EMERGENCY APPEAL

OPERATIONAL STRATEGY

ZIMBABWE, AFRICA | CHOLERA RESPONSE

Manicaland Training Coordinator, handing over PPE and handwashing equipment to Chiadzwa Clinic health staff. MRCS

Appeal №: **MDRZW021EA**	To be assisted: **550,455 people**	Appeal launched: **16/11/2023**
Glide №: **EP-2023-000105-ZWE**	DREF allocated: **500,000 CHF**	Disaster categorization: **Orange**
Operation start date: **10/11/2023**	Operation end date: **31/08/2024**	

IFRC Secretariat funding requirement[1]: 2 million CHF
Federation-wide funding requirement: 3 million CHF

[1] The Federation-wide funding requirement encompasses all financial support to be directed to the Zimbabwe Red Cross Society in response to the emergency. It includes the Zimbabwe Red Cross' domestic fundraising requests and the fundraising appeals of supporting Red Cross and Red Crescent National Societies (CHF 1 million), as well as the funding requirements of the IFRC Secretariat (CHF 2 million). This comprehensive approach ensures that all available resources are mobilized to address the urgent humanitarian needs of the affected communities.

Cholera is suspected or has been confirmed in all 10 provinces of Zimbabwe in the current outbreak. Photo: ZRCS

TIMELINE

12 February 2023: First cholera case reported in Chegutu town, Mashonaland-West.

15 February: Second case reported; government activates cholera response taskforces at all levels and a first cholera treatment centre (CTC) is set up in Chegutu.

18 April: Suspected cases increase to 579 with 9 suspected deaths reported.

6 June: IFRC DREF is allocated covering five districts in Manicaland province and Matebeleland-South.

October: Cholera continues spreading and is reported in 43 districts across the country, making international headlines.

6 November: IFRC issues Emergency Appeal for CHF 3 million, covering 550,455 people.

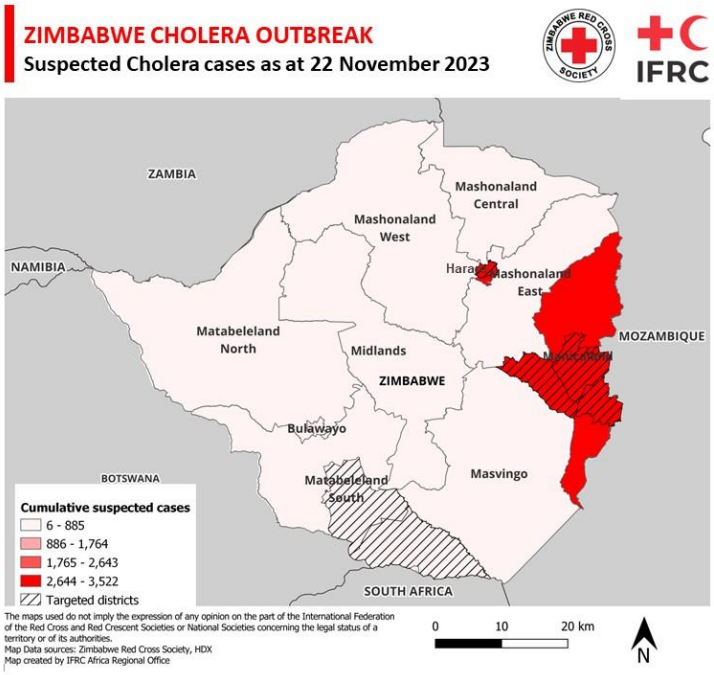
7 November: Suspected cases reach 6,685 according to the Zimbabwe Ministry of Health and Childcare Cholera Situation Report.

17 November: Harare City declares a state of emergency.

DESCRIPTION OF THE EVENT

The first cases of cholera in this outbreak were recorded on 12 February 2023 in Chegutu town, Mashonaland-West province. By 10 November there were 6,114 suspected cases, 48 confirmed deaths, 134 suspected deaths and a case fatality rate of 2.7 per cent. To date suspected and confirmed cases have been reported in all 10 provinces of the country.

The outbreak has spread beyond the 17 previous hotspot districts due to (1) poor hygiene practices, (2) unsupervised gatherings and funerals, (3) high usage of unsafe/unprotected sources of water for drinking and domestic use, (4) low national sanitation coverage with 40 per cent open defecation, and (5) low safe-water coverage, which is just 35 per cent.



Severity of humanitarian conditions

1. *Impact on accessibility, availability, quality, use and awareness of goods and services*

Zimbabwe continues to face challenges in service provision, including in water and sanitation, and some communities are using unsafe water with attendant periodic diarrhoeal outbreaks, including cholera. The health system has now been overstretched due to the high number of admissions.

- There is a lack of local supplies for water treatment, lack of clinical supplies and lack of non-food items (NFIs). There is a lack of water supply and lack of access to sanitation. There are also shortages of cholera beds in cholera treatment centres as well, leading to poor infection control. There is also low safe-water supply particularly in schools and health centres.
- There are not enough cholera treatment units (CTUs), which necessitates converting some health facilities for the response.
- There has been a sharp increase in cholera morbidity in educational institutions with some colleges reportedly closing due to the caseload.
- Illness, death and burials may go unreported among groups whose religious doctrine discourages use of health facilities and medicines, which only worsens the spread.
- There is a significant burden on government health, education and social services.
- Risk of infection for women and children is greater because it is largely they who take on the household caregiver roles for ill family members. Most households also depend on informal work and when family members become ill they may not seek treatment for fear of losing income.
- There is a lack of human resources to manage the caseload and in some cases delays due to the bureaucracy in decision making for the response.
- The community health care system has been disrupted and active case finding and surveillance are a challenge, while there is little or no space for the treatment of cholera cases in the community.
- Measures aimed at containing the outbreak have also exacerbated hardship in communities already experiencing the impacts of global economic disruptions. These impacts in turn have resulted in limited government resources for scaling up preventive measures.
- The general population has become unsettled by the number of cases being reported across multiple districts, this compounded by the stress of commonly held myths, misconceptions and religious beliefs.

2. *Impact on physical and mental well-being*

- The crisis has significantly impacted family cohesion, as family members admitted to cholera treatment centres (CTCs) or CTUs have limited contact with their families.
- With over 7,000 cases and close to 140 deaths recorded there is increased need for mental health and psychosocial support (MHPSS) to lessen the emotional burden on people showing signs of stress.
- Many people are delaying health-seeking behaviours, and this only exacerbates the crisis.

3. ***Risks & vulnerabilities***

- Delays in addressing the risk factors of the outbreak have contributed to increased cases and deaths. Risk factors include limited access to safe drinking water, sanitation and hygiene (WASH), and lack of a better understanding of barriers to health-seeking behaviours, especially in hotspots.
- The wide spread of the outbreak in such a short time this early in the rainy season threatens further worsening of the situation as the rainy season continues.
- The expected movement of people inside the country, and into Zimbabwe from neighbouring countries in both the run-up to the Christmas period and after the holiday, increases risk of cholera in areas where numbers may have been lower, and risk of transporting cholera to other countries as travellers cross borders.
- An imminent El Niño is forecast to bring dry spells and possibly hunger, which, when added to the cholera outbreak, water shortages and poor economic environment, will result in poorer health among people in affected areas.
- Zambia is also experiencing a cholera outbreak as well as an anthrax outbreak, which has spread to most provinces, including the capital, Lusaka. Zambia and Zimbabwe share a boarder and the risk of anthrax crossing over into Zimbabwe cannot be discounted.

