SIMPLIFIED EARLY ACTION PROTOCOL

KENYA | CHOLERA

Community Engagement: KRCS volunteers with community leaders in Dajajabula, Wajir County, Kenya during the 2022/23 cholera outbreak response.

EAP №: sEAP2025KE04	**Operation No:** MDRKE071	**Readiness:** CHF 77,131	**Prepositioning**: CHF 32,694	**Early Action**: CHF 108,342
People to be assisted: **20,000 people out of the 22 million at risk**	EAP Approved: **17/03/2026**	EAP timeframe: **2 Years**	EAP lead time: **7-10 days (T2 activation to EA)** **3 months (T1 EA activities' implementation)**	
Prioritized geographical areas: Cholera prone and recent high-risk counties of Kwale (Coastal region), Narok (South Rift region), and Wajir (North-Eastern region).				

Budget: 218,167 CHF
To assist: 20,000 people

RISK ANALYSIS

Prioritized hazard and its historical impact.

In post-independence Kenya, Cholera was officially first reported in 1971 in Turkana District. This outbreak was linked to the Seventh global cholera pandemic which began in 1961 in Indonesia and later reached Africa in the late 1960s[1]. Since 1997 to date, Kenya has had cholera outbreak relief in only three distinct years when **zero** cases were reported, that is, 2003, 2011, and 2014 (*See Annex 1, figure 1 and 1a*).

For over two decades, cholera outbreaks have caused havoc and devastating impact on the livelihood and unlimited pressure on the Kenya's Healthcare system. Since 1997, Kenya has reported several and frequent cholera outbreaks across multiple counties with approximately less than two (2) years of relief between outbreaks. Cholera is a major public health threat in the country and has been prioritized under Kenya's Integrated Disease Surveillance and Response (IDSR) strategy[2]. Consequently, the country, in its endeavour to mitigate the cholera menace, has developed a National Multi-Sectoral Cholera Elimination Plan for the period 2022-2030[3] that aims to address critical gaps in preparedness, prevention, and response to cholera.

Cholera outbreaks in Kenya have exhibited a **cyclical pattern**, with significant extensive disease waves recorded during the periods **1997–1999**, **2007–2010**, **2015–2020**, and **2022–2024**. Across these outbreaks, the **average case fatality rate (CFR)** was approximately **3%**, with **the highest CFR of 7.1% recorded in 2012** and the **lowest (0.3%) in 2009**. The highest burden of the disease was experienced in 1997 with a case load of **17,200** while the lowest case load of **38 cases** over the period was reported in 2021. The two extremes were largely attributed to the extensive flooding due to the 1997 El-Nino phenomenon and heightened handwashing coupled with high hygienic standards in the wake of covid –19 respectively. Notably, a spike in cholera cases in an active outbreak and emergence of new outbreaks have always been witnessed during the onset of short or long rains and exacerbated by flooding and flash floods due to the rains. During 2020-2021 period, cholera cases were notably low. This was attributed to the increased handwashing and sanitation measures in response to the COVID-19 pandemic thus cementing the essence of heightened hygiene in controlling cholera outbreak. (*See Annex 1, figure 1, 1a, b, c and 2*).

The Ministry of Health – Kenya, based on the past outbreaks and increased vulnerability of cholera outbreak, developed priority areas for Multi-sectoral Interventions (PAMIs) for implementation of the 2022-2030 National Multi-sectoral Cholera Elimination Plan (*See Annex 1, figure 5*). The PAMIs maps out geographically limited areas where cultural, environmental, and socioeconomic conditions can facilitate the emergence and transmission of the disease and where cyclic outbreaks were witnessed in the past. This helps to focus interventions of Cholera elimination on the most at-risk populations. An analysis was conducted between February and March 2024. The PAMIs were selected based on the previous six years' epidemiological data (Jan 2018 - Dec 2023) at the sub-county level. The identification of PAMIs was carried out following the 2023 Global Task Force on Cholera Control (GTFCC) Methodology to identify PAMIs for cholera control. The priority index was calculated using the cholera outbreak line list, i.e. confirmed, probable, or suspected cholera cases of all ages combined, admitted, or reported to the health facilities. *(see Annex 1, figure 4)*

According to WHO, 125,018 cholera cases were reported in Africa with a total economic loss of US$ 53.2 million in 2005 alone[4]. Whereas the public health burden and socio-economic impact of these Cholera pathogens vary over time and across geographical settings, their impact is often underestimated due to limited surveillance and paucity of disease burden data in most developing countries like Kenya.

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[1] https://doi.org/10.11604%2Fpamj.2017.28.101.12806

[3] national-cholera-plan-kenya.pdf.

[2] **Error! Reference source not found.** http://guidelines.health.go.ke:8000/media/Standard_Case_Definitions_for_Priority_Diseases_in_Kenya-_Integ.pdf

[4] Economic burden of cholera in WHO Africa Region - https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-9-8

The recently controlled **2025 cholera outbreak** affected up to **seven (7) counties**, majority being border counties. The 2025 outbreak resulted in a total of 426 cases with 20 deaths, which translated into an average case fatality rate (CFR) of 4.7%, the highest average in over a decade (*see Annex 1, figure 6*). This is an indication that despite the limited number of cases reported, the impact of the outbreak in the general population remains lethal. The index case, reported in Migori, was linked to cross-border transmission which then creates the urgency with which the cross-border epidemic surveillance needs to be heightened.

The choice of the priority counties, that is, Narok, Kwale, and Wajir for this sEAP despite Wajir having not reported cases during the recently controlled 2025 outbreak, is also based on the heightened risk of acute watery diarrhoea (AWD)/Cholera outbreak according to the 2024 PAMI classification[5] (see Annex 1, figure 5). Interestingly, the cases reported in Kwale were not in any way associated with the index case that was reported in Migori (where the index case of 2025 was reported) but rather linked to another cross-border transmission. The cases that were reported in Mombasa, Nairobi and Kisumu, however, were associated with the high socioeconomic activities and population movement along the major transport corridors between Kwale and Mombasa, and Migori – Kisumu and Nairobi respectively. The prioritization of Narok (active) and Kwale (controlled) was by virtue of the two counties being hotbed sources of the recent epidemic transmissions.

Kwale county has high cross border movement with Tanzania at Lunga Lunga and was categorized under 'Alert' drought phase by the National Drought Management Authority (NDMA, 2025)[6] and faces inadequate availability of safe water. Moreover, **Narok county,** more specifically, **Transmara South, West and East Sub counties,** have numerous congested urban settlements with non-conventional sanitation establishment, poor waste management, and experiences increased risk of cross boarder transmission along the Tanzanian border, and poor WASH facilities across the busy mining sites at the border of Narok and Migori county.

Additionally, **Wajir** is both flood prone during the long and short rains (March-April-May and October-November-December seasons) and at high drought risk (January/February and July/August seasons), thus communities heavily rely on unprotected well/springs that are prone to contamination[7]. The county faces limited access to safe water for domestic use and inadequate sanitation facilities. The county also faces high population densities in confined localities, inadequate availability of safe water due to high drought risk and heavy cross border movement and livestock trade with Somalia, hence the heightened risk of AWD outbreak. In the last quarter of 2022, Wajir county was listed among the high-risk counties, and the most affected with a case fatality rate of 2.7%, exceeding the WHO recommended CFR of less than 1%[8].

The above, coupled with the massive scale of the outbreaks in the past and limited capacity by the counties, especially, the border counties to anticipate, detect and respond early to cholera outbreaks increases the risk of extensive in-country transmission hence the necessity of the development of a cholera simplified Early Action Protocol (sEAP) which will help scale down and eventually control the cyclic AWD outbreaks.

