DREF Operational Update

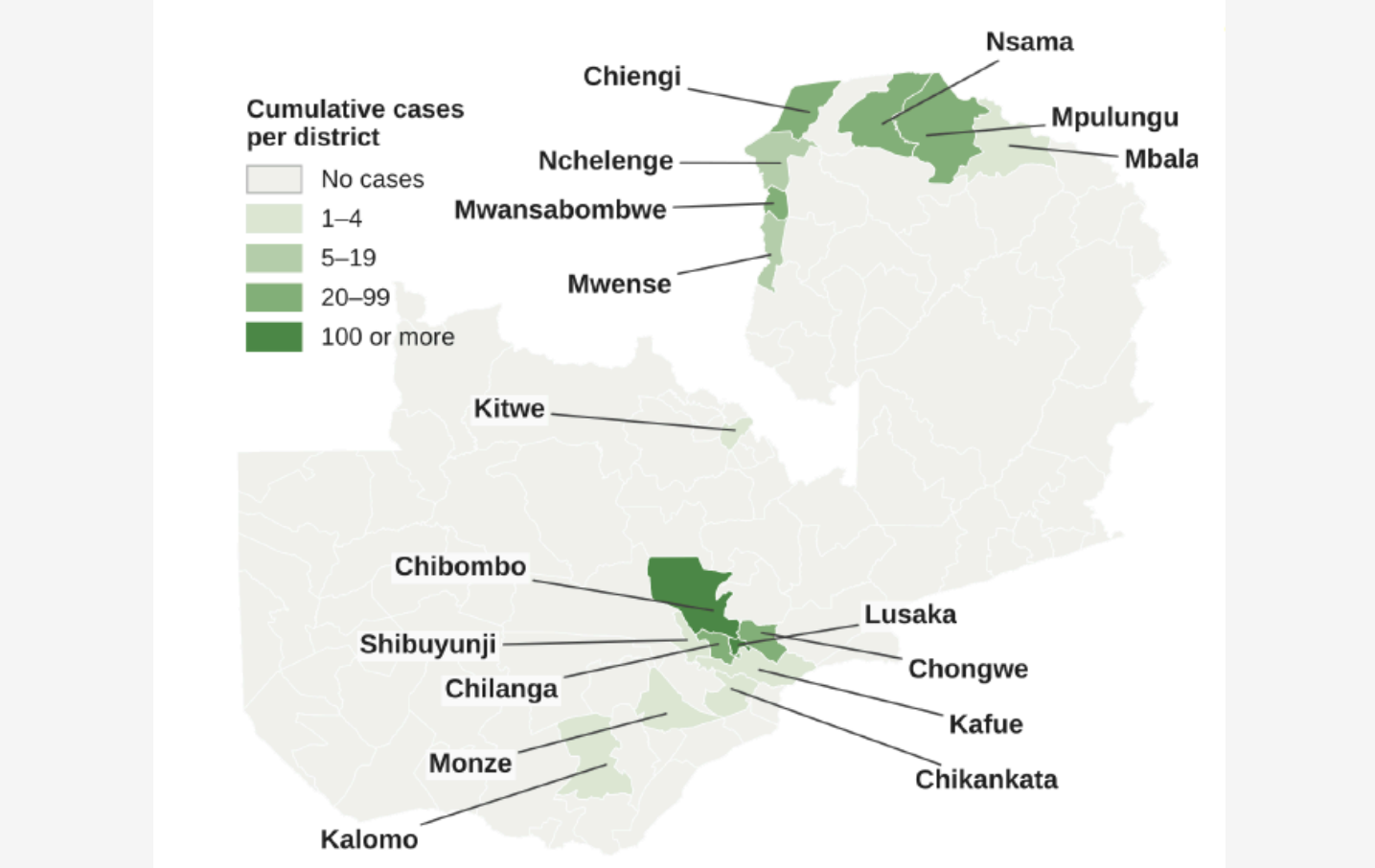
Zambia Cholera Readiness and Response 2026