1. National Society response capacity

1.1 National Society capacity and ongoing response

Established by an act of Parliament in 1981, the Zimbabwe Red Cross Society (ZRCS) is a humanitarian and developmental organization founded on the Fundamental Principles of the Red Cross and Red Crescent Movement. It became a member of the IFRC in 1983. ZRCS operates in all 10 provinces of Zimbabwe, through 168 branches providing emergency response and developmental programming to vulnerable communities and individuals. It maintains a network of 20,000 volunteers, has an extensive membership and is supported by its staff in Harare and provincial and branch offices throughout the country. ZRCS has also established a successful corporate business unit, including a high school and multiple clinics, which generate alternative sources of revenue.

ZRCS implements programmes in different thematic areas, covering humanitarian response and community development. These include:

- Health and social service programmes such as Water, Sanitation and Hygiene (WASH), COVID-19 preparedness and response, addressing HIV/AIDS, Sexual and Reproductive Health and Rights (SRHR), life skills training, child nutrition and food projects;
- Disaster management and emergency response, particularly first aid and early warning systems;
- Climate change adaptation that aims to ensure food security, livelihoods protection and promotion in vulnerable communities, and building resilient communities; and
- Community Engagement and Accountability (CEA) and Protection, Gender and Inclusion (PGI) and safeguarding are mainstreamed throughout all projects and emergency responses.

Partner	Project	Districts
Finnish RC	ECHO HIP 2023 Project – Supporting preparedness and Response to Cholera	Harare
	Climate Smart Resilience Project	Binga
British RC	Supporting ZRCS with National Society Development	All branches

IFRC	USAID WASH	Mudzi
IFRC	Hunger Crisis Emergency Appeal - Sustained food security of people affected by hunger. Objective that by December 2024, improved food and nutrition security of 400,000 people from the most vulnerable groups in rural and urban areas facing acute food insecurity of crisis or worse levels (IPC 3+)	Mwenezi
IFRC	Elections DREF - contribute to put in place a readiness system and held early actions and immediate response post electoral through main actions that include prepositioning of essential emergency relief, Preparedness and readiness of branches identified as hotspots districts (refer to the map) and enhance engagement and advocacy campaigns at community and institutional level ahead of the general elections	Harare and Bulawayo Provinces
IFRC	Drought EAP - To mitigate drought induced food insecurity through implementation of early actions targeting 2,000 households	Binga
IFRC	USAID BHA Covid - Building Trust during the COVID-19 Pandemic in Humanitarian Settings	Mazowe and Shamva
IFRC	Saving Lives and Livelihoods - save the lives and livelihoods and hasten the economic recovery by procuring vaccines, supporting the delivery of vaccinations, and integrating into and supporting the delivery of routine immunization ensuring the strengthening of public health systems in Africa.	Gokwe South, Kwekwe, Gokwe North, Gweru, Hurungwe, Sanyati, Makonde, Chegutu and Zvimba districts.

1.2 Capacity and response at the national level

The Zimbabwe National Cholera Elimination Plan is the basis of this Operational Strategy, supporting government efforts to curb the epidemic. Under the leadership of the Health cluster, the Public Health Emergency Centre of Zimbabwe is coordinating the response. National, provincial and district coordination meetings, and inter-cluster and technical working group (TWG) meetings, take place in all 64 districts of the country. Management meetings are conducted weekly with a focus on coordination, surveillance, laboratory work, case management, Risk Communication and Community Engagement (RCCE) and WASH, while partner support is being updated within the 5W matrix. The RCCE Collective Service[2], of which IFRC is a core partner alongside UNICEF and WHO, is supporting coordination including the re-establishment of the RCCE pillar and re-activation of the inter-agency community feedback mechanism. The RCCE Collective Service will be working closely with ZRCS to support co-chairing the RCCE pillar, strengthening capacity for social science and for the collection, analysis and utilization of community feedback to guide the response.

The Zimbabwe Ministry of Health and Childcare (MOHCC), ZRCS, UNICEF, Médecins Sans Frontiéres (MSF) and other partners are supporting the setting up of CTUs and provision of medical and Infection Prevention and Control (IPC) supplies. Health workers in heavy-burden districts are also receiving capacity building. The WASH sector is leading all WASH interventions and coordinating partners, as well as supporting water quality monitoring, drilling of boreholes and rehabilitation of water points in outbreak hotspots.

In June 2023, ZRCS requested CHF 464,595 from the IFRC Disaster Response Emergency Fund (DREF)[3] to fight the cholera outbreak, which showed a positive response in the targeted districts. However, the outbreak has spread to new districts, prompting the Zimbabwe Multidisciplinary Research Committee (ZMRC) to move the current scenario to “worst-case”. IFRC has therefore been asked to launch this Emergency Appeal for CHF 3 million to enable ZRCS to further scale up their response.

2. International capacity and response

[2] https://www.rcce-collective.net/
[3] https://adore.ifrc.org/Download.aspx?FileId=754347

2.1 Red Cross Red Crescent Movement capacity and response

IFRC membership

The International Federation of Red Cross and Red Crescent Societies (IFRC) Secretariat plays an essential role in ensuring effective coordination across the Movement, through the IFRC Harare Country Cluster Delegation. The Harare Cluster Delegation coordinates regularly with the ICRC Cluster Office. Regular meetings are held to ensure there is strong coordination and effective technical support for ZRCS, and complementarity, to ensure a harmonized response.

The IFRC Secretariat provides technical and financial support to ZRCS through the IFRC Harare Country Cluster Delegation and will play an essential role in ensuring effective coordination within and outside the Movement. The partner national societies (PNSs) in-country, Finnish Red Cross (FRC) and British Red Cross (BRC), have provided bilateral support to ZRCS since the response started. All PNSs participate in the strategic and operational coordination meetings held in-country and are called upon to contribute their expertise to this response. The IFRC has a coordination support structure for the National Society and includes different positions important for the coordination of the response, such as WASH, Project Monitoring Evaluation and Reporting (PMER) Communications, Public Health in Emergencies (PhiE) and RCCE.

IFRC is supporting ZRCS to implement a two-year DG-ECHO[4] funded cholera preparedness project in Harare, focused on developing capacity at the community and institutional levels. The project began in June 2023, and due to the ongoing outbreak has adjusted implementation to frontload response-based activities. This has included training for 200 volunteers in all three pillars of the Branch Outbreak Response Team (BORT) approach and the activation of a "Crisis Modifier" to support the deployment of BORT teams in Harare. The teams have focused on household-level cholera awareness messaging, bucket chlorination and hygiene promotion in public spaces. These interventions will continue based on case levels, and IFRC is preparing to mobilize funds to continue and scale-up these community level interventions. They are also supporting the procurement of 10 Oral Rehydration Point (ORP) kits, five tents and five Wagtech water quality testing units. The ORP kits and tents can be deployed anywhere in the country.

Red Cross Red Crescent Movement coordination

The International Committee of the Red Cross (ICRC)) has a regional delegation hosted in Pretoria, which serves as a hub for operations in Southern Africa countries. In partnership with the ZRCS, the ICRC supports Restoring Family Links (RFL), as well as enhancing operational safety and security through the Safer Access Framework. The IFRC Harare Cluster Delegation is in regular coordination with the ICRC. Regular meetings are held to make sure there is strong coordination and effective technical support for ZRCS, as well as complementarity, to ensure a harmonized response.

2.2 International humanitarian stakeholder capacity and response

The incident management system for cholera response has been activated and a cholera outbreak incident manager appointed at the Public Health Emergency Operations Centre in Harare to coordinate the response, in line with the Zimbabwe Multi-Sectoral Cholera Elimination Plan. The Zimbabwe Ministry of Health and Childcare(MOHCC) coordinates daily national task force meetings for partners for this response with the participation of Red Cross Red Crescent Movement partners and other partners, including the WHO and UNICEF. Through MOHCC's Incident Action Plan (IAP) the response has the following four pillars:

1. Coordination pillar led by an incident manager.
2. The Health Operation pillar, encompassing epi-surveillance, which includes rapid response teams, case management, RCCE, WASH and vaccination and laboratory systems.
3. Planning pillar, which generates information and situation reports, manages data, and visualizes and documents activities.

