREF for this operation. On behalf of the Tanzanian Red Cross Society (TRCS), the IFRC would like to extend gratitude to all for their generous contributions.

A. SITUATION ANALYSIS

1. Description of the disaster

Tanzania still faces challenges to attaining universal access to safe and clean drinking water, along with inadequate sanitation, particularly in unplanned settlements along the lake shores and densely populated settlements in urban settings. According to UNICEF, 61% of the population uses at least basic drinking water services; and 26% use safely managed sanitation services (Source: https://data.unicef.org/country/tza/,). It is notable that, while Cholera is endemic in Tanzania, the country has not had an outbreak since 2019, mostly attributable to multiple cholera preventive interventions being implemented within the context of the country's COVID-19 Prevention Plan.

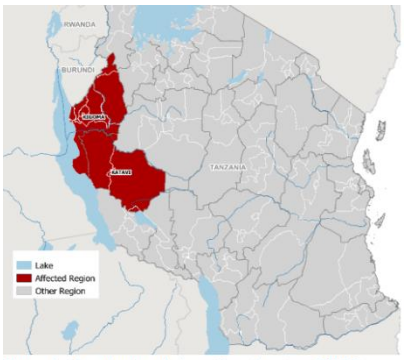


Figure 1: Map showing cholera affected regions ©IFRC

On 18th April 2022, Katavi regional medical officer was notified of a patient presenting with symptoms of profuse watery diarrhea and vomiting, from Lwega in Kalya ward of the Uvinza district. On the following day two more patients with similar presentations were reported, one from the same village of Lwega and another from Karema in Tanganyika DC. As of 23 of April total of 13 patients with similar presentations were reported, ten (10) from Tanganyika DC, and three (3) from Uvinza DC. Out of 13 reported patients, nine (9) of them presented with severe symptoms. In total there were 261 symptomatically suspected cases (137 in Katavi and 124 in Kigoma) of which 200 were confirmed with four deaths recorded. Uvinza district accounts for most of the cases (106 cases) had mild symptoms and one patient had moderate symptoms. As of 28 April 2022, the outbreak had spread to other areas along the neighborhood.

The suspected four cholera samples from Tanganyika DC were sent to the National public health laboratory. All four samples tested culture positive for vibrio cholerae. Following these results, the region and district teams declared the presence of a cholera outbreak in Karema and Ikola villages in Tanganyika and Kalya, sibwesa, Kashagulu villages of Uvinza DC. Cases started to increase on subsequent days irregularly until 6th May 2022, when the situation was contained in Uvinza where numbers decreased to less than two while Tanganyika Dc picked up with more than 30 cases in seven days. The number of affected villages also increased from six to 11 where, with the support from government, TRCs covered all the villages targeting mostly the affected hamlets. The rapid increased of cases has limited the self-capacity of TRCS to support the Government response, thus requesting an allocation from the DREF.

2. Summary of response

Overview of Host National Society

Following the Cholera outbreak declaration on 23 April, TRCS started providing support to the Government. TRCS In collaboration with the Ministry of Health and Social Welfare (MoHSW), Local government authorities and United Nations Children's Fund (UNICEF), and other actors on the ground joined hands to cascade the interventions. TRCS was assigned community-based interventions. TRCS participated in weekly coordination meetings on the RCCE, and WASH sub pillar and the national multi-sectoral coordination meeting led by WHO. See details of the initial action in the EPoA.

TRCS staff visited water source for water quality assessment during assessment in Lufubu village

TRCS capacity was however exceeded by the escalating number of cases forcing the NS to request IFRC financial support through the Disaster Relief Emergency Fund (DREF) and on 18 May 2022 DREF Operation was launched and granted for CHF 78,545 for two months to support the NS in conducting perception survey, complemented by KII and focus group discussions to ascertain the knowledge, attitude, and perception among the communities. In addition, TRCS planned to conduct training of volunteers on health and Hygiene promotion, and address immediate needs on PSS and WASH. The funding also allowed the deployment of community volunteers to support awareness raising on health and WASH risks to support community-based surveillance and case management.

A detailed assessment was carried out jointly with TRCS and local government authorities which identified that there was an urgent need for hygiene promotion and cholera awareness activities at community levels in all affected regions.

TRCS deployed two WASH Regional Disaster Response Team (RDRT) experts in country and PMER to conduct baseline surveys and training for volunteers in Uvinza and Tanganyika. Two regional coordinators and drivers led the coordination with the regional government teams. A total of 84 volunteers who were initially trained in health and hygiene promotion, CEA, and PGI, were deployed to support the RCCE and hygiene promotion activities. Following the escalation of cases, 12 more volunteers were deployed in the new areas to support the RCCE and health promotion campaigns.

TRCS deployed two vans - one for Uvinza Dc, from Kigoma regional office; and one for Tanganyika Dc from Katavi regional office to support movement in the field. For the HQ visits, some vans from HQ were deployed to support mobility.

Health sector:

- Capacity building to TRCS volunteers and CHW on health promotion, in which a total of 96 volunteers and 24 Community health workers from both districts were trained.
- By deployment and conducting capacity building 12 TRCS volunteers for Psychosocial support and 12 Volunteers for CEA were deployed to the affected communities. CEA volunteers supported in collecting community feedback and rumours from the affected areas during operation in which TRCS in collaboration with local authorities activated help desks and house-to-house visits to talk to communities on issues pertaining their knowledge and challenges which continuously informed the team on the situation for immediate decision making.
- Promoted health-seeking behaviour for any symptoms related to cholera and other health challenges instead of using traditional herbs and staying home.
- Engaged community leaders in supporting awareness campaigns and feedback collection from the community to address challenges and early case detection and referrals.
- Engaged community groups in focus group discussions to discuss health challenges related to Cholera.

WASH sector:

- Hygiene promotion campaign - 96 volunteers carried out health and hygiene promotion in the communities using Bango Kitita, targeting household, schools, and shopping centers, fishing sites in the affected areas.

- 30 volunteers supported in conducting surveys and FGD in the affected areas. These volunteers were mobilized from the affected areas to help with social mobilization and were actively involved in running mobile cinemas in the affected areas. With the support from HQ technical teams during the campaigns, the group provided key messaging using the public address (PA) system and at shopping and business centers, provided awareness sessions which culminated in the distribution of fliers and posters.
- At the household level, volunteers distributed aqua tabs, oriented families on water treatment, support them in setting up the hand washing points, assess the sanitation facilities, and advise them accordingly, and demonstrated proper hand washing practices, food hygiene, and general cholera messaging.
- The leaders engaged in promotion also supported the enforcement of measures for proper hygiene.

