



REVISED EMERGENCY APPEAL

REVISED OPERATIONAL STRATEGY

ZIMBABWE, AFRICA | CHOLERA RESPONSE



ZRCS staff and volunteers working with local health workers to set up a cholera treatment centre at Mudzimurema Clinic, Marondera-West. Photo: ZRCS

Appeal No: MDRZW021	To be assisted: 550,455 people	Appeal launched: 16 November 2023
Glide No: EP-2023-000105-ZWE	DREF allocated: CHF 500,000	Disaster categorization: Orange
Operation start date: 16 November 2023	Emergency Appeal end date: 31 December 2024	Response operation closing date: 31 December 2024
Operational strategy revision:	#1	Date: 24/07/2024

IFRC Secretariat funding requirement: CHF 3 million
Federation-wide funding requirement: CHF 4 million¹

¹ The Federation-wide funding requirement encompasses all financial support to be directed to the Zimbabwe Red Cross Society (ZRCS) 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 3 million, increased from CHF 2 million). This comprehensive approach ensures that all available resources are mobilized to address the urgent humanitarian needs of the affected communities.



Volunteers at an ORP training. 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.
- 10 November:** IFRC issues Emergency Appeal for CHF 3 million, covering 550,455 people.
- 17 November:** Harare City declares a state of emergency.
- December 2023:** Norwegian Red Cross WSR ERU team leader to support assessments of WASH needs.
- January 2024:** Full deployment of WSR ERU and Spanish Red Cross HWTS ERU team leader deployed.
- May 2024:** Revised Emergency Appeal.

OPERATIONAL STRATEGY REVISION

A cholera outbreak has been impacting Zimbabwe for over 12 months, with peaks at different times across various regions. Although there has been a significant drop in cases recently, it is important to maintain high readiness and preparedness to act, while still responding to ongoing cases. Through this appeal revision, the time period to strengthen recent gains in prevention and response capacity will be extended and the opportunities to continue working with communities to improve the underlying causes of cholera will be expanded, including on health awareness and promotion and on behaviour change. The end date of the Appeal is being extended from 31 August to 31 December 2024. Funding requirement is being increased from CHF 3 million to CHF 4 million, an increase of CHF 1 million in the IFRC Secretariat requirement. The extended timeframe and additional resources will expand support for communities to rebuild their lives and livelihoods, and ultimately overcome one of the worst cholera crises in recent years.

DESCRIPTION OF THE EVENT

This current cholera outbreak started on 12 February 2023 in Chegutu town, Mashonaland-West province. To date, suspected and confirmed cases have been reported in 63 districts in all 10 provinces of the country. By 30 June 2024, there were 34,549 suspected cases, 4,217 laboratory-confirmed cases, 87 laboratory-confirmed deaths, 719 suspected deaths. The outbreak has now spread beyond the 17 previous hotspot districts of Buhera, Chegutu, Chikomba, Chimanimani, Chipinge, Chitungwiza, Chiredzi, Harare, Gokwe North, Marondera, Mazowe, Shamva, Mutare, Murehwa, Mwenezi, Seke and Wedza. Crude mortality rate remains above 2.1 per cent. And this outbreak is atypical, persisting from the dry season into the current rainy season, increasing the risk of spread. Since May 2024, cases have been dropping as interventions have started to show results, but recurrence cannot be dismissed, and all prevention actions must continue.

The outbreak has slowed economic and social activity in general, especially in Harare, which declared a state of emergency due to the surge in cases. The health system has been overstretched by the high number of hospitalizations, depleting most of the medication and supplies and further straining overburdened hospital personnel. Grief and trauma caused by the disease have affected the sick and their guardians, as well as staff and volunteers supporting the response.

An Oral Cholera Vaccine (OCV) campaign has targeted the 26 districts reporting the highest numbers of cases and there has also been high demand for mental health services and Psychological First Aid (PFA). Communities have also demonstrated a lack of knowledge on preventive measures and on how to support affected individuals with oral rehydration therapy (ORT), resulting in generalized stigma.

The Ministry of Health and Childcare (MOHCC) has been stretched due to the high number of admissions, lack of human resources to manage the caseload and lack of supplies, including disinfection liquids. Primary health care services, which are responsible for ensuring that community members adhere to Water, Sanitation and Hygiene practices (WASH), are overwhelmed. Active case finding and surveillance have also been challenged, compounded by inadequate supplies for logistics.

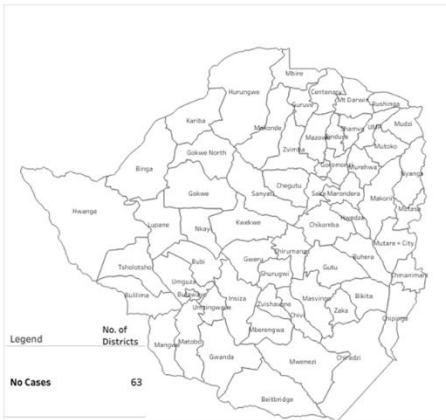
This situation calls for an immediate, multi-disciplinary strategy that includes rigorous surveillance and effective case management, ensuring access to WASH, complemented by robust community education. To control cholera, it is thus critical for partners and donors to unite in a coordinated effort, emphasizing WASH interventions tailored to the needs of the most vulnerable. This includes reinforcement of water treatment, regular testing for water safety, promotion of better WASH practices, fortifying infection prevention and control in medical settings, and ensuring safe burial practices. IFRC is continuing to support ZRCS at this pivotal moment.