[4] Directorate-General for European Civil Protection and Humanitarian Aid Operations

4. Logistics Admin/Finance pillar, which consists of support services, medical supplies, finance and human resources.

According to the 5W matrix, ZRCS, non-Movement partners supported by UNICEF, including Action Against Hunger (AAH) and Oxfam, are carrying out RCCE activities but do have limitations in funding and in their scope of work. An analysis of the country's 5W matrix shows the presence of partners in 5 out of 10 provinces in the country. From the coordination meetings that are being held, the need for countrywide resource mobilization both internally and externally is clear.

Earlier this year ZRCS received a USAID grant for a One WASH initiative where some communities in Mudzi district, Mashonaland-East province, will benefit from resilient water infrastructure and improved hygiene practices.

3. Gaps in the response

Risk Communication and Community Engagement (RCCE) to support protection and prevention, and to encourage health seeking behaviours

Communities in Zimbabwe are genuinely concerned about the increase in deaths being reported daily across multiple districts, yet there are also myths, misconceptions and rumours that perpetuate resistance to proven methods for response. Certain social norms and religious beliefs also discourage good health seeking behaviours and use of medicines as well, and even those who do not object to medical care still often seek it too late.

Other obstacles are lower levels of knowledge on cholera due to low public health education, excessive costs of water tabs, low access to clean water, mistrust of health workers and concerns about funeral/burial practices. Some communities that have had cases in the current outbreak are not historical hotspots for cholera, hence there is a need to research knowledge levels and identify perceptions, beliefs, attitudes, practices and barriers to the response. These findings will guide the response and adaptation of messaging accordingly. RCCE should be leveraged as well to complement the work of Health and WASH teams on these issues.

A mix of different channels has been used in RCCE, and all need to be strengthened. Strategies for RCCE should now aim to move beyond awareness raising sessions and distribution of messages, to utilize more interactive approaches that allow for two-way communication with the public, affected communities, households and individuals.

There is a need for stronger community-based efforts in health and hygiene promotion to appropriately address barriers to behaviour change, considering gender norms, cultural beliefs, religious beliefs and traditional attitudes, to avoid exposure to cholera and avoid late health-seeking behaviours. Communities will continue to be engaged through their leaders and influencers and will be encouraged to come up with community-led solutions to address these.
There is a need as well to strengthen RCCE approaches and feedback systems across all interventions, to promote community-led actions and to promote the agile adaptation of services and interventions to control the outbreak and regain the trust of affected communities.

Improved surveillance

There are significant challenges to active case finding and surveillance. Zimbabwe's surveillance system is health facility-based, and these facilities are overwhelmed, which in turn impacts surveillance. By 16 November there was still no community-based surveillance in place.

Improved case management

Historically the trend has been that the rapid, widespread outbreak in a brief period at the beginning of the rainy season translates to the further rapid spread of the disease. The national health system is now stretched to the limit (1) due to a lack of human resources to manage the caseload and because of inadequate CTUs, resulting in the conversion of health facilities *into* CTUs, (2) due to a lack of cholera supplies, and (3) due to inadequate supply

of disinfectants necessary for reducing transmission. This all adds to severe disruption in the community health system.

MOHCC has set up CTCs and CTUs in the affected districts, but these are still inadequate to accommodate the increasing number of cases requiring admission, putting pressure on the human resources available. More Oral Rehydration Points in communities would reduce the burden on CTUs and allow for more rapid access to ORT for remote communities.

Additional human resources and material support to CTUs would also help improve the current case management capacity. This, coupled with the long distances that people must travel for treatment, has contributed to increased fatalities and transmission, as most cases arrive at treatment centres already in serious condition.

Delays in access to facilities also result in delayed access to rehydration treatment, and by extrapolation lack of community awareness on how to support affected people with ORS. The situation is exerting pressure on the already constrained health system, which is also currently devoting resources to polio vaccination campaigns.

Water and Sanitation

Among the main risk factors contributing to new cholera cases are (1) water from unsafe sources, (2) open defecation, (3) low latrine usage, (4) poor food hygiene and (4) contact with other cholera cases. Low sanitation coverage in rural communities, and the sharing of latrines in high-density urban locations, only increases this risk.

Damaged sewerage infrastructure in cities and lack of capacity in municipalities to maintain infrastructure poses yet further hazard to urban populations particularly in areas that rely on groundwater. Most communities have no alternative sources of safe water, and a lack of water treatment interventions has left some populations with no option but to continue using unsafe sources. Thus, the response must include promotion of household water treatment options with consistent messaging agreed among agencies.

OPERATIONAL CONSTRAINTS

Barrier	Response
Lack of funds to support a scale up in the response	There are significant funding gaps, hence the need to advocate for more financial and in-kind support.
Staff is overstretched	More full-time staff must be recruited and trained, with support for ZRCS to scale up and provide staff dedicated to the response.
Overstretched logistical capacity	Recruit and train personnel, better assess warehouses and continue monitoring the situation.
Limited community participation	More effective engagement of the community.
Unfavourable weather conditions coupled with poor roads make it difficult to deliver supplies to affected populations.	Continue monitoring and re-planning (planning ahead, pre-positioning of materials).
Rising cost of goods and services	Re-budgeting and consultation with IFRC and partners.

FEDERATION-WIDE APPROACH

The Emergency Appeal is part of a **Federation-wide approach** based on the response priorities of the operating National Society and in consultation with all Federation members contributing to the response. The approach, reflected in this Operational Strategy, will ensure linkages between all response activities, including bilateral activities and activities funded domestically, and will assist to leverage the capacities of all members of the IFRC network in the country, to maximize the collective humanitarian impact.

The Federation-wide funding requirement for this Emergency Appeal comprises all support and funding to be channelled to the operating National Society in the response to the emergency event. This includes the operating National Society's domestic fundraising ask, the fundraising ask of participating Red Cross and Red Crescent National Societies and the funding ask of the IFRC secretariat.

Finnish RC with support from their ECHO HIP Project has augmented its Cholera preparedness efforts towards the response specifically in Harare City. Through the project, the prepositioned Oral rehydration Points will be set up in the hotspot areas covered by the appeal. The Brtish Red Cross on the other hand has embarked on resource mobilization to fund the emergency appeal with an initial soft pledge of GBP 95,000. It continues to mobilize for resources from its back donors including the FCDO.

After 31 August 2024, the response to this outbreak will continue under the IFRC Network Zimbabwe Country Plan for 2024. The IFRC Network Country Plans take an integrated view of ongoing emergency responses and longer-term programming tailored to the needs in the country, as well as a Federation-wide view of the country's action. This aims to streamline activities under one plan while still ensuring that the needs of those affected are met in an accountable and transparent way. Information will be shared should there be a need for an extension of the crisis-specific response beyond the above-mentioned timeframe.

OPERATIONAL STRATEGY

Vision

To contribute to the Government of Zimbabwe's Cholera Response Plan in controlling and reducing the cholera outbreak thereby reducing morbidity and mortality, reaching at least 550,455 people from November 2023 to August 2024, focusing on the most affected districts and vulnerable communities.

ZRCS will scale up and expand activities started in the DREF[5] launch in June 2023. It will focus its response on interrupting transmission and improving case management of cholera at the community and facility levels in the affected districts. The core objectives are:

1. To reduce morbidity and mortality by ensuring early access to treatment in affected areas [**save lives**].
2. To prevent and control the spread of cholera through targeted interventions [**interrupt transmission**].
3. To reduce vulnerability and exposure through improved access to safe water and sanitation, improved hygiene practices, and support to vaccination Oral Cholera Vaccine (OCV)) campaigns if and where they occur [**reduce risk**].