Overview of Red Cross Red Crescent Movement in country

IFRC provided assistance through its Juba cluster office and regional office. There was regular contact with Tanzania Red Cross since the onset of the cholera outbreak, the review, and approval of the DREF operation. PNS in country, Spanish RC, and Belgian RC Flanders were updated on the outbreak.

Overview of non-RCRC actors in country

TRCS is a member of the national Cholera Response Taskforce forum, WASH, RCCE and Coordination pillars activated since the COVID-19 Pandemic both at the Regional and district levels. At National levels pillars have actively been conducting meetings weekly or bimonthly to share updates. In addition, TRCS collaborated with other partners on other responses to the control of the cholera outbreak. The National Society also collaborated with UNICEF and CDC Atlanta, to carry out Community-based COVID-19 interventions in different regions since the outbreak.

The Ministry of Health established a coordination mechanism at the national level at the beginning of the outbreak and TRCS participated throughout the operation. The District Cholera Task Force and National Epidemic Response committees have been holding regular coordination meetings where updates are shared amongst partners and operational activities re-designed to meet the set disease control objectives. The Ministry of Health (MoH) and the District Health Team remain the main interveners. The district and sub-county authorities have been enforcing the by-laws such as stopping the sale of cold foods and fluids that aid the spread of the disease and reprimanding households that lack pit latrines.

In line with the Global Task Force on Cholera Control roadmap, the WHO support focused on three strategic pillars: early detection and quick response to contain the outbreak; a multi-sectoral approach to prevent the recurrence; as well as effective coordination mechanism for technical support, advocacy, resource mobilization and partnership at the regional and district level.

Different actors on the ground responded to the outbreak to support IPC, case management, RCCE, and WASH. The students from Muhimbili University (MUHAS) supported Community Based Surveillance (CBS) in the Karema ward of Tanganyika DC; the medical San Frontiers (MSF) in Uvinza supported the erection of temporary Cholera Treatment Centers (CTC) and equipping the center; Save the Children and plan international who have projects in Uvinza and Katavi contributed with IPC supplies and awareness creation using the community health workers. Rural water and sanitation (RUWASA) worked hard to ensure water care and treatment at the sources. From the TRCS warehouse, UNICEF approved some WASH supplies to equip health facilities and CTC and the RRT to conduct rapid assessment. The team comprised 2 epidemiologists, 1 clinician, 1 health officers, 2 advanced FELTP residents and 2 intermediate FELTP residents.

At the beginning of the operation, UNICEF donated water purification tablets (128,000 pieces), hand sanitizers (48 bottles), 1,000 face masks, 8 gallons of hand-washing soap, bar-soap (75 bars), plastic aprons (80 pieces), and 20-liter buckets with stands (5 pieces) to the Katavi region.

Needs analysis and scenario planning

Need analysis

As indicated in the EPoA, TRCS has not conducted any assessment regarding this outbreak. The assessment was conducted by the Ministry of Health technical team. A national Rapid Response Team constituting experts from the Ministry of Health and WHO in the areas of leadership and coordination, risk communication and community engagement, Water, Sanitation and Hygiene (WASH), and disease surveillance were deployed to conduct a rapid assessment jointly with the regional and council health management teams. By June 26th more than 200 cases were reported and confirmed with four deaths in Tanganyika district Katavi region - a case death rate of 2% which was above the acceptable rate for an outbreak under control.

Temporary CTC established in Subwesa village

From that assessment, TRCS has been able to adapt the proposed response and understand the driving factors of the outbreak. The outbreak evolution is summarized in the figures below:

Fig. 1: Epi-curve to showcases of cholera trends in Tanganyika DC, and Uvinza DC from April to June 2022

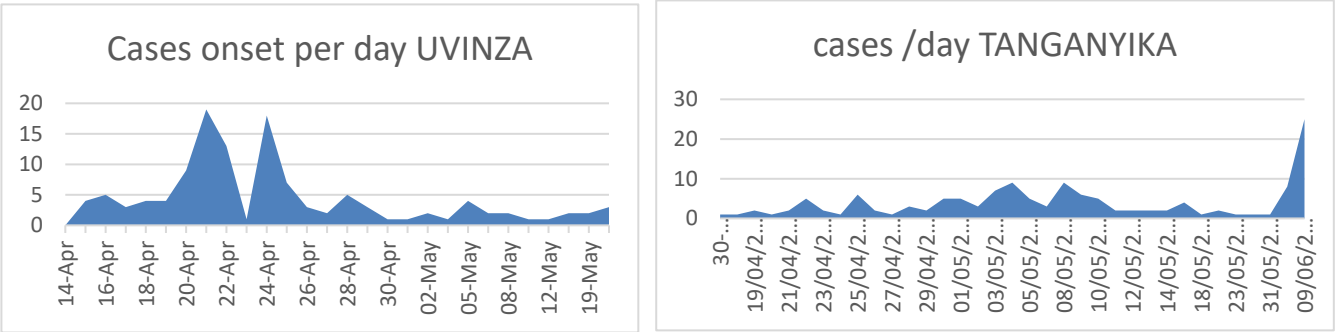


Table 1: Demographic data of affected areas in April 2022

Location				**Demographic data**			
Region/ District	**Ward**	**Village**	**No hamlet**	**Female**	**Male**	**Total**	**HH**
Katavi /	Karema	Karema Kaskazini	6	789	711	1,500	950
Tanganyika	Ikole	Ikole store	8	4,286	3,701	7,987	1,751
		Mchangani	8	4,134	2,734	6,868	1,684
	Isengule	Kasangantongwe	4	2,522	2,328	4,850	600
		Kapalamsenga	6	3918	3764	7682	1087
		Songambele	4	1366	1313	2679	781
	Total		**36**	**17,015**	**14,551**	**31,566**	**6853**
	Kalya	Sibwesa	**5**	3841	3691	7532	1,483
Kigoma / Uvinza		Lufubu	**4**	2101	2019	4,120	824
		Kalya	**5**	1824	1752	3,576	738
		Tambushi	**4**	2092	2009	4,101	654
		Kashagulu	**5**	3054	2934	5,988	1,172
Total			**23**	**12912**	**12405**	**25317**	**4871**