Zimbabwe Cholera Outbreak Dashboard

Suspected Cases	RDT Confirmed	Culture Confirmed	Case Fatality Rate	Attack Rate Per 100K of Population	Culture Deaths	Total Deaths
34,549	4,234	4,217	2.1%	203.5	87	719

Daily Cholera Cases



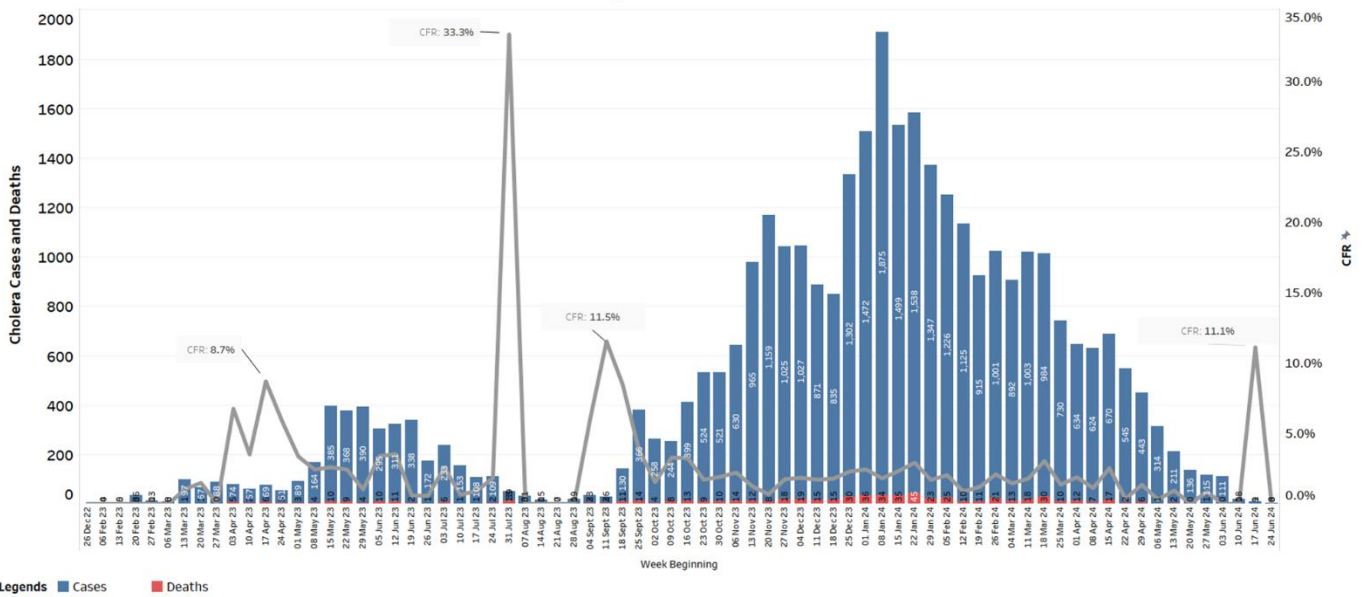
Daily Harare Spot Map



Province	Suspected Cases	RDT Confirmed	Culture Confirmed	Total Deaths	Case Fatality Rate	Attack Rate Per 100K of Populati...
Bulawayo	49	33	13	1	2.0%	6.2
Chitungwiza	2,370	353	54	34	1.4%	479.0
Harare	10,356	546	1,441	73	0.7%	470.2
Manicaland	6,666	678	1,285	168	2.5%	313.0
Mashonaland Central	4,384	603	291	156	3.6%	282.7
Mashonaland East	1,455	657	168	32	2.2%	71.1
Mashonaland West	3,773	569	168	69	1.8%	189.7
Masvingo	3,492	411	279	116	3.3%	185.1
Matebeleland North	307	89	280	8	2.6%	32.5
Matebeleland South	479	106	159	9	1.9%	55.8
Midlands	1,218	189	79	53	4.4%	58.3
National	34,549	4,234	4,217	719	2.1%	203.5

Data as of: June 30, 2024

Distribution of Cholera cases by Week 12 February 2023 to 30 June 2024



Figures 1 and 2: Suspected cases Epi-Curve, MOHCC.

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 constrained due to the high number of admissions leading to overstretched human resources and medical supplies.
- Lack of water supply and lack of access to sanitation have led to people using unsafe water sources like shallow wells and sand abstraction from open sources. Communities also do not treat their drinking water at household level, leading to further outbreaks.
- Lack of non-food items (NFIs) such as soap and buckets has hampered the fight to contain the outbreak.

- The outbreak has affected institutions too, and there is a lack of safe water particularly in schools and health facilities, resulting in the closing of some schools.
- Primary health centres (PHCs) usually cover a large catchment population especially in rural communities, making it difficult for people to access treatment early. This system has been disrupted and active case finding, and surveillance, are a challenge, while there is little or no space for treatment in communities and lack of cholera treatment units (CTUs), which necessitates converting some health facilities for the response.
- 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 significant burden on government health, education and social services. Risk of infection is greater for women and children because it is largely, they who are the household caregivers 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.
- 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, 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 during quarantine.
- With over 33,000 cases and close to 641 deaths recorded, there is increased need for Mental Health and Psychosocial Support (MHPSS) to lessen the emotional burden on family members as well as on health care workers and volunteers staffing CTCs and oral rehydration points (ORPs) who show signs of stress or trauma. 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 and WASH services, and lack of understanding of barriers to health-seeking behaviours, especially in hotspots.
- The expected movement of people inside the country, and into Zimbabwe from neighbouring countries, increases risk of cholera in areas where numbers may have been lower, with risk of transporting cholera to other countries as travellers' cross borders.
- An imminent EL Niño has brought dry spells and hunger, which, when added to the outbreak, water shortages and poor economic environment, results in poorer health among people in affected areas.

1. National Society response capacity

1.1 National Society capacity and ongoing response

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 has made a significant contribution to the fight in reducing cholera cases. They have helped ensure access to WASH resources by drilling boreholes, solarizing pumps, offering improved access to safe and clean water, distribution of NFIs, hygiene promotion and training of communities on household water treatment. They have supported Community Case Management by establishing ORPs, provided hardware, provided WASH facilities/infrastructure to support ORPs and CTCs, trained volunteers in Branch Outbreak Response (BORT) and provided Infection, Prevention and Control (IPC) materials. These actions are complimented by Irish Communication and Community Engagement and Accountability (CEA) approaches, and by robust community education.

ZRCS continues to work closely with the Ministry of Health, WHO, World Vision, UNICEF, the US Centres for Disease Control and Prevention (US CDC), and other organizations. Internally, ZRCS also continues to collaborate with IFRC, British Red Cross and Finish Red Cross. To date ZRCS has been able to significantly contribute to the Government's response with the help of partners.