Anticipated climate-related risks and adjustments in operations

November to April is the rainy season in Zimbabwe, but the rains can start in October, with the hottest months being October and November. The Meteorological Services Department (MSD) issued a statement at the National Climate Outlook Forum (NACOF) that for October to December 2023 there is an increased chance of normal to below normal rainfall for most of the country except the greater part of Matabeleland North, parts of Bulawayo Metropolitan, parts of Midlands and parts of Mashonaland West, which have increased chances of below normal to normal rainfall.

However, the rainfall is expected to be erratic. Violent storms, prolonged dry spells, flash floods and tropical cyclones cannot be ruled out as the season progresses and this will cause damage to crops, roads, schools and hospitals, and may ultimately fuel transmission of cholera by contaminating drinking water and collapsing latrines, which will promote open defecation. Water points will dry up, leading to use of unsafe water sources and increased risk of cholera spread.

[5] https://adore.ifrc.org/Download.aspx?FileId=754347

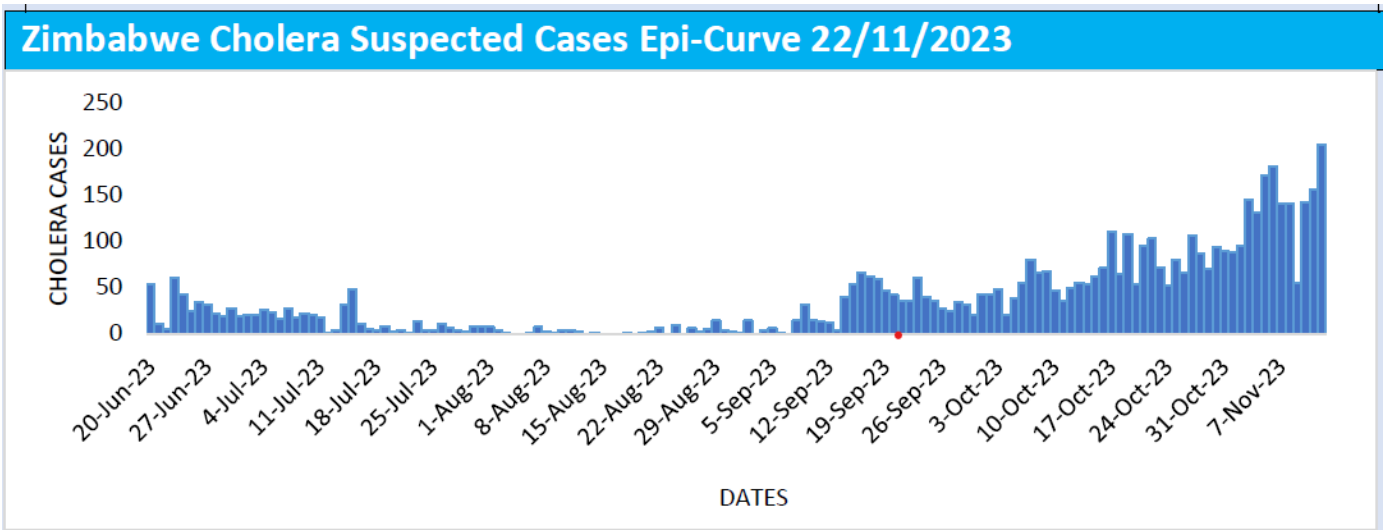
Targeting

1. People to be assisted

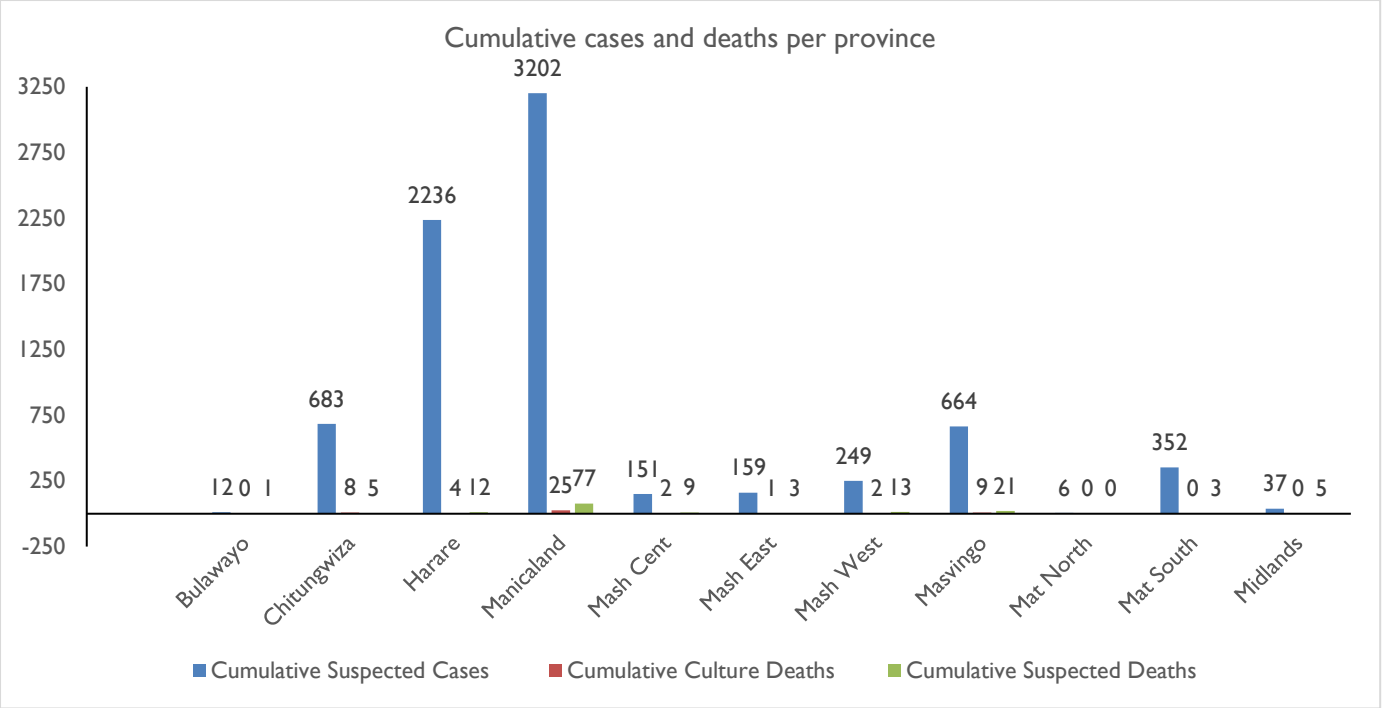
This operation aims to scale up activities and geographical area covered to respond to the increasing cholera caseload and targeted populations will be prioritized based on certain key factors. In coordination with the Ministry of Health and Childcare (MOHCC), operations will target traditional cholera hotspots and urban communities as well as districts with increased numbers of cases and deaths, and high case fatality rate (CFR). This includes districts with high cholera risk factors contributing to new cases and districts registering high numbers of cases per day as well as districts where CTU capacity is limited due to high caseload, taking action immediately upon notification of a case in a new area. This will focus as well on districts with large numbers of cases coming from a specific area. Priority intervention districts will be targeted on epidemiological data and weekly analysis of trends. Geographic areas targeted are also expected to change throughout the outbreak based on external factors such as flood rains and resource flows to and from MOHCC and partners in different locations.

Working closely with District Health Teams (DHTs), partners and communities will help identify priority areas and contribute to adequate planning for oral rehydration, BORT and other preventive activities, through increased understanding, acceptance and cooperation. Agility, flexibility and complementarity of interventions in each location will ensure efficacy and efficient use of resources. At district and community levels, key messaging and activities will be guided by analysis of risk factors as well as by community feedback, to tailor the response to the context. Immediate- to medium-term interventions will be decided based on caseloads, funding, capacity to replicate BORT team modalities and the acceptance of BORT and ORP by the Ministry of Health and Childcare. This appeal will also strengthen the communication line and support assessments where cases suddenly rise.