Table 2: Assessment results on the water test conducted by government Authorities; May 202

No	Village	Water source	Number of samples	Results
1	Karema	Short well	1	Fecal contaminated
2	Karema	Lake	1	Fecal contaminated
3	Karema	Tape	1	Fecal contaminated
4	Karema	Short well	1	Fecal contaminated
5	Kasangantongwe	Deep well	1	Not contaminated
6	Kasangantongwe	River	1	Fecal contaminated
7	Isengule	Deepwell	1	Not contaminated
8	Mchangani	Short well	1	Fecal contaminated
9	Ikola	Tape	1	Not contaminated

The general situation, need, and gaps from observation:

- Overview of final scope as of July: 11 villages affected, 261 suspect cases and 200 confirmed cases identified. Nine villages were identified initially with reported escalating cholera cases due to contamination while transferring patients from community to facility. Two more villages reported suspected contamination in Tanganyika DC and laboratory testing confirmed the results were positive. The teams agreed to establish an Isolation site in Kapalamsenga to reduce traveling distances and the possibility of more contamination. However, the teams were deployed to support awareness in the two new villages of Kapalamsenga and Songambele, making the total village affected with increased cases and to be covered to be 11.

Boat hired to move the assessment team to Rwega sub village of Lubufu in Uvinza DC, where cars cannot reach

- There was only one CTC identified in Tanganyika district to serve more than six villages, which made some patients to cross two villages for more than 30 Km to reach the facility by motorbikes, where the patients had to stop and request to rest or use a latrine on the way. In Uvinza three CTCs were established to facilitate the five affected villages. However, there was a challenge like the roads due to rift valley features which made it hard to reach the facilities, thus resorting to using boats as the only alternative.
- Tracking and reported cases are not harmonized. Some people reported handling cases at the community level where some deaths occurred, but these were neither tracked nor reported. This was the situation in Sibwesa, Lufubu, and Rwega sub-villages which were hard to reach.
- Findings from the risk assessment also highlighted the need to intensify surveillance, increase access to safe water and sanitation, strengthen risk communication and community engagement activities, and overall response coordination and partnership to address the identified gaps and challenges.
- **Baseline survey** (knowledge, attitude, and perception (KAP); key informants' interview(KII) and focus group discussion (FGD)

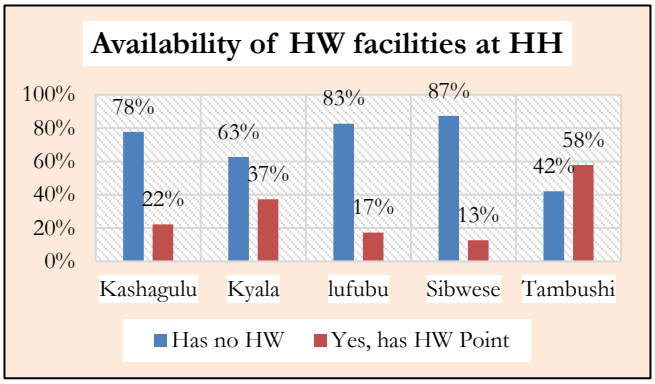
TRCS conducted a KAP survey in the nine affected villages using different methodologies including KII and FDG targeting to reach 30% of the population to ascertain the knowledge gap for designing communication messages and strategies to address the gap. The assessment engaged all community group members eligible to respond to questionnaires from 30th May to 6th June.

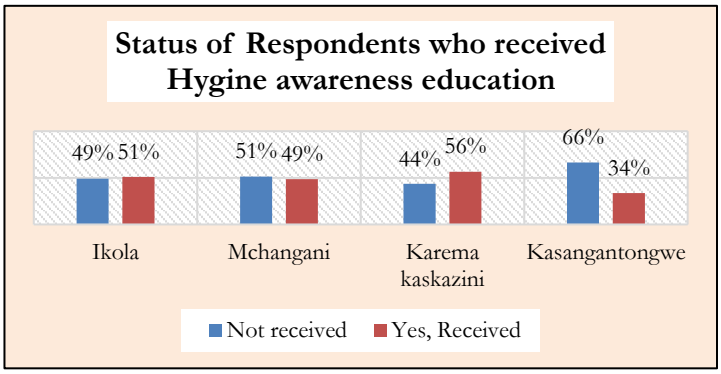
In the KAP survey, the sample size was 10% of the households at risk with (919 HH) 48% males and 51% were females; 113 HH reached in a total of 9 FGD and KIIs involving 50% of males and females of different ages majority being youth below 30 years (70%). In Kigoma, a total of 507 respondents were reached, out of which 65% were males and 35% were females; 196 reached in FGD and KI interviews comprising of 50% male and 50% female. In total 16% were reached during the survey, which was lesser than the target due to wide geographical coverage.

The questionnaires were organized into five thematic areas to collect data in compressive way and to see the key Cholera disease knowledge, attitude, and practices in the community The thematic areas included:

Section	Thematic area
Section 1	Geographical Information
Section 2	General Information of Household
Section 3	Knowledge, Attitudes, Practices Regarding Cholera
Section 4	Water, Sanitation, & Hygiene
Section 5	Community Engagement and Accountability

Fig 2: Some analyzed data from assessment





Following the assessment results, the team took some immediate measures to ensure cases were well managed at the facility level with proper data management. A gap was identified in the community which informed the need for the TRCS to join hands with the government to design community intervention to support community-based surveillance and case management by capacitating the community volunteers and local leaders to monitor cases with related symptoms and report immediately; raise awareness through RCCE to intensify household sanitation monitoring, and campaigns on food hygiene, water treatment, latrine construction, and utilization. In addition, conduct advocacy on behavioral change on communal proper hand washing practices to reduce the risk of cholera transmission. Some of the key recommendations and conclusion worth pursuing to support the cholera outbreak was as follow:

- Need to undertake the campaign activities in the communities.
- Promote interventions that empower households to construct their latrines and utilization.
- Government should support the establishment of permanent and safe water infrastructure.
- Promote proper waste disposal to ensure water sources are protected.
- Continue promoting hand-washing activities.
- WASH project would be useful to address most of the recurring waterborne-related diseases experienced in the areas.