ZRCS Volunteers spraying at ORPs to control cholera. Photo: ZRCS

Health and Care

- ZRCS is supporting the Ministry of Health and Childcare (MOHCC) in setting up 26 ORPs in hotspots.
- 9,955 people have been assisted at ORPs and 1,757 referred to CTCs and health facilities.
- ZRCS has been reaching out in affected areas with prevention information for over 385,319 people through door-to-door, public address system, radio and television.
- 14 water points have been rehabilitated with B-type hand pumps, and 5 water systems have been upgraded and mechanized with solar, and water management committees have been set up and trained.
- Stories developed and posted on IFRC and ZRCS social media pages, with 10 field visits to capture photos and stories.
- 642 responses received on the Risk Communication and Community Engagement (RCCE) cholera dashboard, set up with support from the Collective Service, which is a partnership of IFRC, UNICEF, WHO and Global Outbreak Alert Response Network (GOARN). ZRCS has analyzed this feedback and responded to it.

1.2 Capacity and response at the national level

The basis of this Operational Strategy is the Zimbabwe National Cholera Elimination Plan, 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. ZRCS is active in all management meetings, conducted weekly, with a focus on coordination, surveillance, laboratory work, case management, RCCE and WASH, while partner support is being updated within the 5W matrix. The RCCE Collective Service², 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 works closely with ZRCS to support co-chairing the RCCE pillar,

² <https://www.rcce-collective.net/>

strengthening capacity for social science and for the collection, analysis and utilization of community feedback to guide the response.

MOHCC, ZRCS, UNICEF, Médecins Sans Frontières (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 hotspots.

In June 2023, ZRCS requested CHF 464,595 from the IFRC Disaster Response Emergency Fund (DREF)³ to fight the outbreak, which showed a positive response in the targeted districts. With the number of cases increasing, the Zimbabwe Multidisciplinary Research Committee (ZMRC) then cautioned on the situation worsening, leading to ZRCS, with support of IFRC, launching an emergency appeal in November 2023 to scale up efforts.

2. International capacity and response

2.1 Red Cross Red Crescent Movement capacity and response

IFRC membership

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.

Regular meetings are held to ensure there is strong coordination and effective technical support for ZRCS, and complementarity to ensure a harmonized response. ZRCS convenes weekly operational meetings with all partners, providing a platform to receive updates, align priorities and review workplans. All PNSs participate in strategic and operational coordination meetings held in-country and are called upon to contribute their expertise to this response. IFRC has a coordination support structure for ZRCS 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-funded⁴ 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 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 has continued mobilizing funds to continue and scale-up these community-level interventions. Swiss Red Cross donated 10 ORP kits, five tents and five Wagtech water quality testing units. The ORP kits and tents have been deployed, with some already decommissioned. This support came with a cash pledge of CHF 100,000 and these 10 ORP kits donated by Swiss Red Cross were transported with support of Airbus Foundation. The Norwegian Red Cross also deployed a Water Supply Rehabilitation Emergency Response Unit to Zimbabwe with cash pledge of NOK 3,850,000 to supply WASH interventions. British Red Cross contributed a cash pledge of GBP 95,000 in December 2023 as well. In March 2024, British Red Cross also supported the operation with two more pledges of GBP 1,078,00 from the FCDO. Netherlands Red Cross funded the appeal in January with a cash pledge of EUR 100,000 while Canadian Red Cross, Japanese Red Cross and Monaco Red Cross offered CAD 90,000, JPY 5,000,000 and EUR 10,000.

³ <https://adore.ifrc.org/Download.aspx?FileId=754347>

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

Surge and Emergency Response Units (ERUs)

Partner National Societies that are not working with ZRCS bilaterally are also rendering support to IFRC through surge operations, and where appropriate are mobilizing resources for the ongoing response. The table below provides a summary of the surge and ERU support provided to the Appeal.

Tool	Deployed by
Water Supply Rehabilitation ERU (Team Leader, Cash and Voucher Assistance Delegate and a Logistics and Admin delegate)	Norwegian Red Cross
Household Water Treatment ERU - team leader deployed for assessments and surveys	Spanish Red Cross
Operations Manager - 1 st rotation	German Red Cross
Public Health in Emergencies (PHIE) Coordinator	Finnish Red Cross
PHIE Officer	German Red Cross
IM Coordinator	Netherlands Red Cross
Communications Coordinator 1 st rotation	Netherlands Red Cross
Communications Coordinator 2 nd rotation	Norwegian Red Cross
Logistics Coordinator	Danish Red Cross
CEA Consultant	RCCE Collective Service



WSR team leader assesses a water network in Zvipiripiri. Photo: ZRCS

Red Cross Red Crescent Movement coordination

ICRC has a regional delegation hosted in Pretoria, which serves as a hub for operations in countries of southern Africa. In partnership with ZRCS, 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 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. The regular meetings augment the technical and financial support from the RC movement partners both in country and those not in

country. They include Finnish RC, British RC, Norwegian RC, Swiss RC, Netherlands RC, Canadian RC, Japanese RC and Red Cross of Monaco.

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 in line with the Zimbabwe Multi-Sectoral Cholera Elimination Plan. MOHCC coordinates daily national taskforce meetings for partners for this response with the participation of Red Cross Red Crescent Movement partners and other partners, including 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. 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; and
4. Logistics Admin/Finance pillar, which consists of support services, medical supplies, finance and human resources.

Per the 5W matrix, ZRCS and 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

Based on assessment, the sectors that are not well-represented and that require support to meet the needs of the most vulnerable and most affected communities are as follows:

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 informed 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 include: 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 of them need to be strengthened. Strategies for RCCE should now aim to move beyond awareness raising sessions and distribution of messages, to more interactive approaches that allow for two-way communication with the public, affected communities, households and individuals. There is also a need for stronger community-based efforts in health and hygiene promotion to appropriately address barriers to behaviour change on 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 issues.

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. As the cases have now spread all over the country, there is a need to support and strengthen community-based surveillance where Red Cross volunteers can play an important role even beyond the response.

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 for several reasons: (1) inadequate human resources to manage the caseload; (2) inadequate CTUs, resulting in the conversion of health facilities into CTUs; (3) inadequate cholera supplies; and (3) 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 are reducing the burden on CTUs and allow for more rapid access to ORT for remote communities. This needs to be strengthened and should cover more areas. ZRCS provinces and branches need to be trained in ORPs, and where possible should have ORPs pre-positioned in all provincial warehouses for quick deployment.