Prioritized risks to be addressed by the early actions and their link to the hazard

This sEAP will seek to address high morbidity and related mortality (high CFR – which has constantly been above 2% on average across the past outbreaks, exceeding the WHO recommended threshold of below 1%) that is often reported among the at-risk populations' due to acute watery diarrhoea/cholera outbreaks. This is often tied to a number of predisposing factors and determinants including the PAMI analyses report, recent MOH-

[5] 2022-2030 National Cholera Elimination Plan

[6] National Drought Management Authority report (March, 2025)

[7] https://maarifa.cog.go.ke/sites/default/files/2024-07/Tana%20River%20CCCAP%20Final%20%20OCT%202023.pdf (County Government of Tana River)

[8] https://adore.ifrc.org/Download.aspx?FileId=666785#:~:text=Scope%20and%20Scale,Machakos%2D2%20deaths%20%2D%200.8%25 (Cholera Outbreak – IFRC, 2023)

outbreaks data, compromised water, sanitation and hygiene conditions, limited knowledge on AWD prevention and control, and limited access to basic/primary health care.

The early actions will prioritize active surveillance, access to safe water through establishment of oral rehydration points, protection of water sources, and supply of water treatment chemicals, and risk communication and community engagement on cholera prevention and control among other early action interventions. The actions will help limit the exposure of the at-risk population to contaminated water, enhance social behaviour change around sanitation and hygiene as well as encourage adoption of good WASH practices such as protection of water points/sources etc.

These actions will primarily target the most vulnerable populations in the hotspot sub counties of Transmara West, Transmara South and Transmara East in Narok, Lunga Lunga in Kwale, and Dadajabula in Wajir respectively. Priority will be based on the risk matrix contributed to by the vulnerable population size, (children under 5; the elderly; pregnant and lactating mothers; and displaced populations), available capacities and the level of predisposing factors (hazards).

The earmarked local settings and populations within the targeted hotspot sub counties will comprise areas and populations in areas that are prone to flooding and drought, people living in informal settlements, internally displaced in camp settings, and localities with significant cross border population movements perceived as previous epidemic transmission routes.

Describe the selected early actions and explain how they will address the risks and lead to the intended outcomes

The selection of the priority early actions took an all-inclusive approach that witnessed a series of drafting and review workshop sessions that brought together Kenya Red Cross Society (KRCS), the ministry of health (MOH) counterparts, Partner National Societies (PNS') and other entities, leveraging the technical expertise of the IFRC, Norwegian Red Cross, British Red Cross, the Red Cross Climate Centre (RCCC). and National government health delivery support partners such as the Washington States University (WSU), World Health Organization (WHO), UNICEF, and Palladium Group Kenya.

The multisectoral and inter-agency approach was in the spirit of the **2022-2030 Kenya National Multi-sectoral Cholera Elimination Plan** which advocates for consorted efforts by all health delivery stakeholders aimed at mitigating the impact and eventually controlling the sporadic and frequent nature of AWD outbreaks in Kenya. The prioritized early action interventions were informed by the national cholera emergency preparedness plan as well as the KRCS Operations/Public Health in Emergencies contingency plans and were on the basis of evidence-based undertakings that had, in the past, significantly contributed to the reduction of impact and eventually controlling of active cholera outbreaks. Courtesy of the large network of community-based KRCS volunteers, and the synergized working relationship with the county departments of health through the respective community health strategy and one health coordination structures, the feasibility and sustainability of the good practices through the community health promoters (CHPs) and the volunteers was guaranteed.

The prioritized early action for cholera readiness and early response were specific and structured based on the KRCS – Public Health in Emergencies technical focus areas integrated with core cross-cutting thematic components of protection gender and inclusion (PGI) and Community Engagement and Accountability (CEA);

Surveillance and Community Case Management
On approval of this sEAP, as a readiness initiative, priority will be the deployment of Community Based Surveillance (CBS) system through the KRCS community-based volunteers who shall form part of RC-CATI across the targeted sub counties. This will ensure sustained passive surveillance that would ensure early detection of any potential cases.

In the event the trigger threshold for early action is met, transition to heightened active surveillance/CBS would be initiated involving enhanced collaborative contact tracing/case finding prior to case confirmation.

Leveraging the technical capacities of the RC-CATI teams and CHPs, for enhanced community case management (CCM), establishment of oral rehydration points (ORPs), supply of ORS targeting children of weaning age to 5 years and offering of oral rehydration therapy (ORT) at targeted household level were prioritized to be more efficacious for early control of suspected AWD.

Risk Communication and Community Engagement (RCCE)
Through the Red Cross Case Area Targeted Interventions (RC-CATI) capacities and the CHPs, this sEAP shall prioritise dissemination of AWD associated risks to the targeted communities for enhanced adoption of good practices such as appropriate WASH e.g. proper hand washing, good and early health seeking behaviour, and referral of suspected cases/contacts as well as rumour tracking and reporting.

Infection Prevention and Control and WASH in emergencies
Access to safe water and improved hygiene conditions would be prioritized through distribution of water treatment chemicals such as PURs and aqua tabs to targeted households, protection/securing of community water points, and supply of hygiene kits to targeted households.

These initiatives would leverage the RC-CATI capacities and CHPs who would synergistically collaborate for more efficient interventions across the targeted counties, and more specifically the local hotspots across Kwale, Wajir, Tana River and Migori.

EARLY ACTION INTERVENTIONS

The overall objective of the intervention
Mitigate and reduce AWD/cholera-related morbidity and mortality across the targeted PAMI areas in Kenya through timely and efficacious anticipatory actions defined by the phased triggers informed by the surveillance data of suspected cholera cases from the community-based surveillance (CBS) system and/or other early warning indicators (amplifying factors – such as the destruction of WASH facilities i.e. pit-latrines, major community water points due to flooding phenomenon, , and water scarcity as a result of drought phenomenon).

Justification for receiving funding for this sEAP
The KRCS is seeking anticipatory action funds as a complementary resource mobilization towards mitigating and potentially controlling the periodic cholera outbreaks in Kenya. The activation will be based on phased triggers and the sEAP will not work in isolation has it's already connected to already existing Disaster Risk Reduction and Management Plans and Contingency Plans of key actors including as KRCS, NPHI and MoH.

KRCS has technical experience in the deployment of CBS system in various parts of Kenya comprising of more than 16 localities/sub counties across 10 counties. The system has over the years facilitated early detection and timely response to public health signals as appropriate. The NS will leverage the system deployment in the target areas to obtain critical surveillance data that would inform early action up on realization of trigger. Similarly, amplifying factors – such as the destruction of over 80% of WASH facilities i.e. pit-latrines, community water points, oral rehydration points (ORPs) due to flooding phenomenon, and/or increased vulnerability to water scarcity as a result of drought phenomenon will be critical early warning indicators in any local setting.

Based on the ***2022-2030 National Cholera Elimination Plan***, the four PAMI areas face a heightened risk of AWD/cholera outbreak. **Kwale county** has high cross border movement with Tanzania at Lunga Lunga and was categorized under 'Alert' drought phase by the National Drought Management Authority (NDMA, 2025)[9] and faces inadequate availability of safe water. Moreover, **Narok county,** more specifically, **Transmara South, West and East Sub counties,** have numerous congested urban settlements with non-conventional sanitation establishment, poor waste management, and experiences increased risk of cross boarder transmission along the Tanzanian border, and poor WASH facilities across the busy mining sites at the border of Narok and Migori county.

[9] National Drought Management Authority report (March, 2025)

Additionally, **Wajir** is both flood prone during the long and short rains (March-April-May and October-November-December seasons) and at high drought risk (January/February and July/August seasons), thus communities heavily rely on unprotected well/springs that are prone to contamination[10]. The county faces limited access to safe water for domestic use and inadequate sanitation facilities. The county also faces high population densities in confined localities, inadequate availability of safe water due to high drought risk and heavy cross border movement and livestock trade with Somalia, hence the heightened risk of AWD outbreak. In the last quarter of 2022, Wajir county was listed among the high-risk counties, and the most affected with a case fatality rate of 2.7%, exceeding the WHO recommended CFR of less than 1%[11].

Potential geographical high-risk areas that the EAP would target.
In reference to the PAMI classification as per the ***2022-2030 National Cholera Elimination Plan*** and the GTFCC prioritization methodology, this sEAP has prioritized three (3) of the 34 PAMI counties that is; **Kwale, Narok,** and **Wajir.** The selection of hotspots was informed by the cyclic pattern of AWD/cholera outbreaks, evidential historical devastating impact of the long and short rains, cyclic drought phenomenon, perennial water scarcity and compromised WASH - lack of conventional sewerage system (Narok), uncontrolled cross border population movement, and recent multiple cross-border transmissions of AWD.