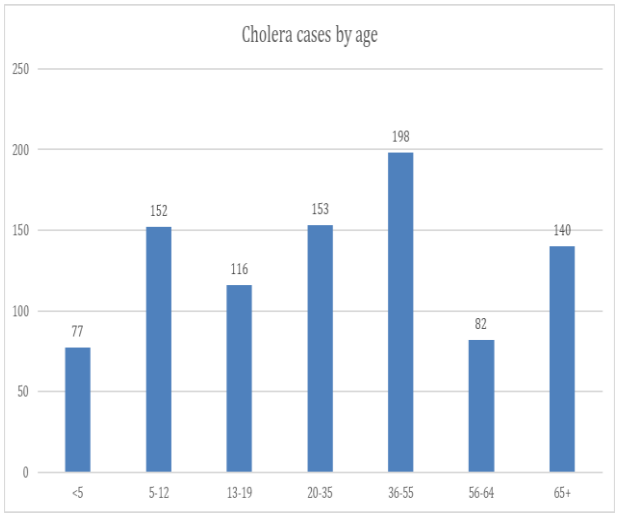
Cholera cases over time

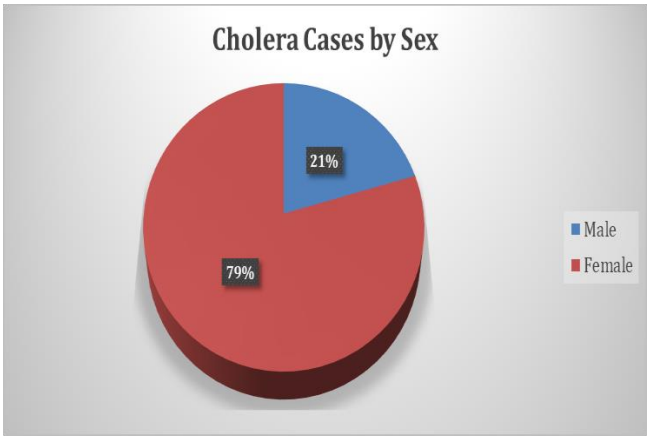


Cumulative cases, cumulative culture deaths and cumulative suspected deaths by province



Cholera cases, by age and sex, in Buhera, one of the targeted districts of Manicaland province





For current target areas, interventions will target the most affected populations in Mutare and Buhera, areas with poor WASH and communities bordering Mozambique and South Africa. Currently, 46 districts are affected, but the outbreak is also starting to come under control in Beitbridge and Gwanda, both in Matabeleland-South province. However, Buhera, Mutare Rural, Mutare Urban, Harare and Chimanimani are still surging. Thus, more support will be needed in Buhera, Mutare Rural, Chimanimani and Harare City, moving toward the southern part of the country.

2. Considerations for Protection, Gender and Inclusion (PGI) and Community Engagement and Accountability (CEA)

The operation will ensure the promotion and participation of both men *and* women, and will include persons with disabilities and persons of different age groups in cholera awareness activities. ZRCS will ensure that volunteers are able to speak the languages of the areas where they are based, to ensure that RCCE is done in the languages of affected people. ZRCS will also recruit volunteers with disabilities.

Continuous advocacy and dialogue among the different stakeholders will be fostered to ensure that minimum standards on PGI in emergencies are met based on the identified needs and priorities of humanitarian imperatives on the ground. ZRCS will ensure that all staff and volunteers are briefed on PGI, sign the code of conduct and are briefed on Prevention of Sexual Exploitation and Abuse (PSEA) and on child safeguarding. PGI mainstreaming will be carried out per minimum standards in cholera interventions while ensuring that all data are disaggregated by sex, age and disability. Zimbabwe Red Cross Society has approved PSEA and child safeguarding policies, which will be disseminated to staff and volunteers engaged in the response to ensure the protection of communities from harm by responders.

PLANNED OPERATIONS

	Health & Care	Female > 18: **148,624**	Female < 18: **148,621**	**1,148,000 CHF**
		Male > 18: **126,606**	Male < 18: **126,604**	**Total target:** 550,455
Objectives:	1. Reduce morbidity and mortality due to cholera by ensuring early access to case management in affected areas including increased cholera awareness and risk perception and early/timely health-seeking behaviours; active case finding and community-based surveillance; early access to treatment through community ORT volunteers and ORPs; Support to referral and CTUs).			
	2. Prevent and control the spread of cholera at household and community levels to interrupt transmission, including targeted interventions at household and community levels through risk-based rapid Branch Outbreak Response Teams (BORTs).			

Key indicators	**Target**
Volunteers in affected communities trained in cholera response including cholera messaging, ORT, BORT and OCV	900
ORPs and BORT established in the targeted communities	40
People seen at ORPs, disaggregated by sex and age	TBD
Severe cases referred to CTCs/CTUs	TBD
Households in the target communities sensitized on cholera through door-to-door visits on cholera awareness, increased risk perception, health-seeking behaviours, and prevention	90%
Additional volunteers trained in epidemic control (Epidemic Preparedness in Communities (EPIC), Epidemic Control for Volunteers (ECV)) and in BORT operations	500
Alerts being generated through simplified Community Based Surveillance (CBS)	TBD
Target population reached with social mobilization and RCCE activities	80%
Complaints and feedback responded to by the National Society	95%
Dialogue sessions on cholera prevention and treatment conducted with assured two-way dialogue for production of community action plans	100
Community road shows in hotspots and schools	100
Volunteers supported to carry out regular activities are issued a pocket guide	900

Referrals made for MHPSS	500
First responders/health workers trained on basic psychological first aid (PFA)	50
Staff/volunteers who benefited from activities focused on well-being	150
Cholera burials completed that were requested of ZRCS teams	>90%

Priority actions:

- The appeal targets 7 districts and will equip 900 community volunteers on a comprehensive cholera response training, including ORT, BORT, RCCE and OCV.
- Strengthening coordination internally and externally, and ensuring that mobilized resources are used efficiently.
- Mapping and updating stakeholders.
- Conducting rapid risk assessments and investigation of outbreak.
- Establishment of oral rehydration points and BORT teams in affected districts.
- Support community actions such as clean-up campaigns and decontamination of the environment.
- Communication on the response through TV spots and social media campaign.
- Conduct rapid assessments to understand communities' understanding of cholera transmission, barriers to prevention and preferred methods for risk communication and engagement with humanitarian actors.
- Support quick fixes to water supply and sanitation infrastructure.
- The ECHO project is importing 10 Movement-standard ORP kits, and the appeal will support the purchase of additional kits to be pre-positioned in Manicaland, Bulawayo and Harare for quick responses. The ORPs procured through the cholera preparedness project can be deployed anywhere in the country where needed. Any deployed kits from the DG ECHO project will be replenished by the EA.
- Up to 40 ORP kits will be procured and available for use in affected districts.

Epidemiological intelligence and outbreak analysis

Conducting the response to an outbreak requires management capacity as well as measuring instruments to ensure that operations are on track. Epidemiological intelligence and outbreak analysis are essential.

- Cholera transmission dynamics evolve rapidly over the course of an outbreak and any response must be guided by epidemiological data and adapted accordingly in real time.
- The team will liaise with MOHCC and district health teams to gather data and perform joint analysis of priority areas for intervention and outbreak trends, on a weekly basis.
- Identifying vulnerable populations and specific risk behaviours, practices or beliefs is important to deliver the appropriate response package and adapted hygiene messages. Such analysis will be conducted together with partners and MOHCC
- Cholera control measures must be tailored to the local disease transmission context, as well as to at-risk populations and practices.
- The choice of interventions and intervention modalities, as well as priority messages, will be guided by community engagement activities, to gain understanding of perceptions, practices and behaviours of communities.
- Monitoring how the response activities lead to actual change in practices and level of risk will shed light on barriers and challenges in communities and will allow adaptation of response. This involves collecting information on the evolution of the outbreak in each district.