Additional human resources and material support to CTUs are needed to help improve 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.

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.

Cash and Voucher Assistance (CVA)

Feedback and assessments done in impacted areas have identified gaps in the CVA approach in support of ORPs, as outlined below.

- a. For ORPs in rural areas:** Lack of patient transportation from ORPs to CTCs once case has been diagnosed as severe; or patient is under age 5 or is a pregnant woman. Here, patients who are referred to CTCs may often decide not to seek further treatment for reasons such as: they are the main income earner in the household and will lose their earnings; or they are the caregiver of the family and go back home and use home remedies while also looking after their families. There is thus a need to have their basic needs covered during admission and recuperation period. Patients

who do seek further treatment must also be provided with meals for accompanying family while admitted, meals once they have recuperated from the severe stage of the disease and basic needs at the household level, return transportation, access to information and access to sanitation to avoid re-infection.

- b. Water points in urban areas:** Households accessing water in urban areas should be required to pay a monthly fee toward maintenance and for treating the water through water point committees. Through the Household Water Treatment and Storage (HHWTS ERU), an assessment was done including risk mitigation, and a proposal was made on how to support households during the peak of the emergency. This was under the ECHO project, by Finnish Red Cross, ultimately as a long-term intervention with the city of Harare Water Department. Currently there are discussions with UNICEF, VEI and Netherlands Red Cross on how to fundraise for urban resilience. Water kiosks in urban areas remain one of the primary safe sources of water, requiring their proper management for continuous supply. They are run by community volunteers who collect fees and distribute the water. One of the challenges they face, however, is collecting enough to purchase chlorine tablets, since many households cannot afford to pay this and rather resort to open water sources. CVA for water has thus been identified as a measure to provide safe drinking water.



Household Water Treatment and Storage ERU team leader checking water quality in Harare. Photo: ZRCS

OPERATIONAL CONSTRAINTS

Barrier	Response
Delays in declaration of the outbreak - (political constraint)	The cholera outbreak was only announced by City of Harare fathers rather than nationwide, due to political sensitivity.
Socio-cultural beliefs in some communities	In remote locations where religious beliefs are strong, to get people to use health structures requires investment in: <ul style="list-style-type: none"> - increasing provincial presence and resources (human and financial). - having officers present daily to follow up on cases.

Barriers to communication	Most hard-hit areas have little access to internet; flow of information is restricted. ZRCS will explore network providers in those areas, or if not possible will adopt local solutions.
Working within the Ministry of Health scope and inclusion of volunteers	Government recognizes community health workers for data reporting and information, and through them all capacity building must take place. Access for, and acceptance of, Red Cross volunteers take time. ZRCS will engage both volunteers and community health workers from the Government to increase buy-in for interventions.

FEDERATION-WIDE APPROACH

This 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 help to leverage the capacities of all members of the IFRC network in the country, to maximize 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.

The ECHO HIP project by Finnish Red Cross has supported cholera preparedness efforts specifically in Harare. Through this project, pre-positioned ORPs will be set up in hotspots covered by the appeal. British Red Cross has also begun resource mobilization to fund the emergency appeal with an initial soft pledge of GBP 95,000. In March 2024, they supported the operation with two more pledges of GBP 1,078,00 from the FCDO. Norwegian Red Cross, Swiss Red Cross, Netherlands Red Cross, Canadian Red Cross, Japanese Red Cross and Monaco Red Cross have also contributed.

Through its IFRC Infectious Disease Outbreak Response Fund Country Plan for Cholera, USAID has disbursed USD 100,000 to the Zimbabwe Cholera Operation in consultation with the Zimbabwe USAID Activity Manager (AM) under three WHO response pillars, RCCE, case management and care for survivors, and Mental Health and Psychosocial Support (MHPSS), addressing the most critical gaps.

After 31 December 2024, the response to this outbreak will continue under the IFRC Network Zimbabwe Country Plan for 2025. This takes 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. It aims to streamline activities under one plan while still ensuring that the needs of those affected are met in an accountable and transparent way.

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 December 2024, focusing on the most affected districts and vulnerable communities."

ZRCS will scale up and expand activities started in the DREF⁵ launch in June 2023. It will focus its response and preparedness on interrupting transmission and improving case management of cholera at the community and facility levels in the affected districts. The core objectives are:

⁵ <https://adore.ifrc.org/Download.aspx?FileId=754347>

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**]; and
3. To reduce vulnerability and exposure through improved access to safe water and sanitation, improved hygiene practices, and support to Oral Cholera Vaccine (OCV) campaigns if and where they occur [**reduce risk**].

ZRCS is integrating preparedness activities and building capacity tailored to the needs in the country, but with a Federation-wide view. 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. If there is a need for extension of the crisis-specific response beyond the above-mentioned timeframe this information will be shared.

Anticipated climate-related risks and adjustments in operations

Zimbabwe is nearing the end of the rainy season, yet rainfall is expected to remain erratic. The country has experienced a drought associated with el Niño, with a total 7.6 million people urgently requiring lifesaving and life-sustaining humanitarian assistance. Since December 2023, subsequent long dry spells and high temperatures, coupled with low overall rainfall, have also pushed crop and livestock production very low. Water points continue to dry up, leading to use of unsafe water and increased risk of cholera.

ZRCS is implementing a hunger crisis appeal as well, as part of the Regional Appeal, active until December 2024. With support from the Southern Africa Regional Drought Operation team, ZRCS is benefiting from technical and financial support to conduct drought assessments in Mwenezi and Gokwe-South districts through July 2024.

Operational Timeline:

The Zimbabwe Cholera Emergency Appeal revised Operational Strategy seeks to adjust the timeline required for ZRCS to finalize interventions outlined in the second operational update, released in February 2024. Initially, the interventions for the Emergency Appeal were due to conclude by 31 August. This revision details activities that will go beyond the current Appeal time frame and be completed under the IFRC Network Country Plan. ZRCS received GBP 882,000 from The Foreign, Commonwealth and Development Office (FCDO) through British Red Cross in March 2024 as part of a bigger pledge to Zambia and Malawi. The interventions for this pledge are expected to be completed by 31 December 2024.