Risk Analysis

- The risk of the outbreak spreading to other parts of the country was high. However, due to preventive measures put in place through awareness campaigns, the spread was not catastrophic as initially anticipated.
- Community perception of water treated with chlorine or Aqua tabs could have equally affected the successful implementation of planned interventions under this DREF operation. Generally, the community has some hesitation in drinking water treated with Aqua tabs with the complaint that the natural taste is lost. Sustained community sensitization weighed in heavily on the derived benefits from chlorinated water changed community perception to treat water with chlorine or Aqua tabs, the proposed action included community engagement and accountability mechanisms.
- The long distances from villages to CTC were also a contributing factor for rapid spread due to limited knowledge in case management and surveillance among the communities. This was highlighted during contact tracing and well communicated among the responsible structures and well managed. Continuous feedback, through TRCS volunteers, was collected and analysed to improve service delivery to the target beneficiaries. A help desk was set up to provide information on activities the NS was implementing and to also allow the community to ask questions and contribute to project activities in ways that helped meet the humanitarian needs.

B. OPERATIONAL STRATEGY

Overall Operational objective:

The operation aimed at providing 38,468 people (7,693 households) with health and hygiene awareness messages on Cholera while integrating CEA and PGI into the strategies in six villages of the Uvinza and Tanganyika districts.

The intervention improved early detection, reporting, and referral of suspected cases to the established treatment centres through community-based disease surveillance. These efforts contributed to controlling the disease spread with no new cases reported in the targeted districts by end of the operation.

One of the poor latrines marked during assessment in Sibwesa village

A joint rapid assessment was conducted by the MoH in collaboration with Tanzania Red Cross and other key actors. Tanzania Red Cross Society (TRCS) has been fully involved in the Cholera response ever since the Government of Tanzania declared the outbreak and requested TRCS support through the Ministry of Health.

TRCS took part in the crisis meeting chaired by the MOH on the strategic response plan for this outbreak. As part of the initial response, the National Society deployed four technical staff and 96 volunteers from its roster of community rapid response teams. During the coordination meetings, to which TRCS was represented in the WASH and RCCE sub-committees, the following were the recommendations.

- Rapid assessment/ situation analysis to determine the predisposing factors for appropriate messaging.
- Community stakeholder sensitization meetings to be held.
- House-to-house hygiene promotion.
- Assessment of water points and water treatment.
- Strengthen community-based surveillance.
- NFI distribution- aqua tabs.

1. TRAINING TO VOLUNTEERS, CHW, AND COMMUNITY LEADERS

TRCS started immediately by orienting 81 volunteers and 24 CHWs on health promotion to cover the 15 affected villages. The volunteers signed a code of conduct and were issued with a contract for two months of social mobilization activities (household visits), which included the distribution of water treatment tabs (aqua tabs) issued by UNICEF to strengthen community surveillance and distribution of IEC materials. From each village, two leaders were involved in the training to ensure they were also part of the mobilization team. Community leaders appreciated being part of the training and had a lot of contributions especially in listening to community problems which they also ascertain as a gap in their undertaking. They promised to be center of receiving community feedback, by placing the help desks in their office and during the community meeting. The training ended with a developed plan of community meetings for every village twice a month for mobilization and following up on the hygienic concerns agreed.

Volunteer training in Uvinza DC

TABLE 4: TRAINED TEAMS DURING RESPONSE

Training /orientation to volunteers	Tanganyika		Uvinza		Total	
	M	F	M	F	M	F
Hygiene promotion, (PGI)	25	20	21	15	46	35
Food, hygiene, and relief	24	18	19	17	43	35
CEA and PSS	7	5	6	6	13	11
KAP/FGD/KI	61	52	104	92	165	142
Leaders' orientation Hygiene/CEA	12	4	9	5	21	9

2. **EQUIPPING VOLUNTEERS WITH FLIP BOOKS, VISIBILITY, AND PPE**

All volunteers were equipped with community awareness guide flip charts for reference from UNICEF stock during the household visit, , PPE to protect them from outbreaks including ongoing COVID 19 which included 1 box of 50Pcs of masks, 1 bottle of sanitizer, RC jacket, and a Pair of gumboots. TRCS also supported the distribution of cholera beds and other IPC materials to facilities in remote areas including 4 cholera beds; 100 pairs of gum boots; to health facilities issued from UNICEF stock.

TRCS HQ handing over PPE and flip books to Kigoma branch

3. DEPLOYMENT OF VOLUNTEERS AND CHW TO CONDUCT HEALTH AND HYGIENE PROMOTION CAMPAIGNS AND COLLECT FEEDBACK

In response to the outbreak, the Tanzania Red Cross Society (TRCS) in collaboration with other partners engaged the affected communities through community volunteers trained in health and hygiene promotion, community engagement and accountability, PSS, PGI, and CEA activities. This increased public awareness of cholera prevention, active case search and referral, and early treatment of cases which contributed to saving more lives in the affected districts.

Volunteers conducting hygiene promotion in Tanganyika DC

TRCS branches in the target districts collectively mobilized 96 community-based volunteers, 24 CHWs, and 30 community leaders, some of whom were already trained in hygiene promotion, for cholera control sensitizations in the affected and at-risk communities. The volunteers moved house to house to sensitize and support households in the affected communities with immediate hygiene supplies like water purification tabs which were issued by UNICEF, assessment of sanitation facilities, and orient the community in proper hand washing orientation. The flip guide was used by volunteers as a reference with pictorial displays during community orientation to improve cholera prevention knowledge and promote safe water use, environmental cleanliness, food, and personal hygiene.

Fig 3: SANITATION MAPPING

	demographic data			HH sanitation			School Sanitation			market sanitation		Water Supply sources used by			
Village	Population	Number of sub-villages	Number of households	improved latrine	temporary Latrine	No latrine	Number of schools	No of pupils	No of Drop holes	Number of Market	No of Drop holes	Piped water system	Protected wells with hand pumps	Unprotected well	Other sources inluding lake
Uvinza district															
Sibwesa	7532	5	1483	43	903	537	2	1286	8	1	0	0	4	5	1
Lubufu	4120	4	824	4	464	356	1	1599	4	0	0	0	0	2	2
Kalya	3576	5	738	11	640	87	2	1254	32	1	4	6	0	0	1
Tambushi	4101	4	654	6	583	63	1	1100	4	0	0	8	0	1	1
Kashagulu	5988	5	1179	34	986	152	1	672	6	1	2	0	3	3	1
Tanganyika District															
Karema	1500	6	950	70	502	448	2	752	8	1	2	1	3	2	1
Ikola store	7,987	8	1751	146	675	830	2	1680	10	1	4	1	4	3	1
Mchangani	6868	8	1684	236	453	995	1	618	4	1	2	1	2	4	1
Kasangantongw	4850	4	600	31	164	416	1	762	4	1	2	0	1	4	1

