

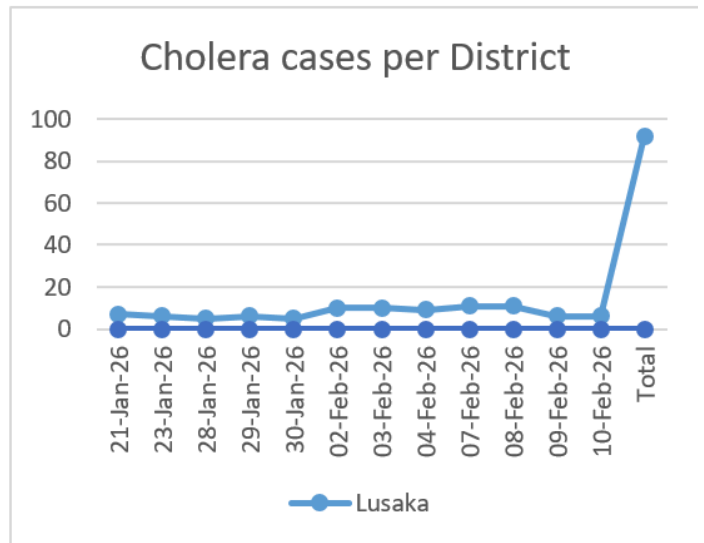


Volunteer supporting distribution

Appeal: <b>MDRZM027</b>	Hazard: <b>Epidemic</b>	Country: <b>Zambia</b>	Type of DREF: <b>Response</b>
Crisis Category: <b>Yellow</b>	Event Onset: <b>Slow</b>	DREF Allocation: <b>CHF 149,882</b>	
Glide Number: <b>-</b>	People Affected: <b>2,172,792 people</b>	People Targeted: <b>1,200,000 people</b>	
Operation Start Date: <b>01-03-2026</b>	Operation Timeframe: <b>6 months</b>	Operation End Date: <b>30-09-2026</b>	DREF Published: <b>05-03-2026</b>
Targeted Regions: <b>Lusaka</b>			

## Date when the trigger was met

09-02-2026



Geographical target area and Epic Curve

## What happened, where and when?

Zambia has been experiencing the cholera outbreak since 5th August 2025. The first case was detected at Chipwa Health post bordering Tanzania in a region that was experiencing cholera then. Within a few weeks, the disease spread to other parts of Northern Province before sporadic cases were reported on the Copperbelt and Lusaka. While the initial phase was brought under control, through robust intervention such as Risk Communication and Community Engagement, Case Area Targeted intervention, including Oral Cholera Vaccination, a resurgence of cases started being recorded in Lusaka district.

Cholera cases in Lusaka Province have been reported in multiple high-density and peri-urban communities, with Chainta identified as a key hotspot requiring intensified response interventions, including oral cholera vaccination and WASH activities. Transmission in Lusaka is largely linked to densely populated settlements with limited access to safe water and sanitation facilities. In Chilanga District of Lusaka Province, confirmed cases have been concentrated in specific localities, notably the Game-Sangalala area (recording the highest number of cases), Game-Kanchenjela, Linda, and Mt. Makulu, prompting community sensitization and environmental health measures.

On 9 February 2026, the Ministry of Health issued a press release on the cholera situation and other priority public health threats. The outbreak, initially concentrated in Mpulungu District of Northern Province, it began to shift southwards from November 2025, with new outbreaks emerging in Monze District and later in Lusaka Province. This shift reflects the influence of urban mobility, informal settlements, and persistent sanitation challenges. Although several districts have achieved the 28-day zero-reporting threshold, the MOH stated Lusaka Province has now become the main centre of transmission, with low-level but widely dispersed sporadic cases across multiple sub-districts and health facilities.

As of 25 Feb, the MOH Daily Surveillance Report reported Lusaka District as having the cumulative totals of 271 cases and 4 deaths. In the past few days, there has been a spike in the number of cases reported daily, with 14 new cases in the past 24 hours, reinforcing Lusaka's role as the current driver of national transmission.

According to the Global Cholera Situation Update released on 20 February, Zambia has been classified as "high risk," with a significant likelihood of rapid transmission acceleration. The country also recorded the highest monthly percentage increase in cholera cases globally, with a surge of +507.7%.





Education during chlorine distribution in Mpulungu

## Scope and Scale

### Overview of the Cholera Outbreak in Zambia

The ongoing cholera outbreak in Zambia continues to exert significant public health and socio-economic impacts, affecting lives, livelihoods, well-being, and essential services. The severity and persistence of transmission are closely linked to pre-existing structural vulnerabilities in water, sanitation, hygiene (WASH), and health service delivery systems across affected districts. Poor living conditions, high population density in informal settlements, and limited access to safe water and sanitation have created conducive environments for sustained transmission.

According to the Daily National Surveillance Update for Epi wk 09 nationally, since August 2025, a cumulative total of 983 cholera cases and 18 deaths have been reported across 21 districts in 9 provinces, reflecting continued localized transmission primarily centered in Lusaka District, with emerging geographic expansion requiring heightened surveillance and rapid response. Lusaka District remains the epicentre of the outbreak, driving the majority of recent cases, while neighbouring Chongwe District remains on high alert following reports of a cluster of suspected cholera cases currently under investigation.

### Geographic scope and context Lusaka Province:

As of 25 February, Lusaka District has recorded a cumulative total of 271 cholera cases and 4 deaths. Over the past several days, the district has experienced an upward trend in daily case reporting, with 14 new cases in the last 24 hours. Overall, from 3 February to 25 February, cases in Lusaka have risen from 170 to 271, indicating sustained transmission. In addition, Chongwe District in Lusaka Province has reported an alert involving a cluster of suspected cholera cases. Investigations are currently underway to determine whether this cluster represents a confirmed outbreak.