Justification for the revision

The decision to revise this timeline stems from significant challenges observed during the review and planning meeting held in March 2024, compounded by the significant drop in cases, which has necessitated the shift from focusing on response to include preparedness and community resilience building. Below is a summary of the key reasons for requesting the revision:

1. Change in the approach to rolling out activities: The current approach is only supporting communities where ZRCS has installed ORPs. This excludes other areas that are showing cases but may not trigger deployment of an ORP because the cases are not highly concentrated in one location. The new thinking is to continue supporting communities through ORPs, in communities registering cases with or without ORPs as well as all areas identified as high risk by the Ministry of Health and Child Care.
2. Introduction of cash for WASH and cash for Health: more cases have appeared in Harare city since December 2023 due to poor access to WASH services, where many residents are using open wells instead of piped water due to their failure to pay the fees. Some patients referred from ORP to CTCs were also foregoing the referrals because they couldn't pay transport costs to CTCs. The proposal is to include CVA for WASH to help households pay their water bills. For transport, the idea is to provide cash to get patients from ORPs to CTCs. This approach builds on the ongoing DG ECHO-funded cholera preparedness project

supported by Finnish Red Cross, which has been providing transport but is currently scaling down operations.

3. Scaling up WASH: all assessments, including reports from the Ministry of Health and Child Care, indicate that lack of access to safe drinking water has been the main cause of the spread of the outbreak in both rural and urban areas. Currently the operation is focusing on provision of WASH services in areas where ORPs are installed. Going forward the operation intends to scale up its WASH component by combining activities. This will focus on provision of WASH infrastructure and its associated software actions as outlined below.
 - a. WASH infrastructure: Mechanization of existing water points through establishment of piped water systems, to improve access for both primary healthcare institutions and community water points. Following WASH assessments in hotspots, the team identified potential areas to be supported through CTCs; ORPs were established in response to a spike in cases and will be provided with solar piped water to ensure availability of clean water. Hand pumps (B-type) and installation of in-line chlorinators will complement the availability and provision of safe water from the non-functioning sources at institutions and communities in hotspots. This will include headworks for all water points to ensure that sources are protected. In provinces, the identified water points will be assessed by the technical team, which will then develop a scope of work, bill of quantities and technical specifications to support the intervention. Priority will be given to CTCs based in institutions and ORPs, later supporting communities and other institutions, such as schools. The 10 water points will be identified, assessed and repaired/rehabilitated, with another 3 mechanized from May to September 2024.
 - b. Water Quality Monitoring: Quality of available water has been very poor. This action will therefore ensure that the quality of all water points is monitored prior to being rehabilitated and mechanized. This will help to ensure that all water points proposed/seconded are suitable for use and meet WHO standards. The action will further support procurement of portable water testing kits to support onsite monitoring. Testing supplies will be pre-positioned at provincial level in Manicaland, Masvingo, Midlands and Mashonaland-Central. One portable testing kit will be positioned at headquarters in Harare, for use by the emergency response team.
 - c. Non-food Items (NFIs): As cases continue to spread, communities find themselves grappling with loss of income and disruption of daily routines. Many households are forced to prioritize basic needs such as food or water, often at the expense of other essential items. ZRCS is therefore prioritizing NFIs as a critical component. These include hygiene kits, menstrual hygiene management kits (MHM), temporary shelter materials at CTCs, handwashing stations and buckets, and cleaning and disinfection as part of Infection Prevention and Control (IPC).
 - d. Capacity Building (Community-based Management - CBM): The Operation has been assessing water points since December 2023 and one key challenge has been capacity for the users to maintain and sustain water points, partly due to low community engagement during the drilling and installation of these water points. Recognizing the critical role of community engagement and empowerment in ensuring the sustainability and resilience of water points, both ZRCS and local authorities will build capacity through training of “water point committees”, village pump minders/operatives and caretakers. Training sessions are aimed at enhancing their knowledge, skills and awareness on water point management and hygiene practices with support from relevant line ministries, supported by technical experts from ZRCS. These sessions allow community members to come together to share insights, exchange experiences and develop practical solutions to common challenges at local level around the established infrastructure.
4. Public Health Activities: Although cases are dropping, there are still some areas requiring more response and risk-reduction activities across all project areas. ZRCS therefore plans to continue with some health activities and intensifying community risk communication and engagement to ensure that myths and misconceptions related to cholera are de-emphasized, including:
 - a. ORPs: Continue to establish ORPs in areas where there may be a spike in cases though the current case index.
 - b. Risk Communication and Community Engagement (RCCE): The action will scale up community engagement activities by supporting provision of more radio jingles, establishing and supporting school clubs to be engaged in in-school cholera prevention and control activities, targeted

organized community meetings with local leaders especially in areas where some traditional practices were hindering cholera treatment.

- c. Capacity building of ZRCS staff, volunteers and frontline Ministry of Health staff and volunteers: As part of the cluster strategy in preparing ZRCS to be ready to respond to the next outbreak, and bearing in mind that cholera has become endemic in the region, the action has organized trainings on PFA, Epidemic Control for Volunteers (ECV, Community Management of Cholera (CCMC) and Complaints Feedback Mechanism (CFM) in epidemics.
5. **Hunger Crisis:** Just like many countries in southern Africa, Zimbabwe has been affected by drought, which has now been declared a national hunger disaster by the President. A poor harvest has led to food insecurity as well as loss of livelihoods, as most people either work in agriculture or sell agriculture products for a living. Poor food security has a direct correlation to cholera especially among children under 5, and households whose members are in cholera treatment centres are still struggling to recover from the loss of livelihood. The action will thus include cash to help households address food security and livelihood needs to prevent malnutrition and to sustain livelihoods.

Thus, extending the timeframe of the operation to 31 December is essential to ensure the objectives. This additional time will allow the Operations team to fulfil its commitment to providing vital support to the affected communities.

Targeting

1. People to be assisted

Through this revised strategy, the Operation will continue to target Matabeleland-South, Manicaland, Mashonaland- Central, Midlands Province, Masvingo and Mashonaland-West, working in 12 districts, but will also be responding to emerging needs per request from the Government. These targeted areas were identified in conjunction with the Ministry of Health and Childcare (MOHCC). The Operation will also continue to target common cholera hotspots and urban communities as well as districts with increased cases and deaths, and high case fatality rate (CFR). This includes districts with high cholera risk factors contributing to new cases and districts with high numbers of cases per day as well as districts where CTU capacity is limited due to high caseload, acting immediately upon notification of a case in a new area. Districts with many cases in a specific area will also be prioritized. Deployment of BORTs to the targeted districts will be guided by data and by weekly analysis of trends.