Kwale County (Lunga Lunga sub county)
The county was the latest worst hit by the 2025 AWD/Cholera outbreak that resulted in the hotspot reporting a CFR of more than 15%. The high CFR necessitated its prioritization for this sEAP among other predisposing factors such as uncontrolled cross-border population movement and its categorization for drought alert by NDMA (March, 2025 forecast report) (*See Annex1, figure 6*). Moreover, owing to the epidemiological linkage of the first case in Mombasa to trade related travel to Kwale, further piled into its prioritization for early detection and early action to mitigate the potential spread of AWD.

Narok County (Transmara West, South and East)
Its selection was heavily based on the recent 2025 AWD/cholera outbreak that had the county report its index case in September 2025, with over 200 cases and a CFR of over 2.5% in less than two (2) months. However, the lack of conventional sewerage systems in Kilgoris in Transmara West and Lolgorian in Trans Mara South, over reliance on unsafe spring and stream water, and compromised waste management are among some of the predisposing factors. This is further exacerbated by the numerous congested urban settlements with poor waste management, and increased flood risk especially across the informal settlement areas during rainy seasons.

Wajir County (Dadajabula)

The selection of Dadajabula was based on the historical cyclic pattern of the AWD outbreaks with the county's worst experience being in the 2022 cholera outbreak that led to the establishment of makeshift facilities to manage cases and resulted in a CFR of >2%. The county also battles with inadequate healthcare capacities that has derailed access to primary health care services. The situation is further worsened by the high cross border population movement and localized congestion in confined localities. The county is among those listed for drought alert by NDMA, 2025 and faces extreme water scarcity.

Which groups of people will be assisted through this operation and what criteria will be used for their selection?
Owing to the undeniable existence of heightened risk among all the communities inhabiting the prioritized areas for this sEAP, subject to the varying risk matrix, priority shall be given to local settings with extreme vulnerability scores of its population, historical outbreak emergence data, and based on received CBS/surveillance data.

[10] https://maarifa.cog.go.ke/sites/default/files/2024-07/Tana%20River%20CCCAP%20Final%20%20OCT%202023.pdf (County Government of Tana River)
[11] https://adore.ifrc.org/Download.aspx?FileId=666785#:~:text=Scope%20and%20Scale,Machakos%2D2%20deaths%20%2D%200.8%25 (Cholera Outbreak – IFRC, 2023)

Target population within the prioritized PAMI counties

People living in flood and drought-prone areas of the target counties owing to the displacement risk factor, children under five years, people within the refugee and/or internally displaced settlement camps, people living in informal settlements with compromised WASH capacities, lactating and pregnant women, the elderly, and food handlers more so within the local eateries.

Selection criteria for the target areas

This will be based on participatory targeting and registration for eligible beneficiaries by performing rapid risk assessments completed typically in a day (24 hours) to determine the extent of vulnerability.

Children Under 5: Weak immunity, poor hygiene practices, high dehydration risk. With the help of Community Health Promoters and Health records of under five in hotspot areas supported by the link health facilities staff.

School-going Children due to crowded spaces, limited sanitation, and hygiene gaps. Schools in flood-prone areas in high-risk counties will be targeted.

Elderly/Immunosuppressed: Weakened defences, chronic illnesses, mobility challenges - This group of the elderly population will be selected through the involvement of local authorities i.e. chief, Nyumba Kumi However the immunosuppressed (PWNCDs) population will be identified through the network groups and respective clinics.

Food/Water Vendors in high-risk counties due to exposure to contamination and transmission risk. Commercial food and water vendors in high-risk counties and areas with a history of reported cholera cases will be targeted.

Cross-border Travelers: Mobility, limited hygiene access, spread potential. Prioritize travellers in cholera-endemic routes, high-contact jobs, limited resources, poor health status, or exposure to known cases

Pregnant/Lactating Mothers: Increased hydration needs, reduced immunity. - They will be selected or identified through MCH clinics/mother-to-mother support groups, household visits by the CHWs

Hotspot Communities: Poor infrastructure, persistent outbreaks. The communities will be selected based on the previous cholera epidemiological data.

Refugees/Displaced: Overcrowding, limited healthcare, unstable resources. They will be targeted based on the epidemiological data and geographical locations.

Primary focus will be to necessitate **access to safe water, adequate hygiene commodities, and enhanced surveillance for timely case finding and early control of an outbreak or potential outbreak**. Areas of priority will include the following but based on realization of the triggers;

- Displacement camps and/or refugee settlements and the respective host communities
- Displaced populations centrally hosted in camps
- Informal urban settlements
- Community settings where AWD signals have been reported.
- Areas with low access to safe water and low access to safely managed sanitations

Readiness and prepositioning

The readiness and prepositioning activities will be initiated as soon as the sEAP is approved independent of trigger activation. Therefore, procurement and prepositioning at the KRCS main warehouse will be initiated when the sEAP has been approved. Readiness phase will also entail training of select KRCS volunteers and CHPs on e-CBS, EPiC, CEA, and RC-CATI.

Prepositioning of WASH supplies and IEC materials at the 3 targeted regional warehouses, that is, Malindi,

Kisumu and Garissa (covering the priority high risk counties; Tana River, Kwale, Migori and Wajir respectively) will be done based on the passive surveillance data and weekly weather forecast information on imminent flood or drought situation.

Owing to the historical trend on the seasons of the previous outbreaks and cholera waves e.g. the 2022-2023 and the 2025 outbreaks, weekly MOH surveillance bulletins and weather forecast i.e. **a flood alert** from the Kenya Meteorological Department (KMD) or **a drought alert** from the Drought Early Warning System of the National Drought Management Authority (NDMA) will provide valuable insight on decentralization of prepositioning.

CBS Implementation in the targeted sEAP implementation sites

Roll out of CBS by KRCS in any of the desired sites follows the criteria that aligns to the Ministry of Health (MOH) through the National Public Health Institute (NPHI) surveillance guidelines as well as the IDSR strategy. The process entails an initial mandatory needs and feasibility assessment that normally precedes the actual roll out with signals picked based on the community/lay case definitions (CCD). Three or more episodes of AWD within a span of 24 hrs stands out as one of the pointer/signals within the KRCS CBS system list of priority diseases.

As a readiness activity up on approval of this sEAP, following the laid down criteria/IDSR guidelines, KRCS will initiate the training of local volunteers on CBS module and subsequent roll out of the system use across the hotspot areas of the targeted counties of Tana River, Kwale, Wajir, and Migori. This will ensure real-time picking of signals during passive surveillance as well as necessitating possible switching to active surveillance once the predetermined action thresholds are met.

Trigger(s) statement

sEAP Activation criteria

The Early Actions trigger will be two (2) phased, that is, the first trigger will be based on *amplifying factors in priority areas*, and *active case reporting in the neighbouring countries/counties* and will inform **activation of low cost/low regret activities and initiation of active surveillance (CBS)-active case finding exercise**. The second trigger will be based on epidemiological information and active CBS data e.g. case of reported AWD cases in the targeted areas within the specified timeframes and **will fully activate the high-cost early actions**.

TRIGGER ONE (1): - activation of low cost/low regret activities and the active CBS

T1 will comprise of *amplifying factors* that have in the past been pointers of potential cholera outbreak as witnessed in the past four significant outbreaks in Kenya i.e. the 2015, 2017, 2022/23 and 2025 outbreaks. Among the scenarios that would trigger low-cost early actions will include:

a. **Confirmation of at least one case of cholera** in a neighbouring county or **declaration of an outbreak** by a neighbouring country in one of its districts/regions that border the potential early action county.

Reference: WHO weekly regional Epidemiological bulletin (cholera cases from neighbouring countries); MoH Cholera SITREP from the reporting county(s) (in country cholera cases); and MOH-NPHI Case specific Spotreps.

Or

b. Reporting of **over 80% WASH infrastructural damage such as submerged latrines and contamination of main community water sources** during an extensive flooding phenomenon in the targeted counties/localities. This will be based on the risk assessment outcome (1 – day rapid health assessment based on the WHO and/or RCRC movement assessment tools) and the sustained daily and weekly Kenya Meteorological Department (KMD) projections/forecasts.