In Lusaka, transmission remains concentrated in densely populated informal settlements, including Chainda, Chawama, and Mandevu. Unplanned settlement patterns, overcrowding, limited piped water coverage, and inadequate sanitation infrastructure characterize these areas. Many households rely on intermittent municipal water supply or shallow wells, increasing reliance on unsafe water sources. The absence of functional sewage systems and weak solid waste management further exacerbates environmental contamination and exposure risks. These structural deficits contribute to recurrent outbreaks and sustained community transmission.

Communities such as Sangalala, Game-Kanchenjela, Linda, and Mt. Makulu face similar vulnerabilities, including limited access to improved latrines, inadequate water supply systems, and overcrowded housing. Water scarcity drives reliance on untreated sources and shared communal water points with limited hygiene facilities. These behavioral adaptations to scarcity increase contamination risks and contribute to ongoing transmission chains.

Key risk factors driving transmission:

- Limited Access to Safe Water: Many affected communities lack reliable piped water systems and functional boreholes. Households depend on shallow wells.
- Inadequate Sanitation Coverage: In some high-risk communities, sanitation coverage remains critically low, with reports of access below 20 per cent. Poorly constructed and poorly sited latrines increase environmental contamination and groundwater pollution.
- Poor Solid Waste Management: In urban informal settlements, particularly in Lusaka, ineffective waste collection systems and blocked drainage contribute to environmental contamination and pathogen spread.
- Low Adoption of Hygiene Practices: Handwashing at critical times remains inconsistent. Many sanitation facilities lack functional handwashing stations with soap, limiting opportunities for effective hygiene behavior.
- Gaps in Risk Communication and Community Engagement: Limited coordinated social and behavior change communication (SBCC) activities reduce community awareness of prevention measures and early care-seeking practices.
- Delayed Access to Treatment: Community-level deaths highlight delays in seeking care and barriers to accessing treatment facilities. Of the reported deaths, a significant proportion occurred outside health facilities, indicating late presentation and gaps in early referral systems.

The outbreak is disproportionately affecting the following vulnerable groups, including:

- Children under five are at increased exposure and rapid dehydration risk. --Pregnant women and the elderly, who face higher morbidity risks.
- Persons with disabilities, who may encounter mobility and access barriers. Informal settlement dwellers have limited access to safe WASH services.
- Traders, with high mobility.

## Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	<b>Yes</b>
Did it affect the same population group?	<b>No</b>
Did the National Society respond?	-
Did the National Society request funding form DREF for that event(s)	-
If yes, please specify which operation	-

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

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### Lessons learned:

During the last DREF operation (March–August 2025), the Zambia Red Cross Society (ZRCS) implemented multi-sectoral interventions in Kabwe, Ndola, Kitwe, Chingola, Chililabombwe, Mpulungu, and Mbala. Activities included cross-cutting areas such as Community Engagement and Accountability (CEA), Protection, Gender, and Inclusion (PGI), and Mental Health and Psychosocial Support Services (MHPSS), alongside health promotion and WASH. Multi-thematic training strengthened volunteer effectiveness, enabling them to integrate health, psychosocial, and protection considerations during household visits. Refresher trainings were essential, as some volunteers initially struggled to apply new skills in fast-changing outbreak contexts.

Community awareness improved through door-to-door outreach and radio programs, with local media partnerships amplifying trust and reach, particularly in cross-border districts like Chililabombwe and Chingola. Integrating CEA, PGI, and MHPSS into health and hygiene activities helped reduce stigma, address anxieties, and ensure protection considerations were mainstreamed.

Challenges included persistent misinformation and rumors about cholera causes and intervention safety. High mobility in border areas, long distances to scattered communities, language barriers, misconceptions linking cholera to witchcraft or contaminated medicines, and competing household priorities limited the impact of engagement activities.

Building on these lessons, the current DREF operation will target Lusaka district, implementing measures to enhance impact. Volunteers will receive both initial and refresher multi-sectoral training, supported by mentorship and supervision. Door-to-door



outreach will be complemented by localized radio programs, SMS campaigns, and community drama sessions. Psychosocial support desks, protection-focused outreach, and culturally sensitive community engagement will ensure inclusion. IEC materials will be delivered in local languages, with volunteers selected for language proficiency. Mobile outreach teams will reach scattered communities, while sessions will be scheduled to suit household priorities. Regular community feedback will guide adaptive messaging and strategies.

These measures aim to strengthen awareness, promote safe behaviours, reduce stigma, ensure protection, and improve overall response efficiency.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	<b>Yes</b>
What was the risk level for Child Safeguarding Risk Analysis?:	<b>The risks are low for children as staff and volunteers do not directly interact during responses like Cholera outbreaks</b>