ZRCS staff conducting hgyene awareness and distributing hygiene supplies

Appeal: **MDRZM027**	Total DREF Allocation: **CHF 338,170**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: -	People Affected: **2,903,105 people**	People Targeted: **2,902,523 people**	
Event Onset: **Slow**	Operation Start Date: **01-03-2026**	New Operational End Date: **31-12-2026**	Total Operating Timeframe: **9 months**
Reporting Timeframe Start Date: **01-03-2026**		Reporting Timeframe End Date: **30-09-2026**	
Additional Allocation Requested: **188,288**		Targeted Regions: **Central, Luapula, Lusaka, Northern**	

Description of the Event



Cholera Affected Districts in Zambia

Date when the trigger was met

29-09-2026

What happened, where and when?

Zambia has been experiencing the cholera outbreak since 15th 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 Chainda 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%.

With continued efforts and support from cooperating partners, the number of cases significantly dropped to the level that the government declared the outbreak over. However, a new case was detected on 13 August 2026 after Vibrio cholerae was laboratory-confirmed in a patient who had travelled from Chibombo District and was admitted at Apollo Mini Hospital in Lusaka.

Zambia Red Cross Society (ZRCS) concluded its interventions under the MDRZM027 response in August 2026, having supported cholera preparedness and response activities in Lusaka. However, a new cholera outbreak was detected on 13 August 2026, affecting Chiengi, Nsama, Chibombo, and other areas of Lusaka District that were not covered under the initial response. This renewed outbreak necessitated further preparedness and response interventions to address the evolving situation and support affected communities.

Subsequent transmission was identified in several districts: Chongwe, Chibombo, Lusaka, Chilanga, Chiengi and Nsama districts. By 29 September 2026, a total of 304 cholera cases had been reported nationally, including 62 laboratory-confirmed cases, 35 patients receiving treatment, 230 discharges and 11 deaths. Eight of the deaths occurred in the community and three in health facilities, highlighting concerns around delayed care-seeking.

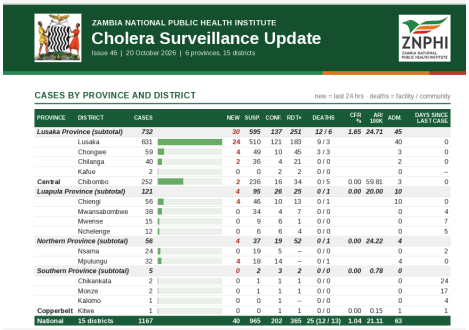
At present, outbreak is affecting Twelve districts across five provinces. In Lusaka Province (537 cases), affected areas include Lusaka, Chilanga and Chongwe districts. Central Province has recorded the second highest cases (221) in Chibombo District four community deaths, with the majority of cases reported from the Mwanjuni Health Facility catchment area around 10 Miles.

The outbreak has also affected Chiengi, Mwansabombwe, Mwense and Nchelenge District in Luapula Province, which has reported 105 cases, including one community death. Nsama and Mpulungu Districts in Northern Province have reported a combined total 42 cases, while Southern Province has reported four cases (Chikankata-2 and Monze-2).

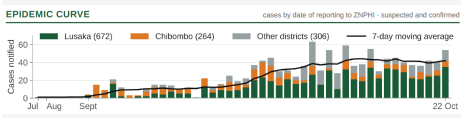
As of 15th October 2026, cumulatively, 966 cases have been recorded with 25 deaths across the Twelve (12) Districts in Five (5) Provinces with a CFR of 1.59 %.



ZRCS Teams conducting hygene awareness



Cholera SitRep



EPI Curve

Scope and Scale

The current cholera outbreak in Zambia poses a significant public health threat, with potential negative impacts on human lives, livelihoods, community well-being and essential health services.
The outbreak is likely to increase demand for health services, including cholera treatment, oral rehydration, laboratory testing, surveillance and emergency response. Health facilities in affected districts may experience pressure on staff, medical supplies, treatment space, transport and other essential resources.
At community level the disease is associated stigma which can lead to delays in seeking medical care and ultimately death as can be deduced in the current trends where about 13/25 deaths occurring in the community. Continued transmission may also divert health workers and resources from routine services, including maternal and child health, immunisation and other essential healthcare.