Or

c. Up on activation of the flood and/or drought EAPs

T1 activation may not necessarily culminate in the activation of T2 and the low-cost interventions will be conducted for a maximum of 90 days (3 months).

TRIGGER TWO (2): will fully activate the high-cost early actions

T2 will entail high-cost interventions informed by epidemiological data and trends such as SITREPS, SPOTREPS, Signals etc. obtained from routine/daily engagement with the respective surveillance health authorities, MOH-EBS, and KRCS-CBS interactions.

Some of the scenarios that will lead to the activation of high-cost activities will include:

a. When two (2) or more hospital reported Acute Watery Diarrhoea (AWD) admissions of persons aged over 2years with positive cholera Rapid Diagnostic Tests (cRDT) results, coupled with severe dehydrations from the same village within a period of 3 days (72hrs) is escalated through the facility surveillance officer to the sub county disease surveillance coordinator and/or county disease surveillance coordinator who subsequently shares through the existing National multiagency surveillance coordination platform. Normally the NS received the information within 24 hrs of receiving the screening test results.

Or

Based on the historic county specific AWD trends, and county specific MOH-NPHI prescribed alert thresholds in the targeted AWD endemic areas, a spike in the AWD true CBS signals (KRCS - CBS or MoH - EBS) such as doubling of the number of signals e.g. from 6 to 12 in a span of 3 to 7 days from the same locality will instigate high cost activities. Normally the NS receives the information within 24 hrs of receiving the screening test results.

Or

b. Confirmation of an outbreak by the MOH-NPHI at the national / county levels

To minimise delay in the NS receiving information at the county level, the project Officer and County Coordinator, will be part of the surveillance coordination mechanism to ensure prompt receipt of alerts/signals whereas at the national level, through the nation multiagency surveillance coordination platform, the PHiE Surveillance Coordinator will ensure timely receipt of alerts/signals based on the daily updates within the platform which KRCS is a member.

Reference: IDSR strategy - cholera threshold reference**,** Real-time AWD validated signals on the **MoH EBS-m-dharura system**. Real-time validated AWD signals on the **KRCS-CBS system**.
The commencement of early action interventions upon activation of **T2 will be within 7 to 10 days lead time**. KRCS will leverage the exiting active projects' funds within the public health in emergencies' unit and/or the larger Disaster Management Operations department to ensure interventions are carried out with the 14 days lead time. This will provide a contingency in the event delayed approvals for disbursement of early action (EA) funds.
Additionally, KRCS will leverage its CBS platform, the Public Health in Emergencies' county specific daily signal monitoring/SITREPs/SPOTREPs, national MOH HEBS and CEBS platform, alerts by KMD, WRA to monitor triggers. Trigger monitoring will be done by the Surveillance Coordinator supported by the respective Public Health in Emergencies Coordinators and Officers in liaison with the county health counterparts in each of the targeted counties under the larger Disaster Management Operations department.

Next steps – For National Societies that intend to develop a full EAP (Optional).

The National Society in its endeavour to scale up the sEAP to a full EAP through the MEA&L and PHiE technical capacities will routinely conduct Early and After-Action Reviews (E/AARs) to help address areas that worked well, and less well (bottlenecks) and postulate the best practices into the development of the full EAP. The NS will leverage the existing KRCS AAR and the WHO approved E/I/AAR tools to achieve clear and specific implementable outcomes.

The NS will organize the E/AAR (lessons learned) workshops made up of the TWG members comprising of the affected county(s) department of health, KRCS technical capacities, and the national MOH where applicable. The process will provide for in-depth consideration of trigger development, selection of early actions, and the implementation process that will enable KRCS to analyse feasibility of developing a full EAP.

PLANNED INTERVENTION

<table>
<tr><td rowspan="2"></td><td rowspan="2">Health & Care</td><td>Budget</td><td colspan="2">52,099 CHF</td></tr>
<tr><td>People targeted</td><td colspan="2">Approx. 21,000 community members (see Annex 2)</td></tr>
<tr><td>Indicator:</td><td colspan="2">1. # of KRCS volunteers/staff and CHPs trained on EPiC and CBS modules.
2. % of targeted population reached with cholera hygiene and health awareness messages
3. % of localities with active CBS coverage
4. # of KRCS volunteers and community health promoters (CHPs) deployed up on activation
5. # of Health Care Workers trained on IPC and cholera case management.
6. % of affected people to whom ORS was administered both at HH and/or ORP.</td><td>Target:</td><td>1. 20 KRCS Volunteers/staff and CHPs per county (drawn from priority sub counties).
2. >80% of the targeted community members and school going children.
3. >80% of the targeted community settings.
4. 20 CHPs and KRCS volunteers per county based on areas/county of activation.
5. 15 HCWs trained to support the local interventions.
6. >90% of the affected population (cases/contacts).</td></tr>
<tr><td>Readiness activities:</td><td colspan="4">Routine readiness activities (Year 1)
1. Train volunteers/CHPs/Staff on EPiC, CBS and ORP set up/management.
2. Roll out CBS across targeted sites.
3. Review and update training materials.
Year 1 to 2
4. Continuity with passive surveillance and monitoring of amplifying factors.
5. Conduct a 2-days refresher training for volunteers/CHPs/Staff on CBS and ORP management.</td></tr>
<tr><td>Prepositioning activities:</td><td colspan="4">1. Print and store appropriate cholera awareness IEC materials (hand washing demos etc.).
2. Procure and appropriately store ORS/Zinc (shell life of 2-3 years-preferred).
3. Procure and store PPEs and volunteers visibility merchandize among other CATI commodities as required.</td></tr>
</table>

Prioritized Early Actions:	***T1 – Low grade early action activation*** 1. Conduct enhanced AWD/cholera related hygiene promotion activities and health education. 2. Engage trained KRCS volunteers and CHPs on enhanced active surveillance and picking of signals based on community case definitions (CCD) through the CBS. 3. Engage the local/opinion leaders and community health committees on cholera/AWD prevention and control. ***T2 – High cost (initial actions at the start of the response)*** 1. Refresh/Sensitize Health Care Workers on IPC and cholera case management 2. Support joint case finding and investigations/rapid assessment by MOH-Health Care Workers and KRCS technical personnel. 3. Deploy trained KRCS volunteers to support MoH (trained CHPs) in cholera early actions including robust sensitization/RCCE on Infection Prevention and Control, and Surveillance – signal picking through active CBS. 4. Distribution of IEC materials. 5. Support MoH in setting up Oral Rehydration Points (ORP's), communal and/or HH and provision of ORS to the sick. 6. Establish communication with neighbouring localities to help them be in alert mode. ***Progressive surge in the number of cases despite activation of T2***. 1. Provide ORS to suspected cases and refer severe cases appropriately. 2. Conduct mass media campaigns on cholera prevention and management. 3. Take part in daily coordination internal and stakeholders' meetings for the outbreak. 4. Develop a cholera DREF and initiate transition of EA activities to the response phase.

	**Water, Sanitation and Hygiene**	**Budget**	**46,418 CHF**	
		People targeted	Approx. 21,000 community members (*see Annex 2*).	
Indicator:	1. # of WASH - NFIs distributed. 2. # of KRCS Volunteer/CHPs trained on CATI/WASH module. 3. # of people reached with hygiene and sanitation promotion messages. 4. # of environmental cleaning exercises undertaken.		**Target:**	1. ~5000 WASH NFIs. 2. 60 KRCVs and CHPs trained on RC-CATI. 3. ~21000 people. 4. 3 times within the EA phase.
Readiness activities:	***Routine readiness activities (Year 1)*** 1. Develop trigger monitoring SOPs for seamless and coordinated activation of the protocol. 2. Conduct a 4-days training on RC-CATI at the branch level for enhanced capacity. ***Year 1 to 2*** 3. Engage with traditional healers, religious and local leaders to enhance their know-how on matters cholera. 4. Refresher training on RC-CATI for staff and volunteers. 5. Customize the National Cholera Action plan into the community context – develop community cholera action plan.			