## Current National Society Actions

### Start date of National Society actions

15-01-2026

<b>Health</b>	<p>Currently, the Zambia Red Cross Society (ZRCS), with support from the IFRC Country Support Platform FCDO CATI-funded Project, is responding to the ongoing cholera outbreak through targeted interventions. A total of 500 cholera kits were donated to the Lusaka and Chilanga District Health Offices (DHO). On-site CATI approach orientations were conducted at three sites: Tubalange (35 participants), Chilanga Urban (14), and Mt. Makulu (28), reaching 44 Ministry of Health staff and 33 community-based volunteers (CBVs). In addition, 40 CATI interventions were supported in Lusaka, covering areas such as Chanida, Munali, and Kanyama. Lusaka also received 1,000 cholera kits in January to further strengthen response efforts.</p> <p>In terms of WASH, the CATI project is constructing toilets and drilling boreholes in Kabwe and Chililabombwe, focusing on areas reporting cholera cases. Furthermore, on-site CATI trainings have been concluded for five health facilities in Chilanga District, strengthening local capacity for rapid cholera detection and response.</p> <p>However, the FCDO CATI-funded project has since exhausted the funds allocated to CATI response activities and community-level activities and is unable to continue supporting the response efforts. In addition, the project has an imminent closing date set for March 31st, 2026, and is now in the closing stages. The gaps requiring urgent support continue to abound, with cases persisting and the need to support case management approaches, including the set-up of ORPs, intensification of community-level activities, and psychosocial support, amongst other gaps. These gaps cannot be covered within the scope of the CATI project as they are outside the proposal design-set activities, and there are no funds available to support these gaps.</p> <p>The IFRC hosts the Cholera Country Support Platform that works as the operational arm of the GTFCC. The CSP, with 4 core mandates, provides direct support to cholera high-risk countries in –</p> <ol style="list-style-type: none"> <li>1. The development and implementation of long-term National Cholera Plans</li> <li>2. Advocating and mobilizing resources to directly support countries in the implementation of their NCPs, bridging relevant funding gaps</li> <li>3. Mobilizing additional technical support as may be required from the wider GTFCC partnership to address specific technical gaps</li> <li>4. Supporting the generation of evidence through driving cholera-specific research in line with the global cholera research agenda</li> </ol> <p>The role of the CSP in countries where they operate is specifically to provide direct support to the government (and not the National Society, though, where possible, the CSP promotes strong visibility and participation of the National Societies in national and sub-national level cholera discussions, giving credibility to the National Societies.</p>
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	<p>Examples include the active participation and representation of the ZRCS in various TWGs within the National Cholera Taskforce, ZRCS bilateral engagement with other key partners within the Cholera Taskforce. The current FCDO CATI project funding the CSP's work with the government is also being channelled through the Zambia Red Cross Society, giving the ZRCS the much-needed visibility and capacity to play its auxiliary role to the government of Zambia.</p> <p>In these cholera high-burden countries where the CSP works, including Zambia, the CSP does not replace existing IFRC traditional mechanisms of response to cholera outbreaks (supporting NSs through DREFs and Appeals as relevant), but the CSP only complements the IFRC's support. This is primarily because, although the IFRC is designed to support the NSs' capacity to respond to outbreaks, the CSP role (as in the design of the FCDO CATI project) is to support the government directly in its cholera control and elimination efforts while engaging the NSs in that process.</p>
<p><b>Coordination</b></p>	<p>The National Society is part of the National Coordination mechanism and Technical Working Groups such as WASH cluster, Risk Communication and Community Engagement and Accountability, Anticipatory Action Technical Working Group, Cross border meetings and Incidence Management System (IMS) at all levels.</p>
<p><b>Activation Of Contingency Plans</b></p>	<p>To effectively respond to the current hazards, including cholera, the country is faced with, the NS activated its Multi-Hazard Contingency Plan after the thresholds were met. This is to ensure there is a coordinated approach to the response and resource mobilization</p>

## IFRC Network Actions Related To The Current Event

<p><b>Secretariat</b></p>	<p>The IFRC Secretariat provides both technical and financial support to the Zambia Red Cross Society (ZRCS) through the IFRC Harare Country Cluster Delegation, ensuring effective coordination within and outside the Movement. Technical support is delivered through existing capacity at the delegation and regional levels. In Zambia, the IFRC office hosts two staff: a Cholera Country Support Platform (CSP) Delegate and a Community Engagement and Accountability (CEA) Officer.</p> <p>IFRC support has significantly strengthened cholera prevention and response efforts in Zambia, particularly through the Country Support Platform (CSP), which is part of the Global Task Force on Cholera Control (GTFCC) and supported by the UK Foreign, Commonwealth and Development Office. The CSP supports the development and implementation of National Cholera Plans (NCPs) and has enabled sustained technical assistance, including: ongoing support to the Incident Management System (IMS); nationwide capacity building on Case Area Targeted Interventions (CATI); implementation of CATI in Mpulungu, Lusaka, Chiengi, Mbala, and Chilanga; procurement and distribution of CATI supplies; and engagement of volunteers to support implementation in targeted districts.</p> <p>Additionally, ZRCS benefited from the Federation-wide Emergency Appeal (MDRZM021) for the 2023/2024 outbreak and the MDRZM024 Cholera DREF, funded by multiple donors, including the UK and Scottish Governments. These operations achieved substantial results, including the mobilization and training of 1,782 volunteers in cholera response (ORT, contact tracing, RCCE, PGI, IPC), sensitization of 3.7 million people, establishment of 55 Oral Rehydration Points (ORPs), support to Oral Cholera Vaccination (OCV) reaching 795,452 people, rehabilitation of 13 water reticulation points, drilling and solarization of 20 boreholes, and construction of 15 waterborne toilets. These interventions were also amplified through the 2025 Cholera DREF, which reached over 1.5 million people in Kabwe, Chililabombwe, Ndola, Chingola, Mpulungu and Mbala districts.</p> <p>While these interventions were instrumental in controlling the previous outbreak and were implemented according to national priorities and outbreak evolution, gaps remain in the current response. Of the six districts currently reporting cases, only two</p>
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	received limited support under the previous Emergency Appeal. The remaining four districts—now accounting for over 95% of reported cases—were not covered. Consequently, significant WASH and health response gaps persist and require dedicated support to effectively contain the current outbreak.
<b>Participating National Societies</b>	<p>The Netherlands Red Cross (NLRC) is currently the only Participating National Society (PNS) supporting the Zambia Red Cross Society (ZRCS) in cholera preparedness activities in-country. Through a Crisis Modifier intervention in Monze District—an area that recorded cholera cases—NLRC supported the training of volunteers in Risk Communication and Community Engagement (RCCE) and community mobilization for Oral Cholera Vaccination (OCV) campaigns.</p> <p>The trained volunteers have since been deployed to support ongoing preparedness and response activities, including hygiene promotion and community sensitization in at-risk areas.</p> <p>At the national level, NLRC actively participates in the Incident Management System (IMS) coordination meetings for the cholera response, ensuring alignment with national strategies and partner interventions. In addition, NLRC is supporting the National Society through an ongoing Health and Care project in Eastern Province.</p> <p>NLRC will continue to provide technical guidance and strategic support to the overall cholera operation through its in-country delegate, contributing to strengthened coordination, quality assurance, and effective implementation of response activities.</p>