Working closely with DHTs, partners and communities will help ZRCS to identify priority areas and contribute to adequate planning for oral rehydration, BORT deployment and other preventive activities, through increased understanding, acceptance and cooperation in the community. Agility, flexibility and complementarity of interventions in each location will ensure efficacy and efficient use of resources. At district and community levels, messaging 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 caseload, funding, capacity to replicate BORT team modalities and the acceptance of BORT and ORP by MOHCC. This appeal will also strengthen communication and will support assessments where cases suddenly rise.

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

Protection Gender Protection and Inclusion (PGI)

Inclusion remains an issue, and meaningful participation of all persons, men, women, boys, girls, persons with disabilities and persons of different age groups, among others, could be strengthened. Disability-friendly access to cholera supplies and materials, including to ORPs, CTCs and water sources, continues to be a challenge. Access to information-education-communication (IEC) materials in various local languages has been a challenge too. Engagement of volunteers who speak different languages has helped, however. ZRCS is promoting disability-friendly water sources and supplies and is advocating to stakeholders on Dignity, Access, Participation and Safety (DAPS) for all. They are working to ensure that all staff and volunteers are briefed on PGI, Prevention of Sexual Exploitation and Abuse (PSEA), child safeguarding, and signing of the Code of Conduct. Per minimum standards,


ZRCS is also mainstreaming PGI and ensuring that all data are disaggregated by sex, age and disability.

Community Engagement and Accountability (CEA)

The community have been involved in planning the revised strategy, and this has increased their understanding, engagement and ownership of the intervention. This will contribute to reducing the spread of the disease through sharing of reliable information about services with a focus on: uptake of ORS; use of ORPs and promotion of health-seeking behaviours; distribution of information through community meetings and door-to-door activities by BORTs. The Operation will continue to hold community meetings, conduct door-to-door activities and consult with communities to (1) learn their preferences on feedback channels and the type of questions that they would like to have answered and (2) establish CFM in strategic places such as at ORPs and vaccination centres where feedback will be shared on different platforms at the community, district, and national levels, including technical and sub-technical working groups using harmonization of feedback collection tools.

During implementation there has been low public awareness about cholera and how it is transmitted, but a knowledge-attitudes-practices (KAP) survey in Harare City did indicate that 85 per cent of respondents were aware of cholera risks and transmission, hence need to address issues of WASH practice and water management. But language barrier and long-held cultural beliefs still prove issues, compounded by a lack of proper infrastructure and lack of facilities such as community radio stations to disseminate information. This action will ensure use of many means, such as radio jingles, news articles, culturally sensitive IEC materials and van publicity to reach at-risk communities.

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:	<ol style="list-style-type: none"> 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 BORTs. 			
Key indicators			Actual	Target
Volunteers in affected communities trained in cholera response including cholera messaging, ORT, BORT and OCV.			936	900
ORPs and BORT established in the targeted communities.			26	40
People seen at ORPs, disaggregated by sex and age.			9,955	TBD
Severe cases referred to CTCs/CTUs.			1,757	TBD
Households in target communities sensitized on cholera through door-to-door visits, increased risk perception, health-seeking behaviours and prevention.			70%	90%

Additional volunteers trained in epidemic control, Epidemic Preparedness in Communities (EPIC), Epidemic Control for Volunteers (ECV) and in BORT operations.	610	500
Alerts being generated through simplified Community-based Surveillance (CBS).		TBD
Target population reached with social mobilization and RCCE activities.	70%	80%
Dialogue sessions on cholera prevention and treatment conducted with assured two-way dialogue for production of community action plans.	60	100
Community roadshows in hotspots and schools.	33	100
Volunteers supported to carry out regular activities are issued a pocket guide.	936	900
Referrals made for MHPSS.	150	500
First responders/health workers trained on basic psychological first aid (PFA).	0	50
Staff/volunteers who benefited from activities focused on well-being.	0	150
Cholera burials completed that were requested of ZRCS teams.	50%	>90%

Priority actions:

- The appeal targets 12 districts and will equip 900 community volunteers in a comprehensive cholera response training, including ORT, BORT, RCCE and OCV.
- Strengthening coordination internally and externally and ensuring that resources are used efficiently.
- Mapping and updating stakeholders.
- Conducting rapid risk assessments and investigation of outbreak.
- Establishment of ORPs 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' knowledge 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 response. The ORPs procured through the project can be deployed anywhere in the country. 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

Responding 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 local 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 2,000 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 response. 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 workers (CHWs) and will ensure that ORT is available at community level, which is particularly important in rural areas where the distance 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, 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.



ZRCS volunteers setting up an ORP. Photo: ZRCS

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

Cholera infection risk is significantly higher for members of households where there is already 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. Thus, in order to reduce risk of secondary infection and control the spread of the disease, the Operation will include a response mechanism that supports targeted interventions:

- In affected districts and communities, BORTs will liaise with Health and WASH authorities, and ORPs, to gather information on hotspot locations, conduct active case finding and provide support to affected households and neighbours on messaging, with training on protective behaviours and practices, supporting them with hygiene/disinfection materials including NFIs, household water treatment products and soap.
- Investigation in the community will also help identify the main transmission routes (water, sanitation, food, hygiene behaviours), and risk factors, supporting community interventions.
- The intervention will support training and mobilizing 900 BORT team members, who will provide the foundation for interventions with the support of community health workers.
- ZRCS has 20 people with experience training BORT teams, who can be deployed anywhere in the country to train new BORT members.
- The project will ensure that BORT teams are provided with standardized BORT kits and household kits, which will allow them to support activities that disrupt transmission.
- 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.



KAP survey in Kadoma. Photo: ZRCS

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. Beyond the immediate distress caused 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 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; and
- 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.