Community awareness on cholera and hygiene promotion at Tambusha village Uvinza DC

Cinema event in Mchangani village, Tanganyika DC,

4. HYGIENE PROMOTION THROUGH MOBILE CINEMA

In response to the cholera outbreak in Katavi and Kigoma regions, TRCS with IFRC support conducted a cinema show in the Katavi region targeting all 11 villages affected by the cholera outbreak which are Ikola, Kalema, and Isengule wards of Tanganyika dc, and Kalya ward of Uvinza DC. This was aimed at engaging the community to reduce the risk caused by the outbreak. The cinema show was conducted in the evening when most people were free. The key Cholera message was delivered to the community in an edutainment model and fully encouraged community participation.

TABLE 5: People reached during Mobile Cinema events

District /Region	Village	Male	Female	Children	Total
Tanganyika DC / Katavi	Ikola	70	30	120	220
	Kalema	150	90	30	270
	Isengule	100	60	40	200
	Kalema Secondary	150	300	20	470
	Mchangani	70	45	60	175
	Kasangantongwe	35	50	60	145
	Kapalamsenga	80	50	30	160
	Songambele	50	45	60	155
Uvinza DC - Kigoma	Sibwesa	150	270	190	600
	Lufubu	130	15	55	200
	Kalya	65	205	80	350
	Tambushi	310	50	170	550

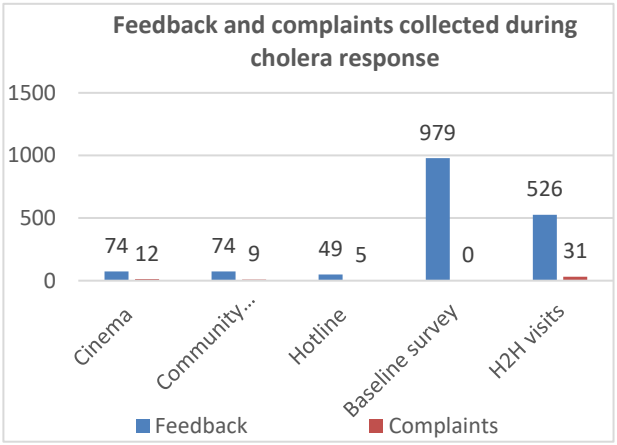
	Kashagulu	270	115	65	450

5. COMMUNITY ENGAGEMENT AND ACCOUNTABILITY THROUGH THE OPERATION

The Cholera response operation made it a very good experience to collaborate and coordinate with government authorities at village and ward levels, who committed to take lead in responding and addressing feedback from the community. The CEA topic was introduced during volunteer training using a one-hour presentation and brought in discussions. The leaders were motivated to implement the concept and planned bi-monthly meetings to respond to community challenges and provide feedback on matters raised from previous meetings. The communities were engaged in several undertakings, including the KAP survey, KII, FGD, Hygiene promotion, cinema, and community meetings.

6. CEA in KAP survey, FGD, and KII

- The surveys were led by TRCS staff and Local Government Authority (LGA), engaging the community in data collection where 60 volunteers were trained in data collection and deployed for four days to collect data. Randomly selected communities provided feedback to map knowledge, attitude, and perception of the community towards cholera prevention and early actions. They provided feedback on the real situation and action taken by communities, in case of new cases. All the 979 who participated in the survey were asked the CEA questions and responded to provide how best feedback can be collected, the best time for community meetings, and the like.
- The community engagement highlighted behavior change where volunteers disseminated key hygiene messages and how communities were supposed to act to forge positive behaviors. This includes, but is not limited to, installing hand washing equipment, improving latrine coverage, and treating drinking water. The results were revealed on the baseline and end-line data where significant change was reported with an average increase by 15%.
- Community participation was well-marked during cinema events where communities participated in edutainment events. More than 400 people participated in cinema events that touched their souls and minds, toward behavior change. A total of 86 feedbacks were collected, 74 appreciations and 12 complaints, which were addressed, and respondents were reached for feedback.
- Community meetings held were a good platform for community participation and feedback, where community leaders, health care workers, and district leaders participated and shared updates on the cholera situation, feedback from the surveys, and recommendations on which communities are responsible to act and the ones for the Government. An average of 2 meetings for each were held during the implementation period, amounting to a total of 21 meetings. In each meeting, an average of 4 general questions were allowed and responded to instantly by community leaders. For other personal questions were encouraged to visit village or health facility offices. TRCS appreciates the good collaboration among the community leaders and health facility workers in the affected area who owned the campaigns to ensure cases are contained.
- The hotline was also active during the implementation and recorded several feedbacks from the affected area, most of which were appreciation to the RC work, requests for support of latrine construction materials, requests for ore aqua tabs, requests for improved water sources and requests to join the RC from Cholera response operation. A total of 54 feedbacks were recorded, among them, 5 were complaints, which were addressed, and feedback sent to complainants.



Cinema event in Karema secondary school, Uvinza DC

- During house-to-house visits volunteers were also collecting feedback from the community and responded to questions using the FAQ guide, where the issue was out of their knowledge, they referred to the health practitioner of a community leader.

C. DETAILED OPERATIONAL PLAN

Health
People reached: 38,468 (7,693 HH)
Male: 18,849
Female: 19,619

Health Outcome 1: Transmission of diseases of epidemic potential is reduced		
Indicators:	**Target**	**Actual**
% Of targeted population reached during survey (Target: 30% of target population)	30%	15%
Health Output 1.1: Community-based disease control and health promotion is provided to the target population		
Indicators:	**Target**	**Actual**
# Of volunteers who receive health and hygiene promotion training	84	96
# Of CHW who receive health and hygiene promotion training	24	24
# Of community leaders who receive the training	30	36
# Of volunteers who sign the Code of conduct	84	96
Health Output 1.2: Transmission is contained through early identification and referral of suspected cases		
Indicators:	**Target**	**Actual**
% Of cases identified through community activities who are encouraged to seek care	80%	70%
Health Output 1.3: Improved knowledge about public health issues among 6 affected villages of Uvinza and Tanganyika districts		
Indicators:	**Target**	**Actual**
% Of the target population reached have access to information pertaining to the cholera epidemic prevention	90%	95%
# Of flip books produced and distributed to volunteers for awareness creation	100	120
Health Outcome 2: National Society has increased capacity to manage and respond to health risks		
Indicators:	**Target**	**Actual**
# Of coordination meetings held with partners during the response	10	2
Health Output 2.1: The National Society and its volunteers are able to provide better, more appropriate, and higher quality emergency health services		
Indicators:	**Target**	**Actual**
# Of volunteers providing support in affected communities	84	96
Health Outcome 6: The psychosocial impacts of the emergency are lessened		
Health Output 6.1: Psychosocial support provided to the target population as well as to RCRC volunteers and staff		
Indicators:	**Target**	**Actual**
# Of volunteers who have received PSS training	12	12