## ICRC Actions Related To The Current Event

Currently there is no ICRC activities directly supporting the response

## Other Actors Actions Related To The Current Event

<b>Government has requested international assistance</b>	Yes
<b>National authorities</b>	<p>Ministry of Health, together with Zambia National Public Health Institute (ZNPPI), is supporting the Provinces and Districts Health teams in Northern, Muchinga, Lusaka and Southern, Western Provinces through:</p> <ul style="list-style-type: none"> <li>• Activation of the District Public Health Emergency Operation Centers and Incident Management System.</li> <li>• Activation of the District Epidemic Preparedness, prevention Control, and Management Committee meetings.</li> <li>• Intensified surveillance activities, including risk assessment, outbreak investigation, active case search, community surveillance, and contact tracing.</li> <li>• Data Management-deployment of Cholera tracker/EIMS.</li> <li>• Enhanced Risk Communication and Community sensitization, activities.</li> <li>• Advocacy and stakeholder engagement.</li> <li>• Isolation, Case management, and IPC</li> <li>• National and Provincial teams deployed to support district responses.</li> <li>• Cleaning of public places and promotion of hygiene practices.</li> <li>• Provision of chlorine in affected communities,</li> <li>• Early detection of cholera cases through Community-Based Surveillance (CBS)/Event-Based Surveillance (EBS)/active case finding systems.</li> <li>• The Ministry of Health has intensified surveillance, conducted contact tracing, chlorinated water sources, and disinfected affected homes.</li> </ul>



## UN or other actors

UN and other actors are part of the cluster system that has been activated and are helping the Government in resource mobilization, surveillance and provision of supplies. They are part of the IMS and cluster coordination. The following are some of the organizations and their roles:

1. UNICEF - provision of WASH services
2. WHO- Supporting OCV and Provision of Vaccines
3. ZNPHI -Risk Communication and Community Engagement/WASH/IPC/CASE MANAGEMENT/ Surveillance/OUTBREAK INVESTIGATION
4. Disaster Management and Mitigation Unit (DMMU) Now heading the IMS as Chair
5. Zambia News and Information Services (ZANIS) -Media and broadcasting

## Are there major coordination mechanism in place?

The Ministry of Health has activated the Incident Management System (IMS) at district, provincial, and national levels to coordinate the cholera response. ZRCS is part of the Multisectoral Cholera Response Mechanism at both national and subnational levels, coordinated by the Ministry of Health (MOH) and the Zambia National Public Health Institute (ZNPHI). This coordination framework helps to avoid duplication of efforts and strengthens overall management of the cholera outbreak response through shared information, joint planning, and collaboration with key partners.

In the current cholera response, coordination remains active and structured under the national IMS, with regular technical working group meetings covering surveillance, case management, WASH, Risk Communication and Community Engagement (RCCE), logistics, and vaccination. Partners, including UN agencies and other stakeholders, participate in these coordination platforms to align interventions with the National Cholera Response Plan. At the district level, response activities are coordinated through District Health Offices and IMS structures to ensure timely reporting, rapid response to hotspots, harmonized community engagement messaging, and efficient deployment of resources. This integrated coordination mechanism supports evidence-based decision-making, prioritization of high-burden districts, and effective implementation of cholera preparedness and response interventions.

# Needs (Gaps) Identified



1. **Inadequate Human Resources for Health and Community Response:** Across the affected districts — Lusaka, there are insufficient trained health workers and surge staff to manage case management, contact tracing, surveillance follow-up, and community engagement at scale. Many health facilities and community teams are operating with limited clinical staff, and existing teams are overstretched, given the daily increases in cases and reporting requirements.  
Lusaka (Chainda, Chawama and Mandevu): High case load with limited dedicated cholera response clinicians and insufficient trained CBVs to support 24/7 community outreach.
2. **Weak Surveillance and Case Referral Systems:** The current cholera response has shown delays in reporting cases from community to facility level in all affected districts due to limited tracer teams in remote settlements and lakeshore settings. Referral pathways are weak — meaning suspected cases often present late to facilities or are managed late in the community.
  - Lusaka: Delays in triaging and referral due to overwhelmed Primary Health Centers.
3. **Insufficient Oral Rehydration and Treatment Commodities:** Several districts are reporting shortages in essential case management supplies, especially Oral Rehydration Salts (ORS), IV fluids, and essential cholera case kits. While national stores distribute commodities to hotspot areas, logistics constraints leave health posts with inconsistent stocks.
  - Chainda & Chilanga: Running low on ORS packets during peak case days.
4. **Inadequate Community-Based Volunteer (CBV) Deployment:** Although volunteers have been mobilized, the number of active community volunteers trained in cholera response (RCCE, case detection, ORT) is still below required thresholds given population risk. This gap is reported in hotspot communities with high population density or remote access needs.
  - Lusaka (Chainda, Chawama, Mandevu & Chilanga): Large population with insufficient volunteer presence to cover all high-risk zones.
6. **Limited Health Education & Risk Communication Saturation:** Although RCCE teams are active, coverage remains incomplete. There are gaps in sustained Behaviour change messaging at scale, especially during peak community interaction hours or through local dialect engagement.





## Water, Sanitation And Hygiene

Gaps in WASH/IPC Integration Within Health Facilities: Many primary health facilities in the affected areas are struggling to maintain infection prevention and control (IPC) standards, particularly handwashing stations, safe water access for communities, and sanitation improvements.