Summary of achievements under Health

- 17 ORPs established so far with patients being assisted with ORS.
- 8,069 patients have been assisted through the established ORPs.
- 385,319 people representing 70 per cent of the target population have been reached through RCCE.
- 465 Households have been sensitized on cholera through door-to-door visits in their communities.
- Four van messaging sessions and hailer messaging sessions in Kadoma, Shamva, Odzi, Chitakatira, Churu farm and Mbare have been conducted to reach more people with hygiene promotion and health education messaging.
- Radio jingle campaigns were conducted through community radio stations (Great Zimbabwe Campus Radio and Diamond FM) to reach target populations in Masvingo province and Manicaland province respectively.

Interventions to be completed by December 2024

- Continuous Community sensitization and awareness creation by volunteers to increase preparedness.
- Procure and pre-position 25 ORPs.
- Procure and pre-position household hygiene kits.
- Procure and pre-position 40 hailers.
- Support demobilization of ORP kits.
- Train 32 volunteers in Community Case Management for Cholera.
- Train 400 volunteers in ECV.
- Train 280 volunteers in PFA.
- Airing of 65 radio jingles.
- Support and sustain the functionality of community feedback mechanism.
- Produce 10 case studies.
- Produce two documentaries as learning materials for cholera response.

	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:			Actual	Target
Households using safe drinking water in targeted high-risk communities (FRC>0,2 mg/L).			75%	100%
Households with appropriate knowledge about cholera and health/hygiene- protective behaviours.			70%	90%
ORPs have access to adequate water and sanitation services.			100%	100%

Water points rehabilitated or upgraded and providing access to safe water supply for the affected communities.	52	70
Households reached with key messages to promote personal and community hygiene.	65%	80%
Solar water pumps in health facilities and schools in affected communities rehabilitated.	3	5
Volunteers trained in Household Water Treatment and Safe Storage.	939	900
Households in the affected communities provided with 1 per cent stock solution for pot-to-pot chlorination.	55%	75%
Temporary sanitation facilities such as latrines, bath shelters and handwashing facilities constructed and maintained in CTUs.	19	20
Households in the target communities sensitized on cholera through door-to-door visits.	70%	95%
Sanitation promotion activities conducted in communities and institutions on latrine use and management, proper waste disposal.	105	150
Priority actions:		
<p>In affected areas, investigations by BORT teams and 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 to select the most appropriate interventions in household water treatment, bucket chlorination, small repairs, water quality monitoring, messaging on funerals/gatherings and hygiene promotion.</p> <ul style="list-style-type: none"> • 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 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 excluded. • 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. <p>Contribute to increased access to safe water through the construction, rehabilitation and disinfection of water points.</p> <ul style="list-style-type: none"> • 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. <p>Water quality monitoring at household and communal water points.</p> <ul style="list-style-type: none"> • 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.


Overall, there is good progress in this sector on targets vs. reach, although ZRCS will give more attention to the solarization of water pumps at health facilities and schools, which is lagging.

Summary of achievements under WASH

- 14 existing water points have been rehabilitated with B-type hand pumps.
- Five existing water systems have been upgraded and mechanized with solar, including setting up and training water management committees.
- Supported provision of WASH services in all 17 ORPs installed, and 3 CTCs established.
- Successful drilling of a community water point.

Interventions to be completed by December 2024

- Procurement and supply of 10 hand pump repair kits.
- Soliciting contractors for the establishment of mechanized piped water scheme and repair of existing mechanized schemes.
- Drilling six new boreholes and equipping with either handpumps or solar depending on the yield resources and timing.
- Training of water point management committees for all water points.
- Solarization of 12 additional boreholes.
- Provision of WASH NFIs, hygiene kits and MHM sessions and kits.
- Monitoring of household water treatment and hygiene promotion at household level.
- WASH assessments and rehabilitation (preparedness phase).
- Post-monitoring of community health clubs and school health clubs.

	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:	The safety and well-being of people affected by crisis is guaranteed, protecting them from violence, abuse, exploitation, discrimination and exclusion.			
Key indicators:		Actual	Target	

Feedback linked to protection concerns that are managed in accordance with IFRC policy and standards.	100%	100%
Target population reached by PGI activities.	70%	90%
Staff and volunteers oriented on the Code of Conduct, Prevention of Sexual Exploitation and Abuse (PSEA) and Child Safeguarding.	100%	100%
Volunteers trained to identify women, men, girls and boys requiring MHPSS after being discharged from CTUs.	100%	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.

There is generally good performance under this component, and moving forward the operation will increase the community understanding of PGI and Child Safeguarding issues by the staff and volunteers. A training on MHPSS will be scheduled to raise capacity for volunteers on identification of people requiring MHPSS post-discharge from CTUs.


Summary of achievements under Protection Gender and Inclusion (PGI)

- 385,319 people representing 70 per cent of the target population have been reached with PGI awareness messages.
- 100 per cent of the staff and volunteers supporting the operation were oriented and signed the Code of Conduct.

Interventions to be completed by December 2024

- Training of staff and volunteers in PSEA and Child Safeguarding policies of ZRCS.
- Training of 900 volunteers on how to identify women, men, girls, and boys requiring MHPSS after being discharged from CTUs.

	Risk Communication, Community	Female > 18: 148,624	Female < 18: 148,621	75,000 CHF
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	Engagement and Accountability (CEA)	Male > 18: 126,606	Male < 18: 126,604	Total target: 550,455
Objective:	Support people to actively participate in addressing cholera by promoting safe, healthier practices, facilitating community action, and helping to reduce fear, stigma and misinformation.			
Key indicators:			Actual	Target
TV and radio campaigns.			3	5
Volunteers trained on CEA and its tools.			936	280
Feedback linked to protection concerns that are managed in accordance with IFRC policy and standards.			100%	100%
Priority actions:				
<p>IFRC RCCE tools will be tailored to the Zimbabwean context:</p> <p>Risk Communication and Community Engagement and Accountability approaches</p> <ul style="list-style-type: none"> • 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 analyze 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, analyze 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 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.
- 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.


Summary of achievements on Community Engagement and Accountability (CEA)


- TV and radio campaigns conducted.
- Stories developed and posted on IFRC and ZRCS social media pages; 10 field visits to capture photos and stories were conducted.
- One consultant was identified to develop additional cholera messages to be aired on radio stations.

Interventions to be completed by December 2024

- Airing of 65 radio jingles.
- Two visibility and profiling sessions to be conducted.
- Support development of two documentaries.
- Support follow-up on feedback linked to protection concerns.
- Support five cholera TV programmes on national television.