	6. Undertake routine hygiene promotion activities, taking into consideration the PGI and CEA approaches across the targeted communities as well as in learning institutions.
Pre-positioning activities:	1. Purchase and store accordingly - the WASH-NFIs and kits including PPEs, Sanitizers, soaps, hand washing stations, water purifying chemicals (aqua tabs, PUR) etc.
Prioritized Early Actions:	***T1 – Low grade early action activation*** 1. Undertake a 2-day refresher training for CHPs and Volunteers on WASH. 2. Review and contextualize WASH/IPC IEC materials per the intervention areas including key messages. 3. Engage trained KRCS volunteers and CHPs on enhanced targeted weekly RCCE on cholera prevention and control using the IEC materials. 4. Engage the local/opinion leaders and community water management committees on cholera/AWD prevention and control. ***T2 – High cost (initial actions at the start of the response)*** 1. Conduct cleaning and disinfection exercises in priority locations at the household level where cholera case (s) has been reported to prevent further spread. 2. Transition to intensive daily RCCE and hygiene promotion targeting affected HH, Schools, local media etc. 3. Distribution of WASH-NFIs and undertaking of related community demonstrations to facilitate access to safe water at household level and community water points in cholera early actions targeted areas 4. Activate RC-CATI within 72hrs of notification of a cholera case for intensive EA aimed at breaking the chain of infection. 5. Establish communication with neighbouring localities to help them be in alert mode. ***Progressive surge in the number of cases despite activation of T2***. 1. Develop a cholera DREF and initiate transition of EA activities to the response phase under DREF.

	**Community Engagement and Accountability**	**Budget**	**17,175 CHF**
		People targeted	Approx. 21,000 community members (*see Annex 2*). Community members from where the trigger is met across the targeted areas by sEAP
Indicator:	**The proportion of at-risk populations aware of cholera prevention measures.** 1. # of community members actively involved over the sEAP implementation period 2. % of community feedback e.g. complaints, suggestions etc. received and timely addressed	**Target:**	1. 20,000 community members (4,000 households) i.e. approximately 5,000 people (1,000HHs) per targeted county. 2. 100% of community feedback that warrants addressing
Readiness activities:	***Routine readiness activities (Year 1)*** 1. Conduct a 2 – days CEA training for KRCS volunteers/Staff as well as CHPs/CDRs. ***Year 1 to 2*** 2. Refresher training on CEA for staff, volunteers and CHPs.		

Prepositioning activities:	-
Prioritized Early Actions:	***T1 – Low grade early action activation*** 1. Prioritized sensitization of communities on complaints and feedback mechanisms (e.g. Toll-Free lines). ***T2 – High cost (initial actions at the start of the response)*** 2. Collect, analyse, and utilize CEA-generated data to facilitate a two-way flow of information for improved seamless implementation.

	**Coordination and Partnerships**	**Budget**	**20,161 CHF**
		People targeted	N/A
Readiness activities:	1 National sEAP Dissemination to MoH/NPHI, WHO, partners and county directors -Conference Package for one day		
Prioritized Early Actions:	1. Lessons Learned workshop		

	**Secretariat Services**	**Budget**	**19,509 CHF**
		People targeted	N/A
Readiness activities:	1 HR Support		
Prioritized Early Actions:	Monitoring Financial Charges		

	National Society Strengthening	**Budget**	**62,805 CHF**
		People targeted	KRCS Volunteers

Indicator:	1. # of staff and volunteers supported by the project to necessitate the implementation and reporting 2. # of County Coordinators trained on the surge function of the VMMS	**Target:**	1. 3 PHiE Assistants (each assistant per targeted county) 2. At least 10 county coordinators drawn from PAMI counties.

Readiness activities:	***Routine readiness activities (Year 1)*** 1. Maintain rosters of trained volunteers/surge capacity on the VMMS for rapid deployment. 2. Provide administrative and technical guidance to inform prepositioning activities ***Year 1 to 2*** 3. Recruit and engage 4 KRCS staff to implement the sEAP. The staff will be responsible for implementation of all the thematic areas/sectors per county of deployment
Prepositioning activities:	N/A
Prioritized Early Actions:	2. Strengthen KRCS-MoH collaboration in the cholera early actions. 3. Generate daily and weekly SITREPs on the Early Actions. 4. The Sitreps shall be the overall Public Health in Emergencies sitrep comprising of all the thematic areas/sectors detailing implemented activities per sector. 5. Provide administrative and technical oversight of Early Action activities. 6. Provide insurance to deployed volunteers. 7. Conduct an sEAP lessons learned - After Action Review (AAR) workshop bringing onboard all the stakeholders (County and other partners – WHO, UNICEF etc. where applicable) – aimed at enhancing future activations by informing development of system strengthening documents such as SOPs etc based on the bottlenecks and best practices from the previous deployments/activations.

CONDITIONS TO DELIVER THE EARLY ACTION

Experience and/or capacity to implement the early actions

Courtesy of its auxiliary role, Kenya Red Cross Society has been a consistent partner to MoH in preparations and response to disease outbreaks and specifically to cholera outbreaks in Kenya. The NS played integral role in the previous outbreaks by supporting the national MOH and respective county departments of health, more significantly in the 2015, 2022 and the current 2025 outbreaks. The efforts have since enabled KRCS to have a guaranteed representation in the national cholera taskforce and technical working groups whenever an outbreak is reported. Through the support of IFRC via DREF, KRCS has supported the response in most of the routinely affected counties in the previous outbreaks i.e. 20 of 28 routinely affected counties.

Leveraging the seamless collaboration and coordination with the national and sub national health authorities, the NS has successfully in the past and presently supported in implementation of preparedness and response activities. Areas of focus have largely been Risk Communication and Community Engagement (RCCE), Surveillance (case investigations and active case search), water sanitation and hygiene (WASH), and infection prevention control (IPC), Case management (set up and management of CTC's) and seamless coordination mechanisms at both national and county level. As an outbreak response vaccination following the 2022-2023 outbreak, KRCS also supported the demand creation for Oral Cholera Vaccination (OCV) campaign in Kenya. The campaign was conducted in select counties based on prioritisation due to limited vaccine stocks that were available then.

To note also is that KRCS, since the 2023 El-Nino phenomenon, remains a critical partner to the Ministry of Health/National Public Health Institute at the Kenya Public Health Emergency Operations Center (KPHEOC) where KRCS routinely deploys technical volunteers through the public health in emergencies unit to support in public health events management (PHEM) coordination and consolidation of national epidemic SITREPs. In the past 2 years, KRCS has strategically invested in capacity building and prepositioning of KRCS volunteers and MoH community health promoters (CHPs) in epidemic prone counties in Kenya. This has resulted in the training of over 2,500 volunteers and CHPs on the IFRC EPiC module. This has enabled county teams to effectively respond to disease outbreaks including cholera in a timely manner. KRCS has trained 266 EPiC TOTs in 21 of 47 counties. The ToT's are drawn from MoH (national and county) and KRCS technical volunteers and staff. This is a critical resource in enabling the scale up of EPiC capacity in the country. Currently KRCS is in consultation with NPHI/MoH to adopt the EPiC module to the minimum training package of the MoH community health promoters and assistants. This is an area of great consideration during and for a successful roll out of the sEAP.

Scale down mechanism

Similar to during the activation, the scale down would be in phases and with high flexibility that would allow for upscaling in the event there are sudden changes in the situation. Based on the epidemiological data analyses outcome, and communication from national IMS, some of the activities may be scaled down or gradually stopped such as scale down of mobile ORPs up on reporting of zero cases within a span of 7 days. On the other hand, the sEAP may be escalated if the disease situation worsens

Stakeholders involved in the development of the sEAP and in Cholera Preparedness and Response.