The most vulnerable populations are likely to include children under five, older persons, people with disabilities, people with underlying health conditions, and households with limited access to safe water, sanitation and healthcare. Children are particularly vulnerable to dehydration and severe illness, while older persons and people with disabilities may face additional barriers in accessing treatment, safe water and sanitation facilities. Low-income households, residents of informal and densely populated settlements, and communities relying on shallow wells or other potentially contaminated water sources are also at increased risk.

In the affected district, vulnerability is likely to be higher in densely populated peri-urban communities where sanitation challenges and pressure on water infrastructure may facilitate transmission and affected households may require targeted support to improve access to safe water, hygiene information and timely treatment.

The outbreak may also affect livelihoods and household well-being. Families may incur additional costs for transport, treatment-related needs, caregiving, safe water and hygiene supplies, while illness among household members can reduce their ability to work, attend school or engage in income-generating activities. Caregivers may have to leave work to look after sick relatives, while affected small businesses and food vendors may experience reduced activity due to concerns about infection and public health restrictions or precautions. Stigma and discrimination against affected individuals and households may further undermine social support and discourage people from seeking care or reporting symptoms.
Historical experience demonstrates that cholera can cause substantial public health and socioeconomic impacts in Zambia.

Source Information

Source Name	Source Link
1. Cholera Surveillance Update-Zambia	https://zambiaredcrosssociety.sharepoint.com/:b:/s/DATARESPOSITORY/IQCxOQv6KO54SZCY0PcOf0B5AXDnjKICYOvnmonnRMT706I?e=wuWTUY

Summary of Changes

Are you changing the timeframe of the operation	**Yes**
Are you changing the operational strategy	**Yes**
Are you changing the target population of the operation	**Yes**
Are you changing the geographical location	**Yes**
Are you making changes to the budget	**Yes**
Are you requesting an additional allocation?	**Yes**

Please explain the summary of changes and justification:

Zambia RC wrapped up interventions under this MDRZM027 response in August 2026 supporting readiness and response activities in Lusaka. However, in August Zambia experiences another cholera outbreak, with the current outbreak initially detected on 13 August 2026 after Vibrio cholerae was laboratory-confirmed in a patient who had travelled from Chibombo District and was admitted at Apollo Mini Hospital in Lusaka.
Subsequent transmission was identified in several districts. The current cholera outbreak in Zambia poses a significant public health threat, with potential negative impacts on human lives, livelihoods, community well-being and essential health services. It has continued to evolve, with sustained transmission and geographical expansion beyond the districts and provinces initially prioritised for interventions. The changing epidemiological situation has significantly increased the scale and complexity of the response, necessitating a review of the original intervention scope to accommodate emerging needs and address the growing public health threat.

As of 15 October 2026, the outbreak had spread to four other provinces—Central, Luapula, Northern and Southern including Lusaka —affecting a total of twelve (12) districts, with cumulative reported cases reaching 966 and 25 deaths since 13th August,2026. This geographical expansion indicates that the outbreak has progressed beyond the initially anticipated areas of concern, placing additional demands on existing public health surveillance, case detection, response coordination and community-level prevention and control mechanisms.

This evolving situation underscores the need to strengthen surveillance and early warning systems, intensify Risk Communication and Community Engagement (RCCE), Case-Management （training of volunteers in ORP management） enhance community-based prevention measures, and reinforce coordination between relevant health authorities, local structures and humanitarian partners. Without timely and adequately resourced interventions, the continued spread of the outbreak may further strain available response capacities and increase the risk of additional cases and associated public health consequences.

In view of these developments, the original application requires expansion to reflect the current epidemiological situation, the increased geographical coverage and the additional response needs arising from the outbreak's progression. Additional support would enable the implementation of targeted interventions in the newly affected districts, complement ongoing government-led response efforts, and strengthen community preparedness and response capacities in areas at risk of further transmission.