Case management

- In affected districts, volunteers will be trained to assess dehydration and offer oral rehydration, as well as on referral and messaging to increase awareness and risk perception, with promotion of early treatment.

- Community ORT volunteers will act as the entry point to get access to oral rehydration and will also provide simplified community-based surveillance.
- If/when cases are coming in increasing numbers, the Community ORT volunteer will alert the health authorities and the ZRCS branch to rapidly set up an ORP.
- ORP kits will be pre-positioned in affected districts and ORPs will be deployed, activated and deactivated according to need through discussion with the community and the District Health Team.
- The Finnish Red Cross's ECHO project has 10 ORPs on the way, at USD 2000 each if procured from the IFRC-recommended supplier. The appeal will purchase additional ORP kits and have them prepositioned in Manicaland, Bulawayo and Harare for quick responses. The appeal will also support logistics to ensure that the kits are correctly packaged and stored after use.
- ORPs will be staffed by trained volunteers with the support of community health works (CHWs) and will ensure that ORT is available at community level, which is particularly important in rural areas where the distances to health facilities can be significant.
- Activities will include training and mobilization of eight volunteers per ORP, to agree with government targets.
- ZRCS will provide temporary latrines and support the procurement of infection prevention and control (IPC) materials, oral rehydration solution (ORS), chlorine, disinfection kits and personal protective equipment (PPE) for volunteers and EHTs at CTUs.
- Ad hoc support to existing CTUs/CTCs will be provided based on need with support in the form of materials, equipment and volunteers.

Preventing and controlling the spread of cholera at household and community levels to interrupt transmission with targeted interventions through risk-based rapid branch outbreak response teams (BORT)

Cholera infection risk is significantly higher for members of households where there is a cholera patient, especially during the first week after the patient seeks treatment. Close neighbours of cholera patients have also been shown to be at higher risk of infection. In order to reduce this risk of secondary infection and control the spread of the disease, this operation will include a response mechanism that supports targeted interventions:

- In affected districts and communities, BORTs will liaise with health authorities and ORPs to gather information on hotspot locations, conduct active case finding and provide support to affected households and neighbours on messaging, and training on protective behaviours and practices, supporting them with hygiene/disinfection materials including NFIs, household water treatment products and soap.
- Investigations in the community will also help identify the main transmission contexts and risk factors, supporting community interventions.
- The intervention will support the training and mobilization of 900 BORT team members, who will provide the foundation for interventions with the support of community health workers.
- ZRCS has 20 trainers with experience training BORT teams, who can be deployed anywhere in the country to train new BORT members.
- The project will ensure that the BORT teams are provided with standardized BORT kits and household kits, which will allow them to support transmission interruption activities.
- As part of routine household visits, volunteers will identify cases and will refer them to community ORT volunteers, ORPs or health facilities.
- Volunteers will use data collection tools and forward data to health facilities and to their ZRCS branch coordinators.
- Affected households will be well informed on cholera including transmission routes and key prevention measures.
- ZRCS will identify stigmatization concerns, which will be managed through engagement meetings.

Risk Communication and Community Engagement (RCCE)

- Teams will use qualitative and quantitative research including focus groups, interviews and questionnaires, some from the Cholera Secretariat RCCE TWG to gain more insights into knowledge, attitudes and practices (KAP) and barriers in communities.
- They will analyse the context and carry out community mapping to understand the structures, groups, power dynamics, capacities and beliefs that may impact the response, and the challenges and needs that should be addressed.
- Each of the seven districts will develop a context specific RCCE strategy using a template. Each strategy will detail the context, most-affected groups, gaps and most appropriate RCCE approaches to employ and indicators for tracking.
- Volunteers will receive capacity building in RCCE to ensure that community members are informed on how to reduce the risk of spreading the disease, how to take personal protective and preventive measures and how to handle situations where there is a cholera patient present. The training will include skills on active listening and how to collect, analyse and respond to feedback to build trust in communities, and ensure that operations are relevant and reflect the latest feedback.
- ZRCS will adapt strategies and activities based on feedback captured through face-to-face, mass media, social media and group approaches. Although there is already considerable knowledge on cholera transmission - and on prevention - the high costs of water treatment, inadequate access to clean water, and concerns about burial practices remain core areas to be addressed. The RCCE approaches employed will focus on working closely with Health and WASH teams on these issues, moving beyond awareness sessions.
- Operations will include community dialogues with select community leaders, local volunteers, community leaders, faith leaders, women and youth. This will promote two-way communication that encourages active listening and participatory dialogue.
- Risk communication channels will include sensitization on cholera through community radio, mobile vans and megaphones to support hygiene promotion, including phone-in radio sessions for people to share their concerns and ask questions, to address their needs. Feedback will be collected through the same channels, and through help desks in communities and a national toll-free line. Action on feedback/complaints collected from the community will be within a mandated timeline.
- Health education at household level will be guided by a cholera pocket guide for volunteers, which will be used along with appropriate information-education-communication (IEC) materials to guide volunteers on household visits, to promote health-seeking behaviours, household water treatment and safe storage, Infant and Young Child Feeding practices (IYCF), and health and hygiene information.
- Through a door-to-door approach, volunteers will inform communities about the early signs of cholera and the importance of reporting it to health authorities. This will ensure that communities are aware of risk factors and can identify and refer suspected cases to community health workers/health facilities/ORPs on time. Included will be the promotion of ORS as early treatment.
- In case a vaccination campaign is organized, communities' perceptions and beliefs around vaccine acceptability will be collected and fed into the messages designed to support uptake of the vaccine.
- Support will be provided on community mobilization for the vaccination campaign.

Mental Health and Psychosocial Support (MHPSS)

Disease outbreaks can significantly impact individuals' mental health and psychosocial well-being, causing heightened anxiety, fear and grief, as well as fostering stigma and discrimination. Isolation, financial stress, disruptions to daily life, and challenges faced by healthcare workers further contribute to the mental health toll. The prevalence of mental health conditions, such as depression and anxiety, are likely to increase, existing conditions may worsen, and access to mental health services can be compromised. Besides the immediate distress cause by the outbreak, the potential for long-term psychological effects underscores the importance of recognizing and addressing the diverse impacts on mental health and well-being from an early stage, including for staff and beneficiaries.

1. Include MHPSS in the health/multisectoral assessment.
2. Train first responders in basic psychological first aid (PFA) and mainstream it across relevant sectors.
3. Train health workers in basic PFA and mainstream it across health activities.
4. Establish a referral pathway for MHPSS needs.
5. Include psychoeducational messages in the RCCE messaging.
6. Establish activities focusing on caring for staff and volunteers.

Burials & Funerals

In Zimbabwe, some current practices for burials and funerals have been shown to play a role in spreading the disease. To prevent disease transmission during burial of a person who was suspected of having, or was confirmed to have died from, cholera, interventions will include social mobilization, training on cholera burials and funeral hygiene, with a focus on handwashing, food safety and availability of safe drinking water, including:

- Training and mobilization to support cholera burials, engage communities and raise awareness about risk of transmission during burials and funerals.
- The affected population is helped by supporting families on cholera burials and funerals.
- Village health workers and volunteers will be trained to provide health and hygiene information and to support concerned families and communities. Burial is a sensitive issue in any community, thus teams will engage communities to ensure that cholera burial protocols are consistent with traditional norms, to avoid compromising safety.