No.	Key Actors	Mandate	Role
1	MOH (DDSR, NPHI)	The government's mandated institution for disease surveillance and response.	Chair of Technical Working Group Updating cholera risk profile. Provision of trigger information
2	World Health Organization	Provides technical assistance to countries, sets international health standards, collects data on global health issues, and serves as a forum	Participate in the development and review of sEAP for cholera Technical assistance to implementation

		for scientific or policy discussions related to health.	
3	UNICEF	Provide technical assistance on RCCE components	Participate in development and review of sEAP for cholera. Technical assistance on RCCE attributes of the protocol development, testing and validation.
4	Kenya Red Cross Society (KRCS)	Auxiliary to both the national and county governments in disaster and public health events management.	Implementation of the choleras AP.
5	Washington State University	Lead support organisation to the MoH on disease surveillance. They supported the development and running of m-dharura Event Based Surveillance (EBS) platform that is in use by 6 counties in Kenya	Provide technical assistance on disease surveillance systems development
6	Palladium Group Kenya	The lead health partner supporting MoH on Health Information System (HIS) including data collation and visualisation.	Provide technical assistance on digital health solutions.
7	Red Cross Climate Centre (RCCC)	To help the Red Cross and Red Crescent Movement and its partners reduce the impacts of climate change and extreme-weather events on vulnerable people.	Technical support in development, revision and operationalization of the EAP

Early Action Protocol Summary

EAPcode - Kenya Red Cross Society
Cholera

Operating Budget	Readiness	Pre-Pos Stock	Early Action	TOTAL
Planned Operations	**24,336**	**31,887**	**59,469**	**115,691**
Shelter and Basic Household Items	0	0	0	**0**
Livelihoods	0	0	0	**0**
Multi-purpose Cash	0	0	0	**0**
Health	12,540	22,334	17,225	**52,099**
Water, Sanitation & Hygiene	9,152	9,553	27,713	**46,418**
Protection, Gender and Inclusion	0	0	0	**0**
Education	0	0	0	**0**
Migration	0	0	0	**0**
Risk Red., Climate Adapt. and Recovery	0	0	0	**0**
Community Engagement and Accountability	2,644	0	14,531	**17,175**
Environmental Sustainability	0	0	0	**0**
Enabling Approaches	**52,795**	**807**	**48,873**	**102,476**
Coordination and Partnerships	605	0	19,556	**20,161**
Secretariat Services	9,082	0	10,427	**19,509**
National Society Strengthening	43,108	807	18,890	**62,805**
TOTAL BUDGET	**77,131**	**32,694**	**108,342**	**218,167**

all amounts in Swiss Francs (CHF)

Contact information

For further information, specifically related to this simplified EAP please contact:

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Annexes

Annex 1 – Cholera epidemiological trends and distribution since 1997.

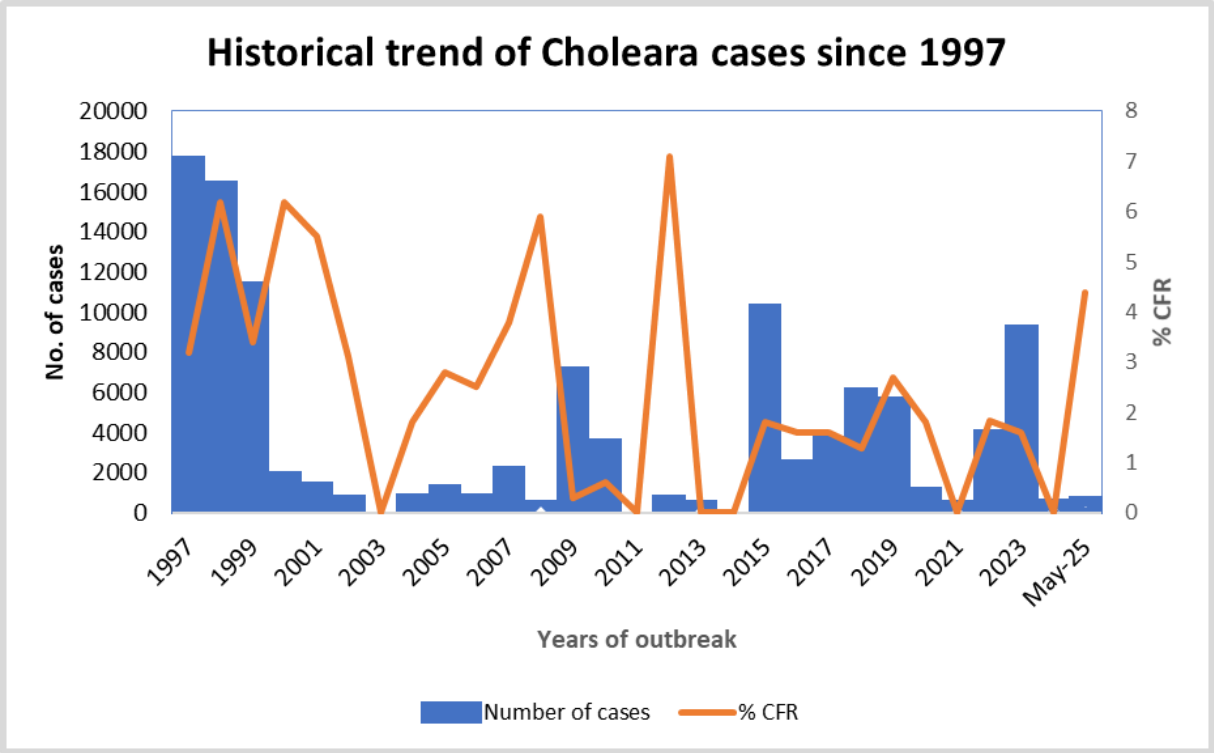

Figure 1: Annual cholera cases and case fatality rate in Kenya analysed for a period 1997 – 2025. Source MoH

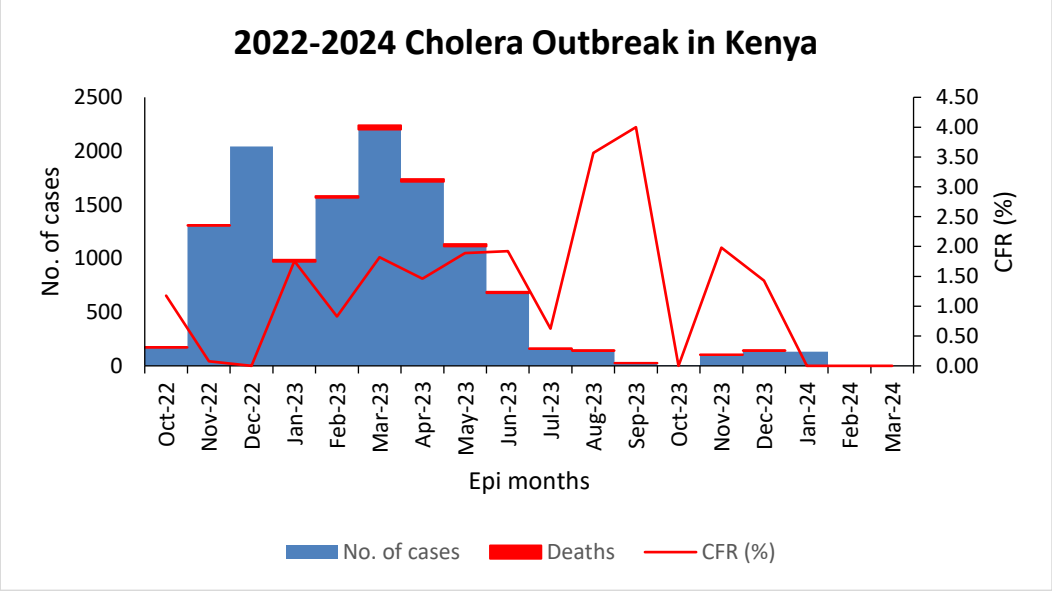

Figure 1a: Epicurve for the 2022-2024 cholera outbreak in Kenya. Source: MOH line list analysis