- Lusaka (Chainda, Mandevu, Chawama & Chilanga health posts: Inconsistent clean water and handwashing facilities. Areas, like Chainda, Mandevu and Chawama, have mostly intermittent supply of water, forcing some households to access water from wells and poorly drilled boreholes in dirty environments.



## Protection, Gender And Inclusion

The cholera response continues to face several challenges from a Protection, Gender and Inclusion (PGI) perspective. Limited safe and accessible infrastructure remains a concern, as some treatment centres and WASH facilities lack adequate privacy partitions, gender-segregated spaces, and disability-friendly access. This increases safety and dignity risks for women, girls, older persons, and persons with disabilities. Overcrowding and long distances to communal water points further heighten the risk of gender-based violence, while reporting and referral pathways are not always fully functional or trusted.

Identified Needs:

Stigma and discrimination toward cholera-affected individuals and families can discourage timely health-seeking behaviour and lead to social exclusion. Marginalized groups, including those living in informal settlements or lacking documentation, may experience barriers to registration and equitable access to assistance. Misinformation and limited community awareness about cholera transmission and prevention also undermine response efforts and disproportionately affect vulnerable populations who may already face communication barriers.

Older persons and persons with disabilities continue to encounter physical access challenges, limited mobility support, and insufficient tailored communication, such as sign language or simplified messaging. At the operational level, capacity and resource constraints, including insufficient funding for inclusive adaptations, affect the consistent integration of protection measures. In some locations, feedback and complaint mechanisms are not yet fully accessible, confidential, or widely known, which limits the early identification and mitigation of protection risks. Addressing these gaps remains critical to ensuring a safe, dignified, and inclusive cholera response.



## Community Engagement And Accountability

The current response faces several challenges due to inadequate training in feedback collection and documentation, which often leads to incomplete or inconsistent data, slowing timely responses. While feedback mechanisms exist, closing the feedback loop remains a challenge, and some community-led solutions not fully adopted, reducing local ownership of interventions. Although the toll-free line expanded to operate with two networks, MTN and Zamtel, insufficient infrastructure and personnel still affect the ability to manage feedback efficiently.

Strengthened volunteer capacity and better infrastructure ensure wider outreach, including remote and vulnerable communities. Closing the feedback loop and adopting community-led solutions builds trust and fosters stronger local ownership of interventions. Overall, these measures lead to a more inclusive, accountable, and effective cholera response, supporting faster outbreak control and enhanced community resilience.

[Assessment Report](#)

# Operational Strategy

## Overall objective of the operation

The DREF operation aims to strengthen Lusaka's readiness to respond quickly to cholera by improving early detection systems, reinforcing community-based surveillance, supporting essential IPC/WASH readiness actions, and ensuring rapid referral and case-management capacity so that any outbreak can be contained faster and more effectively. The DREF aims to reach over 1.2m people during an operational time frame of six months.



## Operation strategy rationale

The Zambia Red Cross Society (ZRCS) is requesting a DREF allocation to strengthen and scale up its readiness for response to the ongoing cholera outbreak. The geographic focus is Lusaka as considered a potential high-risk area with an increasing case load and in need of readiness and response.

While the National Society will leverage existing capacities, such as trained volunteers and operational structures established through previous emergency responses, the current in-country project support, such as CATI interventions, has a limited budgetary scope and cannot comprehensively address the expanding needs across affected districts as cases continue to increase. Available resources are insufficient to sustain large-scale WASH interventions, community engagement, surveillance support, and essential relief assistance required to effectively contain transmission. This DREF will therefore enable ZRCS to bridge critical funding gaps and ensure a timely, coordinated, and impactful readiness and necessary response aligned with national cholera control efforts.

The operational strategy for readiness and response to the cholera outbreak in Lusaka Province is designed to directly address identified gaps in human resources, community surveillance, case management capacity, IPC/WASH standards, and risk communication coverage. The overall goal is to reduce cholera-related morbidity and mortality by strengthening early detection, improving access to timely treatment, and promoting sustained behavior change in high-risk communities.

The strategy prioritizes strengthening community-based surveillance and early case detection through the recruitment and training of 100 Community-Based Volunteers (CBVs) across the affected sub-districts of Lusaka Province. Given the high population density and transmission risk, all 100 volunteers will be trained through a five-day course covering cholera case definition, early warning signs, community-based surveillance reporting, household-level oral rehydration therapy (ORT), referral procedures, risk communication and community engagement (RCCE), data reporting tools, and volunteer safety. Each volunteer will cover approximately 10–15 households per day, extending surveillance and hygiene promotion coverage to an estimated 21,000 households over the six-month implementation period.

To address gaps in timely treatment and overstretched health facilities, the operation will establish 20 community ORT corners across the affected sub-districts. These ORT corners will be equipped with a three-month buffer stock of ORS, chlorine, buckets with taps, and basic IPC materials to enable rapid management of mild to moderate dehydration at the community level before referral. In parallel, 40 frontline health workers will receive a three-day refresher training on national cholera case management protocols, rapid dehydration assessment, and infection prevention and control standards to reduce case fatality rates and improve clinical outcomes.

Recognizing persistent gaps in behaviour change and hygiene practices, the strategy includes an intensified RCCE campaign. Each trained CBV will conduct at least 15 household visits per day, focusing on safe water treatment methods such as chlorination and boiling, consistent handwashing with soap, safe food handling, early health-seeking behaviour, and proper waste disposal. The community engagement approach will be reinforced through monthly radio talk shows and community drama sessions to ensure sustained messaging and community ownership.

To strengthen infection prevention and control and address WASH-related drivers of transmission, the operation will support two high-burden health facilities per sub-district (10 in total) with handwashing stations, chlorine supplies, PPE, and water quality monitoring using Aquagenx. Desludging in dense urban areas such as Chainta, Mandevu, and Chawama will be facilitated in coordination with local authorities to reduce environmental contamination risks.