We therefore seek the donor’s consideration and support for an expanded response that is responsive to the changing outbreak dynamics and aligned with the evolving needs of affected populations. This support will be critical in facilitating timely, coordinated interventions, limiting further transmission, reducing the public health impact of the outbreak, and contributing to the protection of vulnerable communities

IFRC Network Actions Related To The Current Event

Secretariat	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. 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.

	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. 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 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.
Participating National Societies	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. The trained volunteers have since been deployed to support ongoing preparedness and response activities, including hygiene promotion and community sensitization in at-risk areas. 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. 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.

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

Government has requested international assistance	Yes

National authorities	Ministry of Health, together with Zambia National Public Health Institute (ZNPHI), is supporting the Provinces and Districts Health teams in Northern, Muchinga, Lusaka and Southern, Western Provinces through: • Activation of the District Public Health Emergency Operation Centers and Incident Management System. • Activation of the District Epidemic Preparedness, prevention Control, and Management Committee meetings. • Intensified surveillance activities, including risk assessment, outbreak investigation, active case search, community surveillance, and contact tracing. • Data Management-deployment of Cholera tracker/EIMS. • Enhanced Risk Communication and Community sensitization, activities. • Advocacy and stakeholder engagement. • Isolation, Case management, and IPC • National and provincial teams deployed to support district responses. • Cleaning of public places and promotion of hygiene practices. • Provision of chlorine in affected communities, • Early detection of cholera cases through Community-Based Surveillance (CBS)/Event-Based Surveillance (EBS)/active case finding systems. • The Ministry of Health has intensified surveillance, conducted contact tracing, chlorinated water sources, and disinfected affected homes.
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

Health

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 and 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.

7. Inadequate access to safe drinking water, unsafe water storage, poor sanitation, and inconsistent handwashing practices can increase the risk of transmission. The extent of these gaps may differ between fishing communities in Chiengi and Nsama and communities in Chibombo and Lusaka.

8. In Chiengi District, there is a need to strengthen community surveillance, health promotion and referral of suspected cholera cases, particularly in affected communities that may face challenges accessing health facilities. In Nsama District, the response needs to reinforce early recognition of cholera symptoms, prompt care-seeking and community-level prevention, with ORP locations prioritised according to reported cases and access to health services. In Chibombo District, the Mwanjuni Health Facility catchment around 10 Miles has been identified as an area of concern, with reported community deaths highlighting the importance of timely treatment-seeking and effective referral. In Lusaka District, the renewed outbreak has affected areas outside the initial response coverage, necessitating the identification of uncovered wards and health-facility catchments.



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.

Access to safe water water in districts like Nsama, Chiengi and Chimbombo has contributed to the current Cholera outbreaks.



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.

The other gaps identified relate to Community Engagement and Accountability (CEA), particularly in Chiengi and Nsama districts, where communities are not being fully engaged in cholera prevention and response activities. There are gaps in collecting and documenting community feedback, as well as ensuring that community concerns and identified needs are addressed in a timely manner. These gaps may limit community participation, reduce trust in response interventions and hinder the timely identification of rumours, misinformation and barriers to accessing essential services.

Operational Strategy

Overall objective of the operation

The DREF operation aims to support Cholera response 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 indirectly reach over 2.9m people (648,000 to be reached directly and 2,144,000 indirectly) during an operational time frame of up to December 2026 for nine months from March 2026.

Operation strategy rationale

The initial response was providing readiness actions and response interventions in Lusaka upto August 2026. However, this operations update seeks to scale up operations to three additional districts.

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 will extend from Lusaka, to Luapula, Central and Northern Provinces as considered high-risk areas with an increasing case load and in need of response support.

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, impactful and necessary response aligned with national cholera control efforts.

The operational strategy for response to the cholera outbreak in Zambia is designed to directly address identified gaps in human resources, community surveillance, case management capacity, IPC/WASH standards, and risk communication and community engagement. 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.