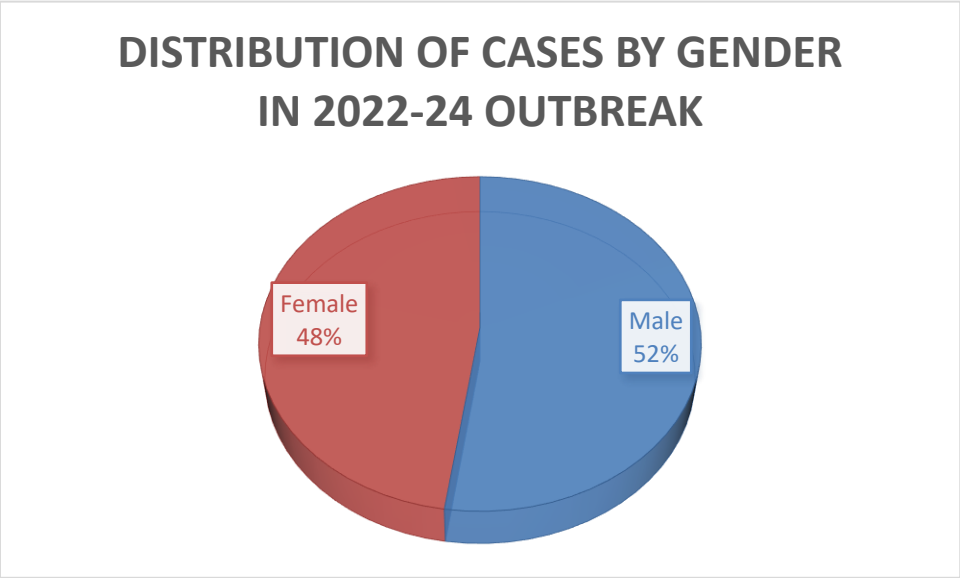

Figure 1b: Distribution of cases by gender for the 2022-2024 cholera outbreak in Kenya

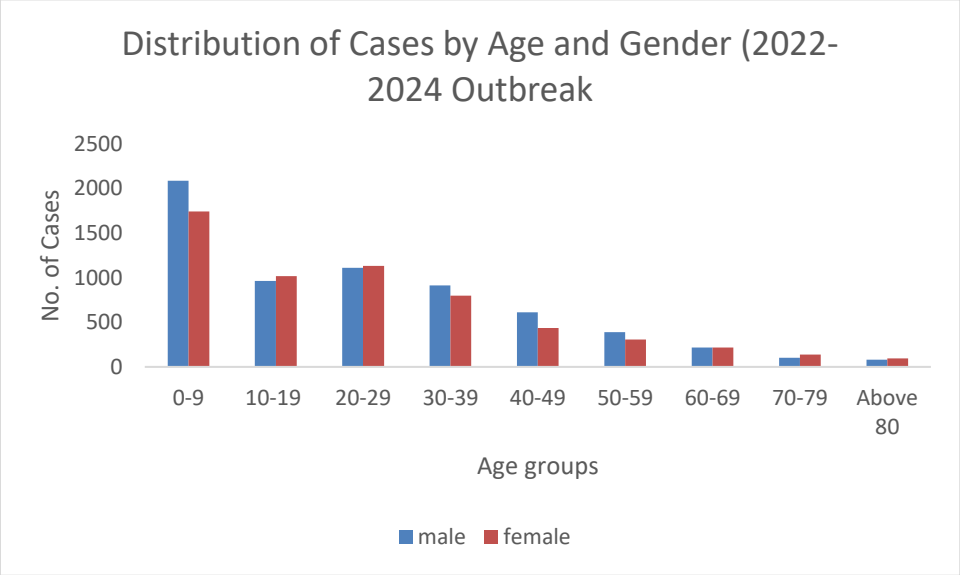

Figure 1c: Distribution of cases by gender and age groups for the 2022-2024 cholera outbreak in Kenya

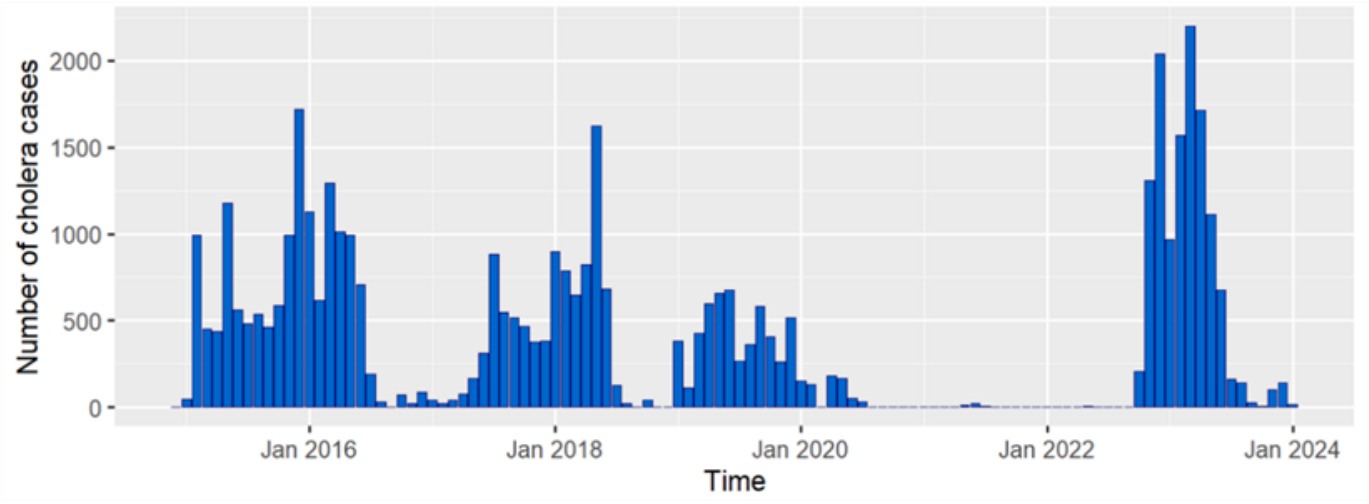

Figure 3: Monthly distribution of cholera reported Cases, Kenya, 2015-2023, source: MoH Division of Disease Surveillance and Response.