Coordination and monitoring mechanisms will be reinforced through the deployment of 10 district-level volunteer supervisors to provide oversight, mentorship, and supportive supervision. Weekly surveillance review meetings will be conducted with District Health Offices to track case trends, identify emerging hotspots, and guide adaptive response measures. A simplified reporting dashboard will ensure real-time data flow from community volunteers to district health teams.

Over the six-month implementation period, the operation aims to reach approximately 1.2m people across the sub-districts, significantly improve early case detection rates, enhance safe water and hygiene practices, and contribute to reducing the case fatality rate to below one per cent, in line with national and WHO standards.

Concerning sustainability and exit strategy, the IFRC is supporting the Zambia Red Cross in developing a Simplified Early Action Protocol (EAP) for cholera. The protocol provides structured, pre-agreed plans outlining the actions to be taken before and at the early onset of a cholera outbreak, guided by risk forecasts, surveillance triggers, and predefined interventions. By establishing these systems in advance, the National Society can strengthen multiyear readiness and reduce reliance on emergency-driven responses.

In addition, the IFRC and the National Society will continue collaborating through the Country Support Platform for Cholera Control, which delivers targeted operational, technical, and coordination support. This platform helps National Societies develop, fund, implement, and monitor their National Cholera Plans, ensuring a sustainable, nationally owned pathway toward long-term cholera control and eventual elimination.



# Targeting Strategy

## Who will be targeted through this operation?

The operation will target approximately 1.2m people residing in cholera-affected and high-risk communities in Lusaka Province, with Chainta being the epicentre. Targeting is guided by epidemiological data from district surveillance reports, hotspot mapping, and vulnerability profiling conducted in coordination with District Health Offices. Priority has been given to areas with confirmed cases, high attack rates, population density, unsafe water sources, poor sanitation coverage, and limited access to timely health services.

The primary target group comprises households living in densely populated informal settlements, Chainta in Lusaka province and the periphery areas. These communities experience structural risk factors that exacerbate cholera transmission, including reliance on untreated water sources, shared sanitation facilities, overcrowded living conditions, and limited hygiene infrastructure. Targeting these locations ensures that interventions are directed where transmission risk is highest and where early detection and prevention efforts will have the greatest epidemiological impact.

Within the geographic target areas, the operation will prioritize vulnerable population groups who face a heightened risk of severe illness and limited access to services. These include:

- Children under five years of age
- Pregnant and lactating women
- Elderly persons
- People living with disabilities
- Female-headed and low-income households

These groups are prioritized due to increased clinical vulnerability to dehydration, limited mobility, financial constraints, and barriers to accessing treatment and prevention services.

The targeting methodology combines:

- Surveillance data and case clustering analysis
- Rapid community vulnerability assessments
- Coordination with district health authorities
- Community leader consultations

Community-Based Volunteers (CBVs) will prioritize households within identified hotspots and high-risk zones, ensuring that interventions such as hygiene promotion, water treatment distribution, and early referral support are concentrated in areas with active transmission or high exposure risk.

This targeted, vulnerability-driven approach ensures efficient use of donor resources by focusing on populations with the highest risk of infection, transmission amplification, and severe outcomes, thereby contributing to reduced case fatality rates and interruption of community transmission.

## Explain the selection criteria for the targeted population

The selection of the targeted population is based on epidemiological evidence, geographic hotspot analysis, and vulnerability profiling conducted in coordination with District Health Offices and surveillance data. Communities were prioritized where confirmed cholera cases have been reported, where attack rates are elevated, and where environmental and socio-economic conditions significantly increase the risk of transmission and severe outcomes.

Geographic targeting focused on high-risk communities in Lusaka province; Chainta, Mt.Makulu, Linda and surrounding areas. The following criteria were applied:

- Presence of confirmed cholera cases or proximity to active transmission clusters
- High population density and informal settlement patterns
- Reliance on unsafe or untreated water sources
- Inadequate sanitation infrastructure and shared latrine facilities
- Limited access to functional health facilities and delayed referral pathways
- High population mobility (border, transit, lakeshore areas)

This evidence-based targeting ensures that interventions are directed toward communities where transmission risk is highest and where health system capacity gaps are most pronounced.

Rationale and Logic for Targeting Specific Groups

The operation prioritizes populations that face both increased exposure to cholera and heightened vulnerability to severe illness and mortality. Targeting is structured to interrupt transmission at the community level while protecting individuals at greatest clinical and socio-economic risk.

Households in hotspot areas are prioritized because cholera spreads rapidly in environments characterized by overcrowding, unsafe



water use, and shared sanitation facilities. Targeting entire households supports collective behavior change, water treatment uptake, and early case detection.

Children under five, pregnant and lactating women, and elderly persons are specifically targeted due to their increased susceptibility to rapid dehydration and complications. Early detection and referral among these groups is critical to maintaining case fatality rates below 1%, in line with national and global standards.

People living with disabilities are included as a priority group due to mobility constraints, potential exclusion from public health messaging, and barriers to accessing treatment facilities. Household-level outreach will ensure inclusive communication and referral support.

Female-headed and low-income households are prioritized as they often reside in high-risk settlements and face financial barriers to accessing safe water, hygiene supplies, and transport to health facilities.

Mobile and transient populations are specifically targeted due to their increased exposure risk and role in potential cross-border and inter-district transmission. Outreach will be conducted at markets, border points, transport hubs, and landing sites to ensure these groups are reached.

#### Inclusion of Vulnerable Groups

The operation incorporates a vulnerability-sensitive approach to ensure equitable access to services. Community-Based Volunteers (CBVs) will conduct household mapping within identified hotspots to identify and prioritize at-risk individuals. Communication materials will be adapted to local languages and literacy levels. Outreach schedules will consider working populations and mobile groups to maximize reach. For elderly persons and persons with disabilities, door-to-door visits will be emphasized to reduce mobility barriers.