Narrative description of achievements

The achievements were reached through close collaboration with government and community authorities during the response period stipulated as follows:

- The initial plan was targeted to reach 30% of communities in the surveys, the number could not be reached due to geographical constraints and budget.
- The perception survey reached an average of 10% and KII and FGD engaged at least 5%, making sure the coverage in the area was 100%, and the most affected wards participate in responding to the survey to get the real perception among the people.
- Other communities were reached with the sanitation mapping during HH visits.
- About 24 Community Health workers and 84 volunteers were trained to strengthen their capacity for health promotion including case management and community-based surveillance to support in initial case management

at the community level and call for health-seeking behaviour, awareness understanding of cholera signs, symptoms, and preventive measures to communities.

- 12 more volunteers were added in the 2 new villages making the total trained volunteers to be 96. Their cost was covered by the printing of the flipbook's budget line, which was donated by UNICEF from the cholera preparedness stocks. Thus, the DMO requested support from more volunteers.
- In collaboration with village leaders, the awareness is estimated to have reached 96% (24,304 people) in Uvinza and 94% (29,672 people) in Tanganyika districts through various approaches including door-to-door visits, public addresses, sanitation mapping, community meetings, IEC materials, and Cinema events.

Volunteers oriented on PSS visited the survivor's households to make sure they are positively regarded by the family and engaged well back to the community. Two volunteers in each village were oriented to support the follow-up of survivors.

By the end of the response action, the spread of the cholera outbreak was controlled to both communities and more than 14 days with no new cases reported. The last case was reported on 9 June.

Challenges

- The escalating number of cases from reported 9 villages to 11 villages (6 villages Katavi and 5 villages Kigoma) within the same wards targeted which needed more deployment of Volunteers and Community Health Worker and education promotion materials.
- Community mode transport of patients was the contributing factor to more transmission during the movement and care of a patient to the hospital.

Lessons Learned

- Community perception of witchcraft could have led to more disease spread if the communication could not address the idea and call for intensified community-based surveillance, case management, and early reporting.
- Working with community Health workers and volunteers together brought more experience and influenced them to become TRCS members. The volunteers' work complemented the work of CHW and made the communication at the community level louder including the close follow-up of sanitation and hygiene at the HH level, which improved family latrine ownership.
- Engaging the community leaders from the beginning made the work of volunteers simple as leaders were following up to ensure the agreed actions are adhered to, and could easily pick up the feedback and work on, including enacting bylaws for hygiene infrastructure.
- Experience gained in the joint intensified awareness has been inherited by the council towards outbreaks interventions, and capacity building among the team is the community assets.
- Coordination with partners through National multi-sectoral, RCCE, and WASH sub-pillar made the coordination at the national level smooth coordinated by MOH, and partner coordination at the regional and district level leveraged resources to support the operation, including the erection of temporary CTC, Medical supplies, RCCE, and gaps could easily be identified and covered.

Water, sanitation, and hygiene
People targeted: 38,468 (7,693)
Male: 18,849
Female: 19,619

WASH Outcome 2.0: Immediate reduction in risk of waterborne and water related diseases in targeted communities

Indicators:	Target	Actual
% Of households reached with health and hygiene promotion messages	100% or 7,693 HH)	100%

WASH Output 2.1: Continuous assessment of water, sanitation, and hygiene situation is carried out in targeted communities

Indicators:	Target	Actual

% Of targeted population reached during KAP survey	2378 HH (100%)	979 HH (41%)
# Of volunteers trained on WASH interventions	60	60
WASH Output 2.2: Daily access to safe water which meets SPHERE and WHO standards in terms of quantity and quality is provided to target population		
Indicators:	**Target**	**Actual**
# Of families sensitized on safe water collection and storage	7,693	7693
WASH Output 2.4: Hygiene promotion activities which meet Sphere standards in terms of the identification and use of hygiene items provided to target population		
Indicators:	**Target**	**Actual**
# Of people reached with hygiene promotion messages	38,468	38,468
% Of households who report improved sanitation conditions	70% or 5,385HH	100%
# Of volunteers trained on ORP kit use	60	0
# Of volunteers trained on hygiene promotion	60	96
Narrative description of achievements		

The National Society's response efforts that involved risk communication, surveillance, and epidemiological activities to detect new cases for early treatment and referrals supplemented those of the government and other partners.

The intervention has enhanced the communities' capacity to prevent waterborne disease outbreaks through the presence of trained community volunteers who continue to promote hygiene education, public vigilance, and case detection for early treatment even after the end of the operation. The hygiene promotion reached to 100% of the communities since all HH were visited for assessment of sanitation in the support of the community leaders as the first means to combat cholera.

Hygiene promotion in Sibeswa village in Uvinza DC

Following the intervention to respond toward cholera containment from June to July 2022 in 11 affected villages of Uvinza district council-Kigoma and Tanganyika district council- Katavi, several achievements were reached through close collaboration with government and community authorities.

Determination of the scope of the cholera problem in communities through a field assessment study conducted by TRCS where a total of 11 villages and 261 suspects and 200 confirmed cases were identified.