	**Water, Sanitation and Hygiene (WASH)**	Female > 18: **148,624**	Female < 18: **148,621**	**429,000 CHF**
		Male > 18: **126,606**	Male < 18: **126,604**	**Total target:** 550,455
Objective:	Reduce the risk of cholera and other water-borne diseases through improved availability of safe water and sanitation facilities, and through good hygiene practices in cholera hotspots.			

Key indicators:	**Target**
Households using safe drinking water in targeted high-risk communities (FRC>0,2 mg/L)	100%
Households with appropriate knowledge about cholera and health/hygiene protective behaviours	90%
ORPs have access to adequate water and sanitation services	100%
Water points rehabilitated or upgraded and providing access to safe water supply for the affected communities	70
Households reached with key messages to promote personal and community hygiene	80%
Solar water pumps in health facilities and schools in affected communities rehabilitated	5
Volunteers trained in Household Water Treatment and Safe Storage	900
Households in the affected communities provided with 1 per cent stock solution for pot-to-pot chlorination	75
Temporary sanitation facilities such as latrines, bath shelters and handwashing facilities constructed and maintained in CTUs	20

Households in the target communities sensitized on cholera through door-to-door visits	95%
Sanitation promotion activities conducted in communities and institutions on latrine use and management, proper waste disposal	150
Priority actions:	

In affected areas, investigations led by the BORT teams and the District Environmental Health technicians will trigger the intervention of both RCCE and WASH teams. Detailed investigations will determine the main transmission contexts and pathways and help select the most appropriate interventions in household water treatment, bucket chlorination, small repairs, water quality monitoring, messaging around funerals and gatherings and hygiene promotion.

- Promoting household water treatment and safe storage; volunteers will be mobilized to distribute water treatment chemicals such as aqua tabs, together with education on their use.
- Training and mobilization of volunteers in household water treatment, transport and safe storage.
- Volunteers will be deployed to scale-up chlorination at the point of source and point of use and in communities and at institutions.
- Provision of water treatment chemicals including aqua tabs and bucket chlorination at point of source.
- Provision of water storage buckets, jerricans and soap to affected communities, ensuring that people living with disabilities, or people with mobility challenges who cannot get to collection points, are not missed.
- Deployment of the HWTS protocols.
- Training in the community on the use of HWTS materials at distribution points and other venues.
- Post-distribution monitoring to promote the correct use of HWTS materials.

Contribute to increased access to safe water through the construction, rehabilitation and disinfection of water points.

- Rehabilitation of water points, including hand pumps, in the target districts.
- Rehabilitation and upgrade of solar water pumps in health facilities/communities.
- Disinfecting contaminated water sources.
- Construction of solar-powered water pumps contributing to increased access to water in hotspots.

Water quality monitoring at household and communal water points.

- Training in water monitoring using field test kits.
- Provision of test kits and refills with water quality sampling and testing by technicians.
- Use of data to inform decisions on HWTS and water supply rehabilitation.

Facilitate construction of latrines in health facilities and public institutions

- Construction of latrines, and handwashing facilities in ORPs and CTUs, ensuring participation of communities in decision-making about their placement and design.
- Rehabilitation and de-sludging of pit latrines in health facilities and public places.
- Support for management of latrines and cleaning of latrines.

Raise awareness on dangers of open defecation and benefits of food hygiene, and advocate for community members to construct latrines

- Conduct sensitization through door-to-door visits in communities.
- Sanitation promotion in communities, institutions and public spaces such as markets, including latrine use/management and proper waste disposal.

Ad hoc support to CTUs

- Provision of IPC supplies for CTUs including hygiene, cleaning and disinfection materials and tents.

- Monitoring of CTUs, public places and communities to determine the need for additional interventions or resources.

	**Protection, Gender, and Inclusion (PGI)**	Female > 18: **148,624**	Female < 18: **148,621**	**18,000 CHF**
		Male > 18: **126,606**	Male < 18: **126,604**	**Total target:** 550,455

Objective:	Communities can identify and respond to the distinct needs of the most vulnerable segments of society, especially disadvantaged and marginalized groups, who are subject to violence, discrimination and exclusion.

Key indicators:	**Target**
Target population reached by PGI activities	90%
Staff and volunteers oriented on the code of conduct, Prevention of Sexual Exploitation and Abuse (PSEA) and Child Safeguarding	100%
Volunteers trained to identify women, men, girls and boys requiring MHPSS after being discharged from CTUs	96%

Priority actions:

- The operation will ensure the promotion and participation of both men *and* women, including persons with disabilities, and persons of different age groups, in cholera awareness activities.
- This will include promoting PGI and prevention of stigmatization of victims of the disease and their families.
- ZRCS will advocate for clear separation of genders in CTUs, adequate lighting around CTUs at night and gender disaggregation in data.
- ZRCS will mobilize volunteers to strengthen protection of children and women in treatment centres and homes.
- Staff and volunteers will identify children without parental care and those experiencing violence and neglect, and will enrol them in social welfare.
- There will be training for volunteers to identify women, men, girls and boys requiring MHPSS after discharge from CTUs to social welfare.
- Volunteers will receive training in treatment centres on PSEA, child safeguarding and gender-based violence (GBV) risk mitigation, including referrals for survivors to social welfare.
- Community-based childcare centres and Children's Corners will have messages and information about cholera prevention and response.
- ZRCS will provide orientation for staff and volunteers on the code of conduct and prevention of/response to sexual exploitation and abuse, including child safeguarding.

	**Community Engagement and Accountability (CEA)**	Female > 18: **148,624**	Female < 18: **148,621**	**75,000 CHF**
		Male > 18: **126,606**	Male < 18: **126,604**	**Total target:** 550,455

Objective:	Develop and deploy standardized approaches for community engagement and for collection and use of data to better understand community perspectives.

Key indicators:	**Target**
TV and radio campaigns	5
Volunteers trained on CEA and its tools	280
Feedback linked to protection concerns that are managed in accordance with IFRC policy and standards	100%

Priority actions:

IFRC RCCE tools will be tailored to the Zimbabwean context:

- Community members will be involved in the planning phase and throughout the response, to increase their understanding, engagement and ownership of interventions. This will contribute to reducing the spread of the disease through sharing of reliable information about services and interventions with focus on the uptake of ORS, use of ORPs and promotion of health-seeking behaviours; scaling up open and honest communication on targeted population selection criteria; and distribution of information through community meetings, mass media and social media, and door-to-door activities.
- ZRCS will consult with communities to learn their preferences on feedback channels and the type of questions they want answered.
- Active feedback systems will be established in strategic places, such as at ORPs and vaccination centres, and feedback will be shared on different platforms at the community, district and national levels, including technical and sub-technical working groups. This will include harmonization of feedback collection tools.
- Feedback and complaints will be collected through community volunteers, community meetings, focus groups and suggestion boxes, and responses provided through community meetings. Feedback will also be collected during hygiene and health promotion sessions. Trained staff and volunteers will also be available to respond directly to individuals, particularly where the feedback is sensitive. A separate mechanism will be put in place for receiving, managing, and responding to sensitive feedback to give a safe space to report any sensitive or serious complaints related to corruption, sexual exploitation and abuse, etc. And these feedback systems will have clear referral pathways.
- A help desk with a toll-free number will be set up at national headquarters and linked to branches and communities.
- There will be a CEA surge to support the response and the establishment of feedback mechanisms, with input from information management systems.
- An FAQ sheet will be developed in collaboration with MOHCC and shared with volunteers so that they can address frequent questions, concerns and beliefs that are seen in the feedback data

Enabling approaches

	National Society Strengthening	**147,000 CHF**

Objective:	National Societies are prepared to respond effectively to epidemics/emerging crises, and their auxiliary role in providing humanitarian assistance is well defined and recognized.