## Total Targeted Population

Women	306,001	Rural	18%
Girls (under 18)	306,001	Urban	82%
Men	293,999	People with disabilities (estimated)	5%
Boys (under 18)	293,999		
Total targeted population	1,200,000		

## Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	Yes
Does your National Society have prevention of sexual exploitation and abuse policy?	Yes
Does your National Society have child protection/child safeguarding policy?	Yes
Does your National Society have whistleblower protection policy?	Yes
Does your National Society have anti-sexual harassment policy?	Yes



Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	Mitigation action
<p>The forthcoming general elections in Zambia present a contextual risk that may negatively affect the implementation, timeline, and overall performance of the cholera response operation. Electoral periods are often associated with increased political activity, public gatherings, population movement, and heightened security sensitivity. These factors may disrupt community-level activities such as household visits, volunteer mobilization, community meetings, and mass awareness campaigns</p> <p>Increased political gatherings and mass movements are potentially accelerating cholera transmission</p> <p>Restricted access to certain communities due to security measures or movement controls</p> <p>Delays in implementation timelines due to public event regulations or curfews</p> <p>Disruption of community meetings, mass campaigns, and volunteer outreach activities</p> <p>Heightened political sensitivity leading to mistrust or misinterpretation of humanitarian activities</p> <p>Increased safety and security risks for volunteers and staff</p> <p>Logistical delays affecting the distribution of supplies and the replenishment of commodities</p> <p>Potential rise in operational costs due to schedule adjustments and security considerations</p> <p>Risk of perceived political bias causing reputational harm to the operation</p>	<p>Reinforce adherence to humanitarian principles of neutrality, impartiality, and independence</p> <p>Proactive engagement with District Health Offices and local authorities to align activities with security advisories</p> <p>Flexible implementation planning allowing rescheduling of community events where necessary</p> <p>Shift from large public gatherings to small-group sessions and door-to-door outreach when required</p> <p>Preposition buffer stocks of essential cholera supplies at district level to prevent logistical disruptions</p> <p>Strengthen volunteer safety protocols, including guidance to avoid political events and ensure visible humanitarian identification</p> <p>Continuous context and security monitoring to enable rapid adaptation of activities</p> <p>Clear community communication emphasizing the non-political, public health nature of the intervention</p> <p>Regular coordination meetings to assess operational risks and adjust strategies accordingly</p>
<p>Has the child safeguarding risk analysis assessment been completed?</p>	<p><b>Yes</b></p>

## Planned Intervention



**Budget:** CHF 37,224

**Targeted Persons:** 1,200,000

### Indicators

Title	Target
# of volunteers trained on RCCE, CEA, PGI, PSS and ORP Level	100
% of trained volunteers demonstrating improved knowledge (post-test vs pre-	80



test)	
# of volunteers trained on ORP management	40
# of MoH staff trained on ORP management	40
# of ORPs supported with trained personnel	20
# of radio call-in programs conducted (2 per district for 3 months)	20
# of estimated listeners reached through radio	1,200,000
# of rapid needs assessments conducted	1
# of households reached through door-to-door visits	21,000
# of volunteers and staff oriented on EBS/CBS	100
% Increase in community-based early alerts reported to district health offices	25

## Priority Actions

- Training of 100 volunteers on specific topics on RCCE, CEA, PGI, PSS, ORP Level 1.
- Training of 40 (2 per ORP) volunteers and 40 MOH (2 per ORP) on ORP
- Conduct 20 Radio call in Programs per districts
- Conduct needs assessment in the target districts
- Conduct door to door activities by volunteers.
- Volunteer outreach activities by raising awareness on common reactions to cholera including psychosocial and physical responses.
- Psychosocial activities by volunteers through door to door.
- Creation of psychosocial support desks at CTCs.
- Orientation of 100 volunteers and staff in EBS/CBS to enhance early detection and reporting of outbreaks
- Procure 20 ORP registers



## Water, Sanitation And Hygiene

**Budget:** CHF 27,213

**Targeted Persons:** 1,200,000

## Indicators

Title	Target
# of Environmental Health Technicians (EHTs) oriented in water quality monitoring using Aquagenx	40
# of water samples tested in targeted communities	50
# of Liquid chlorine distributed	7,500

## Priority Actions

- Procurement of 300 water testing kits (Aquagenx)
- Procurement of liquid chlorine 7500 bottles
- Conduct hygiene promotion activities-5dayspm for 6 months - integrated under Health



- Orientation of 40 EHTs in water quality monitoring using Aquagenx
- Conduct water quality monitoring activities at least 50 samples-allowances



## Protection, Gender And Inclusion

**Budget:** CHF 8,074

**Targeted Persons:** 1,200,000

### Indicators

Title	Target
# of volunteers and MoH staff oriented on PGI	140
# of SGBV referral pathways mapped and disseminated.	5
% increase in identified SGBV, child protection, and disability-related cases appropriately referred through established pathways	80
% of districts with updated SGBV referral pathways mapped and validated.	5
# of child safeguarding risk analyses conducted	1

### Priority Actions

- Orientation of volunteers and MoH staff on PGI (Integrated in health Sector)
- Mapping out and dissemination of safe SGBV referral pathways
- Conduct child safeguarding risk analysis
- Volunteer outreach activities by raising awareness on SGBV, Child protection and disability inclusion
- Psychosocial activities by volunteers through door to door (Integrated in health Sector)



## Community Engagement And Accountability

**Budget:** CHF 17,592

**Targeted Persons:** 1,200,000

### Indicators

Title	Target
# of community entry meetings conducted	15
% of operational days the toll-free feedback line is functional and accessible to communities	100
% of community feedback received analysed, and resolved.	80
# of staff and volunteers oriented on ESPO (CEA feedback data management system).	15