In addition to the 100 volunteers involved in the initial operation, the strategy prioritizes strengthening community-based surveillance and early case detection through the recruitment and training of 150 Community-Based Volunteers (CBVs) across the four districts (Chiengi -30, Nsama - 30, Chibombo - 40 and Lusaka - 50). Given the high population density and transmission risk, all new 150 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 108,000 households in addition to the 41,343 that were reached between March and August 2026. The National Society (NS) will support the establishment of 20 Oral Rehydration Points (ORPs) in districts based on reported cholera cases and local needs. This intervention will promote early identification and management of dehydration, facilitate timely referral of severe cases, reduce preventable deaths at the community level, and improve treatment outcomes among affected populations.

The National Society (NS) will also support community mobilisation activities before, during, and after the Oral Cholera Vaccine (OCV) campaigns where ZNPHI has mobilized 700,000 doses and the vaccination has started in Lusaka and Chibombo which will rolled to Nsama, Chiengi as soon as the procured vaccines are in country. These activities will focus on raising awareness, addressing community concerns and misinformation, promoting vaccine acceptance, and encouraging eligible populations to participate in the vaccination campaigns.

The National Society will deploy 2 NDRTs to support implementation in far flanked areas such as Chiengi and Nsama Districts. This will facilitate coordination and timely implementation as these districts are over 1,200Km from Lusaka.

To address gaps in timely treatment and overstretched health facilities, the operation will establish 20 community ORPs across the affected districts. These ORPs 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. • According to the standard adopted by Zambia Ministry of Health, ORP is managed by 4 volunteers and 2 healthcare workers. Each shift comprises 2 volunteers and 1 healthcare worker. Overall, we will engage volunteers as needed for ORPs and 30 healthcare workers to manage the 20 ORPs.

Recognizing persistent gaps in behaviour change and hygiene practices, the strategy includes an intensified RCCE campaign. Each of the 150 trained CBV will conduct at least 12 household visits per day for 20 days, 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.

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 next 3 months of implementation period, the operation aims to reach approximately 2.9m people across the target districts, significantly improving 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 Swedish Red Cross is supporting Zambia Red Cross Society in developing a Simplified Early Action Protocol (sEAP) 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 multi-year 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 2.9m people residing in cholera-affected and high-risk communities across the affected districts. This operation will directly reach 108,000 HHs (43,200 in Lusaka, 28,080 in Chibombo and 18,360 in Chiengi and 18,360 in Nsama). This is representing 648,000 people, with 2,000 to be reached through ORPs. Meanwhile, 2,144,000 people will be reached indirectly through radio and public address system.

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 vulnerable areas with high cases, high attack rates, population density, unsafe water sources, poor sanitation coverage, and limited access to timely health services.

The primary target 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.

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	**858,158**	Rural	**18%**
Girls (under 18)	**595,717**	Urban	**82%**
Men	**841,029**	People with disabilities (estimated)	**5%**
Boys (under 18)	**607,619**		
Total targeted population	2,902,523		

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
The country is projected to experience extreme weather conditions associated with the anticipated El Niño phenomenon, which may result in below-normal rainfall and disruptions to the usual rainfall patterns. These conditions could compromise the availability and reliability of safe and adequate water supplies for domestic use and personal hygiene, potentially exacerbating the risk of cholera transmission and further spread of the disease. Inadequate Water Supply an effect on Hygiene Practices Reduced water availability may significantly undermine personal and environmental hygiene practices, including handwashing, safe food handling, household sanitation and the cleaning of contaminated surfaces. These challenges could increase communities' vulnerability to cholera and other waterborne diseases, particularly in areas already experiencing inadequate water supply and sanitation services. Increased reliance on unsafe water sources Prolonged water shortages and potential failures of existing water supply systems may compel affected communities to seek alternative sources, including shallow wells and other potentially contaminated water points. Reliance on untreated or unsafe water sources could increase exposure to Vibrio cholerae, the bacterium responsible for cholera, thereby heightening the risk of infection and facilitating further transmission within affected communities. Food insecurity and competing household priorities The anticipated effects of El Niño on agricultural production and food availability may further exacerbate household vulnerability through increased food insecurity and financial constraints. As families struggle to meet competing basic needs, they may be forced to ration water consumption or prioritise food purchases over other essential household requirements, including water treatment products and hygiene supplies. Such coping mechanisms could compromise access to safe drinking water and adherence to recommended hygiene practices, further increasing the risk of cholera transmission. Collectively, these anticipated climatic and socioeconomic pressures highlight the need for proactive, integrated interventions to strengthen water security, promote household water treatment and safe storage, reinforce hygiene promotion, and enhance community preparedness. Timely support will be essential to mitigate climate-related public health risks, protect vulnerable populations and prevent further transmission of cholera.	Preposition water treatment supplies; Chlorine. Strengthen hygiene promotion activities by volunteers. Support communities with hygiene kits Distribution of chlorine.
Has the child safeguarding risk analysis assessment been completed?	**Yes**