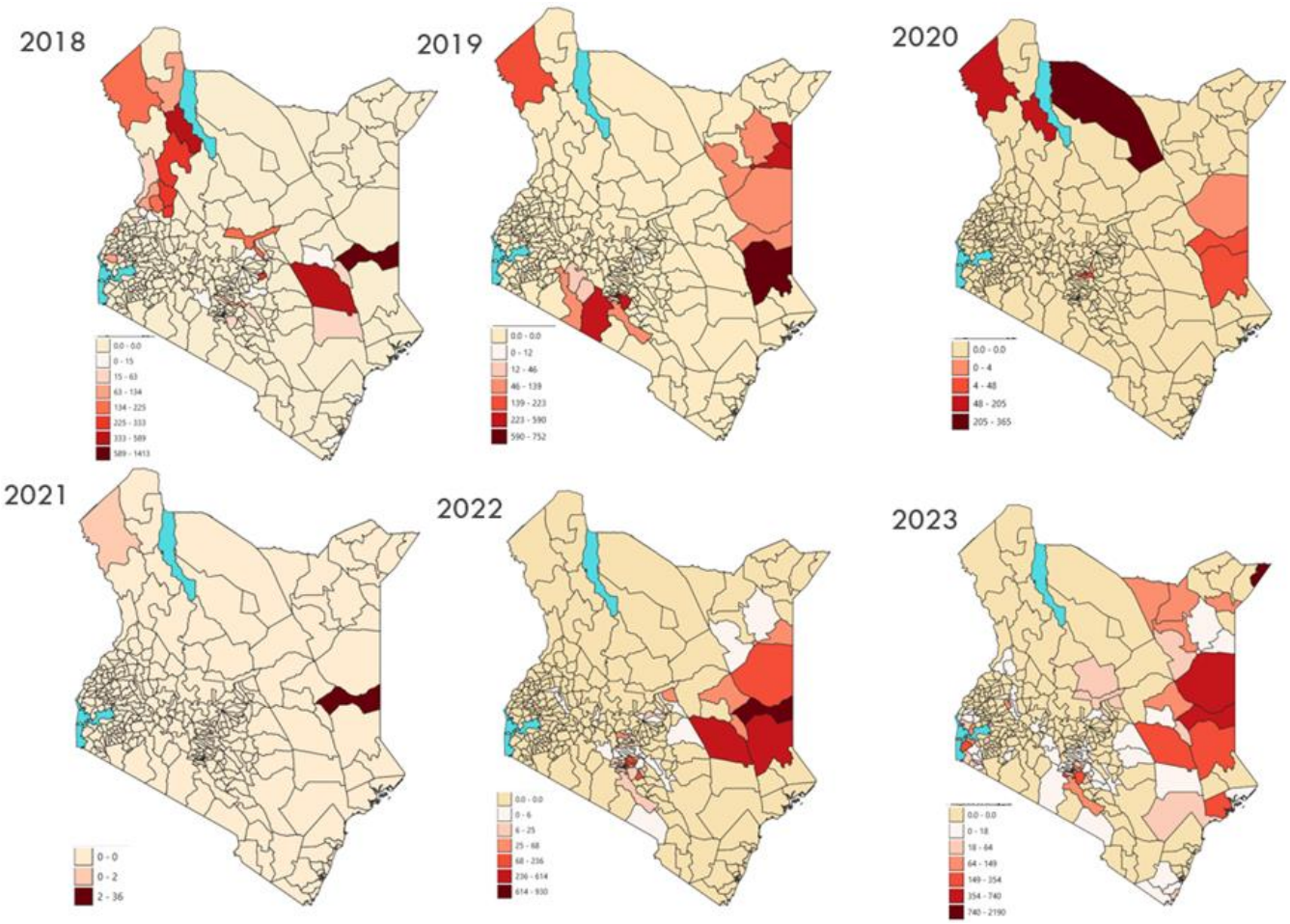

Figure 4: Distribution of the cholera cases per sub-county and per year, 2018-2023, Kenya. Source. MOH March 2024 PAMI report. (To note: the colour gradient is specific to each year)

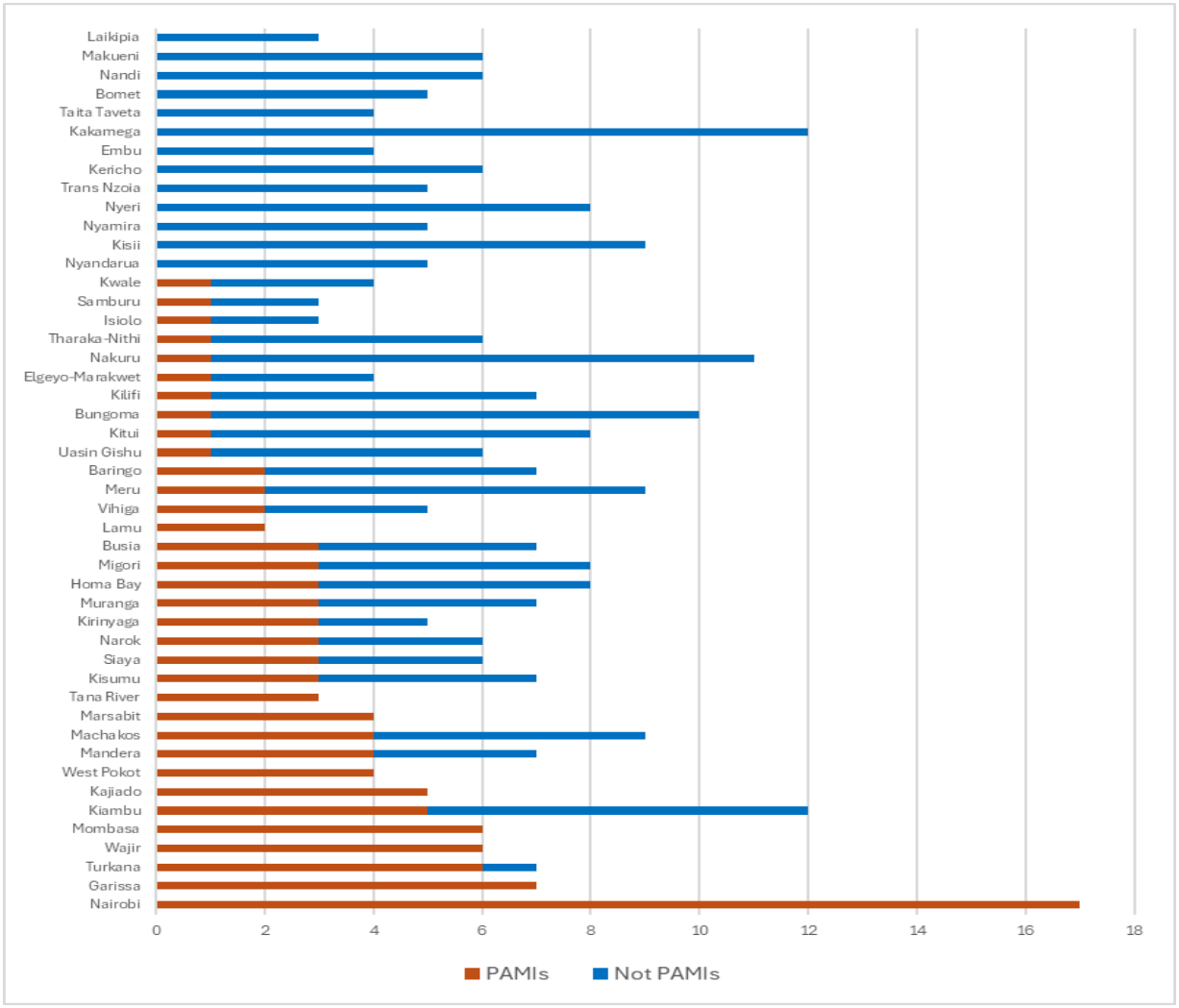

Figure 5. Distribution of the sub-counties by PAMI decision, stratified by county, Kenya 2024

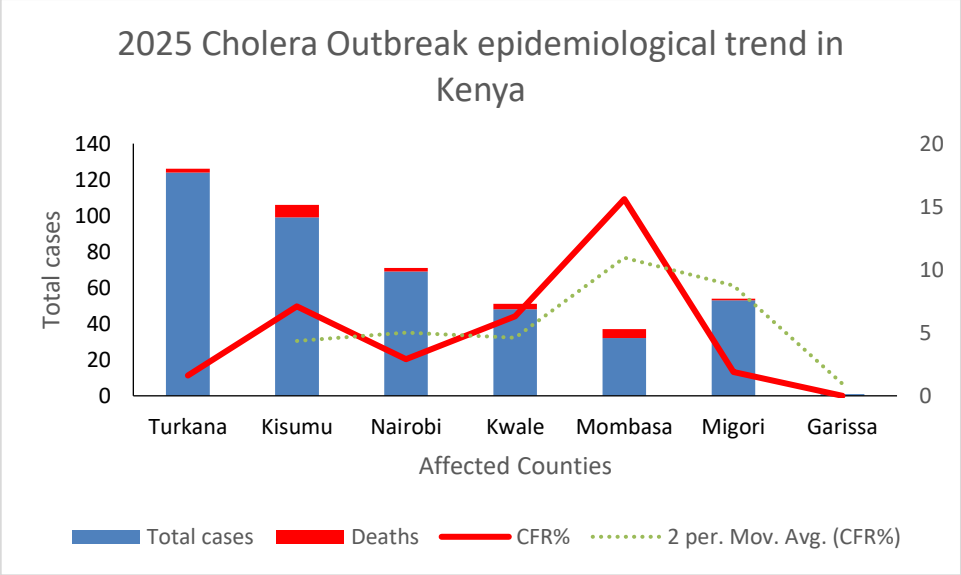

Figure 6. Epicurve for the 2025 cholera outbreak by county in Kenya. Source: MOH line list analysis

Annex 2: sEAP implementation modalities

KRCS Volunteers' Household coverage:

1. Proposed number of volunteers across the 3 target counties; *20x3 = 60pax jointly with 10CHPsx3 =30 CHPs.*
2. Days of deployment; approx. *14days* i.e. T2 - EAP lead time
3. Targeted population:
   1 volunteer per 5HHs (min. threshold) per day (Distribution of water treatment chemicals and sensitization).
   In 14 days = (14x5)/1 = 70HHs per volunteer; approx. – 70x5 = 350 community members per volunteer
   Therefore, for 20 volunteers per county for 14 days; 20x70 = 1,400HHs in 14days per county.
   Hence across the 3 targeted counties = 1,400x3 = 4,200HHs; 4,200x5 = 21,000 community members targeted by the sEAP.