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	Actual	Target
Staff trained on Prevention of and Response to Sexual Exploitation and Abuse (PSEA).	90%	100%
ZRCS has assessed their capacity at headquarters and branch level and has identified areas for improvement.	1	1
ZRCS has received support aligned with National Society Development compact principles.	Yes	Yes
Volunteers working on the project have health, accident and death compensation.	100%	100%
Priority actions:		
<ul style="list-style-type: none"> 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. Epidemic preparedness supplies, fleet and warehousing. Volunteer management through provision of equipment, training and insurance packages. Infrastructure development, communications, fleet and technical services, 		
Many activities have not been implemented yet and will begin this quarter.		
Summary of achievements under National Society Strengthening		
<ul style="list-style-type: none"> Recruitment of 900 volunteers with introduction to Red Cross Red Crescent fundamental principles, roles, responsibilities, and rights of volunteers. Visibility materials procured and distributed to 1,000 volunteers. 		
Interventions to be concluded by December 2024		
<ul style="list-style-type: none"> Support insurance for 1,000 volunteers supporting the operation. Train 30 staff and volunteers in National Disaster Response. 		

	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	Actual	Target
Coordination platforms where ZRCS takes a leading role and provides critical data.	12	10
External partnerships supporting ZRCS in the response established.	11	10
Regular coordination mechanism is in place ensuring alignment and coordination with all Movement partners and local and international partners.	8	6
Priority actions:		
<p>Membership Coordination</p> <ul style="list-style-type: none"> • 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. <p>Engagement with external partners</p> <ul style="list-style-type: none"> • 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. • 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. <p>Movement cooperation</p> <p>The overall coordination of the response has been good with both internal and external partners. The operation has been conducting weekly coordination meetings, and participated in all response pillar meetings, MOHCC Cholera Operations National-level Coordination meetings, Provincial Cholera response coordination meetings as well as IFRC donor engagement meetings.</p>		



ZRCS, Ministry of Health and other stakeholders in Zvirpiripiri CTC. Photo: ZRCS

Summary of achievements under Coordination and Partnerships

- Supported ZRCS to be present in 10 Coordination platforms, where it takes a leading role and provides critical data.
- 11 external organizations established partnerships with ZRCS, both traditional partners and new partners, such as USAID, FCDO and Bill and Melinda Gates Foundation.
- Regular coordination mechanism is in place ensuring alignment and coordination within all movement partners and local and international partners.

Interventions to be completed by December 2024

- Continue supporting coordination meetings.
- Continue supporting donor engagement meetings

	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	Actual	Target	
Global and regional surge.	11	7	
Federation-wide reporting set up by PMER.	1	1	
Risk register set up, mitigation measures identified and monitored once per month.	Done	Monthly	

Communications support provided - communication working group for movement members in country (ZRCs, ICRC & IFRC) will be activated and coordinated.

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Priority actions:

- The Harare Cluster Delegation provides full support across Operations Coordination, WASH, Finance, Logistics, PMER, Security, National Society Development (NSD) and technical sectors.
- IFRC security plans will apply to all IFRC staff throughout the operation. Area specific Security Risk Assessment will be conducted for any area should any IFRC personnel deploy there; risk mitigation measures will be identified and implemented. All IFRC must, and RC/RC staff and volunteers are encouraged, to complete the IFRC Stay Safe e-learning courses, e.g. Stay Safe 2.0 Global Edition Levels 1-3.
- 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)



Operation team receiving ORP kits from Swiss Red Cross aboard free Airbus Foundation. Photo: ZRCs

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.

There has been good surge support since the operation was launched. Nine different surge profiles were deployed and have helped build the capacity of ZRCS in technical, coordination, management and leadership sectors. The operation has already put in place a Federation-wide reporting mechanism, and risk has constantly been reviewed to ensure mitigation measures are put in place. Mentorship and support to the ZRCS communication team continue to be provided to ensure continuity beyond the surge support and the strengthened capacity of the ZRCS communication team is an added advantage to profiling the organization beyond cholera response.

Summary of achievements

- Engaged nine global and regional surge profiles.
- Federation-wide reporting set up by PMER.
- Risk register with its mitigation measures developed and submitted to relevant donors. Reviews will be conducted at the end of operations.

Interventions to be completed by December 2024

- Continue supporting reporting on operations.
- Continue monitoring the risk register.

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; and 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. 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 road access is good. A critical risk factor in the cholera	Medium	Medium	Safety and security of the volunteers and staff will be ensured by appropriate safety and security measures; personal protective equipment will be refreshed at the IFRC Stay Safe 2.0 training.

response operation will be the availability of funds from government to support staff working in the cholera response.			
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 responsible for risk management and will advise ZRCS on these risks and what mitigation measures should be taken. The operations coordinator is responsible for the day-to-day implementation of the risk mitigation measures with ZRCS teams. The Regional Office will support the risk management of this Operation, with technical advice and overall support for 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.

Key indicators identified in the Planned Operations section will be used to set up an M&E framework to monitor approach, quality of work, and beneficiary satisfaction, as well as tracking progress on planned activities. ZRCS and partners will routinely carry out a self-assessment against indicators to make sure that the operation is on track, that products and services meet the minimum quality standards, and that operations remain relevant to the survivors. The monitoring system will also check whether the accountability systems that have been set up are working effectively.

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*



REVISED OPERATIONAL STRATEGY

MDRZW021 - Zimbabwe Red Cross Cholera Emergency Appeal, 2023

FUNDING REQUIREMENTS

Planned Operations	2,430,000
Health	1,448,000
Water, Sanitation and Hygiene (WASH)	829,000
Protection, Gender and Inclusion (PGI)	38,000
Community Engagement and Accountability (CEA)	115,000
Enabling Approaches	570,000
Coordination and Partnerships	32,000
Secretariat Services	291,000
National Society Strengthening	247,000
TOTAL FUNDING REQUIREMENTS	3,000,000

All amounts in Swiss Francs (CHF).

Contact information

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

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

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Reference

Click here for:

- [Link to IFRC Emergency landing page](#)
- [Previous appeals and latest reports for this emergency](#)
- [Additional information on the GO platform](#)