Planned Intervention

Health

Budget: CHF 113,990
Targeted Persons: 2,902,523
Targeted Male: 1,448,648
Targeted Female: 1,453,875

Indicators

Title	Target	Actual
# of volunteers trained on RCCE, CEA, PGI, PSS CBS/EBS and ORP Level	250	100
% of trained volunteers demonstrating improved knowledge (post-test vs pre-test)	80	60
# of volunteers trained on ORP management	40	0
# of MoH staff trained on ORP management	20	0
# of ORPs supported with trained personnel	20	0
# of radio call-in programs conducted (2 per district for 3 months)	20	9
# of estimated listeners reached through radio	2,900,000	2,500,000
# of rapid needs assessments conducted	4	1
# of households reached through door-to-door visits	108,000	41,343
% Increase in community-based early alerts reported to district health offices	60	25
# number of people accessing ORPs	2,000	0
% of volunteers reporting into the CBS system (HF)	100	0
# of alerts investigated within 24hrs	100	0
# of confirmed cases detected via CBS	-	0
# of people reached with OCV	6,540	0

Progress Towards Outcome

100 volunteers were trained in integrated cholera response package (RCCE<CBS, CEA, PGI MHPSS and ORP) and were able to conduct door to door sensitization activities for 30 day reaching out to 41,343 households translating to 206,715 people with key cholera messages. 40 ORPs were supported with registers to enhance information management system at the facilities.

40% of the trained volunteers demonstrated improved knowledge by correctly providing the key messages during and after the training as well during community sensitizations.

9 radio sensitization programmes were conducted on the National Broadcasting cooperation with national wide coverage hence reaching to 2,500,000 people.

Conducted needs assessment in one district (Lusaka). The findings were that communities were faced with challenges of inadequate water supply and poor sanitation.

Water, Sanitation And Hygiene

Budget: CHF 50,536
Targeted Persons: 2,902,523
Targeted Male: 1,448,648
Targeted Female: 1,453,875

Indicators

Title	Target	Actual
# of Environmental Health Technicians (EHTs) oriented in water quality monitoring using Aquagenx	40	18
# of water samples tested in targeted communities	200	139
# of Liquid chlorine distributed	16,000	7,500
# of water testing kits procured	300	200

Progress Towards Outcome

7,500 bottles of chlorine were procured and distributed to the respective communities. With this support ZRCS managed to support the affected districts with training of officers (18) in water quality monitoring and subsequently conducted water sampling collecting about 139 samples across the 3 districts having supported with 200 testing kits.

Protection, Gender And Inclusion

Budget: CHF 16,134
Targeted Persons: 67,500
Targeted Male: 1,448,648
Targeted Female: 1,453,875

Indicators

Title	Target	Actual
# of volunteers and MoH staff oriented on PGI	250	100
# of SGBV referral pathways mapped and disseminated.	5	5
% increase in identified SGBV, child protection, and disability-related cases appropriately referred through established pathways.	80	40
% of districts with updated SGBV referral pathways mapped and validated.	100	25
# of child safeguarding risk analyses conducted	4	1
# of volunteers demonstrating knowledge on PGI	250	100

Progress Towards Outcome

The 100 volunteers recruited under the project received capacity building in PGI.

13 meetings integrated with CEA were conducted with key stakeholders in Chilanga, Chongwe and Chawama sub-district in Lusaka. And one district level meeting for government and non-governmental partners was held in Chongwe District.