## Priority Actions

### Activities

Conduct 15 community meetings in the affected districts

Support community led solution

- Support charges for feedback toll free line
- Conduct radio programmes targeting community members - Integrated in Health interventions
- Conduct focused 15 group discussions targeting key stakeholders



## Coordination And Partnerships

**Budget:** CHF 15,213

**Targeted Persons:** 50

## Indicators

Title	Target
# of scheduled coordination, IMS (national, provincial, district), and cluster meetings (Health, WASH, RCCE) attended and/or supported	7

## Priority Actions

- Support coordination meeting at all levels

Participate in national, provincial and district IMS meetings as per MoH schedule

Participate in cluster meeting on health, WASH and RCCE



## Secretariat Services

**Budget:** CHF 8,499

**Targeted Persons:** 10

## Indicators

Title	Target
# of IFRC CCD monitoring visits conducted and field reports shared	2
Kick off meetings held within 7 days of DREF approval	1

## Priority Actions

- Ensure overall operational coordination in line with IFRC DREF standards and policies.
- Convene a kickoff meeting within one week of approval and conduct monthly operational coordination meetings thereafter
- Cover salary costs for essential strategic positions required for effective operation delivery.
- Provide technical and coordination support through the IFRC Country Cluster Delegation (CCD), including PMER, finance, and logistics, in compliance with DREF and IFRC policies.



## National Society Strengthening

**Budget:** CHF 36,068



## Indicators

Title	Target
# of branch leadership members oriented on disaster response	50

## Priority Actions

Orientation of the branch leadership on disaster response

Fuel and other vehicle costs for field activities

Car rental (lease from IFRC)

NS admin costs 5%

Bank charges

HR Support:

• Health and Care officer 100%

• PMER 12%

• Accountant 50%

# About Support Services

## How many staff and volunteers will be involved in this operation. Briefly describe their role.

A total of 147 personnel will be engaged in this operation, including 7 ZRCS staff members and 100 trained community volunteers and 40 MOH staff.

Roles and Responsibilities:

- Staff: Overall coordination, supervision, data management, reporting, and liaising with health authorities.
- Volunteers: Community sensitization on cholera prevention, hygiene promotion, distribution of water purification materials, support at Cholera Treatment Centers (CTCs), and monitoring of suspected cases through community-based surveillance.
- Leadership Positions: The operation will be overseen by the Health and Care Manager working with Health and Care Officers and NDRTs, with team leaders assigned to each district to ensure smooth implementation and quality control.

## Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

Diversity and Inclusion: The volunteer team reflects the gender, age, and cultural diversity of the affected communities. Special attention has been given to recruiting female volunteers to support single female-headed households and ensure culturally appropriate engagement. Volunteers were also selected from local communities to provide language and cultural alignment, strengthening trust and effective communication. Any gaps in representation are being addressed through branches

## If there is procurement, will it be done by National Society or IFRC?

The Zambia Red Cross Society (ZRCS) is leading procurement for this operation, with technical guidance from IFRC procurement staff. The ZRCS logistics team manages all procurement activities in accordance with the National Society's procedures and IFRC standards, ensuring transparency, accountability, and value for money.

Procurement primarily utilizes local suppliers to guarantee timely access to essential items and support the local economy, while international suppliers may be engaged for items not available locally. Procured items include both replenishment of existing stock and materials for direct distribution, tailored to the operational needs and availability of supplies.



All procurement activities are closely monitored to maintain quality, timeliness, and cost-efficiency, ensuring that the response meets the immediate needs of affected communities.

## How will this operation be monitored?

The operation will be monitored through a structured M&E system led by the ZRCS PMER team, using the National Society's established framework to track progress, performance, and outcomes across all sectors. Mechanisms include daily field reports from volunteers, weekly sector updates, and regular review meetings to assess intervention quality and effectiveness.

The PMER team will consolidate data, verify beneficiary lists, conduct field visits, and ensure activities are implemented according to timelines and standards. Key indicators include the number of households reached with WASH, health, PGI, shelter, and coverage of community engagement activities (RCCE and CEA).

Feedback and complaint mechanisms will capture beneficiary concerns, ensuring inclusion, protection, and accountability. IFRC monitoring visits will provide technical oversight, verify field activities, and support quality assurance at key operational milestones, including post-initial distributions and mid-term review.

## Please briefly explain the National Societies communication strategy for this operation

The Zambia Red Cross Society (ZRCS) will manage communication through a structured approach to ensure timely, accurate, and transparent information flow both internally and externally. Internally, ZRCS has activated its Incident Management System (IMS) to coordinate operational information among staff, volunteers, and stakeholders, providing daily updates, situation reports, and sector coordination across field teams. The NS will also participate in national emergency response meetings, sharing updates with government authorities and humanitarian partners to ensure alignment, avoid duplication, and strengthen coordination.

Externally, ZRCS will maintain transparent communication with affected communities using community engagement and accountability (CEA) mechanisms, including meetings, feedback and complaint channels, and dissemination of information on assistance, distribution schedules, and referral pathways. Local communication channels, such as radio announcements and community leaders, will be used to reach all segments of the population, including vulnerable groups.



# Budget Overview



## DREF OPERATION

### MDRZM027 - Zambia Red Cross Society 2026 Cholera Response

#### Operating Budget

<b>Planned Operations</b>	<b>90 103</b>
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	37 224
Water, Sanitation & Hygiene	27 213
Protection, Gender and Inclusion	8 074
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	17 592
Environmental Sustainability	0
<b>Enabling Approaches</b>	<b>59 779</b>
Coordination and Partnerships	15 213
Secretariat Services	8 499
National Society Strengthening	36 068
<b>TOTAL BUDGET</b>	<b>149 882</b>

*all amounts in Swiss Francs (CHF)*



# Contact Information

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

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[Click here for the reference](#)