- Ninety-six (96) local community volunteers were empowered with knowledge and technics for promoting safe hygiene of water, sanitation, and food. This deployment aims to continue scaling up safe hygiene to the majority of beneficiaries even after the response action.
- About 91% (23,038 people) in Uvinza and 93% (29,356 people) in Tanganyika districts of target villages population beneficiaries were reached with a hygiene promotion campaign through various approaches including door-to-door visits, public *addresses,* and IEC materials.
- In a total of 53 households 234 people were reached with PSS to recover their minds and accommodate their surviving relatives and resume normal economic activities.
- From the baseline assessment water treatment at the household level was 41% (equivalent to 208 HHs) and 40% (equivalent to 188 HHs) in Uvinza and Tanganyika affected villages respectively, in the final evaluation the quantity reached 76% (385 HHs), and 71% (333 HHs) respectively.
- The increment was achieved due to more promotion on the use of aqua tabs/chlorine and boiling. However, a request is being made to address the challenge of taste and odour, through other methodologies, among them being the use of UV bags which makes water safe without changing taste and odour. More discussions are being made with other partners to get the SAWA(brand name) bags (these are bags using solar water treatment innovation system) and pilot in the affected area.

Community meeting held in Uvinza DC

- Latrines Promotion has increased ownership of improved latrines and usage at the household level raised from 31% to 49% in Uvinza and 31% to 53 in Tanganyika. The 2 villages Kasangantongwe in Katavi and Sibwesa in Uvinza are the lesser performing villages where the government has put in place strong more measures.

- The KAP survey was conducted for nine villages which were reported with confirmed cases, however, the sensitization of the response reflected for the entire affected 11 villages
- Training of volunteers on ORP kit was struck out during budget revision and hence none trained

Challenges

- The escalating number of cases from reported 6 villages to 11 villages within the same wards during the implementation.
- The increased need for clean water supply in terms of quantity and quality services for improving hygiene.
- Complex rift valley geographical feature makes it impossible for some Communities along the shore of Lake Tanganyika to make improved latrines; As such, the government has to seek alternative means, as they are leading in contaminating lake water (Sibwesa) where more cases are reported.
- Economic constraints to meet latrine standards and ownership, pushed back the promotion pace to adopt better hygiene practices at household's levels and public institutions such as market, schools, and religions places.

Lessons Learned

- During the response action, it was observed that hygienic practices can be improved if it goes parallel with the distribution of Sanitation and hygiene items.
- More simple and friendly technologies for water treatment at the water source or household level need to be employed in the community in the future to obtain safe drinking water.
- From the KAP survey, the situation of latrine condition was not better in about 25% of community households with no latrines, these tells that open defaecation is going on around, to quickly eliminate this the use of Community Led Total Sanitation (CLTS) needs to be promoted and used in future.

Strengthen National Society

S1.1: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical, and financial foundations, systems and structures, competences, and capacities to plan and perform

Indicators:	Target	Actual
# Of volunteers who are insured	84	96
# Of volunteers provided with PPE	84	96
# Of persons provided with visibility material	94	96

Outcome S2.1: Effective and coordinated international disaster response is ensured

Indicators:	Target	Actual
# Of monitoring visits by TRCS WASH coordinator	1	1
# Of monitoring visits conducted by SBCC coordinator	1	1
# Of feedback mechanisms activated	1	2
% Of feedback received and addressed	70%	80%
# Of volunteers implementing CEA activities	12	12
# Of IFRC Cluster monitoring visits	2	1
# Of lessons learned workshop conducted	1	1

Narrative description of achievements

TRCS HQ conducted one monitoring visit in the affected area during implementation in all the districts to follow up on the implementation of the activities, while the regional team jointly with LGA were frequently monitoring the daily implementation and case management at the community, engaging community structures to track and report any suspect case. The intensive awareness and follow-up succeeded to contain cases before the end of the operation.

Two monitoring visits were planned, however, due to time limitations (response conducted in two months) only one cluster monitoring visit was achieved

Challenges

- Long distances and geographical features made some village hard to reach frequently despite the highest challenges which were coming from those areas. This also contributed to delayed case reporting, and some opted for traditional healers.
- The increased number of cases in the areas out of target villages was also a challenge to the NS. The NS agreed with the government to orient more volunteers from affected villages to support neighboring villages, while the government contributes to the support of transport to reach the villages and involve CHW from the newly affected villages.

Lessons Learned

- Good collaboration and coordination with the government made the work easier and case containment could be reached within the operation time.
- Engagement of community structure made the operation easier and led to the ownership of the operation.

3. D. Financial Report

The operation received an allocation from DREF of CHF 78,545 on which CHF 71,389 was implemented and unspent balance at the end of the intervention is CHF 7,156 (around 10 % of the allocation). There were no major variances except under travel and financial charges. Travel cost was less used than budgeted as monitoring has been easy for this operation even remotely. The negative balance of financial charges is due to currency loss.
The CHF 7,156 balance will be returned to the DREF pot.

Contact information

Reference documents

Click here for:

DREF Operation

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

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For IFRC Resource Mobilization and Pledges support:

- IFRC Africa Regional Office for Resource Mobilization and Pledge: Louise Daintrey, Head of Unit, Partnership and Resource Development, Nairobi, email: louise.daintrey@ifrc.org;

For In-Kind donations and Mobilization table support:

- **IFRC Africa Regional Office for Logistics Unit:** Rishi Ramrakha, Head of Africa Regional Logistics Unit, email: rishi.ramrakha@ifrc.org; phone: +254 733 888 022

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

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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 (NGO's) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian 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.

www.ifrc.org
Saving lives, changing minds.

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

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

International Federation of Red Cross and Red Crescent Societies

5.1 PROJECT PARTNER EXPENDITURE CERTIFICATION

PROJECT PARTNER NAME	TANZANIA RED CROSS SOCIETY			
PROJECT NAME	CHOLERA OUTBREAK			
IFRC PROJECT CODE	M2103053			
CURRENT REPORTING PERIOD	**From:**	**18.05.2022**	**To:**	**31.07.2022**
PLANNED EXPENDITURE PERIOD	**From:**	**18.05.2022**	**To:**	**31.07.2022**