5 referral pathways were identified used in Lusaka including; police, health facility, one stop centre, Toll free line, safe homes.

Conducted 1 child safeguarding risk analysis.



Community Engagement And Accountability

Budget: CHF 26,285
Targeted Persons: 2,902,523
Targeted Male: 1,448,648
Targeted Female: 1,453,875

Indicators

Title	Target	Actual
# of community entry meetings conducted	35	13
% of operational days the toll-free feedback line is functional and accessible to communities	100	100
% of community feedback received analysed, and resolved.	100	89

# of staff and volunteers oriented on ESPO (CEA feedback data management system).	35	21
# of focus Group Discussions conducted	100	58

Progress Towards Outcome

13 community meetings were conducted in Lusaka district with a reach of 410 attendees (119 women and 211 men). And a total of 560 people (352-men and 208-women) were reached through the 58-focus Group Discussion conducted; discussion aimed at getting community insights on persistent risky behaviours such as delayed seeking of medical care that characterize cholera community deaths, continued drinking of unchlorinated water and unsafe excreta disposal practices.

89% of the feedback received was analysed and closed accordingly
The support enabled the NS to orient 21 volunteers and staff were oriented on ESPO.

Coordination And Partnerships

Budget: CHF 33,636
Targeted Persons: 350
Targeted Male: 168
Targeted Female: 182

Indicators

Title	Target	Actual
# of scheduled coordination, IMS (national, provincial, district), and cluster meetings (Health, WASH, RCCE) attended and/or supported	15	7

Progress Towards Outcome

The NS continued to attend the National and sub-national coordination meetings in the respective clusters (4).
The NS and IFRC cluster had scheduled bi-weekly (3) meetings for updates, coordination aimed at performance improvement.

1. Early and continuous community sensitisation: Building on lessons from the cholera response, ZRCS has integrated ongoing community sensitisation into the current DREF activities. Volunteers disseminate key health, hygiene and sanitation messages to affected households to promote positive practices and reduce the risk of disease outbreaks in displacement settings.
2. Strengthened real-time feedback and evidence-based decision-making: ZRCS has incorporated community feedback mechanisms into the current DREF to capture concerns, needs and feedback from affected populations. The information gathered supports the identification of emerging issues and informs operational decisions and adjustments during implementation.
3. Sharing feedback with stakeholders: Feedback from affected communities is shared with relevant stakeholders to support joint decision-making, improve coordination and ensure that response activities remain responsive to the needs and priorities of affected households.
4. Inclusion of people with disabilities and other vulnerable groups: ZRCS has continued to promote the participation of people with disabilities and other vulnerable groups in consultations and feedback processes under the current DREF. This helps ensure that their specific needs, protection concerns and barriers to accessing humanitarian assistance are considered during response planning and implementation.

Overall lesson adopted: The current Cholera DREF demonstrates ZRCS's continued application of lessons from the cholera response by strengthening volunteer engagement, maintaining continuous community sensitisation, using feedback to inform operational decisions, promoting stakeholder coordination, and supporting inclusive humanitarian assistance.

Secretariat Services

Budget: CHF 21,594
Targeted Persons: 10
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of IFRC CCD monitoring visits conducted and field reports shared	5	3
Kick off meetings held within 7 days of DREF approval	4	1

Progress Towards Outcome

The Cluster office continued to support the NS through Bi-weekly meetings as well as onsite visits (3) conducted (one from PMER and 2 from finance).
One kick off meeting was conducted in Lusaka.

National Society Strengthening

Budget: CHF 75,996
Targeted Persons: 297
Targeted Male: 161
Targeted Female: 136

Indicators

Title	Target	Actual
# of branch leadership members oriented on disaster response	50	26

Progress Towards Outcome

One branch (Chongwe) received capacity building of 26 volunteers in Branch operation. All the 100 volunteers that were initially recruited were insured under the IFRC insurance policy cover.

About Support Services

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

A total of 297 personnel will be engaged in this operation, including 7 ZRCS staff members and 250 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 Oral rehydration points (ORPs), 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.

Contact Information

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

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Click here for the reference