Key indicators	Target
Staff trained on Protection of Sexual Exploitation and Abuse (PSEA)	100%
National Society have assessed their capacity at HQ and branch level and identified areas for improvement	1
National Society has been reached by support that is aligned with National Society Development compact principles	Yes
Volunteers working on the project with health, accident and death compensation	100%

Priority actions:

- Facilitate capacity building and organizational development to ensure that the National Society has the necessary legal, ethical and financial foundations, systems, human resources, structures, competencies and capacities to plan and perform.
- Coordination with ZRCS on opportunities for capacity building of staff for strengthening their auxiliary, advocacy and humanitarian diplomacy, particularly in public health emergency preparedness and response for future operations.
- Facilitating capacity building on response capacity.
- Epidemic preparedness supplies, fleet and warehousing.
- Volunteer management through provision of equipment, training and insurance packages.
- Infrastructure development, communications, fleet and technical services,

	Coordination and Partnerships	**12,000 CHF**

Objective:	Technical and operational complementarity among IFRC membership, and with ICRC, enhanced through cooperation with external partners.

Key indicators	Target
Coordination platforms where ZRCS takes a leading role and provides critical data	10
External partnerships supporting ZRCS in the response established	6
Regular coordination mechanism is in place ensuring alignment and coordination with all Movement partners and local and international partners	6

Priority actions:

Membership Coordination

- Engage the IFRC membership to ensure a well-coordinated response through the established in-country coordination framework as well as regular coordination with partners supporting the operation but not present in the country.
- A Federation-wide approach will be maintained by having harmonized planning, implementation, monitoring, reporting and evaluation among IFRC members.
- Regularly update the 5W matrix.

Engagement with external partners

- ZRCS takes part in the National Cholera Taskforce, attending all meetings and supporting the development and implementation of the National Cholera Outbreak Response Plan.
- ZRCS is an active member of the Civil Protection Committee at the national, provincial and district levels. At the community level, ZRCS volunteers will coordinate with EHTs, coordinating primary health care units in communities, village health workers and coordination structures - including village traditional leadership - and water management committees.
- ZRCS staff participate in RCCE coordination meetings at all levels, including interagency coordination with partners like WHO and UNICEF, and will confirm that feedback data is discussed and cross-referenced against other data.
- Monthly coordination meetings will be conducted with RCCE stakeholders, where technical teams will review the feedback collected and develop recommendations. A standardized feedback collection tool will be developed with health education services and partners.

Movement cooperation

- ZRCS, partners and IFRC coordinate with the ICRC regional office in Pretoria.

	IFRC Secretariat Services	**171,000 CHF**
Objective:	To ensure that IFRC is working as one organization, delivering what it promises to ZRCS and volunteers, and leveraging the strength of the communities with which they work as effectively and efficiently as possible.	

Key indicators	**Target**
Global and regional surge	7
Federation-wide reporting set up by PMER	1
Risk register set up, mitigation measures identified and monitored once per month.	Monthly
Communications support provided - communication working group for movement members in country (ZRCS, ICRC & IFRC) will be activated and coordinated	1

Priority actions:

- The Harare Cluster Delegation provides full support across Operations Coordination, WASH, Finance, Logistics, PMER, Security, NSD and technical sectors.
- IFRC will facilitate an effective Federation-wide response with support from the Harare Cluster Delegation and Africa Regional Office. It will offer its expertise in managing epidemics through the deployment of critical functions as agreed with ZRCS and will also equip them with strong risk management and business continuity plans. Given the risk of spread of cholera to neighbouring countries, ZRCS and IFRC will establish regular cross-border communication, information sharing and support, which will allow neighbouring Red Cross and Red Crescent National Societies to conduct effective readiness activities and scale up the response, if necessary.
- Through the IFRC surge system, regional and global alerts have been issued for several profiles: Operations Manager, Public Health in Emergencies Coordinator, Information Management (IM) Coordinator, Communications Coordinator and PMER Coordinator. In the country, the IFRC Cluster WASH Coordinator and CEA Officer will offer support as well.
- Alerts for the team leaders for Emergency Response Units for CCMC and WASH (Water Supply Repair and Household Water Treatment) will be issued to support ZRCS with initial assessments.

- IFRC will take a comprehensive approach to programming, monitoring, reporting, risk management, information management, external communications and resource mobilization.
- Humanitarian Diplomacy: A Communication working group for movement members in country (ZRCS, ICRC & IFRC) will be activated and coordinated by ZRCS, to focus on scaling up visibility.

Risk management

In accordance with IFRC Risk Management Framework the operation is committed to identifying and analysing risks associated with activities and operations with the objective of maintaining a safe workplace, minimizing losses, maximizing opportunities, and developing appropriate risk treatment options for informed decision-making. Risks will be identified across the seven IFRC risk categories: Strategic, Contextual, Operational, Programme Delivery, Fiduciary, Safeguarding, Reputational.

Risk	Likelihood	Impact	Mitigating actions
Insufficient resources are provided to stop the spread, with increase in cases and deaths, and the situation worsens, exacerbated by the movement of people over the end of year holidays.	Medium		Mobilize what resources we have as efficiently and effectively as possible in line with the strategy developed, monitor the situation closely and advocate for more support.
Poor participation of affected communities in the response operation	Low	High	Effective community engagement
Non-adherence to financial management procedures	Low	High	Strengthening internal controls, training
Inactivity and or lack of capacity of local branch structures	Low	low	Adequate capacity building and surge
National Society capacity is depleted, and they are not able to sustain delivery of humanitarian assistance	Medium	Medium	National Society strengthening will be incorporated, to strengthen delivery of humanitarian assistance. Provision of Federation-wide management and technical services to supplement the capacities of the host national societies.
Since the most affected areas are in both urban and rural settings, for the urban populations there are no major security issues and roads accessibility is good. A critical risk factor in the cholera response operation will be the availability of funds from government to support staff working in the cholera response.	Medium	Medium	Safety and security of the volunteers and staff engaged in the operation will be ensured by appropriate safety & security measures and provision of personal protective equipment in as much as they will be refreshed on the IFRC Stay Safe 2.0 training.
Rising cost of goods and services due to inflation	Medium	Medium	Budgeting and consultation with IFRC and partners; all budgeting and financial systems converted to USD instead of local currency to reduce financial loss.

The IFRC Head of Delegation is overall responsible for Risk Management in Zimbabwe and will monitor and advise ZRCS about the nature of these risks and what mitigation measures should be taken to mitigate. The operations Coordinator is however responsible for the day-to-day implementation of the risk mitigation measures with the ZRCS teams. The Regional Office will support the risk management of this operation, with technical advice and overall support to building the risk matrix.

Quality and accountability

ZRCS emphasizes quality and accountability in implementation of short- and long-term operations, ensuring standard operating procedures and use of implementation guides and manuals, as well as training and supervision.

In this operation the following actions will be implemented: completing the Child Safeguarding Risk Analysis; having in place screening, briefing and reporting systems; mapping and testing referral pathways; ensuring community feedback mechanisms; and child friendly information and participation.

Key indicators are available in the Planned Operations section.

FUNDING REQUIREMENT

Federation-wide funding requirement*

**For more information on Federation-wide funding requirement, refer to section: Federation-wide Approach*

IFRC

OPERATIONAL STRATEGY

MDRZW021 - Zimbabwe Red Cross Cholera Emergency Appeal, 2023

FUNDING REQUIREMENTS

Planned Operations	**1,670,000**
Health	1,148,000
Water, Sanitation and Hygiene (WASH)	429,000
Protection, Gender and Inclusion (PGI)	18,000
Community Engagement and Accountability (CEA)	75,000
Enabling Approaches	**330,000**
Coordination and Partnerships	12,000
Secretariat Services	171,000
National Society Strengthening	147,000
TOTAL FUNDING REQUIREMENTS	**2,000,000**

All amounts in Swiss Francs (CHF).

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Reference

Click here for:

- Previous Appeals and updates