5.1.1 BUDGET & EXPENSES BY PROJECT PARTNER ONLY (Local Currency)

		Budgeted Expenditure (as per Project Funding Agreement/ revision) (LOCAL CURRENCY)			Actual Expenditure (LOCAL CURRENCY)			Budget Variance (Year to Date Period)		Budget Variance (Current Period)	
Output code	**Output Description**	**Prior Period(s)**	**Current Period**	**Total (Year to date)**	**Prior period(s)**	**Current period**	**Total (Year to date)**	**Variance**	**%**	**Variance**	**%**
AP011	Health promotion services		14,000,000.00	14,000,000.00		14,690,000.00	14,690,000.00			(690,000.00)	-5%
AP080	Psychosocial support		2,400,000.00	2,400,000.00		2,520,000.00	2,520,000.00			(120,000.00)	-5%
AP029	WASH knowledge and best practice		17,400,000.00	17,400,000.00		17,820,000.00	17,820,000.00			(420,000.00)	-2%
AP030	Hygiene promotion		42,180,000.00	42,180,000.00		42,675,000.00	42,675,000.00			(495,000.00)	-1%
AP040	NS volunteering development		7,520,000.00	7,520,000.00		7,774,035.50	7,774,035.50			(254,035.50)	-3%
AP042	NS corporate /organisational systems		50,049,550.00	50,049,550.00		52,985,110.00	52,985,110.00			(2,935,560.00)	-6%
AP084	Comm. engagement and accountability		14,400,000.00	14,400,000.00		14,950,000.00	14,950,000.00			(550,000.00)	-4%
	TOTAL		**147,949,550.00**	**147,949,550.00**		**153,414,145.50**	**153,414,145.50**			**(5,464,595.50)**	-4%

5.1.2 BUDGET & EXPENSES BY PROJECT PARTNER ONLY ACCORDING TO COST CATEGORIES (Local Currency)

		Budgeted Expenditure (as per Project Funding Agreement/ revision) (LOCAL CURRENCY)			Actual Expenditure (LOCAL CURRENCY)			Budget Variance (Year to Date Period)		Budget Variance (Current Period)	
	Cost Categories	**Prior Period(s)**	**Current Period**	**Total (Year to date)**	**Prior period(s)**	**Current period**	**Total (Year to date)**	**Variance**	**%**	**Variance**	**%**
1	Personnel		2,800,000.00	2,800,000.00		2,800,000.00	2,800,000.00			0.00	0%
2	Relief supplies, transportation and storage		7,520,000.00	7,520,000.00		7,433,500.00	7,433,500.00			86,500.00	1%
3	Contributions to other organisations			0.00			0.00			0.00	
4	Workshops & Training		50,049,550.00	50,049,550.00		52,986,645.50	52,986,645.50			(2,937,095.50)	-6%
5	General Expenditure		49,700,000.00	49,700,000.00		51,200,000.00	51,200,000.00			(1,500,000.00)	-3%
6	Other direct costs		37,880,000.00	37,880,000.00		38,994,000.00	38,994,000.00			(1,114,000.00)	-3%
7	Indirect cost recovery			0.00						0.00	
	TOTAL		**147,949,550.00**	**147,949,550.00**	-	**153,414,145.50**	**153,414,145.50**			**(5,464,595.50)**	-4%

5.1.3 BUDGET & EXPENSES BY PROJECT PARTNER ONLY (CHF) 147,949,550 -

- 0.000415 **First in First Out (refer to sheet 5.4 Calculating Exc Rate)**

63,620.00 -

Output	Budgeted Expenditure (as per Project Funding Agreement/ revision) CHF			Actual Expenditure CHF			Budget Variance (Year to Date Period)		Budget Variance (Current Period)	
	Prior Period(s)	Current Period	Total (Year to date)	Prior period(s)	Current period*	Total (Year to date)	Variance	%		
Overall		63,620.00	63,620.00		63,620.00	63,620.00	0.00	0%		

CERTIFICATION

The undersigned authorised officer of the above mentioned project partner hereby certifies that:

a) they have no knowledge of, nor suspicion of, any fraud and corruption connected in any way to the expenditures included in this report and that they have taken reasonable steps to minimise the risk of fraud and corruption

b) they have taken reasonable steps to minimise the risk of error and mistake in this report. This includes, but is not limited to exercising the appropriate internal controls and employing competent staff

c) Supporting documentation exists for the expenditure included in this report and shall be made available for examination when required and for a period of 8 years from the submission of this report

d) Expenditures have been incurred in line with the agreed project plan and the signed Project Funding Agreement and in accordance with the Project Partners standard procedures and financial regulations, as assessed by the IFRC.

e) The planned expenditure figures and funds transfer request shown above represents estimated expenditures for the next two reporting periods in accordance with the agreed Project Plan

Date Submitted

Name, Title & Signature of Project partner designated official DR. HILARY NGUDE Ag. SECRETARY GENERAL 20/12/22

For IFRC internal use

Approved by IFRC Project Manager _____ **Date** _____

Validated by IFRC Finance officer _____ **Date** _____

Selected Parameters			
Reporting Timeframe	2022/5-11	Operation	MDRTZ031
Budget Timeframe	2022/5-7	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 31/Dec/2022

All figures are in Swiss Francs (CHF)

MDRTZ031 - Tanzania - Cholera Outbreak

Operating Timeframe: 18 May 2022 to 31 Jul 2022

I. Summary

Opening Balance	**0**
Funds & Other Income	**78,545**
DREF Allocations	78,545
Expenditure	**-71,389**
Closing Balance	**7,156**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	30,431	1,646	**28,785**
PO05 - Water, Sanitation & Hygiene	27,285		**27,285**
PO06 - Protection, Gender and Inclusion			**0**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery		69,719	**-69,719**
PO10 - Community Engagement and Accountability	6,594		**6,594**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**64,310**	**71,365**	**-7,055**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	10,647		**10,647**
EA03 - National Society Strengthening	3,588	24	**3,564**
Enabling Approaches Total	**14,235**	**24**	**14,211**
Grand Total	**78,545**	**71,389**	**7,156**

DREF Operation

FINAL FINANCIAL REPORT

Selected Parameters			
Reporting Timeframe	2022/5-11	Operation	MDRTZ031
Budget Timeframe	2022/5-7	Budget	APPROVED

Prepared on 31/Dec/2022

All figures are in Swiss Francs (CHF)

MDRTZ031 - Tanzania - Cholera Outbreak

Operating Timeframe: 18 May 2022 to 31 Jul 2022

III. Expenditure by budget category & group

Description	Budget	Expenditure	Variance
General Expenditure	**9,998**	**3,412**	**6,585**
Travel	9,675	1,821	7,854
Financial Charges	323	1,592	-1,269
Contributions & Transfers	**63,754**	**63,620**	**134**
Cash Transfers National Societies	63,754	63,620	134
Indirect Costs	**4,794**	**4,357**	**437**
Programme & Services Support Recover	4,794	4,357	437
Grand Total	**78,545**	**71,389**	**7,156**